Dedicated to

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Wise Mentors and Gentle Guides
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NM Infant Team Data Documentation 207
“Every seven minutes a baby or toddler in America is removed from his parents’ care because of alleged abuse or neglect. At a time when these children are first exploring the world, when their lives as learners are just beginning, they are learning that the world is a dangerous and frightening place. Their brains are assaulted by stress hormones that can diminish their IQs and social interactions. Their need to find safe, trusting relationships overrides their curiosity. Their future and the future of their communities are compromised. These young children, a disproportionate percentage of whom are children of color, are often overlooked in the range of approaches designed to improve the early learning environments for poor children. Despite this grim forecast, research confirms that the early years present an unparalleled window of opportunity to effectively intervene with very young victims of maltreatment. Research-informed decision-making combined with developmentally appropriate services can change the odds for these babies and toddlers. Yet, the child welfare system is not guided by what science says babies need. As a result, what unfolds is a developmental disaster for babies.”

—Zero to Three (National Center for Infants, Toddlers, and Families),
Safe Babies, Strong Families, and Healthy Communities, 2014
NEW MEXICO PYRAMID PARTNERSHIP: A FRAMEWORK FOR SUPPORTING THE SOCIAL EMOTIONAL WELL-BEING OF INFANTS, YOUNG CHILDREN, AND FAMILIES

VISION
All New Mexico early childhood practitioners, in partnership with families, will have the knowledge, skills, attitudes, and supports necessary to nurture infants and young children’s social emotional well-being within their family, culture, and community.

MISSION
The NM CYFD Pyramid Partnership will develop, evaluate, and sustain a statewide, collaborative professional development system that utilizes the Pyramid framework. The integration of the Pyramid framework with other related promotion, prevention, intervention, and treatment efforts in the state will assure New Mexico practitioners learn to promote social emotional competence and understand the impact of nurturing relationships on children’s capacity to learn.

PYRAMID FRAMEWORK OVERVIEW
The NM CYFD Pyramid Partnership has adopted existing models of evidenced-based practices addressing social-emotional foundations. The Pyramid framework developed is used to promote the social-emotional competence of children birth to age five in the context of nurturing relationships and quality learning environments. The Pyramid framework also provides strategies to prevent and address the challenging behavior of young children.

NM CYFD PYRAMID PARTNERSHIP
The NM CYFD Pyramid Partnership envisions an integrated and aligned system of early childhood programs, practitioners and families versed in the Pyramid Framework. The Pyramid Framework will build a system utilizing existing models and efforts.
THE GOALS
- Promote the social emotional well-being of all infants, young children and address challenging behaviors;
- Increase the number of high quality trainers and coaches; and,
- Achieve community- and state-level commitment to supporting the well-being of all infants, young children and families.

THE RESULTS
- Educated and coached early childhood workforce;
- Families with skills and strategies to support their children; and
- Pyramid implemented across all settings and programs.

INITIATIVES
The Children, Youth and Families Department envisions a competent workforce to address the social-emotional needs of young children. The NMAIMH Endorsement process is used to support new initiatives and to develop and recognize competency-focused, relationship based practice promoting infant mental health. Since the endorsement process has been up and running, CYFD has been offering specialized trainings to meet competency standards and contracting with the NMAIMH to provide group reflective supervision to meet supervisory requirements at each level. There have been many systemic shifts in funding sources to support these efforts. Future proposed efforts include the development of an Infant and Early Childhood Mental Health Training Institute and Leadership initiative.

PYRAMID OFFERINGS
The continuum from Effective Workforce to Treatment promotes the developmental and social-emotional well-being of all children. The Infant Teams represent the upper part of the pyramid that encompasses Clinical Treatment and Intervention. Trainings to address the competency standards that address this top level are represented below along with other offerings:
CLINICAL TREATMENT - INTERVENTION

- Infant Teams provide trauma-informed and developmentally informed assessments and interventions. Provide the specialized treatment for our most challenged children and families that are beyond the skills of the promotion and prevention home-visiting models in our state.
- Child Parent Psychotherapy Fidelity Training with Dr. Alicia Lieberman and Dr. Chandra Gosh-Ippen, Child Trauma Research Program, UCSF
- DC-0-3R Training
- COS Intensive Training Enhancing Attachment in Early Parent-Child Relationships
- Neurosequential Model of Therapeutics for Foster Families (Train the Trainer Model and Brain Metrics)
- Service Definitions for SED, Child Care
- Advanced Clinical Infant Mental Health Seminars: Infant and Early Childhood Institute, UNM- CDD
- Funding: CYFD

