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SERVICE GUIDELINE 4

Infant Mental Health

Assessment and intervention guidance for service providers and families of young children.

September, 2009

Connecticut Birth to Three System

Acknowledgments

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PREFACE

Since the original Infant Mental Health service guideline was published in 1998 there has been a ground swell of activity around infant/early childhood mental health, both nationally and within Connecticut. The research revealing the incredible capacity of the infant/toddler brain and the technology allowing us to see brain changes as a result of environmental limitations has resulted in a renewed focus on the quality of the relationships that infants and toddlers experience during their first three years. The focus has led to programs promoting the importance of early social/emotional development (relationship building and emotional regulation). Research is pointing to the impact these early relationships have on later interactions and learning. Connecticut's Birth to Three early interventionists who provide services in the context of the family are in important positions to support and enhance the primary care giving relationships. Since 1998, Connecticut Birth to Three providers have had an increasing number of resources, albeit still limited, to support them and their families in helping infants and toddlers strengthen their relationships and regulate their emotional responses. Some of those new resources include:

- Mental Health Systems of Care working with families of children at young ages (see Appendix Seven)
- Connecticut Behavioral Health Partnership funding Medicaid eligible services
- Early Childhood Mental Health Consultants working in child care centers
- Connecticut Association for Infant Mental Health offering two annual conferences
- Clinicians in Connecticut trained to use the *Diagnostic Classification: 0-3R* (DC: 0-3R) mental health diagnostic classification systems for infants and toddlers.

INTRODUCTION

Infant mental health speaks to the relationship babies have with their parents or caregivers, a relationship that begins even before they are born (see Appendix Two). Most children nurtured in the warmth and safety of their parents' arms will grow and thrive. Within the context of their family and culture and community they will form secure relationships, experience and regulate their emotions, and explore and learn. We know this nurturing, sensitive, and responsive environment will positively impact the architecture of the brain. The early environment for children has an enormous impact on how the hard wiring of the brains of babies develops. Brain architecture can be disrupted in the absence of the cuddling, singing, and responding that babies need to help them learn.

During these first few years of life the brain undergoes extraordinary changes. Millions of synapses in the brain begin reaching out and connecting to each other. Connections made during sensitive periods directly influence specific learning. For example, an infant's repeated exposure to language helps his brain build the neural links needed for him to learn words. Attention, sensitive care giving and responsive, loving parenting are the foundation for healthy social emotional development and the scaffolding for language and intellectual development (see Appendix Four).

Children with disabilities are more likely than other children to develop social, emotional, and behavioral difficulties. Perhaps even more than other children, they need interactions with caregivers to shape their ability to learn; give and accept love; feel confident and secure; and demonstrate both empathy and curiosity. It is those attributes that are most closely associated with success in school (Oser and Cohen, 2003). Without close, responsive relationships children are at extreme risk for further developmental delays. Developmental interventions and family supports can contribute greatly to increasing capacities in vulnerable children and lessening the risk of later maladaptive behavior.

Not all children though, begin life in the warmth of their parents loving arms. For these children persistent stress (absence of responsive caregiving) can be toxic and harmful and be the cause for social emotional disorders, challenging behaviors and later learning.

Tyler's story on the following pages will illustrate the role Connecticut Birth to Three service providers can play in both providing and connecting families to appropriate services when early experiences have been less than positive. Information in the appendices will expand on development, services, and resources important for providers to know.

DETERMINING ELIGIBILTY

Tyler's Story: The beginning

Tyler was born full term and healthy to 17 year old Brittney while she was living in a juvenile detention center. His father, DeMarcus, 37, was in prison. His parents' brief liaison occurred following DeMarcus parole from prison after serving 15 years for armed robbery. Shortly after Tyler's parents met they robbed a grocery store. The store clerk was shot and critically injured, but recovered. DeMarcus and Brittney were quickly caught and blamed each other for the shooting. DeMarcus was sent back to prison and Brittney to the juvenile center where it was soon discovered she was pregnant with Tyler. Brittney spent most of her pregnancy fighting with both the girls and the boys at "juvie." She often bragged about being the toughest girl there and "your worst nightmare."

Tyler spent his first few weeks with Brittney's aunt Nancy, who quickly decided Tyler was a "handful" and wasn't fitting in with her other children. Nancy passed him on to her cousin Jill. The plan was to eventually reunite Brittney and Tyler once she got out of the juvenile center. But by three months of age, Tyler had lived with three other relatives and one non-relative foster placement. He was not gaining weight, cried nearly constantly, and was impossible to console. It was decided that Brittney would be released from the juvenile home to her great-grandmother's custody. Together, the two of them would care for Tyler.

By the time Tyler was two and a half; his mother described him as being "crazy" and "possessed by the devil." He seldom slept during the night and would roam the house, turning on the television and getting into the refrigerator. He was aggressive and assaultive with children his age and younger but had a near hero-like worship of older children. He was also bright, athletic, and spoke in complete sentences with a large vocabulary. But his mother complained he never listened or complied with any directives from anyone. He had started a fire in a trailer they were living in previously and the family, which now included one year old brother Ryan was living with Brittney's friend Lisa. Brittney described herself as tough, and ready to fight anyone that "messed" with her or her children. But what she wanted most for Tyler was enough drugs to completely knock him out at night and keep him docile during the day. It was at this point that Tyler's pediatrician referred him to Birth to Three.

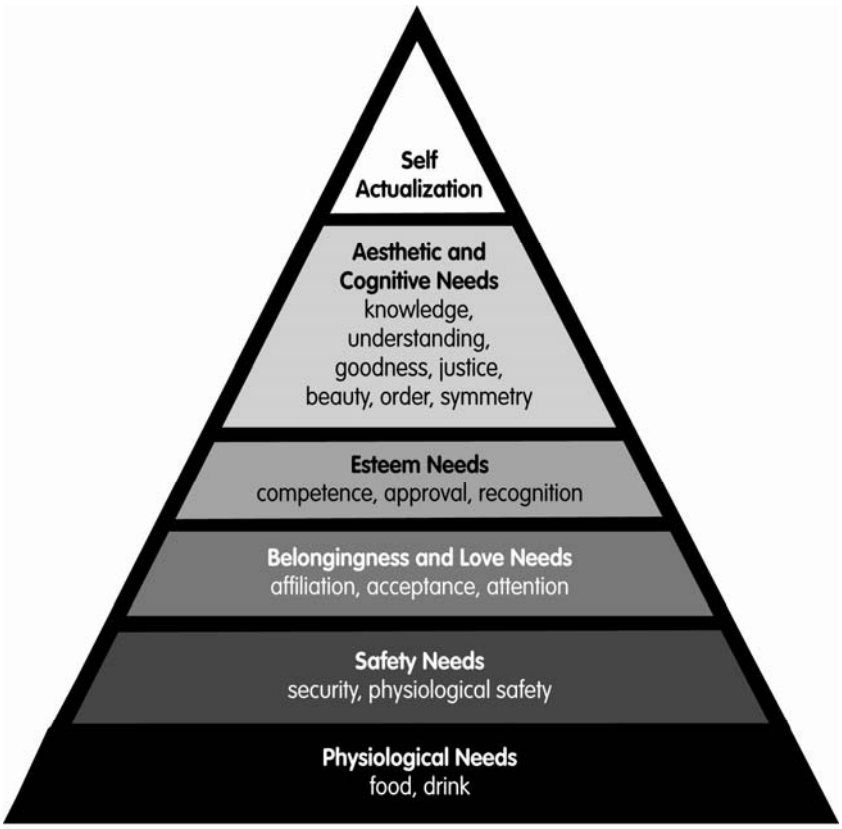
A Ready Birth to Three Provider Network

Supporting the healthy emotional and social development of young children and their families is an important part of every Birth to Three program. That support begins by establishing a caring, trusting relationship with the family.

