

**State of New Mexico
Children, Youth and Families Department**



New Mexico Infant Team MANUAL

Developed by:
Jane Clarke, PhD, IMH-E®IV
and
Deborah Harris, LISW, IMH-E®IV

*Dedicated to
Julie Larrieu, Neil Boris, Soledad Martinez, and Charlie Zeanah
Wise Mentors and Gentle Guides*

Contents

<i>Preface</i>	7
Chapter 1 - Overview of New Mexico Infant Teams	8
CYFD – Behavioral Health, Pull Together and Pyramid Partnership	8
Initiatives and Pyramid Offerings	9
New Mexico Infant Mental Health Teams	12
What a New Mexico Infant Team (NM-IT) Does	13
New Mexico Infant Team Logic Model	14
Chapter 2 - Justification for New Mexico Infant Teams	15
Introduction	15
Justification	16
Safety and Memory	16
Reflective Functioning	17
Timing of Supports	17
Principles of IMH Practice	17-19
Treatment Services	19
Referrals	19
Key Points to Know	19-21
References	22-23
Chapter 3 - Goals, Procedures and Building an Infant Team	24
Goal	24
Outcomes	24
Four Main Considerations	25
Core Service Components	25
Procedure	25-29
Results of NM-ITs and Collaborative Work	29-30
References	30
New Mexico Infant Team Assessment/Intervention Protocol	31-33
Chapter 4 - Principles, Getting Started, Possible Roles and Questions about Roles on Infant Team	34
Principles of Service Delivery	34-35
Getting Started	35-38
Example of Infant Team Role Descriptions	38-39
Questions about Infant Team Roles	39-45

Chapter 5 - Parent Infant Psychotherapy Services	46
Child Parent Psychotherapy as a Treatment Approach	46
The Tulane Infant Team Model	47
Special Features of NM-IT Services	48
NM-IT Services	49
Visitations and NM-IT Services for Infants/Young Children	50
NM-IT Interventions	51
Reflective Supervision/Reflective Consultation	52
References	53
Chapter 6 -Developmental Assessment and Intervention Considerations	54
Principles of Assessment	54
Factors that may Compromise Development	55
Importance of Shared Engagement and Attention	55
Dynamic Approach	56
DIR-Functional Emotional Developmental Levels (FEDL)	56-57
Developmental Capacities and Domains	57
Competency Domain Rating Summary Table (DC:0-5)	58
Infant's/Young Child's Contributions to the Relationship (DC:0-5)	59
References	60
Chapter 7 - Examples of Referral Process and Forms	61
New Mexico Infant Teams: Example of Referral Process and Services	61
Example of New Mexico Infant Team Referral Protocol	62
Example of CAPTA Referral Form	63
Example of New Mexico Infant Team Referral	64
Chapter 8 - Examples of Memorandums of Understanding with CYFD and the FIT Part-C Program	65
Memorandum of Agreement with Child Protective Services (CPS)	65-67
Memorandum of Agreement with Family Infant Toddler (FIT) Part-C Program	68-70
Chapter 9 - Examples of Treatment Goals and Tulane's Assessment of Progress	71
New Mexico Infant Team Treatment Goals and Objectives	71-73

Chapter 10 - Case Formulation, Documentation and Written Reports	74
Case Formulation	74
Documentation	74-75
Written Reports	75-76
Chapter 11 - Expert Testimony Guidelines and Monthly Provider Update Form	77
Expert Testimony in Juvenile Court	77
General Rules and Tips on Testifying	79
Cross Examination: General Rules and Tips	79
Trial Skills: General Guidelines for all Witnesses	80
Examples of Hearsay Rule Exceptions in Testimony	81
New Mexico Infant Team Monthly Provider Update Form	82
Chapter 12 – Infant Mental Health, Child Protective Services, Legal and FIT	83
Early Intervention Glossary of Terms	
Glossary of Terms A-Z	83-99
References	99-100
<i>Appendices</i>	
Appendix One – Forms, Assessment Tools and Instruments	101
Flow of Tools and Instruments	101
Data Input Flow Chart	102
Assessments - Periodicity	103
Appendix Two – Decision Trees	104
Example of Tiered Approach for Intensity of Services	104
New Mexico Infant Teams: Level of Engagement	105
New Mexico Infant Teams: Track Recidivism and Permanency	106
New Mexico Infant Teams: CAPTA Referral Process	106
New Mexico Infant Teams: Working with Substance Abusing Parents	107
New Mexico Infant Teams: Working with Bio-Parents with a History of Domestic Violence	108
Circle of Security—Questions for Parents	109

Appendix Three – References and Articles on IMH	110
References on Infant Mental Health	110-114
Being In Relationship: Opportunities for Change in Foster Care	115-120
A Guide to Practical Interventions to Help Children Affected by Trauma	121-152
The Foundations of Lifelong Health are Built in Early Childhood	153-182
The Role of Healthy Relational Interactions in Buffering the Impact of Childhood Trauma	183-200
Trauma-Informed Part-C Early Intervention	201-211
NCTSN Testifying in Court about Trauma: The Court Hearing	212-218

Preface

The vision and intention of the original New Mexico Infant Team (NM-IT), called the First Judicial District Infant Team established in 2009, was to design a community collaboration for infants and toddlers in state custody that integrated infant mental health principles and mental health treatment, with developmental assessments and interventions. This unified approach would be the cornerstone for partnering with Child Protective Services (CPS), Family Infant Toddler (FIT) Part C Program, attorneys, the Judge, CASAs, GALs, Substance Abuse treatment providers, Domestic Violence treatment providers, medical and other essential services that support the best interest of the infant/toddler and family through the judicial process.

To implement this vision, we set about articulating the goals and the “deliverables” from the NM IT in clearly stated memorandums of understanding (MOUs) with primary stakeholders (CPS, FIT Part C providers). Through meetings and dialogues with primary stakeholders, these MOUs delineated the: 1) primary focus of our work, 2) the research supporting our work, 3) the intention of our interventions and recommendations, and 4) our commitment to provide our services as stated. As a result, CPS and the FIT Part-C Program delineated specific workers as members of the team to expedite referrals and the provision of services to infants/toddlers in state custody and their families.

As subsequent NM ITs were formed in other judicial districts around the state, the partnerships and MOUs between the local CPS department and the FIT Part C Program as well as the collaboration with the legal community and other key partners, has varied depending upon the community resources and operations of the local judicial system. However, each NM IT strives to maintain open communication and collaboration with all involved in the welfare of an infant/toddler in state custody and his/her family.

A major role of the NM ITs has been to provide ongoing psychoeducation in addition to court reports to help all in the judicial process understand and recognize the relational and social-emotional needs of infants/toddlers throughout the reunification and permanency process. Most importantly, NM ITs want the Judge, and others involved in decision-making to consider:

1. Why the period of birth to three is so important for brain development and relationship security,
2. The impact of trauma and stress on the developing brain,
3. The individual needs of an infant/toddler who has experienced abuse or neglect, and
4. The protective capacities of the caregiver.

As New Mexico Infant Teams (NM ITs) have been formed in judicial districts statewide, there has been a corresponding and essential growth connecting providers serving infants and young children funded through the CYFD Behavioral Health Division. This manual will describe these connections along with the training and skills required of members of the NM ITs. Through the efforts of NM ITs statewide along with community collaborators, we are confident that the special needs of infants/toddlers and families in the child welfare system, are being addressed to receive the best support possible.

—Deb and Jane

CHAPTER 1

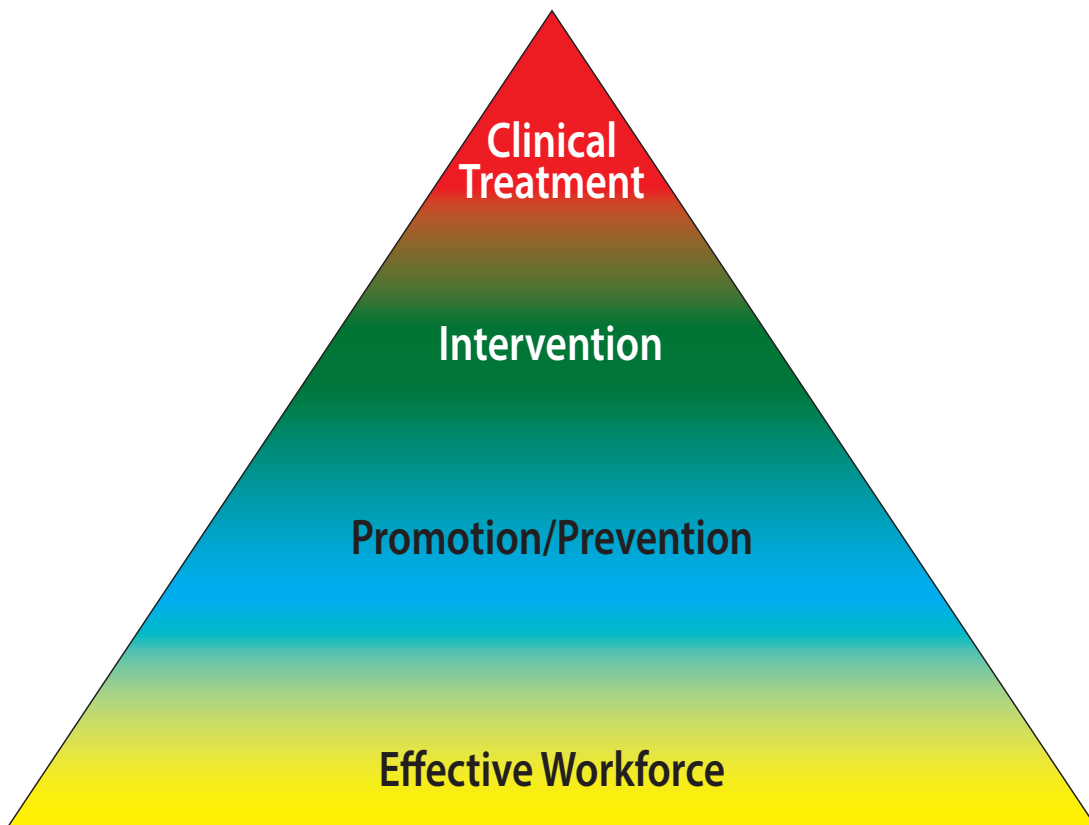
Overview of New Mexico Infant Teams

A FRAMEWORK FOR SUPPORTING THE SOCIAL EMOTIONAL COMPETENCE OF INFANTS, YOUNG CHILDREN, AND FAMILIES

CYFD - BEHAVIORAL HEALTH, PULLTOGETHER AND PYRAMID PARTNERSHIP

The NM Children, Youth and Families Department (CYFD) Behavioral Health Services - Infant and Early Childhood Mental Health (BHS-IECMH) along with the Pyramid Partnership anticipates an integrated and aligned system of early childhood and infant mental health programs, practitioners and families versed in the Pyramid Framework. CYFD Cabinet Secretary Monique Jacobson's PullTogether campaign envisions engaged communities helping families with infants and young children to access resources along the Pyramid to meet their needs. Together the BHS-IECMH along with the Pyramid framework and PullTogether effort, will build and integrate a system utilizing existing models to promote the social-emotional competence of children birth to age five in the context of nurturing relationships and quality learning environments.

The development of a competent community of behavioral health practitioners includes the CYFD funded New Mexico Infant Mental Health Teams (NM-ITs), which provide infants and young children in state custody a coordinated process for assessment and treatment in order to promote permanency planning, reduce recurrence, and support positive developmental outcomes. The NM-IMHTs utilize a BHS-IECMH assessment and treatment protocol that supports the infant/young child in the context of all of their important caregiving relationships in order to enhance optimal and comprehensive developmental progress in all domains. As part of an integrated statewide system of early childhood and infant mental health programs, the intention of the NM-IT services is to address the top tier of the Pyramid and align with other statewide system's building projects, efforts and resources.



INITIATIVES AND PYRAMID OFFERINGS

The Early Childhood Home and Family Services (ECHFS) Division of the University of New Mexico - Center for Development and Disability (UNM-CDD) provides the training and consultation for the PIPs. The ECHFS of the UNM-CDD houses two important state-wide capacity building projects funded by BHS-IECMH: The Early Childhood Infrastructure Development (ECID) and the IMH-Community of Practice (IMH-COP) projects. In tandem, these projects seek to increase the capacity of targeted behavioral health providers throughout NM contracted by BH-IECMH to serve infants/young children who have significant behavioral and social-emotional issues that interfere with age-appropriate developmental functioning and affect the quality of their caregiver-child relationships.

The UNM-CDD and BHS-IECMH have developed an Infant and Early Childhood Mental Health Training Institute (IECTI) which offers different levels of CYFD funded trainings to support the ECID and IMH-COP projects, and to meet competency standards along the Pyramid continuum. The continuum from Effective Workforce to Treatment promotes the developmental and social-emotional wellbeing of all infants/young children and includes a unique leadership academy to build statewide capacity. The matrix below illustrates the BHS-IECMH continuum of training initiatives and supports according to the Pyramid Framework. The next table on page 10 illustrates the ECID and IMH-COP projects.



CYFD-Behavioral Health Continuum of Training Initiatives and Therapeutic Supports:

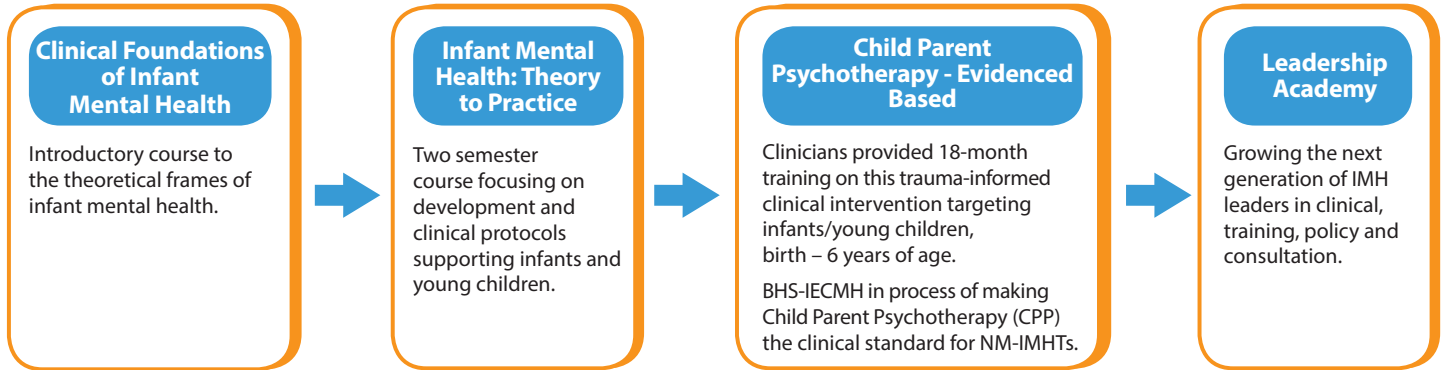
Infant and Early Childhood Mental Health

To Build a Statewide Capacity to Address Maltreatment and Foster the Social-Emotional Needs of Vulnerable Infants, Toddlers, Young Children and Families Using Best Practices and Evidence-Based Methods

STATEWIDE TRAINING/SERVICE	EFFECTIVE WORKFORCE/ PULL TOGETHER	PROMOTION/ PREVENTION	INTERVENTION	CLINICAL TREATMENT
PullTogether Campaign				
Foundations in Infant Mental Health				
Circle of Security – P (Parenting)				
Theory to Practice IMH Seminars				
UCSF-Child Parent Psychotherapy Cohort Trainings				
Circle of Security – T (Treatment)				
Infant Teams Collaborating with CPS				
Parent-Infant Psychotherapists				
UNM-ECHO Model Videoconference: IMH and Developmental Consultations for ITs and PIPs – 1x a month				
Ask the Manager Zoom Call for Improving Program Management – 1x a month				
ZOOM Call for Directors/ Supervisors – 1x a month				
ZOOM call for New Consultants – 1x a month				
Leadership Academy				
Legal Collaboration				
DC-0-5 Training				

Infant Mental Health

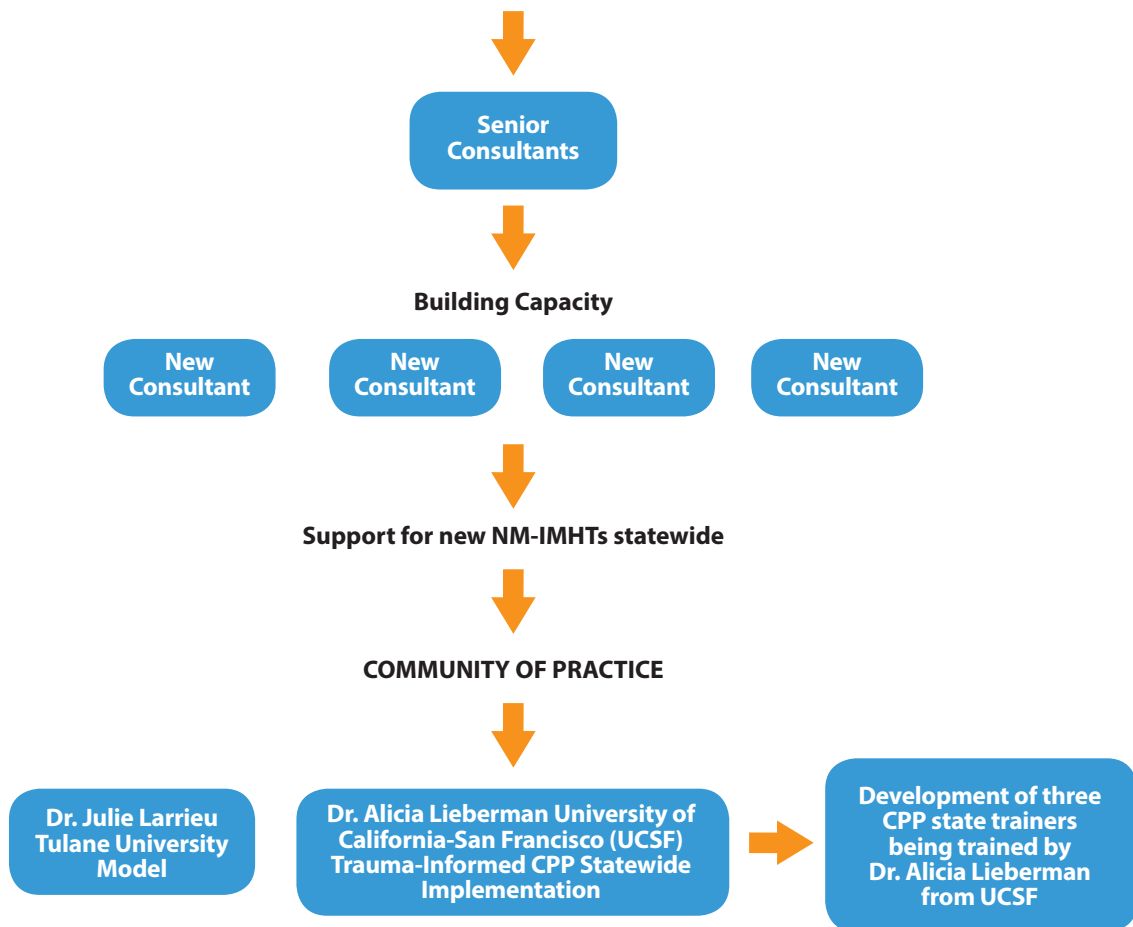
Early Childhood Infrastructure Development (ECID) Project:
 Infant and Early Childhood Mental Health Institute at
 UNM-CDD



CYFD contractors providing Infant Mental Health Services receive monthly case based clinical consultation and quarterly case based clinical consultation with internationally recognized infant mental experts.

Infant Mental Health

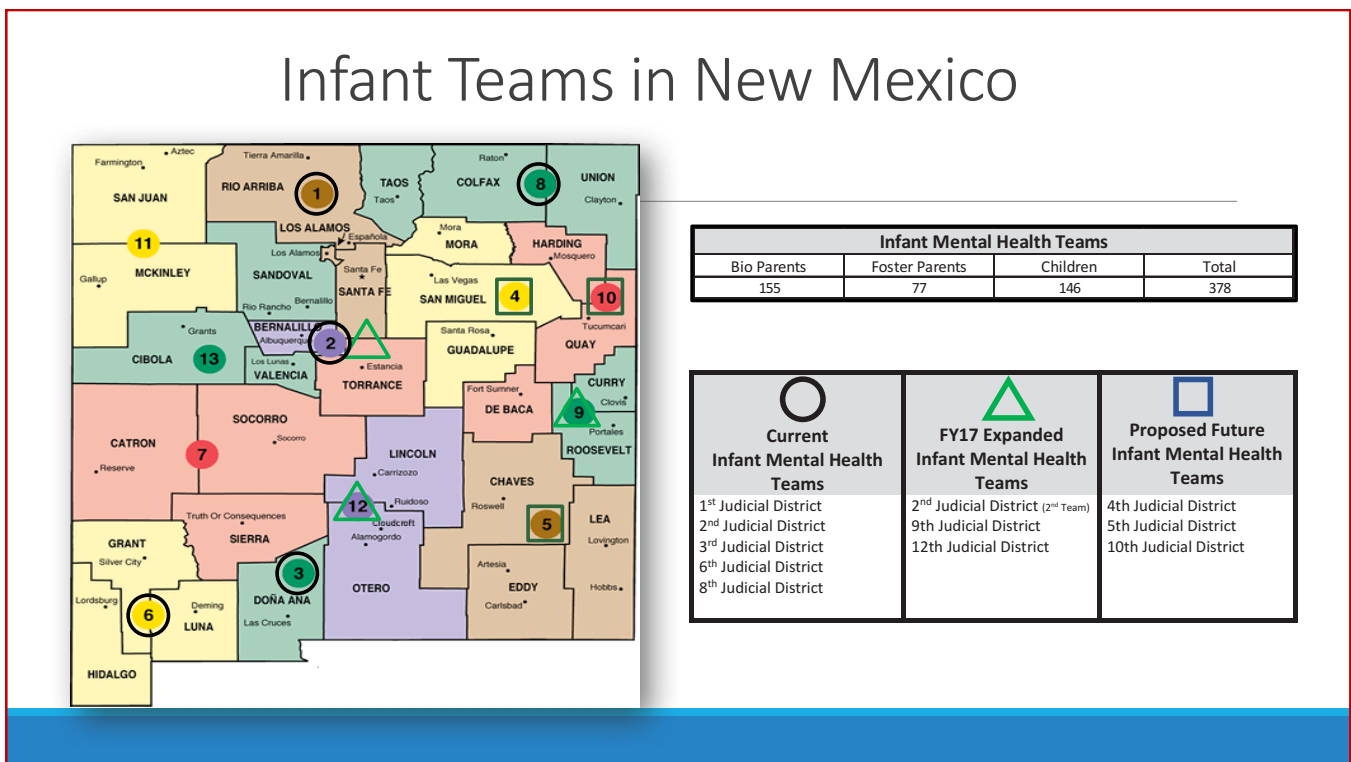
BHS-IECMH in process of making Child Parent Psychotherapy (CPP) the clinical standard.



NEW MEXICO INFANT MENTAL HEALTH TEAMS (NM - ITS)

The NM – ITs represent the upper part of the pyramid that encompasses clinical treatment. The goal of the NM-ITs is to provide infants/young children in state custody with a coordinated process for assessment and treatment in order to promote permanency planning, reduce recidivism, and support positive developmental outcomes. Services provided by the NM-ITs are designed to meet the therapeutic needs at the Judicial District level and are responsive to the ethnic, cultural, racial, linguistic, and socioeconomic diversity of families. Specialized services address behavioral issues that interfere with healthy infant/young child and parent relationships.

The first Infant Mental Health Team was established in the 1st Judicial District, Santa Fe County, New Mexico in October of 2009 as the result of priorities set by the Children, Youth and Families (CYFD) State Agency to address the needs of infants/young children, birth-to-3 years of age, who were in protective custody. The First Judicial District Infant Team continues to serve infants/young children who come into custody in Santa Fe, Rio Arriba and Los Alamos Counties. Subsequent Infant Mental Health Teams were established in the 3rd Judicial District, the 6th Judicial District, the 2nd Judicial District, the 8th Judicial District, the 9th Judicial District, and the 12th Judicial District. and most recently an Infant Team serving Bernalillo County in the 2nd Judicial District respectively. See map of Infant Teams in New Mexico below.



This manual was developed as a guide for NM –ITs to work collaboratively within Judicial Districts. An overview is presented of the principles and process to be considered when building an Infant Team to meet the social and emotional needs of babies and young children taken into state custody. Because there are varying levels of needs for IMH services in each community, as well as different pathways and resources for providing young children and their families services, a prototype is described for developing a NM-IT based upon a trauma-informed and developmentally-informed service delivery approach to improve the welfare of families, and to achieve permanency for infants in an expedited manner.

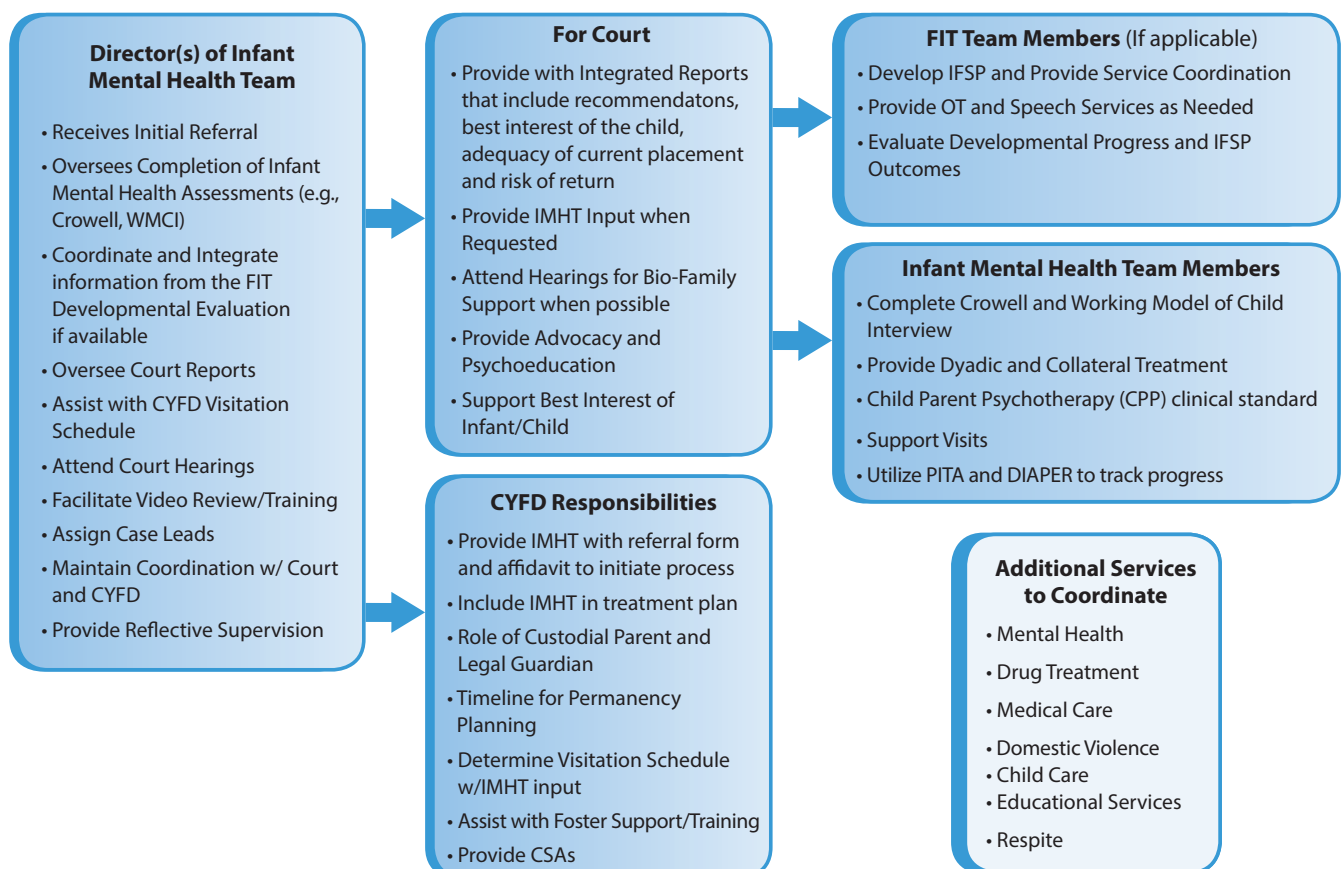
Although each NM-IT differs based upon community needs and resources, they all share three core beliefs:

- Relationships are key to changing systems and practices. Success hinges on relationships between the team members, caregivers, CPS and the judicial system, and, most importantly, between the parents and their children.
- Interventions informed by the science of early childhood development, mental health and trauma informed services lead to better outcomes for children and their families.
- Communication and collaboration among project team members and the family lead to service plans that address the specific needs of young children and their families.

Finally, this manual is developed as a guide to monitor program quality and performance to ensure a comprehensive and aligned infant mental health system of care. Ongoing data collection and evaluation is critical to provide assurances to policy-makers that services are being implemented as intended and that they reach the target audience. The tables below illustrate the NM-IT Logic Model and illustrate the activities of a NM - IT.

TABLES TO ILLUSTRATE INFANT TEAM LOGIC MODEL AND REFERRAL PROCESS

What a New Mexico Infant Mental Health Team (NM-IT) Does





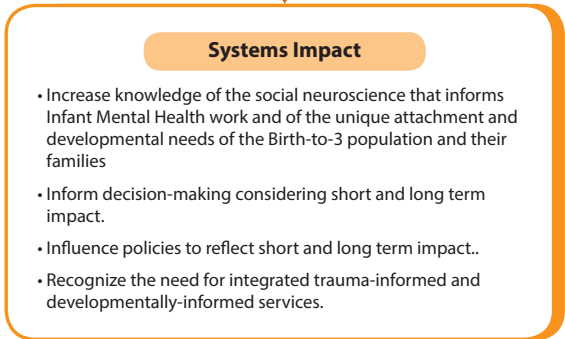
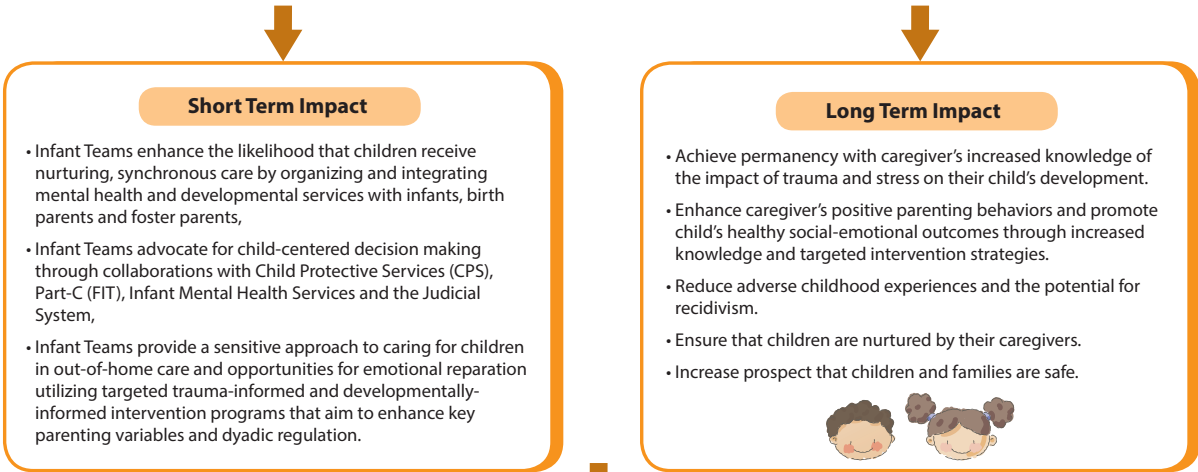
New Mexico Infant Team Logic Model

Program Vision:

New Mexico Families involved in the Child Welfare System will be supported to raise children who are healthy, happy and successful.

Core Service Components:

- **Provide** coordinated, trauma-informed and developmentally-informed process for assessment and treatment in order to promote permanency planning, emotional reparation and positive developmental outcomes.
- **Maintain** best interest of the child throughout process of judicial mandates to permanency.
- **Utilize** state of the art assessment and intervention procedures that strengthen caregiver-infant relationships and provide new ways to understand infant's needs and behaviors.
- **Support** visitations between infant and biological parents.
- **Assist** foster parents and other caregivers in the management of maltreated infants.
- **Reduce** maltreatment recurrence rates for young children taken into custody
- **Improve** the quality of information provided to courts regarding infants' welfare in relation to biological parents, relatives and foster parents.



CHAPTER 2

Rationale for New Mexico Infant Teams

WHAT WE NEED TO KNOW

INTRODUCTION

In order to respond to the unique needs of infants/young children, birth to three, taken into state custody, there is a need for targeted clinical assessment, community collaboration, service planning and treatment that identifies and intervenes in situations that impede infants'/young children's ability to:

- Form close parent/caregiver relationships,
- Experience, regulate and express their emotions,
- Explore their environment and learn, and
- Heal from trauma ¹

Early relationships provide the foundation that determines whether an infant's/young child's brain is hard-wired for social and emotional well-being or isolation and failure. Stress and trauma alter brain development and, as a consequence, maltreated infants/young children are at great risk for future school failure, psychopathology, juvenile justice system involvement, and other poor developmental outcomes.

The relationships between infants/young children and their parents are ruptured by the events that brought them into the child welfare system. The science of early childhood has shaped effective approaches for healing those ruptured relationships and for getting infants/young children and their families back on track or for adequately assessing lack of progress and parental capacity to safely reunify.

Current policy efforts call for trauma-informed as well as developmentally-informed practices and programs to understand and address the range of problems in infants/young children, birth-to-three, related to maltreatment. The complexity of maltreatment for infants/young children requires comprehensive community efforts to minimize their suffering, reduce their developmental deviations, and promote their competence. Using state of the art research and scientific knowledge, assists in making informed decisions and advocating for programs and policies such as the New Mexico-Infant Teams that protect and promote permanency for the youngest children in care.

By translating research and scientific concepts into evidence-based models in our therapeutic approach to maltreated infants/young children in state custody and their parents, we take a first and very important step toward relational reparation. The New Mexico-Infant Teams (NM-ITs) formation and therapeutic approach are based on the Tulane Infant Team, New Orleans Intervention Model, founded by Charles Zeanah, MD and Julie Larrieu, PhD in the 1990s, to ensure appropriate and timely decisions about the permanent placement of infants/young children who are in care due to abuse or neglect.

JUSTIFICATION

The early mental health of the infant/young child lays the groundwork for future relationships, mental health, and even physical health. Conversely, children exposed to early adversity, especially those related to personal relationships and interactions, can compromise development.

Indeed, the results of the Adverse Childhood Experiences (ACE) study demonstrated a strong, graded relationship between childhood trauma and level of traumatic stress with poor physical, mental, and behavioral outcomes later in life.² The key concept underlying the ACE study is that stressful or traumatic early childhood experiences can result in social-emotional and cognitive impairments. Fear-based childhoods disrupt neurodevelopment and can alter brain structure and function. For example, fear can result from familial violence or the chronic failure to receive responsive caregiving. The conclusion is that fear during infancy and childhood has a cumulative impact on childhood development.

When children experience maltreatment or toxic stress that manifest in social-emotional, behavioral, and relationship problems, they learn to modify their behavior to the environment and the caregiving they receive. An infant's or young child's adaptation to maltreatment or toxic stress can result in their cues and behaviors being difficult to understand. Although they develop coping strategies that help them survive in the face of adversity, the same strategies can interfere with many aspects of development. Deprivation of key developmental experiences will result in persistence of primitive, immature behavioral reactivity, and predispose a young child to flight, fright, or freeze responses which contribute to developmental disorganization.³

SAFETY AND MEMORY

Safety is paramount to healthy social-emotional development; but when infants or young children do not feel safe in their relationships or environments, the memories become embedded in sensory and body-based neural connections in the brain. The memories and earliest mental representations that young children have of the parent/caregiver consist of the ways the parent/caregiver did things with the child. If the parent/caregiver leaves or dies, the child loses the feeling of security generated by those reassuring interactions —“hidden regulators”— that helped to organize the child physiologically as well as psychologically. When a young child loses a parent or caregiver, his or her sense of self is altered. Repeated disruptions of caring relationships continually interfere with the child's ability to form a clear sense of who he or she is in relationship to others.⁴

The paradox is that for many infants and young children growing up in high-risk environments, they may be bonded with their caregivers but they do not feel safe with them. The important point is that infants and young children do not just get over or forget early maltreatment or chronic stress; the experience is embedded in their brain and bodies.

Caregivers from high-social-risk populations, especially caregivers with their own traumatic histories, are vulnerable for the development of disturbed, dysregulating caregiver-child relationships and interactions.⁵ Many caregivers with negative experiences during their critical upbringing bring their own early childhood maltreatment experiences forward implicitly into their parenting in the present. Some experiences become encoded in the brain in such a way that awareness is not readily available to the individual. The caregiver may in

fact not know why they behaved in a certain manner. Realizing that caregivers may be operating from implicit memory and understanding how early childhood experiences affect adult behavior, including emotional regulation, help NM-IT service providers to better understand the caregivers that they are working with.

REFLECTIVE FUNCTIONING

Parental reflective functioning is a key determinant of how, within the context of the child's early social relationships, an infant or young child learns to self-organize and self-regulate. Parental reflective functioning is a caregiver's capacity to understand the infant's behavior in terms of internal states and feelings.⁶ Development of self-organization is dependent on the caregiver's ability to communicate an understanding of the child's intentional stance via "marked mirroring" of facial expressions, voice, or touch.⁷ For example, an infant may become fussy and the mother, face-to-face with the infant, shows a concerned affect on her face and says, "You look like you are hungry, it must be time for your bottle."

Being able to read a child's cues and anticipate their needs are important parts of parenting. In another example, a reflective caregiver can interpret her daughter's oppositional behavior as belying feelings of sadness or other feelings that are seemingly inconsistent with the behavior and help the child identify these feelings.⁸ The caregiver is able to understand and reflect the "inner life of the child". This ability allows the caregiver to respond accordingly to the child's behavior and to see the behavior as an expression of the inner state of the child. On the other hand, a caregiver with reflective deficits takes the child's behavior at face value; for example, aggression is viewed as an indication of the child's "badness."⁹

The concept of parental reflective functioning provides a framework for NM-ITS to shift from a behavior "management" approach to a behavior "understanding" approach. This approach as articulated by Slade and colleagues (2014), moves away from identifying and labeling the behavior as a problem within the child and towards identifying the issue as a disruption within the parent-child relationship.¹⁰

TIMING OF SUPPORTS

Because the early years are so crucial to development, supportive services should begin as soon as possible when an infant/young child is taken into state custody, and include IMH principles and practices. NM-ITs assume the responsibility of qualitatively supporting the caregiver-child relationship and early brain development.¹¹ The field of IMH trains practitioners to recognize the complexity of development in the early years and to organize the multiple influences underlying the meaning of behavior as informed by child-specific issues, relationship factors, and environmental conditions. In IMH, the key is to target developmental processes and utilize clinical interventions towards understanding and assisting fragile caregiver-infant or caregiver-child dyads as early as possible. NM-ITs make an essential contribution to the early identification and remediation of dysfunctions in the caregiving relationship of those infants and young children in the child welfare system who are evidencing difficulties in social-emotional development due to maltreatment.

PRINCIPLES OF IMH PRACTICE

The IMH practice of the NM-ITs is guided by six principles, as articulated by Dr. Alicia Lieberman, an internationally renowned leader in the IMH field.

1ST PRINCIPLE

The most basic and widely accepted principle regarding the mental health of infants, toddlers and preschoolers is that their mental health unfolds in the context of their close emotional relationships and moment-to-moment interactions with parents and caregivers.¹² According to Dr. Kristie Brandt, every child must be provided with five essential ingredients for optimal mental health development: 1) a safe, healthy, and low-stress pregnancy; 2) the opportunity and ability to "fall in love" and "be in love" with a safe and nurturing adult; 3) support in learning to self-regulate; 4) support in learning to mutually regulate; and 5) nurturing, contingent, and developmentally appropriate care.¹³

2ND PRINCIPLE

The second principle is that constitutional characteristics, including temperamental predispositions, play a major role in how children register and process real life events and emotional experiences.¹⁴ At the same time, because of the central importance of emotional relationships, the caregiver's supportive response to the infant/child can modulate and even transform constitutional vulnerabilities so that they do not derail the child's developmental course.

3RD PRINCIPLE

The family's cultural values and child-rearing customs form an indispensable matrix for understanding the infant's/child's behavior and developmental course is the third Principle.¹⁵ Each child and caregiver exists in a particular cultural context that deeply affects their individual functioning.

4TH PRINCIPLE

The 4th principle is that NM-ITs make an effort to understand how behaviors feel from the inside, and not just how they look from the outside.¹⁶ Within an IMH perspective, a NM-IT practitioner learns how moment-to-moment interactions are shaping and shaped by the ongoing meaning-making process of both infant/child and caregiver.¹⁷

5TH PRINCIPLE

Central to NM-IT training is learning about empathizing with parents and infants/young children in a dual process which includes practitioners learning about empathizing with and listening to themselves.¹⁸ An intervener's own feelings and behaviors have a major impact on the intervention.

6TH PRINCIPLE

The next principle is to intervene as early as possible. Infant's/young children's brains are organized and all aspects of learning are mediated by their relationships with caregivers. When those relationships are disrupted, brain development and learning are impacted. NM-IT practice then becomes about supporting the infant/young child through the best possible relationships and interactions as soon as possible.

7TH PRINCIPLE

The next principle has to do with the importance of reflective supervision. Professionals who provide services to infants and young children and their families involved in child protective services face multiple daily challenges. Working with stressed and traumatized infants/young children and their families, as well as the systems charged with providing services and oversight affects professionals on many levels. These early professionals (mental health providers, developmental specialists, early interventionists, home visitors, family educators, Head Start teachers, public health nurses, child welfare workers and others) in turn require support and ongoing professional development to provide perspective, increase their skills, and avoid burn-out. Reflective supervision, a practice that has evolved from the multi-disciplinary field of infant mental health provides the support needed by practitioners who are exposed to the intense emotional content and life experiences related to their work with families. An ongoing professional development process, reflective supervision provides a way for professionals working with very young children to reach greater understanding of their own responses, as well as the babies and adults they work with, and as a result, facilitating quality practice and intervention.

8TH PRINCIPLE

The last principle has to do with the importance of cultural considerations and formulation. It includes an approach to incorporating cultural perspectives in the mental health assessment and treatment of infant/young children (Sarche, Tsethlikai, Godoy, Emde, & Fleming (in press), *Cultural Perspectives for Assessing Infants and Young Children*). The goal is to help clinicians reflect on the different facets of cultural identity and their possible influence on the clinical presentation of the infant/young child and the family. The cultural formulation for use with infants/young children and their caregivers includes the following:

- Cultural identity of the Individual - Cultural Identity of Child and Caregivers
- Cultural Conceptualization of Distress - Cultural explanations of the child's presenting problem
- Psychosocial Stressors and Cultural Features of Vulnerability and Resilience – Cultural factors related to the child's psychosocial and caregiving environment
- Cultural Features of the Relationship Between the Individual and the Clinician – Cultural elements of the relationship between the parents/caregivers and the clinician
- Overall Cultural Assessment – Overall cultural assessment for child's diagnosis and care

For more on Cultural Formulation: read pp. 10-12 in *DC: 0-5 – Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Zero to Three*; read pp. 26-27, Lieberman, Ghosh Ippen, and Van Horn, *Don't Hit My Mommy*.

These principles offer a roadmap of skills for NM-ITs and collaborators within their Judicial District to develop a shared language and to be able to see the same baby and family. Each member of a NM-IT is not only viewed as a member of a particular discipline, but also as someone with a distinct set of IMH core beliefs, skills, training experiences, and clinical strategies who incorporates a comprehensive, intensive, and relationship-based approach to working with young children and families.¹⁹

TREATMENT SERVICES

Services that target children in distress or with clear symptoms indicating a mental health disorder are considered treatment. The services address attachment and relationship disturbances and the interplay between the child, parent, and other significant caregivers that jeopardize achieving early mental health and social-emotional development. Specialized early mental health treatment services focus on the caregiver-child dyad and are designed to improve child and family functioning and the mental health of the child, the parents, and other primary caregivers.²⁰ This level of care must be provided by NM-IT members who are licensed mental health therapists trained in IMH.

REFERRALS

Early neglect, trauma, and maltreatment have long-term pathogenic effects, including effects on brain dysfunction and related psychosocial difficulties. Problems in infant emotional development often involve parents' difficulties managing their own inner worlds—difficulties that impair their ability to care for their babies. These individuals' parenting difficulties can range from explicit repetition of early abuse to quite subtle distortions and deficits in parenting.²¹ All referrals to NM-ITs come from CYFD's Protective Services Division when an infant/young child has been taken into state custody and placed in out-of-home care.

Research clearly indicates that NM-IT services utilizing evidence-based, specialized treatment approaches such as Child-Parent Psychotherapy can have a positive impact on the trajectory of outcomes for infants and young children in state custody. "Those first few years are unprecedented in the life cycle for how rapidly the changes occur, as well as for the complexity of the changes," says Dr. Charles Zeanah, a professor of psychiatry at Tulane University, "The experiences that young children have are very important."

KEY POINTS TO KNOW

ATTACHMENT

1. Attachment is the enduring emotional relationship between the parent or caregiver and the infant that brings safety, comfort, security and pleasure. It is the foundation for love and provides the framework for all future relationships that the child will develop.

2. Attachment researchers emphasize the infant's proximity to the caregiver and include an emphasis on the parents' understanding and reflecting the infant's internal world.²² Fonagy (2012) develops the concept of the mother's ability to know her baby's mind as she interacts with, responds to, and makes meaning for her baby.²³
3. One of the saddest examples of this is when the primary caregiver – the source of food, warmth, comfort and love for the dependent infant or child – is also the source of episodic, unpredictable threat, rage and pain. The disorganized attachment relationship that results can impair healthy relational interactions for a lifetime. Again, much of the resulting dysfunctional relational interactions will be beyond the awareness and understanding of the developing child, youth or adult.
4. If the goal is to have a baby use the mother/father as a secure base, then interventions should focus on helping the mother/father serve as a secure base, even in the presence of maternal/paternal insensitivity. Important to identify positive maternal/paternal behaviors that may serve as a buffer against otherwise insensitive behavior.²⁴

STRESS AND TRAUMA

5. Attachment is a memory and a set of associations usually pleasurable and relational. The sequential acquisition of various memories is the primary task of development. Infants form template memories from early experiences.²⁵ Internal catalogs are created from early childhood.
6. For children who have a template of caregivers being unreliable and who will eventually yell and hit me, it takes a long time to lay down a new template for relationships.
7. A young child growing up in a home with a pervasive threat, for example, will create a set of associations –primarily pre-cortical and therefore out of his or her conscious awareness –between a host of neutral cues and threat. These neutral cues for the rest of the child's life have the capacity to activate a fear response and therefore alter emotions, behaviors and physiology. When a child, youth or adult is in a high state of arousal–fearful – their brain will process and function differently.²⁶
8. These fear inducing cues can range from expressions (e.g., eye-contact can become associated with impending threat), to scents (e.g., the abusive parent's perfume or aftershave), to music, to styles of interpersonal interaction.
9. Selma Fraiberg (1975) writes about a system of caring that is transgenerationally transmitted. The "ghost in the nursery" might be an uninvited guest, the unfriendly intruder who interferes with mother and infant establishment of the mother-infant bond that encourages security and growth promoting development.²⁷

NEUROBIOLOGY

10. The most essential functions that the brain mediates – survival, procreation, protecting, and nurturing dependents – depend upon the capacity to form and maintain relationships.
11. Patterns that are novel cause arousal and focus attention – sometimes even alarm. Most of what we do is due to pre-cortical processing.
12. Chaotic and chronically stressful environments may affect the development of self-regulation processes by impairing temperamental adaptability and an aspect of self-regulation involving stress reactivity. Many of the frustrations that the children show is manifested in willful, difficult behavior and manifested in impulsivity.
13. A challenging environment is alright for a child who can self-regulate.²⁸

14. Perry (2013) suggests that successful treatment with traumatized children must first regulate the brainstem's sensitized and dysregulated stress response systems. Only after these systems are more regulated can a sequence of developmentally appropriate enrichment and therapeutic activities be successfully provided to help the children heal.²⁹

RISK FACTORS/ACE SCALE

15. Children's prenatal exposure to "second-hand" smoke, alcohol, and drugs are implicated in a multitude of health concerns, including impaired growth and development.

16. Risk factors such as poverty, family violence, dysfunctional parenting, and inadequate access to health care, further influence a child's developmental outcome.

17. Effects of poverty on a child's educational outcomes are more pervasive when poverty is chronic or when it occurs early in the life of a child (birth to five) than when it is transitory, temporary poverty that occurs during adolescence. 53% of children in New Mexico are living in poverty.³⁰

18. Prenatal drug exposure to any drug cannot reliably predict the outcome of an individual child and does not warrant a self-fulfilling prophecy, but such exposure is often a marker for a child with multiple risks.³¹

19. Children are more vulnerable to Post Traumatic Stress Disorder (PTSD) than adults. According to Dr. Perry, many children who have attachment disturbances and who view domestic violence or other trauma develop PTSD.³²

20. Over 5 million children a year have traumatic events significant enough to cause PTSD. These children are often misdiagnosed as having an attention deficit disorder (ADD) or attachment disorder. Many do not get the help they need.³³

RESILIENCE AND PROTECTIVE FACTORS

21. Resilience is a universal capacity, which allows a person, group or community to prevent minimize or overcome the damaging effects of adversity.

22. Several factors distinguish resilient children from those overwhelmed by risk factors:

- a. A temperament that elicits positive responses from family member as well as strangers;
- b. A close bond with a caregiver during the first year of life;
- c. An active approach to problem solving;
- d. An optimistic view of their experiences even in the midst of suffering; and,
- e. An ability to be alert and autonomous.³⁴

23. Caregiver emotionality may play a central role in moderating the relations between risk, family processes and child outcomes.³⁵

24. The primary therapeutic implication is the need to increase the number and quality of buffering relationships and reparative opportunities for the high-risk child. Also need to recognize the developmental levels of children

REFERENCES

- 1 Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2015). *Don't hit my mommy! A manual for child-parent psychotherapy with young children exposed to violence and other trauma (2nd edition)*. Washington, D.C.: National Center for Clinical Infant Programs.
- 2 Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245–258.
- 3 National Scientific Council on the Developing Child (2010). Persistent fear and anxiety can affect young children's learning and development: Working Paper No. 9. Retrieved from www.developingchild.harvard.edu.
- 4 Center on the Developing Child at Harvard University. (2007). The timing and quality of early experience combine to shape brain architecture (Working Paper #5). Retrieved from www.developingchild.harvard.edu
- 5 Sander, L.W. (2000). Where are we going in the field of infant mental health. *Infant Mental Health Journal*, 21(1-2), 5-20.
- 6 Seligman, S. (2014). Attachment, intersubjectivity, and mentalization within the experience of the child, the parent, and the provider. In K. Brandt, B.P. Perry, S. Seligman, & E. Z. Tronick (Eds), *Infant and early childhood mental health: Core concepts and clinical practice*. Arlington, Va: American Psychiatric Association, 309-322.
- 7 Fonagy, P. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.
- 8 Stroud, B. & Morgan, M.M. (2014). Basics of counseling in infant-parent and early childhood mental health. In K. Brandt, B.P. Perry, S. Seligman, & Tronick (Eds). *Infant and early childhood mental health: Core concepts and clinical practice*. Arlington, Va: American Psychiatric Association, 145-157.
- 9 Stroud, B. & Morgan, M.M. (2014). Basics of counseling in infant-parent and early childhood mental health. In K. Brandt, B.P. Perry, S. Seligman, & Tronick (Eds). *Infant and early childhood mental health: Core concepts and clinical practice*. Arlington, Va: American Psychiatric Association, 145-157.
- 10 Ordway, M.R., Sadler, L.S., Dixon, J. & Slade, A. (2014). Parental reflective functioning: Analysis and promotion of the concept for pediatric nursing. *Journal of Clinical Nursing*, 23, 3490-3500.
- 11 Pawl, J.H. & Milburn, L.A. (2006). Family- and relationship-centered principles and practices. In G.M. Foley & J.D. Hochman (Eds), *Mental health in early intervention: Achieving unity in principles and practice*. Baltimore, MD: Brookes Publishing, 191-226.
- 12 Lieberman, A.F., Barnard, K.E., and Wieder, S. (2004). The DC:0-3 diagnostic classification system. In A. Carter and R. Del Carmen (Eds.), *Handbook of infant and toddler mental health assessment*. New York: The Guilford Press, 141-160.
- 13 Brandt, K. (2014). Core concepts in infant-family and early childhood mental health. In K. Brandt, B.P. Perry, S. Seligman, & E.Z. Tronick (Eds), *Infant and Early Childhood Mental Health: Core Concepts and Clinical Practice*. Arlington, Va: American Psychiatric Association, 1-20.
- 14 Lieberman, A. (1998). A perspective on infant mental health. *The Signal*, 6 (1), 11-12.
- 15 Weatherston, D., Ribaudo, J., & Glovak, S. (2002). Becoming whole: Combining infant mental health and occupational therapy on behalf of a toddler with sensory integration difficulties and his family. *Infants & Young Children*, 15(1), 19-28.
- 16 Lieberman, A. (1998). A perspective on infant mental health. *The Signal*, 6 (1), 11-12.
- 17 Beeghly, M., & Tronick, E. (2011). Early resilience in the context of parent-infant relationships: A social developmental perspective. *Current Problems in Pediatric and Adolescent Health Care*, 41(7), 197-201.
- 18 Lieberman, A. (1998). A perspective on infant mental health. *The Signal*, 6 (1), 11-12.
- 19 Weatherston, D. (2000) The infant mental health specialist. *Zero to Three*, 21 (2), 3–10.
- 20 California Infant-Family and Early Childhood Mental Health Training Guidelines Workgroup. 2009. Revised training guidelines and personal competencies for infant-family and early childhood mental health. Retrieved from <http://www.wested.org/cpei/forms/training-guidelines.pdf>
- 21 Love and learn! Promoting the importance of healthy happy babies, training materials (2004). Retrieved from www.nmaimh.org.

- 22 Seligman, S. (2014). Attachment, intersubjectivity, and mentalization within the experience of the child, the parent, and the provider. In K. Brandt, B.P. Perry, S. Seligman, & E. Z. Tronick (Eds), *Infant and early childhood mental health: Core concepts and clinical practice*. Arlington, Va: American Psychiatric Association, 309-322.
- 23 Fonagy, P. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.
- 24 Cassidy, J., Woodhouse, S.S., Cooper, G., Hoffman, K., Powell, B., & Rodenberg, M. (2005). Examination of the precursors of infant attachment security: Implications for early intervention and intervention research. In L.J. Berlin, Y. Ziv, L. Amaya-Jackson, and M.T. Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention, and policy*. New York: Guilford Press, 34-60.
- 25 Perry, B.D. (2013). The Neurosequential Model of Therapeutics in young children. In K. Brandt, B.D. Perry, S. Seligman & E. Tronick (Eds), *Infant and Early Childhood Mental Health: Core Concepts and Clinical Practice*. Washington DC: American Psychiatric Press, 21-54.
- 26 Perry, B.D. (2013). The Neurosequential Model of Therapeutics in young children. In K. Brandt, B.D. Perry, S. Seligman & E. Tronick (Eds), *Infant and Early Childhood Mental Health: Core Concepts and Clinical Practice*. Washington DC: American Psychiatric Press.
- 27 Fraiberg, S., Adelson, E. , & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytical approach to the problems of impaired mother-infant relationships. *Journal of the American Academy of Child Psychiatry*, 14, 387- 421.
- 28 Perry, B.D. (2006). The Neurosequential Model of Therapeutics: Applying principles of neuroscience to clinical work with traumatized and maltreated children. In N. Boyd Webb (Ed.), *Working with Traumatized Youth in Child Welfare*. New York: Guilford Press, 27-52.
- 29 Perry, B.D. (2013). The Neurosequential Model of Therapeutics in young children. In K. Brandt, B.D. Perry, S. Seligman & E. Tronick (Eds), *Infant and Early Childhood Mental Health: Core Concepts and Clinical Practice*. Washington DC: American Psychiatric Press.
- 30 National Center for Children in Poverty (2013). *Basic facts about low-income children*.
- 31 Sagatun-Edwards, I. & Saylor, C. (2000). Drug-exposed infant cases in juvenile court: Risk factors and court outcomes. *Child Abuse and Neglect*, 24(7), 925-937.
- 32 Perry, B.D. (2008). Child maltreatment: the role of abuse and neglect in developmental psychopathology. In T. P. Beauchaine & S. P. Hinshaw (Eds), *Textbook of Child and Adolescent Psychopathology*. New York: Wiley, 93-128.
- 33 Perry, B.D. & Dobson, C.D. (2009). Surviving childhood trauma: the role of relationships in prevention of, and recovery from, trauma-related problems. *Counseling Children and Young People*, 28-31.
- 34 Masten AS, Hubbard JJ, Gest SD, Tellegen A, Garmezy N, Ramirez M. (1999). Adaptation in the context of adversity: Pathways to resilience and maladaptation from childhood to late adolescence. *Development and Psychopathology*, 11,143–169.
- 35 Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2015). *Don't hit my mommy! A manual for child-parent psychotherapy with young children exposed to violence and other trauma* (2nd edition). Washington, D.C.: National Center for Clinical Infant Programs.

CHAPTER 3

Goals, Procedures and Building an Infant Team

NEW MEXICO INFANT TEAMS

GOAL

The goal of the New Mexico Infant Teams (NM-ITs) is to provide infants and toddlers in state custody with a coordinated, trauma-informed and developmentally-focused process for assessment and treatment to inform permanency planning and support optimal developmental outcomes. The intent of the NM-IT is to develop positive, productive working collaborations between protective services, infant mental health teams, early intervention (Part C), other providers and services, and most importantly, the judiciary, so that the entire system is working from a knowledgeable base on behalf of the best interest of the young child.

OUTCOMES

The intended outcome of the NM-ITs is to reduce maltreatment recidivism rates for infants taken into custody; to improve the quality of information provided to collateral systems and to the courts regarding infants, biological parents, relatives and foster parents as it pertains to the welfare of the infant/young child; to assist foster parents in the care of maltreated infants; to support visitations between infant and biological parents; and, to utilize best and evidence-based practices, assessments, and intervention procedures that strengthen caregiver-infant relationships and provide new ways to understand infant's/young children's needs and behaviors.

The NM-IT assessment and treatment protocol supports the infant/young child in the context of all of his/her important caregiving relationships in order to enhance optimal and comprehensive developmental progress in all domains. The NM-ITS adopts trauma and developmentally-informed, family centered practices that aim to strengthen primary caregiver-infant relationships.

FOUR MAIN CONSIDERATIONS

The NM-ITs help all collaborators and the Judicial System be aware of the following:

1. The importance of the period from birth to three for early brain development and relationship security.
2. The impact of maltreatment, stress and trauma on the developing brain.
3. The individual needs of a particular infant or toddler who has experienced maltreatment.
4. The protective capacities of the caregiver.

CORE SERVICE COMPONENTS

Infants/young children in the custody of CYFD's Protective Services who are referred to NM-ITs receive:

- Coordinated, trauma and developmentally informed assessment and treatment in order to promote permanency planning, emotional reparation and positive developmental outcomes.
- Services that maintain the best interest of the child throughout the process of judicial mandates to permanency.
- Therapies to match the neurobiology and social-emotional needs of the infant/young child.
- State of the art assessment and intervention procedures that strengthen caregiver-child relationships and provide new ways to understand the infant's/young child's needs and behaviors.
- Supported visitations between infants/young children and their biological parents.
- Assistance for foster parents and other caregivers in the management of maltreated infants/young children.
- Services that result in reduction of maltreatment recidivism rates for infants/young children in state custody.
- Improvement in the quality of information provided to courts regarding infants'/young children's welfare in relation to biological parents, relatives and foster parents.
- Assurance of child-centered decision-making through collaborations with CPS, Part-C, Infant Mental Health Services, other Community Providers and the Judicial System.

PROCEDURE

Referral, Intake and New Data Entry

- A. Infants, ages birth-to-three, who have been taken into Child Protective Custody are identified and referred to the NM-IT after the 10-day custody hearing but referral timelines may vary and are determined by each Judicial District Infant Team in collaboration with CPS. The completed referral form includes an attached affidavit.
- B. Prior to the 10-day hearing based upon CAPTA regulations (Child Abuse and Prevention Act), CYFD refers a child under age 3 who is involved in a substantiated case of child abuse or neglect to local early intervention services funded under Part C of the Individuals with Disabilities Education Improvement Act for a comprehensive multidisciplinary evaluation.
- C. The NM-IT Director assigns an IMH clinician who is part of the NM-IT to a referred case and begins with an Intake Assessment with the bio-parent(s) to gather background information and history. In addition, the Adverse Childhood Experiences Scoring (ACES) questionnaire is completed with the bio-parent(s).
- D. Following the referral, the assigned NM-IT clinician supports the infant/young child and when possible the relationship during visits with bio-parent(s) and helps CYFD determine the appropriate visitation schedule to meet the individual needs of the infant/young child.
- E. At least 25% of NM-IT monies are required to be spent on clinical services. Additionally, 75% of Parent Infant Psychotherapy (PIP) monies can be used to provide clinical services to infants/young children who are part of NM-ITs.
- F. As part of the NM-IT services, support is given to foster parent(s) of an infant/young child who is part of NM-IT as long as bio-parent(s) are engaged in services. If bio-parent(s) are discharged from services due to, for example, lack of participation, services can continue with foster parents and infant/young child for no longer than 2 months to anchor skills and help with the transition before closing case.

Comprehensive Infant Mental Health Assessment

- A. The NM-IT conducts a Comprehensive Infant Mental Health (IMH) assessment that includes an assessment of the dyadic interaction, the parental/caregiver capacities (e.g., perceptions and reflective functioning), and the developmental capacities of the infant/young child. The ability to identify protective capacities and risks in the parent-child relationship is essential to treatment and to Child Parent Psychotherapy.
- B. The videotaped assessment of the Dyadic Interaction is determined by the age of the infant/young child with the following observational methods:
 - Videotaped Observation (5-10 minutes) of Infant-Caregiver in Routine Activity (feeding, diapering, play) – for use with birth to 6-7 months (until infant can sit independently).
 - Videotaped Baby Crowell Caregiver-Infant Interaction Procedure – for use when infant can sit independently – approximately 6-7 months to 12 months.
 - Videotaped Crowell Caregiver-Child Interaction Procedure – for use from 12 months – 60 months.
- C. Based upon the initial assessments and observations of the dyad, the Caregiving Dimensions - Levels of Adaptive Functioning from the new DC: 0-5 manual is completed.
- D. To assess a Parent's/Caregiver's Perceptions and Reflective Functioning the Working Model of the Child Interview (WMCI) along with three questions from the Circle of Security Interview (COSI) are administered and videotaped.
- E. To determine the infant/young child's developmental capacities the following are included:
 - DC: 0-5, Developmental Milestones and Competency Ratings
 - DIAPER (Developmentally Informed Assessment Per Each Relationship)
 - Development Information from the FIT-Part C evaluation if available.
- F. Information is then entered into the IMH database reflecting the administration of this IMH assessment protocol.

Individual Treatment Plan and Clinical Services

- A. It is recommended that the NM-IT along with CPS team members jointly formulate specific recommendations and a proposed treatment plan for the infant/young child and bio-parent(s) related to services and interventions.
- B. The NM-IT IMH therapist determines specific goals and a treatment modality (COS-P or CPP) to begin with based upon the comprehensive assessment results.
- C. If the treatment modality the NM-IT IMH therapist determines to be most beneficial to begin with is the Circle of Security-Parenting DVD Program, then the goals would target helping bio-parents/caregivers understand how secure parent-child relationships can be supported and strengthened.
- D. Goals of COS-P are formulated to help parents/caregivers to:
 - Understand their infant's/young child's emotional world by learning to read emotional needs
 - Support their infant's/young child's ability to successfully manage emotions
 - Enhance the development of their infant's/young child's self esteem
 - Honor the innate wisdom and desire for their infant/child to be secure
- E. If the parent/caregiver is ready for dyadic therapy, the unit of treatment is the relationship between the infant/child and bio-parent. The clinical standard and treatment modality recommended by CYFD is Child Parent Psychotherapy (CPP). CPP goals may include:

Global CPP Goals-Objectives:

- Encourage normal development: adapt to infant or young child's developmental capacity
- Offer unstructured reflective developmental guidance
- Encourage and model appropriate protective behavior
- Maintain regular levels of affective arousal
- Interpret feelings and actions
- Establish awareness and trust in bodily sensations

- Achieve reciprocity in the caregiver-child relationship
- Provide emotional support/empathic communication
- Resolution of trauma-related symptomatology

Trauma-Related Goals-Objectives of CPP:

- Increased capacity to respond realistically to threat
- Differentiation between reliving and remembering
- Normalization of the traumatic response
- Placing the traumatic experience in perspective
- Co-construction of a mutually meaningful trauma narrative
- Promote developmental progress through play, physical contact, and language

E. Dyadic Treatment is conducted during visitations between infant/child and the bio-parent(s).

F. At least 25% of NM-IT monies need to be spent on clinical services. In addition, 75% of PIP (Parent Infant Psychotherapy) clinical services can be used to serve infants/young children in state custody and parents/caregivers who are part of NM-ITs.

Intervention/Treatment Progress

- A. The NM-IT has 5 ways to track progress: DAP Notes, PITA, DIAPER, Caregiving Dimensions/Levels of Adaptive Functioning (DC: 0-5 Manual) and CPP Fidelity Measures.
- B. The Data Assessment Plan (DAP) Progress Notes are completed after every treatment session with the parent/caregiver or dyad and then entered into the IMH database. The DAP notes provide an ongoing record of interventions and treatment as well as document fidelity to the clinical treatment model.
- C. The Progress in Treatment Assessment (PITA) developed by Dr. Charlie Zeanah and Dr. Julie Larrieu from Tulane University, is a way to track treatment progress based upon the parent's/caregiver's behavior. The PITA is administered quarterly (4x a year) from the time the case is entered into the database.
- D. The Developmentally Informed Assessment Per Each Relationship (DIAPER) is a new tool that is completed quarterly and offers a way to monitor the parent/caregiver's interactions that support the infant/young child's developmental capacities and progress.
- E. The Caregiving Dimensions-Levels of Adaptive Functioning Scale is completed quarterly (4x a year beginning with Intake) and entered into the IMH database for comparative review to determine progress.
- F. CPP Fidelity Measures guide a NM-IT IMH therapist through the different phases of CPP treatment and include: Reflective Practice Fidelity, Emotional Process Fidelity, Dyadic Relational Fidelity, Trauma Framework Fidelity, Procedural Fidelity and Content Fidelity.

