

"A comprehensive system of care for children, adolescents and their families"

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Ensuring Successful Supports For Early Childhood Mental Health

In December 2007, about 75 people gathered in Pittsburgh for an Infant-Toddler Mental Health Symposium, planned by the Department of Public Welfare's Offices of Child Development and Early Learning, Mental Health and Substance Abuse Services, Medical Assistance Programs, and Children, Youth and Families. Department of Public Welfare Secretary Estelle Richman facilitated the entire symposium and helped to frame the issues for successful supports for infant-toddler mental health. Her remarks are summarized here.

Pennsylvania ranks in the middle on key indicators of child health and well-being. According to the 2007 Kids Count Data Book, prepared by the Annie E. Casey Foundation, the state ranks 21st on these key indicators.

Pennsylvania has one of the highest populations of infants and toddlers in the nation, with more than 437,000 infants and toddlers and ranking seventh in the number of children from birth to age four. Our young children are often the most vulnerable, and are the most likely to live in families who are financially burdened. They are disproportionately at risk for maltreatment, accounting for about 81 percent of child maltreatment fatalities. Infants and toddlers in foster care have rates of developmental delay at 4-5 times the rate of the general population.



Promoting positive social and emotional growth in young children leads to greater success in school and in life. Research tells us that children who are emotionally healthy have a significantly greater chance of achieving success in school compared with those who have emotional difficulties. Since learning begins at birth, and we know that 85 percent of our brain develops before age three, if we want our children to succeed we need to ensure a safe and stable environment for them to be able to thrive.

Promoting social and emotional health saves future costs. When a child is given the opportunity to develop to his or her fullest potential cognitively, physically and emotionally, he or she has a greater chance of entering school ready to learn and ready to succeed, is less likely to require special education services or be held back a grade, and is less likely to drop out of school, commit crimes, or require public assistance as adults.

Promoting social and emotional health requires the efforts and collaboration of many. Our youngest children are raised by a community, and everyone involved in that child's life plays a role in his or her development. We cannot promote healthy child development without addressing the needs of the child, parents, teachers, and other caregivers in the child's life. Pennsylvania has taken steps to promote healthy social and emotional development, and within the Department of Public Welfare we are intentionally working together to create policies that support young children, build partnerships, and make it easier for families and caregivers to get the supports they need.

A written report of the symposium and a set of three DVDs featuring all the presentations and discussion at the Infant-Toddler Mental Health Symposium are available. Contact the editor for a copy of either item.

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The Social and Emotional Development of Young Children

Just over three years ago in December 2004, the topic of the CASSP Newsletter was "Infant and Early Childhood Mental Health," so you might wonder why we are repeating a similar topic so soon. A lot has happened in the meantime, not the least of which is my own journey into the world of early childhood mental health during the last six months. As I have begun learning about that world and assuming various responsibilities on behalf of the Office of Mental Health and Substance Abuse Services for early childhood mental health, I have discovered that this is a burgeoning field with varied initiatives all over the state to address the social and emotional needs (the mental health) of infants, toddlers and pre-schoolers.

I am the grandmother of two young children (one five years old and the other almost two), and so I have some personal investment in this subject. One of my great joys in life these days is spending time with my grandchildren and watching them grow and develop in healthy ways. Fortunately, their parents have the necessary resources to be able to nurture their social and emotional development (and it certainly helps that my son-in-law is himself one of the most socially-developed individuals I know!), but there are many other children in Pennsylvania who are not so fortunate, and who through no fault of their own struggle during their early years into later childhood and adolescence.