PROMOTION – PREVENTION

(Addressed by home visiting programs and other home-based services)

EFFECTIVE WORKFORCE

(Addressed by community providers who come in contact with young children and their families)

TABLES TO ILLUSTRATE INFANT TEAM LOGIC MODEL AND REFERRAL PROCESS

What an Infant Mental Health Team Does

**Director/Coordinator of Infant Mental Health Team**
- Receive Initial Referral
- Oversee Completion of CROWELL/Working Model Procedures
- Coordinates and Integrates information from the FIT Developmental Evaluation
- Oversee Monthly Compiled Reports
- Assist with CYFD Visitation Schedule/Supervision
- Attend Court Hearings
- Facilitate Video Review/Training
- Assign Case Leads
- Maintain Coordination w/ Court and CYFD
- Provide Reflective Supervision

**For Court**
- Provide with Monthly Integrated Reports
- Provide IMHT Input when Requested
- Attend for Bio- and Foster Family Support
- Provide Advocacy and Psychoeducation
- Support Best Interest of Infant/Child

**FIT Team Members**
- Develop IFSP and Provide Service Coordination
- Provide OT and Speech Services as Needed
- Evaluate Developmental Progress and IFSP Outcomes

**Infant Mental Health Team Members**
- Provide Infant Mental Health Support or Treatment
- Supervise Visits
- COS-DVD Training with Biological and Foster Parents
- Conduct Perception Interviews

**CYFD Responsibilities**
- Role of Custodial Parent
- Timeline for Permanency Planning
- Determine Visitation Schedule
- Assist with Foster Support/Training
- Provide CSAs

**Additional Services to Coordinate**
- Mental Health
- Drug Treatment
- Medical Care
**New Mexico Infant Team Logic Model**

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

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

New Mexico provides a coordinated continuum of high quality, community-driven, culturally and linguistically appropriate services that promotes strong parent-child relationships in addition to family, infant, and early childhood mental health, development, and safety.

The following are part of all New Mexico Infant Teams:

**Core Quality Components**
- Trauma-informed and Developmentally Informed Team Expertise
- Culturally, Linguistically & Professionally Competent Service Providers
- Reflective supervision
- Data Management and Support
- Implementing Agencies inform State-Level Programmatic Decision Making
- Community Outreach & Cross-Agency Coordination
- Evidence Informed

**Theoretical Framework**
- Attachment Theory
- Trauma Informed
- Reduction of Adverse Childhood Experiences (ACEs)
- Relationship-Based Practice
- Transdisciplinary Teaming
- Dyadic Regulatory Systems
- Level 3 and 4 Infant Mental Health endorsements to maintain IMH competencies

**Short Term Impact**
- Infant Teams enhance the likelihood that children receive nurturing, synchronous care by organizing and integrating mental health and developmental services with infants, birth parents and foster parents,
- Infant Teams advocate for child-centered decision making through collaborations with Child Protective Services (CPS), Part-C (FIT), Infant Mental Health Services and the Judicial System,
- Infant Teams provide a sensitive approach to caring for children in out-of-home care and opportunities for emotional reparation utilizing targeted trauma-informed and developmentally-informed intervention programs that aim to enhance key parenting variables and dyadic regulation.

**Long Term Impact**
- Achieve permanency with caregiver’s increased knowledge of the impact of trauma and stress on their child’s development.
- Enhance caregiver’s positive parenting behaviors and promote child’s healthy social-emotional outcomes through increased knowledge and targeted intervention strategies.
- Reduce adverse childhood experiences and the potential for recidivism.
- Ensure that children are nurtured by their caregivers.
- Increase prospect that children and families are safe.