Early Intervention – Part C

- A. Several NM-ITs have Early Interventionists from Family Infant and Toddler (FIT) Part-C programs that are core team members. Others have collaborative relationships with Part C programs and Memorandums of Agreement to ensure the cross pollination of information needed to better inform court reports and decision-making.
- B. Following the Part-C Comprehensive Multidisciplinary Evaluation, a determination is made if the infant/young child is eligible for Early Intervention Services.
- C. If the infant/young child is eligible for services, it is recommended that the NM-IT be included in planning the Individual Family Service Plan (IFSP) and social-emotional and relational goals with caregivers are identified for inclusion on the IFSP.
- D. For optimal coordination and integration of services for the infant/young child, involvement of both the bio-parent(s) and foster parent(s) in the IFSP meeting is recommended, unless otherwise specified. NM-IT IMH therapist(s) and CPS workers on a particular case are included in on-going IFSP meetings and reviews as their services relate to the goals. All decisions and changes are discussed and coordinated as a team.

- E. The infant/young child's developmental progress with Early Intervention services is integrated with Infant Mental Health Treatment progress narratives into a NM-IT court report.
- F. Ideally, the Part C Service Provider(s) and Infant NM-IT members would meet regularly with the NM-IT director for consultation and training regarding shared infant/young child custody cases. These meetings would include both discussion of the process of working with challenging cases, as well as the content of family centered interventions

Reports, Court Hearings, Meetings

- A. Reports are prepared for court hearings leading to permanency by the NM-IT IMH clinician working on the case in question with oversight from the NM-IT director.
- B. The reports integrate the treatment goals, progress, challenges and recommendations from each of the team members working with a particular case in order to present the court with a unified document.
- C. The tools used to track progress are utilized by the NM-IT to ascertain and define the parent's capacity for growth and change specific to treatment goals and the level of adaptive relational functioning between the infant/young child and bio-parent(s) as well as the special needs and developmental capacities of the infant/young child.
- D. When possible, a designee from the NM-IT attends court hearings to address the court if requested regarding services and status.
- E. Every NM-IT determines the frequency for getting together to discuss Infant Team cases and compile updated information for the database.
- F. Monthly Provider meetings are recommended with NM-IT, CPS, Part-C Providers, Attorneys, Court Appointed Special Advocates, Guardian Ad Litem, and other providers working with a particular custody case to ensure the best outcomes for infants/young children and bio-parents.

Data Collection and Program Evaluation

- A. The IMH database and program evaluations are necessary to track recurrence, permanency, treatment effectiveness and to provide assurances to policy-makers that services are being implemented as intended and that they reach the target audience.
- B. The UNM-Continuing Education, Early Childhood Services Center has designed a flow chart and tip sheets to allow NM-ITs to maintain fidelity to data entry procedures for each client file on a timely basis.
- C. CYFD Behavioral Health Evaluator provides a longitudinal assessment of NM-ITs outcomes looking at data entered regarding the demographics of a case; the ACES score from intake; and, the Caregiving Dimensions-Levels of Adaptive Functioning (DC: 0-5), PITA and DIAPER scores, which are re-administered quarterly (4x a year) until the case is discharged.

Quarterly and Annual Reports

- A. Every NM-IT is expected to complete Quarterly Reports (October, January, April) and an Annual Report (June) detailing cases served and the overall impact of the services provided.
- B. The reports are used to measure the NM-IT program efficacy and to support continued program funding.
- C. A form developed by the BHS-IECMH Program Director is used for report submission.

Supervision and Consultation

There are three types of supervision that are required to take place within NM-ITs:

Clinical: must take place at least one hour every two weeks with each individual clinician. Group clinical supervision may be incorporated but not to supplant individual supervision.

Reflective: must take place at least one hour every two weeks with each individual clinician. Group clinical supervision may be incorporated as a support.

Administrative: includes the review of case documentation, completion of clinical protocols, goal reviews as well as session notes, data entry etc.

A. Clinical Supervision

1. The goal of the clinical supervision process, is to enhance and support the best clinical skills that lead to improved outcomes for infants/young children and families by:
 - a. Review case formulation and conceptualization
 - b. If using CPP, addressing fidelity strands
 - c. Reviewing comprehensive assessment protocols
 - d. Goal formulation
 - e. Strategies identified to address the goals
 - f. DAP notes that accurately documents, progress in treatment
 - g. Termination as clinical process discussion
 - h. Reports to Protective Services
 - i. Systems Issues and impact on clinical services

B. Administrative Supervision

- Assure that IMH data entry is current and accurate
- Appropriate licensure level to practice
- Endorsement is completed
- Endorsement waiver requested and received
- Participation in all required functions such as quarterly meetings, ECHO calls, consultation and supervision calls.
- Quarterly reports and end of year reports are submitted on a timely basis
- Billing is accurately and submitted timely
- Documentation of the completion of these administrative activities
- Staff evaluations
- Review three (3) case files per quarter for completeness

C. Reflective Consultation and Supervision (see 7th IMH principle, Chapter 2)

- In order to maintain protocol and program fidelity regular reflective supervision and consultation is critical to the NM-IT's work. Reflective supervision is required for all members of the NM-IT due to the evocative nature of working with young children and families, and is most often provided by the NM-IT director.
- A monthly ECHO Model Reflective Consultation Videoconference call with other NM-ITs in the state is required in order, for example, to ask questions about infancy and early childhood, relationship risks and protective capacities, disorders of development, and strategies for effective work as well as to provide case write ups when requested.
- Quarterly Reflective Consultation is often provided at the Community of Practice Meetings with Dr. Julie Larrieu, an international IMH expert, and NM-IT members are required to attend.
- NM-ITs receive quarterly consultation from the BHS-IECMH Program Director on an Ask the Manager ECHO videoconference call to discuss systems and administrative issues.

RESULTS OF NM-ITS AND COLLABORATIVE WORK

The work of the NM-ITs have resulted in the following:

Systems Change

1. Judges who are more knowledgeable about the needs of infants/young children.
2. Dedicated NM-IT members with child development and infant mental health expertise to work with the community collaborators, families and the judicial system.
3. Community teaming that includes CPS, Part-C, Infant Mental Health and the Judicial System as well as other community providers who interface with the infant/young child and bio-parents (e.g., Child Care, Primary Care Physician, Recovery Programs).

4. Attorneys who are more knowledgeable about the needs of infants/young children.
5. Community efforts and awareness of barriers to adequate parental progress in custody cases (e.g., continued substance abuse, ongoing domestic violence, untreated mental illness, lack of stable housing and transportation).

Enhanced Services for Infants/Young Children

6. Infants/young children taken into custody are identified, assessed and served promptly. The time frame depends upon the referral from CPS and the legal parameters of the case. The status will dictate when and what the NM-IT can provide.
7. NM-ITs support stability in placements from the beginning and focus on expediting permanency for infants and young children in custody.
8. NM-ITs assist with and appropriately plan for transitions in infants'/young children's lives, including transitions to new schools and new placements, as well as transitions to home.
9. Trauma-informed IMH services and the use of Child Parent Psychotherapy (CPP) as the evidence based model of treatment has improved permanency outcomes.
10. Integrating Developmental and Infant Mental Health services have improved the developmental outcomes of infants/young children.
11. Services that include Dyadic and Collateral Clinical Treatments improve the reflective functioning of bio-parents.
12. Parents/caregivers are treated as partners in the assessment and treatment process, and the planning, delivery, and evaluation of developmental and infant mental health services.

Procedural Enhancements

13. Frequent case monitoring and tracking through team provider meetings and ongoing communications better assist in transcribing progress and challenges to the court.
14. Relationship-focused services that address what the infant/young child brings to the relationship with his/her bio-parent/caregiver; what the bio-parent/caregiver brings to the relationship; and, what is co-created or co-constructed between them in the dyadic engagement addresses the multicausality and complexity of custody cases.
15. Ongoing psychoeducation and training through the Community of Practice, monthly ECHO Case Based Videoconferences, Consultation Services, and Mentorship with Julie Larrieu, PhD from the Tulane Infant Team, assure continued quality of services and help to improve family outcomes.
16. Ongoing reflective supervision for team members has increased skill levels.

Sustainability Efforts

17. Database procedures help to track progress, permanency and recidivism;
18. Ongoing Program Evaluation to analyze the efficacy of assessment protocols in determining the child welfare (permanency) outcomes, and to inform treatment conceptualization to maximize early access to community resources and minimize financial cost for the state and society in general.

REFERENCES

- 1 ZERO TO THREE (2016). DC: 0-5 – *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*. Washington, D.C.: Zero to Three.
- 2 Cooper, G., Hoffman, K. T., and Powell, B. (2009). *Circle of Security: COS-P Facilitator DVD Manual 5.0*. Spokane, WA: Marycliff Institute.
- 3 Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2015). *Don't hit my mommy! A manual for child-parent psychotherapy with young children exposed to violence and other trauma* (2nd edition). Washington, D.C.: National Center for Clinical Infant Programs.

New Mexico Infant Team Assessment/Intervention Protocol

BIRTH – 3 YEARS	REFERRAL/ELIGIBILITY	TOOLS/RESOURCES	FORM	DESCRIPTION/PURPOSE
Infants/Young Children in State Custody	Referrals to NM-IT from CPS for substantiated cases involving Infants/young child(ren), birth to 3.	<ul style="list-style-type: none"> CPS Investigation and Safety/Risk Assessment 	<ul style="list-style-type: none"> Individual NM-IT Referral Form 	<ul style="list-style-type: none"> Referrals to NM-IT come from CPS for infants/young children taken into state custody. Service Requirements At least 25% of NM-IT monies need to be spent on clinical services. Up to 75% of Parent Infant Psychotherapy (PIP) monies can be used to provide clinical services to infants/young children who are part of NM-ITs. Support given to foster parent(s) of infant/young child who is part of NM-IT as long as bio-parent(s) are engaged in services. If bio-parent(s) are discharged from services due to, for example, lack of participation, services can continue with foster parents and infant/young child for no longer than 2 months to anchor skills and help with the transition Child Parent Psychotherapy(CPP) is the clinical protocol preferred by CYFD since it is evidence-based and trauma-informed.

BIRTH – 0-3 YEARS	ASSESSMENT	TOOLS/RESOURCES	FORM	DESCRIPTION/PURPOSE
Infant/Young Child taken into state custody and bio-parent(s) referred by CPS	<ul style="list-style-type: none"> Qualifications: Licensed and Endorsed Infant Mental Health Specialist 	<ul style="list-style-type: none"> DC: 0-5 Revised System plus tools described below 	<ul style="list-style-type: none"> Observation, Report and Interview, Diagnostic Criteria 	<ul style="list-style-type: none"> Referrals to NM-IT from CPS for substantiated cases involving Infants/young child(ren), birth to 3.
Caregiver Circumstances, Risk and History	<ul style="list-style-type: none"> Experience: Family/Caregiving History, Current Circumstances, History of Trauma, Mental Illness, Domestic Violence, etc., Previous CPS involvement 	<p>CYFD Mandated</p> <ul style="list-style-type: none"> Psychosocial Intake Adverse Childhood Events (ACES) Questionnaire <p><i>Additional Information for Child</i></p> <ul style="list-style-type: none"> Get Birth/Medical Record (if possible) Get Part-C Evaluations (if available) <p><i>CPP Instruments/Tools</i></p> <ul style="list-style-type: none"> Life Stressor Checklist Revised (LSC-R) Traumatic Events Screening Inventory-Revised (TESI-R) 	<ul style="list-style-type: none"> Caregiver Report/ Interview Medical/ Developmental Records 	<ul style="list-style-type: none"> To determine level of risk regarding trauma, mental illness, substance abuse, domestic violence, etc. To gather caregiver's and child's history To determine household configuration, economic and social support systems
Comprehensive Infant and Early Childhood Mental Health Assessment	<ul style="list-style-type: none"> Dyadic Relationship, Caregiver Risks and Protective Capacities, and Child Developmental Competence 	<p>CYFD Mandated</p> <p><i>Dyad</i></p> <ul style="list-style-type: none"> Crowell Caregiver-Child Interaction Procedure – 12 months – 60 months Baby Crowell – When child can sit up independently - 7 months to 12 months Observation of Infant-Caregiver in Routine Activity (feeding, diapering, play)–Birth to 6-7 months• Caregiving Dimensions-Levels of Adaptive Functioning (DC-0-5) Caregiving Dimensions-Levels of Adaptive Functioning (DC-0-5) <p><i>Caregiver</i></p> <ul style="list-style-type: none"> Working Model of the Child Interview (WMCI) <p><i>Child</i></p> <ul style="list-style-type: none"> DC: 0-5 or Observation of Developmental Competence, Domains and Milestones DIAPER 	<ul style="list-style-type: none"> Observation, Report, Interview, Videotaping, Diagnostic Criteria Administration of Tools reflected in IMH database 	<ul style="list-style-type: none"> Look at multicausality by assessing what the child brings to an interaction; what the caregiver brings to an interaction; and, what is co-created in the quality of dyadic engagement and interaction. Interactive or Co-regulation is dependent upon a contingent and reciprocal relationship. Disorder interactions are bidirectional and mutually regulated, with each partner contributing to the exchange. Example of questions to ask about Crowell: How did the dyad relate to one another? What was the overall emotional tone? How did the caregiver relate to the child? How did the child relate to the caregiver? Include any descriptive examples. What strengths could be built on? What areas need help? Ongoing record of tools administered in IMH database.

BIRTH – 5 YEARS	CLINICAL TREATMENT	MODEL/RESOURCES	FORM	DESCRIPTION/PURPOSE
Individualized Treatment, Goals and Strategies	<ul style="list-style-type: none"> • <i>Therapeutic Intervention Targets the Caregiver-Child Relationship</i> 	<p>CYFD Recommended</p> <ul style="list-style-type: none"> • Child Parent Psychotherapy: A Relationship-Based, Trauma-Informed Treatment Model • Circle of Security - Parenting 	<ul style="list-style-type: none"> • Relational Treatment of infants, toddlers, and preschoolers and their parents/caregivers using an integrated psychoanalytic, attachment, body-based, behavior-based, and developmental psychopathology perspective (1) • 8 session COS-P DVD Program 	<ul style="list-style-type: none"> • An Individualized Treatment Plan based upon assessment results includes COS-P or CPP goals targeted on aspects of the relationship as an intervention. • COS-P helps parents or caregivers understand how secure parent-child relationships can be supported and strengthened (child not present) • COS-P Goals: Work with parents and caregivers to help them to: <ul style="list-style-type: none"> • Understand their child's emotional world by learning to read emotional needs • Support their child's ability to successfully manage emotions • Enhance the development of their child's self esteem • Honor the innate wisdom and desire for their child to be secure • CPP is the relational (dyadic) treatment of infants, toddlers, and preschoolers and their parents/caregivers using an integrated psychoanalytic, attachment, body-based, behavior-based, and developmental psychopathology perspective (1) • Global CPP Goals: <ul style="list-style-type: none"> • Encourage normal development: adapt to infant or young child's developmental capacity • Offer unstructured reflective developmental guidance • Encourage and model appropriate protective behavior • Maintain regular levels of affective arousal • Interpret feelings and actions • Establish awareness and trust in bodily sensations • Achieve reciprocity in the caregiver-child relationship • Provide emotional support/empathic communication • Resolution of trauma-related symptomatology • Trauma-Related Goals of CPP: <ul style="list-style-type: none"> • Increased capacity to respond realistically to threat • Differentiation between reliving and remembering • Normalization of the traumatic response • Placing the traumatic experience in perspective • Co-construction of a mutually meaningful trauma narrative • Promote developmental progress through play, physical contact, and language

BIRTH – 5 YEARS	DOCUMENTATION/ DATA ENTRY	TOOLS/RESOURCES	FORM	DESCRIPTION/PURPOSE
Intervention/ Treatment Phases	<ul style="list-style-type: none"> • Track Progress and Services 	<ul style="list-style-type: none"> • Data Assessment Progress (DAP) Notes • Progress in Treatment Assessment (PITA) • Developmentally Informed Assessment Per Relationship (DIAPER) • CPP Fidelity Measures 	<ul style="list-style-type: none"> • Rating Scales • Checklists 	<ul style="list-style-type: none"> • The DAP Notes are entered in the database after every session. • The PITA from Tulane University is a way to track treatment progress based upon the parent's behavior. The PITA is administered quarterly (4x a year) from the time the case is entered into the database. • The DIAPER is a way to track the parent/caregiver's progress in facilitating age appropriate developmental functioning. • CPP Fidelity Measures guide a therapist through the different phases of treatment and include: Reflective Practice Fidelity, Emotional Process Fidelity, Dyadic Relational Fidelity, Trauma Framework Fidelity, Procedural Fidelity and Content Fidelity. • DAP Notes entered into IMH Database after every session • PITA and Caregiving Dimensions-Levels of AdaptiveFunctioning (DC-0-5) completed quarterly and entered into IMH database for comparative review
Data Collection and Program Evaluation	<ul style="list-style-type: none"> • Data Entry Per Case 	<ul style="list-style-type: none"> • IMH Flow Chart and Tip Sheets (available on CYFD.org website) • ACES, Caregiving Dimensions-Levels of Adaptive Functioning (DC-0-5) and PITA 	<ul style="list-style-type: none"> • Specific guidelines and steps to follow to maintain Fidelity • Caregiving Dimensions-Levels of Adaptive Functioning(DC-0-5) and PITA re-administered quarterly 	<ul style="list-style-type: none"> • The database and program evaluations are necessary to track recurrence, permanency, treatment effectiveness and to provide assurances to policy-makers that services are being implemented as intended and that they reach the target audience. Caregiving Dimensions-Levels of AdaptiveFunctioning (DC-0-5) and PITA reentered quarterly from time case is first entered into database • The UNM-Continuing Education, Early Childhood Services Center has designed a flow chart and tip sheets to allow PIP therapists maintain fidelity to data entry procedures for each client file on a timely basis.
Report Writing and Documentation	<ul style="list-style-type: none"> • Quarterly and Annual Reports to NM-IT Contract Manager • Court Reports 	<ul style="list-style-type: none"> • Form developed by CYFD BHS Infant and Early Childhood Services Contract Manager • NM-IT Court Report Form 	<ul style="list-style-type: none"> • Quantitative and Qualitative Information 	<ul style="list-style-type: none"> • Each NM-IMH submits quarterly reports as well as an annual report detailing cases served and benefit of these services provided. • The Court Reports provide information regarding the NM-IT work with a particular case, and include progress, challenges, and recommendations for the Judge.

BIRTH – 5 YEARS	TYPE	SUPERVISION/ CONSULTATION SOURCE	FORM	DESCRIPTION/PURPOSE
Reflective Consultation/ Supervision	<ul style="list-style-type: none"> • Reflective Supervision • Reflective Consultation • Supervision 	<ul style="list-style-type: none"> • It is recommended that PIP contractors receive regular Reflective Supervision and/or supervision by licensed and endorsed IMH specialist from their agency • It is recommended that NM-ITs receive Reflective Supervision by a licensed and endorsed IMH Specialist • ECHO Model Reflective Consultation 1x a month • Reflective Consultation at Community of Practice Quarterly Meeting with Dr. Julie Larrieu 		<ul style="list-style-type: none"> • In order to maintain protocol and program fidelity regular reflective supervision and consultation is critical to the NM-IT's work. • Reflective supervision is recommended for all IMH practitioners due to the evocative nature of working with young children and families. • Providing NM-ITs opportunities to recognize the potential stress of providing relationship-based practice and allowing time for adequate reflection is a component of every NM-IT program. • With regular reflective consultation, members of the NM-IT use internal knowledge and external knowledge to examine and advance practice in their clinical work

CHAPTER 4

Principles, Getting Started, Possible Roles and Questions About Roles on Infant Team

PRINCIPLES OF SERVICE DELIVERY

COLLABORATION WITH THE PARENT(S)

Respect for and active collaboration with the parent/caregiver to address the infant's/child's best interest is the cornerstone to achieving positive developmental and infant mental health outcomes. Parents/Caregivers are treated as partners in the assessment and treatment process, and the planning, delivery, and evaluation of developmental and infant mental health services.

FUNCTIONAL OUTCOMES

Developmental and Infant Mental Health services are designed and implemented to promote healthy brain development, facilitate developmental progress, and foster corrective emotional experiences between child and caregivers. Implementation of the developmental and infant mental health services plan stabilizes the infant's/child's condition and minimizes safety risks. Data is collected to monitor and evaluate outcomes as well as to provide quality assuredness.

COLLABORATION WITH OTHERS

When infants/young children and bio-parents/caregivers have multi-agency, multi-system involvement, the NM-IT contributes to integrating and coordinating a jointly established service plan that is collaboratively implemented.

ACCESSIBLE SERVICES

Infants and young children have access to a comprehensive array of developmental and infant mental health services. When the service needs are outside the scope of the NM-IT (e.g. substance use, domestic violence and mental illness treatment), ancillary community service providers and programs are accessed to augment the Infant Team services and ensure that the child and bio-parent(s) receive the treatment they need to be

successful. Plans identify services to assist with reunification efforts and minimize stress during visits. It is critical that ancillary service providers coordinate interventions and communicate with the Infant Team and CPS regarding bio-parent's treatment progress.

BEST PRACTICES

Competent individuals who are adequately trained and supervised provide developmental and infant mental health services. They are delivered in accordance with evidence-based "best practice" and include state of the art, trauma and developmentally informed practices. Infant Team service plans identify and appropriately address relationship issues that are reactions to abuse or neglect, and substance abuse problems. They address the need for stability and corrective emotional experiences to promote permanency and resilience.

MOST APPROPRIATE SETTING

Children are provided services in their home and community to the extent possible. Visitations between the bio-parent(s) and their infant/young child begin at the CYFD department and then as progress is made in treatment the NM-IT IMH clinician may recommend visits be moved to a setting outside the department. Recommendations are based upon the most natural setting appropriate to the child's needs and safety.

TIMELINESS

Children taken into custody are identified, assessed and served promptly. The length of time in foster care, multiple placements, re-referrals and regularity of services are all considered when treating infants and very young children.

SERVICES TAILORED TO THE CHILD AND FAMILY

The unique strengths and needs of infants/children and their bio-parent(s) dictate the type, mix, and intensity of developmental and infant mental health services provided. Bio-parent(s) are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking to reunify, and what services they think are required to meet these goals.

STABILITY

The Infant Team strives to minimize multiple placements and to expedite permanency for infants and young children in custody. NM-IT service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, as well as transitions to home.

RESPECT FOR THE INFANT/CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE

NM-IT services are provided in a manner that respects the cultural tradition and heritage of the child and caregivers (see Chapter 2 for Cultural Considerations).

GETTING STARTED

BEGINNING—INFANT TEAM TIPS

- Ideally establish a Transdisciplinary Team (e.g., Infant Mental Health Practitioners, Part C Providers, CPS Permanency Planning Workers, Medical Professional) in which members come together from the beginning to jointly communicate, exchange ideas and work together to come up with solutions to problems. A transdisciplinary approach is a framework for allowing members of an Infant Team to contribute knowledge and skills, collaborate with other members, and collectively determine the services that most would benefit a child, and includes representatives from every discipline that works with very young children in the child welfare system.

- Conduct a community needs assessment. Review sample cases involving very young children in foster care to develop a baseline profile to inform the team’s work. Identify significant gaps in community services (e.g., services for parents with co-occurring mental health and substance abuse disorders) and work with public officials to remedy these gaps.
- Conduct community awareness trainings to explain the Infant Team, research and benefits to judicial community, pediatricians, CYFD, Part-C providers, substance use counselors and mental health workers involved in child welfare cases.
- Develop a project plan to begin implementation of Infant Team, complete CAPTA and Infant Mental Health Assessments, and initiate services. Educate all team members about Part C of the Individuals with Disabilities Act, which specifies that maltreated infants and toddlers are eligible for screening and services for developmental delays. Develop the community’s capacity to offer mental health interventions to parents and young children together.
- Coordinate medical, developmental, and behavioral assessments of the child so service providers share information and develop a unified treatment plan that meets the child’s needs.
- Ensure the case plan provides frequent, regular supported visits between parent and child. If limited access to transportation creates a challenge for parents to visit their children, consider strategies to help parents overcome this barrier.
- Hold regular meetings of all individuals and organizations delivering services to infants and toddlers to review case progress. This should include biological family and foster parents; the CPS worker assigned to the case; attorneys for the parents, child(ren), and CPS; Infant Team members responsible for developmental and infant mental health services to child(ren) and caregivers; and a facilitator. At this meeting, discuss the family’s strengths and challenges and provide CPS worker with integrated report of all services provided, progress and challenges to present to the judge and the court.
- Establish a monthly case review process that informs the judge about each family’s progress.
- Collaborate across disciplines by offering transdisciplinary training, and encouraging team providers to participate at child and family provider meetings, conferences, and court hearings.
- Identify staff to coordinate each case, prepare documents for court, oversee services and assure the process is progressing towards permanency.
- Agree on how decisions will be made and how to resolve conflicts and reach consensus among team members.
- Connect team members with their counterparts involved in successful Infant Teams in other communities.
- Assure Infant Team members are provided with reflective supervision and avenues for consultation to avoid burn-out and activation as well as to discuss interventions.
- Build knowledge about the impact of abuse and neglect on early development by providing training opportunities for project team members and other legal and child-serving professionals working with young children and families.
- Educate foster parents about the trauma-informed needs of the children in their care.
- Develop and share resource materials to guide project team members, birth parents, and foster parents.

—Adapted From: *Healing the Youngest Children: Model Court-Community Partnerships* (2007), by Lucy Hudson, Eva Klain, Margaret Smariga, Victoria Youcha, American Bar Association and ZERO TO THREE.

INITIAL STEPS—BUILDING AN NM-IT

- Identify community partners and connect with additional expert resources.
- Identify entry level training needs and capacities of community partners regarding the complexity of families in the CPS system, caregiver-infant assessment procedures, assessing parenting capacity, and trauma informed interventions.
- Developing an Infant Team in the Judicial District may reduce maltreatment recidivism rates of infants referred to the CPS system.

- Develop Memorandums of Understanding (MOUs) with community partners, and develop positive, productive, working collaborations between protective services, infant mental health services, early intervention (Part C) and the judiciary, so that the entire system is working on behalf of the best interest of the infant (examples of MOUs in appendix).
- Infant Teams can improve psychological/developmental care to infants in their community and Judicial District by providing a comprehensive assessment and coordinated services that are trauma and developmentally-informed.
- Infant Teams improve the quality of information provided to courts regarding infants, biological parents, relatives, and foster parents as it pertains to the welfare of the infant/young child by gathering and combining the information from all professionals involved and synthesizing observations and recommendations in a concise and relevant report.
- Developing a coordinated process for assessment and treatment in order to promote permanency planning and positive developmental outcomes including protocols for assessment and intervention strategies, is an essential goal of the Infant Team.
- Determine frequency of Infant Team Meetings, provider meetings with CYFD, and meetings with other collaborating service agencies that are realistic to ensure regularity of communication and information sharing.
- Develop network with other Judicial District Infant Teams.
- All Infant Team members should have ongoing Reflective Supervision or Consultation.
- Evaluate progress and collect information for state database.

HOW TO DESCRIBE—NM-IT AS A TRANS-AGENCY APPROACH

1. The Infant Team Represents a Collaborative Model where:

- Team members work in partnership and pool resources.
- All team members are involved in planning and monitoring goals and procedures, although each team member's responsibility for the implementation of procedures may vary.
- Team members jointly share ownership and responsibility for intervention objectives.
- NM-IT director organizes the team's progress and challenges as well as additional supportive documents for the court and CYFD.

2. The NM-IT Often Involves a Trans-Agency Approach that:

- Provides a process for service providers, the family, and CYFD to come together in the best interest of the child(ren).
- Professionals share roles & see the child as a whole in the context of the family.
- NM-IT director works in close collaboration with other team members integrating & synthesizing information shared to deliver efficient and comprehensive support to CYFD and court system.
- Service delivery can be by one person with supporting services provided through joint visits and consultation and can include coaching.
- Coaching is an interactive process of observation and reflection in which the coach promotes a parent's or other caregiver's ability to support an infant's/child's participation in everyday experiences and interactions with family members across settings.
- Addresses concerns as they occur as a team, rather than only within a certain agency.
- Establishes joint responsibility for problem solution.
- Improves communication and interaction among the family, service providers, CYFD and the Infant Team.
- Assesses needs comprehensively and functionally.
- Supports transfer and maintenance of treatment effects across settings.

3. Bigger Picture

- One agency and one provider cannot meet the multifaceted needs of families and infants/young children in CYFD custody.
- Providers cannot limit themselves to seeing only one specific domain.
- Biological and Foster Families represent complex systems with strengths, challenges, resources, needs, hopes, dreams, and desires.

EXAMPLE OF NEW MEXICO INFANT TEAM ROLE DESCRIPTIONS

DIRECTOR

- Provide consultation and reflective supervision to team members
- Conduct developmental evaluations and provide complete transdisciplinary reports
- Conduct or Oversee Crowell and Working Model of the Child Interview (WMCI) Procedures
- Oversee completion of the reports for court to integrate developmental and infant mental health information
- Review of all referrals
- Oversee the provision of Infant Mental Health collateral and dyadic treatment, and Child Parent Psychotherapy
- Engage in data management and support
- Participate in meetings to build capacity and information sharing in the Judicial District

INFANT TEAM COORDINATOR

- Point person with CYFD regarding identifying information, visitation schedules, meeting schedules, transitions and disposition of cases
- Schedules 1x a month meetings with CYFD personnel involved with Infant Team
- Schedules Crowell and WMCI procedures, and other meetings regarding cases
- Provides the visitation schedule and determines coverage options with other Infant Team members
- Oversees documentation for files and data collection of Infant Team services provided to bio- and foster family, and infant/child(ren)

INFANT MENTAL HEALTH THERAPIST

- Responsible for conducting Crowell Caregiver-Child Structured Interaction Procedures and Perception Interviews
- Assigned to a biological parent with support to corresponding foster parent(s)
- Offers COS-DVD Parenting Program to client(s)
- Conducts Infant Mental Health Treatment that includes Collateral sessions and Dyadic work with a biological parent and infant/child using Child Parent Psychotherapy
- Participates in Reflective Supervision and Consultation as well as Infant Team meetings
- Provides monthly progress notes to be included in comprehensive court reports
- When possible, attends Provider Meetings, Family Centered Meetings, IFSP Meetings, Transition Meetings in addition to any other special meetings called by CPS regarding their case

PART-C SERVICE COORDINATOR (if applicable)

- Arranges date and time for conducting the developmental evaluation with family and CPS and for formulating the IFSP
- Obtains releases from Child Protective Services (CPS) immediately for contact with:
 - ~Biological Parents
 - ~Foster Parents
 - ~Birth Hospital
 - ~Pediatrician
 - ~Other medical and community providers

- Has biological parents, foster parents and CPS review and sign all service agreements and policies
- Puts CPS's address on the front page of the IFSP, not family members' contact information.
- Strives to have biological parents, foster parents, CPS and all providers present for IFSP meetings and reviews. Otherwise spend time with each, gathering and sharing information.
- Assures that IFSP goals should be based on information about the child's functioning from both biological and foster parents. It is important to obtain information about the child's routines in each caregiving setting (including visits). CPS will have important insights into goals, including how to support removing barriers to safety
- Gives copies of the developmental evaluation report and IFSP to bio- and foster parents and to CPS. CPS can share the report with the GAL (Guardian Ad Litem) and the CASA (Court Appointed Special Advocate)
- Assures that discussions with the entire Infant Team in addition to the bio- and foster parents are enlisted before making changes to IFSP goals or services or before offering additional services
- Prepares new providers by sharing the philosophy of the Infant Team and discussing standards for communication and intervention
- Assists with setting a date and time for the monthly provider meetings at CYFD
- Streamlines communication with CPS through the Infant Team Coordinator
- Attends all Infant Team meetings for ongoing training, video review, consultation and ongoing supervision with Infant Team director
- Attends Provider Meetings, Family Centered Meetings, Transition Meetings in addition to any other special meetings called by CPS regarding a client when possible
- According to FIT guidelines, assists with the transition from Part-C Early Intervention Services to Public School Services if eligible when child approaches his/her 3rd birthday
- Attends training and ongoing Reflective Supervision with an Infant Mental Health Specialist/Expert to assure the delivery of trauma-informed, relationship-based developmental services

EARLY INTERVENTIONIST, OCCUPATIONAL THERAPIST, PHYSICAL THERAPIST AND/OR SPEECH-LANGUAGE THERAPIST (when applicable)

- Provides developmental services as documented in the IFSP and according to Part-C state regulations
- Integrates Developmental Goals with Infant Mental Health Goals
- Provides developmental support during visits with biological parent(s) and supports foster parents
- Writes progress notes to be included in monthly reports written by co-directors for CYFD and Court
- Develops activities used to support developmental progress and relationship building to be utilized by all team members
- Visits infants and young children in childcare to offer support and training to staff
- Attends Training and ongoing Reflective Supervision with an Infant Mental Health Specialist/Expert who is knowledgeable about trauma-informed, relationship-based developmental services

QUESTIONS ABOUT INFANT TEAM ROLES

DIRECTOR ROLE

1. What is the role of the Director on the NM-IT and is he/she familiar with the unique challenges associated with providing services to maltreated children and their families?

- The Director provides leadership to the Infant Team and is familiar with the unique challenges associated with providing services to maltreated children and their families
- "Holding" of the Team and the process including oversight for reviewing new referrals, assignments, coordinating information for reports, and collaborative system building.

2. How does the director represent the NM-IT at CYFD and in Court?

- The director or another designated team member represents the Infant Team in Court if possible and is responsible for compiling monthly information from the Infant Team for use by CYFD and to inform the Court.

3. Is the director involved in completing the Infant Mental Health Assessments and Interviews?

- The director participates in and/or oversees completion of the Infant Mental Health Assessments, Perception Interviews, Developmental Evaluations and reports.

4. Would CYFD and the Court use the detailed Infant Mental Health Assessment and monthly reports compiled by director in the permanency planning decision?

- The Infant Mental Health Assessment and monthly reports are used to develop a Treatment Plan with CYFD, to evaluate progress and to assist in the Court's permanency planning decision.

5. Does the director provide direct services to the infant/child who is in state custody and part of the IMHT, along with the biological parent(s)?

- The director may provide direct services to Infant Team families or provide consultation and supervision to Infant Team members implementing the direct services.

6. How often do the director meet with the Infant Team either individually or as a group?

- The director of each New Mexico Infant Team will determine what is feasible in terms of frequency of team meetings, reflective supervision and consultation.
- Respective infant teams meet at least once a month with state wide reflective consultants, meet quarterly in person with all the teams and meet once a month via phone with all teams.

7. Does the director or another appropriate person provide ongoing Reflective Supervision and consultation on service delivery to the Infant Team?

- An important part of participating in an Infant Team is for its members to receive ongoing Reflective Supervision and consultation to assure the quality of service delivery. The director of the NM-IT most often provides this service to the other infant team members.

INFANT MENTAL HEALTH THERAPIST ROLE

1. What is the role of Infant Mental Health Therapist on the infant team? and are they familiar with the unique challenges associated with providing services to maltreated children and their families?

- The Infant Mental Health Therapist's role is to provide dyadic and collateral mental health services to the biological parent(s) and to the infant/child(ren) in custody assigned to him/her. This starts with a comprehensive assessment of the relationship and the respective capacities of the adult and the child.
- The Infant Mental Health therapist should meet the competencies required for a level 3 or 4 endorsement through the New Mexico Association for Infant Mental Health, and, in addition, have specific training with the NM-IT assessment protocol, Child Parent Psychotherapy, trauma informed practice, familiarity with the child protective system, and be able to articulate in reports the progress and challenges related to the relational health and risks currently.

2. Are the Infant Mental Health Specialists responsible for completing the Infant Mental Health Assessments and Interviews?

- Yes, the assigned Infant Mental Health clinician is the likely person to complete the IMH assessments.

3. How should Infant Mental Health providers write reports/contact notes and maintain confidentiality since they can be used in court?

- The mental health provider keeps notes, records and reports in accordance with the governing licensure board they are under. Psychotherapy notes have a higher level of client confidentiality in regards to court.
- The comprehensive, regularly submitted reports serve the purpose of sharing information with the court, CPS the client, GAL, respondent's attorneys, children's court attorneys and CASA workers so that there are no "surprises" in court.

4. Would CPS use the results of the Infant Mental Health Specialist's comprehensive intake information or contact notes in the investigation decision?

- No, any information gathered after the investigation cannot be used in the initial judiciary decision.

5. If the child is in state custody and part of the NM-IT, should both the foster parent(s) and biological parent(s) receive Infant Mental Health Services?

- This is ideal as all primary caretakers for the infant(s) benefit from knowing what supports the infant's social, emotional and physical development, however, the bio-parents receive the treatment and specialized IMH services.
- Foster parents are involved in all Part-C Early Intervention Services and have consultation with the Infant Mental Health Specialist to link information about what supports the infant/young child between the foster parent(s) and bio-parent(s).
- It is also helpful for the foster parents to have support regarding Judicial proceedings and the timeline for permanency in the custody process.
- If the bio-parent(s) is not participating in NM-IT services with the Infant Mental Health Specialist or has been discharged from NM-IT services due to lack of engagement, the Infant Mental Health Specialist can work with the Foster Parent(s) as a transition for an additional 2 months to anchor skills for the infant/child before closing the NM-IT case.

6. How should the Infant Mental Health Specialist consult with other Infant Mental Health Team members?

- Ideally the Infant Team works collaboratively on all aspects of assessment, treatment and recommendations.
- Infant Mental Health Specialist should use discretion regarding the sharing of personal content that is shared in individual psychotherapy sessions.
- It is important to be respectful of adult clients' confidentiality and trust in their primary therapist.

7. Should the Infant Mental Health Specialist receive ongoing Reflective Supervision from an Infant Team member or an outside source?

- The important factor is that the infant mental health specialists receive reflective consultation from a competent professional.
- Whether the Reflective Supervisor or Consultant is part of the NM-IT or an outside consultant depends upon the specific team set up and resources. Often the NM-IT Director will provide this service.

PART-C EARLY INTERVENTIONIST AND SERVICE COORDINATOR ROLE

1. What is the role of Early Intervention on the Infant Team, and are Part C providers familiar with the unique challenges associated with providing services to maltreated children and their families?

- Support and enhance collaboration among public health agencies, the child protection system, and private community-based programs to provide child abuse and neglect prevention and treatment services (including linkages with education systems) and to address the health needs, including mental health needs, of children identified as abused or neglected, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports.

- Many Part C providers are speech language therapists, occupational therapists and physical therapists, who may not be well prepared to address the special considerations required when working with maltreated children.
- Receipt of Part C services is voluntary, so court-ordered services are not part of the culture for early intervention service providers.
- Court-ordered involvement may cause parents or caregivers to view a service provider as an intrusion rather than as a source of assistance.
- They may be suspicious of, or hostile towards, service providers.
- The focus and role of Child Welfare Services is on protecting the child's safety and dealing with the perpetrator and Part C's focus and role is providing services to children with disabilities and their families.
- Early interventionists must also be aware of the ways their own culture, "way of being" or professional agenda may influence a parent child dyadic relationship.
- There are three dyadic relationships to consider when thinking about early intervention work in general, but specifically with IPMH (Infant-Parent Mental Health) work: caregiver-child dyad; caregiver-provider dyad; and provider-child dyad.

2. How should Infant Team Part C - FIT (Family, Infant, Toddler Program) providers write reports or contact notes since they can be used in court?

- It is important that all materials be written clearly and should include factual statements rather than opinions.
- The exception for this would be the informed clinical opinion of the team regarding the child's eligibility.
- The developmental evaluation report is not intended to be a professional assessment of the family's functioning, as might occur in other types of service delivery settings or circumstances.
- The voluntary developmental evaluation is intended to be a family-directed process to identify the family resources, priorities, and concerns related to enhancing their child's development.³¹
- As part of the developmental evaluation process, the evaluator should discuss with the parent how the results of the family assessment should be documented, including what information should be included in the evaluation report (transparency).
- Families can be informed that in case of a subpoena, the notes may be read in court.
- Parents should also be informed that the role of the FIT providers is to record information regarding the early intervention supports and services provided and not to judge the parent(s).
- Dates and times should always be recorded and the full name of the staff person who completed the notes / reports must be included.

3. Will the results of the Comprehensive Multidisciplinary Developmental Evaluation or contact notes be used in the permanency plan developed with CYFD?

- The initial referral to the Infant Team for a developmental evaluation is made under CAPTA to assess the needs of the child.
- The developmental evaluation provides valuable information about a child's strengths and needs that can be used in planning visitations and supportive interventions.
- A developmental evaluation or contact notes from the part C providers of the Infant Team would not typically provide any information that would impact an investigation decision but can be part of developing and evaluating the treatment plan.

4. If the child is in state custody, does the foster parent have the ability to say that the parents cannot receive FIT documents (e.g., evaluation report, IFSP) or participate in the early intervention services?

- No, the foster parent cannot determine what documents the biological parent(s) receive and do not receive.

5. Who signs for medical releases that are subject to HIPAA regulations?

- If the state has custody and is the legal guardian, the Child Protective Services (CPS) caseworker would sign for the medical release.
- If CYFD has not taken custody the legal guardian would still be the parent(s) and they would have to sign for Medical releases.

6. What responsibility does the Infant Team's FIT provider have in reporting any information back to CPS on what they saw on the home visit?

- The FIT provider should report to the director of the Infant Team any concerns related to the development of the child and the success of the FIT provider in providing effective early intervention supports and services with both the foster family and parents.
- The director will communicate with the CPS caseworker on issues and concerns related to safety of the child.
- The Infant Team and the FIT provider staff are mandated reporters for suspected abuse and neglect.

7. If the abuse/neglect investigation is substantiated but the child is not taken into state custody, how long will a CPS caseworker be involved with the family?

- The initial investigation may remain open for 30 days or more in special cases.
- If a court order is not filed, all ongoing involvement with the family is voluntary.
- CYFD policies and procedures allow the department to work with a family on a voluntary basis for a 90-day period with a possible 90-day extension.
- Not all substantiated cases are opened to CYFD - CPS for voluntary services.

8. Is the CPS caseworker involved in the development of the IFSP with the Infant Team, parents and foster family?

- The CPS caseworker as a member of the Infant Team should be involved in the development of the IFSP with other team members and with both the parents and foster family.

9. Does the Infant Team FIT staff provide the CPS caseworker with a copy of all documents, including the initial evaluation, IFSP, case notes and progress reports?

- For a child in the custody of CYFD, the Infant Team provides the CPS caseworker with the results of any evaluations conducted and the IFSP.
- The director of the Infant Team compiles integrated monthly reports for CYFD and the court from all team service providers reflecting participation in services as well as progress and challenges with the child, foster family and parents.
- If a child is not in the custody of the state, the child's parents/guardian must authorize the release of any information to CYFD (Non-Substantiated Referral).

10. Can a FIT provider be required to testify in court?

- Yes, the court can subpoena anyone to testify in court.
- The FIT Provider should make factual statements related to the early intervention supports and services provided if testifying in court.
- If CYFD is requiring the FIT provider to testify in court, the provider typically will meet with the caseworker and children's court attorney to review the nature of the testimony.

11. Is the Infant Team required to testify in court, and can reports and contact notes made by FIT providers be part of the testimony?

- Yes. The Infant Team director(s) attend all court hearings of their assigned families as representatives of the team.
- The court is provided with the compiled, integrated monthly reports from the Infant Team service providers, that includes all evaluations and progress/contact notes in the child's record.

- The monthly reports are written in a way that is clear, factual and objective.
- The court can subpoena the director(s) of the Infant Team to provide additional information and psychoeducation related to work with a particular child and family.

12. Do all children being referred through CAPTA to the Infant Team need a full developmental evaluation or can they be screened?

- It is more cost effective to move straight to the comprehensive multidisciplinary developmental evaluation rather than screen first.
- The Infant Team's developmental evaluation is then part of a comprehensive Infant Mental Health Assessment of the child and family that provides the foundation for determining appropriate services and treatment goals.

13. How can the Infant Team FIT provider and CYFD Case workers promote good communication with each other?

- The Infant Team's FIT service coordinator should give feedback to the CPS caseworker regarding the referral and should inform the caseworker of the results of the developmental evaluation.
- The CPS caseworker should be invited to the IFSP meeting.
- If the CPS caseworker is unable to attend, due to scheduling, the Infant Team FIT service coordinator should inform them of the early intervention supports and services to be provided to the child and family.
- A copy of the IFSP should be sent to the caseworker if the state has custody or if parents authorize such a release of information.
- The Infant Team FIT provider should update the caseworker as the child's developmental information changes and informs the caseworker of any difficulties in carrying out the IFSP.
- The Infant Team FIT service coordinator and the CPS caseworker should remain in regular contact throughout the child's eligibility for the FIT Program as long as CYFD has the authority to be involved with the child.
- The CYFD caseworker should inform the director(s) of the Infant Team and the team's FIT service coordinator if there is a change in caseworkers assigned.

14. What should the Infant Team FIT provider do if the family refuses to attend and/or participate in early intervention?

- If the family does not allow the Infant Team FIT staff to enter their home or does not attend early intervention at another planned location, the FIT service coordinator needs to inform the director(s) of the Infant Team who will communicate with the CYFD - CPS caseworker.

15. Who signs consent the initial evaluation and for early intervention services on the IFSP?

- When the child is in legal custody of the state, the CPS caseworker is the child's legal guardian and signs consent for the initial evaluation for services detailed on the IFSP. The foster family and the parents additionally sign the IFSP as representation of a collaborative plan in the best interest of the child.

16. Is there a need for the Infant Team to develop unique intervention practices to address this population?

- Considerable advances in implementing neuroscience, engaging parents with trauma histories, assisting dyads (caregiver and child) with attachment disturbances, promoting emotional reparation, and utilizing trauma- and developmentally-informed interventions with families in the Child Welfare System are utilized by the Infant Team for the provision of effective services.
- In particular, the research highlights the need for new expertise and interventions for infants (i.e., the first year of life) and toddlers exposed to chronic stress, trauma and neglect.

17. Best practices on Collaboration Models.

- Central to effective service delivery is collaboration between the Infant Team, Child Welfare, Medical Providers, and Specialized Treatment Programs.
- As a consequence, the Infant Team maintains “best practices” in collaboration with other community providers to implement trauma and developmentally informed assessment and intervention practices that can be evaluated in a state database to ensure that children and families benefit from the level of service that is commensurate with their developmental needs.

—Adapted from:

CYFD and New Mexico Department of Health 2008 document, *Child Abuse Prevention & Treatment Act (CAPTA) Referrals to the Family Infant Toddler (FIT) Program*

CHAPTER 5

Parent Infant Psychotherapy Services

INFANT/CHILD-CAREGIVER DYADIC PSYCHOTHERAPY AND EMOTIONAL SUPPORT

A. CHILD PARENT PSYCHOTHERAPY AS A TREATMENT APPROACH

1. INTRODUCTION

Interactional capacities that occur between infants and caregivers in many families are often strained, impaired or absent when there are undue stressors and/or situations where there has been child maltreatment. In addition to identifiable abuse or neglect there can be emotional, behavioral, and engagement problems affecting the relationship.

In response to these dyadic relationship impairments, we bring a trauma informed and developmental lens to our work with the caregiver (which can be the biological parent(s), the foster parent(s), grand-parents, kinship or another primary caregiver for the infant). The Dyadic work focuses on and supports the relationship between the child and the adult and the interactions that take place when they are together. The caregiver's responsive, reflective and protective capacities are the target for enhancement as are the child's regulatory, developmental and interactive capacities. Therefore, in parent infant psychotherapy and Child Parent Psychotherapy (CPP), the relationship becomes our focus and the interactions between the dyad are the target for the therapeutic work. The therapeutic work is based on attachment theory and trauma theory, but also integrates developmental, psychodynamic, psychoeducational, social learning theories and executive functioning informed practices as well.

The focus of the work is to bring the parent's awareness to the infant's experience and needs in a way that is protective and supports the development of security and stability. This is done by addressing the caregiver's history including past and present trauma, their understanding of their child's experience and the impact of trauma on their child's developmental and regulatory capacities as well as their reflective functioning, working models and behavioral interactions with the child.

With CPP, the targets of treatment interventions include caregivers' and young child's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. (Lieberman, 2005)

The NM-IT IMH clinician's mental health goal is to:

Have the adult:

- Develop and maintain a therapeutic relationship with the infant mental health therapist. This involves developing a therapeutic alliance and often dealing with "institutional transference";
- Demonstrate capacity for reflective functioning to understand their own feelings and behaviors as well as their child's;
- Take responsibility for the impact of their behavior on their child and for assuring the child's safety;
- Understand the developmental and emotional needs of their child;
- Understand the experience of the child; and
- Understand the impact of trauma and past experiences as an influence on present functioning and behavior.

2. THE TULANE INFANT TEAM MODEL

The New Mexico Infant Teams utilize the Tulane Infant Team Model from the University of Tulane, School of Medicine, Department of Psychiatry and Behavioral Medicine. The Mental Health Assessment and Treatment Phase is articulated by following excerpts from the body of work by Charlie Zeanah, MD, Julie Larrieu, PhD, and Neil Boris, MD:

Clinical Context and Evaluation

- Young children's development is powerfully affected by their relationships with important caregivers
- Developing an attachment relationship to caregivers is essential for young children
- Young children may have vastly different kinds of relationships with different caregivers
- Clinical Context: Attachment
- Infants are strongly biologically predisposed to form attachments to caregiving adults
- Attachment develops gradually over the first several years of life, based upon relationship experiences with caregivers
- Under usual rearing conditions, infants develop "focused" or "preferred" attachments in the second half of the first year of life seen by:
 - ~ Separation protest
 - ~ Stranger wariness

Importance of Attachment

- Through experiences with caregivers, baby develops expectations about the dependability of attachment figures to provide comfort, support and nurturance in times of need;
- These expectations guide babies' behavior in intimate relationships; and
- Experiences are strongly predictive of child's subsequent social adaptation.

Attachment Disruptions

- Disrupted attachments in early years have long been believed to be harmful;
- Increasing numbers of disruptions are associated with increased risk for clinical problems, including disorders of attachment;
- From the child's perspective, disruptions are impossible to understand; and
- We work to minimize attachment disruptions.

Attachment Essentials

- In order to protect young children adequately, the foster parent must become primary caregiver and attachment figure for child:
 - ~ The young child cannot wait;
 - ~ The young child needs literal physical contact to sustain attachments;
and
 - ~ Emotional availability and dependability are crucial.

3. SPECIAL FEATURES OF NM-IT IMH SERVICES

- Multimodal services
- Relational, infant mental health perspective
- Naturalistic and clinic settings and structured and unstructured assessments
- Integrated treatment plans
- High intensity, low volume case load
- Addresses countertransference
- Systems focus
- Program/funding partnerships

The Initial Case Assessment Process is a comprehensive approach to gathering information from both structured and unstructured observational methods in multiple settings. This approach provides the clinician/team with information that is much more thorough and useful in treatment planning. In particular, when assessing infants and young children, observing them in multiple settings and with different caregivers yields the most helpful information regarding capacities. Observations and interviews may include the following:

- Home visits (Biological and foster parents)
- Clinic visits
- Childcare Center visits
- Part C Developmental Assessment and Evaluation

Following the initial assessment process, there may be collaborative activities, which will depend on the legal status of the case. They may include:

- Family/provider meetings
- Case conferences
- Parent conferences
- Collateral provider consultation.

Case and Treatments goals are defined and intervention and treatment approaches identified, including but not limited to:

- Individual psychotherapy
- Dyadic psychotherapy
- Infant-parent psychotherapy
- Child-parent psychotherapy
- Interaction guidance
- Parent-child interaction therapy
- Circle of Security®
- Trauma informed treatment, including Part C developmental services
- Therapeutic visitation
- Visit coaching
- Couples psychotherapy

- Family psychotherapy
- Sometimes includes extended family, kin, foster parents
- Other intervention and treatment approaches deemed appropriate

Assessment of Relationship:

Considerations for understanding the caregiver child relationship takes an observant and inquiring eye. Clinicians are trained to look at many aspects of the relationship between the child and adult which include:

- Identifying patterns of interaction between caregivers and infants to obtain information about healthy or disturbed aspects of the relationship;
- Caregivers response to teaching tasks, unstructured play, feeding and other caretaking activities;
- Caregiver’s ability to understand and respond to infant’s special needs;
- Caregivers’s capacity to consider objective and subjective experiences of infant and caregiver, which include caregivers’ history, culture, and community;
- Caregiver’s reflective capacity, theory of mind and executive functioning in regards to child’s developmental level and needs, state of mind and experience;
- Caregiver’s working model of the child(ren); and
- Identification of strengths and areas for growth in the relationship.

Essentials:

- Experts who have seen caregiver and child together are best qualified to comment on the quality of their relationship.
- Understanding that the quality of the relationship of the caregiver and child is an essential tool in making decisions regarding “best interest” of child in the placement decision of children in protective custody. Not all PIP cases will involve custody or placement decisions.

Interactive Behavior and Infant Development

- High levels of warmth, synchrony and reciprocal responsiveness during infant parent interaction is associated with enhanced infant development across a number of domains; and
- Low levels of these same qualities dramatically increase risk for a variety of adverse outcomes.

4. NM-IT SERVICES

What Do We Do with the Results?

Our goal is to facilitate safe enough parenting that also supports security and optimal development for the child:

- Bringing benevolence and knowledge of theory and practice, the IMH clinician will focus on identifying strengths as well as areas for growth. Specifically, behaviors that interfere with the caregiver’s capacity to parent productively and protectively.
- Remediate concerns (e.g., help parent address own issues which get in the way of seeing the child clearly, acknowledging the child’s experience and keeping the child safe both physically and emotionally); and
- Supporting the caregiver to support and engage with the child in a manner that promotes optimal growth and well- being.

How Do We Use Relationship Assessments?

- To understand confusing/complex behaviors in a child;
- To understand child’s developmental and emotional needs;
- To understand caregiver’s state of mind;
- To understand caregiver’s history and working models;
- For Treatment planning;

- To measure progress in treatment
 - For Custody cases:
- Visitation issues;
- Permanency planning decisions

What are Predictors of Recidivism in Protective Custody cases?

Cumulative Risk Factors

- Lack of Education
 - Untreated past or current;
- Substance Abuse;
- Psychiatric History;
- Arrest History;
- Childhood Maltreatment;
- Depressive Symptomatology;
- Partner Violence; and
- Multiple ACEs.

To address these risk factors here are Sample Treatment Goals (see more examples in Chapter 7):

Parent/caregiver will;

- Accept responsibility for child(ren)'s maltreatment and the need to change their own behavior;
- Acknowledge longstanding psychiatric, substance use and/or relationship difficulties;
- Place needs of child ahead of their own needs;
- Demonstrate a capacity for change and willingness to try different approaches within a reasonable time frame;
- Work constructively with involved professionals; and
- Make use of available community resources.

5. VISITATIONS AND NM-IT SERVICES FOR INFANTS/YOUNG CHILDREN IN PROTECTIVE CUSTODY

Attachment and Visitation Considerations

- Adults, but not young children, are capable of sustaining attachment relationships across time and space;
 - ~ Adults should bear the burden of difficulties, not young children, for example the adult should do the traveling, not the child, visitation frequency and duration should be scheduled according to child's capacity, perspective and tolerance;
- Who visits whom?
- Travel and familiarity of setting; and
- Biological relatedness does not trump stability (Zeanah, 2001).

Visitation with Biological Parents

- Is it harmful to the child?
 - ~ Stress vs. harm.
- Is it helpful to child's attachment to biological parent?
 - ~ What is the goal?
- Is it helpful to biological parent's attachment to child?
 - ~ Need less contact than child (Zeanah, 2001).

Principles of Visitation

- Child's well-being is primary concern;
- Recommended that an attachment figure is present if child is more than 6 months old;
- Child can sustain a relationship with parent without parent being an attachment figure;
- As parents progress towards reunification, frequency and length of visits should increase;

- Relationships with foster parents should continue after reunification whenever possible; and
- Attachment building efforts begin after parents:
 - ~ Have accepted responsibility for children’s maltreatment;
 - ~ Have begun recovery from mental health/substance abuse problems; and
 - ~ Are making progress towards reunification.

Considerations for Collaborative Visitation

- Visiting without attachment figure (foster parent) causes undue stress on child (separation) by second half of first year;
- Presence of foster parent can improve quality of visit for biological parent:
 - ~ If biological parent understands rationale and can be supported;
 - ~ If foster parent can support child without undermining biological parent.
- Goal of visit with biological parents need not be developing attachment (especially initially) rather to increase pleasurable experiences and understanding of child’s capacities;
- Child’s best interest ought to be paramount in any visitation plan;
- Child must be able to tolerate stress of visit; otherwise, modify visitation schedule; and
- What is in the “child’s best interest” is a process of educating individuals and systems.

6. NM-IT INTERVENTIONS

Interventions Aim to Change Systems

- Infants and families are embedded within powerful and complex systems of care:
 - ~ Child Welfare
 - ~ Legal
 - ~ Mental Health, Substance Abuse, Developmental Disabilities
 - ~ Healthcare
 - ~ Education
 - ~ Other Community Resources

Goals of Systems Intervention

- Change how the system understands and deals with young children;
- System is trauma informed and understands the impact of stress and trauma on the developing brain of the infant (neurobiology) including prenatally. System Recognizes:
 - ~ Developmental differences;
 - ~ Time frame differences; and
 - ~ Importance of caregiving relationships, culture, community.
- Enhance access to services; and
- Improve integration and coherence of services.

3 Levels of System Intervention

- Proximal, immediate clinical context:
 - ~ Infant-parent relationship;
 - ~ Child care setting;
 - ~ Child protective services; and
 - ~ Community providers (Substance Abuse, Domestic Violence Treatment, medication management, individual adult treatment, etc.).
- Legal system:
 - ~ Juvenile or family court judge;
 - ~ Attorneys for protective services, children, parents; and
 - ~ CASA workers.

- Other, larger systems:
 - ~ Part C
 - ~ Educational
 - ~ Pediatrics
 - ~ Policy
 - ~ Legal

7. REFLECTIVE SUPERVISION/REFLECTIVE CONSULTATION

Professionals who provide services to infants and young children and their families involved in stressful situations, including involvement with child protective services, face multiple daily challenges. Working with stressed and traumatized young children and their families, as well as the systems charged with providing services and oversight affects professionals on many levels. These early professionals (mental health providers, developmental specialists, early interventionists, home visitors, family educators, Head Start teachers, public health nurses, child welfare workers and others) in turn require support and ongoing professional development to provide perspective, increase their skills, and avoid burn-out. Reflective supervision, a practice that has evolved from the multi-disciplinary field of infant mental health provides the support needed by practitioners who are exposed to the intense emotional content and life experiences related to their work with families. An ongoing professional development process, reflective supervision provides a way for professionals working with very young children to reach greater understanding of their own responses, as well as the babies and adults they work with, and as a result, facilitating quality practice and intervention.

Ellen Munro states:

Experience on its own is not enough. It needs to be allied to reflection – time and attention given to mulling over the experience and learning from it...The emotional dimension of working with children and families plays a significant part in how social workers reason and react. If it is not explicitly discussed and addressed then its impact can be harmful. It can lead to distortions in reasoning because of the unconscious influence it has on where attention is focused and how information is interpreted. (Munro, 2011)

The use of reflective supervision and/or consultation is an essential component of the New Mexico Infant Mental Health Community of Practice. The principles of RS/RC are that the process;

- a. Takes place with Regularity and Consistency in scheduling and format
- b. Is Collaborative between supervisor/supervisee
- c. Is Reflective and uses self-awareness and parallel process to produce transfer of knowledge to practice
- d. Is differentiated from administrative supervision, although can take place in the same setting with same acknowledgement from both parties
- e. Can take place individually or a group

When professionals who work with infants, young children and their families – as well as with multiple systems and providers- can participate in a supportive, engaged experience to explore their own reactions to their work in this field, they gain emotional stability, clarity of thinking and greater case understanding.

In addition to the resources listed below, please see the definition for on the nmimh.org website for a lengthy description and further details.

REFERENCES

- 1 Lieberman, A. & Van Horn (2005). *Don't hit my mommy: a manual for child-parent psychotherapy with young witnesses of family violence*. Washington DC: Zero to Three.
- 2 Munro, E. (2011). *Munro review of child protection: final report - a child centered system*. Munro Review Reports, Department for Education. Norwich: The Stationery Office Limited.
- 3 Zeanah, C. H., Larrieu, Heller, Valliere, Hinshaw-Fuselier, Aoki, & Drilling (2001). Evaluation of a preventive intervention for maltreated infants and toddlers in foster care. 40, 214-221.
- 4 Zeanah, C. H., Vallier, Heller, & Larrieu (2000). Infant-parent relationship assessment. In C. Zeanah, *Handbook of Infant Mental Health* (2nd ed.). New York: Guildford Press.
- 5 Measuring and Building Reflective Capacity (2016). *Zero to Three Journal*, Vol 37, No2, Washington, DC.
- 6 Heffron, M.C., Murch, T. (2010). *Reflective supervision and leadership in infant and early childhood programs*. Washington, DC: ZERO TO THREE.
- 7 Heller, S., & Gilkerson, L. (2009). *A Practical Guide to Reflective Supervision*. Washington, DC: Zero to Three.

CHAPTER 6

Developmental Assessment and Intervention Considerations

PRINCIPLES OF ASSESSMENT

Development occurs in the context of a caregiving relationship, and the parent/caregiver is vital in supporting the unfolding of the infant's and young child's developmental capacities. The parent/caregiver also exists within a network of relationships and culture, which can either enhance and support the parent's/caregiver's quality of life and relationships, or undermine them. Even if the infant or child is genetically and biologically programmed for development, certain environmental experiences are required at specific times – known as critical periods – in development.¹

Risk factors such as premature birth, prenatal substance exposure, maltreatment, and maternal depression may undermine early development, self-regulation, and co-regulatory processes. These risk conditions may deplete the resources of the infant and the caregiver in ways that compromise their functioning in the present. If this compromised pattern of parent–child functioning persists, it may result in developmental and behavioral problems. For instance, higher levels of maternal depressive symptomatology (when chronic) may contribute to persistent infant dysregulation and compromised parent–infant relationships, which can lead to maladaptive child self-regulatory capacities as well as other developmental outcomes.²

PIP practitioners attend to these parental conditions in order to promote positive parent–child relationships and optimal child functioning, as well as to prevent or ameliorate developmental problems. In order to maximize the effectiveness of interventions and treatment the following principles of assessment should be kept in mind.³

1. Parents Want the Best for their Children

Almost always, parents want the best for their children and family. The PIP's role is to assist them in providing this. PIPs assess a parent/caregiver's strengths and protective capacities as well as the risks that can interfere with infant/young child's developmental functioning. Identifying vulnerabilities and strengths helps shape our interventions.

2. Developmental Context

The perinatal and early childhood period is a time of transition and enormous growth for infant and family. Emotional, behavioral and developmental problems presenting in infancy can have lifelong consequences but some are the manifestation of normal developmental transitions and can be addressed with adequate support.⁴ It is important for the PIP practitioner to be aware of cumulative risk factors that can help distinguish between maladaptive and normal developmental trajectories.

3. A Relational Approach

Although individual factors in the child or parent may contribute to current difficulties, the interaction or “fit” between the needs and capabilities of each family member and the sources of stress and support in the family context, could determine developmental outcome.⁵

4. The Transactional Model of Development

The transactional model of development emphasizes the interaction between genetic and environmental factors over time and the development of the child is seen as a product of the continuous dynamic interactions of the child and the experience provided by his or her family and social context.⁶

FACTORS THAT MAY COMPROMISE DEVELOPMENT

Here are possible Indicators that an infant/child is at risk for compromised development.

Infant/Young Child	Parents/Caregivers	Context
<ul style="list-style-type: none"> • Failure to thrive • Failure to meet expected milestones • Hypervigilant or startling easily • Excessively quiet and withdrawn • Marked aggression in a toddler • Basic needs not met • Role reversal or caregiving behavior towards parent • Emotion regulation problems • Unexplained bruising or medical injury 	<ul style="list-style-type: none"> • Inability to recognize or prioritize the child’s needs • Untreated or inadequately treated psychiatric illness or substance abuse • Lack of insight and lack of engagement with treatment services • Child incorporated in parental delusional system, including positive delusions • Insensitivity to child’s signals and needs (emotionally unavailable) • Thoughts of self-harm or fear of harming child • Scared of infant, ignores infants cries • Frightening or looming behavior, rough handling of infant • Hostile or negative attributions (“he is out to get me”) • Unrealistic developmental expectations • Lack of parenting skills 	<ul style="list-style-type: none"> • No other available and protective adult • Significant cultural or social isolation • Minimal social supports • Domestic/family or community violence • Multiple social risks (e.g., homelessness, multiple moves, multiple partners) • Chronic stress

Developed by: Nicholas Kowalenko, Sarah Mares, Louise Newman, Anne Sved Williams, Rosalind Powrie, and Karin van Doesum.

IMPORTANCE OF SHARED ENGAGEMENT AND ATTENTION

Infants and young children learn about their family’s culture and ways of interacting and communicating through multiple episodes of shared attention. These episodes within a relational context occur during daily routines that happen in a consistent manner and are predictable. First they learn about facial expression, touch, prosodic features of the voice and rhythm of movement. At the same time, infants are typically able to share

attention to an object if the parent/caregiver scaffolds the interaction in ways that allow the infant to focus attention exclusively on the object during a period of supported joint engagement.⁷

Through these episodes of shared attention an infant/child learns how to engage in multiple circles of communication with his/her parent/caregiver. This is how the infant and child begins to learn language and words. Then through patterned repetitive stimulation and interaction, the topics to communicate about expand as the child develops new interests and new skills.

A pivotal period in the developmental course of shared attention occurs from 9 to 15 months of age as joint attention (the active coordination of engagement with a parent/caregiver and interest in shared objects and events) is consolidated and coordinated with shared affect, vocalizations, language, gestures and movement.

In conclusion, communication during periods of joint engagement and attention facilitates an infant's/young child's emerging understanding of words and language. A positive relation exists between joint attention, early word learning and language development. In addition joint attention provides a critical foundation for the subsequent development of the representational skills evident in the 3- to 4-year-old child's emerging theory of mind and growing narrative skills.⁸ Having knowledge of how development unfolds enriches a PIP practitioner's ability to understand behaviors and to support the parent-child relationship.

DYNAMIC APPROACH

Research tells us that affect along with shared engagement and joint attention are central to relating, learning and understanding, and that emotions drive early cognitive development. In this regard, it is best to observe developmental capacities from a dynamic vantage point within a relational context, moment-to-moment, rather than by looking at discrete skills.

The DIR[®] Functional Emotional Developmental Levels (FEDL) represent essential developmental capacities necessary in building the core foundation every child needs for optimum growth and development. The Functional Emotional Developmental Levels that were developed by Dr. Stanley Greenspan and Dr. Serena Wieder offer an integrative perspective on developmental domains, including health and well-being, social emotional, communication and language, regulation, sensory-motor, visual-spatial and ultimately cognitive functioning.⁹

FUNCTIONAL EMOTIONAL DEVELOPMENTAL LEVELS (FEDL)

The first 6 FEDL levels are outlined below to serve as a guide for PIP practitioners to observe an infant's or young child's development while in relationship with his or her parent/caregiver. The **Top** indicates the skills needed to be competent at a particular level, and **Bottom** indicates that an infant or child is having difficulty with a level. The ages are when these levels typically occur.