In a recent policy brief from the Foundation for Child Development, the author states, "The overall rate for PK [pre-kindergarten] expulsion in state-funded programs was found to be more than three times greater than the national rate of expulsion for students in Kindergarten through Twelfth Grade" (Gilliam, 2008). A study in Michigan in 2003 estimated that 6 to 10 percent are

expelled or at risk of expulsion because of emotional or behavioral problems and as many as half to two-thirds of children in foster care under age six exhibit developmental problems because of unmet mental health needs (Michigan League for Human Services, 2007). And according to the National Center for Children in Poverty, while the prevalence of problematic behaviors in young children is about 10 percent, the rate is considerably higher among low-income children, and "the more chronic the economic, social, and psychological stressors that young children face, the greater the likelihood of poor social, emotional, and cognitive outcomes" (Raver & Kntizer, 2002). These are all good reasons for the increased attention in recent years to the healthy social and emotional development of young children.

This edition of the newsletter builds on the momentum created by the Department of Public Welfare's Infant-Toddler Mental Health Symposium held in December (see page 1 for a summary of Secretary Richman's remarks at the symposium), and highlights the partnerships of various program offices in addressing the social and emotional development of young children.

Harriet S. Bicksler, editor

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A Day in the Life of an Early Childhood Mental Health Consultant

By *Leslie Rapsey*

At 8:30 a.m., the director of Little Friends Daycare Center greets me at the door. “We’re so glad you’re here.” After her phone call last week we scheduled this visit. I’ll be observing a toddler whose challenging behaviors are “upsetting the whole center.” Jack is 27 months old, an only child whose parents reluctantly agreed to my visiting Jack’s classroom. Last month, Jack’s parents met with the director and classroom teacher to discuss Jack’s aggressive behavior. The director had already sent home quite a few incident reports. Within a week Jack had scratched several children, pushed a little girl on the playground, bloodying her lip, kicked another child in the face at circle time, causing a bruise. Parents were becoming upset, threatening to pull their children from the center. Defenses were up. “Jack never does that at home,” his parents argued. Miss Betty, Jack’s teacher, is frustrated. “She left last week in tears,” the director shares. “I can’t lose Betty. It’s impossible to find reliable teachers. We are thinking about asking him to leave. I can’t afford to lose other children. We are hoping you can help.” No pressure here, I thought.

I enter the toddler classroom, scanning the carpet for a “troublemaker.” The children are playing calmly. Freeplay. The teachers are wiping the table and sweeping the floor. After introducing myself to Miss Betty she reports, “He’s having a very good morning. He had a little bit of trouble after drop-off. Hit me twice, but he settled down. He’s over there in the block area, pushing the dump truck. He loves trucks.” Miss Betty and I talk about Jack—his likes and dislikes, when he has a tough time, the behaviors most concerning her, how he’s doing developmentally, etc. Miss Betty pulls Jack’s file. She shares documented observations and copies of incident reports. “We’re trying to teach him to use his words. He would rather hit or kick.”

I try to sit discreetly in a corner of the room. Miss Betty announces, “Circle Time! Toys away.” She sings a clean-up song and some children put toys away. Jack continues to play with the truck. He is loading it with blocks and animals, making truck sounds. “Jack, Circle Time. Clean up the blocks and come to the carpet.” Jack does not look up. He repeatedly drives the truck into the wall. “He never listens to my directions.” I encourage Miss Betty to do what she normally does. The rest of the children are sitting (or rolling) on the Circle Time rug Miss Betty calls, “Come to Circle Time, Jack. We’re going to sing.” The assistant teacher takes Jack’s hand, urging him to join the others. Jack goes limp. She tries to lift him under his arms and Jack starts to kick and arch his back. “This is what he does.” Jack is lifted and carried to Circle Time, kicking and shouting, “No, no!” He’s placed next to the group where he lies,

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What is Early Childhood Mental Health Consultation?

Mental health consultation in early childhood settings is a problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals, primarily child care center staff, with other areas of expertise. 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 6 and their families.

The goal of early childhood mental health consultation is neither to “rescue” child care staff...nor to transform them into mental health professionals. Rather, the goals are to assist staff in understanding the mental health perspective, and incorporating it into their work, and to use their own roles, skills, and experience to:

- Foster positive learning and development of each child through careful observation;
- Implement strategies that enhance learning experiences;
- Promote social, emotional, and behavioral development of each child;
- Build relationships and communicate with parents; and
- See further consultation, when necessary (Cohen & Kaufmann, 2005).