**Systems Impact**
- Increase knowledge of the social neuroscience that informs Infant Mental Health work and of the unique attachment and developmental needs of the Birth-to-3 population and their families
- Inform decision-making considering short and long term impact.
- Influence policies to reflect short and long term impact.
- Recognize the need for integrated trauma-informed and developmentally-informed services.
New Mexico Infant Team

Example of Primary Infant Team
Director/Coordinator, 1 FIT Service Coordinator, 1 FIT DS-II, 1 FIT-OTR, 2 Independently Licensed and Endorsed IMH Specialists, 1-2 CYFD Permanency Planning Worker(s), 1 CYFD PPW Supervisor, 1 CPS Investigator

REFERRAL PROCESS

Children Taken into Custody

Infants, Birth-3, who have been placed in the legal and physical custody of Child Protective Services are identified and the Infant Team is notified per CAPTA procedures after a decision has been made to file for continued custody of a child or children that fit into this criteria. Referral is reviewed by Infant Team Director/Coordinator for appropriateness (see decision tree) and assignment to Primary Contact/Therapist.

Assessment

Following referral to the Infant Team a FIT evaluation is immediately scheduled as per CAPTA regulations and the comprehensive Infant Mental Health Assessment procedures are planned and initial information gathered. The FIT evaluation is conducted by two developmental team members.

Within 7 Days of Referral

IFSP Meeting

FIT evaluation is completed and a written report is available. A meeting to interpret results and to initiate the IFSP process is convened at CYFD and includes the CPS Permanency Planning Worker, Infant Team, Foster and Biological parents. Intensity of services and recommendations for interventions are decided upon.

Developmental Services

Following IFSP completion, Developmental Services are initiated by the Occupational Therapist and Service Coordinator. Too many services can overwhelm the family and additional services if needed are provided by consultation. Services are provided in foster home and during visitations, and include supporting child/children in Childcare Facility or Preschool.

Within Two Weeks of Referral

IMH Assessment

The Infant Mental Health Assessment continues and a Parent-Child Structured Interaction Procedure (Crowell, NCAST, or other), Clinical Observations and Parent-Perception Interview (Working Model of the Child or Circle of Security Interview) are scheduled and conducted. The procedures are videotaped, analyzed and scored to determine intervention strategies and points of entry.

IMH REPORT and Services

A report is written for CPS and the Court that includes Observations of Interaction and Perception Sessions, Treatment goals and Recommendations. Upon completion of Infant Mental Health Assessment, assigned Infant Mental Health Specialist(s) begins providing services to Biological Parents and Foster Parents if available. Team members assist with visitations whenever possible.
Monthly Meetings

**CYFD and Primary Infant Team**
Infant Team Director/Coordinator attends regularly scheduled meetings with CYFD/CPS designated team members to review the process and discuss communication, procedures, protocols, cases, and reflective consultation to enhance services to families. The Primary Infant Team meets as a group to staff cases and for reflective consultation. In addition, ancillary case-specific community providers are invited when shared case is discussed. At other times, the Director/Coordinator is available for individually scheduled sessions as needed.

**CYFD, Court, Reflection**
Assigned Team Members attend monthly provider meetings for each child to discuss progress and challenges and attend Family Centered Meetings when scheduled. The Infant Team Director/Coordinator attends Court Hearings for specific cases. NM Infant Teams are provided with regular case consultation, reflective supervision, and quarterly community of practice meetings.

Reports, Visitations, Permanency Planning

**Reports and Visitations**
The Infant Team Director/Coordinator compiles and submits monthly reports to CPS and the Court for each case summarizing all sessions; FIT early intervention services, Infant Mental Health Treatment (Infant-Psychotherapy, Circle of Security, etc.) including Progress, Challenges, Risk of Return, Best Interest of the Child, and Recommendations. When appropriate, the Infant Team assists with moving the supervised reunification visits from CYFD to supervised visits in the community.

**Permanency Planning**
When appropriate, the Infant Team assists with creating positive relations between biological parents and foster parents in the child/ren’s best interest with continued interaction if the plan moves to adoption. The Infant Team assists with developing a transition plan and helps to support the return home when reunification is imminent. The Infant Team moves oversight of services to community agencies once permanency is achieved.
INTRODUCTION TO THE NEW MEXICO INFANT TEAMS

The science of early development and our understanding of the impact of early experience on later social, emotional, and cognitive development has grown dramatically in the past three decades. Because the data are compelling and far-reaching, there has been increasing interest and concern about the quality of the infant’s earliest experiences, and how those experiences shape the child’s later development. The current state of knowledge impacts how every system that works with infants and families needs to contemplate and address the needs of our youngest citizens and their families (Shonkoff & Philips, 2000).