Level 1: Shared Attention/Regulation and Interest in the World (0-3 months)

The early regulation of arousal and physiological states is critical for successful adaptation to the environment. It is needed for mastery of sensory functions and for learning how to calm oneself and respond emotionally to one's environment. During this first level, the infant/child is learning to tolerate the intensity of arousal and to regulate his or her internal states so that he or she can maintain an interaction while gaining pleasure from it.

Top: The child is calm, organized and able to attend and interact with the parent/caregiver.

Bottom: The child is self-absorbed, engages in more self-stimulating behavior (possibly anxious), and/or unable to interact with others.

Level 2: Engagement/Forming Relationships (2-7 months)

An infant's/child's experience of his or her parent/primary caregiver as a person who brings joy and comfort as well as a little annoyance and unhappiness furthers not only his/her emotional development but also his/her

cognitive development. The joy and pleasure an infant/child has in his/her parent/caregiver enable him/her to detect and decipher patterns in their voices. He/she begins to discriminate their emotional states and interpret their facial expressions.

Top: The child is able to engage with others through a range of emotions and activities (does not disengage when upset). The child displays a range of affect including, “the gleam in the eye.”

Bottom: The child has difficulty engaging with others, is self-absorbed or fixated on “things” (plays with objects without engaging parent in play), is easily distressed and/or displays a flat affect.

Level 3: Two-Way, Intentional Affective Signaling and Communication (3-10 months)

At this level, the infant/child is able to enter into two-way purposeful communication. At its most basic level, this involves helping a child open and close circles of communication. This is a child’s ability to be intentional in interactions and activities (e.g., a child is able to initiate with another person and keep activities going, for desired objects or activities, etc.).

Top: The child is intentional, purposeful and persistent and can use gestures to convey intent.

Bottom: The child has no ability to be intentional with others except to maybe whine or grab for basic needs.

Level 4: Long Chains of Co-Regulated Emotional Signaling and Shared Social Problem Solving (9-18 months)

This level involves the ability to string together many circles of communication, and problem solve into a larger pattern (ten – twenty circles). This is necessary for negotiating many of the most important emotional needs in life (being close to others, exploring and being assertive, limiting aggression, negotiating safety, etc.). This is the stage where the child begins to develop sense of self, self esteem, independence (“I did it!” or “Look what I did!” using affect, gestures and words if verbal).

Top: The child can sustain interactions for longer periods of time, uses motor planning to solve problems, is persistent in interactions and displays a strong sense of self.

Bottom: The child has no ability to sustain interactions for longer periods of time or when faced with stress or challenges.

Level 5: Elaborating Ideas/Representational Capacity and Elaboration of Symbolic Thinking (18-30 months)

This level involves the child’s ability to create mental representations. The ability to do pretend play or use words, phrases or sentences to convey some emotional intention (“What is that?” “Look at this fish!, “ or “I’m angry!” etc.). The child begins to have their own ideas and share them with the people around them.

Top: The child begins to use language to express ideas, can have original ideas (not scripted), share them with other, elaborate on his/her ideas, connect emotions to ideas and replicate real life through play.

Bottom: The child has no ability to have original ideas or express their ideas, is often scripted or stresses when encouraged to “think”, has little understanding of emotions and/or the world around him/her.

Level 6: Building Bridges Between Ideas: Emotional and Logical Thinking (30-48 months)

This level involves the child’s ability to make connections between different internal representations or emotional ideas (“I’m mad because you are mean”). This capacity is a foundation for higher level thinking, problem-solving and such capacities as separating fantasy from reality, modulating impulses and mood, and learning to concentrate and plan.

Top: The child can connect ideas logically, answer “why” questions and understand the underlying meaning behind ideas, give reasons behind their emotions, and display higher-level thinking abilities.

Bottom: The child can have ideas, but cannot connect them logically or give reasons behind them.¹⁰

DEVELOPMENTAL CAPACITIES AND DOMAINS

The *Developmental Competency Rating Scale* from the DC:0-5¹¹ is included below and in Appendix A to begin to track an infant’s or young child’s development. The *Developmental Milestones and Competency Ratings* is also included in Appendix A.

COMPETENCY DOMAIN RATING SUMMARY TABLE

On the basis of the review of this infant's/young child's developmental capacities, complete the table below to indicate the category that best describes the infant's/young child's functioning in each of the domains that comprise Axis V:

To be completed for all infants/young children. Indicate competency domain rating scores by placing an "X" in the box for the appropriate score for each developmental domain.

Competency Domain Rating	Emotional	Social-Relational	Language-Social Communication	Cognitive	Movement and Physical
Exceeds developmental expectations					
Functions at age-appropriate level					
Competencies are inconsistently present or emerging					
Not meeting developmental expectations (delay or deviance)					

Overall impression. Provide Axis V formulation as an overall impression on the basis of the ratings above. Indicate any unevenness of developmental competencies highlighting relative strengths and concerns. Also note whether there have been any recent changes in competencies in any developmental domain.

TABLE 2. INFANT’S/YOUNG CHILD’S CONTRIBUTIONS TO THE RELATIONSHIP

Indicate how each of the infant’s/young child’s characteristics contributes to relationship quality.

Indicate how each item contributes to relationship quality:	Contribution to Relationship Quality		
	<i>Strength</i>	<i>Not a concern</i>	<i>Concern</i>
Temperamental dispositions			
Sensory profile			
Physical appearance			
Physical health (from Axis III)			
Developmental status (from Axes I and V)			
Mental health (from Axis I)			
Learning style			

Note: Caregiving dimensions and the infant’s/young child’s characteristics that contribute to relationship quality are inherently culturally bound. Clinicians are encouraged to think carefully about family cultural values and practices that define the infant’s/young child’s characteristics and which parenting practices are endorsed or proscribed.

Specify/Describe Infant's/Young Child's Contributions to Relationship:

REFERENCES

- 1 Mares, S. & Graeff-Martins, A.S. (2012). The clinical assessment of infants, preschoolers and their families. In Rey JM (Ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions.
- 2 Beeghly, M., & Tronick, E. (2011). Early resilience in the context of parent infant relationships: A social developmental perspective. *Current Problems in Pediatric and Adolescent Health Care*, 41, 197–201.
- 3 Mares, S. & Graeff-Martins, A.S. (2012). The clinical assessment of infants, preschoolers and their families. In Rey JM (Ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions.
- 4 Mares, S. & Graeff-Martins, A.S. (2012). The clinical assessment of infants, preschoolers and their families. In Rey JM (Ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions.
- 5 Sameroff AJ, Fiese BH (2000). Models of development and developmental risk. In CH Zeanah (Ed.), *Handbook of Infant Mental Health* (2nd ed). New York: Guilford Press, 10.
- 6 Sameroff AJ, Fiese BH (2000). Models of development and developmental risk. In CH Zeanah (Ed.), *Handbook of Infant Mental Health* (2nd ed). New York: Guilford Press, 10.
- 7 Bruner, J. (1995). From joint attention to the meeting of minds: An introduction. In C. Moore & P. J. Dunham (Eds.), *Joint attention: Its origins and role in development*. Hillsdale, NJ: Erlbaum, 1-14.
- 8 Bruner, J., & Feldman, C. (1993). Theories of mind and the problem of autism. In S. Baron-Cohen, H. Tager-Flusberg, & D. J. Cohen (Eds.), *Understanding other minds: Perspectives from autism*. New York: Oxford University Press, 267-291.
- 9 Greenspan, S.I. & Wieder, S. (2006). *Infant and early childhood mental health: A comprehensive developmental approach to assessment and intervention*. Washington, D.C.: American Psychiatric Publishing.
- 10 Greenspan, S.I. & Wieder, S. (2006). *Infant and early childhood mental health: A comprehensive developmental approach to assessment and intervention*. Washington, D.C.: American Psychiatric Publishing.
- 11 ZERO TO THREE (2016). DC: 0-5 – *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*. Washington, D.C.: Zero to Three.

CHAPTER 7

Examples of Referral Process and Referral Forms: Child Abuse Prevention and Treatment Act (CAPTA) and Infant Team

NEW MEXICO INFANT TEAMS EXAMPLE OF REFERRAL PROCESS AND SERVICES

CAPTA Referral

1. CAPTA (Child Abuse Prevention and Treatment Act) referral goes to Part C FIT Program
2. Please put - Attention: Infant Team

Formal Infant Team Referral:

3. Referral Form sent to New Mexico Infant Team office
4. Affidavit attached to referral form
5. Referral reviewed by infant team and PPW contacted regarding status of case

Flow of Infant Team Services:

10-Day Hearing

- Fulfill CAPTA requirements, complete Developmental Evaluation, complete IFSP and initiate Developmental Services
- Complete Infant Mental Health Assessment to include Caregiver-Child Interactions and Perception Interviews
- Assist with Visits/support the child and when possible the relationship
- Add Infant Team to Initial Assessment Plan to complete recommended assessments

Post-Adjudication

- Begin Infant Mental Health Services with Bio-Parents and Foster Family
- Add Infant Team to Treatment Plan at Disposition Hearing
- Collaborate with other services outside of Infant Team assigned to this family
- Provide Monthly Progress Reports of Developmental and Infant Mental Health Services to CYFD

- Attend FCMs and Provider Meetings as well as any others affecting the well-being of child and family
- Attend Court Hearings when Possible
- Move some of the Visits outside of CYFD when possible
- Support transitions and all other changes affecting the best interest of the child
- Provide reflective supervision to Infant Team
- Get Progress Reports to CYFD – Permanency Planning Worker (PPW) by designated time agreed upon by PPW and team members

What would be helpful?

- For CPS to complete update form weekly if possible
- For CPS to share monthly calendars for families with Infant Team

In Home Services

- Referral Process and Recommended Assessment Protocols developed for In-Home Service clients if appropriate.

Infant Team Contact Information and Data Entry

- Provide CYFD – PPW with contact information for all team members on a shared case.
- Consider setting up a confidential e-mail list of team members on a shared case to expedite setting up meeting times, share changes to court dates or visitation schedule, and to communicate any other pertinent correspondence.
- Enter all data regarding contact hours, assessments, services provided and interventions into the database for each family.

EXAMPLE OF NEW MEXICO INFANT TEAM REFERRAL PROTOCOL

PROTECTIVE SERVICES

Upon legal filing on any child age 0-3:

PS Worker will initiate a staffing with the PS County Office Manager to determine whether or not the case is eligible for IT (Infant Team).

If the case is determined to be eligible for IT services, the PS Worker will initiate a CAPTA service referral to the IT.

At the Temporary Custody Hearing, the PS Worker will ask for the court to order an assessment/screening from the IT.

Upon transfer of the case to Permanency Planning:

PS Worker will staff the case for eligibility and services with the IT.

The PS Worker will be available monthly to staff this case with the IT.

The PS Worker will participate in weekly/bi-weekly case supervision and/or reflective supervision with the IT.

The PS Worker will request written updates at critical legal junctures in the case.

The PS Worker will arrange visitations and assessment opportunities for the IT.



The PS Worker will notify the IT of any upcoming court hearings, and announce their presence to the court. The PS Worker/Placement Worker will explain IT services to any foster or adoptive family that has placement of child working with the IT.

The PS Worker/Placement Worker will support foster parents in the transition/treatment of any child receiving services from the IT.

The PS COM will participate in a monthly administrative meeting to discuss any relevant programming issues.

—Developed by Jolene Torrez, Las Cruces, CYFD

EXAMPLE OF CAPTA REFERRAL FORM

CAPTA Referral Form				
				
The Child Abuse Prevention and Treatment Act (CAPTA) – the Keeping Children and Families Safe Act of 2003 (P.L. 108-36) requires states to refer infants and toddlers birth to three with substantiated abuse or neglect to the Family Infant Toddler (FIT) Program.				
1. CHILD INFORMATION		Medicaid#:	SSN:	
Referral Date:	*Child's Last Name:	*Child's First Name :		MI:
*DOB:	Gender: Male Female	*Address:		
*City:	*State:	*Zip:	County:	
2. CHILD LIVES WITH				
*Caregiver		Relationship:	*Home Phone if Available: ()	
Work Phone: ()		Other Phone: ()		
Best Way to Contact Caregiver?				
Primary Language / Mode of Communication?				
Surrogate parent needed?		<input type="checkbox"/> yes <input type="checkbox"/> no		
3. REASON FOR REFERRAL				
Presenting Concerns: Referral of child birth to three for (check one):				
Substantiated abuse / neglect <input type="checkbox"/> 0-3 year old <input type="checkbox"/> sibling				
Are there any developmental concerns and/or medical conditions <input type="checkbox"/> yes <input type="checkbox"/> no Explain:				
Worker Safety/Security Precautions? <input type="checkbox"/> YES (attach details) <input type="checkbox"/> NO				
Is the Child Currently in the Hospital? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Criminal Domestic Violence? <input type="checkbox"/> YES <input type="checkbox"/> NO				
4. REFERRAL SOURCE / CPS CASEWORKER				
CPS <input type="checkbox"/> Assessment Worker <input type="checkbox"/> Permanency Planning Worker <input type="checkbox"/> In-home Service Worker				
Name:			County Office:	
Address:		City:		State:
ZIP:	Phone: ()		Fax: ()	
Email Address:				
CPS Worker Signature		Date:	<input type="checkbox"/> Non-Substantiated Referral <input type="checkbox"/> Substantiated Referral	
Consent For Evaluation Signature				
5. FIT Program Action Taken:				
Name:			FIT Provider Agency:	

EXAMPLE OF NEW MEXICO INFANT TEAM REFERRAL

Please Attach Affidavit Report

DATE AND TIME OF REFERRAL	DATE		TIME
---------------------------	------	--	------

Referrer Details

Name of CYFD/CPS Worker:		Job Title:		Tel No:	
CAPTA Referral to FIT Program:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Sent:			

Referral Information

Child/ren's Details

Name	DOB	Gender	Social Security #	Medicaid #	In Childcare Y/N
Primary Language:			Medical Needs:		

Parent(s) / Foster Caregiver(s) Details

Name	Relationship	Address	Home Number	Cell Number

Legal Dates

Date of Custody	10-Day Hearing	Adjudicatory Hearing	Other Court Dates	Other Meeting Dates

Legal Assignments

Guardian Ad Lidum (GAL)	
CASA Worker	
Respondent's Attorney (Mother)	
Respondent's Attorney (Father)	

Other

Please include any additional Information:	
--	--

CHAPTER 8

Examples of Memorandums of Understanding with CYFD and the FIT Part-C Program

MEMORANDUM OF UNDERSTANDING EXAMPLE BETWEEN NEW MEXICO INFANT TEAM AND CHILD PROTECTIVE SERVICES

Scope of Work

The Goal of the Judicial District Infant Team is to provide infants (birth-to-3 years of age) in state custody with a coordinated process for assessment and treatment in order to promote permanency planning and positive developmental outcomes. The assessment and treatment protocol will support the child in the context of all of their important care giving relationships in order to enhance optimal and comprehensive mental health and developmental progress in all domains.

Activities

The New Mexico Infant Teams are contracted to provide Infant Mental Health Services and coordinated care for a specified number of infants ages birth-to-3 per contract, who are in CYFD Protective Custody, and their primary caregivers (including foster parents). When there are no infants in PS custody, the infant team may provide services to children birth-to-5 years of age and their caregivers, who have been referred to In Home Services or are in the investigative phase of Protective Services. The Infant Team will provide relational assessments and reports to Protective Services. The Infant Team will also provide consultation and training to PS staff regarding needs of infants and the impact of trauma. This service will depend upon the Infant Team's current caseload when referral is made.

Agreements

Child Protection Services/CYFD

1. Infants, age's birth-to-3, who have been taken into Child Protective Custody are identified by the CYFD Investigator and a CAPTA referral is faxed to the Part C/FIT agency as per federal regulations with Attention: Infant Team on cover sheet or top of form.

2. The CAPTA referral is made after the **initial investigation** and faxed within 48 hrs. following the FCM/decision making meeting to the Part C/FIT agency.
3. A **separate** Infant Team Referral form is completed, faxed and sent to the Infant Team (IT) at the time of the 10-day hearing.
4. Following the 10-day hearing and the referral to the Infant Team a comprehensive Infant Mental Health and Relationship Assessment with the family will be scheduled and CPS notified of the dates and times.
5. When possible, designate specific staff from CPS to be on infant team. Continuity of staff is critical.
6. Designated CPS Infant Team staff agree to attend meetings and commit to a collaborative decision making process.
7. CPS team and the Infant Team will jointly formulate specific recommendations and a proposed treatment plan for the infant and caregivers related to services and interventions (identify specific collaborative community providers for other services needed) within the 30 days prior to adjudication and disposition hearing.
8. CPS and the Infant Team clinicians will agree on treatment outcome measures. CPS will provide the Infant Team with dates of meetings, mediations and court hearings. The Infant Team will provide a comprehensive report to PS 8 days prior to the court hearing.
9. CPS will provide Infant Team with or access to review pertinent history and documentation (such as investigative reports, treatment plans, psychological reports, medical reports, etc.).
10. CPS and Infant Team will collaboratively convene monthly team meetings of service providers to clarify shared goals, expectations, additional supports or expertise needed.
11. CPS and Infant Team will convene meeting with caregivers and provide integrated feedback on progress and/or change in treatment goals.
12. When possible, CPS will provide the Infant Team with a designated observation room for providing supervised visitations, developmental services and infant or child-parent psychotherapy as well as a room for collateral sessions with caregiver.
13. CPS will provide the IT Coordinator with weekly updates on cases (form will be provided).

New Mexico Infant Team

1. Upon receipt of CAPTA referral, the Infant Team will coordinate with the Part C/FIT team to expedite the CAPTA developmental evaluation, schedule the IFSP (Infant Family Service Plan), and initiate developmental services with the child(ren).
2. Upon receipt of the Infant Team Referral Form (at time of 10-day hearing), the Infant Team will schedule the Infant Mental Health assessment protocol. Upon completion of the assessment procedurs, or inability to complete due to client non-participation, a comprehensive report will be completed summarizing the assessment and including recommendations, strengths and concerns.
3. Upon adjudication, Infant Team will oversee direct infant mental health and developmental intervention and treatment services for the infant/family and will collaborate with intervention and treatment provided by other agencies so as to avoid duplication.

4. Within reason, the Infant Team staff will participate in meetings as requested by CPS to include provider meetings, staff meetings, court hearings, etc.
5. The Infant Team will provide direct services which include supervising therapeutic visits, dyadic infant–parent psychotherapy, Circle of Security Parenting, developmental services through Part C , and other services as specified by the team.
6. The Infant Team will provide CPS with monthly progress summaries and comprehensive reports for court hearings (with the requisite 8 days notification).
7. The Infant Team will meet on a regular basis (monthly or every other month) with CPS staff to discuss procedures, planning and strategies for optimal service provision.
8. The Infant Team will track progress and challenges through provider and CPS reports and will compile information into update reports as per contract requirements from CYFD.

Signed _____

Title _____

Child Protective Services/CYFD

Signed _____

Title _____

New Mexico Infant Team

EXAMPLE
MEMORANDUM OF UNDERSTANDING
BETWEEN NEW MEXICO INFANT TEAM AND PART-C FIT SERVICES

Scope of Work

The Goal of the New Mexico Infant Teams are to provide infants (birth-to-3 years of age) in state custody, with a coordinated process for specialized assessment and treatment in order to promote permanency planning and positive developmental outcomes. The assessment and treatment protocols support the child, in the context of all of their important care giving relationships in order to enhance optimal and comprehensive mental health and developmental progress in all domains.

Activities

New Mexico Judicial District Infant Teams are contracted to provide Infant Mental Health Services and coordinated care for a specified number (varies depending upon the Judicial District contract) of infants' ages birth-to-3, who are in CYFD Protective Custody, and their primary caregivers (including foster parents). When there are no infants in PS custody, the infant team may provide services to children birth-to-5 years of age and their caregivers, who have been referred to In Home Services or are in the investigative phase of Protective Services. The Infant Teams provide relational assessments and developmental reports to Protective Services. The Infant Teams also provide consultation and training to PS staff regarding the needs of infants (specific and general) and the impact of trauma. This service will depend upon the Infant Team's current caseload when referral is made.

Agreements

Part-C FIT Agency

1. Infants, age's birth-to-3, who have been taken into Child Protective Custody are identified by the County Supervisor and/or Investigator and a CAPTA referral is faxed to the Part C/FIT agency as per federal regulations with Attention: Infant Team on cover sheet or top of form.
2. The CAPTA referral is made after the initial investigation and faxed within 48 hrs. following the FCM/decision making meeting to the Part C/FIT agency.
3. The CAPTA referral is given to identified Infant Team Part-C Service Coordinator to schedule developmental evaluation and subsequent IFSP meeting.
4. The IFSP meeting includes PPW, Foster Parent(s) and Biological Parent(s) who collaborate on developmental goals through a trauma-informed lens. All parties sign the IFSP document.
5. IFSP goals will be integrated with Infant Mental Health goals and reflected in the Treatment Plan and Court Documents.
6. Fit Service providers will provide a brief monthly update outlining progress and challenges to the co-directors of the Infant Team to be included in the report for CYFD and the court.
7. Fit service providers will attend Infant Team supervision and training meetings when possible.

Infant Mental Health Process

8. A separate Infant Team Referral form is completed, faxed and sent to the Infant Team (IT) office.
9. Following the 10-day hearing, the Infant Team Referral will be completed and faxed to the Infant Team in order to begin a comprehensive Infant Mental Health and Relationship Assessment with the family. All meetings will meet ASFA guidelines in order to support the CPS team time lines and planning.
10. When possible, designate specific staff from CPS to be on infant team. Continuity of staff is critical.
11. Designated CPS Infant Team staff agree to attend meetings and commit to a collaborative decision making process.
12. CPS team and the Infant Team will jointly formulate specific recommendations and a proposed treatment plan for the infant and caregivers related to services and interventions (identify specific collaborative community providers for other services needed) within the 30 days prior to adjudication and disposition hearing.
13. CPS take the lead in designating time lines for reports/updates due and agree on outcome measures. CPS will allow at least 8 days from notification to provide a comprehensive report to the courts.
14. CPS will provide Infant Team with or access to review pertinent history and documentation (such as investigative reports, treatment plans, psychological reports, medical reports, etc.).
15. CPS and Infant Team will collaboratively convene monthly team meetings of service providers to clarify shared goals, expectations, additional supports or expertise needed.
16. CPS and Infant Team will convene meeting with caregivers and provide integrated feedback on progress and/or change in treatment goals.
17. When possible, CPS will provide the Infant Team with a designated observation room for providing supervised visitations, developmental services and child-parent psychotherapy as well as a room for collateral sessions with caregiver.

The New Mexico Infant Team

1. Upon receipt of CAPTA referral, the Infant Team will coordinate with the Part C/FIT team to expedite the CAPTA developmental evaluation, schedule the IFSP (Infant Family Service Plan), and initiate developmental services with the child(ren).
2. Upon receipt of the Infant Team Referral Form (at time of 10-day hearing), the Infant Team will schedule and complete the Infant Mental Health assessment and evaluation protocol. The protocol will be taped and a comprehensive report completed summarizing the assessment and including recommendations, strengths and concerns.
3. Upon adjudication, the Infant Team will oversee direct Infant Mental Health and Developmental Intervention and Treatment services for the infant/family and will oversee intervention and treatment provided by other agencies so as to avoid duplication.
4. Within reason, the Infant Team staff will participate in meetings as requested by CPS to include provider meetings, staff meetings, court hearings, etc.

5. The Infant Team will provide direct services, which include supervising therapeutic visits, dyadic infant–parent psychotherapy, Circle of Security Parenting, developmental services through Part C, and other services as specified by the team.
6. The Infant Team will provide CPS with monthly progress summaries and comprehensive reports for court hearings (with the requisite 8 days notification).
7. The Infant Team will track progress and challenges through provider and CPS reports and will compile information into update reports as per contract requirements from CYFD.

CHAPTER 9

Examples of Treatment Goals and Tulane's Assessment of Progress

NEW MEXICO INFANT TEAM TREATMENT GOALS AND OBJECTIVES

1. Assess biological parent(s) capacity for engagement in services (see decision tree regarding challenges and barriers).
2. Provide appropriate level of intervention, i.e. COS, Infant Parent or Child Parent Psychotherapy to explore past and current trauma.
 - a. Help caregiver to understand the reasons for PS involvement and parenting issues related to this such as inappropriate reversal of roles displayed in her/his relationship with infant, and change her actions that result in that behavior.
 - b. Support caregiver to be able to carry the emotional responsibility for the relationship with infant.
 - c. Support and assist caregiver in setting appropriate limits and boundaries with infant.
 - d. Support and strengthen caregiver's ability to be a safe and protective parent.
 - e. Assist both caregiver and infant in integrating the difficulties associated with removal, change in placement, CYFD involvement and visitations, in order to increase feelings of safety, trust and competence.
3. Give caregiver basic information about the critical role of attunement, affect-arousal regulation, security, exploration, and play in brain development.
 - a. Educate and expand caregiver's awareness of concepts and interactions that support brain development and social-emotional well-being in vivo during moment-to-moment interactions.
 - b. Determine caregiver's learning style and best way to impart information to help with generalization.
4. For caregiver to become aware of the infant's arousal dysregulation and behavioral disorganization during specific situations or differing environments, and to reduce her/his own arousal in order to expand her/his ability to read infant's nonverbal communications.
 - a. Learn strategies for reading and anticipating infant's autonomic and behavioral cues that signal hypo- or hyperarousal and stress to modulate for social engagement.

- b. Learn strategies for supporting and anticipating infant's nonverbal engagement cues, subtle and potent, to match affect through prosody, tone of voice, facial expressions, eye contact, gestures, touch, and rhythmic movements.
 - c. Learn strategies to support infant's vestibular, proprioceptive and tactile sensory processing to provide foundation for arousal regulation, contingency, and social-emotional engagement.
 - d. Learn strategies to support infant's ability to regulate behavior and enter into shared attention while being interested in a wide range of sensations (sounds, sights, smells, touch, own movement patterns and imposed, rhythmic movement patterns).
 - e. Become aware of and learn strategies to modulate caregiver's own arousal dysregulation and emotional states so that infant will not mirror dysregulation and be less available for social-emotional engagement.
 - f. Help support caregiver as he/she attaches affective meanings to situations, and provides social expectations and values related to infant's specific emotional responses.
5. For caregiver to recognize infant's disengagement and withdrawal behaviors as a cue to not increase but decrease her/his stimulation and give infant more interpersonal space.
- a. Learn strategies for reading, responding to and anticipating infant states of behavior or states of consciousness, distress behaviors and subtle and potent disengagement cues.
 - b. Learn to recognize changes in motor tone and organization, eye contact, breathing, vocalizations, and color changes that communicate infant's inability to interact fully in the moment.
 - c. Help infant with managing and communicating strong emotions, distress or overstimulation, and allowing different comforting strategies by caregiver.
 - d. Help support caregiver to manage stimulation within a comfortable range for infant and help alter her/his behavior if it is intrusive, aversive or insensitive to infant's coping behaviors.
 - e. Help support caregiver to be able to pace their interactions within a comfortable range, give infant a break when "I've had enough" is communicated nonverbally, and pause to allow infant to respond to social overtures.
 - f. Help caregiver be aware of her/his own unconscious cues that adults give when under some sort of stress, be it positive or negative.
 - g. Help support caregiver understand how she/he attaches affective meanings to situations with infant, and provides social expectations and values related to infant's specific emotional responses that may indicate role reversals or unreasonable projections.
6. Help caregiver engage in nonintrusive play by following infant's lead and amplifying infant's states of regulated positive arousal.
- a. Learn play strategies and activities at infant's developmental level and be able to interact with appropriate developmental expectations and anticipate and support the next level of development.
 - b. Help caregiver be able to support infant's ability to take turns in a reciprocal interaction and amplify infant's states of regulated positive arousal.
 - c. Support caregiver to be emotionally available and an active participant in moment-to-moment interactions following the infant's lead.
 - d. Develop caregiver's ability to interpret infant's experiences; develop action schemes; support infant's cognitive organization; support motivation, attentional skills and persistence; and, provide eternal support or co-regulation in the establishment of emotional and self-regulation.
7. Include ongoing assessment of child's capacities, progress and challenges and recommendations.
8. Include ongoing assessment of parental capacity to take responsibility, progress, challenges and recommendations.

9. Work with CYFD to determine visitation schedule and additional supports needed in the best interest of the infant; participate in provider and family-centered meetings; and, support visitations with biological parents and family.
10. Educate and guide the court based on Infant Team evaluations and interventions in order to make informed placement decisions in the best interest of the infant.

—**Goals Adapted from: Allan Schore (2012), *The Science of the Art of Psychotherapy*,
and Julie Larrieu, Ph.D., Tulane Infant Team

CHAPTER 10

Case Conceptualization, Documentation and Written Reports

CASE FORMULATION

Case formulation is the first step to clarifying and articulating the assessment of a specific infant or young child and her respective caregiver(s).

We have discussed the assessment procedures and intervention considerations in previous chapters. In this section, we will discuss the process of putting the information that has been gathered into verbal and written form, which is a critical next step. As we articulate our clinical process and conclusions, we, as infant mental health specialists, have a duty to both educate our respective audience and to advocate for the infant's distinctive needs at any given time. Therefore, it is essential that we be comfortable with articulating our observations and what they mean, using appropriate vocabulary (not *jargon*) and specificity in how we describe our observations, assessments, and recommendations—which should always be based on objective, behavioral examples supported by research and best practice.

Whether you are called upon to present at a provider meeting, submit a written report, provide court testimony—or in any situation where you are called on to provide information and opinion as an expert in infant mental health—consider the continuum of clinical thinking. Start with assessment, which includes both background information, collateral reports and your own direct multi-tool assessments of the infant, the care-giver and the dyadic interactions. This should lead to a formulation that encompasses input from your observations and those of your team (supervisor, staff, consultants, etc.), identifying the salient issues regarding the infant's needs and potential intervention strategies that will address those targeted concerns.

DOCUMENTATION

As of this writing, the format for reports to CPS, the court and others is being revised and will be provided, with updated information, as it becomes available. But regardless of a specific structure for reporting, it is important to keep in mind several points when organizing your thinking and writing:

- Organize your information in a consistent and logical manner. Title your sections clearly, with labels such as dates of contact, cancellations, developmental needs, parental progress, challenges, summary, etc.
- Be succinct and concise, use observation examples, and use “as evidenced by” to support your assessment of the child-adult, relationship.
- Avoid repetition; you do not need to repeat the same information in different sections.
- Avoid contradictory statements as well as generalizations and global references—such as, “they really love each other”—which cannot be measured; instead, provide objective examples of relating or avoiding behaviors.

Additionally, it may be useful to consider some questions, and address these in your report:

- Who is this child? (i.e., how would you describe the child and his/her capabilities and limitations). Use support statements such as, “he is comfortable in their home.”
- What have we learned from our assessments about the child, the caregiver, and their interactions? (Be specific and give examples that are observable.) What have you gleaned from the WMCI, the Crowell, and other assessment tools? How will you articulate this in regards to the infant/child’s current state, supportive needs and safety? The caregiver’s responsiveness and capacity?
- What are the child’s strengths and challenges?
- What are the supports and barriers for the child and caregivers, specific to development, regulation, interaction, reflective level and protective capacities?
- How do the infant’s developmental needs help or impede her relationships with caregivers?
- What other information about developmental behaviors and needs can I provide, i.e. how is the child using his skills functionally, one-to-one with caregivers, and how is this reflected in the home (or not)?

WRITTEN REPORTS

When composing your reports, don’t mix information on development (i.e. challenges and needs) with guidance for how caregivers should interact with the child in the same sentence or paragraph. Focus on specific considerations and recommendations that will support the child in a separate section.

Use the tools, such as the PITA, to provide language that addresses the caregiver’s progress and challenges, and relate this directly to the provision of or impediment to the safety of the infant or toddler in care. Keep in mind that you are providing assessment of risk of return as it relates to caregiving protective capacity.

More tips for writing reports for the Infant Team Summaries

1. Refer to yourself in the third person, i.e. “the infant mental health therapist, the service coordinator”, etc. Remember that there are many voices being combined in the report and if everyone uses “I said this..” it is very difficult to sort out who is speaking.
2. Refer to caregivers as Mr. Ms. or Mrs., vs. “mom, dad, bio-mom”, etc. This conveys respect and this is how parties are addressed in court.
3. Be concise and coherent in responding to the report section headings, Treatment Goals, and Progress and Challenges Related to Those Goals.
4. Do not mix progress and challenges in the same paragraph, as this is confusing and makes it harder to establish coherency in the report and testimony.
5. Stick to your area of observation and expertise when writing your section.
6. Use bullet points or narrative to share your observations.

Take time to read over what you have written before sending it in, reading critically and editing to ensure you clearly and concisely say what you want to say.

Keep reports short so that they will be read in their entirety and/or included in the file to the court. While you may be tempted to write a 10-15-page report that you believe to be rich with information and comprehensive, keeping your written document in the range of 2-5 type written pages will make it more effective. The report should have a comprehensive summary paragraph that could be included in a CPS report.

As was stated in Chapter 3, there are specific issues we want considered in the decision making of caregiving placement. To reiterate:

- 1. Why the period of birth to three is so important for brain development and relationship security.**
- 2. The impact of trauma and stress on the developing brain**
- 3. The individual needs of a infant or toddler who has experienced abuse or neglect**
- 4. The protective capacities of the caregiver**

Categories for articulating and summarizing the Infant Team's recommendations for present and future safety and well-being of the infant/toddler can include the following;

- Risk of Return/Protective Capacities**
- Adequacy of Current placement**
- Infant /Toddler Needs and Considerations**

New and Sample report forms will be added to the document section when finalized.

CHAPTER 11

Expert Testimony Guidelines and Monthly Provider Update Form

EXPERT TESTIMONY IN JUVENILE COURT

I. PREPARATION

A. Know your case:

1. Be familiar with the entirety of the family's situation;
2. Review all case records for essential background information;
3. Be able to locate documents easily in the case records;
4. Make notes of pertinent dates and events to refresh your memory.

B. Find out questions, problem areas, hot topics:

1. Attorneys and witnesses **MUST** communicate before testimony;
2. Don't mistake preparation for testimony; remember what was discussed in preparation and say it again in testimony;
3. Discuss strategy and things to avoid;
4. Discuss/anticipate cross examination;
5. Bring out problems on direct and deal with them instead of being on the defensive;
6. Preparation and pre-trial discussions are okay; do not be uncomfortable with cross-examination about your preparation.

C. Look and act prepared and professional.

II. COURTROOM PROCEDURE

A. Direct vs. Cross exam

1. Purpose of cross is to undermine and rebut direct evidence;
2. Re-direct can clarify and explain

B. Objections

C. Rules of evidence

1. Leading questions
2. Hearsay
3. Laying a foundation

D. EXPERTS – See Code of Evidence articles

1. Qualifications – Curricula Vitae
 - a. Scope of Expertise
2. Differences from lay testimony
 - a. Opinions
 - b. Leading questions
 - c. Hypotheticals
3. Facts and Foundation: support for your conclusions

III. PRESENTATION IN COURT

A. Listen to the question

B. Language and terminology: Use of special terms and language in questions and answers: ask for or give clarification; know the term and use it properly; cut jargon to a minimum – say it in plain English.

C. Body language and attitude: Think about your reaction to a question: surprise, defensive, upset, defeated. Watch body language. 75% of communication is physical and only 25% is verbal.

D. Testimony hints: See list

1. What to bring with you;
2. What not to bring with you;
3. Do not show bias/interest; having an opinion and expressing it is okay; hostility is not; be an educator or informer rather than an advocate;
4. Refreshing your memory;
5. Don't object to your own answer, i.e., "This is probably hearsay, but..."; "I probably can't say this but..."
6. Tell the truth. Juries expect it, judges like it, attorneys will deal with it;
7. Know the limits of your expertise and don't be pressured or tempted to go beyond it;
8. If the question is compound or unclear, clarify with the attorney or judge before attempting to answer;
9. If the answer is longer than one sentence, look at the judge, not the questioning attorney while giving your answer.

E. Common tactics on cross examination:

1. Mispronouncing names of witnesses;
2. Suggestive questions;
3. Friendly counsel;
4. Condescending counsel;
5. Badgering, belligerent;
6. Demanding "yes" or "no" answers
7. Demanding percentages, statistics.

F. Post-hearing feedback

1. Watch others testify;
2. Review with attorney

GENERAL RULES AND TIPS ON TESTIFYING

1. Keep your temper: don't argue, whine, roll eyes, tsk, ask questions to answer for the answer;
2. Answer in the shortest possible way; answer the question that is asked;
3. Be willing to admit uncertainty or ignorance of a subject matter, or that you do not remember;
4. Never show partiality or vindictiveness; be polite and professional to parents, court staff, etc.;
5. Never show reluctance to concede a point that is fairly in the opposition's favor;
6. Use short, simple language; avoid slang or jargon;
7. Ask for a question to be repeated or rephrased if you don't understand;
8. Be sincere, dignified, and warm; humane attitude; not a place for comedy; show concern;
9. Speak clearly and distinctly;
10. Don't double-think or overthink the question;
11. Avoid off-handed responses or too technical ones – avoid "policy" reliance;
12. Let the attorney develop your testimony; don't jump ahead or fall behind – even if the attorney knows your answer, the judge does not;
13. Don't guess or speculate; say you don't know or remember;
14. Don't make your testimony conform to others' testimony; you are not expected to agree or parrot; tell the truth—but discuss problems/contradictions with B.G.C. in advance;
15. When answering, look at the judge – you are imparting information to him – do not look to your lawyer or other people in the room for help – watch for note-taking (interest) or doodling/nodding off (too wordy, irrelevant); assess judicial attitude;
16. Concede error readily – you are not expected to be perfect; being direct about errors will enhance your credibility;
17. Don't respond to objections – let the attorneys and judge handle them – they are not personal to you, but relate to the question or admissibility of evidence.

CROSS EXAMINATION: GENERAL RULES AND TIPS

1. State only what you remember;
2. Don't give in to the power of suggestion;
3. Listen to the question and make sure you understand it;
4. Answer "yes" or "no"; if it requires explanation, ask for a chance to explain;
5. Don't volunteer; it provides additional opportunities to confuse you;
6. Remember that the attorney offering your testimony has a chance to ask additional questions after cross to clear up any problems;
7. Don't explain why you know something unless you are asked;
8. If a question has two parts with different answers, answer it in two parts – avoid "yes/no" until you have stated part number;
9. Answer positively rather than doubtfully – avoid "qualifiers" such as "I think...", "to the best of my recollection...", "I guess..." – they weaken your testimony;
10. Admit your beliefs or sympathy honestly – e.g., "yes, I believe Johnny should stay in foster care, but I have answered your questions honestly";
11. Don't get caught by trick questions; it is okay to discuss the case with lawyers and supervisors;
12. Don't get provoked; hostility, blaming, and aggression are to make you react and lose your professionalism and credibility; don't get defensive or over-emotional; how you handle tension outside the court;
13. Take the time you need to respond; don't be rushed;
14. Don't be pushed into agreeing;
15. Stay focused on the task and the child; relate all of your answers to the focus;
16. RESPOND (to answer, reply); don't react (to act again, repeat); don't replicate the attorney's behavior;
17. Don't argue.

TRIAL SKILLS: GENERAL GUIDELINES FOR ALL WITNESSES

1. *Always tell the truth.* Remember that a lie can lose the case. Testify as accurately as you can about the facts.
2. *Never guess.* If you don't know, say so.
3. *Take your time.* Give every question enough thought. Be sure you understand the question before you answer. If you don't understand a question, ask to have it repeated.
4. *Answer only the question asked.* Don't volunteer information.
5. *Speak up.* Talk loudly enough so that everyone can hear you. Don't nod your head. Say yes or no. Don't chew gum. Keep your hands away from your mouth.
6. *Don't look at the attorney for help.* Once on the stand, you are on your own. You know the information you have better than anyone else. You won't get any help from the judge, either. If you look at the attorney for help, the judge will notice and it will create a bad impression.
7. *Pause briefly before answering questions.* This allows the attorney enough time to object to any improper questions. If an objection is made, do not answer the question until the judge has ruled on the objection.
8. *Beware of questions involving distances and time.* If you do not know, say so. If you are estimating, say so. Also, know your name, address, date of birth, date of marriage, etc.
9. *Don't lose your temper.* It may appear at times that the opposing lawyer is trying to pin you down. He/she has the right to test your memory and knowledge of the facts. Don't fence or argue with the opposing lawyer and don't give him/her smart talk or evasive answers. Such behavior will give a bad impression and may lose the case.
10. *Be courteous.* Don't make jokes or wisecracks – a trial is a serious matter. Courtesy is one of the best ways to make a good impression on the court. Answer "yes sir/ma'am" or "no sir/ma'am." Address the judge as "Your Honor."
11. *Be alert.* Bright crisp answers leave the best impression.
12. *Give a positive answer when possible.* Don't let the opposing lawyer catch you by asking whether you are willing to swear to your version of what you saw or heard. You know what you know or don't know; don't be afraid to swear to it. You were already sworn to tell the truth when you took the stand.

EXAMPLES OF HEARSAY RULE EXCEPTIONS IN TESTIMONY

<i>Second -hand Information</i>	<i>Admissible</i>	<i>Hearsay rule Exception</i>	<i>Comments</i>
Parent admitted abusing child to social worker	Yes	Admission	Only if parent is a party to the action.
Mother exclaims spontaneously to the doctor who is beginning to treat her abused child: "Oh my God! Have I killed my poor baby?"	Yes	Excited utterance	Even if mother is not a party.
Neighbor told you he saw sitter leave child in hallway for four hours in the evening. You testify.	No		No guarantee of truthfulness or completeness of neighbor's statement unless neighbor testifies.
Certified copy of child's birth certificate.	Yes	Official record	
Hospital records show that child was brought in four times within six months with severe head injuries.	Yes	Regularly kept business records	
Parent tells doctor treating child for severe head injuries that the child "falls from her crib all the time."	Yes	Statement for medical treatment or diagnosis; Admission	
Definition of terms from the Encyclopedia of Social Work	Yes	Learned writing	Not as substantive evidence.

**NEW MEXICO INFANT TEAM
MONTHLY PROVIDER UPDATE FORM**

Month and Year of Update:

Child:	Provider Name:
DOB:	Discipline:
Biological Parents:	Agency:
Foster Parents:	Services Provided:
Custody Entry:	
Date Services Began:	Dates of Sessions and who was present:
Cancellations:	No Shows:
Collateral Meetings and Other (e.g. Provider, Video-Case Study, Court):	Length of Sessions:

Treatment Goals:

Progress:

Challenges:

Best Interest of Child:

Risk of Return:

Plans/Recommendations to Further or Change Goals:

Please attach copies of your family notes.

CHAPTER 12

Infant Mental Health, Child Protective Services, Legal and FIT Early Intervention Glossary of Terms



GLOSSARY OF TERMS

A

Abuse:

- **Physical:** Information indicates the existence of an injury that is unexplained; not consistent with the explanation given; or is non-accidental. The information may also only indicate a substantial risk of bodily harm.
- **Emotional:** Information indicates psychopathological or disturbed behavior in a child, which is documented by a psychiatrist, psychologist, or licensed mental health practitioner to be the result of continual scapegoating, rejection, or exposure to violence by the child's parent/caregiver.
- **Sexual:** Information indicates any sexually oriented act, practice, contact, or interaction in which the child is or has been used for the sexual stimulation of a parent, the child, or other person.

Acculturation: Cultural modification of an individual, group or people which involves adapting or borrowing traits from another culture; a merging of cultures as a result of prolonged contact.

Adjudication and Disposition: (also called the adjudicatory hearing) This hearing is held within 120 days of the initial custody hearing. The court will rule on whether the child has been abused or neglected and may order services for the family and continued custody.

Adrenalin: A hormone and neurotransmitter that increases heart rate, contracts blood vessels, dilates air passages and participates in the fight-or-flight response of the sympathetic nervous system.

Affect: Behavior that expresses a subjectively experienced feeling state (emotion); affect is responsive to changing emotional states, whereas mood refers to a pervasive and sustained emotion. Common affects are euphoria, anger, and sadness.

Age Appropriate: Experiences, a learning environment, and interactions with caregivers that match the infant's and/or toddler's age and/or stage of growth and development.

Amygdala: A part of the brain, considered part of the limbic system, located deep within the medial temporal lobes with a primary role in the processing and memory of emotional reactions.

Anhedonia: Inability to derive pleasure from previously pleasurable activities including eating, sex, hobbies, sports, social events, and family functions.

Annual Review: IFSP team meeting held each year to evaluate and, as appropriate, revise the child's IFSP.

Apathy: Lack of feeling, emotion, interest, or concern.

Apraxia: Inability to carry out motor activities despite intact comprehension and motor function.

Assessment: An ongoing process including the use of tests and tools to identify your child's or family's needs and strengths. A systematic procedure for obtaining information from observation, interviews, tests, and other sources that can be used to document behaviors and characteristics of infants/young children and their families that can be used for treatment planning. "Formative" **assessment** is measurement for the purpose of improving it. "Summative" **assessment** is what we normally call 'evaluation.' **Evaluation** is the process of observing and measuring a thing for the purpose of judging it and of determining its "value," either by comparison to similar things, or to a standard.

Assessment: The ongoing practice of informing decision-making by identifying, considering, and weighing factors that impact children, youth, and their families. Assessment occurs from the time children and families come to the attention of the child welfare system or PIP and continues until case closure.

Assimilation: To assume the cultural traditions of a given people or group.

Attachment: Child's connection to a parent or other caregiver that endures over time, establishes an interpersonal connection, and aids in the development of a sense of self. Refers to the quality of the emotional relationship between two people. Attachment styles are generally formed through early relationships between a caregiver and infant and evolves over time.

B

BABYNET: The statewide information and referral line (1-800-552-8195).

Behavioral Health: A state of mental/emotional being and/or choices and actions that affect wellness. Substance abuse and misuse, as well as serious psychological distress, suicide, and mental illness, are examples of some behavioral health problems that can be far-reaching and exact an enormous toll on individuals, their families and communities, and the broader society.

Best interests of the Child: The deliberation that courts undertake when deciding what type of services, actions, and orders will best serve a child as well as who is best suited to take care of a child. "Best interests" determinations are generally made by considering a number of factors related to the circumstances of the child and the circumstances and capacity of the child's potential caregiver(s), with the child's ultimate safety and well-being as the paramount concern.

Bias: Interpreting and judging phenomena in terms particular to one's own culture; judging people or phenomena associated with people based on the race/ethnicity, region of origin, or tribe of the people, rather than based on more objective criteria.

Bio-social context: For young children, the bio-social context includes the family culture and its influence on the values, beliefs, child rearing practices and expectations related to child development, and social-emotional health and well being. For those children in out-of-home care, this includes the experience of the culture, practices, and expectations of the program and those who provided care.

Bonding: The process of forming an emotional attachment. It involves a set of behaviors that will help lead to a close personal bond between the parent/caregiver and their child. It is seen as the first and primary developmental achievement of a human being and central to a person's ability to relate to others throughout life (Child Trauma Academy).

C

Capacity building: To improve or increase the ability of early childhood programs, providers, family members, and community partners to address the social and emotional needs of young children (adapted from Cohen Kaufmann, 2005)

Caregiver: One who provides for the physical, emotional, and social needs of a dependent person. The term most often applies to parents or parent surrogates, child care workers, health-care specialists, and relatives caring for children.

CASA/ Court-appointed Special Advocates: Legislatively mandated volunteer organization that operates in most New Mexico judicial districts. The court or other parties to the case may request a CASA be assigned to a child abuse case by order of the court. The CASA becomes an integral member of the case by advocating for what they believe are the best interests of the child and make recommendations to the court. CASAs are entitled to all information related to their cases.

Case Closure or Discharge: The process of ending the relationship between the caseworker and the family. This often involves a mutual assessment of progress and includes a review of the beginning, middle, and end of the helping relationship. Optimally, cases are closed when families have achieved their goals and the risk of maltreatment has been reduced or eliminated or the child has achieved his/her permanency goal.

Central Register: The central registry is a list of individuals identified as having been responsible for child abuse or neglect following an investigation either by law enforcement, CYFD, or both.

Central Registry: Data pertaining to child abuse or neglect.

Child Abuse and Neglect: Defined by the Child Abuse Prevention and Treatment Act (CAPTA), as, at a minimum, any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act that presents an imminent risk of serious harm. While CAPTA sets Federal minimum standards for States that accept CAPTA funding, each State provides its own definitions of maltreatment within civil and criminal statutes. (CAPTA Reauthorization Act of 2010)

Child Maltreatment: Sometimes referred to as child abuse and neglect, includes all forms of physical and emotional maltreatment, sexual abuse, neglect, and exploitation for infant/child birth to 17 years of age that results in actual or potential harm to the child's health, development, or dignity. Within this broad definition, five subtypes can be distinguished – physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse, and exploitation. (World Health Organization)

Child Protective Services (CPS): The social services agency designated (in most States) to receive reports, conduct investigations and assessments, and provide intervention and treatment services to children and families in which child maltreatment has occurred. Frequently, this agency is located within larger public social service agencies, such as departments of social services.

Child's Record: Is the file that includes evaluations, reports, progress notes and the child's IFSP, which is maintained by the service coordinator.

Child Welfare: A broad spectrum of services that starts with assessment of safety and risk to the child and provides needed intervention when indicated. It includes services that help to preserve families and enhance family strengths and functioning by actively engaging families decision making, assessing needs and linking with resources. It also includes services that children require when out of the home foster care, and different levels of group and therapeutic living arrangements. Finally, when children aren't able to return safely home, children are assisted to permanent living arrangements through services such as adoption, guardianship, or other long-term arrangements.

Citizens Review Panel: A panel of private citizen volunteers who review policies, procedures, and specific cases handled by State as well as local child protective services agencies to determine whether these agencies are effectively managing individual cases and/or child welfare systems.

CRB/ Citizens' Review Board: Legislatively mandated volunteer boards of child advocates are active in most counties in New Mexico. These boards hold meetings for parties to child abuse cases every six months and make independent recommendations to the court as to the status and direction of the case. CRB members are entitled to all information related to their cases.

Community Partners: Family, friends, neighbors, church organizations, health care systems, specialized childcare, social services, educational services, and other resources a family needs to care for an infant or toddler with a disability as close to home as possible.

Complex trauma: Also known as Developmental Trauma Disorder, complex trauma describes how children's exposure to multiple or prolonged traumatic events impacts their ongoing development. Typically, complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment and may include psychological maltreatment, neglect, physical and sexual abuse, and witnessing domestic violence.

Concurrent Plan: Children who enter foster care are screened for a potential concurrent permanency plan. A concurrent plan/ concurrent placement occurs when circumstances in the case indicate the child may not be able to safely return home. Foster parents who agree to a concurrent foster care placement make a commitment to adopt the child if they become available for adoption or become a permanent support for the child.

Concurrent Planning: A case planning approach that involves considering all reasonable options for permanency at the earliest possible point following a child's entry into foster care and simultaneously pursuing those that will best serve the child's needs. Typically, the primary plan is reunification with the child's family of origin. This primary plan and an alternative permanency goal are pursued at the same time, with full knowledge of all case participants. Concurrent planning seeks to eliminate delays in attaining permanency for children.

Confidentiality: The legally required process and ethical practice of not disclosing to the public or other unauthorized persons any private or identifying information regarding children, their parents, or other family members that may be collected while providing services in the home or community, including child protection, foster care, and adoption services.

Consent: The parent gives permission for the agency(ies) to evaluate the child, provide services, share information with other agencies.

Continuity of Care: Continuity of care is inclusive of what caregiving practices happen to a child at home and when he or she is under the care of another adult. In addition to daily routines familiar to the child, continuity of care includes the ability of the provider to understand, respect and build upon cultural and linguistic practices of the home.

Coping resources: Coping resources (or mechanisms) can be described as the sum total of ways in which we deal with minor to major stress and trauma. Some of these processes are unconscious ones, others are learned behavior, and still others are skills we consciously master in order to reduce stress, or other intense emotions like depression. Not all coping mechanisms are equally beneficial, and some can actually be very detrimental.

Cortisol: A steroid hormone produced by the adrenal gland in response to stress; sometimes referred to as the "stress hormone".

Court-Appointed Special Advocate (CASA): A person, usually a volunteer appointed by the court, who serves to ensure that the needs and interests of a child in child protection judicial proceedings are fully protected.

Court Jurisdiction: The legal authority of a court to hear and decide a certain type of case. It is also used as a synonym for venue, meaning the geographic area over which the court has territorial jurisdiction to decide cases. (Also see United States Courts.)

CME: A Comprehensive Multi-Disciplinary Evaluation is a group or team of persons responsible for evaluating the abilities and needs of an infant or toddler to determine whether or not the infant or toddler is eligible to receive early intervention and/or related services.

Culture: An integrated pattern of human behavior which includes thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, role, relationships and expected behaviors of a racial, ethnic, religious or social group and the ability to transmit this pattern to succeeding generations.

Cultural Competence: The ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities, and protects and preserves the dignity of each. Cultural competence is a vehicle used to broaden our knowledge and understanding of individuals and communities through a continuous process of learning about the cultural strengths of others and integrating their unique abilities and perspectives into our lives. Adapted from the Child Welfare League of America .

Cultural reciprocity: In the context of early care and education, this term refers to the effort of staff to understand families' cultural beliefs, and to use this understanding as a way to help promote the healthy development of infants and toddlers; including the ability to respect families' beliefs and traditions, and look for ways to meet the families' unique needs while still upholding early care and education program objectives. (ZERO TO THREE, 2003)

Custody (in child welfare): Refers to the legal right to make decisions about children, including where they live. Parents have legal custody of their children unless they voluntarily give custody to someone else or a court takes this right away and gives it to someone else such as a relative or a child welfare agency. Whoever has legal custody can enroll the children in early intervention, childcare, school, give permission for medical care, and give other legal consents.

Custody Hearing: (Also called the 10-day or initial custody hearing). State law requires that a hearing be held in district court within 10 legal days of a child being placed in the custody of the state by ex parte custody. The state, children and parents are represented and/ or heard at this hearing in which the court determines if enough evidence is provided by the state for continued custody of up to 120 days. The court may order assessments to determine family needs requested by the state at this hearing.

Custody Standard: The federal laws regarding risk of child abuse/ neglect are interpreted liberally in New Mexico. Investigations regarding child abuse and neglect can be based on the perceived risk of potential abuse and do not require the abuse to have been perpetrated in order for the state to investigate. The safety and protection of the alleged child victim is always the overriding standard when assessing or determining custody.

D

Decree of Adoption: The document signed by a judge to finalize an adoption. It formally creates the parent-child relationship between the adoptive parents and the adopted child, as though the child were born as the biological child of its new parents. It places full responsibility for the child on the new parents.

Defense Mechanism: Automatic psychological process that protects the individual against anxiety and from awareness of internal or external stressors or dangers. Defense mechanisms mediate the individual's reaction to emotional conflicts and to external stressors. Some defense mechanism (e.g., projection, splitting, and acting out) are almost invariably maladaptive. Others, such as suppression and denial, may be either maladaptive or adaptive, depending on their severity, their inflexibility, and the context in which they occur.

Development and Learning: The process of change in which the infant or toddler comes to master more and more complex levels of moving, thinking, feeling and interacting with people and objects in the environment. Development involves both a gradual unfolding of biologically determined characteristics and the learning process. Learning is the process of acquiring knowledge, skills, habits and values through relationships, experience and experimentation, observation, reflection, and/or instruction. Neither takes place in isolation.

Developmental Delay: Any of the disability classifications or conditions which qualifies a child for early intervention services.

Detachment: A behavior pattern characterized by general aloofness in interpersonal contact; may include intellectualization, denial, and superficiality.

Dispositional Hearing: Hearings held by the juvenile and family court to determine the legal resolution of cases after adjudication. Dispositional hearings may determine where the children will live for the time being, who will have legal custody of them, and what services the children and family will need to reduce the risk and to address the effects of maltreatment.

Domestic/Family Violence: A pattern of assaultive and/or coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners. Intimate partners include spouses, sexual partners, parents, children, siblings, extended family members, and dating relationships.

Due Process: The principle that every person has the protection of a day in court, representation by an attorney, and the benefit of procedures that are speedy, fair, and impartial.

Dyad: A two-person relationship, such as the therapeutic relationship between doctor and patient in individual psychotherapy.

Dyslexia: Inability or difficulty in reading, including word-blindness and a tendency to reverse letters and words in reading and writing.

E

Early Childhood Intervention: A support system or collection of services for infants and children with developmental disabilities or delays and their families under the IDEA Part C program. The term is also used to describe services and supports that promote healthy development and a readiness to learn in children up to age 5 and that create safe, stable, and nurturing families and communities.

Early Childhood Mental Health Consultation: A problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more caregivers, typically an early care and education provider and/or family member. Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat and reduce the impact of mental health problems among children from birth to age 5 and their families (adapted from Cohen Kaufmann, 2000).

Early Childhood Mental Health: The social, emotional and behavioral well-being of young children and their families, including the developing capacity of a child to experience, regulate and express emotional; form close secure relationships; and explore the environment and learn (adapted from ZERO TO THREE, www.zerotothree.org)

Early Intervention Program: The point of entry to service coordination for eligible infants and toddlers as identified by each Early Intervention provider via the stat system contract.

Early Intervention Services: The early Intervention system contains entitled services and access to other available services designed to meet the developmental needs of each eligible infant or toddler with disabilities and the needs of the family related to enhancing the development of their infant or toddler.

Emotional Development: A component of early childhood mental health encompassing a child's ability to experience, regulate and express emotion.

Endorsement: Affirmation of specialized knowledge and competencies to provide services with a high level of quality and integrity based on formal education, in-service training, supervised practices, and testing or portfolio review. For example: Michigan Association for Infant Mental Health's endorsement in infant or early childhood mental health (Adapted from Michigan Association for Infant Mental Health (MI-AIMH), www.mi-aimh.org).

Entitlement: Benefits of a program granted by law to persons who fit within the defined eligibility criteria. Entitlement through Early Intervention ACT includes services coordination and development of the (IFSP) Individual Family Services Plan.

Entry: The process of joining or “entering” a relationship, work place, or program and the essential elements that facilitate a smooth transition. In early childhood mental health consultation, this process includes an introduction, communicates collaboration, clarifies shared expectations, and provides time for relationship building.

Ethnic or Culture Related Trauma: Traumatic experiences and stress that are linked to or associated with ethnicity or culture, such as discrimination, violence, war, etc.; for example, refugees who have been exiled or sought asylum and safety in a different country.

Ethnicity: Ethnic quality or affiliation, of or relating to large groups of people classed according to common racial, tribal, religious, or linguistic, or cultural origin or background.

Evaluation: The measurement, comparison, and judgment of the infant’s/young child’s development and/or of their programs, schools, caregivers, teachers, or a specific educational program based upon valid evidence gathered through assessment.

Evidence-Based Practice: Involves approaches to prevention or treatment that are validated by some form of documented scientific evidence. This includes findings established through controlled clinical studies, but other methods of establishing evidence are valid as well.

Evidence-Informed: Use of the best available research and practice knowledge to guide program design and implementation within the context of the child, family and community characteristics, culture and preferences. (Guidelines for Community-Based Grants for the Prevention of Child Abuse and Neglect Programs - CBCAP) Also see evidence-based practice.

Ex Parte Custody Hearing: Occurs before a district court judge within 48 hours of a child being placed in the custody of the state by a law enforcement officer. The state can also request this hearing by providing an affidavit for ex parte custody as described above. Parents are not present at this hearing and the judge rules on the evidence presented by the state.

F

Failure to Thrive: Problem in pediatrics in which infants or young children show delayed physical growth, often with impaired social and motor development. Nonorganic [not caused by a medical problem] failure to thrive is thought to be associated with lack of adequate emotional nurturing (Edgerton & Campbell, 1994).

Family Assessment: An in-depth assessment of family issues where their contributing factors are identified. This assessment lays foundation for a family centered, child focused approach to case planning and service delivery.

Family Court: A family court is a court of limited jurisdiction that hears cases involving family law. For example, family courts typically hear cases involving divorce, child custody, and domestic abuse. Family courts are governed by State and local law. Depending on the jurisdiction, these courts might be called domestic courts. In some jurisdictions, family courts also handle guardianship and incompetence hearings. Other jurisdictions leave these matters to probate courts. (See Cornell University Law)

Family Reunification: Refers to the process of returning children in temporary out-of-home care to their families of origin. Reunification is both the primary goal for children in out-of-home care as well as the most common outcome. (See Family Reunification: What the Evidence Shows)

Family Visiting (visitation): Face-to-face contact between a child (or children) in out-of-home care and his or her biological family. Family visiting is considered a major feature of permanency planning for children in foster care (Adapted from (Information Packet: Visiting with Children in Foster Care).

Family Cultural Context: The family cultural context refers to the values, beliefs, practices and customs that influence family life. This can include the influence of community as well as living circumstances such as poverty, refugee status, etc.

Fictive Kin: People not related by birth or marriage who have an emotionally significant relationship with an individual.

Findings: There are five categories of findings: Court substantiated, Petition to be filed, Inconclusive, Unable to locate, and Unfounded.

- **Court Substantiated:** A District Court, county Court, or Separate Juvenile Court has entered a judgment of guilty on a criminal complaint.
- **Petition to be filed:** a criminal complaint indictment or information or a juvenile petition that has been filed in District Court, county, court, or Separate Juvenile Court, and that allegations of the complaint, indictment, information, or juvenile petition relate or pertain to the same subject matter as the report of abuse or neglect.
- **Inconclusive:** The evidence indicates it is more likely than not (preponderance of evidence standard) that the child abuse or neglect occurred, and court adjudication did not occur.
- **Unable to Locate:** Subjects of the maltreatment report have not been located after a good-faith effort on the part of the CYFD/CPS.
- **Unfounded:** All reports not classified as court substantiated, petition to be filed, inconclusive or unable to locate, will be classified as unfounded.

Foster Care: A 24-hour substitute care for children placed away from their parents or guardians, and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and preadoptive homes (Adapted from the Code of Federal Regulations).

Foster Care Adoption: Adoption of children who are in the custody of their State or county's Department of Child and Family Services. These adoptions are usually handled by local public agencies and/or private agencies under contract with their State or county (Also see Adopting Children from Foster Care.).

Full Disclosure: Information provided to the family by the child welfare agency regarding the steps in the intervention process, the requirements of the case plan, the expectations of the family, the consequences if the family does not fulfill the expectations, and the rights of the parents to ensure that the family completely understands the process.

G

Guardian Ad Litem (GAL): A lawyer or layperson who represents a child in juvenile or family court. Usually this person considers the best interests of the child and may perform a variety of roles, including those of independent investigator, advocate, advisor, and guardian for the child. A layperson who serves in this role is sometimes known as a court-appointed special advocate (CASA). (See A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice)

Guardianship: A judicially created relationship between a child and caretaker that is intended to be permanent and self-sustaining as evidenced by the transfer to the caretaker of the following parental rights with respect to the child: protection, education, care and control of the person, custody of the person, and decision-making. (Adapted from the Code of Federal Regulations)

H

Hippocampus: A major component of the brain that is part of the limbic system and plays important roles in long-term memory and spatial navigation.

Holding Environment: The capacity of a family or other caregiving relationship that can both provide attention, nurturance, and safety that a child needs and can allow that child to grow, develop, and have appropriate independence.

Home Study: The process of gathering information, preparing, and evaluating the fitness of prospective foster, kinship, and adoptive parents. The primary purpose of a home study is to ensure that each child is placed with a family that can best meet his/her needs. Home study requirements vary greatly from agency to agency, State to State, and (in the case of intercountry adoption) by the child's country of origin.

Identity: A term used to describe a person's conception and expression of their individuality or group affiliation, such as national identity and cultural identity.

Immunity: Legal protection from civil or criminal liability for individuals making reports in good faith of suspected or known instances of child abuse or neglect. (Adapted from the Child Welfare Information Gateway State Statutes Series, Immunity for Reporters of Child Abuse and Neglect) Indian Child Welfare Act (ICWA)

Individualized Education Program (IEP): A written education plan for a child with special needs developed by a team of professionals and the child's parent(s); it is reviewed and updated yearly and describes how the child is presently doing, what the child's learning needs are, and what services the child will need.

Individualized Family Service Plan (IFSP): Refers both to a process and a written document required to plan appropriate activities and interventions that will help a child with special needs (birth through age 3) and his or her family progress toward desired outcomes. It is reviewed and updated yearly and describes how the child is presently doing, what the child's learning needs are, and what services the child will need. The written plan includes goals, outcomes, location duration and intensity of each service provided.

IDEA - Individuals with Disabilities Education Act: A federal law that provides funding and guidance to states to support the planning of service systems and the delivery of services, including evaluation and assessment, for young children who have or are at risk of developmental delays/disabilities. Funds are provided through the Infants and Toddlers Program known as Part C of IDEA for services to children birth through 3 years of age, and through the Preschool Program (known as Part B-Section 619 of IDEA) for services to children ages three to five.

Informed Consent: In medical jurisprudence, a physician must disclose to a patient sufficient information regarding a proposed procedure to enable the patient to make a knowing decision about whether to participate. In addition to sufficient information, any consent given must be voluntary and made by a person considered legally competent.

In-Home Services: Services provided to children and families who have been reported to child protective services (CPS) for possible child abuse or neglect and who are assessed as being able to benefit from services delivered in the home. Services are generally provided to families who have an "open case" with the child welfare agency and whose children remain at home or have returned home from out-of-home care. (Adapted from Child Welfare Information Gateway Issue Brief: In-Home Services in Child Welfare).

Initial Permanency Hearing: By the end of the 12th month of custody the state must provide evidence to the court at the initial permanency hearing that the causes and conditions that led to the abuse have not been alleviated and that the child's safety cannot be assured if returned to the home. Unless the permanency plan for the child has changed to something other than a return home prior to this hearing and approved by the court the state can also recommend an alternative permanency plan at this hearing.

Intake: The process of documenting all Child Welfare related contacts with CYFD/CPS. Intake includes the activities associated with the receipt of a referral, the assessment of screening, the decision to accept, and the referral of individuals or families to services. In New Mexico this occurs when reporters call Statewide Centralized Intake (SCI) located in Albuquerque and staffed 24 hours. SCI staff complete assessment and other structured decision making tools to determine how CYFD or other agencies will respond based on the information provided.

Initial Investigation: The gathering and analyzing of information in response to reports of suspected child abuse or neglect, to determine which families need further intervention. During this phase the CPS worker is primarily concerned with child safety. The CPS worker determines if child maltreatment did occur, determines the level of risk, and arranges services as necessary to protect the child (See Child Maltreatment 2013).