In Pennsylvania, the Early Childhood Mental Health Consultation Project is a collaboration between the Office of Mental Health and Substance Abuse Services (OMHSAS) and the Office of Child Development and Early Learning (OCDEL). In each of OCDEL’s six regional Key programs (see www.pakeys.org), early childhood mental health consultants are available to early learning facilities and frontline workers when specific young children are exhibiting emotional and behavioral difficulties. With the permission of the parent(s) of individual children, the consultants are able to advise childcare workers and/or the parents on how to change the environment or the way they interact with the child; sometimes they refer the child for additional services, such as mental health or early intervention. OMHSAS offers the services of a child psychiatrist for clinical consultation, and is also providing professional development opportunities for both early childhood mental health consultants and county mental health personnel. Contact Kelli Thompson at kelltho@berksiu.org for more information.

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Facilitating Secure Attachments between Parents and Child: The Ultimate Purpose of Infant-Toddler Mental Health Programs

By John Biever, M.D.

Our six-year-old granddaughter Madeline came tearfully into our living room in search of her mother. She had been playing in our library with her brother and cousins, and had accidentally knocked some of my papers off a shelf. Her grandmother was first to respond, and reassured her that no harm was done. I overheard the goings-on, and later offered Madeline my own reassurances as she completed the work begun by herself and her grandmother of resolving her anxiety and self-reproach. In no time she was back to joyful play.

I later remarked to my wife that I'd almost taken for granted that Madeline would so readily come and report a misdeed she had clearly felt as egregious and of substantial negative consequence. Madeline has had a wonderfully secure attachment to both her parents, despite the sort of temperament that has made her the most challenging of our four grandchildren for their parents to raise. On reflection I feel so happy for her that she is trusting enough of her parents that she can readily "confess" her wrongdoings, that she does not have to endure the emotional pain and energy required to conceal them, that she has a conscience that propels her to intensely love doing right while not excessively fearing doing wrong, and finally that she has parents who have nurtured her along to this felicitous state of mind and self through their cultivation and maintenance of a secure attachment bond between them.

As children move beyond infancy and complete their first five years of life, they necessarily experience in succession the two negative emotions that, when in excess or when not effectively managed, will pose the

greatest threat to their mental health for the rest of their lives. These two emotions are shame and guilt. As with all emotions, these are *interpersonal* in essence. In shame the child (or adult) feels exposed as inadequate, as though the eyes of others are gazing upon him and observing that inadequacy. In guilt the child feels bad in the moral sense, and hears in her mind the disapproving voice of her parent. Children who have experienced a secure attachment during the first 18 or so months of life feel good enough about themselves that they do not generate excessive feelings of shame or guilt in the aftermath of their wrongdoings, trust others enough to expect them to properly manage their disapproval and have some self-esteem "insulation" against those adults and peers who may respond unfairly or excessively.

This basic feeling about self and others is what enables children to venture forth to master all the most important tasks of later childhood and adolescence: the ability to ask questions in school without feeling embarrassed about what one does not know; the ability to enter into new relationships with classmates or neighbors with enough self-esteem to anticipate acceptance, and enough confidence that the inevitable times of disruption that will occur because of human frailty will be overcome by reparative and restorative actions like apology and forgiveness; the ability to exert one's self artistically, athletically or academically in the public eye without excessive self-consciousness; and the ability to behave acceptingly toward others while not accepting their inappropriate or distasteful behavior.

While secure early attachments might not be *sufficient* to ensure this happy state of affairs – features like intellectual and physical endowment, social and environmental factors and later developmental trauma can also have an impact – they are nevertheless *necessary*. And this gets us to the role of infant-toddler mental health teams.

We have long recognized that successful treatment of children and adults with mental health problems hinges on the strength of the *therapeutic alliance*. In infant-toddler mental health this alliance can very meaningfully be thought of as the degree of *attachment security* existing between professional and parent/caregiver. For research tells us that the best predictor of attachment security in an infant is the attachment security of the parents! And experience teaches us that the attachment security of parents and other caregivers *can* be enhanced by purposeful, security-building outreach from members of the mental health treatment team.