- Early interventionists should have an infant mental health point of view: looking for family strengths, listening actively to family needs, helping the family identify stressors, and helping the family to keep the baby in mind. They also develop healthy professional relationships with the family while assisting the family in meeting the outcomes identified by the family (see Appendix Nine).

- Early interventionists should understand the importance culture plays in the social and emotional development of children (see Appendix Three).

- Early interventionists should have a capacity for empathy and support when helping families that face multiple challenges. Often a family facing multiple challenges is unable to focus on the early intervention goals or effectively use services until their other challenges have been addressed. Early interventionists should develop strategies to assist the family with these challenges, as the family prioritizes them, in order for that family to utilize the early intervention service most effectively.



MASLOW'S HIERARCHY OF NEEDS

Maslow's Hierarchy of needs is a simple and powerful tool for early interventionists to use when working with families facing multiple challenges. The fundamental premise of Maslow's Hierarchy is that families struggling with basic physiological and safety needs are unable to address higher level needs. A homeless family will not be able to identify and satisfy their child's social or emotional needs until an unstable housing situation is solved.

When children referred have involvement with Child Protective Services (CPS) at the Department of Children and Families (DCF), it is especially important to review their history carefully. CPS involved children have experienced some kind of family disturbance (substance abuse, trauma, family violence, etc.) and are at risk for social/emotional delays. Some examples of behaviors may be observed or reported and that signal concerns are:

- feeding and eating abnormalities: rejecting bottle, spitting up formula, Insatiable eating or hoarding or stuffing of food;
- prolonged screaming or crying at night, nightmares;

- difficult to comfort, irritable beyond early infancy;
- concerns about emotional or behavioral functioning reported by caregiver;

Using a specific social/emotional assessment protocol is suggested for all children involved with CPS prior to determining them ineligible for the Connecticut Birth to Three System. If the assessment results in specific concerns then an evaluation instrument specific to social/emotional development may be completed. (See suggested instruments listed in Appendix Ten.) Specific social/emotional assessment tools are suggested for these children as part of Birth to Three ongoing assessment activities as well. For children in foster care it is recommended that screening or assessment occur every six months (Silver and Dicker, 2007).

The initial visit with every family should be more then just a flurry of paper signing and evaluation questions. The early interventionist should be attentive to the surroundings, asking important questions about relationships and routines, and observing patterns of interactions and reactions. As the relationship between the early interventionist and the family unfolds the early interventionist should be prepared to observe and question the following items that could signal a young child is at risk:

- parent depression and health concerns;
- family history of mental health issues;
- risky parenting beliefs;
- parent substance abuse;
- domestic partner abuse and other trauma;
- poverty level;
- history of homelessness;
- educational and age level of mother;
- child health concerns;
- history of Child Protective Service (CPS) involvement with Department of Children and Families (DCF); and
- concerns with deployment or other matters related to families in the military.

Always allow the parent to pass on answering any questions that might make them feel uncomfortable but note the emotion and do not ignore it. Some suggested responses are:

That's okay; we can talk about this another time." (and remember to follow up) or "*That seems a hard topic for you." (pause) Parent: "I had a bad experience when I was young." (wait) Parent goes on to describe experience. Interventionist role is to listen, to make no judgment statements, to ask questions for understanding the meaning for the parent.*

Developmental evaluations address the multiple factors that affect a child's social/emotional development. These factors can be divided into four domains:

- environmental strengths and risks;
- child's physical health and development;
- parental/caregiver factors; and
- the relationship between the infant and the caregiver (Zeanah, Stafford, Nagle and Rice, 2005).

In using any measure with young children it is always important to take into account young children's changeable emotional state. This is particularly critical for children with social/emotional concerns. Typical evaluation practices rely on cooperation between evaluator and young child. Young children often resist participating in structured activities with an adult they have never met before. They may act shy, frightened or appear to lack understanding of what is being asked of them. The importance of evaluating a child in the context of his primary relationships with an integrated, developmental and collaborative approach can not be emphasized enough.

Tyler's Story: Birth to Three Intervention

In order to ensure a mental health perspective in early intervention, each of Connecticut's Birth to Three programs should have the availability of a social worker or psychologist for on-going consultation by all staff. The referral concerns for Tyler clearly indicated the possibility of the presence of relationship or behavioral disorders. For that reason the Birth to Three team that did the eligibility evaluation with Brittney and Tyler included a social worker.

Although it is difficult to identify all the strengths and needs at the initial visit the Birth to Team noted the following strengths of this very needy family:

- Brittney saw many positive skills of her little boy.
- Brittney was very protective of her children.
- Brittney had a friend willing to share her home.
- Brittney was determined to get what she needed for her child.

The team also recognized immediately the many challenges to establishing a relationship with the family:

- Unstable housing/homelessness
- Teen parent
- Criminal activity in the home
- Substance abuse issues
- Attachment disorders
- Sleep disorders
- Multiple partners/boyfriends of mother

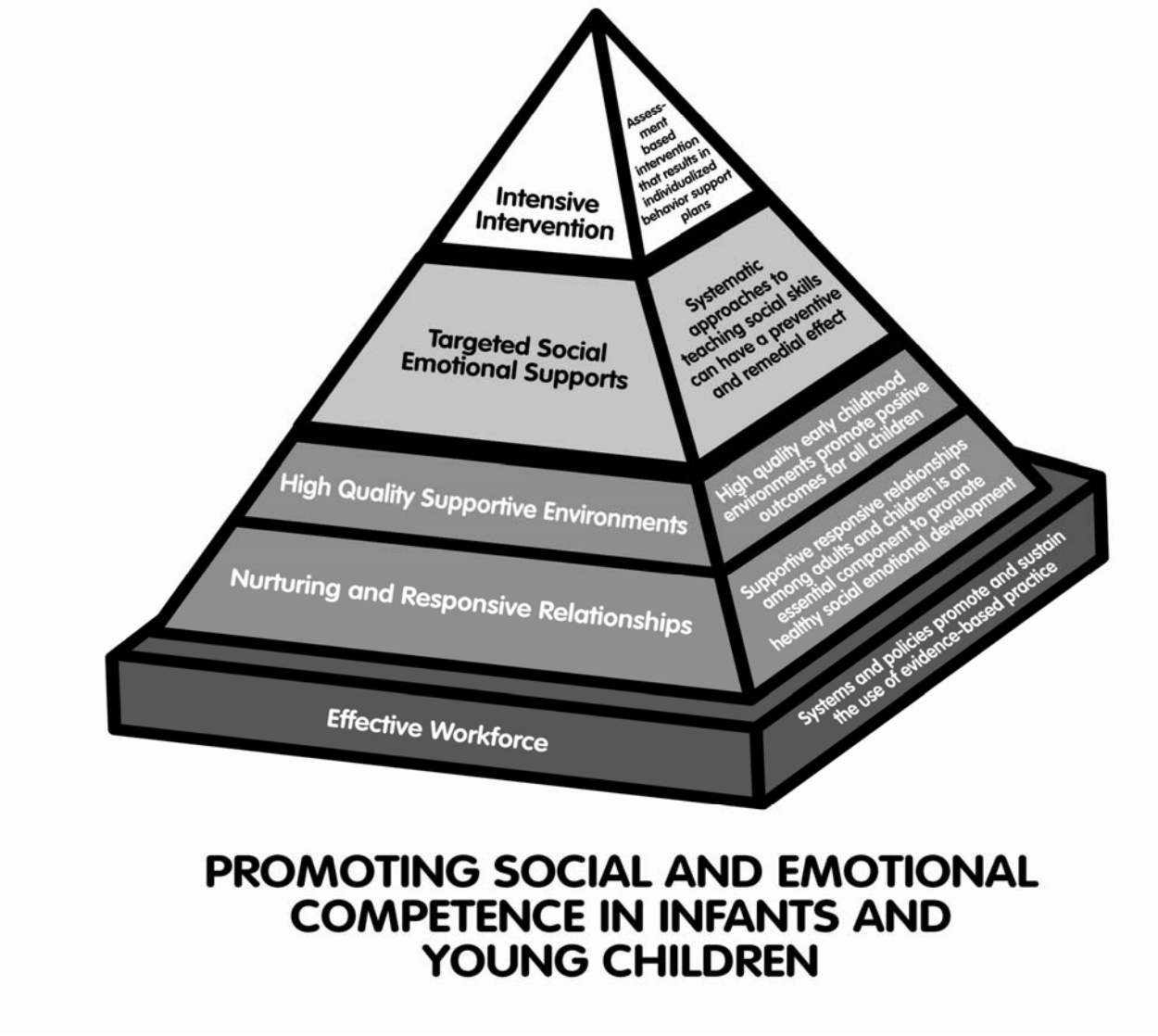
The Birth to Three team initially met resistance from Tyler's mother Brittney. She was certain Tyler was very bright; not delayed or disabled in any way. She also was very insistent that in order for Tyler's doctor to prescribe medication for Tyler to control his behavior, he had to be found eligible. The team struggled with understanding how much involvement Brittney's new boyfriend of several weeks should have providing information that might be used in determining eligibility. During the course of the evaluation, the boyfriend tried to dominate by answering the questions. Understanding the family dynamics and developing an empathic and non- judgmental relationship with the family was critical for the team in order to make a fully informed eligibility determination. Tyler was found to be 2.0 standard deviations below average in the Personal-Social domain based on the Battelle Developmental Inventory. Tyler was eligible for Birth to Three services.