Infant Mental Health has been defined as the developing capacity of the child from birth to three to: experience, regulate, and express emotions; form close interpersonal relationships; and explore the environment and learn—all in the context of family, community, and cultural expectations for young children (Zero to Three Infant Mental Health Task Force Steering Committee, 2001). This definition incorporates a broad range of factors that impact current and later functioning and development. These factors are dynamic and interact with each other. When developing and administering Infant Teams, the following information is considered to be foundational to the work:

- IMH is considered synonymous with healthy social and emotional development.
- Warm, nurturing, protective, stable, and consistent relationships provide the fundamental building blocks to IMH.
- Behavioral “markers” of IMH include emotion regulation, the ability to communicate feelings to caregivers, and active exploration of the environment. These behaviors lay the groundwork for later social and emotional competence, readiness to enter school, and better academic and social performance.
- Risk and protective factors have been clearly identified that relate to current and later function; infants can experience psychological disorders in the first three years of life.
- Any factors which impact the relationship between the infant and caregiver have the potential to impact the IMH.
A continuum of services is needed to address preventive and treatment aspects of IMH; integration into existing networks and cross-system collaboration is essential.

Programs that address IMH must focus on relationships, be based in current developmental knowledge, and be supportive of the family.

Families need to be involved in the planning and delivery of IMH services.

Values, including personal, family, ethnic, cultural, professional, and organizational, impact every aspect of IMH.

Professionals working on IMHTs need training and reflective supervision in order to meet the social and emotional needs of children in state’s custody.

—From: Sameroff & Emde, 1989; Zeanah & Zeanah, 2001

Old models or inattention to the infant mental health, developmental, and behavioral needs of children involved in maltreatment investigations not only may compound the immediate effects of abuse, neglect, and deprivation but also may increase the risk of future long-term impairment for these children. The New Mexico Infant Teams integrate and coordinate services to young children in state’s protective custody in order to avoid or minimize long-term impairment for these children.

The first Infant Mental Health Team was established in the 1st Judicial District, Santa Fe County, New Mexico in October of 2009 as the result of priorities set by the Children, Youth and Families State Agency to address the needs of infants aged Birth-to-Three who were in protective custody. The First Judicial District Infant Team continues to serve all babies who come into custody in Santa Fe, Rio Arriba and Los Alamos Counties. Additional Infant Mental Health Teams were established for Dona Ana County in Las Cruces in 2011, the 6th Judicial District in 2013 and most recently an Infant Team serving Bernalillo County in the 2nd Judicial District.

In this handbook, we present an overview of the principles and process that need to be considered when building an Infant Team to meet the social and emotional needs of babies and young children taken into state’s custody. Because there are varying levels of needs for IMH services in each community, as well as different pathways for providing young children and their families services, we describe a prototype for developing an New Mexico Infant Team based upon a trauma-informed and developmentally-informed service delivery approach to improve the welfare of families, and to achieve permanency for infants in an expedited manner.

Although each New Mexico Infant Team differs based upon community needs, they all share three core beliefs:

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

### ADDRESSING SPECIFIC NEEDS OF BIRTH-TO-3 POPULATION

#### NEED

To strengthen the capacity of New Mexico’s Child Protective Services in responding to the unique needs of children birth to three taken into state’s custody through strong clinical assessment, community collaboration, service planning and treatment that identifies and intervenes in situations that impede infants’/toddlers’ ability to:
• Form close parent/caregiver relationships,
• Experience, regulate and express their emotions, and
• Explore their environment
• Heal from trauma

Early relationships provide the foundation that determines whether a baby’s brain is hard-wired for social and emotional well-being or isolation and failure. Stress and trauma alter brain development and how chronically neglected children view the world. Maltreated babies are at great risk for future school failure, juvenile justice system involvement, and other poor developmental outcomes.

Early developmental experiences with caregivers create a set of associations and “templates” for an infant’s brain about what humans are (Perry 2013). These initial caregiving experiences create the “template” that a child carries into future relational interactions, either increasing or decreasing the capacity of the child to benefit from future nurturing, caring, and invested adults. Relationships in early childhood can alter the vulnerability-resilience balance for an individual child.

The primary caregiver, through consistent, nurturing, and predictable responsive caregiving, provides the patterned, repetitive neural stimulation for the infant’s developing brain required to build in an adaptive and flexible stress-response capacity (self-regulation) as well as healthy attachment capabilities (Perry 2013). If the caregiver is depressed, stressed, high, inconsistent, or absent, these two crucial neural networks (stress-response and relational) develop abnormally. The result is a child more vulnerable to future stressors and less capable of benefiting from the healthy nurturing relational supports that might help buffer future stressors or trauma.