Finally, an inescapable but routinely overlooked corollary to all of this: we in the "field" must accept that, to serve our little friends and their parents the best, we need to be mindful of our own attachments – to family, friends, fellow congregants and professional colleagues – and constantly work to enhance the strength of those attachments.

John Biever, M.D., is a child psychiatrist and consultant to the Bureau of Children's Behavioral Health Services and to the Early Childhood Mental Health Consultation Project.

The Social-Emotional Well-Being of Young Children in Foster Care

By *Chelsea Quattrone*

Toni and her husband Steve love kids. When they did not conceive after trying for a year, they began to consider adoption or foster parenting. Right after they completed their initial training session they found out Toni was pregnant. Seven years and three children later, they began to think about opening their home to kids who needed a safe and healthy place.

About ten months ago they received a call. Three brothers were in need of a placement immediately or they would have to be separated. Toni said she really wasn't sure about this at first. She knew that her husband felt strongly that brothers and sisters should stay together if at all possible. "I think that the agency knew we would probably not be able to say no," Toni said.

Soon after the boys came to their home they realized just how much they needed their support and stability when they found them eating out of their kitchen trash can. The youngest child, Ben, was having the most difficulty. About 20 months old, he cried most of the time for the first three weeks. He would sit on the floor and scream and cry and not allow anyone to pick him up.

"We were not sure what to do. Ben didn't seem to want to be around anyone. He slept for 19 hours at a time. We knew we needed help with him." Toni and Steve began to discuss the possibility that they may not be able to meet Ben's challenging needs. "It was so hard because we wanted to keep them together and we couldn't understand why this was happening."

Through the Screening and Intervention Program for Young Children in Allegheny County, the family was visited at home by an Early Intervention Specialist. A partnership between Child Welfare, Early Intervention and Behavioral Health in Allegheny County provides access to early intervention, treatment, and support services for all children ages birth to three in substantiated cases of abuse and neglect. For toddlers and preschoolers in substitute care, quarterly screening and tracking continues until age five. Transition

to appropriate early learning environments is facilitated and supported by the Alliance for Infants and Toddlers, a local provider agency.

The parents completed the Ages and Stages Social-Emotional questionnaire (ASQ-SE) and developmental questionnaires with their foster care case worker. These showed a concern in Ben's ability to regulate emotions and to communicate needs. "Doing the questionnaires and interview helped us explain what was going on. Having someone listen to us and actually see his behavior first hand made a big difference."

The Ages and Stages questionnaires (ASQ) are completed at designated intervals depending on the child's age, assessing children in their natural environments to ensure valid results. Each one can be completed in 10 – 15 minutes and covers five key developmental areas: communication, gross motor, fine motor, problem solving, and personal-social.

Professionals convert parents' responses of "yes, sometimes" and "not yet" to color-coded scoring sheets, enabling them to quickly determine a child's progress in each developmental area. The user's guide then offers clear guidelines for determining whether children are at high or low risk in the various domains. With the results of the Ages and Stages Social-Emotional questionnaires, professionals can quickly recognize young children at risk for social or emotional difficulties, identify behaviors of concern to caregivers, and identify any need for further assessment.

Toni and Steve's family is now receiving Behavioral Health Rehabilitation Services such as play therapy and service coordination through the Allegheny County Office of Behavioral Health. Toni and Steve are more confident in their ability to manage this family and continue a successful placement. Toni said, "The therapist helped us to understand that Ben had created a wall around himself to help keep out the chaos and confusion."

Amanda Reagle, the Program Services Coordinator from the Alliance from Infants and Toddlers, explains, "The ASQ and The ASQ SE, as part of the Screening and Intervention Program for Young Children have helped focus the importance of children's development and mental health in foster care. By using this accessible and understandable tool, we have been able to generate focus and interest on the part of foster care workers, children and youth caseworkers, foster families and birth families. These children are now more consistently receiving the supports they need."