"It Depends": This statement is used widely in child welfare services. Just as all individuals and families are unique, circumstances and situations related to all child protective services cases are variable and differ widely. Each case presents its own unique set of issues, weaknesses, strengths and opportunities. Situations and circumstances are different in the case of every child we serve so we must respond to each child, family and case differently to preserve families, protect each child's best interests and achieve permanency for all children

J

Judicial Review: This hearing is held between the adjudicatory hearing and the initial permanency hearing for all parties to the case in order to review the progress in alleviating the causes and conditions that led to the court ordering the child into state custody.

K

Kinship Adoption: Adoption of a child by someone related by family ties or a prior relationship.

Kinship Foster Care: Kinship foster care refers to those arrangements that occur when child welfare agencies take custody of a child after an investigation of abuse and/or neglect and place the child with a kinship caregiver who is an approved placement based on the assessment standards developed by the agency. (See State Child Welfare Policy Database)

L

Lead Agency: The Department of Health, Family Infant Toddler Program is the lead agency appointed and responsible for planning, implementation, and administration of the federal early intervention program and the Early Intervention Act (Part C).

Life Book: Life books are created for children in foster care over 60 days. These books chronicle the child's activities while in foster care and may include photos and information about birth relatives, siblings, foster families, friends or anything important in the child's life. Life books remain permanently with the child as a historical reference of the child's time spent in foster care.

Learning Disability (LD): A neurological condition that interferes with an individual's ability to store, process, or produce information. Learning disabilities can affect one's ability to read, write, speak, spell, compute math, and reason, and can affect an individual's attention, memory, coordination, social skills, and emotional maturity. (Learning Disabilities Association of America)

Legal Counsel: Another term for a lawyer or attorney. A legal counsel advises clients about their legal rights and obligations and represents clients in legal proceedings.

Legal Guardian: An adult to whom the court has given parental responsibility and authority for a child. Appointment as guardian requires the filing of a petition and approval by the court and can be done without terminating the parental rights of the child's parents.

Life Book or Life Story Book: A journal or scrapbook that provides a chronicle of a child's life story and personal history. A social worker, therapist, foster parent, or adoptive parent can help a child to make a life book. It can then serve as a therapeutic tool to help facilitate the child's identity formation and understanding of adoption, and provides a way to share parts of the child's life not spent with their parents.

Linguistic Competence: The capacity to effectively communicate with persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. May include being bilingual/bicultural, using cultural brokers, using interpreters and translators, and easy to read or low literacy print materials.

Locus Coeruleus: A small area in the brain stem containing norepinephrine neurons that is considered to be a key brain center for anxiety and fear.

Long-Term Memory: The final phase of memory in which information storage may last from hours to a lifetime.

M

Mediation: A nonadversarial, voluntary process that allows the parties involved to agree on a permanency decision in the best interests of the child with the help of a trained, neutral, third party. Mediation generally avoids adversarial court hearings. Parties are more invested in the outcome because they participated in decision-making. Parties to mediation may include birth parents, foster/adoptive parents, relatives, the

child, the agency worker, attorneys, and others. Mediations can be court-based or may take place at other, more neutral locations. Mediation is a way to settle a conflict so that both sides win. For example, parents and other professionals discuss their differences and, with the help of a trained and independent mediator, reach a settlement that both sides accept.

Medical Neglect: Failure to provide or to allow needed care as recommended by a competent health care professional for a physical injury, illness, medical condition, or impairment, and/or the failure to seek timely and appropriate medical care for a serious health problem that any reasonable person would have recognized as needing professional medical attention.

Mental Health Consultant: A mental health professional providing early childhood mental health consultation services.

Memory: Episodic: Refers to memory for specific events; Implicit: refers to memory for automatic skills; Semantic: Refers to memory of facts; Short-term/Immediate memory: Recall of material within seconds to minutes; and, Long-term: Recall of events over the past few hours to years

Mentoring: A personal developmental relationship in which a more experienced or more knowledgeable person helps a less experienced or less knowledgeable person. Foremost, mentoring involves communication, is relationship based, and provides both knowledge and psychosocial support over a sustained period of time.

Multidisciplinary Team: A team established between agencies and professionals within the child protection system to discuss cases of child abuse and neglect and to aid in decisions at various stages of the child protective services' case process. These terms may also be designated by different names, including child protection teams, interdisciplinary teams, or case consultation teams. (See Child Protective Services: A guide for Caseworkers)

N

Native Language: Mode of communication normally used by the child's family.

Natural Environments: Settings that are natural or normal for the child's age and include the home, childcare and other community settings.

Neglect:

- **Emotional neglect:** Information which indicates that the child is suffering or has suffered severe negative effects due to a parent's failure to provide the opportunities for normal experience which produce feelings of being loved, wanted, secure and worthy. Lack of such opportunities may impair the child's ability to form healthy relationships with others.
- **Physical neglect:** The failure of the parent to provide for the basic needs, or provide a safe and sanitary living environment for the child.
- **Medical Neglect:** the withholding of medically indicated treatment (appropriate nutrition, hydration, well-child care, and medication) from a special needs or disabled infant with life-threatening conditions or conditions that impede their developmental progress.

Neonatal Abstinence Syndrome (NAS): A group of problems that occur in a newborn who was exposed to addictive opiate drugs while in the mother's womb. (National Institute of Health)

Neural Circuit: A functional entity of interconnected neurons that influence each other, particularly in the brain.

Neurobiological Chemicals: Chemicals that support neurotransmission in the brain are responsible for regulating all physiological processes, including our ability to sense and respond to our environment, maintain consciousness, express emotions and display fluctuations in mood; these include those hormones that are organized in the limbic system of the brain, such as adrenalin and cortisol.

O

Open Adoption: A type of adoption in which birth and adoptive families have some form of initial and/or ongoing contact. Parents have several options available related to openness, including closed adoption, semi-open or mediated adoption, and open or fully disclosed adoption.

Outcome: The anticipated or actual effect of program activities and outputs. An outcome constitutes changes or improvements in the target populations being served or the target systems being affected. The Child and Family Services Reviews incorporate the following seven outcomes in evaluating State child welfare programs: (1) Children are, first and foremost, protected from abuse and neglect; (2) children are safely maintained in their homes whenever possible; (3) children have permanency and stability in their living situations; (4) the continuity of family relationships and connections is preserved for children; (5) families have enhanced capacity to provide for their children's needs; (6) children receive appropriate services to meet their educational needs; and (7) children receive adequate services to meet their physical and mental health needs. American Bar Association Center on Children and the Law In early intervention, outcomes are statements of changes wanted for a child and family that are documented in the IFSP.

P

Parallel Process: The perspective in relationship-based mental health consultation work that all relationships influence one another. For example, a positive experience in the relationship between the consultant and the early care and educator, positively influences the relationship between the early care and education provider and the children in his or her care and their families.

Permanency: Each child in care is assigned one of five potential permanency plans that will guide services to ensure the child achieves the goal of placement in a safe, loving and permanent family environment. Unless the state proves unusual circumstances in a case at the adjudicatory hearing a child's first permanency plan is always reunification, sometimes also referred to as return home. Other permanency plan options include: adoption, permanent guardianship, placement with a fit and willing relative or planned permanent living arrangement. Permanent plans are recommended by CYFD and approved by the court. A permanent plan for all children entering care is expected to be finalized within 24 months of entering care.

Permanency Planning: In child welfare work, permanency planning is a systematic effort to provide long-term continuity in a dependent child's care, as an alternative to temporary foster placements. This might be done by facilitating adoption, by establishing clear guidelines for remaining in foster care or by helping the child's family become capable of meeting the child's needs. (Adapted from Office of Children & Families in the Courts)

Perpetrator: The person who has been determined to have caused or knowingly allowed the maltreatment of a child. (U.S. Department of Health and Human Services)

Physical Abuse: Generally defined as "any nonaccidental physical injury to the child" and can include striking, kicking, burning, or biting the child, or any action that results in a physical impairment of the child. In approximately 38 States and certain territories, the definition of abuse also includes acts or circumstances that threaten the child with harm or create a substantial risk of harm to the child's health or welfare.

Physical Neglect: Failure to provide for a child's basic survival needs, such as nutrition, clothing, shelter, hygiene, and medical care. Physical neglect may also involve inadequate supervision of a child and other forms of reckless disregard of the child's safety and welfare.

Post-Traumatic Stress Disorder: A mental health diagnosis associated with symptoms following an exposure to any event that results in psychological trauma - involve a perceived or actual threat of death to oneself or to someone else, or to one's own or someone else's physical, sexual, or psychological integrity, overwhelming the individual's ability to cope.

Prefrontal Cortex: The anterior part of the frontal lobes of the brain that plays an important part in planning complex cognitive behaviors, decision making and moderating correct social behavior.

Protective Custody: A form of custody required to remove a child from his or her home and place in out-of-home care. Law enforcement may place a child in protective custody based on an independent determination that the child's health, safety, and welfare is jeopardized. A child can also be placed in protective custody via court order.

Protective Factor: A characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes. Protective/promotive factors include nurturing and attachment, parental resilience, knowledge of parenting, opportunities for engagement within school and the community, and individual coping skills. (Adapted from Youth.gov)

Pruned Neural Synapses: The cutting back or elimination of excess neurons and neural connections in the developing brain.

R

Reasonable Efforts: Efforts made by State social services agencies to provide the assistance and services needed to preserve and reunify families.

Recovery: The term recovery describes the process by which a person becomes more aware of the substance use, mental disorder, or co-occurring disorders as a problem and initiates and maintains a substance-free or symptom-managed life and, as a part of that process, generally achieves a stronger sense of balance and control over his or her life. Recovery is a lifelong process that takes place over time and often in specific stages.

Referral: When a parent or professional (with the parent's permission), for example, thinks that a child may benefit from early intervention services and makes contact with CMS (Children's Medical Services) or a local early intervention provider agency.

Reflective Dialogue: Describes interactive conversation used in the process of reflective supervision for identifying motivations, feelings, and insight toward self-awareness by associated with relationship-based work. See also Reflective Practices; Supervision.

Reflective Practice: A means of developing a greater level of self-awareness about and insight into the nature and impact of one's actions and interactions as an opportunity for personal and professional growth and development. In early care and education, reflective practice helps staff members understand their own reactions to the children and families with whom they work and help them to use this self-awareness to develop strategies to enrich their work.

Reflective Supervision: See Supervision.

Relationship-Based: The theoretical and developmental perspective that relationships and the interaction between caregiving adults and children have a primary role in the social/emotional development and mental health of young children. It also refers to the nature of the work between a mental health consultant and consultee, building on the collaborative relationship between the two.

Relinquishment: Voluntary termination or release of all parental rights and duties that legally frees a child to be adopted. This is sometimes referred to as a surrender or as making an adoption plan for one's child.

Resilience: The ability to adapt well to adversity, trauma, tragedy, threats, or even significant sources of stress. Parental resilience is considered a protective factor in child abuse and neglect prevention. Resilience in children enables them to thrive, mature, and increase competence in the midst of adverse circumstances. Resilience can be fostered and developed in children as it involves behaviors, thoughts, and actions that can be learned over time and is impacted by positive and healthy relationships with parents, caregivers, and other adults. (Adapted from the American Psychological Association)

Respite Care Services: Beneficial activities involving temporary care of the child(ren) to provide relief to the caretaker. It may involve care of the children outside of the caretaker's own home for a brief period of time, such as overnight or for a weekend. Not considered by the State to be foster care or other placement. (Children's Bureau)

Retraumatize, Retraumatizing, Retraumatization: These terms refer to an individual experiencing another traumatic event and the impact of that experience and or the experience of delayed onset or reactivated symptoms related to a past traumatic experience. For example, a child who suffered abuse and neglect that included sitting in a chair in isolation may be unintentionally "retraumatized" if placed in an isolating, time-out chair in the child-care setting.

Review Hearing: An opportunity to evaluate the progress that has been made toward completing the case plan and any court orders and to revise the plan as needed. (Children's Bureau)

Risk: In child welfare, the likelihood that a child will be maltreated in the future.

Risk Assessment: Collection and analysis of information to determine the degree to which key factors that increase the likelihood of future maltreatment to a child or adolescent are present in a family situation.

Risk Factors: A term to describe those individual aspects or circumstances that may be associated with potentially negative effects on healthy growth, development, and adaptation or resilience, such as premature birth, health problems, poverty, etc.

S

Safety Assessment:

A part of the child protective services case process in which available information is analyzed to identify whether a child is in immediate danger of moderate or serious harm. Safety assessments also are conducted throughout the life of a case, including while in-home services are provided, when a child is in out-of-home care, preceding and during family visitation, and throughout the process of achieving permanency for the child. (Children's Bureau)

Safety Plan: A casework document developed when it is determined that a child is in imminent or potential risk of serious harm. In the safety plan, the caseworker targets the factors that are causing or contributing to the risk of imminent serious harm to the child and identifies, along with the family, the interventions that will control the safety factors and assure the child's protection. (Children's Bureau)

Scaffolding: A term used to describe the interactional support and the process by which adults mediate a child's attempts to take on new learning. Scaffolding represents the helpful interactions between adult and child that enable the child to do something beyond his or her independent efforts.

Secondary trauma: Secondary trauma (traumatic stress) or vicarious trauma, refers to the behavioral and emotional experience of those people who care for, or are involved with, those who have been directly traumatized. Those who work with traumatized people may experience intrusive thoughts, nightmares, feeling withdrawn and isolated, feel depressed, have difficulty concentrating, and feel helpless. For this reason, those who work with children and families impacted by trauma need an ongoing support system to deal with the intensity of their reactions in their relationship with the victim, or perpetrator.

Sensitive periods: A term to describe times in a child's development where the brain is most open to the influence of external experiences.

Service Coordinator: A person who works with your family to help coordinate the evaluation, the IFSP and early intervention services as well as other community support and resources for your child and family.

Sexual Abuse: According to the Child Abuse Prevention and Treatment Act (CAPTA), the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

Shaken Baby Syndrome: The collection of signs and symptoms resulting from the violent shaking of an infant or small child. The consequences of less severe cases may not be brought to the attention of medical professionals and may never be diagnosed. In severe cases that usually result in death or severe neurological consequences, the child usually becomes immediately unconscious and suffers rapidly escalating, life-threatening central nervous system dysfunction. Adapted from National Center on Shaken Baby Syndrome

Socio-cultural context: The physical, material, social and political aspects associated with a particular cultural group or community that influence family life.

Social Support: Formal and informal activities and relationships that provide for the needs of children and families in their efforts to live successfully in society. These needs include education, income security, health care, and, especially, a network of other individuals and groups who offer encouragement, access, empathy, role models, and social identity. (Adapted from Indiana University of Pennsylvania)

Special Education: Specially designed instruction and services to meet the education needs of children over the age of three. Provided by the local school district for children who are eligible in preschool or other settings.

Special Needs Children: Children in foster care available for adoption or adopted from foster care who meet a State's definition of "special needs." There is no Federal definition of special needs, and the guidelines for classifying a child as special needs vary by State. The term is used in State law to indicate eligibility for Federal financial assistance, and most frequently refer to children who are school-aged; part of a sibling group; children of color; or those with specific physical, emotional, or developmental needs. The phrase "special needs" can apply to almost any child or youth adopted from foster care. The preferred term is "children with special needs."

Standardized assessment tool: A testing instrument that is administered, scored, and interpreted in a standard manner. It may be either norm-referenced or criterion-referenced.

State Custody: Children can enter state custody in New Mexico by one of two methods. Children can be placed into CYFD custody in an emergency for a maximum of 48 hours by any law enforcement officer in New Mexico. During this period CYFD will assess the situation and either return the child home at 48 hours of filing a petition for continued custody with the district court. If the child is not returned home by CYFD within this time period an affidavit for continued or Ex Parte custody is provided to the court and the court will rule on the evidence of the affidavit within this 24 hour time period. The court can dismiss or place the child in continued Ex Parte custody for up to 10 days. Parents do not have a legal right to be present at the Ex Parte custody hearing but do have a legal right to be heard before the court within the initial 10 days of a child being placed in state custody.

Any person can also petition the district court to place a child in the custody of the state due to the perceived risk of abuse or neglect. The court will rule based on the preponderance of evidence submitted to the court and may place a child in the temporary custody of the state for no longer than 10 days.

A note on legal time: Once a child is placed into the custody of the state legal time overrides calendar time. Legal time is determined by the number of work (or court) days and do not include weekend days or holidays on which the court is closed. In the event a child is placed into 48 hour emergency custody on a Friday the 48 hour custody would expire by close of business in Tuesday. In this case if the following Monday were a national holiday the 48 hour emergency custody would expire by close of business on Wednesday.

State Ward: When a court of competent jurisdiction gives custody of a child under the age of 18 to the state, that child becomes a ward of the state. This is done to provide for safety and/or facilitate the provision of services. The state acts as the child's parent.

Strategies: The methods and activities developed to achieve outcomes. Strategies are written into the IFSP.

Subsequent Permanency Hearing: This hearing is held within three months of the initial permanency hearing to review the status of the case and review the plan for achieving permanency for children within 24 months of custody. Subsequent Judicial Reviews: In the event the child is not returned home within 18 months of custody these hearings are held every six months to review the status of the case until permanency is achieved.

Substantiated: An investigation disposition concluding that the allegation of child maltreatment or risk of maltreatment was supported or founded by State law or State policy. A child protective services determination means that credible evidence exists that child abuse or neglect has occurred. (Children's Bureau)

Supervision: The act of providing guidance, oversight, or shared responsibility in the work or tasks of another in a work, professional, or personal context. In early childhood mental health consultation, a mental health consultant may experience:

- **Administrative supervision:** Includes guidance on organizational structure and personnel/family interaction by an early childhood program director or supervisor,
- **Clinical supervision:** Includes guidance on diagnosis and intervention by a more senior or licensed clinician
- **Reflective supervision:** Includes reflective practices and guidance on identifying motivations, feelings, and insight toward self-awareness by a mental health professional trained in this type of supervision associated with relationship-based work

Surrogate Parent: Means the person appointed in accordance with these regulations to represent the eligible child in the IFSP Process when no parent can be identified or located or if the child is a ward of the state. A surrogate parent has all the rights and responsibilities afforded to a parent under Part C of IDEA.

Synapses: A synapse is a junction that permits a neuron to pass an electrical or chemical signal to another cell. Symbiosis A mutually reinforcing relationship between two persons who are dependent on each other; a normal characteristic of the relationship between the mother and infant child.

System of Care: System of care is an evidence-based approach to the care of children and adolescents with serious emotional disturbances and their families. It incorporates a broad array of services and supports that are organized into a coordinated network, integrate care planning and management across multiple levels, are culturally and linguistically competent, and build meaningful partnerships with families and youth at service delivery and policy levels. Guiding principles in a system of care specify that services should be • Comprehensive, incorporating a broad array of services and supports • Individualized • Provided in the least restrictive, appropriate setting • Coordinated at the system and service delivery levels • Involve families and youth as full partners • Emphasize early identification and intervention.

T

Temperament: Constitutional predisposition to react in a particular way to stimuli.

Temporary Assistance for Needy Families(TANF): A program that provides assistance and work opportunities to needy families by granting States the Federal funds and wide flexibility to develop and implement their own welfare programs. The focus of the program is to help move recipients into work and to turn welfare into a program of temporary assistance. (Adapted from Office of Family Assistance)

TPR/ Termination of Parental Rights: In some cases children are abandoned by their parents or cannot return to their care. In some of these cases the state may recommend the state pursue a termination of parental rights trial. During these trials the court will rule on evidence presented to the court as to whether a parent's legal rights to their children should be terminated. The courts may subsequently establish another legal parent-child relationship by means of adoption. Parents may appeal the district court's decision regarding termination of parental rights. There are currently no laws or regulations regarding time frames for higher court decisions. Appeals place children in legal-limbo until a decision by the appeals court is made.

Therapeutic Foster Care: Intensive care provided by foster parents who have received special training to care for a wide variety of children and adolescents, usually those with significant emotional, behavioral, or social problems or medical needs. Therapeutic foster parents typically receive additional supports and services.

Transition: The process of planning for support and services for when a child experiences a disruption in care or placement or will leave the Family Infant Toddler Program or if the family moves to a new community.

Transitional Object: An object, other than the mother, selected by an infant between 4 and 18 months of age for self-soothing and anxiety-reduction. Examples are a "security blanket" or a toy that helps the infant go to sleep. The transitional object provides an opportunity to master external objects and promotes the differentiation of self from outer world.

Trauma trigger: An experience that, for an individual, represents a troubling reminder of a traumatic event. The trigger need not be frightening or traumatic, but can prompt emotional or physical symptoms associated with the original trauma. The trigger can take many forms, such as a person, place, noise, image, smell, taste, scene, body sensation, etc. Also known as trauma reminders.

Trauma: A term to describe the unique individual experience of an event or enduring conditions in which the individual's ability to integrate his/her emotional experience is overwhelmed, and the individual experiences (either objectively or subjectively) a threat to his/her life, bodily integrity, or that of a caregiver or family.

Traveling File: A traveling file is created for children in foster care over 60 days which includes their medical, education, demographic and historical information. These files travel with the child in the event the child's placement changes.

Treatment Plan: A treatment plan is a plan of care that is designed especially for each child and family, based on individual strengths and needs. Ideally, mental health specialists and primary care clinicians collaborate with the child and family to develop the plan. The plan establishes goals and summarizes appropriate treatment and services to meet the special needs of the child and family, leading toward optimal function, self-sufficiency, and recovery.

U & V

Unsubstantiated (not substantiated): An investigation disposition that determines that there is not sufficient evidence under State law or policy to conclude that a child has been maltreated or is at risk of maltreatment. A child protective services determination means that credible evidence does not exist that child abuse or neglect has occurred. (Children's Bureau)

Validity: A term used to describe measures and instruments used in screening, assessment, and evaluation. If a measure is valid, this means that the measuring instrument accurately reflects what it is intended to measure.

Visitation: Scheduled contact among a child in out-of-home care and his or her family members. The purpose of visitation is to maintain family attachments, reduce the sense of abandonment that children may experience during placement, and prepare for permanency.

W

Wraparound Services: Wraparound services are a package of community services and natural supports that are flexible and tailored to meet the unique needs of children with serious emotional disturbances. Wraparound services are based on a definable planning process and are designed for children and their families to achieve a positive set of outcomes in the home setting. Services are provided by multidisciplinary teams that may include case managers, psychiatrists, nurses, social workers, vocational specialists, substance abuse specialists, community workers, peer specialists, and family members or caregivers.

GLOSSARY REFERENCES:

- Cohen, E. and Kaufman, R. (2000). Early childhood mental health consultation. Washington, D.C: Center for Mental Health Services, SAMHSA, (US Department of HHS).
- Cross, T., Bazron, B., Dennis, K., Isaccs, M. (1989). Towards a culturally competent system of care: A monograph on effective services for minority children who are severely disturbed, Volume, I. Washington DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
- Goode, T. (1997, revised 2000). Definitions. Washington, DC: Georgetown University Child Development Center, Center for Child Health and Mental Health Policy, University Affiliated Program.
- Harkness, S. Super, C. M. (1992). Parental ethnotheories in action. In I.E. Seiger, A. V. McGuillicuddy-DeLisi, J. Goodnow (Eds.), Parental belief systems: The psychological consequences for children. Hillsdale, NJ: Erlbaum.
- Hoagwood, H., Burns, B. J., Kiser, L., Ringeisen, H., Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52(9), 1179-89.
- Jezewski, M. A. (1990, August). Culture brokering in migrant farm worker health care. *Western Journal of Nursing Research*, 12(4), 497-513.
- Jezewski, M. A., Sotnik, P. (2001). Culture brokering: Providing culturally competent rehabilitation services to foreign-born persons. (J. Stone, Ed.). Buffalo, NY: Center for International Rehabilitation Research Information and Exchange.
- Mercedes Martin Billy Vaughn (2007). Strategic Diversity Inclusion Management magazine, pp. 31-36. DTUI Publications Division: San Francisco, CA.

Michigan Association for Infant Mental Health (MI-AIMH), www.mi-aimh.org). Mental Health Association of Michigan (2009) MI-AIMH Endorsement (IMH-E): Overview. Southgate, MI: Author. Retrieved from the MI-AIMH Website http://mi-aimh.org/endorsements_overview.php.

W.K. Kellogg Foundation (2004). Using logic models to bring together planning, evaluation, and action: Logic model development guide. Battle Creek, MI: Author. Retrieved from the W.K. Kellogg Foundation Web site: <http://www.wkkf.org/Pubs/Tools/Evaluation?Pub3669/pdf>.

ZERO TO THREE (2003) What is cultural reciprocity? Center for Program Excellence. Washington DC: Author.

APPENDIX ONE

FORMS, ASSESSMENT TOOLS AND INSTRUMENTS

1. INTAKE

- Psychosocial Intake Assessment
- Adverse Childhood Experiences Scoring (ACES) – for caregiver(s) and child.

For Child-Parent Psychotherapy Trained PIP Clinicians

- Life Stressor Checklist –Revised
- Traumatic Events Screening Inventory – Parent Report Revised (TESI)

2. INFANT MENTAL HEALTH ASSESSMENT

- Working Model of the Child Interview (WMCI) - full or modified versions
- Caregiver-Child Structured Interaction Procedure (Crowell) – full, modified or baby versions. * At the end of Crowell administration, three questions from the Circle of Security Interview (COSI) are asked of parent/ caregiver.

3. DEVELOPMENTAL INFORMATION

- **DC:0-5:** Developmental Milestones and Competency Ratings (Axis V) - not required.
- **DC:0-5:** Infant's/Child's Contributions to the Relationship (Axis II) – not required.
- Developmentally Informed Assessment Per Each Relationship (DIAPER) – administered quarterly.

4. TRACKING TREATMENT PROGRESS AND PROGRAM EVALUATION

- Progress in Treatment Assessment (PITA) – administered quarterly
- **DC:0-5:** Dimensions of Caregiving and Relational Range of Functioning – Axis II Relational Context) – administered quarterly
- Developmentally Informed Assessment Per Each Relationship (DIAPER) – administered quarterly
- D.A.P. (Data, Assessment and Plan) Progress Note

6. QUARTERLY REPORTS

- PIP Quarterly Report Form

* All forms, assessment tools and instruments are available in a Stand Alone file for PIP providers.

Data Input Flow Chart

Register New Case Infant/Child
Name
Facts # for Case
DoB
Sex
Ethnicity
Address/zip/county
Phone #
Primary Language
Affidavit: Y/N
Lead Clinician
IMHT or PIP
Referral Source
Notes

Register Infant
Name
Facts Person #
DoB
Sex
Ethnicity

Register Family Constellation
Name
DoB (bio parents)
Sex
Ethnicity (bio parents)
Relation to infant
Role in Case
Notes

Services & Activities
Start – End Time
Provider (self populate)
Clinician
Activity/Service
Fund
Staff Present
Notes

Assessments
ACES
Working Model (Y/N)
DAP
Crowell Plus (Y/N) DAP
PITA
DIAPER
DC 03 0-5
Review of Axis (Y/N) DAP
CPP: TESSI
CPP: LSC-R
Notes

GOAL: Relational Adaptive Behavior
Objectives
DAP Notes
Data -. Assessment. -Plan
Strategies as evidenced by Progress

INTAKE
Psycho-Social

Quarterly Updates

Other Inputs For Staff
Training
Endorsement
Waiver

DISCHARGE Case Determination (IT)
IMH Recommendation
Permanency Hearing
Notes
---OR---
Reasons (PIP)
Notes

Note: every activity needs date

Assessments

CYFD Required	Periodicity	Subjects++	TYPE OF INPUT
ACES	Once	Bio parents & infants	Data
Working Model *	Once	Bio parents	Yes/No
Crowell ** Plus	Once	Bio parents	Yes/No
DIAPER	Quarterly	Dyads with bio parents	Data
PITA	Quarterly	Dyads with bio parents	Data
DC 03 [0-5] ***	Quarterly	Dyads with bio parents	Data
Review of Axes 1, 2, 3	As Clinically Appropriate	Bio Parents	Yes/No

** CROWELL. DAP summary notes

*** DC03 will be replaced and overlap with DC 0-5 (Axis II)

++ If >1 child, on each relationship

CPP Required	Periodicity	Subjects	Data Input
TESSI	Once	On bio parents	Yes/No
LSC-R	Once	On bio parents	Yes/No

APPENDIX TWO

Decision Trees

EXAMPLE OF TIERED APPROACH FOR INTENSITY OF SERVICES ADAPTED FROM CONVERSATIONS WITH DR. JULIE LARRIEU, TULANE INFANT TEAM

Tier 1

- CAPTA (Child Abuse Prevention and Treatment Act) Referral fulfilled
- Infant Team Intake and Determination for Level of Service Intensity
- Infant Mental Health Assessments and Report (helps to determine Level of Service)
- Observations of Visits
- Developmental Services if Recommended
- Recommendations given to Permanency Placement Worker (PPW) and Court

Tier 2

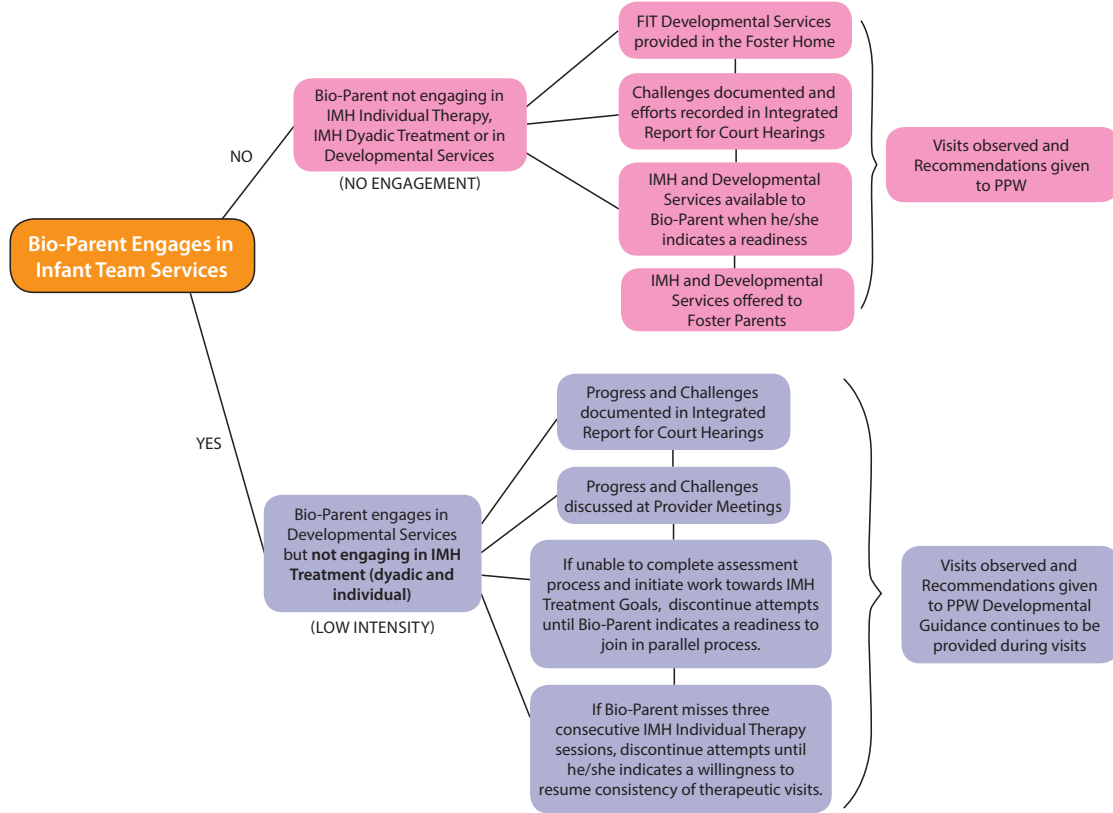
- Progress/Challenges and Recommendations given to PPW and Court
- COS (Circle of Security – P) DVD-Parenting Program
- Therapeutic/Dyadic Visitation Support
- Possible Co-Visits between IMH and Developmental Services
- Progress Reports for Court

Tier 3

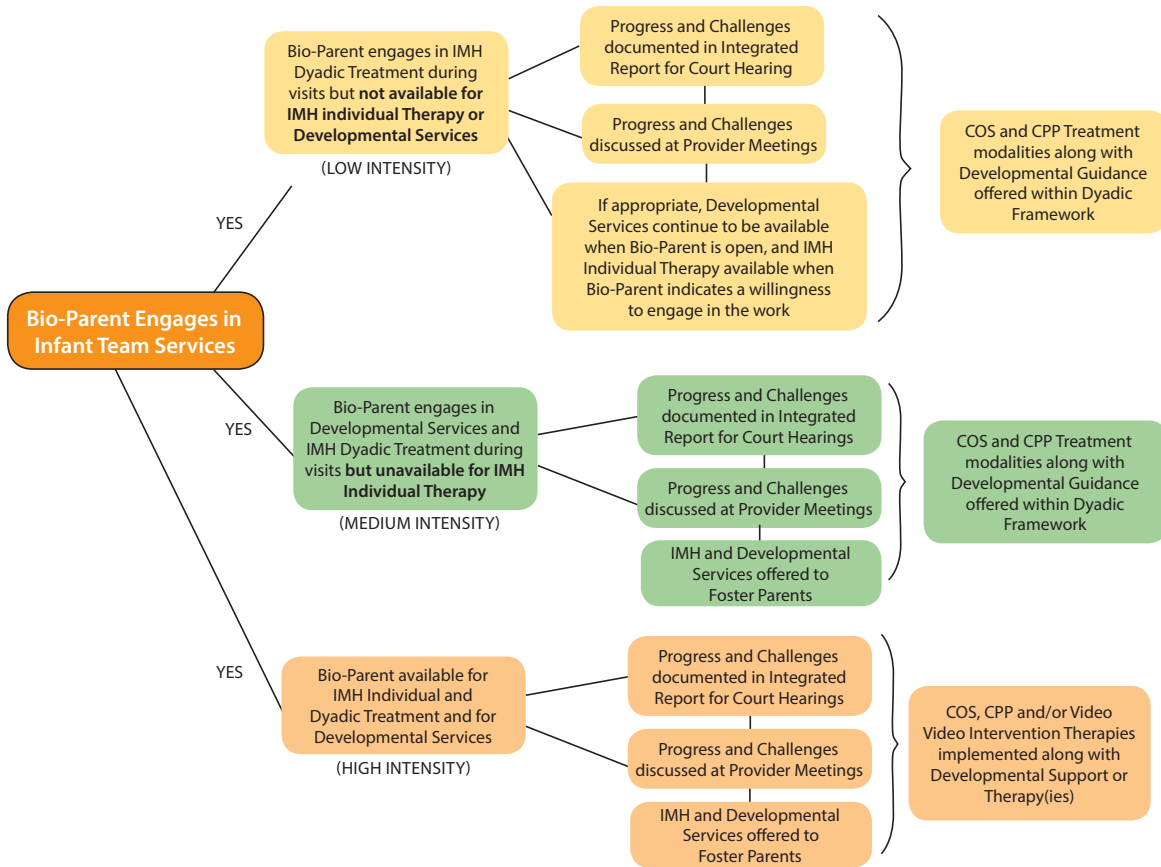
- Infant Mental Health Treatment—Dyadic and Collateral (may include Parent-Infant Psychotherapy (PIP), Child Parent Psychotherapy (CPP) and COS (Circle of Security) Treatment methods) or other approved intervention.
- Video Intervention Therapy
- Therapeutic/Dyadic Visitation Support
- Progress Reports for Court

New Mexico Infant Teams: Level of Engagement

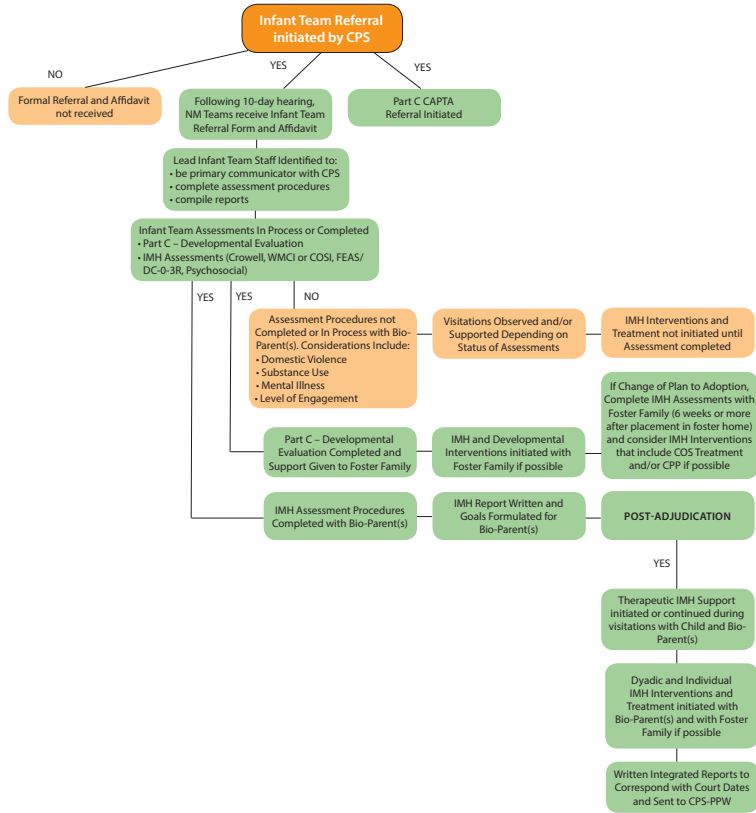
Clarke-Harris 2014



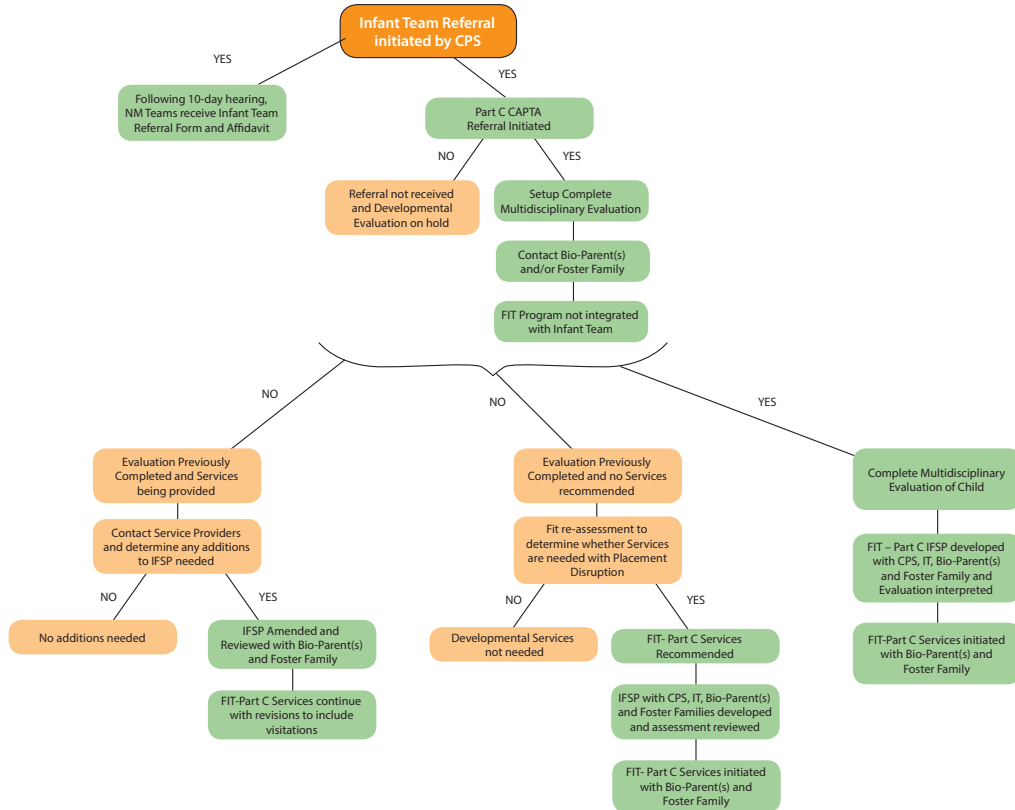
Clarke-Harris 2014



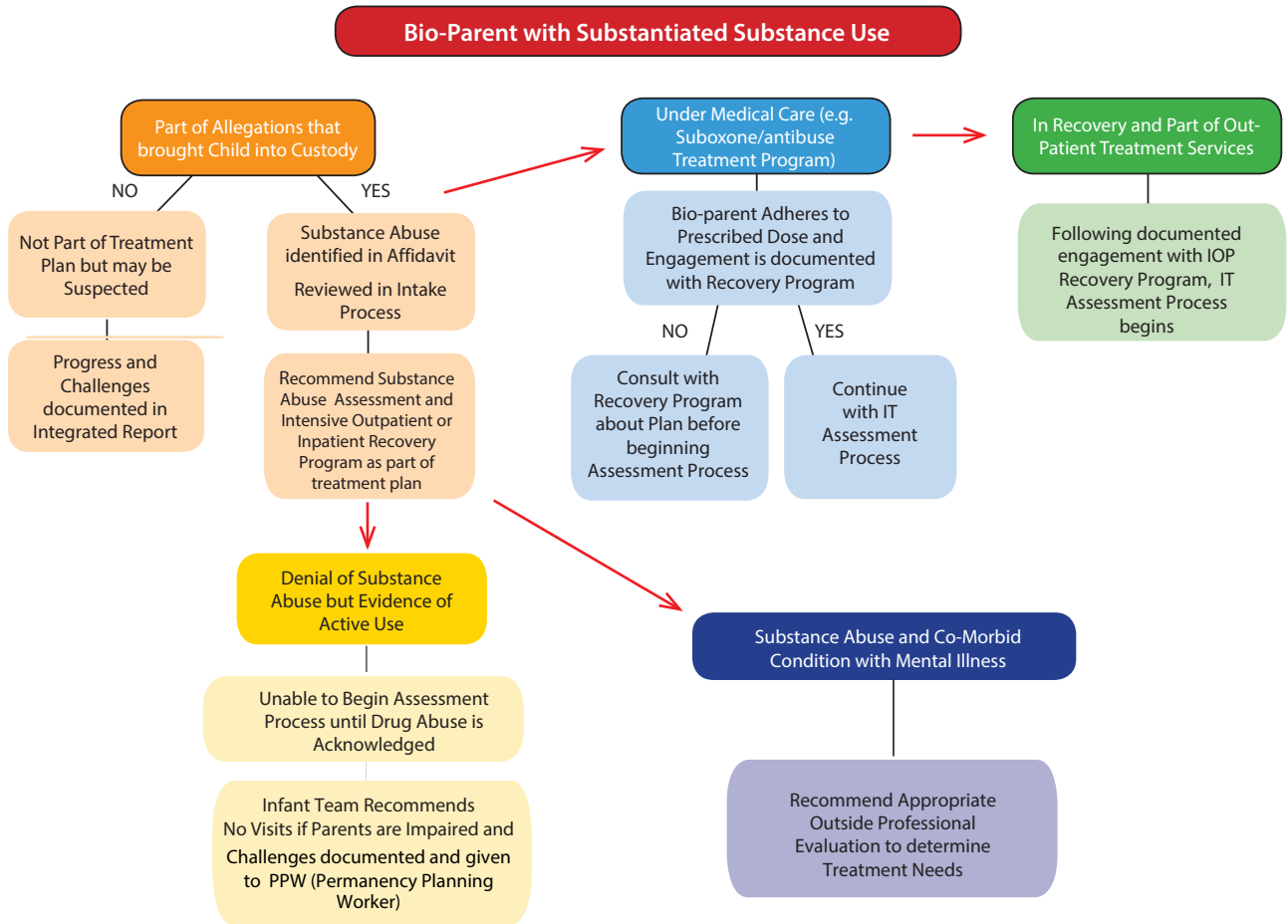
New Mexico Infant Teams: Track Recidivism and Permanency



New Mexico Infant Teams: CAPTA Referral Process

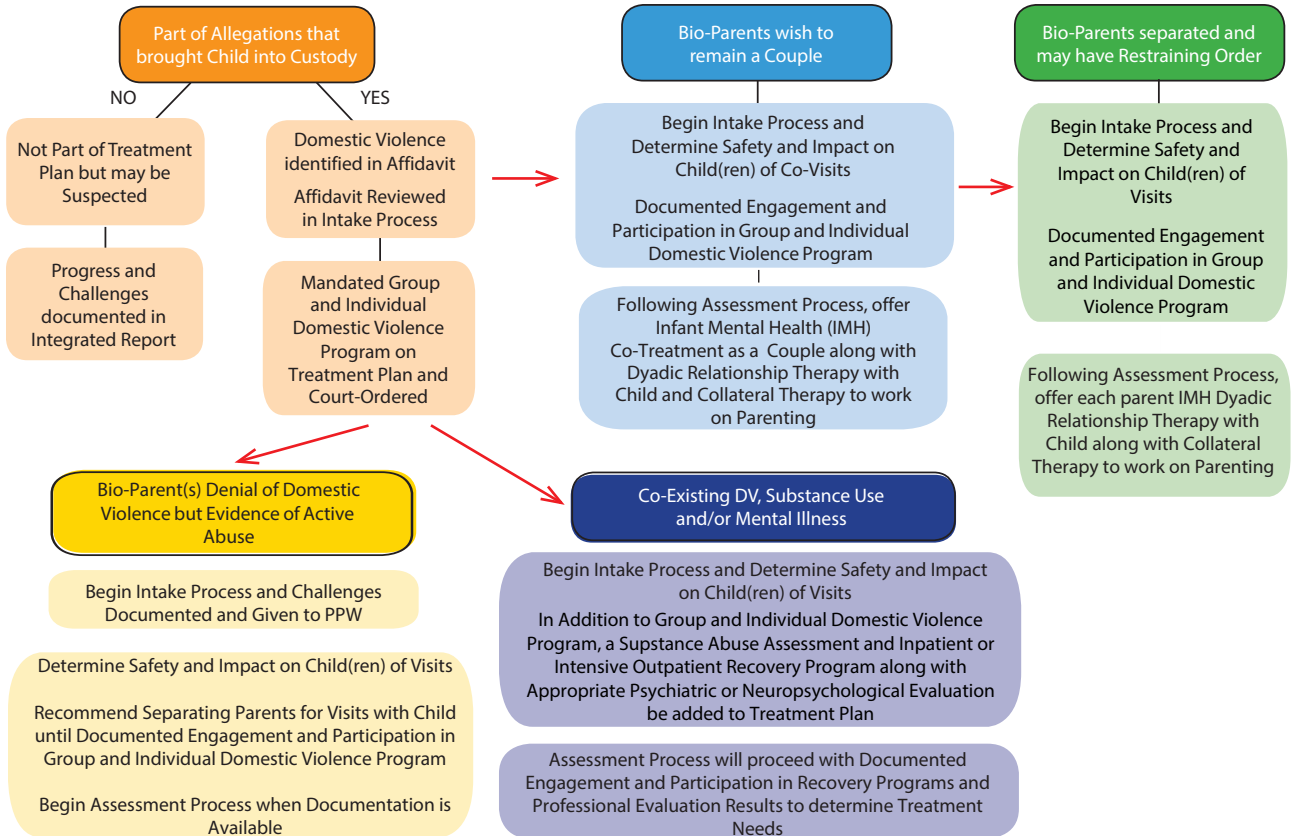


New Mexico Infant Teams: Working with Substance Abusing Parents



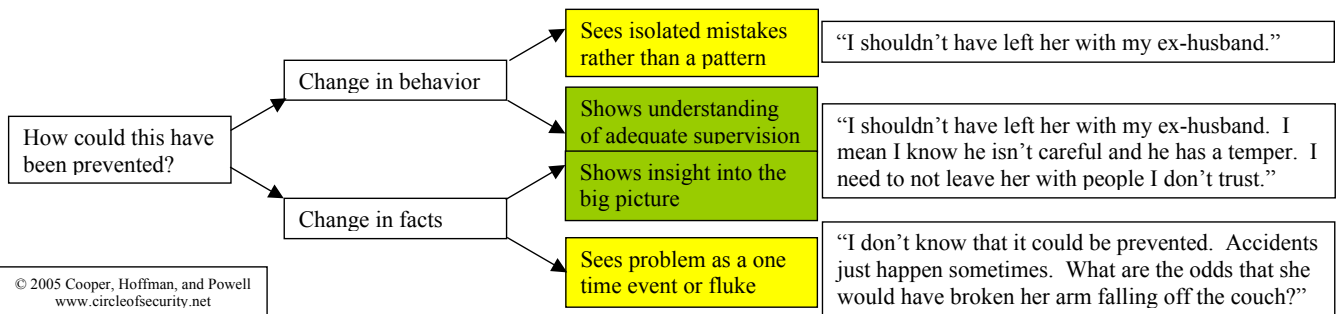
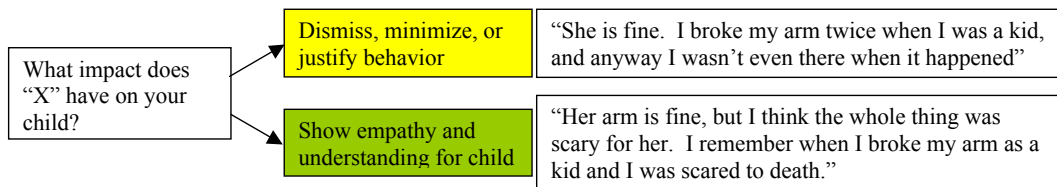
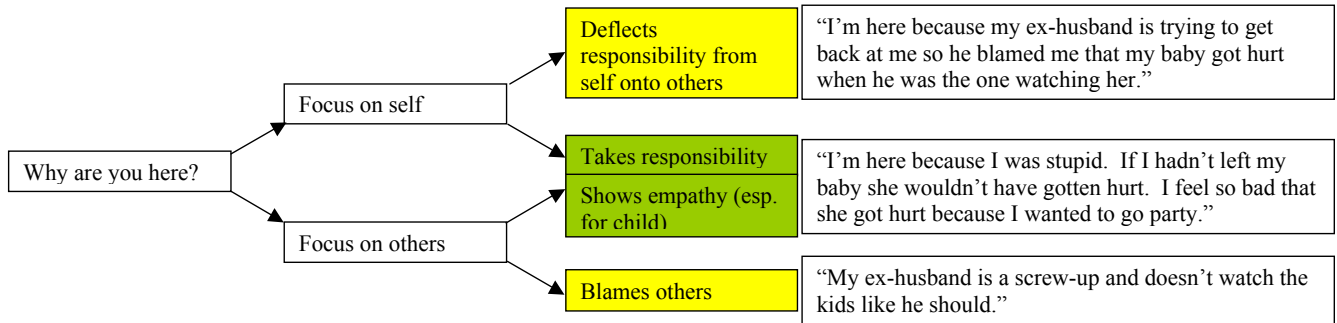
New Mexico Infant Teams: Working with Bio-Parents who have History of Domestic Violence (DV)

Domestic Violence (DV) also called Intimate Partner Violence (IPV)



Questions for Parents

Taking responsibility for behavior, having empathy for children, and reflecting on the “big picture” are key indicators of parents’ ability to protect children from imminent harm. How a parent answers the following three questions gives clues to that parent’s capacity in the above areas. Answers in yellow boxes suggest a need for increased caution and answers in green boxes suggest greater potential for change. **Parents maybe coached so listening for coherence will be important**



© 2005 Cooper, Hoffman, and Powell
www.circleofsecurity.net

APPENDIX THREE

References and Articles on Infant Mental Health

REFERENCES ON INFANT MENTAL HEALTH

With Contributions from Julie A. Larrieu, Ph.D.

OVERVIEW OF INFANT MENTAL HEALTH: DEFINITIONS AND DEVELOPMENT

Brazelton, T. B. & Cramer, B. G. (1987). *The earliest relationship: Parents, infants, and the drama of early attachment*. Reading, MA: Addison-Wesley Publishing Co.

Brazelton, T. B. (1984). *To listen to a child: Understanding the normal problem of growing up*. Reading, MA: Addison-Wesley Publishing Co.

Brazelton, T. B. (1992). *Touchpoints: The essential reference*. Reading, MA: Addison-Wesley Publishing Company.

Brazelton, T. B., & Sparrow, J. (2001). *Touchpoints three to six: Your child's emotional and behavioral development*. Cambridge, MA: Perseus.

Cassidy, J., Woodhouse, S.S., Cooper, G., Hoffman, K., Powell, B., & Rodenberg, M. (2005). Examination of the precursors of infant attachment security: Implications for early intervention and intervention research. In L.J. Berlin, Y. Ziv, L. Amaya-jackson, and M.T. Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention, and policy*. (pp. 34-60). New York: Guilford Press.

Lieberman, A. F. (1993). *The emotional life of the toddler*. New York, NY: The Free Press.

National Center for Children in Poverty (2013). *Basic facts about low-income children*.

Sagatun-Edwards, I. & Saylor, C. (2000). Drug-exposed infant cases in juvenile court: Risk factors and court outcomes. *Child Abuse and Neglect*, 24(7), 925-937.

- Sameroff, A.J., & Emde, R.N., eds. (1989). *Relationships disturbances in early childhood: A developmental approach*. New York: Basic Books.
- Schore, A. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. New Jersey: Erlbaum Publishing.
- Schore, A. (2003). *Affect regulation and disorders of the self*. New York: W.W. Norton & Co.
- Schore, A. (2003). *Affect regulation and the repair of the self*. New York: W.W. Norton & Co.
- Shonkoff, J. P., & Phillips, D. A. (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.
- Siegel, D., & Hartzell, M. (2004). *Parenting from the inside out*. Los Angeles, Ca: Tarcher Press.
- Siegel, D. (2012). *The developing mind, second edition: How relationships and the brain interact to shape who we are*. New York: Guilford Press.
- Tronick, E. (2007). *The neurobehavioral and social-emotional development of infants and children* (Norton Series on Interpersonal Neurobiology). New York: W. W. Norton & Co.
- Zeanah, C. H. & Zeanah, P. D. (2001). Towards a definition of infant mental health. *Zero to Three*, 22, 13-20.

CHILD CARE: OVERVIEW, OBSERVATION, AND CONSULTATION

- Boem, A. E., & Weinberg, R. A. (1997). *The classroom observer: A guide for developing observation skills* (pp. 1-3, 9-15, 23-30, 39-41, 56-59). New York: Teachers College Press.
- Hungerford, A., Brownell, C.A., & Campbell, S.B. (2000). Child care in infancy: A transactional perspective. In C.H. Zeanah (Ed.) *The handbook of infant mental health* (2nd ed.). New York: Guilford.
- NICHD Early Child Care Research Network (1997). The effects of infant child care on infant-mother attachment security: Results of the NICHD study of early child care. *Child Development*, 68, 860 - 879.
- Johnston, K., (2000). Inclusive interaction in mental health consultation to the childcare community. *Responding to infants and parents: Inclusive interaction in assessment, consultation, and treatment in infant/family practice*. (pp. 15-18). Washington, DC: Zero to Three.
- Johnston, K., & Brinamen, C. (2006). *Mental health consultation in child care: transforming relationships among directors, staff and families*. Washington D.C.: Zero to Three Press.

TRAUMA IN CHILDREN AND HEALTH PROBLEMS

- Graham-Bermann, S. & Seng, J. (2005) Violence exposure and traumatic stress symptoms as additional predictors of health problems in high-risk children. *Journal of Pediatrics*, 146, 349-354.
- Luthar, S.S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71(3), 543-562.

Masten AS, Hubbard JJ, Gest SD, Tellegen A, Garmezy N, Ramirez M. (1999). Adaptation in the context of adversity: Pathways to resilience and maladaptation from childhood to late adolescence. *Development and Psychopathology*, 11,143–169.

Perry, B.D. (2008). *Child maltreatment: the role of abuse and neglect in developmental psychopathology*. In Textbook of Child and Adolescent Psychopathology In (Theodore P. Beauchaine & Stephen P. Hinshaw, Eds) pp. 93-128, Wiley, New York.

Perry, B.D. (2013). *The Neurosequential Model of Therapeutics in young children*. In Infant and Early Childhood Mental Health: Core Concepts and Clinical Practice. (K. Brandt, B.D. Perry, S. Seligman & E. Tronick, Eds) American Psychiatric Press, Washington DC, pp. 21-54.

Perry, B.D. & Dobson, C.D. (2009). *Surviving childhood trauma: the role of relationships in prevention of, and recovery from, trauma-related problems*. Counseling Children and Young People: Journal of CCYP, a division of British Association for Counseling and Psychotherapy, March, 2009 28-31

Seng, J. S., et al.(2005). Posttraumatic stress disorder and physical comorbidity among female children and adolescents: Results from service-use data. *Pediatrics*, 116 (6), 767-776.

Vondra, J.I., Shaw, D.S., Chrisman, J., Cohen, L., Swearinger, E., & Owens, E.B. (2001). Attachment stability and emotional and behavioral regulation from infancy to preschool age. *Development and Psychopathology*,13, 13-33.

ASSESSMENT IN INFANT MENTAL HEALTH

Benham, A. L. (2000). The observation and assessment of young children including use of the infant-toddler mental status exam. In C. H. Zeanah (Ed.), *Handbook of infant mental health*, (2nd ed.). New York: Guilford Press.

Larrieu, J. A., & Bellow, S. (2004). Relationship assessment of young traumatized children. In J. D. Osofsky, (Ed.), *Young children and trauma: Intervention and treatment*. New York: Guilford Press.

Zeanah, C. H., Valliere, J., Heller, S. S., & Larrieu, J. A. (2000). Infant-parent relationship assessment. In C. H. Zeanah (Ed.), *Handbook of Infant Mental Health*, (2nd ed.). New York: Guilford Press.

TREATMENT IN INFANT MENTAL HEALTH

Carter, S., Osofsky, J., & Hann, D. (1991). Speaking for the baby: A therapeutic intervention with adolescent mothers and their infants. *Infant Mental Health Journal*, 12, 291-301.

Dunn, W. (2003). A sensory-processing approach to supporting infant-caregiver relationships (pp.152-187). In A. Sameroff, S. McDonough, & K. Rosenblum (Eds.), *Treating parent-infant relationship problems: Strategies for intervention*. New York: Guilford Press.

Fraiberg, S., Adelson, E. , & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytical approach to the problems of impaired mother-infant relationships. *Journal of the American Academy of Child Psychiatry*, 14, 387- 421.

Hudson, L., Klain, E., Smariga, M., & Youcha, V. *Healing the Youngest Children: Model Court-Community Partnerships* (2007), American Bar Association and ZERO TO THREE.

- Lieberman, A. F., Compton, N., Van Horn, P., & Ghosh Ippen, C. (2003). *Losing a parent to death in the early years: Guidelines for the treatment of traumatic bereavement in infancy and early childhood*. Washington, D. C.: Zero to Three Press.
- Lieberman, A. F. (1991). Attachment theory and infant-parent psychotherapy: Some conceptual, clinical and research considerations. In D. Cicchetti & S. Toth (Eds.), *Rochester Symposium on Developmental Psychopathology*, (Vol. 3). Hillsdale, N.J.: Erlbaum.
- Lieberman, A. F. (1992). Infant-parent psychotherapy with toddlers. *Development and Psychopathology*, 4, 559-574.
- Lieberman, A. F. (2004). Child-parent psychotherapy: A relationship-based approach to the treatment of mental health disorders in infancy and early childhood. In A. J. Sameroff, S. C. McDonough, & K. L. Rosenblum (Eds.), *Treating parent-infant relationship problems*, (pp. 97-122). New York, NY: Guilford Press.
- Lieberman, A. F., & Van Horn, P. (2005). *Don't hit my mommy! A manual for child-parent psychotherapy with young witnesses of family violence*. Washington, DC: Zero to Three Press.
- Lieberman, A. F., & Van Horn, P. (2008). *Psychotherapy with Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment*. New York: Guilford Press.
- McDonough, S.C. (1993). Interaction guidance: Understanding and treating early infant-caregiver relationship disturbances. In C.H. Zeanah, Jr. (Ed.) *Handbook of infant mental health* (pp. 414-426). New York: Guilford.
- McDonough, S. C. (2000). Interaction guidance: An approach for difficult to engage families. In C. H. Zeanah (Ed.), *Handbook of infant mental health*. (2nd ed.). New York: Guilford Press.
- Muir, E. (1992). Watching, waiting and wondering: Applying psychoanalytic principles to mother-infant intervention. *Infant Mental Health Journal*, 13, 319-328.
- Osofsky, J. D. (Ed.), (2004). *Young children and trauma: Intervention and treatment*. New York: Guilford Press.
- Powell, B., Cooper, G., Hoffman, K., & Marvin, B. (2014). *Circle of security intervention: Enhancing attachment in early parent-child relationships*. New York: Guilford Press.
- Sameroff, A., McDonough, S., & Rosenblum, K. (2003). (Eds.), *Treating parent-infant relationship problems: Strategies for intervention*. New York: Guilford Press.
- Schore, A. (2012). *The science of the art of psychotherapy*. New York: Norton. Infant-Parent Psychotherapy and Child-Parent Psychotherapy
- Seligman, S. (2005). Dynamic systems theories as a metaframework for psychoanalysis. *Psychoanalytic Dialogues*, 15 (2), 285-319.
- Siegel, D., & Bryson, T. P. (2011). *The whole-brain child: 12 revolutionary strategies to nurture your child's developing mind, survive everyday parenting struggles, and help your family thrive*. New York: Random House.

MALTREATED INFANTS AND CAREGIVERS: ASSESSMENT AND TREATMENT

- Bateman A., & Fonagy, P., eds. (2012). *Handbook of mentalizing in mental health practice*. Arlington, VA: American Psychiatric Publishing, Inc.
- Heffron, M.C., & Murch, T. (2010). *Reflective supervision and leadership in infant and early childhood programs*. Washington, DC: Zero To Three.
- Larrieu, J. A., & Zeanah, C. H. (2003). Treating parent-infant relationships in the context of maltreatment: An integrated systems approach. In A. Sameroff, S. McDonough, & K. Rosenblum (Eds.), *Treating parent-infant relationship problems: Strategies for intervention*, New York: Guilford Press.
- Larrieu, J. A. (2002). Treating infant-parent relationships in the context of maltreatment: Repairing ruptures of trust. *Bulletin of Zero to Three: National Center for Infants, Toddlers, and Families*, 22 (5), 16-22.
- Larrieu, J., & Valliere, J. (1999). A relationship-focused approach to permanency decisions. *Bulletin of Zero to Three: National Center for Infants, Toddlers, and Families*, 19 (3), 31-32.
- Lieberman, A. & Van Horn (2005). *Don't hit my mommy: A manual for child-parent psychotherapy with young witnesses of family violence*. Washington DC: Zero To Three.
- Munro, E. (2011). *Munro review of child protection: final report - a child centered system*. Munro Review Reports, Department for Education. Norwich: The Stationery Office Limited.
- Perry, B.D. (2006). *The Neurosequential Model of Therapeutics: Applying principles of neuroscience to clinical work with traumatized and maltreated children*. In: *Working with Traumatized Youth in Child Welfare* (Nancy Boyd Webb, Ed.), pp. 27-52, The Guilford Press, New York.
- Heffron, M.C., & Murch, T. (2010). *Reflective supervision and leadership in infant and early childhood programs*, Washington, DC: ZERO TO THREE.
- Zeanah, C. H., Larrieu, J. A. (1998). Intensive intervention for maltreated infants and toddlers in foster care. *Child and Adolescent Psychiatric Clinics of North America*, 7(2), 357-371.
- Zeanah, C. H., Larrieu, Heller, Valliere, Hinshaw-Fuselier, Aoki, & Drilling (2001). Evaluation of a preventive intervention for maltreated infants and toddlers in foster care. 40, 214-221.
- Zeanah, C. H., Vallier, Heller, & Larrieu (2000). Infant-parent relationship assessment. In C. Zeanah, *Handbook of Infant Mental Health* (2nd ed.). New York: Guildford Press.

Websites:

nctsn.org

zerotothree.org

childtraumaacademy.org

Being in Relationship

Paradoxical Truths and Opportunities for Change in Foster Care

JANET C. MANN

*The Children's Ark
Spokane, Washington*

MOLLY D. KRETCHMAR

NANCY L. WORSHAM

Gonzaga University

One September, in the early years of The Children's Ark, a young woman showed up on our doorstep. "Desirae*" had just given birth to her second child, who was removed from her custody because of prenatal drug exposure. She was currently in drug treatment and desperate to reunify with both her newborn and her older son, who was also in foster care. Because we offered mothers the opportunity to reside full-time with their children while participating in services, The Children's Ark (see box, next page) was an attractive option for this mother.

Typically, families were referred to The Children's Ark by the Department of Social and Health Services. The kind of initiative that this young woman demonstrated by arriving without a referral was unusual, and was perhaps our first hint that she had courage and wisdom well beyond her 17 years, buried beneath her tough exterior. Desirae's journey with us over the next 12 months and, indeed, to the present day, has taught us some invaluable lessons.

The following story of Desirae and her children highlights the sometimes paradoxical truths about families in crisis and the nature of lasting change that challenge the current system's good faith attempts to assist families fractured by addiction, abuse, and neglect. If those of us who work in the child welfare system are to make a lasting difference in the lives of at-risk families, we must find ways to reconcile each family's complex needs with the efficient functioning of a system and with what is in the best interests of the children. Much of it in Janet Mann's words, this article focuses on Janet's experience with Desirae at The Children's Ark and in the years following Desirae's departure from The Ark. As such, Janet's voice

throughout the paper is primary; unless otherwise indicated, all first person referents involve her direct work with Desirae and her insights regarding that work.

Desirae and Her Children

DESIRAE HAD A familiar history. She had been physically and sexually abused as a child and had been in and out of foster care herself. Her childhood experience of violence, deprivation, and abandonment had already played out in dramatic ways in her life. After being found guilty of second degree manslaughter following the death of a fellow gang member when she was just 12 years old, she had served time in a lockup facility and was still on probation. Her first son, Jacob, was removed from her care when he was a toddler, after he swallowed cocaine. At the time we met Desirae, Jacob was 2 years old and living in a local foster home. Desirae's second son, David, was a newborn, and it was with him that she requested entry to The Children's Ark.

*The names of the mother and her children have been changed to protect their privacy; however, Desirae read the final draft of this paper so is fully aware and affirming of its content.

Desirae and David moved into The Children's Ark, together, a few weeks after she first knocked on our door. It was immediately clear that Desirae was suffering from depression, struggling to bond with her infant son, and preoccupied with her older son, Jacob. She was resistant, defensive, cold, and harsh, both with her baby and with the other parents and staff. Her tendency toward chaos and disorganization were problematic, and she and I were constantly in conflict as I struggled to find a way to connect with and help her.

Jacob began visits shortly after Desirae and David entered The Children's Ark, and

Abstract

This article focuses on the experience of "Desirae," a young mother who participated with her children in services at The Children's Ark, an attachment-based intervention for families in foster care. The story of Desirae and her children highlights both the sometimes paradoxical truths about families fractured by addiction, abuse, and neglect and the nature of lasting change that challenge the current child welfare system. Informed by attachment theory and other psychodynamically oriented perspectives as well as Buddhist psychology and mindfulness, the authors stimulate further thinking about how professionals can manage challenges with creativity and compassion by keeping relationships at the center of care for families in crisis.