At birth, the developing stress-response networks in the brain are rapidly organizing. The primary source of the patterned somatosensory interactions that provide the organizing neural input to the developing stress-response system is the primary caregiver (Perry 2013). The role of the stress response system is to sense distress (e.g., hunger, thirst, cold, threat) and then act to address this challenge to promote survival. Infants are incapable of meeting their own needs and depend upon their caregiver to become the external stress regulator. Once the caregiver meets the infant’s needs, the stress-response network returns to homeostasis or baseline equilibrium in the face of external changes.

When an infant or young child is threatened and activates this stress response in an extremely prolonged or repetitive fashion, the neural networks involved in this adaptive response will undergo a “use-dependent” alteration. The end effect is an alteration in the baseline activity and reactivity of the stress response system so that the brain “resets” itself acting as if the child is under persistent threat (Perry 2013).

Child maltreatment such as trauma, neglect, prenatal exposure to drugs or alcohol and impaired early bonding disrupt the stress-response network and negatively influence the developing brain. These adverse experiences interfere with normal patterns of experience-guided neurodevelopment by creating extreme and abnormal patterns of neural connections and neurohormonal activity (Perry & Dobson 2009). Developmental trauma and maltreatment increase the risk of dysfunction in any brain-mediated function from language to motor functioning to social, emotional, or behavioral regulation.

The relationships between young children and their neglectful or abusive parents have been damaged by the events that brought them to the child welfare system. The science of early childhood is shaping effective approaches for healing those relationships and getting young children and their families back on track or for adequately assessing lack of progress and parental capacity to safely reunify. Using scientific knowledge, professionals in the child welfare system can make informed decisions and advocate for programs and policies that protect and promote permanency for the youngest children in care.
Current policy efforts call for trauma-informed as well as developmentally-informed practices and programs to understand and address the range of problems in children birth-to-three related to maltreatment. Without intervention, these risk factors can result in developmental and mental health disorders including self-regulatory disorders, language and cognitive delays, depression, attachment disorders, and traumatic stress disorders which can have an effect on later school performance and daily life functioning.

Awareness of key principles of relational health, neuroscience and neurodevelopment can improve practice, programs, and policy in child maltreatment. By translating the emerging concepts into practical improvements in our clinical systems and in our therapeutic approach to children birth-to-three in state’s custody due to maltreatment, we take a first and very important step toward reparation.

By encompassing the latest evidence-based research and therapeutic responses, the New Mexico Infant Teams provide children birth-to-three in CYFD protective custody with a coordinated trauma-informed and developmentally informed process for assessment and treatment in order to promote permanency planning, encourage relational reparation, and assure positive developmental outcomes. The New Mexico teams are based on the 20-year work of the Tulane Infant Team and the research of other Zero-to-Three supported model court-community partnerships that apply research to court practices to improve outcomes for maltreated infants, toddlers, and their families.

The New Mexico Infant Teams have adopted the following components based upon the work of other successful models (Hudson, et al. 2007) that fuel their success:

**SYSTEMS CHANGE**
1. Judge who knows about the needs of very young children and considered as a catalyst
2. Dedicated local staff with child development and infant mental health expertise to work with the community collaborators, families and the judicial system
3. Community team that includes CPS, Part-C and Infant Mental Health collaborators
4. Attorneys who know about the needs of very young children
5. Awareness of barriers to adequate parental progress (continued substance abuse, ongoing domestic violence, untreated mental health needs, environmental risks, etc.)

**FOCUS ON SERVICES FOR VERY YOUNG CHILDREN**
5. Research-based interventions including promising practices and evidence based models
6. Access to early intervention Part-C (EI) services
7. Trauma informed mental health services for children and caregivers
8. Ongoing reflective supervision for team members

**PROCEDURAL ENHANCEMENTS**
9. Frequent case monitoring and tracking
10. Relationship-focused court-ordered services
11. Ongoing training and technical assistance
12. Resources for professionals and caregivers

**SUSTAINABILITY EFFORTS**
13. Funding
14. Program evaluation
KEY POINTS TO KNOW

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

2. Attachment researchers emphasize the infant’s proximity to the caregiver and include an emphasis on the parents’ understanding and reflecting the infant’s internal world (Seligman, 2003). Fonagy (2004) develops the concept of the mother’s ability to know her baby’s mind as she interacts with, responds to, and makes meaning for her baby.