Toni spoke with us about Ben's progress: "He is like a new child now. Within weeks he seemed to want more contact with others, and was able to look at them and listen to them playing and talking without becoming upset. Soon after, he began to make sounds and seemed to be trying to talk. Before when I would come to the crib in the morning, he seemed so tired and lifeless, and now he is all smiles. This gives me hope."

Chelsea Quattrone is the special projects coordinator for the Allegheny Department of Human Services, Pittsburgh.



Addressing Maternal Depression to Improve Healthy Child Development

We all remember the story of Andrea Yates who suffered from severe postpartum (maternal) psychosis and one day drowned all five of her children in the bathtub. That's the extreme, but the story clearly demonstrates the devastating effects on children of their mother's postpartum illness.

Research has shown that about one in seven women is moderately to severely depressed after the birth of their baby, and many more experience what have commonly been called "baby blues." The rates are even higher among low-income women, with estimates of 40-60 percent of low-income mothers of young children reporting symptoms of depression (Knitzer, Theberge, & Johnson, 2008). According to Dr. Andres Pumariega, chair of the Department of Psychiatry at Reading Hospital, maternal depression affects infants and young children both physically and emotionally. Young children of mothers who are depressed are less able to regulate their emotions and comfort themselves, and are at increased risk for depression, separation anxiety, attention problems and conduct issues. Between 50-80 percent exhibit problems like these (Pumariega, 2007).

These findings echo those of Dr. Katherine Wisner, director of Women's Behavioral HealthCARE at Western Psychiatric Institute and Clinic in Pittsburgh. She and her colleagues documented the public health problem of maternal depression and concluded: "Mental health is crucial to a mother's capacity to function optimally, enjoy relationships, prepare for the infant's birth, and cope with the stresses and appreciate the joys of motherhood" (Wisner, Chambers, & Sit, 2006). Dr. Wisner and others, including the Department of Public Welfare's Office of Medical Assistance Programs, the Department of Health's Bureau of Family Health, Division of Child and Adult Health Programs, and the Pennsylvania Perinatal Partnership, are working on initiatives that address maternal depression and offer screening programs

and mental health services to mothers who otherwise would not choose or have access to them.

A research project in Pittsburgh, led by Dr. Wisner, has demonstrated that screening postpartum women for depression is feasible. The project has found that 75 percent of women will agree to be screened, and 13.6 percent are identified as being depressed or at risk for depression, as well as for other mental health issues like anxiety disorders and substance abuse. Besides screening, the project provides home visits and depression care management for one year, where the most common request from mothers is for more visits and someone to keep in touch with them. Dr. Wisner's work also includes providing treatment beyond medication and psychotherapy, including coaching in life skills, nutrition and exercise, and consultation with primary care professionals.

Through the Office of Medical Assistance Programs, case management services develop linkages between women who have been identified as being at high risk for maternal depression with behavioral health services. By providing financial incentives through pay-for-performance indicators related to rates of depression screening and treatment, OMAP encourages managed care organizations to increase access to both screening and services. In addition, new efforts to promote telemedicine and telepsychiatry will provide busy obstetricians and pediatricians with a way to address the needs they identify during postpartum and well-baby visits.

The Department of Health also has a number of initiatives addressing maternal depression. Through a grant from the Centers for Disease Control to implement the Pregnancy Risk Assessment Monitoring System (PRAMS), the Department is able to collect data from the women they survey regarding their experience with postpartum depression and get a better overall picture of the health of mothers and babies, which in turn will help them build better programs to serve these women. More Women,

Infants and Children (WIC) sites are providing screening for pregnant and postpartum women, and the Department is developing educational programs for obstetricians and pediatricians to help them be more knowledgeable about and comfortable talking with women about mental health issues.