THE CHILDREN'S ARK

The Children's Ark was developed by foster parents, Janet and Paul Mann, as a placement option for children in foster care, in which mothers could also live. Grounded in attachment theory, The Children's Ark provided a safe, structured, and therapeutic environment in which mothers retained primary caregiving responsibilities, under the supervision of the Ark staff, while they worked toward improving their capacities for parenting and self-sufficiency. Shortly after its development, Nancy Worsham and Molly Kretchmar were invited to engage in a descriptive study of The Children's Ark focusing on the experiences and outcomes of the mothers and children (Kretchmar, Worsham, & Swenson, 2005; Mann, Kretchmar, & Worsham, 2008; Worsham, Kretchmar-Hendricks, Swenson, & Goodvin, 2009). Although space precludes a more complete presentation of our findings, the analysis of Desirae's case completed for research purposes further confirms Janet's experience as described in this article.

in the early spring, we had transitioned him into The Ark full-time. Things deteriorated quickly with Jacob also in the house. Desirae was stressed beyond her coping abilities trying to manage two children, go to school, and maintain even minimal living skills in The Children's Ark environment. On May 1, she negotiated an exit. Jacob returned to his former foster home, David stayed on in care with us, and Desirae moved in with her boyfriend.

Over the next 5 months, we cared for David while trying to inform those in charge of this family's future what we had learned during our 7 months living with them. It was our strong opinion that Desirae would not be able to care for her children safely, and we worked harder than we usually do to discourage reunification. The following is an excerpt from one of the letters we sent to Desirae's case worker.

...Desirae's internal working model is based on experiences in relationship with primary caretakers that were characterized by abandonment, insensitivity, devaluation, bullying/belittling, aggression and so on. Desirae learned that the experience of being attached is unpredictable, chaotic, frightening, and dangerous. As she enters into relationship with her own children, the same dynamics will likely play out, just as they did so clearly here at The Children's Ark.

Abandonment or avoidance was an issue from the beginning with David. There was little interaction between them. She often placed him facing away from her, sat with her back to him, and spent long periods of time not speaking

to him. She seemed to have the most difficulty responding to his cries, when he needed her the most. The first night that Jacob spent at The Ark (after being in foster care for more than a year), Desirae took free time and was gone for the evening, leaving Jacob without her in his new surroundings.

Desirae devalued, bullied, and belittled both children in many ways. She carried David under her arm like a football even when he was a very small infant. She resisted soothing him when he was distressed. She mocked and teased him, once reportedly blowing a horn loudly in his ear and laughing at his frightened response. Desirae engaged in derisive name calling and frequently yelled at both boys. This alternated with periods in which she was flamboyantly affectionate, kissing them in a way that was overwhelming and intrusive.

Desirae's aggression towards both boys escalated as her confusing and sometimes frightening behavior (loud voice, threatening posture, sudden mood shifts, and so forth) and failure to set appropriate and consistent limits involved them in frequent power struggles. Jacob's bedtime was a good example. Her lack of consistency coupled with a need to be obeyed led to a nightly screaming match. One incident of striking Jacob was reported to CPS. We then entered into a contract to discourage the verbal and physical aggression and instituted an "open door" policy, a step we felt necessary to ensure the safety of the children.

Desirae's developing relationship with her children, then, mirrors her own experience in relationship with a caregiver. Her children have also come to expect that closeness to her is unpredictable, chaotic, and frightening.

My assessment of what happened here at The Children's Ark is that Desirae became overwhelmed and "hit the wall." This was the result not only of the circumstances of her life, but also of her beginning to come to grips with her past in a way that exposed the pain of her own internal working model. She was not yet ready to confront that pain. Lack of information is not the problem: she knows intellectually that hitting and screaming are not the best ways to parent. If Desirae is ever to have access to her full potential as a parent, however, she will need to explore more completely her past relationships with caregivers and the role they played in her own emotional development. She needs to understand her working model and let down the armor of her defenses. She needs to grieve for her pain and losses and eventually find resolution. That will be a very long process. In the meantime, in my opinion, her children would be at very high risk for abuse and/or neglect should they be returned to her.

In spite of our concerns, and after 12 months with us, 13-month-old David was returned to Desirae's custody and care, along



PHOTO: ©ISTOCKPHOTO.COM/LAURA EISENBERG

One Halloween, Desirae, her husband, and all of the children arrived on our doorstep, and this began a tradition of a visit each year.

with Jacob. Life became even more complicated for Desirae. Unbeknownst to us, she was pregnant when she left The Children's Ark. She married her boyfriend and soon was also parenting one of his children from a previous relationship. The state of Washington then placed in their custody her sister's three children, so suddenly there were seven.

Desirae and her husband struggled over the years to create and maintain a home for themselves and the children, participating in drug treatment, parenting classes, and family preservation services. Sometimes the family was split up with some of the children living with relatives. Sometimes Child Protective Services was just a half step behind. Always they flirted with addiction, homelessness, poverty, and simply being overwhelmed by life.

Although we worked hard to discourage reunification after Desirae left The Children's Ark, we worked equally hard to stay in relationship with her, and not ambush, mislead, or abandon her. I visited occasionally during the first 2 years or so, when I was able to keep track of an address. On occasion, they would contact us, usually when their backs were against the wall. Then one Halloween, Desirae, her husband, and all of the children arrived on our doorstep, and this began a tradition of a visit each year, something we looked forward to immensely. Over the years, we noticed that, in spite of their continuing struggles, Desirae and her husband were becoming more attuned to, more sensitive to, and more affectionate with the children, and the children were less chaotic, calmer, and more direct about their emotional needs.

Each Halloween we hugged them and told them to come and visit anytime. Each year they came only at Halloween. Then last January, in a follow-up to a promise for pictures of David in his football uniform, I received an email from Desirae, updating us on the children. Her “love you guys lots” salutation prompted a response from me including “I think about you with such admiration, Desirae; you have hung in for yourself and these kids with such strength and courage and wisdom against so many odds at such a young age. I truly stand in awe.” Several emails later, we set up a lunch during which we discussed her time at The Children’s Ark and the events of the intervening years.

The Lessons

DESIRAE’S REFLECTION ON her own experience coupled with Janet’s insight and interpretation has helped to frame the following lessons and their implications for practice. In its initial conceptualization, The Children’s Ark was informed and influenced by attachment theory (Bowlby, 1969/82). As reflected in the following, our thinking is also influenced by other psychodynamically oriented perspectives (Fosha, 2000; Heineman & Ehrensaft, 2006; Richo, 2008) as well as by work in Buddhist psychology and mindfulness (Bayda, 2002; Kabat-Zinn, 1990).

Lesson 1: Safe parenting is not an information issue, but an emotional integration issue.

Like you could pull on the grownup end and sooner or later you would get to the child, just like pulling a bucket out of a well. Like you would never be left holding a broken end, with nothing attached to it at all (Cleave, 2008, p. 70).

Decades of research show that the intergenerational forces operating on one’s parenting are powerful, that even when parents intend to care for their children differently they often find themselves repeating what they experienced. Researchers and clinicians have described how the parent, once the child, reenacts dynamics of previous formative relationships with her own children, whether those are rooted in security and trust or in insensitivity and pain (Fraiberg, Adelson, & Shapiro, 1975; Kovan, Chung, & Sroufe, 2009; Kretchmar & Jacobvitz, 2002; Richo, 2008). Desirae’s interactions with her own children illustrate how these dynamics play out.

Desirae’s Story

Desirae came to The Children’s Ark a charming, intelligent, strong, insightful young woman, who knew that hitting and yelling were not the way she wanted to parent. And



PHOTO: ©ISTOCKPHOTO.COM/NORIKO COOPER

Decades of research show that the intergenerational forces operating on one’s parenting are powerful.

yet, as her time with us demonstrated, she repeated with her own children many of the behaviors she herself experienced as a child. She was somehow unable to translate her insight into action, but retreated instead into defensive withdrawal or hostile self-reliance. Clearly Desirae possessed a softer, more sensitive, vulnerable side. The challenge was in overcoming her fear of parenting from that sensitive place inside of herself. When faced with her children’s need for open-hearted tenderness, whenever they cried out to be seen, heard, understood, and held, Desirae’s own emotional deprivation and longing were triggered. The pain was then too deep, the risk too great. Her only option was to protect her own heart.

These history-in-the-moment experiences powerfully color, shape, and drive parents’ behavior even when they have some insight into them. Desirae stated to her Ark therapist, “I feel like I’m living with my mother and nothing I say matters, and it is never good enough.” This emotional reenactment with me of her own experience threw Desirae into a protective, defensive stance that felt critically necessary to her survival on some level, but from which she could not possibly parent with any sensitivity.

What she needed were not instructions regarding the proper way to interact with children, but some experience herself of how security felt. Parents cannot give their children what they have never experienced, partly because they cannot bear to acknowledge what they did not have, or their yearning for it, and partly because only in receiving security are they able to soften and open the

heart enough to give it.

So what Desirae needed were repeated overriding experiences during which she felt all the nurturing care her childhood lacked. She needed these experiences long enough to begin to trust them, to let them in. Only then would she be able to nurture her children in the same way. Providing her with opportunities to grieve what she did not get would also be essential in helping her integrate her own painful experience enough to operate from the more positive feelings generated by her new relationships.

Lesson 2: Being engaged in a caring, long-term relationship within the safety of a holding environment optimizes growth and change.

No longer is insight and interpretation the key to therapeutic success; the current consensus is that the actual relationship between therapist and child is what results in change (Bonovitz, 2006, p. 148)

Desirae, like all people, seeks connection; even while she resists it. All people develop, and can change, within the context of relationship. In order to begin to trust new transforming relationships, however, or to embark on the important work of grieving what they did not have, they require a reliable, safe haven or holding environment. Until they feel the safety of an environment that can contain the vulnerability of everything they think, feel and are, they will not come out from behind their protective walls.

Although my relationship with Desirae was conflicted, we both held on to a strong



Having compassion does not mean condoning behavior that harms children.

enough thread to keep the connection alive. Even as we at The Ark fought reunification, we were careful to maintain enough relationship with Desirae that she always knew we were available to her and that our care for her was unconditional. For her part, Desirae contacted us just enough to stay “on our screen.” I remember, for instance, a call from her several years after her exit from The Ark asking us how to cook an artichoke. In the end, that thread of relationship is what made it possible for us to connect again in a significant way. At that recent lunch, Desirae talked, with warmth and wisdom, about how all we had offered her at The Children’s Ark had gone in at some level, but she was just too overwhelmed in the moment to use it. She talked about knowing always that everything we did and everything we said, we did and said out of love for her and her children. She understood too that, even when she couldn’t hear it, we cared about her. All knowledge that she could hold—because there was “enough” relationship—until she was in a place where she could access it, articulate it, and act on it.

Desirae also talked about how, upon leaving The Children’s Ark, she had to keep all that she had learned tucked away behind her tough, self-reliant front until she had tried many parenting strategies and had become more grounded. Then, years down the road, as she watched others all around her parent from defended, fearful places, she kept hearing our voices and could finally open herself up to the tender, real place in herself that knew what to do. What she was finally able to do, in essence, was meet her children’s

vulnerability with her own. That is where — vulnerability meeting vulnerability—change happens.

Lesson 3: Meeting the needs of children at risk requires an ability to hold with compassion the ambiguity of good people doing bad things.

I realized that genuine compassion can never come from fear or from the longing to fix or change. Compassion results naturally from the realization of our shared pain (Bayda, 2002, p. 138).

How easy it is to reach out to and love a battered baby; how much harder to hold compassion for the batterer. No matter how angry and frustrated the cruelty human beings inflict upon one another makes professionals feel, without the compassion that understanding another’s pain brings, those who engage in this work can be of no help to anyone, including the children. Living with Desirae’s abandoning, belittling, insensitive, devaluing, and aggressive behavior toward her children was never easy...making us want to scream out with frequency, “STOP IT!” As the stories of her childhood began to unfold, however, and her pain and fears were revealed, our hearts began to open in understanding and compassion.

Over one of the Christmas holidays at The Children’s Ark, the mothers were sharing stories. Desirae started talking about how many agencies “adopted” her family at Christmas when she was little, and how as each stranger arrived bearing gifts, the

pile of toys and goodies under the tree grew larger and larger. But then as her mother, who was an addict, fell into more depression and desperation—along with her own painful ghosts from the past—the pile began diminishing. As Christmas approached Desirae witnessed kids in the neighborhood riding “her” bike and playing with “her” doll. Tears rose in Desirae’s eyes as she described the shame, humiliation, and deep pain of watching others with gifts intended for her because her mother put her next drug fix before her children.

Suddenly instead of wanting to respond with “STOP IT!” we were thinking, “OF COURSE.” As Desirae was faced with her children’s genuine need to be met and embraced, she could only be plummeted into grief and despair regarding her own unmet needs. In order to survive, she chose to protect and defend, at great cost to herself and her children.

Having compassion does not mean, however, condoning behavior that harms children; any more than understanding the genuine need behind children’s difficult behavior means condoning their misbehavior (Mann & Kretchmar, 2006). Having compassion also does not necessarily mean recommending that families be reunited. Compassion requires facing the truth. We did not support Desirae’s children being returned to her, but we were honest with Desirae about what we were doing and why. We were clear also that we cared about her as well as her children and that our position in no way diminished our care and concern for her. She was, in our opinion, just not ready. She had more work to do.

Lesson 4: Real change takes time.

But walls, whether built by bricks or isolation, don’t come down without a corresponding amount of labor (Caldwell, 2010, pp. 86–87).

The walls that take a lifetime to build up also take time to dismantle; there are no quick fixes or easy roads. The challenge, of course, is to give families the time they need—and deserve—to do the work, while not leaving children in limbo for too long. At our recent lunch Desirae talked about how it took time: time to try other, easier routes; time for life to get manageable enough to access and use her knowledge; time to allow herself to work through the pain and grief of her own experience so that her knowledge was more integrated; time to let her carefully constructed defenses fall enough that she could operate from a softened, opened heart; and so on. Anything less time-consuming would probably have been compliance, and thus transparent and transient. In essence what Desirae was talking about was the beginning

of a rewiring of her way of seeing the world and herself in it, giving her access to her full potential as a parent, referred to in the letter above.

The Implications

WHAT ARE THE implications in practice? How do child welfare professionals reconcile the need for timely resolutions for children with the time it takes parents to do the work they need—and should be allowed—to do, all within the constraints of an overwrought system? There are, of course, no simple or easy solutions, but there are things each of us can do to render interventions with fragile families both more nurturing and more effective.

First, the best interests of the children must always lead, especially the need for timely resolutions (Hudson et al., 2008; Katz, 1990; Mann et al., 2008). While keeping that in mind, and insisting that it drive and shape decisions, professionals must also do a better job of considering the bigger picture in which children exist. Abuse and neglect do not effect only the children, they impact whole families, and sometimes multiple families. Although a primary goal is to reconcile families, the professionals in charge often put families at the mercy of an adversarial system that pits party against party, parent against parent, parent against treatment provider, and, sometimes it even seems, parent against child. Until professionals manage the whole family, with creativity and compassion, they are not really helping anyone and in some cases are adding to the harm.

Next, not only must the whole family be considered, but also the whole family should be treated. Although individuals bring unique histories, issues, and ways of being in the world, problems reside in the dynamics between individuals, or in relationships (Sameroff & Emde, 1989). Professionals must therefore treat relationships: parents and children together (Cooper, Hoffman, Powell, & Marvin, 2005). Really serving children may mean offering services to them, both with their biological parents and with their foster parents. Children will resolve and heal only if those with whom they are in relationship, past and present, are on board and aware of their own contributions to the relationship dynamic.

Parents and children may well also benefit from individual treatment in conjunction with the relationship-based treatment. Two factors are important to remember regarding any treatment. One is that change is optimized within in the context of a safe relationship; and so, whenever possible, therapists and treatment providers should remain constant. For example, The Children's Psychotherapy Project, started by a nonprofit



PHOTO: ©ISTOCKPHOTO.COM/LESLIE BANKS

The challenge is to give families the time they need—and deserve—to do the work, while not leaving children in limbo for too long.

organization called A Home Within, developed the following model for its work with children and youth in foster care: “One child. One therapist. For as long as it takes” (Heineman, 2006, p. 3). This approach grew out of a consistent finding in research and clinical work: “The single most important factor in the lives of children and youth in foster care is a stable and lasting relationship with a caring adult” (Heineman, p.11).

Related to the idea of constancy, the system should not change or rotate workers and providers except when absolutely necessary, and parents should be discouraged from repeatedly changing providers, except in the case of a truly inappropriate match. In Desirae's case, several gaps in case workers allowed an advocacy group to take a stronger role in decision-making than they were authorized to provide, which ultimately shifted the process toward reunification, despite our deep concerns.

The second factor regarding change is that it takes time. Not only should parents be required to attend services, they also have the right to complete the work they've begun. That may mean that treatment continues after children are returned home. That may even mean that parents be allowed to continue treatment after relinquishing children, both for their own benefit and also for the benefit of any future children. Children also are entitled to ongoing, uninterrupted treatment that follows them wherever they go and involves their current caretaker.

Finally, relationships between biological families and foster families or relatives should be encouraged and facilitated, not discouraged (Ehrensaft, 2006). Not only do the children benefit from all their caretakers working together, but foster families and

relatives can often be the best resource for a family in crisis. Foster families are entitled to information about the children in their care specifically, and they should be better trained about the needs of children facing significant loss and trauma generally (Bass, Shields, & Behrman, 2004; Dozier et al., 2009). A well-intended, well-informed, well-supported foster or relative family can be a critically important member of the team and a caring bridge between parents and children at risk (Harrison, 2004). Had Desirae and I not been able to tolerate each other's imperfections enough to stay connected over time, she would never have been able to use what The Children's Ark had to offer.

Conclusion

AT ITS CORE, Desirae's story reflects the importance of relationships. A primary paradox facing the foster care system is that relationships take time, but it is time that none of us has. Given that paradox, our goal in this article was to stimulate further thinking about possibilities for approaching challenges with creativity and compassion by keeping relationships at the center of how all of us care for our society's most vulnerable children and families.

Learn More

CIRCLE OF SECURITY EARLY INTERVENTION PROGRAM
www.circleofsecurity.org

A HOME WITHIN
www.ahomewithin.org

More of Desirae's Story

Just as Desirae maintained enough connection to ultimately access the softer, wiser part of herself, so David held, on some level, the "knowing" of another way to be in relationship. One day, about 2 years after the family had left The Children's Ark, I encountered Desirae, David, and the new sibling (who was now 2 years old) at a nearby park. David was playing in the wading pool. Desirae called him over to say hello to me. Quite appropriately, he first peeked out from behind his mother's skirt, then ran off to play on the climbing equipment with his sister. As I left the park I walked by where David was playing up on a platform and stood eyeball to eyeball with him. I said hello to his sister, tousled her hair, and remarked, "You don't know me, do you?" as she stared at me with a bit of apprehension. David, however, was staring intently into my eyes. I said quietly, "But you do, don't you?" David nodded, slowly, almost imperceptibly, without taking his eyes off me. Finally he fell into my arms and held on tight and long. Even after 2 years something in his deeply rooted, perhaps unconscious, memory system allowed him to trust the safety and connection in my arms. That moment in the

park floated through my mind recently as I stood with Desirae on the sidelines of the now-14-year-old David's football game, cheering him on. ❧

JANET C. MANN, with her husband Paul, founded The Children's Ark in 1994 where she served as its director until she retired in 2009. Since 1988, Mrs. Mann and her husband have loved, nurtured, and transitioned more than 120 foster children to permanent homes. For the past 17 years she has trained in the areas of object relations theory, attachment theory, brain development, and child development. In December of 2005 she completed an advanced training in infant mental health assessment and in January of 2008 she passed Level One certification in Circle of Security Assessment and Treatment Planning. The Manns have been the recipients of numerous awards including the first annual Foster Parent Leadership Award from Children's Administration, Region One in 2007.

MOLLY D. KRETCHMAR, PhD, is a professor of psychology at Gonzaga University, Spokane, Washington, where she teaches courses in developmental psychology and attachment. Her research

focuses primarily on attachment-based interventions with at-risk parent-child dyads and with children in foster care. She is also exploring the impact of HIV/AIDS on attachment processes in children and families in Zambia, Africa.

NANCY L. WORSHAM, PhD, is a professor of psychology at Gonzaga University, Spokane, Washington, where she teaches courses in clinical psychology, and is a licensed psychologist in the state of Washington. Her research interests include parent-child attachment and intervention with at-risk dyads, the study of attachment to companion animals (especially canines), and mindfulness-based intervention approaches with children.

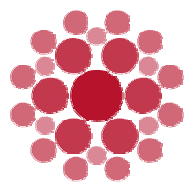
Authors' Note

Janet Mann extends her gratitude to her family as well as to the families and staff at The Children's Ark. In particular, she wishes to acknowledge therapist Glen Cooper for his support of her relationship with Desirae. All of us are deeply grateful to Desirae for her honesty and insight and for her permission to publish this account. Correspondence concerning this article should be addressed to Molly Kretchmar, Department of Psychology, 502 E. Boone, Gonzaga University, Spokane, WA, 99224.

References

- BASS, S., SHIELDS, M. K., & BEHRMAN, R. E. (2004). Children, families, and foster care: Analysis and recommendations. *The Future of Children*, 14, 5-29.
- BAYDA, E. (2002). *Being Zen: Bringing meditation to life*. Boston: Shambhala.
- BONOVITZ, C. (2006). Falling through the cracks: The complications of reunification for an adolescent in foster care. In T. V. Heineman & D. Ehrensaft (Eds.), *Building a home within: Meeting the emotional needs of children and youth in foster care* (pp. 131-149). Baltimore: Brookes.
- BOWLBY, J. (1982). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books. (Original work published 1969)
- CALDWELL, G. (2010). *Let's take the long way home*. New York: Random House.
- CLEAVE, C. (2008). *Little bee*. New York: Simon and Schuster.
- COOPER, G., HOFFMAN, K., POWELL, B., & MARVIN, R. (2005). The Circle of Security intervention: Differential diagnosis and differential treatment. In L. J. Berlin, Y. Ziv, L. M. Amaya-Jackson, & M. T. Greenberg (eds.), *Enhancing early attachments: Theory, research, intervention, and policy* (pp. 127-151). New York: Guilford.
- DOZIER, M., LINDHEIM, O., LEWIS, E., BICK, J., BERNARD, K., & PELOSO, E. (2009). Effects of a foster parent training program on young children's attachment behaviors: Preliminary evidence from a randomized clinical trial. *Child & Adolescent Social Work Journal*, 26(4), 321-332.
- EHRENSAFT, D. (2006). Many parents, one child: Working with the family matrix. In T. V. Heineman & D. Ehrensaft (Eds.), *Building a home within: Meeting the emotional needs of children and youth in foster care* (pp. 175-190). Baltimore: Brookes.
- FOSHA, D. (2000). *The transforming power of affect: A model for accelerated change*. New York: Basic Books.
- FRAIBERG, S. H., ADELSON, E., & SHAPIRO, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problem of impaired mother-infant relationships. *Journal of the American Academy of Child Psychiatry*, 14, 387-422.
- HARRISON, K. (2004). *Another place at the table*. New York: Tarcher/Penguin.
- HEINEMAN, T. V. (2006). The children's psychotherapy project: One child. One therapist. For as long as it takes. In T. V. Heineman & D. Ehrensaft (Eds.), *Building a home within: Meeting the emotional needs of children and youth in foster care* (pp. 3-20). Baltimore: Brookes.
- HEINEMAN, T. V., & EHRENSAFT, D. (Eds.). (2006). *Building a home within: Meeting the emotional needs of children and youth in foster care*. Baltimore: Brookes.
- HUDSON, L., ALMEIDA, C., BENTLEY, D., BROWN, J., HARLIN, D., & NORRIS, J. (2008). Concurrent planning and beyond: Family-centered services for children in foster care. *Zero to Three*, 28(6), 47-53.
- KABAT-ZINN, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Dell.
- KATZ, L. (1990). Effective permanency planning for children in foster care. *Social Work*, 35(3), 220-226.
- KOVAN, N. M., CHUNG, A. L., & SROUFE, L. A. (2009). The intergenerational continuity of observed early parenting: A prospective longitudinal study. *Developmental Psychology*, 45, 1205-1213.
- KRETCHMAR, M. D., & JACOBVITZ, D. B. (2002). Observing mother-child relationships across generations: Boundary patterns, attachment, and the transmission of caregiving. *Family Process*, 41, 351-374.
- KRETCHMAR, M. D., WORSHAM, N. L., & SWENSON, N. (2005). Anna's story: A qualitative analysis of an at-risk mother's experience in an attachment-based foster care program. *Attachment and Human Development*, 7, 31-49.
- MANN, J., & KRETCHMAR, M. D. (2006). A disorganized toddler in foster care: Healing and change from an attachment theory perspective. *Zero to Three*, 26(5), 29-36.
- MANN, J., KRETCHMAR, M. D., & WORSHAM, N. L. (2008). Critical issues in foster care: Lessons the Children's Ark learned from Barbara and Nathan. *Zero to Three*, 28(6), 41-46.
- RICHO, D. (2008). *When the past is present: Healing the emotional wounds that sabotage our relationships*. Boston: Shambhala.
- SAMEROFF, A. J., & EMDE, R. N. (Eds.). (1989). *Relationship disturbances in early childhood: A developmental approach*. New York: Basic Books.
- WORSHAM, N. L., KRETCHMAR-HENDRICKS, M. D., SWENSON, N., & GOODVIN, R. C. (2009). At-risk mothers' parenting capacity: An epistemological analysis of change through intensive intervention. *Clinical Child Psychology and Psychiatry*, 14, 25-41.

A GUIDE TO PRACTICAL INTERVENTIONS TO HELP CHILDREN AFFECTED BY TRAUMA



**Multiplied
Connections**

Positive development
for all children



Acknowledgements

A Guide to Practical Interventions for Children Affected by Trauma would not have been possible without the exceptional contributions of Lucy Marcil. Lucy, spent tireless volunteer hours in the summer before entering medical school at the University of Pennsylvania researching and writing this guide. She delved into books, scoured the internet, and met with local experts to find the best, most current and practical information to include in the pages that follow. The Multiplying Connections Initiative is deeply grateful to her for the gift of her time and her work.

Additional thanks go to the Multiplying Cross System Training Institute and Steering Committee who carefully reviewed and edited the content of the guide and to Suzanne Cohen for publishing the guide in a user friendly format.

A GUIDE TO PRACTICAL INTERVENTIONS TO HELP CHILDREN AFFECTED BY TRAUMA

Introduction

The aim of Multiplying Connections is to promote positive development for all children, especially those who have been traumatized by repeated exposure to violence, abuse and neglect. To accomplish this aim, we offer training to children's services professionals on the impact of trauma on development; how to recognize children's reactions to trauma; and how to promote healing through trauma informed care. This guide is designed to supplement the information and skills learned in the Becoming Trauma Informed course by providing you with specific:

techniques (behavioral and structural changes you can make when interacting with children),

activities (focused interactions with children designed specifically to help them cope with their responses to trauma and any trauma triggers present in the environment), and

environmental changes (ways you can rearrange your office, classroom, etc to make it calmer and more secure for children)

With a little practice, all of these strategies can easily be implemented and integrated into your daily work and they do not require any special clinical training.

Since childhood trauma is “any physical or physiological threat or assault to a child’s physical integrity, sense of self, safety or survival or to the physical safety of another person significant to the children” (*MC definition – BTI*), the overall goal of all of these interventions is to increase a child’s sense of self, safety, stability, and positive connections with others.

Perhaps the most important thing you can do for a traumatized child is to create a positive, nurturing relationship with him. Research has repeatedly shown that not only do secure relationships with adults help all children feel safe, stable and develop a sense of self, they also can help these children function in a ‘normal’ state of arousal (as opposed to hyper-arousal or disassociation, common states for traumatized children). Operating at a normal state of arousal is crucial for proper brain development and for creating the optimal brain state for learning.

The interventions in this guide are helpful for ALL children because they expose them to positive experiences that promote healthy brain development. Children who experience trauma, however, need more deliberate and more frequent exposure to these interventions because their exposure to such positive experiences has often been limited and curtailed.

Repeated positive experiences enable children affected by trauma to develop new neural pathways in their brains, increasing the opportunity for healthy development and growth. As clinician David Bath points out, traumatized children have stress response systems that have fundamentally changed; they “focus on the need to ensure safety rather than on the many growth-promoting interests and activities that secure children find attractive and stimulating” (Bath, p.5). For maximum effectiveness, these interventions, particularly the techniques and environmental changes, need to be done continually, on a permanent basis. Doing so takes practice and patience. It also takes advanced planning, but over time it will become intuitive.

In the video series “Helping Traumatized Children” neuroscientist Bruce Perry, MD, outlines the five most important things adults can do to help children who are traumatized:

Stay and teach **CALM**, be **ATTUNED**, **PRESENT**, and **PREDICTABLE** and **DON'T** let children’s emotions escalate your own.

We have created the mnemonic **CAPPD** to help you remember these skills. All the activities, techniques, and environmental changes in this guide incorporate one or more of the five principles of **CAPPD**:

CALM: aims to keep both you and the child(ren) you work with in a relaxed, focused state. It is normal for children to react emotionally to things that upset or agitate them. Learning to regulate their emotions and return to a calm state after being alarmed or triggered by something that upsets them fosters positive relationships and experiences by helping children function in the, the neocortex, the optimal part of the brain for complex thinking and learning.

ATTUNED: asks you to be aware of children’s non-verbal signals: body language, tone of voice, emotional state. These signals tell you how much and what types of activity and learning the child can currently handle. These signals are also constantly shifting, so being attuned to children requires constant vigilance. Furthermore, children affected by trauma experience both life and their trauma in the midbrain, or the implicit, sensory part of the brain rather than in the “thinking/ learning” neocortex. (Steele, p. 14). Consequently, you must connect with the child(ren) on an emotional, sensory level before moving to a cognitive level.

PRESENT: requires that you focus your attention on the child(ren) you are with, that you be in the moment. All children can sense when you are not truly engaged or focused on them; to compound this intuition, a “pervasive mistrust of the adults with whom they interact” (Bath, p. 6) is a key characteristic of children who have experienced trauma. Despite their wariness, these children need to and, with support, can form secure relationships with loving adults.

PREDICTABLE: asks that you provide children with routine, structured, and repeated positive experiences that they need to thrive. Children who have experience trauma view the world as scary and unreliable. Being predictable in your actions and routines will help children feel safe. When they feel safe, they can stop devoting a majority of their brain energy to the fight-or-flight response and instead be free to grow and explore. Engaging in age-appropriate growth-promoting activities will help their brains develop new, positive neuro-networks.

DON'T let Children's Emotions Escalate Your Own: requires you to remain in control of your emotions and of your expression of them. When children lose control and become angry, frustrated, overly excited, or scared, our own emotions can spiral out of control as well. When this happens, we can escalate the situation and trigger further trauma responses in children. However, these are the moments when children most need us to be calm and steady. They need to know that even though they have lost control, and are experiencing difficult and frightening feelings, the world can still be a reliable and safe place and that they can depend on trustworthy adults. One of the main challenges when working with children who have experienced trauma is teaching them to regulate their own emotions, since their brain systems are often in a hypervigilant or disassociated state. The best way for children to learn to regulate their emotions is by watching us regulate ours.

We hope you will find these interventions informative and useful. Please visit our website, www.multiplyingconnections.com, to let us know how you are using CAPPD in your work and if you have further questions or comments!

TECHNIQUES

CREATE EMOTIONAL/PHYSICAL SAFETY

Age: 0–5 *Applicable To:* Groups or Individuals

CAPPD Concepts: predictable, attuned, calm

What It Is: Children affected by trauma will often cling or want to stay close to their primary caregiver; or conversely can be indiscriminate about who they hug. It is important to provide appropriate physical touch to these children. Sit close together, hug them, rub their backs, etc, but ONLY provide physical affection when the child seeks it; requesting/giving un-asked for affection can re-traumatize the child or trigger trauma-related behaviors.

Why It Helps: Physical comfort can help calm children and help them cope with the trauma. When children feel free from fear and physical harm, they can better regulate their emotions and behavior.

PROVIDE CHOICE AND CONTROL

Age: 1.5–5 *Applicable To:* Groups or Individuals

CAPPD Concepts: predictable, attuned, present

What It Is: It is normal and necessary for children to go through a demanding/controlling phase of development, but trauma exacerbates it. For chil-

dren who have been traumatized, many of their life experiences involve control being taken away from them; they need to regain a sense of control. For demanding/controlling/stubborn kids, give them control over small things. For example, say to them “For snack, you can have A or B” or “Which activity would you like to do, A or B?”. Cheer children on as they try new things and try to accomplish things independently.

Why It Helps: Feeling they have control, children will be calmer and less controlling. Having choice and some control also lets children learn that they are important and can make things happen. This technique builds self-efficacy, fosters trust, and promotes a sense of identity.

COMMUNICATE RESPECT/TRANSPARENCY:

Age: 2–5 *Applicable To:* Groups or Individuals

CAPPD Concepts: predictable, attuned, present

What It Is: When you communicate with children, use words, tone, and body language that show you respect them as people. Don’t try to hide information from children or evade their questions. If they ask you about something that you truly cannot tell them, say: “I wish I could tell you the answer to that, but I can’t. I can tell you, though, that...”

Why It Helps: Respecting children promotes their sense of identity and helps them feel competent and worthy. Receiving respect and open, honest communication from adults helps children learn to communicate more effectively. In turn, these experiences will help them regulate their emotions and behavior.

BE NURTURING

Age: 0–5 *Applicable To:* Groups or Individuals

CAPPD Concepts: attuned, present

What It Is: The ability to nurture measures the extent to which a caregiver is available and able to sensitively meet the needs of a child. Some examples of nurturing behavior are: being fully present in your interactions with children (verbally and non-verbally), validating their feelings, providing physical affection and comfort when sought, laughing and playing games, providing safe mental, physical and social challenges that promote healthy growth and development.

Why It Helps: Children who are adequately nurtured feel more secure, which leads to the healthy development of self-esteem.

PROVIDE STABILITY

Age: 0–5

Applicable To: Groups or Individuals

CAPPD Concepts: predictable

What It Is: Stability means a child's environment is predictable and consistent. A key factor in providing stability is **establishing a routine**, such as doing things at the same time and in the same way as much as possible every day. Children benefit from knowing the routine. Use visual charts with pictures whenever possible to help kids see the schedule and what comes next. Sometimes, verbal processing is too much. If the routine has to change, tell the children about the change as soon as you can. Explain how it will change and why, if possible. Try to engage them in making the change.

Why It Helps: Planning the day and having a daily routine makes life much more predictable and manageable for traumatized kids. Traumatizing experiences, especially chronic trauma, are inherently unpredictable. Children need to learn that the world and their life can be predictable to regain a sense of trust and control. Establishing routine also reassures children that an adult is in charge and will help keep them safe. Stability/safety and repeated experiences are essential for children to be able to learn and function from the neocortex.

GET DOWN ON EYE LEVEL

Age: 0–5

Applicable To: Groups or Individuals

CAPPD Concepts: attuned, present

What It Is: When interacting with –or especially, speaking with – children, make sure you are on eye level with them and make regular eye contact with them. For babies, this means getting close to the child so they can make eye contact—it might mean lying on the floor with the baby, or holding the baby at the adult’s eye level,

Why It Helps: Being on the same physical level as you makes children feel safer, more in control, and more connected to you. It communicates to them that you are there for them and really paying attention to them.

MODEL OPEN DISCUSSION

Age: 3–5

Applicable To: Groups or Individuals

CAPPD Concepts: attuned, present

What It Is: Whenever possible in your conversations with children, talk with them openly. Provide them with honest, clear information in age-appropriate language. Allow them time to process the information and ask questions. Don’t avoid talking about subjects or answer their questions just because you feel awkward discussing them. You will find that over time you gain more comfort and confidence talking about uncomfortable issues and children in turn will be more open with you.

Why It Helps: Open discussion helps kids learn *generally* to talk openly and develop good conversation skills. Open dialogue will also help children feel more comfortable discussing difficult issues. When children have the truth and the facts, it decreases their impulsivity and aggression. Open discussion also communicates respect for the children, which helps build their self-esteem.

DISCIPLINE STRATEGIES

Age: 1–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, attuned, predictable, don't...

What It Is: Make sure you have a well-established discipline and consequences system. Generally, though, a behavior modification program (like stickers) does not work for children affected by trauma. Use direct, specific, positive wording for both written and verbal rules and directions. For example, instead of saying, "Will you stop being so hyperactive?", you can say, "Please walk quietly and calmly in the hallway."

Think about the causes of a child's behavior before giving disciplining. Try to make the experience something from which they can learn. Try to select consequences that address the causes of the behavior and that are logical. Also keep in mind that children who have experienced trauma often need adults to react to their developmental age, not their biological age (i.e. – a 5 yr old throwing a tantrum like a 2 yr old may need to be rocked and held, not sent out to time out). Give choices, if possible, for consequences. Children affected by trauma are very sensitive to displeasure, so err on the side of under-reacting, when possible. Don't criticize or shame children for regression (i.e. – a potty-trained child starts wetting his pants again after trauma); regression is a normal response to trauma. Try to ensure that the consequence will not trigger a trauma response, for some children discipline strategies such as isolated time out may be very retraumatizing if they have been neglected or abandoned in the past. It is NEVER acceptable for children's services professionals caregiver to use hitting, spanking, verbal abuse or yelling as a consequence for a child's negative behavior.

Give warm, abundant praise as much as you can (ratio of praise to criticism should be at least 6:1). In other words, make more effort to catch and acknowledge children doing "good" things. Make sure to use "labeled" (specific) praise. For example, instead of giving vague encouragement like "Good job," praise the specific behavior or action – "I really like

how quickly you stopped playing the game when I said it was time to go inside” or “I really like how you used many different colors to draw your butterfly today”

Why It Helps: *Why It Helps:* Knowing what to expect for various types of behavior helps make children’s lives predictable and helps them learn how to act. Responding to children’s developmental age, not their biological age starts where they really are and helps their brains develop in ways that they may have missed earlier in life. Children impacted by trauma often practice reenactment: the habit of recreating old relationships with new people. Even if these are negative relationships, they are familiar and therefore feel safer/more predictable to children affected by trauma. These children are so sensitive to criticism, they need abundant praise to help them develop a healthy sense of self-esteem and self-worth. Giving children choices for consequences gives them a sense of control, helps avoid battles, and increases their sense of self.

ACTIVITIES

MAKE A SAFETY PLAN

Age: 2–5

Applicable To: Groups and individuals

CAPPD Concepts: attuned, predictable

What It Is: Create and practice safety plans (for fires, hurricanes, tornados, earthquakes, school lock-down, etc) and educate children about it. If you are in the midst of disaster or trauma (especially acute, public trauma), inform children that the school, institution, or other authority is working to keep them safe; emphasize the plan.

Why It Helps: The plan will help them feel a sense of control and predictability – know what to do and expect if something goes wrong. Useful as soon as children are old enough to start worrying/being aware of danger.

BREATHING RETRAINING

Age: 3–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, present

What It Is: Walk children through taking deep, slow breaths. If possible, have children lie on their backs. Tell them to focus on breathing in through the nose and out through the nose or mouth. Young children may have to do both through the mouth as it's harder for them to coordinate nose breathing. The goal is to expand the abdomen, not the chest; to help focus on this, have children place their hands on their abdomens. To help them focus, ask them to close their eyes if they want to and visualize a balloon. They should imagine a color for their balloon and that they are trying to fill the balloon from their stomach. You can also place a stuffed animal on their belly and ask them to try and make the animal go up and down with their breathing.

Alternatively, if you have bubble soap and wands available, you can blow bubbles with children to help them focus on taking slow, deep breaths.

Why It Helps: Deep breathing leads to calmness as it calms all of the physiological processes associated with the fight or flight response in the body. Children's brains need to be in a calm state to function and develop and learn normally. When children become upset, you can ask them to remember their breathing practice and take 5 slow, deep breaths.



MUSCLE RELAXATION

Age: 3–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, present

What It Is: Have children squeeze their face muscles tight (while making a face), notice how it feels, squeeze tighter – as tight as they can. Then, tell them to let those muscles relax and ask them how it feels now? Move down through the body – shoulders, arms/hands, legs/feet, whole body.

For younger children, give them concrete images to focus on. For example, ask them to imagine that they are a frozen snowman – they should make their muscles tight and hard, just like ice. Ask them to notice how they feel. Then, tell them that the sun comes out and starts to melt them; they should relax into a puddle. Ask them how it feels to be a puddle. Young children respond well to the use of sensory imagery.

Why It Helps: Relaxing their muscles helps children release stress and become calmer. This activity will also calm their brain activity and bring them into their present, safe reality, which will help them focus better on daily tasks and learning.

POSITIVE IMAGERY

Age: 2–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, present

What It Is: Ask children to close their eyes if they want to (for some children who experienced trauma closing their eyes can be frightening and/or a trauma trigger) and imagine a nice place in their minds. They can imagine some place they've been or some place that is very familiar and comfortable. Ask them to take 3 deep breathes and imagine any 'bad' thoughts they are having drifting away as they breathe out. Tell them to think about their nice place and imagine it with all their senses. What does it feel/smell/look/sound like? They should enjoy being in the place and notice

how being there makes them feel. When they are ready, they should slowly let go of this image and bring themselves back to the room.

For younger children, ask them to blow their ‘bad’ feeling away in bubbles (imaginary or real), then “sparkle like a bright star,” “shine like the sun,” “be gentle like a bunny,” and “be quiet like a mouse.”

Why It Helps: Letting go of negative emotions and thoughts, at least temporarily, will help children calm down, re-focus and think more positively. It also helps to teach them that they do have control, to some extent, over their feelings and can choose to focus on positive experiences and places.

CREATIVE ACTIVITIES

Age: 6 mo–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm

What It Is: Positive creative activities include: painting/drawing (finger painting), playdough, puppets, rhythmic music/dance (including clapping patterns and listen & move songs; see Appendix I for a list of suggested songs). Give children open prompts; for example – draw your strongest memory, nightmare or a good dream, happy or bad thoughts, family, friends, home, etc. Let them talk about their art work without too much outside interference.

Why It Helps: The physicality of these activities helps keep children calm and decreases anxiety. Rhythmic music or dancing is soothing and brings the brain function back to normal/calm – where it needs to be for proper brain development, learning and functioning. Even very young children/babies can benefit from these types of activities. The creative aspect of these activities is also important because it can help children safely process their trauma at their own pace and in their own ways.

OUTDOORS

Age: 6 mo–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, present

What It Is: Let children run, jump, climb, scream and play outside. Toddlers, as well as older children, like to play ‘hide and seek.’ Let children be creative in their play.

Why It Helps: Physical activity helps calm children, decreases anxiety, and releases tension and stress. It also helps physical development as well as brain development. ‘Hide and seek’ is a good outdoors game because it comforts children to be ‘lost’ and then ‘found.’ The creative aspect of outdoors play also helps children process their trauma.

READ STORIES

Age: 0–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, predictable

What It Is: Read age appropriate, familiar books to and with children. Rhythmic books are especially good. See Appendix I for a list of suggested books.

Why It Helps: Reading is relaxing, which decreases anxiety and stress. Re-reading familiar stories is especially good as it provides a sense of control/predictability and helps pathways develop in the brain. Reading also can be good opportunity to safely sit close together and experience physical comfort (but do not force or pressure children to sit near you/touch you unless they want to).



FREE PLAY

Age: 0–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, present

What It Is: Give children time for unstructured play.

Why It Helps: Free, unstructured play is thought to help with pruning of excess nerves during brain development. In studies, the play curve matches the cerebellum growth curve. Research has found that rats deprived of play had immature neuron connections in the pre-frontal cortex. Studies have also found that for rats with ADHD, one extra hour of play significantly decreased their hyperactive symptoms; thus, for hyperactive children, extra play may help calm and refocus them. Since many children who have experience trauma operate in a chronically hyper aroused state, play may help calm and refocus them as well.

It is important to remember, though, that children benefit from **CHILDLIKE** play (play that is creative, imaginative, active, engrossing, all-consuming). Many children affected by trauma lose the ability to engage in childlike play. Instead, their play (focused on stress, win/lose situations, control, conflicts) can actually create a negative cycle that worsens trauma. Adults may need to help refocus their play so they re-learn, or learn for the first time, childlike play.



TODAY I FEEL...

Age: 3–5 (appropriate for 2s in an abbreviated way and with more help from the adult, who will do more narrating of what the child is expressing since the child will be communicating emotional states non-verbally)

Applicable To: Groups or Individuals

CAPPD Concepts: attuned

What It Is: Ask children to complete the sentence describing how they feel. If they are too young to answer verbally, they can draw their answer or you can hold up drawings for them to identify. Draw pictures of feeling faces with children and talk about different times that make them feel this way. When you notice a child experiencing or hear a child expressing a strong emotion, comment to them: “I wonder if you’re feeling _____ because of _____.” This technique is called reflective listening. Help children identify ways to deal with specific emotions. For example, if they are feeling overwhelmed or stressed, perhaps some time in a quiet, calm area will help soothe them. If they are feeling sad because they miss people, maybe they will feel better if they talk to you about those people. Help each child learn what works for him.

Why It Helps: These exercises help children become more attuned to their own emotions, which is a first step toward regulating their emotions. They also teach them to express their emotions, which is the first step toward healthy communication. Once children recognize what their emotions are, then they can learn to self-regulate. Research shows that children experience a calming benefit from simply identifying their emotions (Bath, p. 7). Recent studies have also indicated that being able to label our negative feelings actually helps us feel better. Reflective listening is also important because it teaches children that adults care about their feelings; this type of communication builds trust, and models healthy relationships.

TEACHING ATTUNEMENT

Age: 3–5

Applicable To: Groups or Individuals

CAPPD Concepts: attuned

What It Is: Similar to the above “Today I Feel...” activities, except that it focuses more on other people’s feelings. Ask and discuss with the children:

- “How can you tell if someone is happy?”
- “How can you tell if someone is sad?”
- “How does it feel when no one listens to you?”
- “When someone is speaking to you, you should look at them.”
- “You can understand someone if you listen to their words and watch how they behave.”

Why It Helps: Children will develop healthier relationships with others when they can accurately read other people’s emotions. Social development is a very important part of normal development. Children who have experienced trauma often have difficulty accurately interpreting other people’s emotions. For example, they may have trouble differentiating among neutral, sad, and angry faces. Thus, they need re-learn how to interpret people’s body language, facial expression, and tone.



GROUNDING EXERCISE

Age: 4–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, present

What It Is:

Lead the children through the following:

sit comfortably and relaxed; breathe deeply

look around and name 5 pleasant objects you see

breathe slowly and deeply

name 5 pleasant sounds you hear

breathe slowly and deeply

name 5 pleasant things you can physically feel

breathe slowly and deeply

name 5 colors you see in the room

breathe slowly and deeply

the goal of this activity is to limit intrusive thoughts about the trauma; to redirect attention to the outside world.

Why It Helps: This exercise calms children and brings them into the “here and now” which is safer than the stress or trauma–related thoughts and feelings they may be experiencing. Calming helps bring their brain activity from hyper aroused to normal.

TREASURE HUNT

Age: 2–5

Applicable To: Groups or Individuals

CAPPD Concepts: predictable

What It Is: Have children look for certain objects (yellow star, etc) around the room. Repeat the activity often.

Why It Helps: Finding items where you expect them to be, and repetition in general, provides predictability, which decreases hyper-arousal. Repetition is also necessary for the brain to build new pathways and leads to competence and skill development.

I SPY

Age: 2–5

Applicable To: Groups or Individuals

CAPPD Concepts: attuned

What It Is: Ask children to find/identify other children with certain traits – gender, hair/eye color, shirt color, etc. Other, similar activities would be I Hear and I Feel.

Why It Helps: Children who have experienced trauma often have difficulty with peer relationships. This activity helps them learn about their peers and relate to others. Focusing on sensation also helps calm them.

INTERACTIVE STORY TELLING

Age: 2–5

Applicable To: Groups or Individuals

CAPPD Concepts: attuned, present

What It Is: Use simple, short stories with large words and pictures. Ask children questions about the story as you go along (How do you think the boy feels? What happened at the beginning of the story? What happened in the middle? What do you think will happen next? Have you ever done anything like this? etc)

Why It Helps: Children who have experienced trauma operate in their mid-brain, the emotional and sensory part of the brain. They often have difficulty organizing and expressing themselves. This activity will increase their literacy skills, narrative cohesion, and sequencing skills and promote the development of their neocortex. It will also help them achieve a sense of accomplishment and engagement with others.

SIMON SAYS

Age: 2–5

Applicable To: Groups or Individuals

CAPPD Concepts: present, predictable, calm

What It Is: Direct the children to do various large motor movements (Simon says: touch your toes, bend over, reach up high, jump up and down, shake your right hand, etc).

Why It Helps: Children who have experienced trauma can have difficulty with higher-level brain functions, such as attending, planning, and organizing. This activity promotes these skills. The physicality of the activity can also help calm

EMOTIONAL MATCHING

Age: 3–5

Applicable To: Groups or Individuals

CAPPD Concepts: attuned

What It Is: Use pictures of different facial expressions and calm/scary/exciting/etc scenes. Ask children to match the facial expression to the appropriate scene.

Why It Helps: Children affected by trauma have trouble accurately identifying emotional states; they often over-interpret people's displeasure or upset. For example, they have difficulty differentiating between neutral, sad and angry expressions and may interpret even the slightest sign of annoyance as threatening to them; i.e. expression of fury. The activity provides the opportunity to practice accurately identifying emotional expression and builds neural pathways.

DRAMATIC PLAY

Age: 3–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, attuned

What It Is: Using props, have children pretend that the police come to help a girl who is lost (assign roles to the children), etc (other dramas might

involve the hospital, social workers, firefighters – anything with which the child might have had negative experiences).

Why It Helps: Children who have experienced trauma are often afraid of the police (or other people/situations) and often naturally re-enact their trauma through their play. This activity helps them reframe their experiences with police (or others) to learn that police help maintain safety in the community. Research shows that developing ‘stories’ about their experiences is a crucial part of the recovery process (Bath, p.7). By interacting calmly with children as they do these re-enactments, you will help them manage their stress and create perspectives that go beyond their traumatic experiences.

ENVIRONMENTAL CHANGES

LIMIT TV

Age: 0–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, present, attuned

What It Is: If possible, don’t allow children to watch TV at all, but especially programming that exposes them to traumatic events (disaster, murder, accident, death, etc.). If you do watch media on trauma or violence with children, actively engage them and talk about what’s happening while watching it and after the program is over.

Why It Helps: TV hinders healthy brain development, especially in very young children (0–3). The rapid movement from scene to scene on TV keeps children’s brains on high alert, and interferes with the development of a normal attention span and with children’s ability to follow story lines. Being continuously re-exposed to a traumatic event, especially in the sensationalized format of TV can worsen trauma for children. If children do see reminders of trauma they have experienced on TV, discussing it with them is an excellent way to remain attuned and be present for them and to help them make sense of the trauma.

COZY CORNER

Age: 2–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, attuned

What It Is: Create a cozy area where children can go when stressed, angry, sad, or fearful. Make the area as warm and homelike as possible – soft blankets, soft chairs, beanbag chairs, cushions, stuffed animals, etc.

Why It Helps: Two major problems children affected by trauma experience are an absence of feeling safe and the inability to self-soothe, particularly when they are operating in a hypervigilant state. Providing them with a calm, cozy area can provide them with a safe retreat when they feel overwhelmed or unsafe and gives them the opportunity to practice self-soothing and regulating their emotions.

PLAY BACKGROUND MUSIC:

Age: 0–5

Applicable To: Groups or Individuals

CAPPD Concepts: calm, present, attuned

What It Is: Play soft, classical/instrumental music in the background.

Why It Helps: This technique can help create a soothing environment. The rhythms of music help bring brain functioning from hyperactive or disassociated states to “normal”, which promotes neurological development.

APPENDIX I

Recommended Books and Music for Infants and Toddlers

(Taken from *Helping Children Rebound*)

BOOKS

Black and White Illustrations

Baby Animals: Black and White by Phyllis Limbacher Tildes

Black on White by Tana Hoban

What is That? by Tana Hoban

White on Black by Tana Hoban

Who Are They? by Tana Hoban

Bold Illustrations

Animal Noises by Stephan Cartwright

Brown Bear, Brown Bear, What Do You See? by Bill Martin, Jr.

Color Farm by Lois Ehlert

Pet Animals by Lucy Cousins

My Car by Byron Barton

Baby Faces

Baby Face by Phyllis Limbacher Tildes

Eat (Baby Faces series) by Roberta Grobel Intrater

How Sweet It Is To Be Loved by You (MotownBaby Love Board Book series) by Charles R. Smith, Jr.

Peekaboo Baby (Look Baby! Series) by Margaret Miller

Books For Toddlers

A You're Adorable by Buddy Kaye, Fred Wise, and Sidney Lippman

Baby Dance by Ann Taylor

Busy Fingers by C.W. Bowie

Can I Have a Hug? by Debi Gliori

Counting Kisses: A Kiss and Read Book by Karen Katz

Goodnight Moon by Margaret Wise Brown

Hear Are My Hands by Bill Martin, Jr.

Hush Little Baby by Sylvia Long

I Love You Baby from Head to Toe! by Karen Pandell

Just Like Me by Miriam Schlein

"More, More, More," Said the Baby by Vera B. Williams

Pretty Brown Face by Andrea Davis Pnkney

The Runaway Bunny by Margaret Wise Brown

Ten Little Fingers by Annie Kubler

Ten, Nine, Eight by Molly Bang

Tickly Under There by Debi Gliori

Toes, Ears and Nose!: A Lift-the-Flap Book by Marion Dane Bauer

What Does Baby Say? by Karen Katz

Where is Baby's Belly Button? by Karen Katz

Will You Carry Me? by Heleen van Rossum

MUSIC

Lullabies

A Child's World of Lullabies by Hap Palmer

Dream a Dream by Mary Stahl

Lullabies for Little Dreamers by Kevin Roth

The Baby Record by Bob McGrath

Wee Sing Nursery Rhymes and Lullabies
by Pamela Conn Beall and Susan Hagen Nipp

Gentle Music

Baby's First Classics, Volume 1,2,and 3
by various artists, St. Clair Records

Baby's First Guitar Music by various artists, St. Clair Records

Quiet Places and Seagulls by Hap Palmer

Playful Songs and Nursery Rhymes: Recordings

Babysongs and More Babysongs by Hap Palmer

Early, Early Childhood Songs by Ella Jenkins

Peek-A-Boo and So Big by Hap Palmer

Songs and Games for Toddlers by Bob McGrath

Tiny Tunes by Carole Peterson

Wee Sing and Pretend by Pamela Conn Beall and Susan Hagen Nipp

Wee Sing Children's Songs and Fingerplays by Pamela Conn Beall
and Susan Hagen Nipp

Wee Sing for Baby by Pamela Conn Beall and Susan Hagen Nipp

Songs and Nursery Thymes: Resource Books for Caregivers

I Love You Rituals by Becky A. Bailey

The Book of Bounces by John M. Feierabend

The Book of Simple Songs & Circles by John M. Feierabend

The Book of Tapping and Clapping John M. Feierabend

The Book of Wiggles and Tickles John M. Feierabend



REFERENCES

Bilmes, J., & Heroman, C. (2005). *Helping Children Rebound: Strategies for Infant & Toddler Teachers After the 2005 Hurricane*. Washington, D.C: Teaching Strategies, Inc.

Gabowitz, D., Konnath, K. (2008). Developing Trauma-Informed Services for Families Experiencing Homelessness. An Interactive Training Video and Guide

Grounding Exercise for Traumatic Stress. Psychosocial First Aid Field Operations Guide (2nd Ed). The National Child Traumatic Stress Network. Retrieved from <http://www.nctsnet.org/>.

Handout Packet. (2008). Trauma Course, presentation Multiply Connections workgroup. Philadelphia. (The National Child Traumatic Stress Network)

Head Start School Intervention Project. Southwest Michigan Children's Trauma Assessment Center.

Henig, R.M. (Feb 17, 2008). Taking Play Seriously. *The New York Times*.

Parent Tips for Helping Infants and Toddlers after Disasters. Psychological First Aid – Field Operations Guide. National Child Traumatic Stress Network.

Perry, Bruce. *Trauma Up to Age Five*. Video #4 in Film Series: Childhood Trauma. VB 9.08

Preventing Child Maltreatment Through the Promotion of Safe, Stable, and Nurturing Relationships Between Children and Caregivers. (2009) Atlanta: Center for Disease Control.

HOW I STAY CAPPD

To stay **Calm** I _____

To be **Attuned** I _____

To be **Present** I _____

To be **Predictable** I _____

So I **Don't** escalate I _____

Multiplying Connections is a cross-system initiative funded by the **William Penn Foundation** to build the capacity in Philadelphia's public children's service system to

- Provide developmentally appropriate and trauma informed services for all children;
- Understand and respond to children suffering from trauma in ways that "do no further harm;" and
- Support ways to expand the quality and quantity of children's relationships, and nourish their healthy development.

The Health Federation of Philadelphia is home to *Multiplying Connections*. Our steering committee public system partners include the **School District of Philadelphia, Early Childhood Education Program** and the **City of Philadelphia's Departments of Human Services, Public Health, Maternal Child Family Health Division, and Behavioral Health, Children's Division**. We are also proud to partner with the **Institute for Safe Families, The Center for Non-violence and Social Justice** , **The Children's Crisis Treatment Center, The Behavioral Health Training and Education Network** and the **Pennsylvania Council for Children Youth and Family Services**..

To learn more about Multiplying Connections visit our website:
www.multiplyingconnections.org

For Supporting this project, special thanks to:

The William Penn Foundation



For more information contact:

Leslie Lieberman

The Health Federation of Philadelphia

1211 Chestnut Street, Suite 801

Philadelphia, PA 19107

215-567-8001, x3031

llieberman@healthfederation.org

© pending. All Rights Reserved. Health Federation of Philadelphia. 201032

NATIONAL SCIENTIFIC COUNCIL ON THE DEVELOPING CHILD
NATIONAL FORUM ON EARLY CHILDHOOD POLICY AND PROGRAMS

The Foundations of Lifelong Health Are Built in Early Childhood



Center on the Developing Child  HARVARD UNIVERSITY

NATIONAL FORUM ON EARLY CHILDHOOD POLICY AND PROGRAMS

FORUM MEMBERS

Jack P. Shonkoff, M.D., Co-Chair
Julius B. Richmond FAMRI Professor of Child Health and Development, Harvard School of Public Health and Harvard Graduate School of Education; Professor of Pediatrics, Harvard Medical School and Children's Hospital Boston; Director, Center on the Developing Child, Harvard University

Greg J. Duncan, Ph.D., Co-Chair
Distinguished Professor, Department of Education, University of California, Irvine

Hirokazu Yoshikawa, Ph.D., Science Director
Professor of Education, Harvard Graduate School of Education

Philip A. Fisher, Ph.D.
Professor of Psychology, University of Oregon
Senior Research Scientist, Oregon Social Learning Center & Center for Research to Practice

Bernard Guyer, M.D., M.P.H.
Zanvyl Kreiger Professor of Children's Health, Johns Hopkins Bloomberg School of Public Health

Katherine Magnuson, Ph.D.
Associate Professor, School of Social Work, University of Wisconsin, Madison

CONTRIBUTING MEMBERS

Susan Nall Bales
President, FrameWorks Institute

Jeanne Brooks-Gunn, Ph.D.
Virginia and Leonard Marx Professor of Child Development and Education, Teachers College and the College of Physicians and Surgeons; Co-Director, National Center for Children and Families; Co-Director, Institute for Child and Family Policy, Columbia University

Deborah Phillips, Ph.D.
Professor of Psychology and Associated Faculty, Public Policy Institute; Co-Director, Research Center on Children in the U.S., Georgetown University

FUNDING SUPPORT FOR THE FORUM AND COUNCIL

The Birth to Five Policy Alliance

The Buffett Early Childhood Fund

Casey Family Programs

The Norlien Foundation

An Anonymous Donor

ADDITIONAL FUNDING SUPPORT PROVIDED BY

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention

PARTNERS

The FrameWorks Institute

The National Governors Association Center for Best Practices

The National Conference of State Legislatures

NATIONAL SCIENTIFIC COUNCIL ON THE DEVELOPING CHILD

COUNCIL MEMBERS

Jack P. Shonkoff, M.D., Chair
Julius B. Richmond FAMRI Professor of Child Health and Development, Harvard School of Public Health and Harvard Graduate School of Education; Professor of Pediatrics, Harvard Medical School and Children's Hospital Boston; Director, Center on the Developing Child, Harvard University

Pat Levitt, Ph.D., Science Director
Director, Zilkha Neurogenetic Institute; Provost Professor of Neuroscience, Psychiatry & Pharmacy; Chair, Department of Cell and Neurobiology, Keck School of Medicine, University of Southern California

W. Thomas Boyce, M.D.
Sunny Hill Health Centre/BC Leadership Chair in Child Development; Professor, Graduate Studies and Medicine, University of British Columbia, Vancouver

Nathan A. Fox, Ph.D.
Distinguished University Professor; Director, Child Development Laboratory, University of Maryland College Park

Megan Gunnar, Ph.D.
Regents Professor and Distinguished McKnight University Professor, Institute of Child Development, University of Minnesota

Linda C. Mayes, M.D.
Arnold Gesell Professor of Child Psychiatry, Pediatrics, and Psychology, Yale Child Study Center; Special Advisor to the Dean, Yale School of Medicine

Bruce S. McEwen, Ph.D.
Alfred E. Mirsky Professor; Head, Harold and Margaret Milliken Hatch Laboratory of Neuroendocrinology, The Rockefeller University

Charles A. Nelson III, Ph.D.
Richard David Scott Chair in Pediatric Developmental Medicine Research, Children's Hospital Boston; Professor of Pediatrics and Neuroscience, Harvard Medical School

Ross Thompson, Ph.D.
Professor of Psychology, University of California, Davis

CONTRIBUTING MEMBERS

Susan Nall Bales
President, FrameWorks Institute

Judy Cameron, Ph.D.
Professor of Psychiatry, University of Pittsburgh

Greg J. Duncan, Ph.D.
Distinguished Professor, Department of Education, University of California, Irvine

Philip A. Fisher, Ph.D.
Professor of Psychology, University of Oregon
Senior Research Scientist, Oregon Social Learning Center & Center for Research to Practice

William Greenough, Ph.D.
Swanlund Professor of Psychology, Psychiatry, and Cell and Developmental Biology; Director, Center for Advanced Study at University of Illinois, Urbana-Champaign

Eric Knudsen, Ph.D.
Edward C. and Amy H. Sewall Professor of Neurobiology, Stanford University School of Medicine

Deborah Phillips, Ph.D.
Professor of Psychology and Associated Faculty, Public Policy Institute; Co-Director, Research Center on Children in the U.S., Georgetown University

Arthur J. Rolnick, Ph.D.
Senior Vice President and Director of Research, Federal Reserve Bank of Minneapolis

Contents

The Foundations of Lifelong Health Are Built in Early Childhood

INTRODUCTION	2
RECONCEPTUALIZING THE HEALTH DIMENSION OF EARLY CHILDHOOD POLICY	3
UNDERSTANDING THE BIOLOGY OF HEALTH IN THE EARLY YEARS OF LIFE	5
Physiological Adaptations or Disruptions in Early Development	5
Cumulative Exposures to Adverse Childhood Experiences	5
Biological Embedding During Sensitive Periods of Development	6
The Physiological Consequences of Social and Economic Disadvantage	7
PROMOTING THE FOUNDATIONS OF HEALTHY DEVELOPMENT	7
Creating a Stable and Responsive Environment of Relationships	7
Safe and Supportive Chemical, Physical, and Built Environments	9
Sound and Appropriate Nutrition	10
STRENGTHENING THE CAPACITIES OF CAREGIVERS AND COMMUNITIES	
TO PROMOTE THE HEALTH OF YOUNG CHILDREN	11
Caregiver Capacities	11
Community Capacities	12
RETHINKING THE HEALTH IMPLICATIONS OF A BROAD RANGE OF POLICIES	
AND PROGRAMS IN THE PUBLIC AND PRIVATE SECTORS	13
Policies and Programs that Promote Stable and Responsive Relationships	13
Policies and Programs that Assure Safe and Supportive Chemical, Physical, and Built Environments	15
Policies and Programs that Promote Sound and Appropriate Nutrition	16
Building a Broader, Multi-Sector Perspective on the Early Childhood Roots of Lifelong Health	17
A CALL FOR INNOVATION	20
REFERENCES	22

This publication was co-authored by the National Scientific Council on the Developing Child and the National Forum on Early Childhood Policy and Programs, which are both initiatives of the Center on the Developing Child at Harvard University. The content of this paper is the sole responsibility of the authors and does not necessarily represent the opinions of the funders or partners. Copies of this document, as well as more information about the authors and the Center, are available from www.developingchild.harvard.edu.

The authors gratefully acknowledge the contributions of Kamila Mistry, Ph.D.; Anne Riley, Ph.D.; Sara Johnson, Ph.D.; Lisa Dubay, Ph.D.; Cynthia Minkovitz, M.D., M.P.P.; and Holly Grason, M.A., of the Women’s and Children’s Health Policy Center, Johns Hopkins Bloomberg School of Public Health.

Suggested citation: Center on the Developing Child at Harvard University (2010). *The Foundations of Lifelong Health Are Built in Early Childhood*. <http://www.developingchild.harvard.edu>

© July 2010, Center on the Developing Child at Harvard University

Introduction

A VITAL AND PRODUCTIVE SOCIETY WITH A PROSPEROUS AND SUSTAINABLE FUTURE IS BUILT ON A FOUNDATION OF HEALTHY child development. Health in the earliest years—actually beginning with the future mother’s health before she becomes pregnant—lays the groundwork for a lifetime of well-being. When developing biological systems are strengthened by positive early experiences, healthy children are more likely to grow into healthy adults. Sound health also provides a foundation for the construction of sturdy brain architecture and the associated achievement of a broad range of abilities and learning capacities.

Health is more than merely the absence of disease—it is an evolving human resource that helps children and adults adapt to the challenges of everyday life, resist infections, cope with adversity, feel a sense of personal well-being, and interact with their surroundings in ways that promote successful development. Nations with the most positive indicators of population health, such as longer life expectancy and lower infant mortality, typically have higher levels of wealth and lower levels of income inequality. In short, children’s health is a nation’s wealth, as a sound body and mind enhance the capacity of children to develop a wide range of competencies that are necessary to become contributing members of a successful society.^{1,2}

Adverse events or experiences that occur early in childhood can have lifelong consequences for both physical and

of disturbing the neurobiological systems that guide physiological and behavioral responses to stress, potentially for the remainder of an individual’s life. Altering these regulatory mechanisms (e.g., setting the stress response system on a “short fuse”) can permanently increase the risks of acute and chronic disease, and even a shortened life span, by undermining the normally adaptive response of the body to the challenges and stressors of everyday life. These alterations to developing biological systems can lead to greater susceptibility to a wide range of illnesses well into the adult years, even in the absence of any conscious memory of early trauma.