DETERMINING SERVICES AFTER ELIGIBILITY

Now that Tyler had been found eligible for Birth to Three services, the early intervention team, including Brittney, needed to consider what kinds of services best fit his family.

Regardless of the reason for eligibility, Birth to Three procedures and mission requires that staff take a holistic and comprehensive approach to development. For all children the approach is to promote and foster nurturing and responsive relationships (see Appendix 1).

Promotion of Effective Workplace, Nurturing and Responsive Relationships and High Quality Environment



A popular way to look at infant mental health services is to consider a pyramid in which the base is the broadest part. That bottom three sections represent the services that all children need for healthy social/emotional development regardless of the presence or absence of developmental delay. The middle section represents those children and families with social/emotional concerns who can benefit from intervention. The top of the pyramid, a small segment, represents those children who will benefit from clinical mental health services.

Promoting healthy social and emotional development can be achieved through a variety of activities. The following are a few examples:

- Providing information about social-emotional development in the context of care giving relationships to all parents, health care providers, child care providers and others who make up the constellation of a child's world. Birth to Three providers are encouraged to use the Creative Curriculum listed in Appendix Eleven (Dombro, Colker and Dodge, 1998) for information to share with families.

- Distributing information about school readiness to parent of young children with disabilities, and talking to them about how emergent learning and school readiness apply to their children. For example, encouraging curiosity in a child who needs assistance in mobility or developing self-regulation in a premature infant.

- Talking with families about social and emotional milestones as well as other age appropriate developmental milestones of children (see Appendix Six).

- Incorporating the concepts of infant mental health into trainings for personnel working with young children and their families.

Tyler's Story: Assessment of needs

It was clear to Tyler's Birth to Three team that Tyler's mother felt her son needed treatment for what she considered to be a mental illness. She attributed much of his behaviors to him being "crazy" and "bipolar." Brittney saw no connection between the turmoil in the household and Tyler's attention seeking and extremely challenging behaviors. Brittney was very candid that the only reason she wanted Birth to Three was to placate Tyler's pediatrician who she then felt would finally prescribe drugs. The team however, was much less sure as to whether Tyler had a mental health disorder. They were confident that a comprehensive assessment would allow the team and Tyler's family to decide the best approach to support the healthy emotional and social development of Tyler. (For more information on diagnosing please refer to Appendix Five)

ASSESSMENT

For all children who are eligible for Birth to Three services, an assessment indicating the child's unique abilities in each area of development must be completed by a multidisciplinary team and must cover all five area of development (CT Birth to Three System Procedures Manual, Initial Child Assessment).

Identification of social and emotional concerns is of significant importance and should be a part of every child's assessment process including both initial and annual assessments. An appropriate and thorough assessment provides the information essential in the determination of needed services and supports including the need for further assessment or referral. If social and emotional concerns are significant, the assessment should delve deeper in the following areas:

- Infant and toddler feelings, relationships and behaviors
- Family concerns particularly regarding the feelings, relationships and behaviors of the child
- Family resources that include extended family and other natural supports
- Family issues (substance abuse, mental illness, domestic violence, poverty, economic constraints, job loss, homelessness)
- Environmental stressors (community violence, multiple foster home placements)

The most common strategies for assessment are:

- Family interview
- Observation of infant and toddler play
- Observation of family-child ways of relating
- Assessment Instruments (on the following page and in Appendix Ten)

ASSESSMENT TOOLS

	Tools for Eligibility Evaluation	Tools for Assessment	Tools for Screening
Ages & Stages Questionnaires: Social-Emotional			X
Battelle Developmental Inventory -2	X		X
Brief Infant Toddler Social Emotional Assessment		X	X
Child and Adolescent Needs and Strengths 0-3			X* A care coordination planning guide
Developmental Assessment of Young Children	X		
Devereux Early Childhood Assessment for Infants/Toddlers	X	X	
Infant Toddler Developmental Assessment		X	
Infant Toddler Sensory Profile		X	
Infant Toddler Social Emotional Assessment	X* (problem behavior domain not accepted at this time)	X	
Mental Health Assessment of Infants in Foster Care		X	
Parent Stress Index		X	
Temperament and Atypical Behavior Scales		X	X
Vineland Social Emotional Early Childhood Scale	X		

Please see Appendix Ten for more information on this list of instruments useful in examining social and emotional development.

Targeted Social Emotional Supports

The assessment will reveal the areas of intervention and support needed by a particular family. Supporting healthy parent/caregiver - child relationships as an interventionist can be achieved by:

- screening and assessment of social and emotional development as a part of the early identification process;
- carefully listening to families to help them identify, clarify, and address issues that may be affecting the developing relationship with their child (Heffron, 2000);
- coordinating services with community mental health and public health providers when there is concern about maternal depression, parental substance abuse and other family mental health disorder;
- assisting parents/caregivers in understanding and responding sensitively to the cues of their child;
- providing parents with support as they increase their coping skills and build resilience in their children (Heffron, 2000); and
- using relationship based practice with families in order to model and promote the parent-child relationship.

For Tyler, the initial strategies addressing his development included:

- completing the Sensory Profile;
- finding community mental health resources for Brittney;
- finding a preschool with mental health consultation services; and
- identifying activities that Brittney and Tyler could enjoy together (physical activities since Tyler excels in that area).