3. One of the saddest examples of this is when the primary caregiver – the source of food, warmth, comfort and love for the dependent infant or child – is also the source of episodic, unpredictable threat, rage and pain. The disorganized attachment that results can impair healthy relational interactions for a lifetime. Again, much of the resulting dysfunctional relational interactions will be beyond the awareness and understanding of the developing child, youth or adult.

4. If the goal is to have a baby use the mother/father as a secure base, then interventions should focus on helping the mother/father serve as a secure base, even in the presence of maternal/paternal insensitivity. Important to identify positive maternal/paternal behaviors that may serve as a buffer against otherwise insensitive behavior (Cassidy, Woodhouse, Cooper, Hoffman, Powell, and Rodenberg, 2005).

5. For a baby to use the mother as a secure base, intervention should help the mother to feel “comfortable enough” as a secure base. To help the mother gain greater capacity for and comfort with serving as a secure base, it helps to: a) make sure the mother knows what is needed and knows how to respond, and b) explore whether anything makes the mother uncomfortable about specific aspects of secure-base provision (Cassidy, et al, 2005).

STRESS AND TRAUMA
6. Attachment is a memory and a set of associations usually pleasurable and relational. The sequential acquisition of various memories is the primary task of development. Infants form template memories from early experiences (Perry, 2006). Internal catalogs are created from early childhood.

7. For children who have a template of caregivers being unreliable and who will eventually yell and hit me, it takes a long time to lay down a new template for relationships.

8. A young child growing up in a home with a pervasive threat, for example, will create a set of associations – primarily pre-cortical and therefore out of his or her conscious awareness –between a host of neutral cues and threat. These neutral cues for the rest of the child’s life have the capacity to activate a fear response and therefore alter emotions, behaviors and physiology. When a child, youth or adult is in a high state of arousal – fearful – their brain will process and function differently (Perry 2013).

9. These fear inducing cues can range from expressions (e.g. eye-contact can become associated with impending threat), to scents (e.g. the abusive parent’s perfume or aftershave), to music, to styles of interpersonal interaction.

10. Selma Fraiberg writes about a system of caring that is transgenerationally transmitted. The “ghost in the nursery” might be an uninvited guest, the unfriendly intruder who interferes with mother and infant establishment of the mother-infant bond that encourages security and growth promoting development.
NEUROBIOLOGY

11. The most essential functions that the brain mediates—survival, procreation, protecting, and nurturing dependents—depend upon the capacity to form and maintain relationships.

12. Patterns that are novel cause arousal and focus attention—sometimes even alarm. Most of what we do is due to pre-cortical processing.

13. Chaotic and chronically stressful environments may affect the development of self-regulation processes by impairing temperamental adaptability and an aspect of self-regulation involving stress reactivity. Many of the frustrations that the children show is manifested in willful, difficult behavior and manifested in impulsivity.


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

RISK FACTORS/ACE SCALE

16. Children’s prenatal exposure to “second-hand” smoke, alcohol, and drugs are implicated in a multitude of health concerns, including impaired growth and development.

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

18. Effects of poverty on a child’s educational outcomes are more pervasive when poverty is chronic or when it occurs early in the life of a child (birth to five) than when it is transitory, temporary poverty that occurs during adolescence. 53% of children in New Mexico are living in poverty (National Center for Children in Poverty, 2010).

19. Prenatal drug exposure to any drug cannot reliably predict the outcome of an individual child and does not warrant a self-fulfilling prophecy, but such exposure is often a marker for a child with multiple risks (Sagatun-Edwards & Saylo, 2002).

20. Children are more vulnerable to Post Traumatic Stress Disorder (PTSD) than adults. According to Dr. Perry, many children who have attachment disturbances and who view domestic violence or other trauma develop PTSD (Perry, 2010).

21. Over 5 million children a year have traumatic events significant enough to cause PTSD. These children are often misdiagnosed as having an attention deficit disorder (ADD) or attachment disorder. Many do not get the help they need (Perry & Dobson, 2009).