Beyond its effect on individuals, poor health early in life also imposes significant societal costs that are borne by those who remain healthy. For example, when large numbers of children become ill because they did not receive their immunizations, the entire population becomes vulnerable to epidemics of infectious diseases. Similarly, the consequences of adversity and poor health in childhood can lead to higher rates of chronic diseases in adults, such as diabetes, hypertension, cardiovascular disease, and various forms of cancer, as well as depression, anxiety disorders, addictions, and other mental health impairments. These conditions affect all of society by reducing the productivity of the workforce and increasing the incidence of disability,

the demand on medical facilities, and the costs of medical care. Thus, a focus on health promotion in the early childhood period—where an extensive body of evidence supports the promise of effective prevention programs that can change the trajectory of children’s lives—can help reduce the social and economic burdens of illness, not only in childhood but also throughout the adult years. This connection between early life experiences and the health of a nation underscores the importance of strategic investments in the care and protection of pregnant women, infants, and young children, and it suggests that most current attempts to prevent adult disease and create a healthier workforce may be starting too late.

Health in the earliest years—actually beginning with the future mother’s health before she becomes pregnant—lays the groundwork for a lifetime of well-being.

mental well-being. That is to say, developmental and biological disruptions during the prenatal period and earliest years of life may result in weakened physiological responses (e.g., in the immune system), vulnerabilities to later impairments in health (e.g., elevated blood pressure), and altered brain architecture (e.g., impaired neural circuits). For example, exposure of expectant mothers to highly stressful environments can influence the birth weight of their babies, and lower birth weight has been linked to substantially increased risk for obesity, diabetes, and cardiovascular disease later in life. Traumatic experiences during childhood, such as physical abuse or the adversities that accumulate for children reared in deep and persistent poverty, are also capable

Reconceptualizing the Health Dimension of Early Childhood Policy

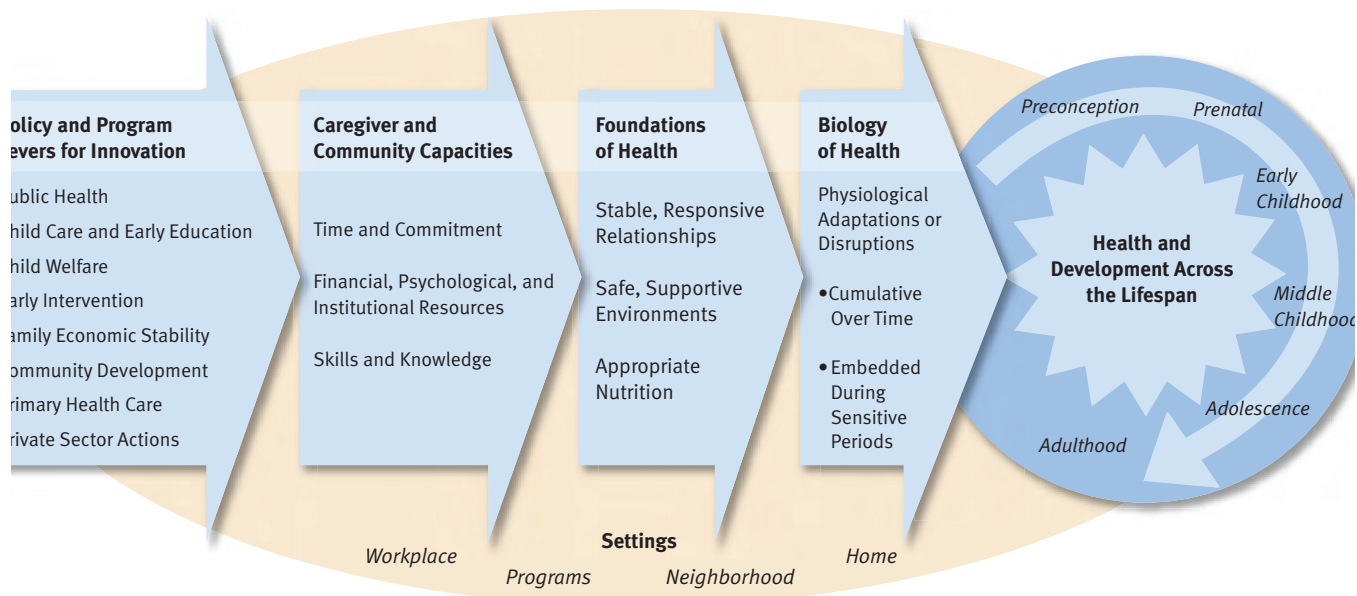
THE KNOWLEDGE BASE SUMMARIZED IN THIS DOCUMENT presents a compelling rationale for fundamentally rethinking the health dimension of early childhood policy. Science tells us that meeting the developmental needs of young children is as much about building a strong foundation for lifelong physical and mental health as it is about enhancing readiness to succeed in school.³ This insight points to the importance of viewing a broad array of policies and programs—beyond the provision of medical services—as potentially important vehicles for reducing the social burdens, human capital consequences, and medical-care costs of health impairments in the adult years.⁴ In other words, significant progress in lifelong health promotion and disease prevention could be achieved by reducing the burden of significant adversity on young children—and this progress could be accelerated through science-based enhancements in a wide range of policy domains, including child care and early education, child welfare, public assistance and employment programs for low-income parents, housing policies, and community development initiatives, to name just a few.

Driven by converging evidence from neuroscience, molecular biology, genomics, and advances in the behavioral and social sciences, this call for a broader perspective on health promotion and disease prevention is guided by the following three overarching concepts:

- Experiences are built into our bodies (for better or for worse) and significant adversity early in life can produce physiological disruptions or embedded biological “memories” that persist far into adulthood and lead to lifelong impairments in both physical and mental health.
- Genes and experiences interact to determine an individual’s vulnerability to early adversity and, for children experiencing severe adversity, environmental influences appear to be at least if not more powerful than genetic predispositions in their impact on the odds of having chronic health problems later in life.
- Health promotion and disease prevention policies focused on adults would be more effective if evidence-based investments were also made to strengthen the foundations of health and mitigate the adverse impacts of toxic stress in the prenatal and early childhood periods.

This new scientific knowledge compels us to think and act creatively to enhance the healthy development of young children by reducing the disruptive effects of significant adversity on developing biological systems. Progress toward this goal will be most effective if innovative actions are guided by an understanding of four interrelated dimensions that together comprise a new framework for improving physical and mental well-being: (1) the biology of health; (2) the foundations of health; (3) caregiver and community

A Framework for Reconceptualizing Early Childhood Policies and Programs to Strengthen Lifelong Health



capacities to promote health and prevent disease and disability; and (4) public and private sector policies and programs that can influence health outcomes by strengthening caregiver and community capacities.

The biology of health is defined by advances in science that explain how experiences and environmental influences “get under the skin” and interact with genetic predispositions, which then result in various combinations of physiological adaptation and disruption that affect lifelong outcomes in learning, behavior, and both physical and mental well-being. These

Experiences are built into our bodies and significant adversity early in life can produce biological “memories” that lead to lifelong impairments in both physical and mental health.

findings call for us to rethink current, adult-focused approaches to health promotion and disease prevention by incorporating an understanding of the early childhood origins of lifelong illness and disability.

The foundations of health refer to three domains of influence that establish a context within which the early roots of physical and mental well-being are either nourished or disrupted:

- *A stable and responsive environment of relationships.* This domain underscores the extent to which young children need consistent, nurturing, and protective interactions with adults that enhance their learning and behavioral self-regulation as well as help them develop adaptive capacities that promote well-regulated stress response systems.
- *Safe and supportive physical, chemical, and built environments.* This domain highlights the importance of physical and emotional spaces that are free from toxins and fear, allow active exploration without significant risk of harm, and provide supports for families raising young children.
- *Sound and appropriate nutrition.* This domain emphasizes the foundational importance of health-promoting food intake,

beginning with the future mother’s pre-conception nutritional status and continuing into the early years of the young child’s growth and development.

Caregiver and community capacities to promote health and prevent disease and disability refer to the ability of family members, early childhood program staff, and the social capital provided through neighborhoods, voluntary associations, and the parents’ workplaces to play a major supportive role in strengthening the foundations of child health. These capacities can be grouped into three categories: (1) time and commitment; (2) financial, psychological, and institutional resources; and (3) skills and knowledge.⁵

Public and private sector policies and programs strengthen the foundations of health through their ability to enhance the capacities of caregivers and communities in the multiple settings in which children develop. Relevant policies include both legislative and administrative actions that affect systems responsible for public health, child care and early education, child welfare, early intervention, family economic stability (including employment support for parents and public assistance), community development, housing, and primary health care, among others. It is also important to underscore the role that private-sector practices as well as government-sponsored programs can play in strengthening the capacities of families to raise healthy and competent children. Workplace policies related to parental leave, flexible working hours, and time off to care for a sick child or attend a parent-teacher conference are a few examples.

This framework suggests a new way of conceptualizing policies and practices in multiple sectors, all of which affect the early childhood origins of lifelong health. The goal is to catalyze informed investments and creative innovations that build on a shared scientific base to achieve significantly improved outcomes for children and society above and beyond the impacts of existing efforts. Although the framework can be adapted to address challenges facing all nations, the policy and program context for this document is focused on current circumstances and opportunities in the United States.

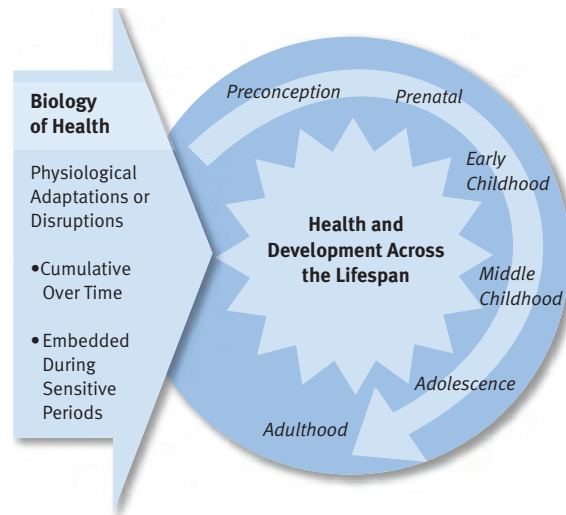
Understanding the Biology of Health in the Early Years of Life

IN ORDER TO UNDERSTAND HOW POLICIES and programs strengthen the capacities of families and communities to promote the foundations of health, it is essential to begin with an understanding of how personal experiences, environmental conditions, and developmental biology work together in early childhood to influence the roots of lifelong physical and mental well-being. Early childhood is a time of rapid development in the brain and many of the body's biological systems that are critical to sound health. When these systems are being constructed early in life, a child's experiences and environments have powerful influences on both their immediate development and subsequent functioning. These effects may appear early and be magnified later as children grow into adolescence and adulthood. Some have compared a child's evolving health status in the early years to the launching of a rocket, as small disruptions that occur shortly after take-off can have very large effects on its ultimate trajectory.⁶ Thus, "getting things right" and establishing strong biological systems in early childhood can help to avoid costly and less effective attempts to "fix" problems as they emerge later in life.

PHYSIOLOGICAL ADAPTATIONS OR DISRUPTIONS IN EARLY DEVELOPMENT

An extensive body of scientific evidence now shows that many of the most common chronic diseases in adults—such as hypertension, diabetes, cardiovascular disease, and stroke—are linked to processes and experiences occurring decades before, in some cases as early as prenatally.^{3,7} For example, longitudinal studies have demonstrated that lung disease in adulthood is commonly associated with a history of respiratory illness in childhood, particularly among premature infants and young children exposed to tobacco smoke.⁸ Chronic, life-threatening cardiovascular disease in adulthood can also be linked to nutritional deficits and growth impairments occurring as early as the prenatal period.^{9,10}

Early experiences or exposures can affect adult health in two ways—by the chronic wear



and tear of repeated damage over time or by the biological embedding of specific physiological disruptions during sensitive developmental periods.^{11,12} If a physiological maladaptation occurs in response to cumulative exposure to adverse social and/or physical conditions, then an ensuing chronic disease can be seen as the consequence of repeated encounters with psychologically or physically toxic environments. When damaging exposures occur during sensitive periods in the early development of specific biological processes, the resulting disruptions can become biologically embedded and subsequent adult diseases appear as the latent (or delayed) outcomes of early environmental assaults. In either case, science shows that there can be a lag of many years, even decades, before early harm is expressed in the form of overt disease.

CUMULATIVE EXPOSURES TO ADVERSE CHILDHOOD EXPERIENCES

An extensive and growing body of research demonstrates multiple linkages between childhood adversity and health impairments in the adult years. The Adverse Childhood Experiences (ACE) Study, for example, documents strong associations among multiple instances of traumatic or abusive childhood events (as recalled

in adulthood) and an extensive array of conditions later in life, including cardiovascular disease, chronic lung disease, cancer, depression, alcoholism, and drug abuse.^{13,14} Individuals reporting more adverse childhood experiences also had substantially greater risks for life-threatening psychiatric disorders,¹³ overlapping mental health problems,¹⁵ teen pregnancies,¹⁶ obesity, physical inactivity, and smoking.¹⁷ Other longitudinal studies have found comparable linkages between early stressful life events and adult disease.^{18,19,20} In all cases the pattern has been the same—the greater the number of adverse experiences in childhood, the greater the likelihood of health problems later in life.

Research on the biology of adversity illustrates how the body's physiological equilibrium breaks down under cumulative conditions of chronic stress (or what has been called “allostatic load.”)²¹ The activation of stress management systems in the brain results in a tightly integrated repertoire of responses involving the secretion of stress hormones, increases in heart rate and blood pressure, elevation in blood sugar and inflammatory protein levels, protective mobilization of nutrients, redirection of blood flow to the brain, and the induction of vigilance and fear.²² The normal, healthy, temporary activation of these systems represents a “positive stress response” and is protective, even necessary, in the face of an acute threat. A “tolerable stress response” is a more serious and sustained activation that is mitigated by supportive adults, who help the child develop adaptive coping responses. A “toxic stress response” in early childhood can weaken developing brain architecture and recalibrate the threshold for activating the stress response system for life. It occurs under circumstances of chronic or overwhelming adversity without the buffering support of caring, consistent, and supportive relationships.^{3,23} Animal studies indicate that toxic stress also can have direct, negative, and persistent effects on brain circuits that control reward and motivation. For example, research on rodents has demonstrated that profound neglect during early development increases drug-seeking behavior in adult rats.²⁴

Recently documented patterns of allostatic load that parallel racial disparities in health outcomes suggest that chronic physiological stress may play a role in the premature and disproportionate burden of physical and mental

illness experienced by African-Americans and other groups that experience discrimination.²⁵ African-Americans, for example, sustain earlier deteriorations of health compared with whites, leading to racial health disparities that increase with age and resulting in a life expectancy for blacks in the United States that is four to six years less than for whites.²⁶ This finding is consistent with research suggesting that the “weathering” of the body under conditions of chronic stress reflects an acceleration of normal aging processes.^{25,27,28}

BIOLOGICAL EMBEDDING DURING SENSITIVE PERIODS OF DEVELOPMENT

During sensitive periods of early growth and development, the evolving architecture of the brain (as well as the maturation of other organ systems) is highly receptive to a wide range of environmental signals or cues, whether positive or negative.²⁹ A considerable body of research suggests that adult disease and risk factors for poor health can be biologically embedded in the brain and other organ systems during these sensitive periods, with resulting health impairments appearing years, or even decades, later. Biological embedding as a function of malnutrition, toxic stress response, or exposure to damaging chemicals can occur in various ways, including mechanisms that change the regulation of genes that affect brain and body development.³⁰ For example, poor living conditions in early life (e.g., inadequate nutrition or recurrent exposure to infectious diseases) are associated with increased rates of chronic cardiovascular, respiratory, and psychiatric diseases in adulthood.^{10,31,32} Also, lower birth weight is associated with several risk factors for later heart disease, such as hypertension, central body fat distribution, insulin resistance, metabolic syndrome, and diabetes.^{9,33,34}

These findings are supported by evidence from a variety of animal and human studies. For example, lower birth weight in rats has been associated with higher blood pressure,³⁵ and studies in humans have linked poor growth *in utero* to later problems with heart disease³⁶ and hypertension.³⁷ Research investigating the underlying mechanisms that explain these associations have found linkages between early experiences of child maltreatment and evidence of heightened inflammatory responses in

adulthood that are known risk factors for the development of cardiovascular disease, diabetes, asthma, and chronic lung disease^{38,39} as well as new evidence of elevated inflammation as early as age 12 in children experiencing maltreatment and depression, regardless of their socioeconomic status.⁴⁰

THE PHYSIOLOGICAL CONSEQUENCES OF SOCIAL AND ECONOMIC DISADVANTAGE

Children who grow up in families or communities of low socioeconomic status appear to be particularly vulnerable to the biological embedding of disease risk. Researchers have hypothesized that this association may be the result of excessive stress related to high rates of neighborhood risk factors such as crime, violence, boarded-up houses, abandoned lots, and inadequate municipal services.⁴¹ Economically disadvantaged children also tend to live in housing that is crowded, noisy, and characterized by structural defects, such as leaky roofs, rodent infestation, and inadequate heating,⁴² and they are exposed to greater air pollution from traffic, industrial emissions, and caregiver smoking.⁴¹ Children raised in low-income environments, on average, also experience less and

lower-quality parental responsiveness,⁴³ and are more likely to experience conflictive and punitive parenting behavior.^{41,44,45} Together, these adverse conditions create repeated physiological and emotional disruptions that can have long-lasting effects on health and development.

Socioeconomically patterned differences in children's emotional, cognitive, and social experiences have been linked to several aspects of brain development, particularly within those areas of the brain that are tied most closely to the regulation of emotion and social behavior, reasoning capacity, language skills, and stress reactivity.⁴⁶ Children from lower socioeconomic backgrounds are more likely to show heightened activation of stress response systems,^{47,48} and some emerging research suggests that differences in caregiving related to income and education—such as responsiveness in parent-child interaction—can alter the maturation of selected brain areas such as the prefrontal cortex.⁴⁹ Animal models of early, stress-related changes in brain circuitry show that such modifications can persist into adult life, altering emotional states, decision-making capacities, and bodily processes that contribute to substance abuse, aggression, obesity, emotional instability, and stress-related disorders.^{50,51}

Promoting the Foundations of Healthy Development

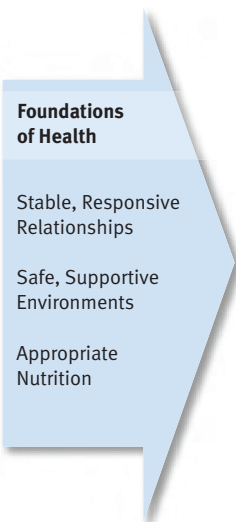
THE BIOLOGY OF EARLY HEALTH AND development illustrates how complex interactions among genes, environmental conditions,

and experiences produce either positive adaptations or negative disruptions in basic biological systems—with life-long consequences for both physical and mental health. There is much that society can do to ensure that children's environments provide the conditions that their biological systems need to produce positive health

outcomes. Three critically important foundations invite careful scrutiny: a child's environment of relationships; the physical, chemical, and built environments; and sound and appropriate nutrition.

CREATING A STABLE AND RESPONSIVE ENVIRONMENT OF RELATIONSHIPS

Human infants are unique among all species in their prolonged period of extreme dependence on adult care and protection for their survival and healthy development. The care that infants receive, whether from parents, extended family members, neighbors, or child care professionals, lays the groundwork for the development of a wide range of basic biological processes that support emotion regulation, sleep-wake patterns, attention, and ultimately all psychosocial functioning.^{52,53} Stable, responsive, and



nurturing caregiving early in life is also associated with better physical and mental health, fewer behavior problems, higher educational achievement, more productive employment, and less involvement with social services and the criminal justice system in adulthood.^{54,55} In biological terms, a child's environment of relationships can affect lifelong outcomes in emotional health, regulation of stress response systems, immune system competence, and the early establishment of health-related behaviors.

A child's environment of relationships can affect lifelong outcomes in emotional health, regulation of stress response systems, immune system competence, and the early establishment of health-related behaviors.

Thus, supports for families and appropriate training for providers of early care and education across all types of care, including informal arrangements as well as established centers, can improve health outcomes throughout the life course as well as enhance the current quality of life for young children and the adults who care for them.

Secure attachments. One important way in which responsive caregiving has long-lasting effects on physical and mental well-being is through the formation of strong, positive bonds between young children and the important adults in their lives. Securely attached infants show more positive emotion and less anxiety in early childhood and have an easier time establishing relationships with teachers and peers at school.^{56,57} Attachment patterns develop over the first few years of life and can influence mental health and psychological functioning throughout childhood and the adult years.^{56,58,59} Caregivers struggling with overwhelming problems such as depression may be unable to be sufficiently responsive to a young child during that early period when the foundations of attachment relationships are developing.^{60,61} This lack of consistent responsiveness disrupts what has been called the “serve and return” interaction between infants and adults that is fundamental to the development of healthy brain

architecture. When appropriate responses are missing, this can lead to a range of poor outcomes, including physical and mental health problems later in life.⁶²

Effective self-regulation and sleep cycles. Another way in which the caregiving environment affects the health of young children is the extent to which the consistency, quality, and timing of daily routines shape their developing regulatory systems. Beginning in the earliest weeks of life, the predictability and quality of these experiences influence the most basic biological rhythms related to waking, eating, eliminating, and sleeping.^{63,64} For example, infants who are exclusively breast-fed through about 3 months of age ingest levels of nutrients and hormones that reflect the mother's circadian rhythm (i.e., her 24-hour sleep-wake cycle) and appear to assist in establishing better sleep patterns and sleep efficiency.⁶⁵

Early experiences stimulate a wide variety of nerve transmissions that activate different parts of the brain and other body systems. When positive experiences are repeated regularly in a predictable fashion, the complex sequences of neural stimulations create pathways that become more efficient (i.e., “neurons that fire together wire together.”) For example, infants who learn that being soothed and comforted occurs shortly after they experience distress are more likely to establish more effective physiological mechanisms for calming down when they are aroused and are better able to learn to self-soothe after being put down to sleep.^{63,66} In contrast, when eating and being put to bed occur at different times each day and when comforting occurs unpredictably, the organization and consolidation of sleep-wake patterns and self-soothing responses do not develop well, and biological systems do not “learn” healthy routines and self-regulation.⁶⁷

This finding highlights the importance of secure, stable housing with quiet and predictable sleeping areas for babies. Although children differ in how much sleep they require, inadequate amounts lead to disruptive behavior problems, diminished cognitive performance, and greater risk for unintentional injuries.^{68,69} Growing evidence also suggests that poor sleep is associated with obesity in later childhood and early adulthood.^{70,71,72} Given that babies' internal clocks do not initially differentiate day from night, how

and when they are put to sleep shapes their development of sleep-wake rhythms.^{63,73}

Healthy stress response systems. Just as early experiences affect the architecture of the developing brain, they also shape the development of other biological systems that are important for health. For example, responsive caregiving plays a key role in the normal maturation of the neuroendocrine system.^{74,75,76} A wealth of animal research that is now being replicated in humans demonstrates that caregiving behavior also shapes the development of circuits that regulate how individuals respond to stressful situations.^{77,78} Specifically, variations in the quality and quantity of maternal care that a mother received in her own early life can affect how genes are turned on or off in her own offspring.^{79,80} Genes involved in regulating the body's stress response are particularly sensitive to caregiving, as early maternal care leaves a signature on the genes of her offspring that carry the instructions for the development of physiological and behavioral responses to adversity. That signature (known as an epigenetic marker) is a lasting imprint that affects whether the offspring will be more or less likely to be fearful and anxious later in life.⁸¹ Consequently, early overloading of the stress response system can have a range of adverse, lifelong effects on learning, behavior, and both physical and mental health. That said, effective programs are available that prevent specific types of stress-inducing events, such as physical or sexual abuse, and that provide successful treatments for children experiencing high levels of anxiety or chronic fear.⁸²

Immunologic responsiveness. Regulatory mechanisms that manage stress also influence the body's immune and inflammatory responses, which are essential for defending against disease. Young children cared for by individuals who are available and responsive to their emotional and material needs develop well-functioning immune systems that are better equipped to deal with initial exposures to infections and to keep dormant infections in check over time.⁸³ Some protections, such as maternal antibodies, are passed directly from mother to fetus through the placenta or from mother to infant through breast milk. These protections confer important passive immunity until the infant's own antibody response is developed.⁸⁴ Thus,

caregiving practices such as breastfeeding not only provide important opportunities for social bonding but also help the baby develop a more competent immune system.⁸⁵ Conversely, inadequate caregiving and limited nurturance very early in life can have long-term (and sometimes permanent) effects on immune and inflammatory responses, which increase the risk of chronic impairments such as asthma, respiratory infections, and cardiovascular disease.^{38,39}

Learned health-promoting behaviors. Another way in which early caregiving practices matter is the extent to which young children develop behavioral routines and patterns that influence long-term health trajectories. These early behaviors include a wide variety of domains: tooth brushing, television viewing, routine levels of physical activity, and risk-taking behaviors, among many others. One example is the type, amount, and frequency of foods offered to infants and toddlers, which together shape the processes that affect their taste and texture preferences and their developing dietary likes and dislikes.^{86,87} Increasingly persuasive scientific evidence shows that early learning of both food preferences and routine levels of physical activity affect the risk for obesity.⁸⁸

SAFE AND SUPPORTIVE CHEMICAL, PHYSICAL, AND BUILT ENVIRONMENTS

Unsafe environments are not only a threat to the immediate physical well-being of young children but also jeopardize their future health and development. These threats can manifest themselves in a variety of forms, many of which are amenable to effective preventive actions that simply await the political will required for widespread implementation.

Chemical exposures. Environmental toxins pose a significant threat to immature biological systems, as low-level exposures before or shortly after birth often produce more damaging and longer-lasting harm than exposures at higher levels in later childhood or adult life.⁸⁹ At the same level of exposure, embryos, fetuses, and children absorb much larger doses of toxins relative to their body weight than adults, which is another reason why the adverse impacts are greater in the prenatal period and early in life, when important developmental processes are

underway. Of all the body's organ systems, the brain is especially vulnerable to environmental toxicity, as even small injuries can produce significant effects on future health, learning, and behavior. Early chemical exposures also may prompt changes in other organs and tissues, resulting in structural malformations or greater susceptibility to diseases that may even be passed on to subsequent generations.⁹⁰ For example, prenatal exposure to diethylstilbestrol (DES), a drug prescribed for many pregnant women until the 1970s, has been linked to reproductive cancers in young women whose mothers were medicated while pregnant.⁹¹

In contrast to the long latency of adverse effects for many chemical exposures, the health impacts of some toxins are apparent much sooner. For example, lead ingestion is a well-established risk factor for cognitive deficits across the life course, largely because lead disrupts neurotransmitter regulation of synaptic development in the brain.⁹² Although most lead exposure is related to lead-based paint, soil, and dust,⁹³ recent problems have been detected from contaminated consumer products, including toys.⁹⁴

Physical and built environments. The danger of toxic chemical exposures as an environmental threat to child health is easy to understand. Less immediately apparent is the growing evidence that the way a child's physical environment is designed, built, and maintained can also significantly affect the risk of disease, disability and injury.⁹⁵ Beyond the safety of homes and child care settings, the "built" environment offers multiple opportunities to influence health-related behaviors. The availability of food choices and options for healthy eating illustrates one important example. This can be seen in many low-income, urban communities that are less likely to have grocery stores that stock healthy foods such as fresh fruits or vegetables and more likely to have multiple fast-food outlets and liquor stores, all of which undermine good nutrition.⁹⁶

Neighborhoods designed with parks, green space, sidewalks, and playgrounds away from traffic offer children and their families an opportunity to play and socialize with friends and other caregivers, as well as encourage greater physical activity, reduce child pedestrian injuries, and increase social ties.⁹⁷ Children living in such communities tend to be more physically active and have a lesser risk for obesity

than those who live in neighborhoods with fewer recreational facilities.^{98,99} Neighborhood features such as parks and sidewalks also influence social interactions: people can come together and develop a sense of mutual trust and responsibility for the community and its inhabitants, which often leads to a willingness to intervene on behalf of the common good.^{100,101} This neighborhood-level phenomenon, called "collective efficacy" or social capital, has been linked to lower rates of childhood obesity,¹⁰² better adult mental health,¹⁰³ and reduced crime rates.¹⁰⁴ Thus, zoning laws and regulations that influence the built environment can have an important influence on the well-being of children and caregivers, which contributes to the overall health of a community.

SOUND AND APPROPRIATE NUTRITION

Health at every stage of the life course is influenced by nutrition, beginning with the mother's pre-conception nutritional status, extending through pregnancy to early infant feeding and weaning, and continuing with diet and activity throughout childhood and into adult life. Adequate intake of both macronutrients (e.g., protein, carbohydrates, and fats) and micronutrients (e.g., vitamins and minerals) is particularly important in the early months and years of life, when body growth and brain development are more rapid than during any other period. In this context, nutrition serves as an important example of how early influences contribute to developmental patterns of health over time.

Although levels of severe hunger and malnutrition that persist in many of the world's poorest countries are rarely found in the United States, food insecurity remains a problem for a subset of the population that lacks access to sufficient food to meet their basic needs because of inadequate financial resources. That said, the growing epidemic of both childhood and adult obesity in the United States is receiving far more public attention than concerns about poor growth.

The relation between nutrition and health in childhood is broadly understood. The extent to which the nutritional status of a pregnant woman can influence the long-term growth and health of her child is less well appreciated. Inadequate maternal nutrition during pregnancy is associated with a range of undesirable

outcomes in the offspring, including obesity in childhood and adulthood as well as subsequent hypertension and cardiovascular disease.^{9,33} When mothers do not receive adequate calories and nutrients while pregnant, their fetuses develop in anticipation of “making do” with fewer nutritional resources. This response is beneficial if the post-natal environment provides minimal calories. However, if the post-natal environment offers access to sufficient nutrients, the infant’s prior adaptation becomes a liability, predisposing children to obesity and other diseases of excess because they were prepared for a world of scarcity.³³ Children born at very low birth weight also show marked insulin resistance and other changes that put them at risk for diabetes.³⁴

Maternal nutrition also affects the development of the fetal and infant immune system, as the adversity of under-nutrition can stimulate the release of maternal stress hormones that impair thymus development in the fetus.¹⁰⁵ The thymus gland is important, because it plays a key role in the development of the immune system by incubating immature immune cells, and decreased thymus size in infancy is associated with higher rates of infection and mortality.¹⁰⁶

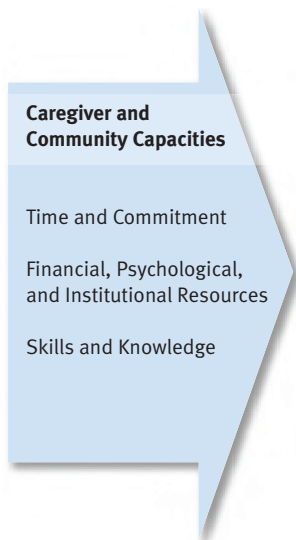
Indeed, a smaller thymus has been linked to poor immune responsiveness from the neonatal period through adolescence.^{105,107} As a result, adults who experience prenatal and early childhood under-nutrition are 10 times more likely to die from an infection than others.¹⁰⁶

Successful public health efforts to improve maternal nutrition, even prior to conception, have had beneficial effects on the health of both expectant mothers and their children. For example, maintaining adequate levels of folate for women in their child-bearing years has important implications for both pregnancy and the health of the newborn,¹⁰⁸ with folate fortification of foods leading to a 20 to 30 percent reduction in neural tube defects.^{109,110} Nevertheless, iron deficiency and inadequate levels of vitamins A and D remain significant health concerns for many children, who need increased levels of these nutrients to support the rapid growth of blood cells, bones, and other tissues. These types of deficiencies early in life can have adverse impacts on a wide range of cognitive, motor, social-emotional, and neurophysiological development and behavioral outcomes as well as lead to chronic medical conditions such as osteoporosis, asthma, and diabetes.^{111,112,113}

Strengthening the Capacities of Caregivers and Communities to Promote the Health of Young Children

THE MULTIPLE, INTERRELATED CAPACITIES OF caregivers and communities are essential promoters of the foundations of child health. Thus, policies and programs designed to promote the well-being of young children will be more effective if they bolster these capacities. The influences of caregivers and communities are played out in a wide variety of settings and contexts, including neighborhoods, parents’ workplaces, early care and education settings, health care facilities, and, of course, in the home. When caregiver and community capacities reinforce each other in positive ways, the

foundations of health are strong. When they function at cross purposes, or collectively in the wrong direction, child health is threatened and society’s future is at peril.



CAREGIVER CAPACITIES

Because young children develop in an environment of relationships, it is critically important that adult caregivers interact with them in a consistent and responsive manner. All parents and other adults (both within and outside of the family) bring a range of capacities to the care and support of young children. These include

(1) *time and commitment* (i.e., the nature and quality of time spent with children and on their behalf); (2) *resources*—both *financial* (i.e., economic ability to purchase goods and services) and *psychological, emotional, and social* (i.e., physical and mental health and parenting style); and (3) *skills and knowledge* (i.e., human capital acquired through education, training, interactions with child-related professionals, and personal experiences).⁵ Extensive documentation of the important impacts of these capabilities on child health and development is provided throughout this paper.

The fact that the majority of young children in the United States currently live in families with working parents provides a clear illustration of the importance of this issue. The pressures and demands of balancing parenting and work responsibilities, along with other changes in family structure and social roles, lead to considerable strain on time for parenting and other caregiver capacities across the socioeconomic spectrum.¹¹⁴ That said, most policies and programs for families with young children in the United States are focused on either parenting education or financial support for those with limited income. The fact that relatively limited attention is focused on addressing the shortfalls in time and/or psychological resources that overwhelm many parents across all social classes threatens the healthy development of many children, with the greatest burdens on those whose families and communities are impoverished and those whose children have special needs.

COMMUNITY CAPACITIES

Just as children develop in an environment of relationships, families function within a physical and social environment that is influenced by the conditions and capacities of the communities in which they live. In the context of community capacities, *commitment* is evident when child health and developmental outcomes are monitored, and responsibility for their promotion is assigned and accepted, such as through enforcement of legislation and regulations that affect child well-being. *Resources* at the community level include services and organizations dedicated to the promotion of children's healthy development as well as the availability of supportive structures such as parks, child

care facilities, schools, and after-school programs. Finally, *skills* comprise both political and organizational capabilities that can be leveraged to accomplish strategic goals.¹¹⁵ Thus, community capacities can range from enforcement of standards for child safety seats to the availability of high-quality markets selling affordable fresh fruits and vegetables and the presence of local leaders and organizations that can mobilize collective action.

Communities vary widely in their collective commitment, resources, and skills. For example, while there is strong evidence regarding the link between quality child care and positive child health and developmental outcomes, not all communities have the same level of resources to ensure access to affordable, quality options. Moreover, although problems in affordability and access to quality child care are an important issue for low-income neighborhoods, they also present significant challenges for middle-income communities where parents are employed but do not qualify for public subsidies.¹¹⁶

To summarize, although both individual caregivers and communities as a whole can influence the foundations of child health, not all have the same capacities. When necessary resources are not available, effective policies and programs can fill the gaps by building those under-developed or missing capacities. Healthy children are raised by people and communities, not by government and professional services—but public policies and evidence-based interventions can make a significant difference when caregivers and neighborhoods need assistance. It is also important to note the potential impacts of private-sector actions, above and beyond the effects of public policies, to address unmet needs. Creative, new strategies from multiple sources represent vital and highly promising contributions to community-wide health that are likely to produce substantially greater returns across the lifespan.

Rethinking the Health Implications of a Broad Range of Policies and Programs in the Public and Private Sectors

BUILDING ON THE FRAMEWORK

presented in this document, a science-based approach to the promotion of health and prevention of disease would be well served by strategic investments that build the capacities of communities and families to strengthen the foundations of healthy development in young children. This broader focus does not in any way diminish the importance of primary health care for all children and high-quality medical treatment for those who are ill. It does, however, underscore extensive and growing evidence that many of the major threats to the health of children cannot be addressed effectively in a hospital or a physician's office. In fact, the origins of health-related behaviors and many adult diseases can be found in the environments and experiences of early childhood.

The time has come to view primary health care as one important component of a multi-dimensional approach: building the capacities of communities and caregivers to strengthen the foundations of lifelong health during the prenatal period and early childhood years. With this goal in mind, two strategies for investment are worthy of attention. First, sufficient resources should be allocated to assure that all eligible children and families are served by existing policies and programs with demonstrated effectiveness factors that strengthen each of the three foundations of health. Second, a consistent portion of expenditures should be invested in the design and evaluation of new approaches to health promotion and disease prevention that are grounded in rigorous science. The need for innovative interventions across a wide range of sectors is particularly important for young children who are at greatest risk for early physiological disruptions that lay a foundation

Policy and Program Levers for Innovation

- Public Health
- Child Care and Early Education
- Child Welfare
- Early Intervention
- Family Economic Stability
- Community Development
- Primary Health Care
- Private Sector Actions

for later stress-related physical and mental health impairments.

Examples of policies and programs that focus on each of the three foundations of health—stable and responsive relationships; safe and supportive environments; and sound nutrition—are described below. Collectively, they cover a range of informal family supports, voluntary community efforts, private sector actions, and publicly funded policies and programs. Some are well-documented initiatives

that deserve broader implementation. Others represent promising new directions that are grounded in sound scientific reasoning yet await formal testing and evaluation. Both strategies are worthy of investment.

POLICIES AND PROGRAMS THAT PROMOTE STABLE AND RESPONSIVE RELATIONSHIPS

The goal of strengthening parent-child relationships is central to many existing policies and services for families with young children. Parents who are raising children in environments with multiple stressors and few supports comprise a critical constituency for such assistance. Working parents in well-functioning families with low incomes constitute another important target group. The need for relationship-strengthening support is particularly compelling for families whose economic security depends on low-wage jobs, often during non-standard working hours, and for working parents whose children have chronic health problems or special developmental needs that require multiple medical and therapeutic appointments, skilled child care, and a variety

of specialized interventions. In the absence of sufficient support for families facing such circumstances, many young children are subjected to excessive stresses that can have lifelong effects on their physical and mental health. These adverse effects incur substantial costs, for affected individuals personally and for society as a whole, that could be reduced by more timely and appropriate intervention early in life.

The following four policy/program domains are excellent candidates for re-examination through this new lens of health promotion and disease prevention.

Parenting education and home visiting programs, with their origins in public health nursing, occupy a growing niche within the broad array of existing programs designed to ensure that primary caregivers have the knowledge and skills required to provide the kinds of safe environments and learning experiences that young children need. Research has demonstrated the extent to which higher levels of staff training and expertise predict the effectiveness of these kinds of services in such areas as developmental progress and reduction of child maltreatment.¹¹⁷ Even so, an important subgroup of families who face considerable hardship needs more assistance than parenting education and social support alone can provide. Science suggests that highly skilled personnel with the training and programmatic resources needed to reduce the impacts of these specific stressors on the home environment (whether related to severe poverty, maternal depression, substance abuse, or family violence) will improve the long-term physical and mental health of the children.

Parental leave policies are designed to promote the enhanced bonding and responsive caregiving needed to build a strong foundation for healthy development by providing families with sufficient time to adjust to the birth or adoption of a new child. Although universal family leave arrangements with varying levels of income replacement are part of the policy environment in virtually all economically developed nations in the world, the United States remains a highly conspicuous outlier.¹¹⁸ Continuing debate on this issue in both the public and private sectors could be informed by a greater understanding of its implications for child well-being and long-term human capital development.

Although relevant empirical evidence on the merits and costs of paid leave is limited because of the paucity of studies that have been conducted in the United States, we do know that children of mothers who have the financial support to delay their return to work receive more timely well-child care and are more likely to be breastfed and for longer durations.^{119,120,121} Job-protected, paid leave also has also been shown to be associated with lower rates of infant mortality and low birth weight.^{122,123} Although several states have begun to implement parental leave initiatives, evaluation data are currently limited. Both government and the private sector continue to face the important responsibility of determining how to respond to the reality that all parents need time to adjust to the arrival of a newly born or adopted child.

Income supports and “make work pay” programs are designed to augment the capacity of low-income families to provide basic necessities and positive learning environments for their children, thereby enhancing their developmental outcomes,¹²⁴ and a growing body of program evaluation research has confirmed this expectation.¹²⁵ While the effects of these programs on health have not been studied, research on the biology of adversity suggests that reducing serious, sustained stress in the lives of families with young children should in theory help to reduce the higher rates of stress-related chronic diseases that are consistently documented in low-income populations.

Expanded professional development for early care and education providers offers another strategy for strengthening the relationships that young children have with the important adults in their lives. This is particularly important for children who exhibit emotional difficulties or behavioral problems that present a challenge in out-of-home settings.¹²⁶ Expanded access to expert assistance in identifying and treating emergent mental health problems could provide much-needed support for program staff to strengthen their capacity to help young children who exhibit excessive fear, withdrawal, aggressive behavior, or difficulties with attention, impulsivity, and hyperactivity—all common problems for which considerable new knowledge has been generated but access to evidence-based services remains markedly limited.^{127,128}

POLICIES AND PROGRAMS THAT ASSURE SAFE AND SUPPORTIVE CHEMICAL, PHYSICAL, AND BUILT ENVIRONMENTS

Two major studies by the Institute of Medicine have reviewed evidence on the influences of biology and the environments in which children spend most of their time.^{1,129} Both reports agree on the following clear and consistent conclusions. First, health outcomes are profoundly influenced by a range of factors beyond children's biological endowment and the medical care they receive. Second, since these influences are rooted in the social and physical environments in which families and children live, learn, work, and play, enhancing these environments is necessary to both improve child health generally and to reduce disparities in outcomes related to socioeconomic disadvantage.

Health and safety requirements for early care and education programs represent an important reference point for measuring the extent to which a community takes responsibility for protecting the well-being of its children. This issue is broadly relevant to the nearly 75 percent of children under the age of 5 in the United States who are enrolled in early child care and education programs in a variety of settings (including center-based and family child care as well as informal care provided by family members, friends, and neighbors). Recent reviews of state regulations show that one-half to two-thirds of the states fail to require even minimally acceptable care¹³⁰ and that many care providers operate legally beyond the purview of state licensing laws.¹³¹ Children who attend child care facilities of poor quality receive less of the individualized attention that is necessary for healthy development, and they incur increased risk of exposure to multiple communicable diseases and a variety of potential injury hazards, including unsafe playground surfaces and equipment, missing or broken child safety gates, unattended window-blind cords, and a variety of equipment (such as cribs and bedding) and toys that do not meet current safety codes.¹³² In the absence of national standards for monitoring the quality of the child care environment, each state currently formulates its own regulations and criteria. Although some guidance is available from professional organizations, such as the American Academy of Pediatrics' National Health and

Safety Performance Standards,¹³³ widespread deficiencies in this highly fragmented diversity of settings are well known to child care directors and program staff.

Physical features of a community (e.g., sidewalks, bicycle trails, and parks that are safe from crime¹³⁴ and neighborhood resources (e.g., grocery stores that sell fresh fruits and vegetables)) are selected examples of what is meant by the "built" environment. These features are heavily influenced by community zoning laws and land use policies, which provide a promising vehicle to facilitate the development of health-enhancing characteristics and to limit the proliferation

Health outcomes are profoundly influenced by a range of factors beyond children's biological endowment and the medical care they receive.

of those that are health-endangering. Examples of the former include parks that provide a place for physical activity and for parents to engage in positive interactions with their children as well as opportunities for caregivers to meet and interact with other adults to enhance their network of social support and thereby facilitate positive mental health.¹⁰³ Examples of the latter include pollution-generating factories, an abundance of fast-food restaurants and liquor stores, and congested, unsafe walkways. Zoning laws and land use policies that protect green space and limit the density of fast-food outlets also encourage neighborhood awareness of the health-related benefits of these decisions, and thus embed health-enhancing behaviors in the fabric of the community. Together, these kinds of policies strengthen the capacities of caregivers and communities to support the foundations of child health and improve well-being across the lifespan.

Laws and safety regulations for commercial products provide another illustration of how state policies and standards can not only protect the healthy development of children directly but can also build caregiver and community capacities to assure a safer physical environment. For example, motor vehicle injuries are the leading cause of death among children in the United

States, and both serious injuries and fatalities can be reduced by more than half through the use of age-appropriate and size-appropriate child safety and booster seats.^{135,136} Standards for child restraints serve to strengthen individual caregiver capacity by increasing awareness about the importance of safety measures. At the state level, the establishment and enforcement of standards can increase community capacity by creating a marketplace for child seats and boosters, implementing hospital discharge policies requiring approved safety seats, and supporting child restraint checks by law enforcement officials. The enforcement of regulations mandating maximum temperatures on residential hot water tanks is another example of a characteristic of the built environment that reduces threats to child health, as scald burns represent one of the more common household injuries.

Policies that regulate the chemical environments in which children grow and develop include lead paint laws, emissions restrictions that require filtering of mercury, guidelines on the use of bisphenol A (BPA) in plastic baby bottles, and restrictions on the use of toxic insecticides near playgrounds, schools, and child care centers. As described in greater detail in a previous working paper,¹³⁷ the decreased prevalence of lead poisoning is an example of an effective public policy that has reduced exposure to one of the most widely recognized neurotoxins.^{138,139} Another example is the use of organophosphate pesticides, on which the U.S. Environmental Protection Agency imposed new restrictions in 1999-2000, largely because of concerns about the potential exposure of young children. Subsequently, the percentage of food samples with detectable residues of these pesticides declined from 29 percent in 1996 to 19 percent in 2001.¹³⁹ Although progress has been made in reducing environmental levels of some toxins, policies that could restrict the exposure of embryos, fetuses, and infants to other chemicals whose neurotoxicity is well documented, such as mercury and other industrial organic compounds, have fared less well.^{139,140,141,142,143} Beyond the compelling moral responsibility to reduce known threats to the health of young children, there are also persuasive economic arguments for greater attention to the value of prevention, both as a strategy for reducing

the continuously escalating treatment costs of disease and disability and as an investment in human and economic development.^{141,144,145} Specifically, one study, using a widely accepted measure of basic cognitive skills, calculated that, for every decrease equivalent to a 15-point drop on an IQ test, an individual's earnings were 20 percent lower a decade later.¹⁴⁶

Among the most significant environmental toxins that affect lifelong health, the exposure of pregnant women, fetuses, and young children to tobacco smoke, is particularly important.¹⁴⁷ Maternal smoking during pregnancy continues to expose about half a million newborns to this toxic substance.¹⁴⁸ Although exposure of nonsmokers to environmental smoke decreased substantially beginning in the 1990s, due in large part to policies affecting workplaces and commercial and public spaces, the median exposure level of children age 4 to 11 years has remained twice as high as that of adults.¹⁴⁹ Numerous reports conclude that between one-quarter and one-half of all preschool age children are exposed to smoke.⁷ The health consequences of these exposures include increased risk of low birth weight, increased hospitalization, and serious respiratory disease,¹⁵⁰ and the direct medical costs of all pediatric diseases attributable to parental smoking is estimated to be \$7.9 billion (in 2006 dollars).^{7,151}

POLICIES AND PROGRAMS THAT PROMOTE SOUND AND APPROPRIATE NUTRITION

Community actions that affect child nutrition range from zoning laws that favor stores selling nutritious foods over fast-food restaurants, to guidelines for healthful snacks and lunches that are served in early care and education programs. Until recently, the health-related nutritional problems facing children living in low-income families were largely manifested in iron deficiency anemia and poor growth. Currently, the major problem facing U.S. children across all social classes (with low-income populations still affected disproportionately) is the phenomenon of increasing obesity and its associated health complications, most prominently in the form of increasing rates of type 2 diabetes. Given what science now shows about how early experiences can biologically embed vulnerability to diseases later in life, much greater attention to maternal and prenatal health is clearly needed

in order to address the early childhood roots of obesity. Other public and private sector policies that affect nutrition and health include the following examples.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a good example of a long-standing federal-level program (implemented at the state and local levels) that is designed to build the capacities of families to provide appropriate nutrition for their children by providing financial support (i.e., cash for food purchases) and strengthening knowledge and skills (i.e., health education and nutrition counseling, including the promotion of breastfeeding). Since 1972, WIC has grown to serve about 45 percent of all pregnant women in the United States and over 25 million children annually.¹⁵² Concerns about the quality and appropriateness of the WIC food package have been addressed in recent years by including fresh fruits and vegetables, legumes and alternative proteins, and culturally appropriate foods. Conflicting claims have been made about the health benefits of the program, with good evidence that it prevents iron deficiency anemia in low-income infants but conflicting data on its effectiveness in reducing low birth weight.^{153,154,155,156} Despite these differences, a Congressional report found that, for every dollar spent on WIC, the government saved \$3.50 on reduced payments for Medicaid, Supplemental Security Income, special education, and unneeded medical costs in the first year of life.¹⁵⁷

Private sector policies that support breastfeeding by working mothers represent a promising, non-governmental example of promoting community and caregiver capacities that enhance infant nutrition and strengthen mother-infant relationships. Approximately 60 percent of the mothers of children under the age of 6 are employed full- or part-time.¹⁵⁸ Research shows that full-time work has a significant negative effect on breastfeeding initiation and duration,^{159,160,161} as many women wean their babies early in anticipation of returning to work or dealing with the difficulties of balancing work and breastfeeding.¹⁶² Preliminary evidence suggests that corporate lactation programs—including the provision of worksite lactation rooms and lactation counselors—bolster caregiver and

community capacities and enable women to maintain breastfeeding for at least 6 months, with rates equivalent to those of mothers not employed outside the home.^{163,164} The potential health benefits of breastfeeding include fewer

Reducing the number and severity of early adverse experiences and strengthening relationships that mitigate the effects of toxic stress on young children will decrease the prevalence of a wide range of stress-related physical and mental health problems.

and less severe illnesses in general among young children¹⁶⁵ and indications of potential protection against obesity in childhood and later in life.^{166,167}

BUILDING A BROADER, MULTI-SECTOR PERSPECTIVE ON THE EARLY CHILDHOOD ROOTS OF LIFELONG HEALTH

Although public interest in health promotion and disease prevention programs for adults is high, public understanding of the relation between early childhood experiences and adult illnesses remains low. Even expert understanding of the broad array of factors and conditions that either support or compromise child health is constrained by the “silos” of existing domains of policy and practice that make it difficult to test creative, new ideas that cross sectors.

A rich and growing body of epidemiological evidence and research in neuroscience, molecular biology, and genomics indicates that reducing the number and severity of early stressful and traumatic experiences, such as child maltreatment, family violence, parental mental illness and substance abuse, and the adversity associated with significant economic hardship, will decrease the prevalence of a wide range of stress-related physical and mental health problems. Guided by this scientific knowledge, multiple policies and programs outside the jurisdiction of the medical sector offer promising opportunities to improve health outcomes by mitigating the impact of adversity on young children. The examples presented in each of the

following policy sectors illustrate some of many potential options.

Public Health. The time has come in the continuing debate over spiraling health care expenditures to look beyond strategies for limiting the costs of hospitalization and medication and to invest in policies that keep people healthy. The impacts of current health promotion and disease prevention efforts that begin in the adult years are limited by three important constraints.³ First, they are burdened by the increasing difficulty of changing behavior and lifestyles as people get older. Second, they face the difficult challenge of overcoming the biological vulnerabilities that remain from early

Early care and education programs that incorporate efforts to reduce toxic stress offer the possibility of considerable returns, not only in stronger academic gains but also in better health well into the adult years.

adverse experiences, which could have been prevented by intervening earlier to change the environments in which children live. Third, by addressing adult behaviors only, without also addressing the conditions faced by families of young children, they shift the focus toward individuals whose health risks have been shaped already and away from the circumstances that shaped them. Thus, science suggests that a more effective approach to health promotion would invest more resources in the reduction of significant adversity during the prenatal and early childhood periods, in contrast to the current disproportionate emphasis on campaigns to encourage more exercise and better eating habits in middle-aged adults.

Early Care and Education. Programs designed to promote readiness to succeed academically in school (such as Early Head Start, Head Start, and pre-kindergarten) serve large numbers of young children and their families and offer a rich infrastructure for testing innovative approaches to address the stress-related roots of disparities in learning, behavior, and health. As child development experts work

on new teaching strategies to enhance learning outcomes for vulnerable young children, neuroscience and genomics suggest that further decreases in disparities in educational achievement will require *both* the provision of rich learning experiences *and* the reduction of significant adversity that disrupts the developing architecture of the brain. Research on the biology of stress further demonstrates that such adversity also threatens the function of other organ systems, leading to higher rates of hypertension, obesity, and diabetes. Thus, early care and education programs that incorporate efforts to reduce toxic stress in the service of promoting healthy brain circuitry—for example, by addressing sources of serious family stress, including economic instability, maternal depression, or family violence—offer the possibility of considerable returns, not only in stronger academic gains but also in better health well into the adult years. In this context, the current approach to funding child care of variable quality through the Temporary Assistance for Needy Families (TANF) program illustrates a striking example of an important gap between what we know from research and what we do in policy and practice. Despite persistent resistance to the enforcement of quality standards, science indicates that TANF funds for child care should be viewed as an opportunity to invest in high-quality programs that promote the healthy development of vulnerable, young children and not simply as an obligatory expense to facilitate mandated maternal employment.

Child Welfare. For more than a century, child protective services have focused on issues related to physical safety, reduction of repeated injury, and child custody. Now, recent scientific advances are increasing our understanding of the extent to which the toxic stress of abuse, neglect, or exposure to family or community violence can produce physiological changes in young children that increase the likelihood of mental health problems and physical disease throughout their lives. Based on this heightened risk of stress-related illness, science suggests that all investigations of suspected child abuse or neglect should include a comprehensive assessment of the child’s cognitive, language, emotional, social, and physical development, followed by the provision of effective therapeutic services as needed. This could be accomplished

through regularized referrals from the child welfare system (which is a mandated service in each state) to the early intervention system for children with developmental delays or disabilities (which provides services under an entitlement established by federal law). Although the most recent federal reauthorizations of the Keeping Children and Families Safe Act and the Individuals with Disabilities Education Act both included requirements for establishing such linkages, sufficient funding has not been provided, and the implementation of these requirements has moved slowly. The availability of new, evidence-based interventions that have been shown to improve outcomes for children in the child welfare system¹⁶⁸ underscores the compelling need to transform “child protection” from its traditional concern with physical safety and custody to a broader, more science-based focus on health promotion and disease prevention. The Centers for Disease Control and Prevention has taken an important step in advancing this issue by promoting the prevention of child maltreatment as a public health concern.^{169,170}

Mental Health. In view of the many advances that have been made in the development of evidence-based treatments for a range of child mental health problems, the limited availability of appropriate therapeutic services for young children and families dealing with toxic stress requires urgent attention. Reports of youngsters with disruptive behaviors being expelled from preschool programs^{171,172} and the dramatic rise in off-label prescription of antipsychotic medications for very young children¹⁷³ underscore the extent to which this situation has reached crisis proportions. Timely access to specialists in the identification, assessment, and clinical treatment of young children with serious mental health problems within existing early childhood programs could enhance their capacity to address unmet needs without creating a separate mental health system for young children. Because of the close association between children’s emotional well-being and the mental health of their caregivers, mental health services for parents would have a broader impact if they routinely included attention to the needs of their children as well.¹²⁶ Finally, more effective treatment of stress-related problems in early childhood is likely to

reduce the prevalence of a wide range of stress-related health disorders later in adulthood.

Primary Health Care. The association between an expectant mother’s preconception health and the subsequent well-being of her baby is well documented, but there are few policies or programs that connect these periods explicitly in the delivery of primary health services. The absence of attention to the mother-child relationship in the treatment of depression in women is another striking example of the gap between science and practice, given extensive evidence of the negative impact of diminished maternal responsiveness on the development of young children.⁶² Payment mechanisms that provide incentives for coordinating child and parent medical services (e.g., automatic coverage for parent-child intervention linked to reimbursement for the treatment of maternal depression) offer one promising strategy for addressing this problem.

The most striking challenge related to the role of primary health services in promoting child well-being is reflected in a longstanding debate within the pediatric health care community about the possibilities and limitations of well-child care within a comprehensive health system.^{174,175} For at least half a century, this debate has focused on the need for family-centered approaches to address the concerns of children with developmental impairments, behavioral difficulties, and chronic health problems, along with the complex challenge of providing more effective interventions for children living in highly adverse environments.¹⁷⁶ Despite longstanding calls for an explicit community-focused, primary care strategy, a recent national study of pediatric practices identified the persistent inability to achieve better linkages with community-based resources as a major challenge.¹⁷⁷ A parallel survey of parents also noted the limited communication that exists between pediatric practices and community-based services such as WIC programs, child care providers, and schools.¹⁷⁸ Moreover, both groups agreed that pediatricians cannot be expected to meet all of a child’s needs.

Notwithstanding this broad accord, history tells us that continuing calls for reduced fragmentation among community-based services will have little impact. The time has come for bold and innovative leadership to develop new

strategies for coordination that are:

- grounded in a shared science base;
- able to leverage the benefits of new information technologies for sharing information more effectively while protecting confidentiality; and
- genuinely committed to trying new models of working collaboratively across disciplines and sectors.

Recommendations for providing a “medical home”¹⁷⁹ for all children within the provisions of the Patient Protection and Affordable Care Act of 2010 offer a promising starting point.

However, successful transformation to a more effective model of primary health care will require deeply committed attention to a wide range of factors, including strong leadership, financial resources, personal and organizational relationships, engagement with families, management expertise, health information technology, support for care coordination, and staff development¹⁸⁰ as well as the extent to which practitioners in the medical, educational, and social services worlds are truly ready to work together (and to train the next generation of practitioners) in new ways.

A Call for Innovation

THE STABILITY, PROSPERITY, AND SUSTAINABILITY of a society depend on the healthy development of its population. Knowing this, a recent analysis of data from the United States and six other countries (Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom) raises serious concerns that require thoughtful attention. In addition to noting that the U.S. health care system ranks last or next-to-last on four dimensions associated with high performance (quality, access, efficiency, and equity), the report also indicated that the United States ranks last on mortality amenable to health care, last on infant mortality, and second-to-last on healthy life expectancy at age 60.¹⁸¹ The fact that the U.S. spends more money per capita on medical care than any other industrialized nation¹⁸² makes these findings particularly problematic. Extensive evidence that effective health promotion and disease prevention depend on more than simply assuring the availability and affordability of high-quality medical care further underscores the need for creative, new strategies to improve our nation’s health.

As we look to the scientific community for new ways to address this challenge, advances in neuroscience, molecular biology, and genomics are converging on three compelling conclusions: (1) early experiences are built into our bodies; (2) significant adversity early in life can produce physiological disruptions or embedded biological “memories” that undermine the development of the body’s stress response systems and affect the developing

brain, cardiovascular system, immune system, and metabolic regulatory functions; and (3) these physiological disruptions can persist far into adulthood and lead to lifelong impairments in both physical and mental health.

These broadly accepted scientific principles send two clear and powerful messages to decision-makers who are searching for more effective ways to improve the health of the nation. First, health promotion and disease prevention policies focused on adults would be more effective if evidence-based investments were also made to strengthen the foundations of health in the prenatal and early childhood periods. Second, the increasing prevalence of chronic disease across the life course could be lowered by reducing the number and severity of adverse experiences threatening the well-being of young children and by strengthening the protective relationships that help mitigate the harmful effects of toxic stress.

Although much important research still remains to be done, sufficient knowledge to address these challenges more effectively is already available. Disjointed medical care in the crucial periods of preconception, pregnancy, and early childhood demands better coordination, as do a broad range of policies that affect families with young children who are facing significant adversities that threaten their physical and mental well-being. These policies include early care and education, child welfare, early intervention, workforce development, housing, urban planning, economic development, and environmental protection, among many others.

Simply calling for a more comprehensive approach to the challenges facing disadvantaged young children and their parents, however, offers nothing new. Equally important, enhanced coordination across systems that are guided by disparate values and disconnected bodies of knowledge is unlikely to produce sufficiently greater impact. What is needed instead is creative new thinking about how to apply a unified science base about the early childhood origins of health, learning, and behavior across multiple sectors.¹⁸³

The framework presented in this document is offered in the spirit of attempting to catalyze such innovative policymaking and creative interventions. Promising ideas include the following:

- Child welfare agencies can help prevent long-term adult impairment, not just provide immediate child protection.
- Zoning laws and land development policies can facilitate healthy lifestyles, not just generate commercial profit.
- Alternative child care arrangements for young children whose mothers are mandated to work as a condition of receiving public assistance provide an opportunity to build foundations for healthy development, not just support maternal employment.
- High-quality early care and education programs can promote health and prevent disease, not just prepare children to succeed in school.

Dramatic advances in the biological sciences are transforming the diagnosis and treatment of illness—and the products of these efforts will undoubtedly improve the effectiveness of medical care as well as increase its cost. It is equally important to note that these same advances could also be mobilized to transform the way

Every system that touches the lives of children offers an opportunity to strengthen the foundations and capacities that make lifelong healthy development possible.

we address the promotion of health, prevention of disease, and reduction of disparities related to social and economic disadvantage. Every system that touches the lives of children—as well as mothers before and during pregnancy—offers an opportunity to strengthen the foundations and capacities that make lifelong healthy development possible. Investments in the early reduction of significant adversity are particularly likely to generate strong returns.

References

- National Research Council and Institute of Medicine. (2004). *Children's health: The nation's wealth*. Washington, DC: The National Academies Press.
- Marmot, M. (2010). *Fair society, healthy lives: Strategic review of health inequalities in England post-2010*. <http://www.marmotreview.org/>
- Shonkoff, J. P., Boyce, W. T., & McEwen, B. S. (2009). Neuroscience, molecular biology, and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. *JAMA*, *301*, 2252-2259.
- Robert Wood Johnson Foundation Commission to Build a Healthier America. (2009). *Beyond health care: New directions to a healthier America*. <http://www.commissiononhealth.org>
- Brooks-Gunn, J., Brown, B., Duncan, G., & Moore, K.A. (1995). Child development in the context of family and community resources: An agenda for national data collections. In National Research Council and Institute of Medicine, *Integrating federal statistics on children: Report of a workshop* (pp. 27-97). Washington, DC: The National Academies Press.
- Coe, C. L., & Lubach, G.R. (2003). Critical periods of special health relevance for psychoneuroimmunology. *Brain, Behavior and Immunity*, *17*, 3-12.
- Guyer, B., Ma, S., Grason, H., Frick, K., Perry, D., Sharkey, A., & McIntosh, J. (2009). Early childhood health promotion and its life-course health consequences. *Academic Pediatrics*, *9*, 142-149.
- Colley, J. R., Douglas, J. W., & Reid, D. D. (1973). Respiratory disease in young adults: Influence of early childhood lower respiratory tract illness, social class, air pollution, and smoking. *British Medical Journal*, *3*(5873), 195-198.
- Barker, D. J. (2004). The developmental origins of adult disease. *Journal of the American College of Nutrition*, *23*, 588S-595S.
- Roseboom, T.J., van der Meulen, J. H., Osmond, C., Barker, D. J., Ravelli, A. C., Schroeder-Tanka, J. M., et al. (2000). Coronary heart disease after prenatal exposure to the Dutch famine, 1944-45. *Heart*, *84*, 595-598.
- Kuh, D., & Ben-Shlomo, Y. (2004). *A life course approach to chronic disease epidemiology*. Oxford: Oxford University Press.
- Hertzman, C. (2000). The biological embedding of early experience and its effects on health in adulthood. *Annals of the New York Academy of Sciences*, *896*, 85-95.
- Felitti, V. J., Anda, R. F., Nordenberg, D., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine*, *14*(4), 245-258.
- Edwards, V. J., Holden, G. W., Felitti, V. J., & Anda, R. F. (2003). Relationship between multiple forms of child maltreatment and adult mental health in community respondents: Results from the Adverse Childhood Experiences study. *American Journal of Psychiatry*, *160*(8), 1453-1460.
- Anda, R. F., Felitti, V. J., Bremner, J. D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(3), 174-186.
- Hillis, S. D., Anda, R. F., Dube, S. R., Felitti, V. J., Marchbanks, P. A., & Marks, J. S. (2004). The association between adverse childhood experiences and adolescent pregnancy, long-term psychosocial consequences, and fetal death. *Pediatrics*, *113*(2), 320-327.
- Dong, M., Giles, W. H., Felitti, V. J., et al. (2004). Insights into causal pathways for ischemic heart disease: Adverse Childhood Experiences study. *Circulation*, *110*(13), 1761-1766.
- Caspi, A., Harrington, H., Moffitt, T. E., Milne, B. J., & Poulton, R. (2006). Socially isolated children 20 years later: Risk of cardiovascular disease. *Arch Pediatr Adolesc Med*, *160*(8), 805-811.
- Horwitz, A. V., Widom, C. S., McLaughlin, J., & White, H. R. (2001). The impact of childhood abuse and neglect on adult mental health: A prospective study. *J Health Soc Behav*, *42*(2), 184-201.
- Schilling, E. A., Aseltine, R. H., & Gore, S. (2007). Adverse childhood experiences and mental health in young adults: A longitudinal survey. *BMC Public Health*, *7*, 30.
- McEwen, B. S. (1998). Protective and damaging effects of stress mediators. *New Engl J Med*, *338*(3), 171-179.
- McEwen, B. S. (2000). The neurobiology of stress: from serendipity to clinical relevance. *Brain Res*, *886*(1-2), 172-189.
- National Scientific Council on the Developing Child (2005). Excessive stress disrupts the architecture of the developing brain: Working paper no. 3. <http://www.developingchild.net>.
- Zhang, X. Y., Sanchez, H., Kehoe, P., & Kosten, T. A. (2005). Neonatal isolation enhances maintenance but not reinstatement of cocaine self-administration in adult male rats. *Psychopharmacology*, *177*(4), 391-399.
- Geronimus, A. T., Hicken, M., Keene, D., & Bound, J. (2006). "Weathering" and age patterns of allostatic load scores among blacks and whites in the United States. *Am J Public Health*, *96*(5), 826-833.
- Harper, S., Lynch, J., Burris, S., & Davey Smith, G. (2007). Trends in the black-white life expectancy gap in the United States, 1983-2003. *JAMA*, *297*(11), 1224-32.
- Geronimus, A. T. (1992). The weathering hypothesis and the health of African-American women and infants: Evidence and speculations. *Ethn Dis*, *2*(3), 207-21.
- Geronimus, A. T. (1996). Black/white differences in the relationship of maternal age to birthweight: A population-based test of the weathering hypothesis. *Soc Sci Med*, *42*(4), 589-97.
- Johnson, M.H. (2005). Sensitive periods in functional brain development: Problems and prospects. *Dev Psychobiology*, *46*(3), 287-92.
- National Scientific Council on the Developing Child (2010). Early experiences can alter gene expression and affect long-term development: Working paper no. 10. <http://www.developingchild.net>.
- Barker, D. J., et al. (2005). Trajectories of growth among children who have coronary events as adults. *New Engl J Med*, *353*(17), 1802-1809.
- Nomura, Y., Wickramaratne, P. J., Pilowsky, D. J., et al. (2007). Low birth weight and risk of affective disorders and selected medical illness in offspring at high and low risk for depression. *Comprehensive Psychiatry*, *48*, 470-478.