ONGOING ASSESSMENT

Tyler's Story: Ongoing Assessment

Understanding Tyler's behaviors was not possible until the early intervention team spent time building a relationship with Brittney. It was only then that Brittney began to feel comfortable talking about her life. The team quickly began to gain a better understanding of why Brittney and Tyler both responded to each other in the ways they

did. By providing a warm, non-judgmental and caring atmosphere, the team was able to watch, listen to, and observe the interactions between Brittney, Tyler and the rest of the family. They learned that Brittney had suffered severe physical, sexual, and emotional abuse as a child. She was also severely neglected. Brittney's mother had a series of boyfriends that moved into the house, took on the role of parent, and just as quickly left. These same boyfriends were often the perpetrators of Brittney's abuse. Brittney also explained that as a child she had been diagnosed with hyper-activity attention deficit disorder. Her prescription drugs made a huge difference in her ability to concentrate at school. For a brief time she was able to do well in school and be accepted by her peers, two things that she desperately wanted for her own children. But substance abuse was all around her and by the time she was 11 she was drinking and using drugs with her mother and her mother's friends.

Brittney also talked about being terrified as a child of being out in the streets and homeless. She worried that Tyler's tantrums and behaviors would cause her already precarious living situation to unravel and leave her and her children out in the cold. For Brittney, having her doctor write a prescription for drugs that would quiet Tyler was really more about being able to stay in a safe and stable place.

Building a relationship with Brittney and Tyler was never an easy process. Relating with Brittney required patience, perseverance, and lots of listening and clarification. The IFSP that Brittney and her team developed reflected an assessment process that revealed both issues readily identifiable from the beginning and others that weren't. Tyler's sensory integration issues were often misunderstood even by those closest to him as simply bad behaviors. Through this process both Brittney and her team agreed that while Tyler's behaviors were very challenging, he really did not need medication. Tyler did not need treatment for a mental health disorder but rather targeted social emotional supports.

The Birth to Three team was able to connect Brittney, Tyler, and their family with a series of supportive community programs. These programs included mental health counseling for Brittney to deal with addiction and her own past history of abuse, subsidized housing and respite care. They found a preschool program for Tyler with a staff that was highly experienced in working with children with social emotional concerns. The team also contacted the Early Childhood Consultation Partnership (ECCP) to provide additional support for Tyler and the preschool staff in order to circumvent problems with challenging behaviors (see Appendix Eight). The Birth to Three staff helped Brittney understand the sensory issues Tyler experienced and how to help Tyler manage those issues. They also were able to support Brittney and build her confidence in herself as a mother and as a person. They repeatedly found ways to praise Brittney and acknowledge her successes as a mother. By the time Tyler was

ready to turn three, Brittney and her Birth to Three team were confident that despite a rocky and turbulent beginning, Tyler was on his way to becoming a healthy, happy little boy ready to relate and learn in his next school environment.

Intensive Intervention/Treatment

For the very small percentage of children enrolled in Birth to Three with diagnosable mental health conditions, the goal is to design a program to alleviate the symptoms and support the return to healthy development and behavior. In addition the team would develop strategies to improve the quality of family life and child development. These would be considered Part C services and should be listed on the IFSP. These services would be provided by a social worker or psychologist trained to work with children under age three (see Appendix 9).

Part C psychological services would include:

- administering psychological and developmental tests and other assessment procedures;
- interpreting assessment results;
- obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development; and
- planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education.

Part C social work services would include:

- during observations and assessments identifying emerging competencies of the infant and young child within a relationship context;
- supporting and reinforcing each parent's strengths, emerging parenting competencies and positive parent-child interactions and relationships;
- making home visit to evaluate a child's living conditions and patterns of parent-child interaction;
- preparing a social or emotional developmental assessment of the child within the family context;
- providing individual and family-group counseling with parent and other family members and appropriate social skill-building activities with the child and parents;
- working with those problems in a child's and family's living situation (home, community, and any center where early intervention services are provided) that affect the child's maximum utilization of early intervention services; and

- identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services.

If no social worker or psychologist is on staff the program would be responsible for contracting with one. The social worker or psychologist would serve as primary service provider or service coordinator and in this role would assist families in the following ways:

- maintaining a collaborative and responsive relationship between parent/caregiver, Birth to Three team members and infant mental health treatment professionals to assure a coordinated, integrated intervention approach; and
- creating or adapting models for multidisciplinary and transdisciplinary work between Birth to Three and behavioral/mental health services (see Appendix Nine)

NOT ELIGIBLE FOR SERVICES

Tyler's Story Revisited

Scenario I (Not eligible)

Let's revisit Tyler when he was an infant and alter his story just a little. Tyler at three months was referred to Birth to Three by his DCF worker while his mother was still in the juvenile detention center. He was living with a cousin of his great aunt. The cousin contacted Tyler's mother who agreed to an eligibility evaluation. On the day of the evaluation Tyler was alert, responsive, and no developmental delays were observed. Because of the risk factors noted the team completed the Ages and Stages Social Emotional Questionnaire with the caregiver. The screening suggested overall no current developmental concerns. What is the responsibility of the Birth to Three staff at this point? Here are some suggestions:

- encourage the caregiver or DCF case worker to enroll Tyler in Help Me Grow;
- provide family information about other mental health serving agencies that can offer services to the family around social/emotional development given Tyler's risk factors (See Appendices Six and Twelve);
- support the caregiver in her role with Tyler;
- provide developmental information for the caregiver, stressing the risks that Tyler has already experienced;

- suggest to the pediatrician, the DCF case worker, and the relative caregiver a re-referral in 3-6 months;

- recommend community activities for Tyler and his caregiver such as library story time for infants, “mommy and me” activities at hospitals and youth service bureaus

ELIGIBLE

Scenario II (eligible but not for social/emotional concerns)

In this second scenario, Tyler was evaluated by the Birth to Three team at three months of age and was found eligible based on his adaptive scores; his eating and sleeping were of concern to the cousin, his caregiver, and he was not gaining weight. These issues should alert the Birth to Three team to relationship, emotional, and sensory issues. Because the promotion of social/emotional well being of all infants and toddlers is part of the Birth to Three services the following supports should be considered:

- parent and caregiver guidance to social, emotional, and behavioral development issues;

- assistance to parents and caregivers in reading infant and toddler cues;

- development of individual and care giving strategies to use with infants and toddlers that address specific delays as well as social and emotional development;

- assistance to parents to obtain services to reduce financial and other stressors;

- assistance to parents in accessing and using other support systems; and

- screening for social emotional wellness whenever families have concerns about social/emotional and behavioral issues.

Appendices Index

MISSION

The Mission of the Connecticut Birth to Three System is to strengthen the capacity of Connecticut's families to meet the developmental and health-related needs of their infants and toddlers who have delays or disabilities. The system will ensure that all families have equal access to a coordinated program of comprehensive services and supports that:

- foster collaborative partnerships
- are family centered
- occur in natural environments
- recognize current best practices in early intervention
- are built upon mutual respect and choice

Connecticut Birth to Three System

Partnerships: *Effective supports for families depend on providers and families working closely with a variety of community, state and federal programs.*

Family Centered: *Evaluation, planning and services are designed around the family's needs, concerns, and priorities and keep the whole family in mind.*

Natural Environments: *Providing services within activities that occur in the child and family's home and community offers opportunities for the child to learn and practice new skills and participate more fully in his regular daily routine.*

Best Practices: *Research and laws continually require new approaches to services. Providers use up-to-date, effective service strategies.*

Respect and Choice: *Families choose their Birth to Three program. Decisions about services and supports reflect the family's knowledge, beliefs, hopes, family characteristics and culture. Achievements are made by families and providers working together on the same level and recognizing that each has important information to share.*

Appendix Two

Definition of Infant Mental Health

The term infant mental health has come to refer to both the social/emotional development of the young child and to the definition of a field of study.