These state efforts fit with findings and analysis at the national level. In a recent Issue Brief published by the National Center for Children in Poverty on "Reducing Maternal Depression and Its Impact on Young Children: Toward a Responsive Early Childhood Policy Framework," the authors provide some suggestions for helping parents of young children with or at risk of depression. Their strategies fall into three categories:

- "screening and follow-up for women, typically in ob/gyn or pediatric practices;
- targeted interventions to reduce maternal depression and improve early parenting in early childhood programs such as home-visiting and Early Head Start Programs; and
- promoting awareness about the impact of maternal depression and what to do about it for the general public, low-income communities, and early childhood and health practitioners" (Knitzer, Theberge, & Johnson, 2008, p. 6).

They also note that "educating parents about the effects of their depression on their children may also encourage mothers to seek treatment" and that settings such as primary care physician offices and early childhood education programs that parents trust and where they feel supported are crucial to the success of any intervention efforts.

A 2005 monograph from Zero to Three's National Center for Infants, Toddlers and Families, "Improving Maternal and Infant Mental Health: Focus on Maternal Depression," further emphasizes the connection between maternal depression and early childhood development: "Infants who develop secure attachment with a

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primary caregiver during the early years of life are more likely to have positive relationships with peers, be liked by their teachers, perform better in school, and respond with resilience in the face of adversity as preschoolers and older children” (Onunaku, 2005). Conversely, infants with mothers who are depressed are more likely not to develop positive relationships and to develop emotional and behavioral problems. The monograph offers five recommendations or strategies to address maternal depression:

1. Increase maternal depression awareness to providers in the health care community, early care and education, and family support.
2. Perform outreach and education to expectant and new mothers to address stigma and patient barriers.
3. Assure earlier identification of maternal depression in health care settings by addressing barriers to

recognition, screening, assessment, and referral.

4. Invest in evidence-based interventions that improve the mother-child relationship.
5. Build a comprehensive network of community perinatal service providers to strengthen mental health in the pregnant and postpartum family.

Thankfully, tragic stories like Andrea Yates are uncommon, and by paying more attention to maternal depression, which is *not* uncommon and is treatable, we can assure that more babies and young children have mothers with the emotional tools they need to parent successfully. For more information, refer to the web site funded by the National Institutes of Health at www.MedEdPPD.org.

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Reported by Harriet Bicksler, editor

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kicking. The other children move away from him, obviously accustomed to this behavior. "After he calms down I'll hold him on my lap and he'll actually enjoy himself. He loves the music."

I observe the rest of the morning, completing an *Ages and Stages Social/Emotional Screener* with input from Jack's teachers. Jack enjoys the music at Circle Time, smiling and gesturing to "Wheels on the Bus," marching with the rest of the class to "The Ants Go Marching." He has difficulty transitioning from Circle Time to hand-washing and again when lining up to go outside, though his teachers report that the playground is his favorite. During art, Jack pushes a boy painting next to him and grabs a paint brush from another child. His teachers encourage Jack to wait his turn and "say sorry." Jack leaves the art table, heading back to the block area and his favorite truck. When anyone comes near him he pushes them.

When I leave the classroom at 11:30, I have a lot to think about. Next steps? I will share my observations and assessments with Jack's parents, teachers and the director. I'll ask the director to organize the meeting, leave my contact information for Jack's parents. They may want to talk with me before the meeting. Jack's developmental screening shows a delay in his expressive language. He may have sensory issues, trouble with self-regulation, difficulty with social interactions. I'm not an expert in these areas. I will recommend an Early Intervention evaluation. Jack scored just beyond the cutoff on the *Ages and Stages Social/Emotional Screening*. I'd like to keep an

eye on Jack's social development, continue to visit his classroom and work with his teachers to create an Action Plan. He's an only child. Sharing and interacting with peers takes practice. He may just need some time to mature.

As an Early Childhood Mental Health Consultant, my job is to provide Jack's teachers and family with information and resources. Together we can help Jack be successful.

Leslie Rapsey is an early childhood mental health consultant in the South Central Regional Key, working out of the Capital Area Early Childhood Training Institute in Harrisburg.