33. Gluckman, P., & Hanson, M. (2006). The conceptual basis for the developmental origins of health and disease. In P. Gluckman & M. Hanson (Eds.), *Developmental origins of health and disease* (pp. 33-50). Cambridge, UK: Cambridge University Press.
34. Cutfield, W. S., Jefferies, C. A., & Hofman, P. L. (2006). Perinatal influences on the endocrine and metabolic axes during childhood. In P. Gluckman & M. Hanson (Eds.), *Developmental origins of health and disease* (pp. 206-222). Cambridge, UK: Cambridge University Press.
35. Schreuder, M. F., Fodor, M., van Wijk, J. A., & Delemarre-van de Waal, H. A. (2006). Association of birth weight with cardiovascular parameters in adult rats during baseline and stressed conditions. *Pediatr Res*, 59(1), 126-30.
36. Massin, M. M., Withofs, N., Maeyns, K., & Ravet, F. (2001). The influence of fetal and postnatal growth on heart rate variability in young infants. *Cardiology*, 95(2), 80-83.
37. Shankaran, S., Das, A., Bauer, C. R., et al. (2006). Fetal origin of childhood disease: Intrauterine growth restriction in term infants and risk for hypertension at 6 years of age. *Arch Pediatr Adolesc Med*, 160, 977-981.
38. Danese, A., Pariante, C. M., Caspi, A., Taylor, A., & Poulton, R. (2007). Childhood maltreatment predicts adult inflammation in a life-course study. *Proc Natl Acad Sci USA*, 104(4), 1319-1324.
39. Chen, E., Hanson, M. D., Paterson, L. Q., Griffin, M. J., Walker, H. A., & Miller, G. E. (2006). Socioeconomic status and inflammatory processes in childhood asthma: The role of psychological stress. *J Allergy Clin Immunol*, 117, 1014-1020.
40. Danese, A., Caspi, A., Williams, B., et al. (2010). Biological embedding of stress through inflammation processes in childhood [Letter to the editor]. *Molecular Psychiatry*. Advance online publication. doi:10.1038/mp.2010.5
41. Evans, G. W. (2004). The environment of childhood poverty. *Am Psychol*, 59(2), 77-92.
42. Evans, G. W., Saltzman, H., & Cooperman, J. (2001). Housing quality and children's socioemotional health. *Environment and Behavior*, 33, 389-399.
43. Hart, T., & Risley, T. R. (1995). *Meaningful differences in the everyday experience of young American children*. Baltimore, MD: Brookes Publishing.
44. Dodge, K. A., Pettit, G. S., & Bates, J. E. (1994). Socialization mediators of the relation between socioeconomic status and child conduct problems. *Child Development*, 65, 649-665.
45. McLoyd, V. C. (1998). Socioeconomic disadvantage and child development. *Am Psychol*, 53(2), 185-204.
46. McEwen, B. S. (2007). Physiology and neurobiology of stress and adaptation: Central role of the brain. *Physiol Rev*, 87(3), 873-904.
47. Lupien, S. J., King, S., Meaney, M. J., & McEwen, B. S. (2000). Child's stress hormone levels correlate with mother's socioeconomic status and depressive state. *Biol Psychiatry*, 48(10), 976-980.
48. Lupien, S. J., King, S., Meaney, M. J., & McEwen, B. S. (2001). Can poverty get under your skin? Basal cortisol levels and cognitive function in children from low and high socioeconomic status. *Development & Psychopathology*, 13, 653-676.
49. Farah, M. J., Shera, D. M., Savage, J. H., et al. (2006). Childhood poverty: specific associations with neurocognitive development. *Brain Res*, 1110(1), 166-174.
50. Isgor, C., Kabbaj, M., Akil, H., & Watson, S. J. (2004). Delayed effects of chronic variable stress during peripubertal-juvenile period on hippocampal morphology and on cognitive and stress axis functions in rats. *Hippocampus*, 14(5), 636-648.
51. Kaufman, D., Banerji, M. A., Shorman, I., et al. (2007). Early-life stress and the development of obesity and insulin resistance in juvenile bonnet macaques. *Diabetes*, 56(5), 1382-1386.
52. Morris, A. S., Silk, J. S., Steinberg, L., Myers, S. S., & Robinson, L. R. (2007). The role of family context in the development of emotional regulation. *Social Development*, 16(2), 361-388.
53. Scaramella, L.V., & Leve, L. D. (2004). Clarifying parent-child reciprocities during early childhood: The early childhood coercion model. *Clin Child Fam Psychol Rev*, 7, 89-107.
54. Schweinhart, L. J., Montie, J., Xiang, Z., Barnett, W. S., Belfield, C. R., & Nores, M. (2005). Lifetime effects: The High/Scope Perry Preschool study through age 40. Ypsilanti, MI: High/Scope Press.
55. Heckman, J. J. (2007). The economics, technology, and neuroscience of human capability formation. *PNAS*, 104, 13250-13255.
56. Cassidy, J. (1988). Child-mother attachment and the self in six-year-olds. *Child Dev*, 59, 121-134.
57. Bohlin, G., Hagekull, B., & Rydell, A. (2000). Attachment and social functioning: A longitudinal study from infancy to middle childhood. *Social Development*, 9, 24-39.
58. Crowell, J., Treboux, D., & Waters, E. (1999). The adult attachment interview and the relationship questionnaire: Relations to reports of mothers and partners. *Personal Relationships*, 6, 1-18.
59. Thompson, R. (2000). Early attachment and later development. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment*. New York: Guilford Press.
60. Ashman, S. B., Dawson, G., & Panagiotides, H. (2008). Trajectories of maternal depression over 7 years: Relations with child psychophysiology and behavior and role of contextual risks. *Dev Psychopathology*, 20, 55-77.
61. Maughan, A., Cicchetti, D., Toth, S. L., & Rogosch, F. A. (2007). Early-occurring maternal depression and maternal negativity in predicting young children's emotion regulation and socioemotional difficulties. *J Abnorm Child Psychol*, 35, 685-703.
62. Center on the Developing Child at Harvard University (2009). Maternal depression can undermine the development of young children: Working paper no. 8. <http://www.developingchild.harvard.edu>
63. Burnham, M. M., Goodlin-Jones, B. L., Gaylor, E. E., Anders, T. F. (2002). Nighttime sleep-wake patterns and self-soothing from birth to one year of age: A longitudinal intervention study. *J Child Psychol Psychiatry*, 43, 713-725.
64. Heraghty, J. L., Hilliard, T. N., Henderson, A. J., & Fleming, P. J. (2008). The physiology of sleep in infants. *Arch Dis Child*, 93, 982-985.

65. Cubero, J., Valero, V., Sanchez, J., et al. (2005). The circadian rhythm of tryptophan in breast milk affects the rhythms of 6-sulfatoxymelatonin and sleep in newborn. *Neuro Endocrinol Lett*, 26, 657-661.
66. Spruyt, K., Aitken, R. J., So, K., Charlton, M., Adamson, T. M., & Horne, R. S. (2008). Relationship between sleep/wake patterns, temperament and overall development in term infants over the first year of life. *Early Hum Dev*, 84, 289-296.
67. Rosen, L. A. (2008). Infant sleep and feeding. *J Obstet Gynecol Neonatal Nurs*, 37, 706-714.
68. Touchette, E., Petit, D., Seguin, J. R., Boivin, M., Tremblay, R. E., & Montplaisir, J. Y. (2007). Associations between sleep duration patterns and behavioral/cognitive functioning at school entry. *Sleep*, 30, 1213-1219.
69. Koulouglioti, C., Cole, R., & Kitzman, H. (2008). Inadequate sleep and unintentional injuries in young children. *Public Health Nurs*, 25, 106-114.
70. Al Mamun, A., Lawlor, D. A., Cramb, S., O'Callaghan, M., Williams, G., & Najman, J. (2007). Do childhood sleeping problems predict obesity in young adulthood? Evidence from a prospective birth cohort study. *Am J Epidemiol*, 166, 1368-1373.
71. Reilly, J. J., Armstrong, J., Dorosty, A. R., et al. (2005). Early life risk factors for obesity in childhood: Cohort study. *BMJ*, 330, 1357.
72. Taveras, E. M., Rifas-Shiman, S. L., Oken, E., Gunderson, E. P., & Gillman, M. W. (2008). Short sleep duration in infancy and risk of childhood overweight. *Arch Pediatr Adolesc Med*, 162, 305-311.
73. Anders, T. F., Halpern, L. F., & Hua, J. (1992) Sleeping through the night: A developmental perspective. *Pediatrics*, 90, 554-560.
74. Coe, C. L., Lubach, G. R., Schneider, M. L., Dierschke, D. J., & Ershler, W. B. (1992). Early rearing conditions alter immune responses in the developing infant primate. *Pediatrics*, 90, 505-509.
75. Hanson, L., Silfverdal, S. A., Stromback, L., et al. (2001). The immunological role of breast feeding. *Pediatr Allergy Immunol*, 12(14), 15-19.
76. McGowan, P. O., Sasaki, A., D'Alessio, A. C., et al. (2009). Epigenetic regulation of the glucocorticoid receptor in human brain associates with childhood abuse. *Nature Neuroscience*, 12, 342-348.
77. Gunnar, M. R., & Donzella, B. (2002). Social regulation of the cortisol levels in early human development. *Psychoneuroendocrinology*, 27, 199-220.
78. Tarullo, A. R., & Gunnar, M. R. (2006). Child maltreatment and the developing HPA axis. *Horm Behav*, 50, 632-639.
79. Francis, D. D., Champagne, F. A., Liu, D., & Meaney, M. J. (1999). Maternal care, gene expression, and the development of individual differences in stress reactivity. *Ann NY Acad Sci*, 896, 66-84.
80. Liu, D., Diorio, J., Tannenbaum, B., et al. (1997). Maternal care, hippocampal glucocorticoid receptors, and hypothalamic-pituitary-adrenal responses to stress. *Science*, 277, 1659-1662.
81. Caldji, C., Tannenbaum, B., Sharma, S., Francis, D., Plotsky, P. M., & Meaney, M. J. (1998). Maternal care during infancy regulates the development of neural systems mediating the expression of fearfulness in the rat. *PNAS*, 95, 5335-5340.
82. National Scientific Council on the Developing Child (2010). Persistent fear and anxiety can affect young children's learning and development: Working paper no. 9. <http://www.developingchild.net>
83. Shirtcliff, E. A., Coe, C. L., & Pollak S. D. (2009). Early childhood stress is associated with elevated antibody levels to herpes simplex virus type 1. *PNAS*, 106, 2963-2967.
84. Coe, C. L., & Lubach, G. R. (2007). Mother-infant interactions and the development of immunity from conception through weaning. In R. Ader (Ed.), *Psychoneuroimmunology* (pp. 455-474). Burlington, MA: Elsevier Academic Press.
85. Else-Quest, N. M., Hyde, J. S., & Clark, R. (2003). Breastfeeding, bonding and the mother-infant relationship. *Merrill-Palmer Quarterly*, 49, 495-517.
86. Birch, L. L., & Fisher, J. O. (1998). Development of eating behaviors among children and adolescents. *Pediatrics*, 101, 539-549.
87. Gaillard, D., Passilly-Degrace, P., & Besnard, P. (2008). Molecular mechanisms of fat preference and overeating. *Ann NY Acad Sci*, 1141, 163-175.
88. Huang, T. T., & Goran, M. I. (2003). Prevention of type 2 diabetes in young people: A theoretical perspective. *Pediatr Diabetes*, 4, 38-56.
89. Hertz-Picciotto, I., Park, H. Y., Dostal, M., Kocan, A., Trnovec, T., & Sram, R. (2008). Prenatal exposures to persistent and non-persistent organic compounds and effects on immune system development. *Basic Clin Pharmacol Toxicol*, 102, 146-154.
90. Grandjean, P., Bellinger, D., Bergman, A., et al. (2008). The Faroes statement: Human health effects of developmental exposure to chemicals in our environment. *Basic Chemical Pharmacology and Toxicology*, 102(2), 73-75.
91. Hatch, E. E., Palmer, J. R., Titus-Ernstoff, L., et al. (1998). Cancer risk in women exposed to diethylstilbestrol in utero. *JAMA*, 280, 630-634.
92. Cleveland, L. M., Minter, M. L., Cobb, K. A., Scott, A. A., & German, V. F. (2008). Lead hazards for pregnant women and children: Part 1: Immigrants and the poor shoulder most of the burden of lead exposure in this country. Part 1 of a two-part article details how exposure happens, whom it affects, and the harm it can do. *American Journal of Nursing*, 108(10), 40-49, quiz 50.
93. Dozier, M., & Peloso, E. (2006). The role of early stressors in child health and mental health outcomes. *Arch Pediatr Adolesc Med*, 160(12), 1300-1301.
94. Weidenhamer, J. D. (2009). Lead contamination of inexpensive seasonal and holiday products. *Sci Total Environ*, 407, 2447-2450.
95. Cummins, S. K., & Jackson, R. J. (2001). The built environment and children's health. *Pediatric Clinics of North America*, 48, 1241-52.
96. Morland, K., Wing, S., & Diez Roux, A. (2002). The contextual effect of the local food environment on residents' diets: The atherosclerosis risk in communities study. *Am J Public Health*, 92, 1761-1767
97. Cohen, D. A., McKenzie, T. L., Sehgal, A., Williamson, S., Golinelli, D., & Lurie, N. (2007). Contribution of public parks to physical activity. *Am J Public Health*, 97, 509-514.
98. Davison, K. K., & Lawson, C. T. (2006). Do attributes in the physical environment influence children's physical activity? A review of the literature. *Int J Behav Nutr Phys Act*, 3, 19.
99. Kerr, J. (2007). *Designing for active living among children*. San Diego, CA: Active Living Research, Robert Wood Johnson Foundation. <http://www.rwjf.org/files/research/builtdesign.pdf>.

100. Cohen, D. A., Inagami, S., & Finch, B. (2008). The built environment and collective efficacy. *Health Place, 14*, 198-208.
101. Evans, G. W. (2006). Child development and the physical environment. *Annu Rev Psychol., 57*, 423-451.
102. Cohen, D. A., Finch, B. K., Bower, A., & Sastry, N. (2006). Collective efficacy and obesity: The potential influence of social factors on health. *Soc Sci Med., 62*, 769-778.
103. Araya, R., Dunstan, F., Playle, R., Thomas, H., Palmer, S., & Lewis, G. (2006). Perceptions of social capital and the built environment and mental health. *Soc Sci Med., 62*, 3072-3083.
104. Sampson, R. J., Raudenbush, S. W., & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science, 277*, 918-924.
105. Langley-Evans, S. C. & Carrington, L. J. (2006). Diet and the developing immune system. *Lupus, 15*, 746-752.
106. Moore, S. E., Collinson, A. C., Tamba N'Gom, P., Aspinall, R., & Prentice, A. M. (2006). Early immunological development and mortality from infectious disease in later life. *Proc Nutr Soc., 65*, 311-318.
107. McDade, T. W., Beck, M. A., Kuzawa, C. W., & Adair, L. S. (2001). Prenatal undernutrition and postnatal growth are associated with adolescent thymic function. *J Nutr, 131*, 1225-1231.
108. Eichholzer, M., Tonz, O., & Zimmermann, R. (2006). Folic acid: A public-health challenge. *Lancet, 367*, 1352-1361.
109. Grosse, S. D., Waitzman, N. J., Romano, P. S., & Mulinare, J. (2005). Reevaluating the benefits of folic acid fortification in the United States: Economic analysis, regulation, and public health. *Am J Public Health, 95*, 1917-1922.
110. Su, L. J. & Arab, L. (2001) Nutritional status of folate and colon cancer risk: Evidence from NHANES I epidemiologic follow-up study. *Ann Epidemiol., 11*, 65-72.
111. Beard J. (2003). Iron deficiency alters brain development and functioning. *J Nutr., 133*, 1468S-72S.
112. Lozoff, B. & Georgieff, M. K. (2006). Iron deficiency and brain development. *Semin Pediatr Neurol., 13*, 158-165.
113. Huh, S. Y. & Gordon, C. M. (2008). Vitamin D deficiency in children and adolescents: Epidemiology, impact and treatment. *Rev Endocr Metab Disord., 9*, 161-170.
114. Halfon, N., McLearn, K. T., Schuster, M. A. (eds.) (2002). *Child Rearing in America: Challenges facing parents with young children*. Cambridge, UK: Cambridge University Press.
115. Mayer, S. (2002). *Building community capacity: How different groups contribute*. Effective Communities Project. http://www.effectivecommunities.com/pdfs/ECP_GroupContribution.pdf
116. Leventhal T, & Brooks-Gunn, J. (2000). The neighborhoods they live in: The effects of neighborhood residence on child and adolescent outcomes. *Psychol. Bull, 126*, 309-337.
117. Center on the Developing Child at Harvard University (2007). A science-based framework for early childhood policy: Using evidence to improve outcomes in learning, behavior, and health for vulnerable children. <http://www.developingchild.harvard.edu>
118. Smolensky, E., & Gootman, J. A. (Eds.). (2003). *Working families and growing kids: Caring for children and adolescents*. Washington, DC: The National Academies Press.
119. Visness, C. M. & Kennedy, K. I. (1997). Maternal employment and breast-feeding: Findings from the 1988 national maternal and infant health study. *American Journal of Public Health, 87*, 945-950.
120. Baker, M. & Milligan, K. (2008). Maternal employment, breastfeeding, and health: Evidence from maternity leave mandates. *J Health Econ., 27*, 871-887.
121. Berger, L. M., Hill, J., & Waldfogel, J. (2005). Maternity-leave, early maternal employment and child health and development in the U.S. *The Economic Journal, 115*, F29-F47.
122. Ruhm, C. (2000). Parental leave and child health. *Journal of Health Economics. 19*, 931-960.
123. Tanaka, S. (2005). Parental leave and child health across OECD countries. *The Economic Journal, 115*, F7-F28.
124. Morris, P., Duncan, G., & Clark-Kauffman, E. (2005). Child well-being in an era of welfare reform: The sensitivity of transition in development to policy change. *Developmental Psychology, 41*(6), 919-932.
125. National Forum on Early Childhood Program Evaluation (2008). Workforce development, welfare reform, and child well-being: Working paper no. 7. <http://www.developingchild.harvard.edu>
126. National Scientific Council on the Developing Child (2008). Mental health problems in early childhood can impair learning and behavior for life: Working paper no. 6. <http://www.developingchild.net>
127. Bierman, K. L., Domitrovich, C. E., Nix, R. L., Gest, S. D., Welsh, J. A., Greenberg, M. T., . . . Gill, S. (2008). Promoting academic and social-emotional school readiness: The Head Start REDI program. *Child Development, 79*(6), 1802-1817.
128. Raver, C. C., Jones, S. M., Li-Grining, C. P., Zhai, F., Metzger, M. W., & Solomon, B. (2009). Targeting children's behavior problems in preschool classrooms: A cluster-randomized controlled trial. *Journal of Consulting and Clinical Psychology, 77*, 302-316.
129. National Research Council and Institute of Medicine. (2009) *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: The National Academies Press.
130. Marsland, K., Zigler, E., & Martinez, A. (2003). *Regulation of infant and toddler child care: Are state requirements for centers adequate?* Unpublished manuscript. Yale University, New Haven, CT.
131. Brauner, J., Gordic, B., & Zigler, E., (2004). Putting the child back into child care. *Social Policy Report, XVIII* (III), 5.
132. Alkon, A., To, K., Mackie, J. F., Wolff, M., & Bernzweig, J. (2010). Health and safety needs in early care and education programs: What do directors, child health records, and national standards tell us? *Public Health Nursing, 27*(1), 3-16.
133. American Academy of Pediatrics, American Public Health Association, & U.S. Department of Health and Human Services, Health Resources and Services Administration. (2002). *Caring for our children: National health and safety performance standards: Guidelines for out-of-home child care programs* (2nd ed.). Washington, DC: American Public Health Association.
134. Goodell, S. & Williams, C. H. (2007). The built environment and physical activity: What is the relationship? Policy brief no. 11. Princeton, NJ: Robert Wood Johnson Foundation. <http://www.rwjf.org/files/research/no11policybrief.pdf>

135. Centers for Disease Control and Prevention. *Web-based injury statistics query and reporting system*. <http://www.cdc.gov/injury/wisqars/index.html>.
136. U.S. Department of Transportation, National Highway Traffic Safety Administration. *Traffic safety facts 2006*. <http://www-nrd.nhtsa.dot.gov/pubs/tsf2006fe.pdf>.
137. National Scientific Council on the Developing Child (2006). Early exposure to toxic substances damages brain architecture: Working paper no. 4. Retrieved from <http://www.developingchild.net>
138. Etzel, R. A., & Balk, S. J., eds. (2003). *Pediatric environmental health* (2nd ed.) Elk Grove Village, IL: American Academy of Pediatrics, Committee on Environmental Health.
139. U.S. Environmental Protection Agency. (2003). America's children and the environment: Measures of contaminants, body burdens, and illnesses. http://www.epa.gov/opeedweb/children/publications/ace_2003.pdf
140. Needham, L. L., et al. (2005). Concentrations of environmental chemicals associated with neurodevelopmental effects in the U.S. population. *NeuroToxicology*, 26(4), 531-545.
141. Landrigan, P. J., et al. (2002). Environmental pollutants and disease in American children: Estimates of morbidity, mortality, and costs for lead poisoning, asthma, cancer, and developmental disabilities. *Environmental Health Perspectives*, 110(7), 721-728.
142. Centers for Disease Control and Prevention. (2001). *National report on human exposure to environmental chemicals*. Atlanta, GA: Centers for Disease Control and Prevention.
143. Goldman, L. R., et al. (2004). Environmental pediatrics and its impact on government health policy. *Pediatrics*, 113(4), 1146-1157.
144. Rice, G., & Hammit, J. K. (2005). *Economic valuation of human health benefits of controlling mercury emissions from U.S. coal-fired power plants*. Boston, MA: Northeast States for Coordinated Air Use Management.
145. Muir, T., & Zegarac, M. (2001). Societal costs of exposure to toxic substances: Economic and health costs of four case studies that are candidates for environmental causation. *Environmental Health Perspectives*, 109(Suppl. 6), 885-903.
146. Neal, D. A., & Johnson, W. R. (1995). The role of pre-market factors in black-white age differences: Working paper no. 5124. Cambridge, MA: National Bureau of Economic Research.
147. Harrison, E., Partelow, J., & Grason, H. (2009). Environmental toxicants and maternal and child health: An emerging public health challenge. Baltimore, MD: Women's and Children's Health Policy Center, Johns Hopkins Bloomberg School of Public Health. http://www.jhsph.edu/wchpc/publications/Environ_Tox_MCH.pdf
148. Martin, J. A., Hamilton, B. E., Sutton, P. D., Venture, S. J., Menaker, F., & Munson, M. L. (2003). Births: final data from 2002. *National Vital Stat Rep*, 52, 12.
149. Pirkle, J. L., Bernert, J. T., Caudill, S. P., Sosnoff, C. S., & Pechacek, T. F. (2006). Trends in the exposure of nonsmokers in the U.S. population to secondhand smoke: 1988-2002. *Environmental Health Perspectives*, 114(6), 853-8.
150. Samet, J. M., Lewitt, E. M., & Warner, K. E. (1994) Involuntary smoking and children's health. *The Future of Children: Critical Health Issues for Children and Youth*, 4(3):94-114.
151. Aligne, C. A., & Stoddard, J. J. (1997). Tobacco and children. An economic evaluation of the medical effects of parental smoking. *Arch Pediatr Adolesc Med*, 151(7), 648-53.
152. U.S. Department of Agriculture, Food and Nutrition Service, Office of Analysis, Nutrition and Evaluation (2007). *WIC Participant and Program Characteristics 2006* (WIC-06-PC). Alexandria, VA.
153. Joyce, T., Racine, A., & Yunzal-Butler, C. (2008). Reassessing the WIC effect: Evidence from the pregnancy nutrition surveillance system. *Journal of Policy Analysis and Management*, 27, 277-303.
154. Besharov, D. J., & Germanis, P. (2000). Evaluating WIC. *Evaluation Review*, 24,123-190.
155. Owen, A. L., & Owen, G. M. (1997). Twenty years of WIC: A review of some effects of the program. *Journal of the American Dietetic Association*, 97, 777-782.
156. Bitler, M.P., & Currie, J. (2005). Does WIC work? The effects of WIC on pregnancy and birth outcomes. *Journal of Policy Analysis and Management*, 24(1), 73-91.
157. U.S. General Accounting Office. (1992). *Early intervention: Federal investments like WIC can produce savings* (GAO/HRD-92-18). Washington, DC.
158. Danziger, S., & Waldfogel, J. (Eds.). (2000). *Securing the future: Investing in children from birth to college*. New York: Russell Sage Foundation.
159. Hawkins, S. S., Griffiths, L. J., Dezateux, C., Law C. (2007). Maternal employment and breast-feeding initiation: Findings from the millenium cohort study. *Paediatric and Perinatal Epidemiology*, 21, 242-247.
160. Hawkins, S. S., Griffiths, L. J., Dezateux, C., & Law, C. (2007). The impact of maternal employment on breast-feeding duration in the millenium cohort study. *Public Health and Nutrition*, 10, 891-896.
161. Ryan, A. S., Zhou, W., & Arensberg, M. B. (2006). The effect of employment status on breastfeeding in the United States. *Women's Health Issues*, 16, 243-251.
162. Fein, S. B., & Roe, B. (1998). The effect of work status on initiation and duration of breastfeeding. *American Journal of Public Health*, 88, 1042-1046.
163. Cohen, R., & Mrtek, M. B. (1994). The impact of two corporate lactation programs on the incidence and duration of breast-feeding by employed mothers. *American Journal of Health Promotion*, 8, 436-441.
164. Ortiz, J., McGilligan, K., & Kelly, P. (2004). Duration of breast milk expression among working mothers enrolled in an employer-sponsored lactation program. *Pediatric Nursing*, 30, 111-119.
165. Cohen, R., Mrtek, M. B., & Mrtek, R. G. (1995). Comparison of maternal absenteeism and infant illness rates among breast-feeding and formula-feeding women in two corporations. *American Journal of Health Promotion*, 10, 148-153.
166. Hora, B. L., Bahl, R., Martines, J. C., & Victora, C. G. (2007). *Evidence on the long-term effects of breastfeeding: Systematic reviews and meta-analyses*. Geneva, Switzerland: World Health Organization.
167. Owen, C. G., Martin, R. M., Whincup, P. H., Smith, G. D., & Cook, D. G. (2005). Effect of infant feeding on the risk of obesity across the life course: A quantitative review of published evidence. *Pediatrics*, 115, 1367-1377.
168. Fisher, P., Gunnar, M., Dozier, M., Bruce, J., & Pears, K. (2006). Effects of therapeutic interventions for foster children on behavioral problems, caregiver attachment, and stress regulatory neural systems. *Ann NY Acad Sci*, 1094, 215-225.

169. Middlebrooks, J. S., & Audage, N. C. (2008). *The effects of childhood stress on health across the lifespan*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
170. Mercy, J. A., & Saul, J. (2009). Creating a healthier future through early interventions for children. *JAMA*, 301(21), 2262-2264.
171. Gilliam, W.S. (2005). *Prekindergartners left behind: Expulsion rates in state prekindergarten programs*. FCD Policy Brief Series, no. 3. New York: Foundation for Child Development.
172. Gilliam, W.S., & Shahar, G. (2006). Preschool and child care expulsion and suspension. *Infants & Young Children*, 19(3), 228-245.
173. Olfson, M., Crystal, S., Huang, C., & Gerhard, T. (2010). Trends in antipsychotic drug use by very young, privately insured children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(1), 13-23.
174. Halfon, N., DuPlessis, H., & Inkelas, M. (2007). Transforming the U.S. child health system. *Health Affairs*, 26, 315-330.
175. Schor, E. (2007). The future pediatrician: Promoting children's health and development. *Journal of Pediatrics*, 113(6), 1802-1809.
176. Palfrey, J., Tonniges, T., Green, M., & Richmond, J. (2005). Addressing the millennial morbidity: The context of community pediatrics. *Pediatrics*, 115, 1121-1123.
177. Tanner, L., Stein, M., Olson, L., Frinter, M., & Radecki, L. (2009). Reflections on well-child care practice: A national study of pediatric clinicians. *Pediatrics*, 124, 849-857.
178. Radecki, L., Olson, L., Frinter, M., Tanner, L., & Stein, M. (2009). What do families want from well-child care? Including parents in the rethinking discussion. *Pediatrics*, 124, 858-865.
179. Sia, C., Tonniges, T., Osterhus, E., & Taba S. (2004). History of the medical home concept. *Pediatrics*, 113(5 suppl.), 1473-1478.
180. Homer, C., & Baron, R. (2010). How to scale up primary care transformation: What we know and what we need to know? *J Gen Intern Med*, 25(6), 625-629.
181. Davis, K., Schoen, C., & Stremikis, K. (2010). Mirror, mirror on the wall: How the performance of the U.S. health care system compares internationally: 2010 update. The Commonwealth Fund.
182. Anderson, G. F., Frogner, B. K., & Reinhardt, U. E. (2007). Health spending in OECD countries in 2004: An update. *Health Affairs*, 46(5), 1481-1489.
183. Shonkoff, J. P. (2010). Building a new biodevelopmental framework to guide the future of early childhood policy. *Child Development*, 81(1), 357-367.

ALSO FROM THE CENTER ON THE DEVELOPING CHILD

A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children (2007)

The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do (2007)

Early Childhood Program Evaluations: A Decision-Maker's Guide (2007)

WORKING PAPER SERIES

Working Paper #1

Young Children Develop in an Environment of Relationships (2004)

Working Paper #2

Children's Emotional Development is Built into the Architecture of their Brains (2004)

Working Paper #3

Excessive Stress Disrupts the Architecture of the Developing Brain (2005)

Working Paper #4

Early Exposure to Toxic Substances Damages Brain Architecture (2006)

Working Paper #5

The Timing and Quality of Early Experiences Combine to Shape Brain Architecture (2007)

Working Paper #6

Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life (2008)

Working Paper #7

Workforce Development, Welfare Reform, and Child Well-Being (2008)

Working Paper #8

Maternal Depression Can Undermine the Development of Young Children (2009)

Working Paper #9

Persistent Fear and Anxiety Can Affect Young Children's Learning and Development (2010)

Working Paper #10

Early Experiences Can Alter Gene Expression and Affect Long-Term Development (2010)

http://developingchild.harvard.edu/library/reports_and_working_papers/

Center on the Developing Child  HARVARD UNIVERSITY
NATIONAL SCIENTIFIC COUNCIL ON THE DEVELOPING CHILD
NATIONAL FORUM ON EARLY CHILDHOOD POLICY AND PROGRAMS

50 Church Street, 4th Floor, Cambridge, MA 02138
617.496.0578
www.developingchild.harvard.edu
www.developingchild.net

CHAPTER 3

The Role of Healthy Relational Interactions in Buffering the Impact of Childhood Trauma

CHRISTINE R. LUDY-DOBSON
BRUCE D. PERRY

Humans are social creatures. We live, work, and grow up in social groups. For the vast majority of the last 200,000 years, humans have lived in multigenerational, multifamily hunter-gatherer bands characterized by a rich and continuous relational milieu; the concept of personal space and privacy is relatively new. Child mortality during our history was high; children were highly valued by the band and in these groups of 40–60 members, there were roughly four developmentally more mature potential caregivers for each child under the age of 6. This enriched relational ratio helped the group protect, nurture, educate, and enrich the lives of each developing child.

These living groups were the source of safety and sustenance for individuals in a dangerous world. Survival depended upon the ability to communicate, bond, and share with and receive from other members of the band. Then, as today, the presence of familiar people projecting the social–emotional cues of acceptance, understanding, compassion, and empathy calmed the stress response of the individual. We feel safest in the presence of familiar and nurturing members of our family and com-

--

munity. These powerful regulating effects of healthy relational interactions on the individual—mediated by various key neural networks in the brain—are at the core of relationally based protective mechanisms that help us survive and thrive following trauma and loss. Individuals who have few positive relational interactions—a child without a healthy family/clan—during or after trauma have a much more difficult time decreasing the trauma-induced activation of the stress response systems. The result is an increased probability of developing trauma-related problems. Further, children in a relationally impoverished setting will likely be unable to recover or heal from these effects without a change in the relational milieu. Positive relational interactions regulate the brain's stress response systems and help create positive and healing neuroendocrine and neurophysiological states that promote healing and healthy development both for the normal and the maltreated child.

There is another aspect to the interconnectedness of the stress response and relational neurobiology. Human history, to this very day, is characterized by clan on clan, human on human competition for limited resources. Indeed the major predator of humans has always been other humans. In our competitive, violent past, encounters with unfamiliar nonclan members were as likely to result in harm as harmony. As the infant becomes the toddler and the toddler becomes the child, the brain is making a catalogue of “safe and familiar” attributes of the humans in his or her clan; the language, the dress, the nonverbal elements of communication, the skin color of the family and clan become the attributes of “safe and familiar,” which, in future interactions with others, will tell his or her stress response networks to be calm. In contrast, when this child interacts with strangers, the stress response systems activate; the more unfamiliar the attributes of these new people, the greater the activation. In some cases, a clan's beliefs may have exacerbated this response; if the child grows up with ethnic, racial, or religious beliefs and values that degrade or dehumanize others, the stress activation that results in an encounter with different peoples can be extreme. In this case, relational interactions activate and exacerbate trauma-related stress over activation. A recent study by Chiao and colleagues (2008), for example, has shown that fear-related social cues from individuals from one's own group/ethnicity have greater “power.” We are more tuned into people in our own “group.” Fear of a member in our group will induce greater amygdalar activation than similar cues from nongroup members.

The social milieu, then, becomes a major mediator of individual stress response baseline and reactivity; nonverbal signals of safety or

threat from members of one's "clan" modulate one's stress response. The bottom line is that healthy relational interactions with safe and familiar individuals can buffer and heal trauma-related problems, whereas the ongoing process of "tribalism"—creating an "us" and "them"—is a powerful but destructive aspect of the human condition that only exacerbates trauma in individuals, families, and communities attempting to heal.

THE IMPACT OF CHILDHOOD EXPERIENCES

The experiences of early life have the profound ability to shape the infant, child, adolescent, and ultimately the adult. Each child has his or her own unique genetic potential, yet this potential is expressed differentially depending upon the nature, timing, and patterns of developmental experience (see Perry, 2001, 2002). An understanding of how early experiences shape neurodevelopment is imperative if we seek to impact the lives of children with whom we live and work. This is especially true in the case of children growing up in homes plagued by violence, maltreatment, and neglect.

For many, childhood is a very violent time; for others, childhood is permeated with unpredictability, chaos, threat, and other forms of adverse developmental experience. There is a wealth of research describing the negative impact of childhood trauma on the physical, behavioral, cognitive, social, and emotional functioning of children (Perry & Pollard, 1998; Bremner & Vermetten, 2001; Read, Perry, Moskowitz, & Connolly, 2001; Malinosky-Rummell & Hansen, 1993; Fitzpatrick & Boldizar, 1993; Graham-Berman & Levendosky, 1998; Margolin & Gordis, 2000; Sanders-Phillips, 1997; Berenson, Wieman, & McCombs, 2001; Anda et al., 2006). Children exposed to trauma have increased neuropsychiatric problems (e.g., posttraumatic stress disorder [PTSD], depression, dissociation, conduct disorders), school and academic failure, involvement with the juvenile justice system, drug and alcohol use, antisocial behaviors, and engagement in high-risk sexual behavior and teenage pregnancy. The impact of early trauma is so profound because it occurs during those critical periods when the brain is most rapidly developing and organizing. Because the experiences of early life determine the organization and function of the mature brain, going through adverse events in childhood can have a tremendously negative impact on early brain development, including social and emotional development.

THE HUMAN BRAIN AND THE IMPACT OF TRAUMA

The brain of a newborn is composed of billions of neurons and glial cells that, from conception, have been changing—dividing, moving, specializing, connecting, interacting, and organizing. This organization takes place from the bottom, simplest area (brainstem) to the highest, most complex (cortex). The various functions of the brain parallel this structure: The brainstem regulates the simplest reflexive functions (e.g., body temperature and heart rate), and the cortical areas mediate complex functions such as abstract thought and language (Perry, 2001). The brain is a use-dependent organ that changes in response to patterned, repetitive activity. Thus the more any neural network of the brain is activated, the more that part will change. Among other things, this process is the basis for memory, learning, and development.

All experience, therefore, changes the brain—even if in the subtlest, microscopic ways. Yet experiences in childhood have disproportionate power in shaping the brain. Early in life the brain organizes at an incredible rate, with more than 80% of the major structural changes taking place during the first 4 years. Experiences that take place during this window of organization have a greater potential to influence the brain—in either positive or negative ways. Because the majority of brain growth and development takes place during these first years, early developmental trauma and neglect have a “disproportionate influence on brain organization and later brain functioning” (Perry & Hambrick, 2008; see also, Perry, 2008). Unfortunately, traumatic experiences that take place during this critical window impact the brain in multiple areas and can actually change the structure and function of key neural networks, including those involved with regulating stress and arousal (Perry, 2008). These stress response systems in the brain are designed to sense and respond to threats, either from internal (body) or external sources. Thus, the end effect is that children who are exposed to chronic threat develop overactive and overly reactive stress response neural systems. In short, they live in a persistent state of fear. Although these neuronal changes are useful and protective when the child is living in an abusive environment, they lead to problems in other settings. For example, a hyperaroused child is often preferentially alert to non-verbal cues, which is adaptive with an unpredictable, violent parent but maladaptive in a classroom where the child will miss much of the verbal information presented by a teacher.

As the brain develops in a use-dependent manner, it requires stimulation at specific times in order for the systems to function at their best

(see Perry, 2001; Perry & Szalavitz, 2007). If these sensitive periods of development are missed, “some systems may never be able to reach their full potential” (Perry & Szalavitz, 2007, p. 85). Inconsistent, abusive, or neglectful caregiving in early childhood alters the normal development of neural systems involved in both relationships and the stress response. It is through patterned, repetitive neural stimulation provided by consistent, nurturing, predictable, responsive caregivers that the infant’s brain receives what is needed to develop the capacity for healthy attachment and self-regulation capabilities. The caregiver becomes the external stress regulator for the infant. However, if the caregiver is depressed, stressed, “high,” inconsistent, or absent, these two crucial neural networks (relational and stress response) develop abnormally. The result is a child more vulnerable to future stressors and less capable of benefiting from the healthy nurturing supports that might help buffer stressors or trauma later in life.

These early developmental experiences with caregivers create a very literal template or set of associations for the child’s brain about what humans are. The brain of a child growing up in a home with attentive, attuned caregivers will create a template of humans as safe, predictable, and a source of sustenance, comfort, and pleasure. The brain of a child living in a home plagued by domestic violence and whose primary caregiver is preoccupied and chaotically neglectful will create a template in which humans are unpredictable and a source of fear, chaos, pain, and loss. Children carry these templates created by their initial caregiving experiences into all future relational interactions, either increasing or decreasing their capacity to benefit from future nurturing, caring, and invested adults. Relationships in early childhood, then, can alter the vulnerability–resilience balance for an individual child. Negative or neglectful primary caregiving relationships have the capacity to increase the likelihood that the child will have a more vulnerable, dysregulated stress response network and a less receptive relational capacity to buffer and heal following trauma as the child grows.

SOCIAL AND EMOTIONAL DEVELOPMENT

Understanding healthy social and emotional development in children underscores why disruptions to, or disorganization in, early attachment has such far-reaching implications. *Attachment* is defined as an enduring relationship with a specific person that is characterized by soothing, comfort, pleasure, and safety. It also includes feelings of intense distress

when faced with the loss, or threat of loss, of this person. By far the most important attachment relationship is that of mother and infant. Even before birth, the emotionally healthy mother begins the process of attaching to her baby as she grows attuned to its patterns of movement and the way it responds to stimuli such as sound (Greenspan & Wieder, 2006). Bowlby (1969) describes maternal–infant attachment as a reciprocal relationship. Greenspan and Wieder (2006) note that “the rhythmic, near-synchronous patterns of movement and vocalization between infant and caregiver enable the infant to begin attending to and appreciating the world” (pp. 14–15). In fact, many have aptly described this mother–infant relationship as a dance, the moves of which will be used with many partners throughout the child’s life.

The importance of healthy attachment has been extensively studied. Research in this area has identified four categories of attachment: secure, insecure-resistant, insecure-avoidant, and insecure-disorganized/disoriented. Securely attached children feel a consistent, responsive, and supportive relation to their mothers even during times of significant stress. Children with insecure attachment feel inconsistent, punishing, unresponsive emotions from their caregivers and feel threatened during times of stress. Ainsworth, Blehar, Waters, and Wall (1978) posited that the type of attachment a child develops is dependent on the kind of caregiving received during the first year of life. A solid and healthy attachment with a primary caregiver predicts healthy relationships with others as the child grows.

Development in many other areas is rooted in the development of a healthy attachment to a primary caregiver. These areas include development of emotional, social, cognitive, and self-regulatory capabilities. These first relationships, including those formed with other significant people during early childhood, “are the prism through which young children learn about the world, including the world of people and of the self” (Thompson, 2002, p. 10). These early experiences literally provide the organizing framework for the infant/child. Regulation of the infant’s emotional states develops through the repeated appropriate responses of an attentive, attuned caregiver to the baby’s changing emotional states (e.g., fear, anger, distress). Through this consistent, predictable, and repetitive nurturing the child develops the capacity to self-regulate these emotional states as well as to communicate his or her emotions (Emde, 1998). These nurturing behaviors also provide feelings of safety and security. According to Lyons-Ruth and Spielman (2004), a mother’s capacity to regulate her infant’s distress and fear is vital to the child’s ultimate sense of security.

The timing of relational interactions is critically important for the development of attachment and social–emotional functioning. An absence of nurturing during the first 3 years of life can lead to disorganization of the neural systems that mediate social–emotional functioning (Perry, 2002). Without the vitally important relational input from caring, attuned caregivers, children may develop as if the entire world were a cold, dangerous place. Not surprising, many studies have found that maltreated infants exhibit disturbed or insecure attachment (Carlson, Cichetti, Barnett, & Braunwald, 1989; Crittenden, 1985; Lamb, Gaensbauer, Malkin, & Schultz, 1985; Schneider-Rosen, Braunwald, Carlson, & Cichetti, 1985). Children who have experienced abuse and neglect in infancy and early childhood are at greater risk for developing maladaptive behaviors and mental health problems as they get older.

CASE 1: CAREGIVER ISSUES IMPACTING BONDING AND ATTACHMENT

Mark, age 2, was brought to our clinic by his adoptive mother due to concerns that he may have an attachment disorder. He had been adopted at 10 months of age from a small Eastern European orphanage, where he had been placed at birth. His adoptive mother, Sarah, had no knowledge of Mark’s biological parents but reported that the orphanage seemed “better than most,” as Mark had relatively stable caregivers to whom he appeared attached and areas in which he could explore and play. She reported that her difficulties with Mark began almost immediately upon returning home. According to Sarah, he would not look her in the eyes, didn’t enjoy being held, and didn’t engage in exploratory play. In an effort to strengthen the attachment bond, she had taken Mark to multiple therapists specializing in attachment. Further, she had been trained in holding therapy and had read countless books on the subject.

In an effort to get to know Sarah and Mark better, clinicians observed their interaction over the course of the first two interview sessions. During the initial interview Sarah sat and talked with the lead clinician while Mark explored the room. Mark quickly discovered that he could climb from the chair to the desk, and within minutes he was happily walking on top of the desk and onto the adjoining table. The observing clinicians watched in dismay as Sarah continued the interview with no acknowledgment of her son’s precarious situation. Only

when the suggestion was made that Mark might fall and injure himself did she remove him from the table.

During the second interview, Sarah offered to demonstrate the activities she was currently implementing to increase her son's attachment to her. She picked Mark up and held him tightly in her arms, her hand under his chin, in an effort to force him to look directly into her face. The child squirmed and fought to get loose; eyes closed, he turned his head violently in an effort to avoid her gaze. The more he fought and screamed the more resolute she became. Finally, she looked at the clinician and said, "See, this is exactly what I've been dealing with." However, to the clinician, Mark's reaction was not a surprise. When infants or young children are distressed due to pain, pervasive threat, or a chaotic environment, they will have difficulty participating in even a supportive caregiving relationship (Perry & Pollard, 1998)—which this obviously was not.

A second clinician participated in the third session with the family. While the primary clinician talked with Sarah about healthy development, the second clinician sat on the floor with Mark, who was playing with a large plastic dinosaur. The second clinician engaged in parallel play with another dinosaur. Within a short time, Mark had moved close to the clinician, interjecting his dinosaur into her play. He interacted easily with the clinician, making appropriate eye contact and happily describing the dinosaur's activity. In subsequent sessions it became clear that the issue was not centered in the child but in the parenting behavior. Sarah had experienced abuse at the hands of her own mother as a child. Relationships, it seemed, had been difficult for her throughout her adult life, but her hope was that by adopting a child she would fill this relational void. Unfortunately, it is not uncommon that caregivers who themselves experienced trauma or maltreatment as children carry these experiences into their own maternal-child relationships. The frightened or frightening behaviors of such a caregiver often creates a contradiction that is impossible for the child to resolve: The caregiver is both the source of, and solution to, the child's distress (Main & Hess, 1990). Without an acknowledgment of the impact that their own childhood experiences have on their parenting, these caregivers are unlikely to change their behavior. This was the case with Sarah. Attempts to help her better understand how her own trauma history impacted her ability to respond to her son's needs and to teach her appropriate nurturing activities ultimately were unsuccessful, leading ultimately to her decision to relinquish her parental rights. Mark was later adopted by

another family who was more open to understanding the impact of his early experiences and to providing the necessary reparative experiences that would allow him to grow into a healthy happy child.

CASE 2: THE DEVASTATING IMPACT OF MALTREATMENT ON SOCIAL–EMOTIONAL DEVELOPMENT

Sydney never knew her biological parents. She had been removed from their care at birth due to the severe physical abuse of her three older siblings by her mother and father. Sydney was fortunate. She was placed in a loving home with foster/adoptive parents who cared for her as if she were their own child. Sydney thrived in the care of these nurturing, attentive, and attuned caregivers. In her mind, they were her mommy and daddy, and that's what she called them. Tim and Jan thought of Sydney as their child even though they had been reminded, time and time again by her caseworker, that there was no guarantee that they would be able to adopt her. Despite torturing their older children, the parental rights of Sydney's parents had not been terminated. The Child Protective Services (CPS) caseworker was concerned about the ethnic differences between the foster parents and Sydney, although that difference was only noticeable to those who didn't know them. They were a very happy family.

Then when Sydney was 3 years old the judge made a surprising decision. Her biological parents had completed all of the requirements placed upon them by CPS, including parenting classes, anger management classes, and domestic violence and drug and alcohol counseling. It now seemed that after several years they had finally gotten their act together and were once again ready to parent their four children. Sydney did know her brothers and sister; they had monthly visits during their time in foster care, although the infrequency of the time together did little to forge a sibling bond. Her parents, on the other hand, had rarely made the parental visits. However, this made little difference as the judge handed down his decision. They were her biological parents and that's what mattered. Tim and Jan hired an attorney, and they fought Sydney's removal from their home with all they had—but biology won out. On a crisp February morning, Sydney was taken from them. Jan later described how Sydney's screams haunted her day and night.

But that was just the beginning of the trauma for Sydney. She had been taken from her mommy and daddy and given to two people whom

she didn't know. They said that they were her "real" mommy and daddy, but she knew that wasn't true, so she called them by their names. That was only one of the things that infuriated them about her. Within a short period of time, the torture began: beatings, burning with cigarettes, being locked in her room, and denied food. Sydney's world had completely changed and her 3-year-old mind couldn't begin to understand why.

Thankfully, Tim and Jan never gave up. They were not able to see Sydney but, based upon the reports when her siblings initially came into care, they could only imagine what she was going through. They continued to fight. They told Sydney's story to the media and sought the help of children's rights groups. But ultimately it was a neighbor who put an end to Sydney's suffering. She had seen Sydney only on rare occasions over the year and a half that the children had been back in the home. The older children went to school and played in the neighborhood park, but not Sydney. One day she witnessed the father kicking Sydney as she tried to walk out onto the front porch. The neighbor immediately called the police. When they arrived with CPS there was little doubt of the abuse suffered by this child. She was rushed to the hospital. Both parents were arrested, and her brothers and sister were once again placed in foster care.

When Jan and Tim entered the hospital room, they barely recognized their little girl. Her once beautiful hair was now matted to her head and was completely gone in some places. Her eyes, once so sparkling and full of life, stared right through them. She didn't speak. Ultimately the results of days of tests and X-rays told the horrible truth. Sydney had suffered countless beatings that ended in broken bones that were never treated. She would have to endure multiple surgeries to chip away the calcium deposits that had formed on the healed bones in her legs. She had regressed in every developmental domain, and she exhibited severe PTSD.

It wasn't until she returned home that the healing could begin. Her room was just as she left it—the consistent, nurturing, and safe home was waiting for her. She would need hours of physical and occupational therapy and the efforts of therapists experienced in working with traumatized children. Most important, she needed the love and care of her family to provide the patterned, repetitive, and reparative experiences that would help build the developmental capacities that anger and cruelty had stolen from her. Ultimately Sydney did heal from all this early trauma because of her strong spirit and the parents who never gave up on her.

CASE 3: NEGLECT IN INFANCY AND THE DEVELOPMENTAL CONSEQUENCES

Haley was adopted from an orphanage outside of the United States when she was 9 months old. While the information her adoptive parents had about her past was minimal, they did know that she had spent the first 2 months of her life with her biological mother, who was a known alcoholic. At the time she was placed, Haley had a serious illness and several bruises on her legs, and she spent at least a month in the hospital. Haley's adoptive parents had an opportunity to tour the facility, which they described as a "typical" orphanage—a cold place with large rooms filled with rows of cribs or beds and only a few caregivers.

Upon returning home with their new baby, the parents were surprised by her behavior. She cried very little during the day; she would often just sit and stare into space. At night, however, she would wake several times screaming uncontrollably. No matter what they tried, they were rarely able to comfort or soothe her when she was upset. She didn't like to be touched or held, and her eating was always rushed, as if she hadn't eaten in days and didn't know when she would eat again. Haley would often hurt herself by banging her head or pulling her hair until it came out, and she would also try to hit or bite anyone who tried to hold her.

Haley's adoptive parents, Kristy and Sam, worked to make home a safe place. Kristy quit her job to stay home with her daughter. They hired a psychologist to come into their home and teach them appropriate attachment techniques such as cuddling, gentle holding, and rocking. They worked very hard to build routines and predictability into Haley's day. Over time, Haley's self-injurious behaviors began to diminish, although they did not completely go away. However, following an outing to visit family out of state, Haley's behaviors regressed significantly. Once again she was rageful, hitting everyone within reach, touch averse, and exhibiting severe sleep disturbances. Only through limiting her exposure to those outside of the family and not venturing outside the home did her behaviors get better.

Haley seemed to be making progress. A massage therapist had worked with the family and now both parents used massage as a way to help soothe and calm their daughter. They built rocking and music and movement into their daily routine. They followed every recommendation to the letter—they were doing everything right. But without warning, Haley's behaviors began to escalate into severe mood swings. Her

parents describe her as exceptionally gentle and loving one minute and defiant, rageful, rejecting, and hurtful the next. Despite all of the empathy, patience, and nurturing, Haley did not seem to be getting better. What Sam and Kristy didn't know was that the absence of critical organizing experiences during Haley's neglectful first 8 months was a major contributing factor to the devastating developmental problems they witnessed on a daily basis.

THE POWER OF RELATIONSHIPS TO HEAL

Understanding the power of traumatic events to shape the brain helps us to better determine what a child needs to heal. Although negative early life relational experiences have the ability to shape the child's developing brain, relationships can also be protective and reparative (see Figure 3.1). The cases of Mark and Sydney are examples of the power of relationships both to injure and to heal. There exists a wide body of research suggesting that social connectedness is a protective factor against many forms of child maltreatment—including physical abuse, neglect, nonorganic failure to thrive—as well as a means of promoting prosocial behavior (Belsky, Jaffee, Sligo, Woodward, & Silva, 2005; Caliso & Milner, 1992; Egeland, Jacobvitz, & Sroufe, 1988; Rak & Patterson, 1996; Travis & Combs-Orme, 2007; Chan, 1994; Coohy, 1996; Guadin, Polansky, Kilpatrick, & Shilton, 1993; Hashima & Amato, 1994; Pascoe & Earp, 1984; Altemeier, O'Connor, Sherrod, & Vietze, 1985; Benoit, Zeanah, & Barton, 1989; Crnic, Greenberg, Robinson, & Ragozin, 1984; Gorman, Leifer, & Grossman, 1993). Sydney's early experiences had taught her that home was a place where she was safe and loved. Her foster/adoptive parents and their extended family supplied her with the emotional connections, healthy interactions, and nurturing that provided a strong basis for surviving the horrors of life with her biological parents. We can only infer that Mark had something similar built in by his first caregivers in the orphanage that helped buffer the experiences with his first adoptive mother.

Haley, unfortunately, missed out on the nurturing, touch, and love that she needed in order to grow into a healthy, secure little girl. Her brain, literally, was a reflection of the severity of her neglect, likely combined with some type of physical maltreatment. Her stress response system overly active, Haley spent most of her time either hyperaroused or dissociating when her little system could take no more. Also, not surpris-

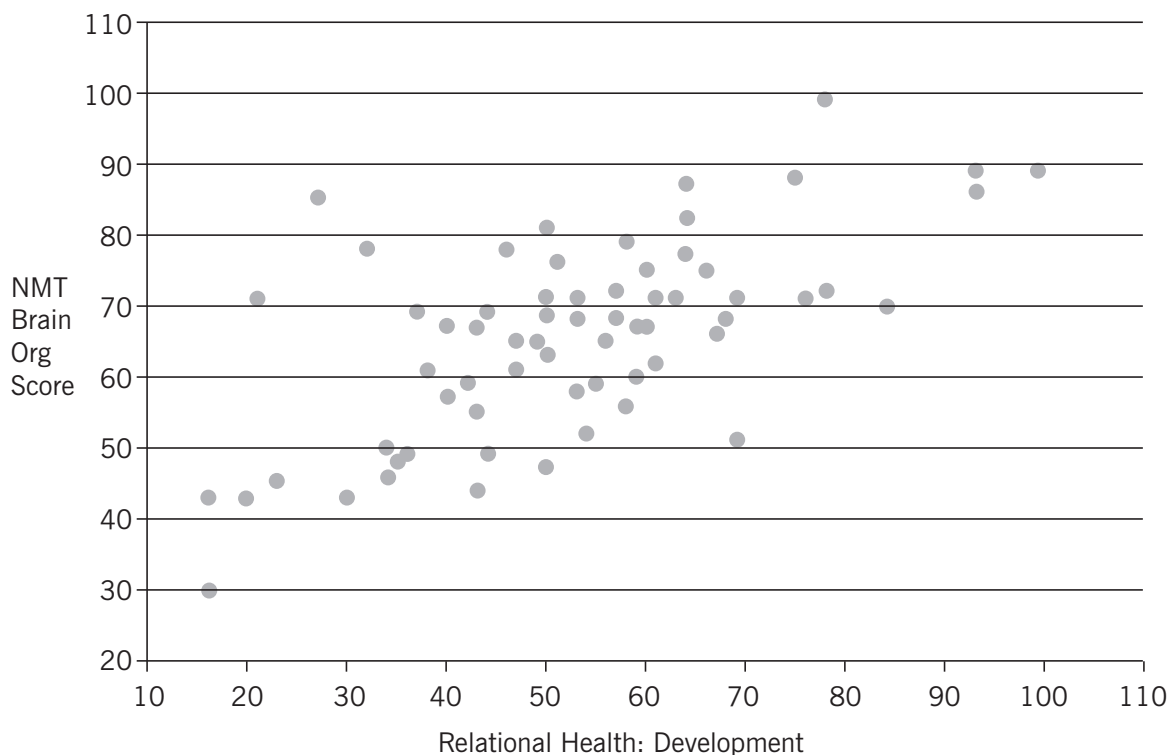


FIGURE 3.1. Relational health during development is protective. This graph is from research with a group of maltreated children. A retrospective measure of the presence, quality, and number of relational supports during each child’s development was obtained as part of a clinical assessment (Relational Health: Development) using an approach called the Neurosequential Model of Therapeutics (NMT; Perry, 2009). This is plotted against a measure of the development and functional capabilities of 28 brain-mediated functions (NMT Brain Organization [org] Score). A clear relationship between the relational health scores and overall quality of brain organization and functioning is seen.

ingly, the strategies that helped her survive in the environment of the orphanage made it more difficult for her to “take advantage of good-quality, loving and responsive” caregiving in her new home (Howe & Fearnley, 2003, p. 372). Experience in her earliest caregiving relationships had taught her that adults were frightening, hurtful, unpredictable, and confusing. Children with early neglect histories and subsequent attachment-related problems rarely feel safe when placed in new, healthy caregiving situations. Instead, they work to avoid close relationships, often becoming aggressive and controlling as a way to protect themselves from further hurt. Howe and Fearnley (2003) aptly describe the situation this way.

Close relationships are the one thing these children avoid. Their developmental agenda is to control and not to engage people. This denies them exposure to the very experiences they need. So long as they remain unable to relinquish control and relate fully and accurately with their carers and therapists, the children make little emotional or developmental progress (p. 380).

Sydney's case, in particular, provides an example of how healthy caregiving and strong attachments can help protect children from the lasting impact of traumatic events. That is not to say that all of the scars disappear or that the memories of trauma no longer exist, only that the reestablishment of predictable routines, reconnections with attentive, attuned, committed caregivers, and solid therapeutic treatment provide the opportunity for children to heal.

PRACTICE AND POLICY IMPLICATIONS

Our current mental health, child welfare, and judicial systems, as well as child-placing agencies deal with traumatized and maltreated children as if they were completely unaware of these essential findings in development, attachment, and trauma. We have few metrics to measure the number, quality, and patterns of healthy (or unhealthy) relational interactions; we move traumatized children from therapist to therapist, school to school, foster home to foster home, community to community. Indeed our systems often exacerbate or even replicate the relational impermanence and trauma of the child's life (see Figure 3.2). We expect "therapy"—healing—to take place in the child via episodic, shallow relational interactions with highly educated but poorly nurturing strangers. We undervalue the powerful therapeutic impact of caring teacher, coach, neighbor, grandparent, and a host of other potential "cotherapists."

Future effective therapeutic interventions—both preventive and healing—must be developmentally informed and trauma sensitive. There is much to learn, yet we know enough now to begin to evaluate and modify our current therapeutic practices, programs, and policies to take full advantage of the biological gift of the healing power of relationships.

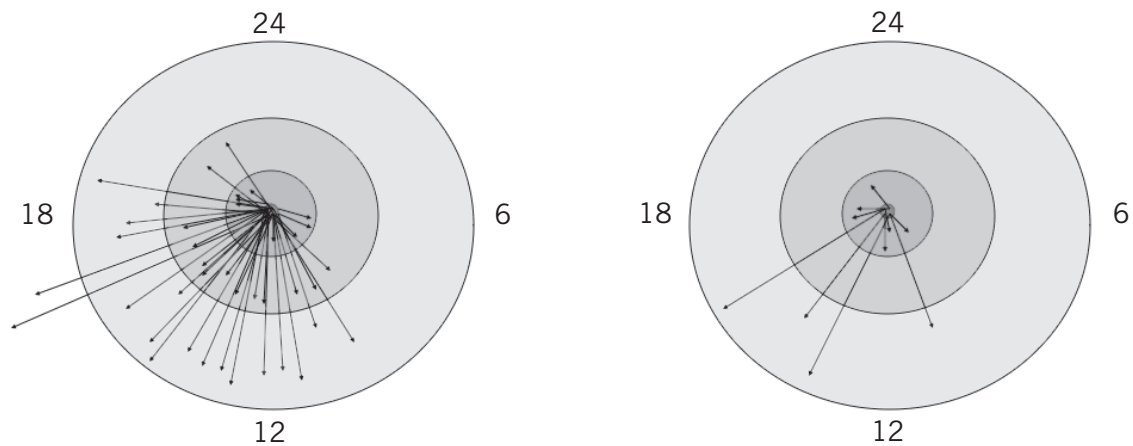


FIGURE 3.2. Positive relational interactions: Typical and foster child. These two figures are representative 24-hour relational contact maps examining the number of positive relational interactions in two children. Arrows represent positive interactions (as rated by observer and child); arrows ending in the inner circle represent interactions with family; additional circles represent friends, then classmates/acquaintances. Arrows outside the circle represent interactions with strangers. The figure on the right is based on a 10-year-old boy in foster care who was moved in the middle of the school year to a new foster home away from extended family and community. This figure is the best 24-hour map for a 2-week period for this child. Several days were completely devoid of any positive relational interaction. The relational poverty played a major role in this child's inability to progress; symptoms related to trauma and neglect persisted and increased while he was in relationally impoverished settings. Once in a stable placement with positive relationships created in school and the community, he stabilized and improved.

REFERENCES

- Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Hillsdale, NJ: Erlbaum.
- Altemeier, W., O'Connor, S. M., Sherrod, K. B., & Vietze, P. M. (1985). Prospective study of antecedents for nonorganic failure to thrive. *Journal of Pediatrics*, *106*, 360–365.
- Anda, R. F., Felitti, R. F., Walker, J., Whitfield, C., Bremner, D. J., Perry, B. D., et al. (2006). The enduring effects of childhood abuse and related experiences: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatric and Clinical Neuroscience*, *256*(3), 174–186.
- Belsky, J., Jaffee, S. R., Sligo, J., Woodward, L., & Silva, P. A. (2005). Intergenerational transmission of warm-sensitive-stimulating parenting: A prospective study of mothers and fathers of 3 year olds. *Child Development*, *76*, 384–396.

Buffering the Impact of Childhood Trauma

- Benoit, D., Zeanah, C. H., & Barton, M. (1989). Maternal attachment disturbances and failure to thrive. *Infant Mental Health Journal, 10*, 185–202.
- Berenson, A., Weiman, C., & McCombs, S. (2001). Exposure to violence and associated health-risk behaviors among adolescent girls. *Archives of Pediatric Adolescent Medicine, 155*, 1238–1242.
- Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.
- Bremner, J. D., & Vermetten, E. (2001). Stress and development: Behavioral and biological consequences. *Development and Psychopathology, 13*, 473–489.
- Caliso, J. A., & Milner, J. S. (1992). Childhood history of abuse and child abuse screening. *Child Abuse and Neglect, 16*, 647–659.
- Carlson, V., Cichetti, D., Barnett, D., & Braunwald, K. (1989). Disorganized/disoriented attachment relationships in maltreated infants. *Developmental Psychology, 25*, 525–531.
- Chan, Y. (1994). Parenting stress and social support of mothers who physically abuse their children in Hong Kong. *Child Abuse and Neglect, 18*, 261–269.
- Chiao, J. Y., Iidaka, T., Gordon, H. L., Nogawa, J., Bar, M., Aminoff, E., et al. (2008). Cultural specificity in amygdala response to fear faces. *Journal of Cognitive Neuroscience, 20*(12), 2167–2174.
- Coohey, C. (1996). Child maltreatment: Testing the social isolation hypothesis. *Child Abuse and Neglect, 20*, 241–251.
- Crittenden, P. M. (1985). Maltreated infants: Vulnerability and resilience. *Journal of Child Psychology and Psychiatry, 26*, 85–96.
- Crnic, K., Greenberg, N., Robinson, N., & Ragozin, A. (1984). Maternal stress and social supports: Effects on the mother–infant relationship from birth to eighteen months. *American Journal of Orthopsychiatry, 52*, 550–557.
- Egeland, B., Jacobvitz, D., & Sroufe, L. A. (1988). Breaking the cycle of abuse. *Child Development, 59*, 1080–1088.
- Emde, R. N. (1998). Early emotional development: New modes of thinking for research and intervention. *Pediatrics, 102*(5) Supplement, 1236–1243.
- Fitzpatrick, K. M., & Boldizar, J. P. (1993). The prevalence and consequences of exposure to violence among African American youth. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(2), 424–430.
- Gaudin, J., Polansky, N., Kilpatrick, N., & Shilton, P. (1993). Loneliness, depression, stress, and social support in neglectful homes. *American Journal of Orthopsychiatry, 63*, 597–605.
- Gorman, J., Leifer, M., & Grossman, G. (1993). Nonorganic failure to thrive: Maternal history and current maternal functioning. *Journal of Clinical Child Psychology, 22*(3), 327–337.
- Graham-Berman, S. A., & Levendosky, A. A. (1998). Traumatic stress symptoms in children of battered women. *Journal of Interpersonal Violence, 13*(1), 111–128.
- Greenspan, S. I., & Wieder, S. (2006). *Infant and early childhood mental health: A comprehensive developmental approach to assessment and intervention*. Washington, DC: American Psychiatric Association.

- Hashima, P., & Amato, P. (1994). Poverty, social support, and parental behavior. *Child Development, 65*, 394–403.
- Howe, D., & Fearnley, S. (2003). Disorders of attachment in adopted and fostered children: Recognition and treatment. *Clinical Child Psychology and Psychiatry, 8*(3), 369–387.
- Lamb, M.E., Gaensbauer, T. J., Malkin, C. M., & Schultz, L. A. (1985) The effects of child maltreatment on security of infant–adult attachment. *Infant Behavior and Development, 8*, 35–45.
- Lyon-Ruth, K., & Spielman, E. (2004). Disorganized infant attachment strategies and helpless-fearful profiles of parenting: Integrating attachment research with clinical intervention. *Infant Mental Health Journal, 25*(4), 318–335.
- Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. Greenberg, D. Cicchetti, & E. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 161–182). Chicago: University of Chicago Press.
- Malinosky-Rummell, R., & Hansen, D. J. (1993). Long-term consequences of childhood physical abuse. *Psychological Bulletin, 114*(1), 68–79.
- Margolin, G., & Gordis, E. B. (2000). The effect of family and community violence on children. *Annual Review of Psychology, 51*, 445–479.
- Pascoe, J., & Earp, J. (1984). The effect of mothers' social support and life changes on the stimulation of their children in their home. *American Journal of Public Health, 74*, 358–360.
- Perry, B. D. (2001). The neuroarcheology of childhood maltreatment: The neurodevelopmental costs of adverse childhood events. In K. Franey, R. Geffner, & R. Falconer (Eds.), *The cost of maltreatment: Who pays? We all do* (pp. 15–37). Binghamton, NY: Haworth Press.
- Perry, B. D. (2002). Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. *Brain and Mind, 3*, 79–100.
- Perry, B. D. (2008). Child maltreatment: The role of abuse and neglect in developmental psychopathology. In T. P. Beauchaine & S. P. Hinshaw (Eds.), *Textbook of child and adolescent psychopathology* (pp. 93–128). New York: Wiley.
- Perry, B. D. (2009) Examining child maltreatment through a neurodevelopmental lens: Clinical application of the neurosequential model of therapeutics. *Journal of Loss and Trauma, 14*, 240–255.
- Perry, B. D., & Hambrick, E. P. (2008). The neurosequential model of therapeutics. *Reclaiming Children and Youth, 17*, 38–43.
- Perry, B. D., & Pollard, R. (1998). Homeostasis, stress, trauma, and adaptation: A neurodevelopmental view of childhood trauma. *Child and Adolescent Psychiatric Clinics of North America, 7*, 33–51.