Zero to Three: National Center for Infants, Toddlers and Families defines infant mental health as:

> *The developing capacity of the child from birth to age 3 to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn, all in the context of family, community and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development (Zero to Three, 2005).*

Infant mental health refers to "the mental wellness of the actual caregiving relationship between caregiver and child" (Onunaku, 2005). It is in this unfolding relationship that the optimal growth and social emotional, behavioral and cognitive development of the infant will take place. In a healthy, stable and loving environment most children will thrive.

The World Association of Infant Mental Health (WAIMH) describes infant mental health as:

> *A field dedicated to understanding and treating children 0-3 years of age within the context of family, caregiving and community (WAIMH, 2005).*

Infant mental health is a growing field of interdisciplinary research and practice devoted to the promotion of healthy social emotional development; prevention of mental health problems; and treatment of the mental health problems of very young children in the context of their families.

Appendix Three

Culture and Infant Mental Health

Key aspects of social/emotional development are developing relationships and regulating emotions. More than a set of skills to acquire individually, infant mental health includes care giver responses; the culture and environment; and expectations and responses.

Culture in this context can be viewed as "shaper of children" (Lieberman 1998. It encompasses and surrounds a child providing rules of living that include language, ethnicity, religion and moral values. Culture teaches a child how to relate in social situations and what to expect of oneself. More importantly, culture teaches a child what she can expect of others in her group or family. It is from this point that a child begins to form secure attachments.

Healthy social and emotional development reflects the context of the life of each child. Culture in infant mental health is more than customs; it is the way of being with each other, the way of expecting relationships to be. Culture defines the world of the child.

The child's world may look very different from the world the early interventionist comes from. Religion, sexuality, moral values and even hygiene standards may be completely unlike anything the early interventionist has ever experienced. Yet this is the culture the child is growing up in. Care must be taken to avoid critical or disapproving assumptions about the family. Observations and gentle inquiries surrounding culturally related activities should occur at every visit. Most families love to tell their stories. Giving families an opportunity to speak about their life and what is important to them while listening nonjudgmentally is essential if an interventionist truly wants to understand what a family needs most.

The early interventionist will also be aware of the more subtle cultural experience of a family that typically operates outside of conscious awareness. The intimacy between mother and child that involves knowing and understanding the feelings and sensitivities of each other according to what feels right, is often referred to as the "goodness of fit" (Christensen, Emde and Fleming, 2004). The "goodness of fit" is especially important for children who are developmentally or emotionally vulnerable. Knowing there is one person who understands and accepts him exactly as he is provides a child with a solid foundation from which to grow. The role of the early interventionist is to help parents become aware of the unique way they "fit" with their child.

Cultural differences exist in attachment and parenting styles. It is a challenge for the early interventionist and infant mental health programs to explore and promote healthy multicultural development in families and integrate this "cultural knowledge" into their work (Huang and Isaacs, 2007).

Appendix Four

Brain Development

> "Children grow and thrive in the context of close and dependable relationships that provide love and nurturance, security, responsive interaction, and encouragement for exploration. Without at least one such relationship, development is disrupted and the consequences can be severe and long lasting" (Shonkoff and Phillips, 2000).

Infants and children who live in violent, chaotic environments are poorly equipped to respond to stress and trauma. Without the presence of at least one strong, stable adult figure young children adapt by becoming hypervigilent of their environment. They remain in a perpetual state of hyperarousal; highly stressed and in a constant state of fear (Perry, 1997). Cortisol, a vital hormone that is often referred to as the "stress hormone" floods through their body. It increases blood pressure, blood sugar levels and has an immunosuppressive action. The elevated cortisol disrupts the developing brain architecture, leading to cell death or cell damage with disordered brain connections. This especially affects the hippocampus, the center for learning and memory.

Prolonged stress in young children leads to lifelong problems in learning, as well as mental and physical health. In infants, stress might be reflected in physical symptoms such as failure to thrive, constipation, inconsolable crying and sleep problems. Toddlers often exhibit stress with aggressive or impulsive behavior and paralyzing fears (Zero to Three, 2007).

Some stress is normal and healthy for babies, but the healthy baby is one whose stress is reduced by the presence of a sensitive and receptive care giver. Responsive, nurturing relationships protect the brain from toxic levels of stress and protect the brain of the infant from damage.

It is important to know that there are real genetic and neurobiological disorders that can affect the mental health development of very young children. Children are being identified earlier than in past years with mental health disorders. These disorders respond well to early and intense treatment that often lead to successful future learning. The context for many of these mental health disorders is often biologically based.

Appendix Five

Diagnosing Infant/Toddler Mental Health

A number of the diagnosed conditions that automatically convey eligibility relate to infant/toddler mental health. A few of those conditions include:

- Childhood Depression
- Childhood Disintegrative Disorder
- Reactive Attachment Disorder

The above conditions are considered medical disorders and can be diagnosed based on criteria in the Diagnostic and Statistical Manual of Mental Disorder IV (DSM IV TR) or the International Statistical Classification of Diseases and Related Health Problems 10 (ICD-10). The diagnoses are made by clinically trained and licensed professionals such as social workers or psychologists.

The Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood Revised (DC: 0-3R) is designed to complement the DSM IV TR. It provides a developmental framework for understanding mental health and developmental problems in the earliest years. DC: 0-3R identifies emotional and behavioral patterns that represent significant deviation from normal behaviors. Some of the categories in DC: 0-3R are new categories reflecting mental health and developmental difficulties. Other categories mirror the DSM IV disorders of infancy. Still others describe the earliest signs of mental health problems seen in older children and adults, but have not yet been attributed to infants and toddlers. In infancy and early childhood, mental health disorders may have very different characteristics from those diagnosed at a later age. DC: 0-3R allows for the earliest identification of mental health disorders so that effective intervention can occur. Cross-walks between DC: 0-3R and DSM IV TR are available for insurance reimbursement purposes (see Appendix Eleven, Michigan Association for Infant Mental Health Crosswalks). Like all early intervention, it is the hope that more optimistic prognoses will result from this earliest intervention.

Appendix Six

Social Emotional Development

The following changes in social emotional development from birth to three are meant to highlight those key elements and the course they take as a baby grows and matures. For some babies the growth will be slower or faster than listed. What is important is that there is change over time from one step to the next.

From Birth to 6 Months

Babies are learning ways to be soothed and are establishing regulation and predictable cycles of eating and sleeping. Young infants need to know that a familiar caregiver will respond promptly when they feel distressed. Learning that they can count on being cared for helps infants build a sense of security. Specifically an infant at this time:

- is alert to voices and faces;
- follows caregiver with eager eyes;
- show enormous joyful smiles to interesting facial expressions;
- vocalizes happily;
- spends lots of time getting to know own body: sucks hands, look at hands, pulls feet to mouth;
- moves arms and legs to the rhythm of caregivers' voices;
- Interacts best when in an alert state or inactive and attentive state;
- will engage, disengage, then reengage with caregiver for short periods of time; and
- is learning to trust, love, and feel emotionally close to caregivers.

From 6 to 18 Months

Exploration takes center stage as infants become more mobile. It is important for caregivers to remember that at this stage infants practice independence but very much need trusted adults as a secure base of support. A baby at this time:

- responds to caregiver gestures with gestures in return: hands toys back and forth, plays peek a boo;

- initiates interactions and looks expectantly for caregiver response, shares pleasure;
- expresses desires and wants by pointing to food or toy or caregiver;
- initiates comforting and closeness by pulling on caregivers' legs and eventually runs to give hugs;
- may express feelings of anger by banging or throwing and later with gestures and sounds;
- may show anxiety when separated from primary caregiver; and
- recognizes self in pictures or mirror.