Buffering the Impact of Childhood Trauma

- Perry, B. D., & Szalavitz, M. (2007). *The boy who was raised as a dog; and other stories from a child psychiatrist's notebook: What traumatized children can teach us about life, loss and healing*. New York: Basic Books.
- Rak, C. F., & Patterson, L. E. (1996). Promoting resilience in at-risk children. *Journal of Counseling and Development, 74*, 368–373.
- Read, J., Perry, B. D., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. *Psychiatry, 64*, 319–345.
- Sanders-Phillips, K. (1997). Assaultive violence in the community: Psychological responses of adolescent victims and their parents. *Journal of Adolescent Health, 21*(6), 356–365.
- Schneider-Rosen, K., Braunwald, K. G., Carlson, V., & Cicchetti, D. (1985). Current perspectives in attachment theory: Illustration from the study of maltreated infants. *Monographs of the Society for Research in Child Development, 50*(1–2, Serial No. 209), pp. 194–210.
- Thompson, R. A. (2002). The roots of school readiness in social and emotional development. In Kaufman Early Education Exchange, *Set for success: Building a strong foundation for school readiness based on the social–emotional development of young children*. (pp. 8–29). Kansas City: Ewing Marion Kaufman Foundation.
- Travis, W. J., & Combs-Orme, T. (2007). Resilient parenting: Overcoming poor parental bonding. *Social Work Research, 31*(3), 135–149.

Trauma-Informed Part C Early Intervention

A Vision, A Challenge, A New Reality

LINDA GILKERSON

Erikson Institute

MIMI GRAHAM

Florida State University Center for Prevention and Early Intervention Policy

DEBORAH HARRIS

*New Mexico Infant Team
Santa Fe, New Mexico*

CINDY OSER

*ZERO TO THREE
Washington, DC*

JANE CLARKE

*First Judicial District Infant Team
Santa Fe, New Mexico*

TODY C. HAIRSTON-FULLER

Baltimore (Maryland) Infants and Toddlers Program

JESSICA LERTORA

University of Maryland School of Medicine's Taghi Modarressi Center for Infant Study/Secure Starts Program

A convergence of compelling evidence has linked traumatic early childhood adverse experiences with a lifetime trajectory of serious mental and physical health problems. Advances in the understanding of trauma such as the landmark Adverse Childhood Experiences Study (Anda et al., 2004) compel early childhood professionals to re-examine traditional systems and practices and bring a trauma lens to the work with young children and families. Nowhere is the need to rethink services more apparent than in the Part C Early Intervention System (which we will refer to as EI), a federal program designed to serve infants and toddlers with disabilities or delays, or who are at high risk of risk of delay. Federal legislation now requires the child welfare system to refer all infants and toddlers with substantiated abuse or neglect to the EI system for an evaluation of need for EI services. Within the diversity of groups eligible within each state's definition, EI also serves other groups of children—such as low birth weight babies and young children with established disabilities—who are at elevated risk for abuse and neglect (Spencer, Wallace, Sundrum, Bacchus, & Logan, 2006; Sullivan & Knutson, 2000) and infants and toddlers with disabilities who may have experienced medical trauma from repeated hospitalizations and painful procedures.

Although EI providers are well-trained to address developmental disabilities and general developmental delay, they are not typically trained to consider the impact of trauma on development and

Abstract

Federal directives require that any child less than 3 years old with a substantiated case of abuse be referred to the early intervention (EI) system. This article details the need and presents a vision for a trauma-informed EI system. The authors describe two exemplary program models which implement this vision and recommend steps which the field can take to move toward a trauma-informed EI.

on relationships. For example, intervention for a language delay in a child who has experienced complex trauma calls for a very different approach than a language delay related to cerebral palsy. Although there are models for trauma-informed child welfare, health care, education, mental health, and juvenile justice, there is not yet a model for trauma-informed EI. In this article, we describe the national policies that link the child welfare system to EI and create the need for states to build trauma-informed EI systems. We briefly review the tenets of trauma-informed systems, present a vision for trauma-informed EI, and describe two program models which illustrate what trauma-informed EI can look like in practice. The article concludes with recommendations to the field to infuse a trauma perspective and trauma expertise into EI.

Policies Supporting Trauma-Informed Early Intervention

TWO PIECES of federal legislation compel states to address trauma-informed EI services: the Individuals With Disabilities Education Act (IDEA, 2004) Part C Program for Infants and Toddlers With Disabilities and the Child Abuse Prevention and Treatment Act (CAPTA, U.S. Department of Health & Human Services, 2010)

Part C Early Intervention and CAPTA

The original intent and the legislative language of Part C EI provide the basis for a collaborative and comprehensive system of services to eligible infants, toddlers, and their families. Part C requires states to serve children who have established conditions or disabilities (e.g., spina bifida, Down Syndrome), but gives states flexibility in defining the criteria for the amount of “delay” necessary for services. As a result, states differ in the amount of delay necessary for EI eligibility, ranging from 20% to 50% delay in one or more areas (Ringwalt, 2012). States are encouraged but not required to serve children at “high risk” of substantial delay. Only six states currently serve at-risk children, despite compelling evidence of the likelihood of delay when multiple risk factors are present (Ringwalt, 2012).

Evidence confirms that infants and toddlers in child welfare are at higher risk for developmental delays. National data shows that 38-65% of infants and toddlers encountered by child welfare have delays (Barth et al., 2008) and up to 82% of maltreated infants will have attachment problems (Goldsmith, Oppenheim, & Wanlass, 2004). A national longitudinal study found that 35% of infants and toddlers needed EI services at the time of contact with child welfare (meeting the strict



Early intervention serves infants and toddlers with disabilities who may have experienced medical trauma from repeated hospitalizations and painful procedures.

criteria of 2 standard deviations of delay; Casanueva, Cross, & Ringeisen, 2008). This high incidence of developmental delays and the potential benefits of EI for children encountering the child welfare system were so compelling that the federal government amended both CAPTA and IDEA to address this unmet need.

CAPTA now requires that states develop “provisions and procedures for referral of a child under age 3 who is involved in a substantiated case of child abuse or neglect to EI services funded under EI of the Individuals with Disabilities Education Improvement Act” (Sec. 106(b)(2)(A)(xxvi); IDEA, 2004) While the definition of “substantiated case” varies from state to state, it typically means that an incident of child abuse or neglect is believed to have occurred. Part C EI contains parallel language to that included in CAPTA and requires that states “. . . must include a description of state policies and procedures that require the referral for EI services ...of a child under the age of 3 who (A) is involved in a substantiated case of child abuse or neglect, or (B) is identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure (Sec. 637 (a)(6)).” CAPTA and EI both require that a child with substantiated abuse or neglect be referred to EI to determine the child’s eligibility for EI services; neither federal law requires the child’s automatic eligibility for EI. The determination of eligibility for services remains the responsibility of the EI system and follows the dictates of the state’s EI eligibility criteria.

Challenges and Successes in Implementing CAPTA Requirements

The parallel requirement in child welfare and EI for referring children with substantiated abuse or neglect for developmental services creates opportunities to strengthen ties between the two programs while presenting challenges to each system. To better understand the challenges from the child welfare perspective, ZERO TO THREE and Child Trends conducted a survey of state child welfare agencies. Data from 46 agencies responding identified the following barriers in implementation: (a) birth parents’ lack of familiarity with EI services and lack of training in identifying developmental needs, (b) need and cost of EI services exceeds that available through current funding, (c) EI staff’s inability to engage children and families in the child welfare system, and (d) transportation and other access-related issues. The survey found that child welfare agencies are addressing these challenges by: (a) collaborating with EI agencies to implement requirements of federal, state, and local laws (36 states); (b) formal information sharing about each system’s policies/procedures (28 states); and (c) clearly delineating the roles/responsibilities of EI and child welfare staff (24 states; Changing the Course for Infants and Toddlers, 2013).

In 2008, a survey of EI state administrators shed light on the experiences of EI staff with referrals of children under the CAPTA requirements (IDEA Infant Toddler Coordinators Association [IITCA], 2008). Thirty states responded to the survey,

ne EI program. At the time of the survey, 0% of states had an interagency agreement or memorandum of understanding with child protective services regarding CAPTA referrals. Survey results indicated that children less than 3 years old involved in substantiated abuse or neglect are routinely receiving developmental screening; the developmental screening was being conducted primarily by EI (44%), but also by child protective services (37%) and others such as state-funded at-risk, follow-up programs, and medical providers. The impact of CAPTA on the numbers of children in EI tended to vary depending on the state's EI eligibility requirements. States with narrow eligibility criteria reported high ineligibility rates among CAPTA-referrals. Survey results also indicated that from 2007–2008, 1% of state Part C systems experienced an increase in referrals from child welfare and 29% experienced a decrease in referrals. Fifty percent of respondents did not know whether there had been an increase or decrease in referrals from child welfare, demonstrating the need for additional effort in data collection and reporting (IITCA, 2008). It is troubling that because of the pressures on state budgets, EI eligibility requirements are becoming more restrictive at the same time that the infant-toddler population is the fastest-growing segment of the child welfare population. These children are highly vulnerable to delays in social, emotional, and cognitive development and are at high risk for special education placement (Scarborough & McCrae, 2008; Wulczyn, Ernst, & Fisher, 2011) and are able to benefit from EI services.

Both the EI and child welfare systems experienced challenges in the implementation of CAPTA—challenges which heightened shortcomings in each system (IITCA, 2008). CAPTA drew attention to the need for and lack of access to community-based infant and early childhood and adult mental health services. CAPTA also emphasized the need for new skills and training for providers in both systems. EI evaluation teams were not familiar with the signs of traumatic stress in infants and toddlers, nor how a trauma history might affect parental involvement in EI services. Child welfare staff and families were not familiar with EI services, nor with identifying developmental needs of infants and toddlers. CAPTA referrals strained states where EI funding was insufficient to respond to new referrals, changes in data collection and reporting, training needs, and other infrastructure requirements. Questions around consent for EI services and participation in the Individual Family

Federal legislation now requires the child welfare system to refer all infants and toddlers with substantiated abuse or neglect to the EI system for an evaluation of need for EI services.

Service Plan process had to be addressed (e.g., biological parents, custodial parents, child protective services; Herman, 2007; IITCA, 2008) and remain unclear in many circumstances.

A focus group study of frontline child welfare and EI professionals in Illinois found many of the same concerns as those articulated at the state agency level: lack of professional preparation to address trauma, absence of trauma screening, limited involvement of biological parents in EI, struggles around eligibility for children without identified disabilities, and funding concerns from fears of flooding the system with referrals of high-risk families (Gilkerson et al., 2012). The focus groups highlighted not only the needs of children who are referred through CAPTA for prior abuse or neglect but also the needs of families and of children who are already in EI for developmental reasons and who experience trauma while in EI (e.g., abuse, neglect, accidents, witnessing violence, and medical trauma).

The study (Gilkerson et al., 2011) found that the potential for retraumatization exists from the EI experience itself for traumatized children when there is a lack of knowledge of a trauma-sensitive approach (e.g., abrupt separation of a child from caregivers to complete an assessment task when that child had recently been removed from the home, asking biological or foster parents to leave the room so the provider can work with the child alone, or routine procedures that can be intrusive such as an oral exam of a child's mouth if conducted without awareness of a child's trauma experience). Barriers to considering trauma were identified: (a) belief that infants and young children are too young to be affected by trauma experiences; (b) reticence of parents to talk about trauma and mental health concerns (and providers reticence to ask) because of the associated stigma and fear their child may be taken away; and (c) lack of preparation and supervision in professionals to address the social-emotional domain in general, not just trauma-related responses and, for some,

part of their role. In addition to an absence of appropriate tools or processes for trauma screening, respondents reported that the approved tools for eligibility determination were not adequate for quantifying social-emotional delays, especially those related to attachment issues, trauma, or both.

Collaborative, Integrated Approach to Addressing Trauma in EI

The requirements in EI and CAPTA provide new opportunities for child welfare and EI to work together to infuse developmental perspectives into child welfare and trauma-informed approaches into EI. Identified positive outcomes of the CAPTA requirements include increased attention to the developmental needs of maltreated infants and toddlers, greater dialogue between EI and child welfare lead agencies, increased opportunities for professional development and training across systems, and most important, more children identified who can benefit by receiving EI services (Herman, 2007; Keller-Allen, 2007). The EI system offers infants and toddlers referred through CAPTA a reliable system with predictable responses and timetable for referrals, home-based services easily accessible for families, interventions from a range of disciplines and linkages with other services in the community; and lastly, EI “often goes the extra mile to help a child or family” (Gilkerson et al., 2011).

The U.S. Department of Health and Human Services issued a joint guidance letter intended to “encourage the integrated use of trauma-focused screening, functional assessments and evidence-based practices in child-serving settings for the purpose of improving child well-being” (U.S. Department of Health and Human Services, 2013, p. 1). Issued in partnership with the Administration for Children and Families, Centers for Medicare & Medicaid Services, and Substance Abuse and Mental Health Services Administration, the letter acknowledged the impact of trauma on health and development, affirmed the collaborative approach to effectively address complex trauma, and provided essential financing information to state program directors. The stage was set for a new integration of a trauma-informed approach with the philosophy and practices of EI.

Vision for a Trauma-Informed EI System

THE NATIONAL CHILD Traumatic Stress Network (NCTSN) defined a trauma-informed child- and family-service system as:

respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family. NCTSN Trauma-Informed Service Systems Working Group, 2012).

NCTSN described the characteristics of trauma-informed systems as:

- (1) routinely screen for trauma exposure and related symptoms;
- (2) use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms;
- (3) make resources available to children, families, and providers on trauma exposure, its impact, and treatment;
- (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma;
- (5) address parent and caregiver trauma and its impact on the family system;
- (6) emphasize continuity of care and collaboration across child-service systems; and
- (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.” (NCTSN Trauma-Informed Service Systems Working Group, 2012)

Building on these characteristics of a trauma-informed system and the focus group study of EI and child welfare (Gilkerson et al., 2011), Gilkerson (2012) presented a vision for the elements of a trauma-informed EI system. The first two essential elements relate to the philosophy of EI which guides the approach for the all children in EI; the remaining elements are trauma-specific.

FOR ALL CHILDREN IN EI AND THEIR FAMILIES

- **EI Values:** Rests on the values of an individualized, family-centered, relationship-based, child-sensitive, culturally responsive approach for all children in EI.
- **Social-Emotional Competence:** Fully recognizes the social-emotional domain as one of the five developmental areas specified under Part C EI, implements procedures to identify eligibility for services in the social-emotional domain, and provides intervention services to address social-emotional developmental delays.



Although there are models for trauma-informed child welfare, health care, education, mental health, and juvenile justice, there is not yet a model for trauma-informed early intervention.

FOR CHILDREN EXPOSED TO TRAUMA AND THEIR FAMILIES

- **Unique Needs:** Views children who are impacted by trauma as having unique needs which must be considered at each phase of the EI process. EI recognizes and responds to the special impact of trauma—both interpersonal and medical trauma—on an infant or toddler’s development and uses a trauma-sensitive lens and adequately trained professionals to understand (a) risks to the child’s development and family relationships and (b) how to intervene to promote developmental growth.
- **Broad Eligibility:** Uses a definition of EI eligibility broad enough to include infants and toddlers with developmental delays associated with trauma exposure and with multiple environmental risks; formal procedures for informed clinical opinion are in place and used to help with eligibility determination.
- **Trauma Screening:** Routinely screens for trauma exposure and related symptoms at intake and throughout the EI process; medical trauma is assessed at intake and again when hospitalizations and painful procedures occur. Providers respect the family boundaries around trauma and seek to create a safe, trusting relationship in which trauma experience can be shared, understood, and considered in the EI process.
- **Priority on Emotional Safety:** Places priority to the child’s emotional safety and the need for co-regulating caregivers during all aspects of EI: intake, assessment, and service provision; avoids retraumatizing the child; and helps the child gain or regain competence derailed through trauma.
- **EI Trauma Specialists:** Includes professionals in EI with trauma-specific expertise such as infant mental health specialists with trauma-training; these specialists can provide trauma-informed evidence-based services to infants, toddlers, and families; collaborate with other EI providers to integrate trauma-related and developmental services; and help develop the capacity of other providers to work from a trauma-informed perspective.
- **Trauma Training, Consultation, and Reflective Supervision:** Infuses and sustains a trauma awareness, knowledge, and basic skills in all EI professionals through training, reflective supervision, and consultation; training is not one-time but over time with opportunities for reflective supervision and case consultation; at a minimum, all managers, service coordinators, and providers receive awareness training in trauma and trauma-informed practices; follow-up training, consultation, reflective supervision, or a combination of these are provided by trauma-trained, infant mental health specialists or consultants. Because trauma affects regulation, cognition, and language, special provisions

are made to ensure that developmental specialists, occupational therapists, and speech and language pathologists receive trauma training and consultation.

- **Involvement of All Caregivers:** Biological parents and foster parents are able to be involved in the child's evaluation and service delivery. Providers receive special training to work with all caregivers.
- **Coordination of EI Services:** Coordinates services between EI disciplines to ensure the smooth integration of services; considers reducing the numbers of professionals involved to provide security and continuity for the child and family; co-treatment between developmental professionals and infant and adult mental health providers is planned and provided; infant mental health provider is available to provide reflective consultation to the developmental professional on cases that are shared.
- **Interagency Agreements:** Implements coordinated, statewide interagency agreements between the child welfare agency and EI lead agency to effectively implement CAPTA requirements; expands these state agency partnerships to include mental and behavioral health, health, and the court system; state level partnerships create funding mechanisms to cover staff development, coordination, and reflective supervision needed for trauma work.
- **Community Partnerships:** Develops innovative partnerships at the community level between EI, mental health, health, and child welfare to provide side-by-side, collaborative services; partners with community-based mental health and social service agencies to engage families in other services to expand the intervention services and address the impact of trauma
- **Secondary Trauma:** Provides ongoing supports and reflective supervision to EI professionals to manage professional and personal stress in working with infants and toddlers with developmental issues who have been affected by trauma and their families and to build their resilience and competency.

Trauma-Informed EI in Practice

IN THIS SECTION, we describe two existing programs which illustrate the vision for trauma-informed EI. The first model, in Baltimore, Maryland, describes the effort of an EI program to infuse a trauma-informed, infant mental health framework into its screening, assessment, and referral practices. The second model, the New Mexico Infant Team approach, exemplifies a comprehensive

The original intent and the legislative language of Part C EI provide the basis for a collaborative and comprehensive system of services to eligible infants, toddlers, and their families.

interagency, transdisciplinary, collaborative model which fully merges EI and mental health in collaboration with child welfare and the court system.

Baltimore Infants and Toddlers Program

Beginning in 2011, Baltimore City Department of Health, the lead agency for EI in Baltimore, has made the integration of EI and early childhood mental health a priority. This priority led to the development of a trauma-informed EI program which is a partnership between Baltimore Infants and Toddlers Program (BITP), an interagency EI program serving more than 900 infants and toddlers in Baltimore City, and the University of Maryland School of Medicine's Taghi Modarressi Center for Infant Study (CIS)/ Secure Starts program, an agency with a long history of providing infant mental health training, consultation, and direct services to young children and families. Developed by Tody C. Hairston-Fuller, BITP coordinator of evaluation and assessment, and Jessica Lertora, associate director from CIS, the model integrates trauma screening into the eligibility process for all children referred to EI, including those referred through CAPTA. On the basis of screenings and assessment, referrals are made for infant mental health consultation or treatment depending upon need. A central feature of the Baltimore program is the strong foundation that the EI professionals have in trauma and infant mental health. The EI services are funded by the EI agency; the infant mental health services are funded by EI funds via a contract with the CIS Program.

STAFFING

The BITP program includes the director, service coordinators, and the full array of EI disciplines with the addition of a developmental pediatrician. The coordinator of evaluation and assessment oversees the evaluation process and integrity of referral process. CIS provides a trauma-trained,

infant and early childhood mental health consultant who has provided consultation with the EI program in different capacities over the past 5 years. Her role includes providing staff training, participating in the review of the trauma screenings, and providing referral sources and services to the CAPTA-referred EI families who need infant mental health consultation or treatment. She also participates in a special evaluation team which focuses on helping to assess children with specific social-emotional concerns.

Through the partnership with CIS, all service coordinators have been trauma trained. They understand how trauma affects development, can recognize the symptoms of trauma, and are confident with helping families through the referral process. The CIS and the University of Maryland School of Medicine's Department of Child and Adolescent Psychiatry also offers an Early Childhood Mental Health Certificate Program which highlights trauma as a vital part of the core curriculum. All the EI administrative staff and team leaders have received this certification, which allows everyone on the staff to aid the service coordinators around family and child needs and with next steps in referrals when the CIS therapist is not present.

REFERRAL TO SERVICES

Baltimore has a single point of entry for all children referred to EI, inclusive of those in the foster care system. The foster care children referred through CAPTA receive a developmental evaluation using the *Battelle Developmental Inventory, 2nd edition* (Newborg, 2004). If they are eligible for Part C, they receive an *Ages and Stages: Social Emotional Questionnaire (ASQ: SE; Squires, Bricker, & Twombly, 2003)* and a six-question trauma screen.

TRAUMA SCREENING

The program developers reviewed a range of trauma screeners and chose a two-part screener, adapted from the *Young Child PTSD Screener* (Scheeringa, 2011) for use in the EI evaluation process. The screening assesses the child's exposure to trauma and the trauma impact. To assess trauma exposure, the service coordinator asks the current caregiver (e.g., biological parent, grandparent, foster parent) a series of questions about trauma (e.g., has the child been a witness to violence [inside or outside the house], had a severe adjustment to illnesses, been attacked by an animal, or experienced natural disasters). To assess the impact of trauma on the child, the service coordinator asks the following six questions, each scored on a 3-point scale from none, a little, to a lot.

1. Does the child have intrusive memories of the trauma? Does s/he bring it up on his/her own?
2. Is your child having more nightmares since the trauma occurred?
3. Does s/he get upset when exposed to reminders of the event (s)?
4. Has s/he had a hard time falling asleep or staying asleep since the trauma?
5. Has your child become more irritable, or had outbursts of anger, or developed extreme temper tantrums since the trauma?
6. Does your child startle more than before the trauma? (For example, if there's a loud noise or someone sneaks up behind him/her, does s/he jump or seem startled?) (Scheeringa, 2011, p.1)

For very young children, the service coordinators review the medical passport from the Department of Social Services and talk with foster parents to understand the child's exposure to trauma and its impact. At this point, the trauma screening is provided only at the initial eligibility; follow-up screening is not currently provided. Providing routine follow-up screening at the 6 month IFSP reviews would ensure that each child is rescreened, avoiding the likelihood of missing a child affected by trauma. Repeated screening would also help uncover how a child's symptoms are affected through developmental gain or regression, in addition to perhaps identifying the possibility of new traumas occurring.

SERVICES PROVIDED

On the basis of the screening scores, the impact of the trauma is categorized in three tiers, each with a different referral response.

- **Tier 1:** Child passes trauma screen and ASQ: SE (Squires et al., 2003)—Child receives follow-up service coordination and relevant EI services
- **Tier 2:** Child fails ASQ: SE and passes trauma screen—Child may receive up to 6 sessions of consultation visits from a CIS infant mental health therapist and relevant EI services
- **Tier 3:** Child does not pass ASQ: SE and has positive endorsement for trauma screen—The child is referred to CIS therapist for infant mental health intervention services, including—but not limited to—mental health consultation (6–8 sessions), or infant mental health treatment (up to 1–2 times/week until the child ages out of EI), or referral to a more intensive mental health intervention or program.



Photo: ©iStockphoto.com/JANI BRYSON

Although EI providers are well-trained to address developmental disabilities and general developmental delay, they are not typically trained to consider the impact of trauma on development and on relationships.

Information is sought from the EI providers in efforts to attain a fuller picture of the child within the context of the family. However, the EI and infant mental health providers do not interact regularly, but can co-treat if needed.

NICOLE'S STORY

Nicole was a 14-month-old toddler, part of a sibling group who were referred to child welfare for neglect and abandonment. Nicole was in the care of a foster mother who had strong concerns about her inconsolability; Nicole cried endlessly and, after 2 months, she had not shown any connection to her foster mother. Nicole was referred to BITP and found eligible for EI because of delays in adaptive behavior with feeding problems (e.g., she would not take textured solid foods) and social-emotional concerns, as she did not pass the ASQ: SE (Squires et al., 2003). The trauma questionnaire was completed by the foster mom, who reported that Nicole had difficulty with sleeping and significant hypersensitivity to noise. These findings cued the EI service coordinator to contact protective services and learn more about Nicole's early birth history as well as the months just prior to placement. Nicole's history revealed significant periods of abandonment, including the children being found alone.

Because Nicole did not pass the ASQ: SE (Squires et al., 2003) and had a trauma history with significant symptoms, she was considered a Tier 3 referral. In addition to EI occupational therapy services for oral motor

and feeding skills, she received a referral to an intensive feeding clinic which required daily attendance for 6 weeks. A referral to the CIS infant mental health specialist for home-based infant mental health services was made to address the attachment and relationship concerns and to facilitate Nicole's ability to interact with her peers. The foster parent and child were involved in each of the sessions with the infant mental health specialist, who used a Child-Parent Psychotherapy approach (Lieberman & Van Horn, 2008) to this family's needs. Treatment focused on goals which included reducing the child's inconsolability, increasing the foster parent's feelings of effectiveness in caring for Nicole, and psycho-education around the effects that neglect may have had in Nicole's life, all in the context of play and focusing on building the dyadic relationship between caregiver and child. After receiving EI, including infant mental health services for 9 months, Nicole was functioning at her developmental level and was no longer eligible for special education services when she turned 3 years old. Nicole was adopted by her foster mother and has maintained regular visits with her siblings. Follow-up with her adoptive parent after Nicole turned 3 revealed that Nicole continues to attend weekly playgroups at the local library and interacts with her peers with ease. Her mother reports that Nicole is loving, affectionate, and seems to never get enough of "Mommy's Love." It was noted that Nicole does take time to warm up to strangers, but looks to Mom for reassurance that all is well.

SUCCESS OF THE MODEL

The model provides a universal trauma screening for all children referred to EI. Because all children in foster care are screened, the program ensures the likelihood that no trauma experienced from a substantiated case of abuse or neglect will be unattended. Children receive EI developmental services depending on their individual needs and, as appropriate, they receive infant mental health services or referrals to address attachment relationship and social/emotional/behavioral concerns. This is the CAPTA and IDEA legislation in action. The commitment of the Department of Health has been instrumental in the success of this program, first prioritizing the integration of EI with infant mental health and then standing behind their priority with funding for staff training in infant mental health, trauma screening, and contracting with CIS for infant mental health services to supplement EI. The partnership with CIS has provided EI with the expertise in infant mental health which was integral to implement the Department's vision for integrated services. While the program is funded by the Part C allotment to the state, these funds do not fully cover special projects that are designed to enhance service provision. Special projects, like the trauma screening and follow-up infant mental health home visiting services, are vulnerable to budget cuts when resources tighten and funds are needed to provide basic EI services mandated by law. Again, strong lead agency support is key to the sustainability of the model.

New Mexico Infant Team

New Mexico is one of the six states whose EI eligibility includes an at-risk category. If an infant or toddler does not qualify with the requisite percentage of delays, New Mexico providers have an option to qualify children who are in protective custody for EI through the state's at-risk criteria. Since 2009, New Mexico has implemented an inter-agency, transdisciplinary, Infant Team model program linking EI with three other state systems: (a) child protection, (b) behavioral (mental) health, and (c) the family courts. The goal of the New Mexico Infant Teams is to provide infants in state custody with a coordinated, trauma-informed, and developmentally based process for assessment, early developmental intervention, and mental health treatment to promote safety, permanency planning, and positive developmental outcomes (Clarke & Harris, 2013). Funding for the Infant Teams is provided by the New Mexico Department of Children, Youth and Families where Child Protection is housed. EI services are funded by the Department of Health through a Memorandum of Agreement that specifies the mutually

After receiving EI, including infant mental health services for 9 months, Nicole was functioning at her developmental level and was no longer eligible for special education services.

agreed-upon responsibilities and collaborative protocols for the model.

Like the Baltimore model, the New Mexico Infant Teams were developed by leaders, Deborah Harris and Jane Clarke, who had extensive experience in EI and infant mental health. Guided by the principles of infant mental health and developmental intervention, the Infant Team model does not infuse one approach into the other; rather, the model conceptualizes the fields of early developmental intervention and infant mental health treatment as two equal parts that together create a sum greater than the individual components.

STAFFING

Although the staffing differs by region, typically the Infant Team includes: (a) a director(s) with a background in infant mental health and early intervention who supervises all aspects of the Infant Team, including providing clinical and reflective supervision, (b) a coordinator who is the liaison with Child Protective Services, (c) infant mental health specialists who provide the infant and parent mental health treatment, and (d) EI providers assigned to the Infant Team: a service coordinator, developmental specialist, and occupational therapist or speech and language pathologist. The EI providers have specialized training and reflective supervision focused on trauma-informed care.

REFERRAL TO SERVICE

Referral to the Infant Team starts with the CAPTA referral from Child Protective Services which goes simultaneously to the Infant Team coordinator and to the EI program. The EI developmental evaluation is put on a fast track and is completed by the Infant Team EI staff within 1 to 2 weeks of the referral. By federal guidelines, EI evaluations can take up to 45 days from referral. The shortened time frame for an evaluation responds to the infant's needs during a stressful period

and provides important, timely information to Child Protective Services and the courts during the initial adjudicatory process. Rapid response to the CAPTA referral, prompt development of the IFSP, and immediate initiation of services are critical to address the effects of trauma and essential to trauma-informed EI.

SERVICES OFFERED

The Infant Team provides a braided array of developmental and mental health services including:

- Developmental assessment provided by Infant Team EI providers.
- EI service coordination provided by the Infant Team EI service coordinator, including facilitation of IFSP development with the child protective worker, foster parent(s), biological parent(s) and infant mental health specialist and mid-year/annual IFSP reviews. The service coordinator has an expanded role and is part of the Child Protection and Infant Team meetings, provides input into the monthly court report, and works in tandem with the infant mental health specialist to coordinate developmental services through a trauma-informed lens.
- Parent-child relationship assessment conducted after the EI developmental assessment by Infant Team infant mental health specialists. The assessment includes the *Crowell Parent-Child Interaction Procedure* (Crowell, Feldman, & Ginsberg, 1988), parent perception and reflective functioning interviews such as the *Working Model of the Child Interview* (Zeanah & Benoit, 1995), and other protocols (e.g., Traumatic Events Screening Inventory-Parent Report Revised; Gosh-Ippen et al., 2002; and the *Neurosequential Model of Therapeutics Metrics*; Perry, 2006).
- EI developmental services as outlined in the IFSP are offered by the EI providers and include co-treatment with the infant mental health specialist.
- Parent-child dyadic psychotherapy with the biological parent(s) and child provided by the infant mental health specialist. The IFSP developmental interventions addressing the child's specific needs are incorporated into the dyadic work with primary caregivers as well as provided in separate sessions with the parent, foster parent, and child. Therapeutic supervision of visits may also be included.
- Family Court education and liaison provided by the infant mental health

specialists; this includes educating the judges about infant's response to trauma, family risk factors, and the current needs of the particular infant in custody (e.g., relationship and interaction patterns, placement recommendations, visitation arrangements, EI services, and medical condition and medical needs). The team provides regular reports to the court and expert witness testimony on behalf of the infant.

- **Infant Team liaison with Child Protective Services:** The Infant Team works closely with Child Protective Services on treatment plan development and case coordination. The Infant Team coordinator provides regular and comprehensive reports to Child Protective Services in addition to monthly provider meetings (specific to each case) and ongoing contact about status of each case.

The Infant Team meets twice a month for 3 hours to discuss organizational issues, staff and assign cases, and participate in reflective supervision

TWEETY'S STORY

Tweety was a toddler who came into custody when she was 14 months old. Tweety, a nickname her parents gave her, and her younger sister, who was 4 months old at the time, were removed from their parent's home because of unexplained injuries to the infant. During the initial investigation, the mother disclosed an extensive history of domestic violence and substance abuse by the children's father. The girls were placed in kinship foster care.

During initial visits and assessments, Tweety cried, whined, and grunted continuously, looking down or into space but not making eye contact with the staff or either of her parents, who visited separately. She sucked vigorously on a pacifier much of the time and did not respond to most of the attempts that her parents or other caregivers made to soothe, engage, or distract her. She was so distressed that the initial EI developmental evaluation could not take place and was rescheduled for a later time at the foster home. Tweety's inconsolability and disengagement were difficult for her parents as well as her foster parents and challenged the professionals who attempted to evaluate her. All of the adults—parents, foster parents, grandparents, Infant Team Staff, Child Protective Services staff, Court-Appointed Special Advocate workers, and other involved parties—experienced personal activation regarding the children's situation. Both of these very young girls had experienced trauma in a number of forms



PHOTO: © IStockPHOTO.COM/NUMBEOS

Advances in the understanding of trauma compel professionals and policymakers to once again rethink EI policies and practices

and were demonstrating significant signs of distress and dysregulation. How to address and intervene when the adults are also distressed and dysregulated became a focus of the Infant Team staffings for Tweety and her infant sister.

During the EI developmental evaluation, Tweety showed delays in motor, language, and social-emotional and regulatory domains. In the infant mental health interactive evaluation session with her mother, Tweety was not engaged and did not use any language at 17 months old. She did not show particular interest in the toys or activities. She did not look at her mother for much of the procedure, nor did she explore the environment. For most of the session, Tweety was stationary or lay in her mother's lap. When her mother began to talk to the Infant Team staff about her situation and upcoming court appearance, Tweety became very focused on her mother's tearful face and sucked more intensely on her pacifier as she continued to watch her mother. The mother was sharing her sorrow and guilt at not protecting her children from the domestic violence and her fear of future repercussions. When the mother occasionally looked down at Tweety, the little girl covered her face with her blanket or looked away.

The Infant Team's service plan was to integrate social-emotional, relational, and developmental services for Tweety with the therapeutic supervised parent visits and parent-child psychotherapy for Tweety and her caregivers. The services included occupational and speech and language therapy as well as infant mental health. The

goals for the work with Tweety's parents were three-fold: (a) help them to see and to acknowledge their children's developmental and emotional challenges, (b) explore and manage their own dysregulation and distress in response, and (c) make behavioral changes in their responses to and support of their daughter's needs. All team members were trained in the advanced Circle of Security or the Circle of Security DVD-P® (2010) and used the terminology and imagery of Circle of Security with the parents to help the parents observe and communicate about their child's needs

Developmental and infant mental health goals were integrated into a treatment plan. The occupational therapist worked closely with the speech-language consultant and the infant mental health supervisor to develop strategies that would help both the parent(s) and the child with their arousal system activation, which was interfering with the parent(s) and child's capacity for mutually responsive and satisfying interactions. The misattunement between the parents and child, in turn, was not supporting Tweety's developmental progress. The next section outlines the kinds of interventions designed to address Tweety's trauma-related dysregulation and to promote attuned interactions between the parent(s) and child. These goals and interventions blend developmental, relational, psychotherapeutic, and body-based approaches.

- Provide Tweety with patterned, repetitive somatic activities to entrain more rhythmic regulation. Tweety's frustration, stress reactivity, inattention, and

sleep disturbances originate from problems in the brainstem and diencephalon likely due to her ongoing exposure to intense domestic violence and stress. Because cognitive interventions do not change lower areas of the brain, rhythmic interactions through movement and music will provide Tweety with the patterned, repetitive stimulation these brain areas need.

- Tweety may have distorted templates and biases about what nonverbal cues mean. The brain makes new memories only for novel experiences. In order to help Tweety build a sense of safety in her relationship with her father, the team supported her father to create new experiences with Tweety that allowed her to feel safe, confident, and appreciated; build awareness of Tweety's regulatory and emotional needs; and suggest new shared experiences and support the father with pacing, tone of voice, and sharing in play.
- The most effective communication is synchronous verbal and nonverbal, a combination of words connected to affect and matching actions. When words do not match the facial expression, Tweety will trust the facial expression. When Tweety experiences inconsistency between the words, affect, and the actions, she will feel confused. Help her parents understand how to communicate with their eyes, smiles, touch, voices, and the consistency of their actions.
- Help parents to learn how to narrate their actions and become a "play-by-play" announcer, showing her how to put words to Tweety's and their own actions, feelings, and thoughts.
- Novelty activates the stress response and because of Tweety's experiences, even the tiniest little stimulation causes her to have a big reaction. Help her to become less reactive through using smooth movements, clear facial expressions, calm speech, and slow actions to help her to lower her high arousal level.

These intricate interventions are not a simple matter in the best of circumstances and a very complicated order when considering individual histories of trauma and high levels of activation and arousal due to the current traumatic situations (e.g., injuries, removal, court hearings, separations, conflict, and substance abuse and domestic violence issues). For example, the team had a lengthy discussion about Tweety's constant use of her pacifier and about the strong desire on the part of EI team members to discourage the use of the pacifier in order to promote

When a system or program takes the step to become trauma-informed, every component is assessed and potentially modified to include a new trauma lens.

speech development. During reflective supervision, the team was able to discuss their own "presses" around the use of a pacifier as well as the meaning or need for Tweety to use her pacifier as a regulatory tool at this time.

Both of Tweety's parents successfully completed their individual court-ordered programs (domestic violence and substance abuse treatment); they each individually completed the Circle of Security DVD Parenting (2010) and repeated it as co-parents. Both Tweety and her younger sister made significant developmental gains in motor, regulatory, and social-emotional domains. Both girls and were reunified with their parents, who agreed upon a co-parenting plan, and the case was deemed a "wonderful success" by the family court judge.

SUCCESS OF THE MODEL

The Infant Team has received positive recommendations from all parties, including the biological parents, guardian ad litem, children's court attorneys, and Court Appointed Special Advocate. All have stated that since the Infant Team has been involved, the nature of the legal cases has changed and the information regarding the infant's experience and needs are now brought to the forefront during court hearings. Initial evaluation of the model shows fewer no-shows, more involvement with EI services, and in New Mexico more voluntary relinquishments (vs. court-ordered termination of parental rights). The Children, Youth and Families Department has developed a new database to track outcomes which will help the Infant Teams assess progress and challenges. New Mexico now has Infant Teams in four judicial districts. The Children, Youth and Families Department is funding on-going consultation and a community of practice for all of the Infant Teams. EI has recently approved increased hours for collaborative and transdisciplinary consultation, which allows the EI staff to bill for Infant Team meetings and consultation.

IMPLEMENTING THE VISION

Both of the Baltimore and New Mexico programs exemplify the vision for a trauma-informed EI system and the promising outcomes achieved. The programs embrace

a relationship-based approach to EI and have complemented the developmental expertise of EI with trauma-informed expertise in infant mental health. EI staff receive training in trauma and reflective supervision to support the integration of the new concepts into practice. Community collaborations play a central role in helping families receive the specialized services needed. Clearly, the leadership from the funding agencies is essential in making trauma-informed EI a reality.

Summary and Recommendations

JUST AS EI has benefited from major paradigm shifts over the years—from child-centered to family-centered, relationship-based practices; from medical models to natural environments—advances in the understanding of trauma compel professionals and policymakers to once again rethink EI policies and practices. This article has proposed a vision for a trauma-informed EI system-building on the federal policies that link the child welfare system to EI and frameworks around trauma-informed systems. The impressive work of the NCTSN in developing resources for trauma-informed systems and the pioneering work of the New Mexico Infant Team and the BITP provide inspiring examples of what is possible for children and families when trauma is assimilated into EI systems. The wealth of science and promising practices can guide the next steps.

Experience from previous paradigm shifts also provides the wisdom to know that system change is not quick, nor easy; that it has to come from top down and bottom up; and that all aspects of the system must share the vision. When a system or program takes the step to become trauma-informed, every component is assessed and potentially modified to include a new trauma lens. At the program level, professionals can begin by simply asking the question: "Have I considered whether trauma has played a role in the child's development and behavior?"

At the system level, there are also steps that could lead to a more trauma-informed system. Some of these might include:

- NCSTN might develop a work group on trauma and EI, creating a toolkit for a trauma-informed EI system similar to their valuable materials for trauma-informed child welfare systems.
- Council for Exceptional Children Division for Early Childhood might include a trauma perspective in their revision of the *Recommended Practices in Early Intervention/Early Childhood Special Education* (Sandall, Hemmeter, Smith, & McLean, 2005).

- ZERO TO THREE, in partnership with other national organizations, could provide direction for policy action steps for trauma and EI in a document such as the policy recommendations made in *A Call to Action on Behalf of Maltreated Infants and Toddlers* (American Humane Association, Center for the Study of Social Policy, Child Welfare League of America, Children's Defense Fund, & ZERO TO THREE, 2011).
- The U.S. Department of Education Office of Special Education Programs (the federal agency responsible for Part C), and the U.S. Department of Health and Human Services Administration for Children, Youth and Families (the agency responsible for child welfare policy) might jointly convene key stakeholders from federal and state government, parent advocacy and professional associations, national experts, and interested foundations to identify issues, review relevant data, and identify areas of innovation and joint recommendations for the field related to trauma and EI.
- Federal agencies funding trauma-related projects can specifically include Part C EI in their requests for proposals; training and research initiatives funded by the Office of Special Education Programs could include projects related to early childhood trauma.
- Part C Statewide Training Systems can offer foundational training in trauma for EI service coordinators and providers; they can develop reflective consultation groups for EI providers facilitated by infant mental health specialists with trauma training.
- State Early Intervention Interagency Coordinating Councils can review the vision for Trauma-Informed Part C presented here and begin to assess the needs and opportunities at the local and state levels to move toward a trauma-informed system.

Creating a new vision, a trauma-informed vision, for Part C EI has already begun. Federal legislation, state policies, and program practices are beginning to acknowledge and address child and family development using the knowledge of brain development, the impact of adverse early experiences, and trauma research. We hope that by sharing examples of what trauma-informed care looks like in practice, and by proposing a

trauma-informed framework for Part C EI, this vision will become more of a reality for the many infants and toddlers affected by trauma and who could benefit greatly from EI. The need is compelling; the science irrefutable; and the opportunity is at hand to elevate trauma-informed practices into EI systems. 🌱

LINDA GILKERSON, PhD, LSW, professor, Erikson Institute, directs the Irving B. Harris Infant Studies Program, the Infant Mental Health Certificate Program, and is founder and executive director of the Fussy Baby Network®, a national model preventive intervention program. Dr. Gilkerson has served on Illinois' State Early Intervention Coordinating Council, co-lead a state-wide initiative to add a social-emotional component to the Illinois EI system, and directed multiple federally funded training and research grants related early intervention. Dr. Gilkerson is on the Board of Zero to Three.

MIMI GRAHAM, EdD, is director, Florida State University (FSU) Center for Prevention & Early Intervention Policy. Dr. Graham specializes in policy, training, and special projects for vulnerable infants and toddlers including: The Harris Infant Mental Health Training Institute, FSU Early Head Start, The Young Parent Project, Child Welfare Community Collaboration, and the Partner's For A Healthy Baby Home Visiting Training Institute. Dr. Graham is president of the Florida Association for Infant Mental Health and is spearheading "baby" court teams to address the trauma of young children in the state. She is a fellow of ZERO TO THREE: National Center for Infants, Toddlers, and Families.

DEBORAH HARRIS, MSW, Endorsed Infant Mental Health Mentor, created and directs the First Judicial District Infant Team and trains and consults with the New Mexico Infant Team initiative. Deborah has a master's degree in social work from the University of California, Berkeley. She trained in infant-parent psychotherapy at the Infant Parent Program, started by Selma Fraiberg. Deborah completed a post-graduate fellowship in family therapy and is certified in the advanced Circle of Security (COS) assessment and treatment protocol and is an Endorsed COS DVD trainer and consultant. Deborah has completed the 3-year Train the Trainers Neurosequential Model of Therapeutics developed by Dr. Bruce Perry. She is a graduate Fellow of the ZERO TO THREE Leadership Development Initiative. She is endorsed through the New Mexico Association for Infant Mental Health as a level 4 infant mental health mentor and practice leader.

CINDY OSER, RN, MS, is director of Infant-Early Childhood Mental Health Strategy, ZERO TO THREE Policy Center. Ms. Oser has more than 30 years of experience in pediatric nursing, public health, early intervention for infants and toddlers with disabilities, and early childhood policy. She has been with ZERO TO THREE since 1998 and currently staffs the DC:0-3R Revision Task Force as well as providing technical assistance to state early childhood systems. She is the author of many publications, including America's Babies: The ZERO TO THREE Policy Center Data Book (2003), Making It Happen: Overcoming Barriers to Providing Infant-Early Childhood Mental Health (2012) and most recently, Nurturing Change: State Strategies for Improving Infant and Early Childhood Mental Health (2013). Ms. Oser also served on the national board of the Division for Early Childhood (DEC), Council for Exceptional Children, from 2008-2011, and she continues to lead the DEC Policy Special Interest Group (SIG).

JANE CLARKE, PhD, is the co-director of the First Judicial District Infant Team. Jane has a master's in speech/language pathology and a doctorate in special education specializing in early childhood language/learning disabilities. She has done post-graduate work at Fielding University and at the University of Massachusetts in Infant Mental Health with Dr. Ed Tronick as mentor, and is a trainer of the Bruce Perry Neurosequential Model of Therapeutics.

TODY C. HAIRSTON-FULLER, MS, coordinator of evaluation and assessment, Baltimore City Infants and Toddlers Program, has more than 20 years of experience in early intervention. She received her certification in early childhood mental health from the University of Maryland's Department of Child and Adolescent Psychiatry and currently directs the mental health component for the local Part C Program.

JESSICA LERTORA, MSW, LCSW-C, is the associate director and lead clinician for the Taghi Modarressi Center for Infant Study (CIS): Secure Starts program. Over the past 8 years she has been providing early childhood mental health therapeutic and consultation services to families with infants, toddlers, and preschoolers in Head Start, Early Head Start, Part C and outpatient clinical settings specializing in trauma and grief and loss. Jessica is a National Endorsed Trainer for Child Parent Psychotherapy and has completed training as a Parent Coach for the Attachment, Bio-Behavioral Catch-Up model.

References

- AMERICAN HUMANE ASSOCIATION, CENTER FOR THE STUDY OF SOCIAL POLICY, CHILD WELFARE LEAGUE OF AMERICA, CHILDREN'S DEFENSE FUND, & ZERO TO THREE. (2011). *A call to action on behalf of maltreated infants and toddlers*. Retrieved from www.zerotothree.org/child-development/health-nutrition/childwelfareweb.pdf
- ANDA, R. F., FLEISHER, V. I., FELITTI, V. J., EDWARDS, V. J., WHITFIELD, C. L., DUBE, S. R., & WILLIAMSON, D. F. (2004). Childhood abuse, household dysfunction, and indicators of impaired adult worker performance. *The Permanente Journal*, 8(1), 30–38.
- BARTH, R. P., SCARBOROUGH, A. A., LLOYD, E. C., LOSBY, J. L., CASANUEVA, C., & MANN, T. (2008, April). *Developmental status and early intervention service needs of maltreated children: Final report*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.
- CASANUEVA, C. E., CROSS, T. P., & RINGEISEN, H. (2008). Developmental needs and individualized family service plans among infants and toddlers in the child welfare system. *Child Maltreatment*, 13, 245–258.
- Changing the Course for Infants and Toddlers: A Survey of State Child Welfare Policies and Initiatives*. (2013). Retrieved September 27 from www.zerotothree.org/cwsurvey
- CIRCLE OF SECURITY PARENTING®. (2010). Retrieved from <http://circleofsecurity.net/seminars/parenting-training>
- CLARKE, J., & HARRIS, D. (2013). *Handbook and Guidelines for New Mexico Infant Teams*. State of New Mexico Children, Youth, and Families Department.
- CROWELL, J. A., FELDMAN, S. S., & GINSBERG, N. (1988). Assessment of mother-child interaction in preschoolers with behavior problems. *Journal of the American Academy of Child & Adolescent Psychiatry*, 27(3), 303–311.
- GILKERSON, L. (2012). *Vision statement: Trauma-Informed Part C Early Intervention System*. Erikson Institute: Unpublished manuscript.
- GILKERSON, L., CEREZCI, B., EVENSON, A., KEISER, D., MALDONALDO, L., SPARR, M., & ZHANG, Y. (2011). *Trauma-informed Part C early intervention: Services, challenges, and initial recommendations*. Erikson Institute: Unpublished document.
- GOLDSMITH, D. F., OPPENHEIM, D., & WANLASS, J. (2004). Separation and reunification: Using attachment theory and research to inform decisions affecting the placements of children in foster care. *Juvenile and Family Court Journal*, 55(2), 1–13.
- GHOSH IPPEN, C., FORD, J., RACUSIN, R., ACKER, M., BOSQUET, M., ROGERS, K., ... EDWARDS, J., (2002). *Traumatic Events Screening Inventory–Parent Report Revised*.
- HERMAN, B. (2007) CAPTA and early childhood intervention: policy and the role of parents. *Children & Schools*, 29(1), 17–24.
- IDEA INFANT TODDLER COORDINATORS ASSOCIATION (2008). *ITCA CAPTA Survey Results*. Retrieved from www.ideainfanttoddler.org/pdf/ITCA_CAPTA_Survey_Results_2008.pdf
- INDIVIDUALS WITH DISABILITIES EDUCATION IMPROVEMENT ACT. (2004). Retrieved from www.copyright.gov/legislation/pl108-446.pdf
- KELLER-ALLEN, C. (2007). *Implications of the CAPTA requirement for referrals from child welfare to Part C*. Project Forum at the National Association of State Directors of Special Education (NASDE).
- LIEBERMAN, A. F., & VAN HORN, P. (2008). *Psychotherapy with infants and young children*. New York, NY: Guilford.
- NATIONAL CHILD TRAUMATIC STRESS NETWORK (NCTSN). (2012). Trauma-Informed Service Systems working group. *What is a trauma-informed child- and family- service system?* Retrieved from www.nctsn.org/resources/topics/creating-trauma-informed-systems
- NEWBORG, J. (2004). *Battelle Developmental Inventory* (2nd ed.). Rolling Meadows, IL: Riverside Press.
- PERRY, B. D. (2006). The neurosequential model of therapeutics: Applying principles of neuroscience to clinical work with traumatized and maltreated children. In N. B. Webb (Ed.), *Working with traumatized youth in child welfare* (pp. 27–52). New York, NY: Guilford.
- RINGWALT, S. (2012.) *Summary table of states' and territories' definitions of criteria for IDEA Part C eligibility*. Retrieved from <http://ectacenter.org/topics/earlyid/partcelig.asp>
- SANDALL, S., HEMMETER, M.L., SMITH, B. & MCLEAN, M. (2005). *DEC recommended practices: a comprehensive guide for practical application*. Missoula, MT: Division for Early Childhood
- SCARBOROUGH, A., & MCCRAE, J. (2008). Maltreated infants: reported eligibility for Part C and later school-age special education services. *Topics in Early Childhood Special Education*, 28, 75–89.
- SCHEERINGA, M. (2011). *Young Child PTSD Screen (YCPS)*. Retrieved from www.infantinststitute.org/MikeSPDF/YCPS_versFeb2011.pdf
- SPENCER, N., WALLACE, A., SUNDRUM, R., BACCHUS, C., & LOGAN, S. (2006). Child abuse registration, fetal growth, and preterm birth: A population based study. *Journal of Epidemiology & Community Health*, 60, 337–340. DOI:10.1136/jech.2005.042085
- SQUIRES, J., BRICKER, D., & TWOMBLY, E. (2003). *Ages and Stages Questionnaires: Social-emotional*. Baltimore, MD: Brookes.
- SULLIVAN, P., & KNUTSON, J. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse & Neglect*, 24(10), 1257–1273.
- U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. (2010). *The Child Abuse Prevention and Treatment Act As Amended by P.L. 111-320 The CAPTA Reauthorization Act of 2010*. Retrieved from www.acf.hhs.gov/programs/cb/resource/capta2010
- U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, JOINT HEALTH AND HUMAN SERVICES-ADMINISTRATION FOR CHILDREN AND FAMILIES, CENTERS FOR MEDICARE & MEDICAID SERVICES, AND SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION. (2013). *Guidance Letter on the use of trauma-focused screening, functional assessments and evidence-based practices in child-serving settings*. Retrieved from www.medicare.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf
- WULCZYN, R., ERNST, M., & FISHER, P. (2011). *Who are the infants in out-of-home care? An epidemiological and developmental snapshot*. Chapin Hall Issue Brief, May 2011. Retrieved from www.chapinhall.org/sites/default/files/publications/06_08_11_Issue%20Brief_F_1.pdf
- ZEANAH, C. H., & BENOTT, D. (1995). Clinical applications of a parent perception interview. In K. Minde (Ed.), *Infant psychiatry* (pp. 539–554) Child Psychiatric Clinics of North America. Philadelphia, PA: W.B. Saunders.
- ZEANAH, C. H., LARRIEU, J. A., HELLER, S. S., VALLIERE, J., HINSHAW-FUSELIER, S., AOKI, Y., & DRILLING, M. (2001). Evaluation of a preventive intervention for maltreated infants and toddlers in foster care. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 214–221.

Tip Sheet for Clinicians (2)

Testifying in Court about Trauma: The Court Hearing



“Testifying in court can be a difficult and stressful experience for clinicians. But judges and lawyers are not experts in child development or the impact of trauma on children. The knowledge clinicians bring to bear is essential if the legal system is to have any hope of making sound decisions that will serve children’s interests. By educating the court through testifying, clinicians provide an invaluable service to the legal system and, most importantly, to children.”

Frank E. Vandervort
Clinical Professor of Law
University of Michigan Law School

CASE EXAMPLE (Introduction):

Heather is the clinician for Sam, a five-year-old girl who, with her sister, was placed in foster care one year ago because of the severe abuse and neglect they suffered in the care of their biological parents. Due to extreme behavioral issues, Sam and her sister have had five placements. Heather began seeing Sam when she arrived at her current foster home and now has been subpoenaed to testify at a hearing to discuss a permanency plan. The attorney representing the child welfare agency told Heather that she would ask about Sam’s diagnosis, her trauma exposure, the effect of the trauma on Sam, and Heather’s recommendations regarding the child’s needs in terms of placement and permanency.

Heather, although nervous about testifying, feels confident that she has reviewed the case, has some idea of what she will be asked in court, and has met with her supervisor Josh on several occasions. Josh, who has testified in court many times, reminded her that testifying will be a chance for Heather to educate the court on Sam’s traumatic events and their effects and how Sam exhibits common traits seen in children who have suffered from early childhood traumatic experiences. Josh also encouraged Heather to engage in self-care activities to help manage her stress level through the court process.

WHAT TO EXPECT IN COURT

Despite all the unknowns of a court hearing, the process of testifying follows a predictable, predetermined path. Just as we prepare our clients for a court hearing, preparing yourself by knowing what to expect can help you feel more confident in your testimony and ease anxiety.

Self-Care Tips for Managing Anxiety during the Hearing

- Be prepared to wait; expect frequent delays in court. Bring an activity (e.g., a book, knitting, crossword puzzles) to occupy you while you wait your turn on the witness stand.
- Remember to breathe! This can decrease your anxiety, give you an opportunity to pace the question and answer process, and permit you to pause and think before you respond.
- Use relaxation strategies (e.g., muscle relaxation, grounding techniques) or positive affirmations to stay calm and focused when you are on the witness stand.

1. **Direct examination:** The attorney who called you as a witness questions you. Generally, you will be asked first about your qualifications, education, and work history and second about your client and your treatment. You then may be asked to give recommendations or opinions based on your professional knowledge and treatment of the client. The attorney will ask open-ended questions and ask you to elaborate on your responses.
2. **Cross-examination:** The opposing attorney will ask you questions designed to bring out points in your testimony that may be favorable to his or her client's case or that may appear contradictory. These questions typically will be short, closed-ended questions requiring a "yes" or "no" answer.
3. **Objections:** Sometimes an attorney will interrupt a question by saying, "Objection." If this happens, stop talking. If the judge *sustains* (approves) the objection, you should not answer the question. If the judge *overrules* (denies) the objection, you will be asked to answer the question.
4. **Examination by the judge:** At any point in the proceeding, the judge may question you.



After cross-examination, the attorney who originally called a witness has two options: (a) to "redirect" the witness' testimony by asking follow-up questions to further develop or clarify a certain point, or (b) to decide the concerns raised during the cross-examination were not significant to warrant further questioning. The latter may leave the witness feeling frustrated or misunderstood; however, the attorney's decision is not a reflection of the content or value of the witness' testimony, but rather a judgment based on legal strategy.

TYPES OF CASES

The following are four types of cases in which clinicians may be asked to testify about the impact of trauma on children.

Criminal

A *criminal* case involves the charging and prosecution of an individual for actions that violate state or federal law (e.g., child abuse or maltreatment, child sex trafficking)—a “crime.” There are two named parties to the case: the defendant and the state (or US), which is represented by the prosecution. In criminal trials, clinicians may be called to testify as a *fact* or *expert witness* about the child victim of the accused. At trial, this testimony may be used to determine whether a crime took place. During sentencing, this testimony may be used to influence the defendant’s sentencing (See below for more information about types of witnesses.).



Delinquency

A *delinquency* case is the charging of a juvenile for a delinquent act (behavior by a minor that would be criminally punishable if committed by an adult) or status offense (an act that is only illegal if committed by a juvenile and not an adult, such as truancy or running away). Youth tried in the juvenile delinquency court are treated differently than adults in the criminal court, as juvenile court is intended to provide rehabilitation for offenders, while adult criminal court is intended to provide sentencing. The parties involved in a delinquency case are the juvenile defendant and the prosecution.

In delinquency cases, clinicians may be called to testify on behalf of a juvenile victim or a juvenile offender. Testifying for the victim will be similar to testifying for a victim in the adult criminal court. However, a clinician may also testify for the juvenile offender by offering insight into his or her past mental, physical, and behavioral histories, providing context for the juvenile’s action. Fact and expert witness testimony may be used in either of the two phases of a delinquency case: adjudication and disposition. During an adjudication hearing, the judge or jury will determine the culpability of the defendant; while the disposition hearing determines how the youth will be sentenced (i.e., treatment, training, or services.)

Dependency

A *dependency*, or child welfare, case is a proceeding that addresses alleged neglect or inadequate care by parents or guardians of the children in their charge. Although parental abuse and neglect may be severe enough to warrant the filing of separate criminal charges, a dependency case is NOT a criminal case. The parents and the child welfare agency are parties to the case. Children may also be parties, depending on the jurisdiction, and may also be represented by an attorney, who advocates for the *wishes* of the child, or a *guardian ad litem*, who advocates for the *best interests* of the child. Clinicians may be called by any of these parties to support that party’s position (e.g., removal of the child, return of custody, permanency placement). Clinicians will be called to give their opinion of the child’s social-emotional, mental, and behavioral well-being.

Family Law

Family law cases involve a wide range of issues relating to marriage, divorce, and the care of children, including custody, guardianship, and adoption. A *custody* case is a proceeding that determines the legal and physical custody of a child. *Guardianship* grants a non-parent physical custody as well as the power to make significant decisions about the child's upbringing. *Adoption* is a judicial order that creates a legal parent-child relationship. In any of these cases, there may be only one party, e.g., the person seeking uncontested adoption, or there may be multiple parties, e.g., parents or other relatives contesting the custody or adoption of a child. Sometimes the child has his or her own legal representative, such as a *guardian ad litem*. In all of these cases, the judge must determine which placement and custody arrangement is in the best interests of the child. Parties will often call clinicians as fact or expert witnesses to inform the court's decision.

TYPES OF WITNESSES

A clinician's testimony may be used either as an "expert witness" or a "fact witness." The following describes these different roles:

Expert Witness

An *expert witness* is an individual qualified by knowledge, skill, experience, or training to provide a scientific or other specialized opinion about evidence that is beyond the common knowledge of the jury. The expert witness provides clarifying information for the judge or jury on a substantive topic area. The expert witness gives testimony based on facts and materials provided to him or her by one of the parties to the case, and she or he is not required to meet with or evaluate the client. Examples of expert testimony are information on child development, childhood traumatic stress, and the behavioral characteristics of abused children. Expert witnesses must be qualified by the judge in order to testify in this role, but the rules for qualifying as an expert witness vary by jurisdiction.

Fact Witness

More often, a clinician will be called to testify as a *fact witness* (also known as a *lay witness*) whose testimony is restricted to providing information based on his or her firsthand knowledge or observations, rather than providing expert testimony on a particular subject. This opinion is based on his/her "rational perceptions." While a clinician has specialized training that makes him or her an expert in the field, this differs from an expert witness who must be qualified by the court. The court may ask the clinician as a fact witness to give his or her professional opinion of the client, but it is still based on firsthand knowledge and facts gathered during interactions with the client. For example, a clinician testifying as a fact witness may be asked to speak about a client's attendance, the assessments conducted, or treatment goals. Interpretation and opinion related to a client's treatment needs and progress may be included in this testimony. As a fact witness, the clinician can only speak about his or her client, and cannot extrapolate as to other parties to the case with whom he or she has not interacted. The determination between fact versus expert witness may vary based on jurisdiction. Be sure you understand the requirements for the jurisdiction in which your testimony will be used. It is also possible that a judge may decide on his or her own to qualify you as an expert during your testimony, allowing you to testify as an expert witness.



TESTIFYING EFFECTIVELY

To testify successfully, simply convey information as you would in your practice as a clinician and in your personal life: use a confident, firm, controlled, and calm, yet alert demeanor.

1. Maintain a respectful attitude. Avoid speaking at the same time as others.
2. Listen carefully to the question asked. Make sure you understand each part of the question. Ask for clarification or for the question to be repeated, if you do not fully understand.
3. When you answer, speak directly to the judge or to the jury (in a jury trial), not to the person who asked the question. The judge and jury are the ones who need to understand your responses.
4. Speak slowly and thoughtfully. Answer only the question asked. Do not volunteer extra information. Provide short, succinct answers; answer “yes” or “no” if possible. If you must explain your answer, or cannot answer “yes” or “no,” be brief.
5. Be prepared to answer questions about the number of times you interacted with the child/family, length of service, treatment methods, your clinical qualifications and training. (For more information on how to prepare, see Tip Sheet on How to Prepare for Court.)
6. Respond directly and honestly to the questions asked of you.
7. Do not add comments or opinions.
8. Limit your testimony to what you know, and do not guess or speculate.
9. Do not allow yourself to become defensive or argumentative when being questioned.

Your Rights as a Witness

- You have the right to ask for a glass of water, to go to the bathroom, to consider a question or request, to have the question repeated, or to speak to the attorney who has called you to court.
- You have the right to look at a document (including your own reports) to which the attorneys or judge are referring while you are a witness.
- You have the right to say that you cannot give an opinion, because you do not have the necessary data. If you do not know the answer to a question or feel that you are asked something that is out of the scope of your knowledge or expertise, say so.

Trauma Talking Points

You will want to be prepared to define, discuss, give examples, and explain how the following apply to your client:

- Types of trauma (physical and psychological)
- Acute, chronic, and complex trauma and how the appropriate type applies to your client’s experience
- DSM criteria for PTSD, depression, and other trauma-related diagnoses, and methods used to diagnose and monitor the client’s symptoms, including results of standardized measures pre- and post-treatment for your client

- Trauma stress reactions and their role in the client’s life
- Impact of trauma on the child’s social development and ability to form healthy, secure relationships
- “Evidence-Based Practice” and supporting research for selected interventions
- Trauma-specific treatment provided and what that treatment addresses
- Client’s progress with the selected treatment model
- Caregiver involvement in treatment, impact on the client of the caregiver’s willingness and ability to participate in treatment

Behaviors and Symptoms Commonly Explained in Testimony

The following chart lists behaviors demonstrated by children with traumatic stress. Note that this is not an exhaustive list, nor do traumatized children fit neatly into these descriptions. They may display more than one behavior.

Behaviors Displayed	Possible Contributing Factors from a Trauma Perspective
Anger, irritability, defiance, oppositionality with authority	Emotional/mood dysregulation (depression/anxiety), hyperarousal, survival strategies, getting needs met
Lying or profound distrust of authority	Negative beliefs about self, caregivers and world view based on traumatic experience
Running away	Survival (fight/flight), hypervigilance, hyperarousal
High risk behavior (e.g., substance use, promiscuity, rule breaking, self-mutilation)	Pain numbing, attempts to increase sense of power, control, and self-worth
Impulsivity	Impact on brain development, hyperarousal (fight/flight response)
Difficulty falling asleep or staying asleep	Re-experiencing, hyperarousal
Distractibility, difficulty following through with tasks, poor concentration, daydreaming	Difficulty regulating attention and cognition (problem solving), re-experiencing, hyperarousal, dissociation (pre frontal cortex “off line”)
Denying experiences of harm/trauma, avoiding talking about history	Primary symptom of trauma (avoidance); strategy for managing overwhelming emotions
Avoiding activities, isolating from others	Poor self-concept, anxiety and/or depression

CASE EXAMPLE (conclusion)

Heather initially felt uncertain and unsure of herself when she got on the stand, but was able to breathe, manage her anxiety, and focus herself. Because Cindy, the attorney representing the child welfare agency, asked the questions she said she would, Heather felt prepared with good answers. After Heather testified, she experienced a common reaction—relief—but with some uncertainty about her testimony. She felt slightly anxious about whether her testimony was ultimately helpful to Sam and concerned about how the information she presented in her testimony would be interpreted. She felt slightly better after Cindy, the attorney representing the child welfare agency, thanked her and talked to her about the hearing. Cindy pointed out that her testimony was helpful in explaining to the court that Sam’s behaviors were common to children that are abused and helped the court understand the dynamics of trauma and abuse and the purpose of Heather’s treatment. Heather decided to take her supervisor’s advice and take care of herself by watching a funny movie after she got home.

Prior to the Day of the Hearing

- Call the attorney who subpoenaed you to make sure the hearing is scheduled and that you are still expected to appear.
- Find out the name of the judge and the courtroom where the hearing will take place.
- Make sure you have the phone number of the attorney or the court in case of an emergency on the day of the hearing.
- Make sure the Court has your contact information in case there are changes in the schedule.
- Engage in self-care activities and arrive rested.
- Check in with the attorney or wait outside the courtroom until you are called in. Do not discuss your information with other witnesses.