From 18 to 36 Months

Through dramatic play, increasing facility with language, and negotiation of conflicts with peers and adults, toddlers build a sense of themselves as social beings – competent, cooperative, and emotionally connected. A toddler at this time:

- engages in pretend play with others: puts doll to sleep, races cars/trucks;
- uses words or combines gestures to express feelings: "me mad" or "no bed";
- communicates desire for closeness by saying "hug" or gesturing to sit on lap;
- can recover from anger and be cooperative;
- watches others; and
- defends possessions.

<u>Behaviors That May Signal Concern</u>

The following signs may indicate the need for assistance, depending on the intensity and frequency. The early interventionists can help family members decide if the signs warrant specific assistance.

Infant (birth to 12 months)

- unusually difficult to soothe or console
- limited interest in things or exploring the environment

- limited interest in interacting with people, difficult to engage
- lack of joy in interaction with caregiver, somber
- consistent strong reactions to touch, sounds, or movement
- always fearful or on guard
- reacts strongly for no reason
- evidence of abuse or neglect
- lack of use of gestures to communicate, like pointing
- somatic disregulation, sleep disturbance

Toddler:

- displays very little emotion, sad, withdrawn, somber
- unable to comfort or calm self; difficulty self-regulating; prolonged tantrums
- hyper-vigilant, anxious, fearful
- limited interest in things or exploring the environment
- limited interest in interacting with people; difficult to engage
- chaotic, unfocused activity; frequently hurt
- does not turn to familiar adults for comfort, help, or shared pleasure
- indiscriminant affection
- has inconsistent sleep patterns
- aggression directed to self or others
- regression with loss of previous milestones

Appendix Seven

Early Childhood Mental Health Systems of Care

> "A system of care is a coordinated network of community-based services and supports that is organized to meet the challenges of children and youth with serious mental health needs and their families" (U.S. Department of Health and Human Services 2006).

For children with social/emotional concerns and their families, services can cut across a wide swath of medical, mental health, educational and community based services and supports. For providers and families alike, understanding the concept of a system of care and child care partnerships is integral in order to effectively coordinate and advocate for services for children with social/emotional concerns.

Background on Systems of Care

According to Friedman and Stroul (1986) there are four principles in providing a system of care for very young children with social/emotional disturbances. They are:

1. Children should have access to a comprehensive and integrated array of services that address each child's unique physical, emotional, social and educational needs.

2. Services should be guided by a family driven IFSP and set in a child's natural environment.

3. Families and caregivers should be full participants in all aspects of planning and delivery of services. Multiple services should be coordinated in such a way so that all providers can deliver comprehensive coordinated care as the child's needs change.

4. Early identification and intervention for children with social/emotional concerns should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

Knitzer (2006) further expands on this model by suggesting developing systems of care be:

- *Grounded in developmental knowledge.* Early childhood systems of care must be deeply grounded in the developmental knowledge of what are typical and atypical behaviors for infants, toddlers and preschoolers.

- *Relationship based.* The system of care design should reflect the philosophy that healthy relationships among parents, children and caregivers are essential for the child's healthy emotional development.

- *Family supportive.* In almost all instances, the best way to help young children is to enhance and strengthen the families' abilities to meet their emotional needs. This includes supporting families as they struggle with economic, physical and mental health issues.

- *Infused into the existing early childhood networks and services.* All children and families connect with a constellation of people who play integral roles in their lives. These people may be relatives, caregivers, pre-school and Early Head Start and Head Start programs, pediatric and well child clinics, social service programs and Birth to Three programs.

- *Responsive to the community and cultural context.* When designing a system of care one size does not fit all. Responding to families' ethnic and cultural strengths and customs is essential to facilitate understanding among all families and the people who are part of their system of care.

- *Attentive to outcomes.* Developing mechanisms to assess the impact of an early childhood mental health system of care shows both public and private funders the impact the investment of dollars has on school readiness, early learning and more costly interventions for children with social/emotional disturbances.

Connecticut's Early Childhood Systems of Care

Systems of Care also known as Community Collaboratives for children's behavioral health are organized throughout Connecticut as a result of legislation passed in the late 1990's. This is a statewide effort to reform the children's behavioral health services by coordinating, financing and delivering services to children and their families (Connecticut Department of Children and Families, 2008). Community Collaboratives have been established in twenty-five regions across the state representing all of Connecticut's one hundred sixty-nine cities. These collaboratives are comprised of representatives from children's behavioral health, education, juvenile justice, child

welfare community service providers, parents and advocates who meet on a regular basis to improve the way behavioral health is delivered in local communities. The Community Collaboratives focus on serving families of children with complex behavioral health needs. These are children who exhibit behavior that meet the criteria for a psychiatric disorder as outlined by the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV TR). While much of the early focus of these collaboratives has been on coordinating services for older children, the state mandate includes all children from 0-18 years of age. Please check Appendix Eleven for the web site directing you to the Community Collaborative serving each town.

Two programs that incorporate the philosophy of a system of care and specifically serve children birth to three are Building Blocks serving families and children in New London County and Child FIRST serving greater Bridgeport. Both programs provide relationship based, family focused and culturally competent services in children's natural environment. Staff in both programs are specifically trained in providing developmentally appropriate services to children zero to three years of age with social/emotional disturbances.

Much of what early interventionist do in their work with families involves drawing on a family's system of care. A system of care simply means coordinating and collaborating with the existing constellation of service providers working with a family. A system of care is not just a specific program or model, but a philosophy that incorporates the basic tenets of the Birth to Three System.

Appendix Eight

Early Childhood Mental Health in Child Care Settings

Early Childhood Mental Health Consultants

Early interventionists frequently provide services for children in a child care setting. Young children with social/emotional disturbances often present particular challenges to child care staff. Engaging an early childhood mental health consultant may be appropriate for a young child exhibiting challenging behaviors in child care. The goal of the Early Childhood Mental Health Consultation Partnership (ECCP) is to improve the quality of early childhood programs and reduce the likelihood of suspensions and expulsions in child care settings. Early childhood mental health consultants are available to center-based child care programs to improve the social/emotional development of an individual child or the climate of a classroom. Approximately 20 to 25 percent of classrooms served by ECCP include infants and toddlers. Birth to Three staff can share this resource with families and with child care providers when social/emotional concerns arise with a child in Birth to Three who is also in child care. Exact location of consultants can be found in Appendix Eleven.

Another source for mental health consultants to child care programs in Connecticut are those consultants trained through the multidisciplinary consultation project led by the Head Start Collaboration Office. These consultants receive training on becoming child care consultants as well as training specific to infants and toddlers. One of the three infant/toddler modules has an in depth focus on relationships: the heart of development and learning. A list of these consultants can be found at www.ctnurses.org.

Other family programs and support services working specifically with very young children with social/emotional disturbances can be found in Appendices Eleven and Twelve.

Working with Child Care Providers and Families around Social Emotional Issues

Child care providers are a resource for both the family and the interventionist in determining plans for the child. Children with social/emotional disturbances can provide particular challenges to child care staff. Suggestions for interventionists as they discuss issues with the child care provider are:

- identify the child care's mental health consultant or source for a consultant;
- discuss with the child care center using a screening instrument routinely with families, such as the ASQ:SE;

- discuss using a specific social/emotional curriculum such as: Creative Curriculum used by Head Start programs, the Bingham Curriculum used in Southeast CT, Promoting First Relationships, DECCA and Bright Futures (See Appendix Eleven for information about these curricula);

- see Appendix Eleven for information regarding biting, sharing and shyness that may be helpful to the child care provider and family;

- suggest contacting the ECCP if the classroom environment seems to be impacting the child's behavior and/or the child's behavior is impacting other children's activities;

- discuss with the director opportunities for staff training in the areas of social/emotional development in order to promote infant mental health well being

Appendix Nine

Training

Infant Mental Health is a transdisciplinary field and is not limited to mental health clinicians. Yet finding professionals who are trained to work in the field of infant mental health can be challenging. Despite this challenge an effective workforce knowledgeable about systems and practice is the foundation for promoting infant/early childhood social and emotional development (www.vanderbilt.edu/csefel). According to Knitzer (2002) there are individuals who are trained in child development and there are mental health clinicians. There are very few professionals who are trained to function as early childhood mental health specialists. Infant mental health specialists need a broad range of skills that include:

- developmental knowledge of infants toddlers and pre-schoolers;
- clinical sensitivity and expertise;
- understanding of and comfort with working with families from diverse cultural backgrounds; and
- understanding and background in working with families with multiple psycho/social stressors that might include parental substance abuse, mental illness, poverty, domestic violence, homelessness, child abuse and neglect.

The need is great for trained and skilled early interventionists who are able to identify and evaluate the social/emotional and behavioral challenges of infants and toddlers and their families and who are able to plan and implement appropriate intervention strategies for young children in the context of their families. Early Interventionists as home visitors are in strategic positions to effect the caregiver-young children relationship development and can serve as infant/family specialists. This level of training does not require licensed clinical skills but rather the understanding of relationship-based approach to working with young children and their families. A job description statement might read:

> "Practice reflects understanding of the centrality of relationships in supporting children's and families' growth and development. Is able to establish a therapeutic alliance with families on behalf of the identified child." (Norman-Murch, 2007).

Training sources available to interventionists are:

- Birth to Three System through State Education Resource Center (SERC)

- Connecticut Association for Infant Mental Health
- Building Blocks System of Care in Southeastern CT that has a goal of building the capacity of the infant/early childhood workforce.
- Online training opportunities. Please see Appendix Eleven for a complete training list

Weatherston (2002) suggests that an infant mental health specialist is "someone with a distinct set of core beliefs, skills, training experiences, and clinical strategies who incorporates a comprehensive, intensive, and relationship-based approach to working with young children and families."

Those basic beliefs are:

- optimal growth and development occur within nurturing relationships;
- the birth and care of a baby offer a family the possibility of new relationships, growth, and change;
- what happens in the early years affects the course of development across the life span;
- early developing attachment relationships may be distorted or disturbed by parent's histories of unresolved losses and traumatic life events ("ghosts in the nursery);" and
- the therapeutic presence of an Infant Mental Health specialist may reduce the risk of relationship failure and offer the hopefulness of warm and nurturing parental responses.

The Connecticut Association for Infant Mental Health and its partners are promoting Infant Mental Health Competency Guidelines with the expectation that an endorsement/credential will be established in Connecticut within the next few years.

Those competencies include:

- theoretical foundations (e.g. pregnancy, infant and toddler
    - development, attachment theory, relationship development, cultural
    - sensitivity, families, disorders, and adult mental health)
- policy knowledge

- systems and service skills
- collaborative relationships
- communication skills
- reflective practice and
- critical thinking

Reflective Practice

Research indicates a critical component of a comprehensive infant mental health program is the use of reflective supervision. The work of infant/early childhood mental health is challenging. Having the opportunity for infant mental health specialists to reflect on their experiences with a team or a supervisor is both an essential element of their work as well as best practice. Reflective supervision is the regularly scheduled opportunity to share observations, reflect on their meaning and implications in a non judgmental environment with a supervisor who does not direct but reflects. Supervision by an experienced, licensed, mental health clinician allows the practitioner an opportunity to learn and grow in the context of the relationship with her supervisor. (Shahmoon-Shanok et al 2006).

Reflective supervision acknowledges that practitioners bring their own values, past experiences and expectations to the relationship in the same way that family values, past experiences and expectations are brought to the parent child relationship and parent practitioner relationship. The guided supervision allows for revelation of those experiences in a supportive and cooperative and respectful environment.

Finding time and leadership for reflective supervision often is a barrier in Birth to Three. Suggestions to incorporate reflective supervision into Birth to Three include:

- devote one staff meeting per month to small group working in pairs or threesomes;
- develop an online group to “chat” regularly about developing relationships and one’s own impact;
- set up regular telephone or e-mail discussions after exchanging video materials; and
- provide individual reflective supervision at least monthly.

Training Outcomes in Infant Mental Health

The professional will:

1. Understand the critical requisites needed for social and emotional health and development.

2. Understand biological, familial, experiential and community influences on the social and emotional well-being of infants and toddlers.

3. Provide careful family centered screening, assessment and intervention that promotes the social and emotional well-being of infants and toddlers and meets the developmental needs of infants and toddlers with social and emotional risk indicators or mental health diagnoses.

4. Understand systems issues that address the social and emotional well-being of infants and toddlers and their families.

Content

1. Social and emotional health and development in infants and toddlers

   A. Overview of social and emotional health and development:

      - Indicators of infant/toddler resilience
      - Indicators of infant/toddler risk

   B. Critical requisites needed for children to thrive are:

      - Attachment/relationships
      - "Goodness of fit"
      - Self-efficacy
      - Development of self
      - Routines and rituals
      - A "protective environment" and parent as buffer

   C. Biological and constitutional influences:

      - Temperament
      - Neurodevelopmental status
      - Physical health
      - Developmental disability
      - Chronic illness
      - Prematurity

D. Family influences: parental, family and extended family:

- Supports
- Resources
- Risk factors: abuse and neglect

E. Experiential influences:

- Loss of primary caregiver
- Multiple caregivers
- Out of home placement
- Multiple placements
- Hospitalizations

F. Community and Societal influences:

- Network of community support
- Cultural issues
- Economic opportunity
- Community stability

2. Social and emotional developmental screening, assessment, and diagnosis:

- Best practices in screening for infant and toddler social and emotional risk indicators
- Infant and toddler social and emotional screening protocols
- Current referral resources for assessment and diagnosis within the community
- Best practices in assessing infant and toddler social and emotional risk and resilience indicators
- Infant and toddler social and emotional assessment protocols
- Classification systems for diagnosis: e.g., DSM IV, Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood

3. Early prevention and intervention:

- Interventions for infants and toddlers with identified social and emotional/ mental health disorders (e.g., pervasive developmental disorders, failure to thrive, traumatic stress disorders, attachment disorders, etc.)

- Care giving strategies that promote healthy social and emotional development enhancing infant/toddler resilience
- Care giving strategies that address needs of infants and toddlers demonstrating social and emotional risk indicators
- Infant-parent developmental supports
- Infant-parent psychotherapy
- Parent and family supports
- Working with hard to reach “high need” families
- Designing effective infant-toddler family service plans
- Current resources in the community that address infant and toddler social and emotional needs and parent and family needs for support
- Incorporation of strategies that promote healthy social and emotional development into existing prevention and intervention programs

4. Systems Issues:

- Overview of current system addressing infant mental health and social and emotional development
- Tapping existing community, state and national resources to developing a continuum of care within the community
- Community resources for assessment and diagnosis
- Best practices in service delivery
- Interagency service and care coordination
- Funding sources
- Personnel preparation and in-service training and mentoring

Appendix Ten

Evaluation, Assessment and Screening Tools

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Appendix Eleven

Websites and Curricula

Bazelon Center for Mental Health Law http://www.bazelon.org/Information and resources on legal issues and advocacy for children and adults with mental/behavioral health needs.

Building Blocks www.buildingblocksct.org An initiative of the Southeastern Mental Health System of Care focusing on children birth through five years in southeastern Connecticut, serving New London County.

Child & Adolescent Bipolar Foundation http://www.bpkids.org/site/PageServer Extensive information on pediatric bipolar disorder and resources.

Connecticut Nurses Association www.ctnurses.org Contains information about the multidisciplinary consultant training for nurses, early childhood educators, and mental health consultants. Three infant/toddler modules were developed by Zero to Three for Health Childcare New England and included in Connecticut trainings.

CT Department of Children & Families http://www.ct.gov/dcf/site/default.aspLead agency for children's mental health with information on services available for families and their children with behavioral and mental health needs. (Systems of Care)

Early Childhood Behavior Project
http://cehd.umn.edu/ceed/projects/preschoolbehavior/ Provides strategies, useful materials and interventions, case studies, presentations, and publications promoting positive behavioral supports for young children who engage in challenging behaviors. Designed to help services providers and families. Also Link to Positive Behavior Support and Technical Assistance Center on Social Emotional Intervention

Michigan Association of Infant Mental Health

http://www.mi-aimh.org/crosswalk.php

Crosswalk between Diagnostic Classifications 0-3, ICD 9 CM and DSM IVR+
This crosswalk was developed by the Michigan Department of Community Health, Division of Children's Mental Health Services in collaboration with representatives from the Michigan Association for Infant Mental Health.

The National Early Childhood Technical Assistance Center
http://www.nectac.org/topics/menhealth/menhealth.asp Provides extensive information on early childhood mental health and social emotional development and challenging behaviors.

National Technical Assistance Center for Children's Mental Health
http://gucchd.georgetown.edu/programs/ta_center/ Information on policy, research, and clinical practice to improve the lives of families and their children with special needs including: developmental disabilities and special health care needs, mental health needs, young children and those in the child welfare system.

PBS Parents http://www.pbs.org/parents/inclusivecommunities/ Information to help parents and caregivers of children with disabilities improve the overall quality of life for their children and family. Includes section on challenging behaviors.

Portland State U: Family Support & Children's Mental Health
http://www.rtc.pdx.edu/ Information on research, training, access to resources and publications on effective community-based, culturally competent, family centered services for families and their children who are, or may be affected by mental, emotional, or behavioral disorders.

Positive Behavioral Intervention & Supports
http://www.pbis.org/schoolwide.htm#ComponentsOSEP funded National Technical Assistance Center on Positive Behavior and Intervention to address the behavioral systems needed for successful learning and social development of children.

Skillstreaming: http://www.skillstreaming.com/ Instructional materials designed to show how to teach prosocial skills to preschool and kindergarten children.

The Center on the Social and Emotional Foundations for Early Learning
http://www.vanderbilt.edu/csefel/ Designed to promote social emotional outcomes and enhance school readiness of low-income children birth to age 5, and to serve as a national resource center for disseminating research and evidence-based practices to Head Start and Child Care programs across the country.

The Mental Health Family Tree Program http://www.familyaware.org/familytree/ Designed for families who may have concerns about the existence of mental health disorders in their family; provides an online tool to assist families in learning about their family's mental health history.

Tourette Syndrome "Plus" http://www.tourettesyndrome.net/index.htmExtensive collection of articles, materials, and practical resources for parents and professionals pertaining to a variety of behavioral/mental health disorders.

Young Children with Challenging Behavior
http://challengingbehavior.fmhi.usf.edu/tools.html Provides extensive research, resources, practical materials, training opportunities, and publications to promote the use of evidence-based practice to meet the needs of young children who have, or are at risk for, problem behavior.

Zero to Three This web site addresses some common issues (biting, aggression, self control etc…) that interventionists and child care providers encounter with young children. Click on "Key Issues" on the home page.

http://www.zerotothree.org

Curricula available for child care providers and parents

Bright Futures http://www.brightfutures.org/mentalhealth/index.html

Bingham Early Childhood Prosocial Behavior Program
The curriculum is available in A Blueprint for the Promotion of Pro-Social Behavior in Early Childhood (Vol. 4 in the series Issues in Children's and Families' Lives), edited by Elda Chesebrough, Patricia King, Thomas P. Gullotta, and Martin Bloom (New York: Springer, 2005).

Creative Curriculum http://www.creativecurriculum.net/

Partners in Parent Education (PIPE): Manualized activities for promoting parent-child relationships available online at www.HowtoReadYourBaby.org

Promoting First Relationships http://www.pfrprogram.org/

Appendix Twelve

Community Resources and Mental Health Organizations

List of Child Guidance Clinics Mental Health Organizations

http://www.infoline.org/referweb/MatchList.aspx?c;;0;;N;145040;MENTAL%20HEALTH%20CARE;Counseling,%20Outpatient;Child%20Guidance

Community Collaborative Systems of Care

To find the Community Collaborative that serves you go to www.ct.gov/dcf Scroll down to and click on DCF: Find the Community Collaborative That Serves You.

Early Childhood Consultation Partnership (ECCP)

Early Childhood Consultation Partnership (ECCP)

ECCP Administrative Assistant: (860) 704-6378

Fax: (860) 638-5302

Help Desk (860) 704-6444

ECCP Program Manager: (860) 704-6198

ECCP Assistant Program Manager: (860) 704- 6810

Lead ECBC Consultant: (860)-704-6448

Mental Health Organizations:

Connecticut Association for Infant Mental Health (860-443-7192) ct-aimh.org The Connecticut Association for Infant Mental Health provides statewide opportunities to enhance knowledge and to promote a positive influence on the social emotional health and development of infants, young children and their families.

Connecticut Association of Marriage and Family Therapists (1-877-987-6534)ctamft.org A professional association that represents Marriage and Family Therapists--or MFTs-- in Connecticut. We work to promote the well-being of individuals, couples, families, and other systems through the advancement of the profession and practice of marriage and family therapy.

Connecticut Clearing House, a program of Wheeler Clinic (800-232-4424) Ct.clearinghouse.org
Wheeler Clinic's Connecticut Clearinghouse is a statewide library and resource center for information on substance use and mental health disorders, prevention and health promotion, treatment and recovery, wellness and other related topics. Materials from our specialized library and resource center are available to Connecticut families, teachers, students, professionals, communities and children.

Connecticut Psychological Association (860-586-7522) Connpsych.org

Department of Mental Health and Addiction Services
Network of Care Ct.networkofcare.org is a single web resource providing information on behavioral services and resources for people of all ages. CT Network of Care reflects the collaboration of 14 state agencies and the Judicial Branch who are committed to improving Connecticut's Mental Health Care System.

Families United for Children's Mental Health (860-537-6125) (families: 1-866-439-0799) ctfamiliesunited.homestead.com/
See web site for information on support, diversity, empowerment, and community resources.

FAVOR (860-563-3232) Favor-ct.org
FAVOR is a non-profit Statewide Family Advocacy Organization serving families, children and youth dealing with a broad spectrum of behavioral and mental health needs, by providing policy and family advocacy

Mental Health Association of CT, Inc. (1-800-842-1501) Mhact.org

National Mental Health Alliance (860-882-0236, 800-215-3021) Namict.org Support, education, advocacy: a family and consumer organization

APPENDIX Thirteen

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