CAPTA, ADOPTION AND SAFE FAMILIES ACT, PERMANENCY AND CONCURRENT HOME

22. In July 2003, the federal government made an attempt at removing some of the inconsistency in state policy approaches to substance-exposed newborns through an amendment to the Child Abuse Protection and Treatment Act (CAPTA).

23. This amendment to CAPTA is intended to encourage Child Welfare Services linkage with developmental, mental health, early intervention and health services in order to access supportive help for at-risk children.
24. In January 2000, the Federal Department of Health and Human Services announced regulations that hold states accountable for services to at-risk children with a new, results-oriented approach to federal monitoring of state child welfare programs. Their interest is in the prevention of abuse and neglect.

RESILIENCE AND PROTECTIVE FACTORS
25. Resilience is a universal capacity, which allows a person, group or community to prevent minimize or overcome the damaging effects of adversity.

26. Several factors distinguish resilient children from those overwhelmed by risk factors:
   a. A temperament that elicits positive responses from family member as well as strangers;
   b. A close bond with a caregiver during the first year of life;
   c. An active approach to problem solving;
   d. An optimistic view of their experiences even in the midst of suffering; and
   e. An ability to be alert and autonomous.

   —(Masten, Best, & Garmezy, 1999).

27. Caregiver emotionality may play a central role in moderating the relations between risk, family processes and child outcomes (Shaw & Vondra, 2000).

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

Please refer to references in Appendix 1
NEW MEXICO INFANT TEAMS

1. GOAL
The goal of the New Mexico Infant Teams is to provide infants in state custody a coordinated, trauma-informed and developmentally informed process for assessment and treatment in order to promote permanency planning and positive developmental outcomes. The intent of the Infant Teams is to develop positive, productive working collaborations between protective services, infant mental health teams, early intervention (Part C-FIT) and the judiciary, so that the entire system is working on behalf of the best interest of the infant.

2. OUTCOMES AND PROTOCOL
The intended outcome of each Infant Team is to reduce maltreatment recidivism rates for infants taken into custody in their catchment area; to improve the quality of information provided to courts regarding infants, biological parents, relatives and foster parents as it pertains to the welfare of the infant; to assist foster parents in the management of maltreated infants; to support visitations between infant and biological parents; and, to utilize state of the art assessment and intervention procedures that strengthen caregiver-infant relationships and provide new ways to understand infant’s needs and behaviors.

The New Mexico Infant Team assessment and treatment protocol supports the infant in the context of all of his/her important caregiving relationships in order to enhance optimal and comprehensive developmental progress in all domains. The Infant Team adopts trauma-informed and developmentally-informed, family centered practices that strengthen both the foster and biological caregiver-infant relationships. The concepts of self- and mutual regulation derived from a system approach to the study of infant-caregiver interaction, permit a more detailed view of treatment and change. Interventions take into account the relationships within which they are taking place.
3. PROCEDURES

Infants, ages birth-to-three, who have been taken into Child Protective Custody are identified and referred to the Infant Team after the 10-day hearing for a transdisciplinary developmental evaluation that meets FIT and CAPTA regulations. Referrals are reviewed by the Infant Team for appropriateness, and FIT eligibility is determined.

The Infant Team assessment protocol includes taped interactions using the CROWELL Child-Caregiver Interaction Procedure and The Working Model Interviews or COSI Parent Perception interview with parents and foster parents. From the designated Part C Provider staff, usually a Family Service Coordinator/Developmental Instructor and an Occupational Therapist participate in the evaluation, and provide on-going services as needed. Other consultative services are utilized as needed.

The Infant Team compiles the Infant Team assessments and incorporates the information from the comprehensive FIT report summarizing the assessment including strengths and concerns that meets the Part C requirements for a multi-disciplinary evaluation.

The Infant Team along with CPS team members jointly formulate a proposed treatment plan and specific recommendations for the infant and caregivers related to services and interventions. If the infant's evaluation qualifies them for Part C services, the IFSP is conducted with the Infant Team as part of the meeting, and social-emotional and relationship goals with caregivers are identified for inclusion on the IFSP. For optimal coordination and integration of services for the infant, involvement of both the biological and foster caregiver in the IFSP meeting is recommended, unless otherwise specified. Mental health providers and CPS workers servicing a particular case are included in on-going IFSP meetings and reviews as their services relate to the goals. All decisions and changes are discussed and coordinated as a team.

The intention is that all team members including Part C Providers and Mental Health Providers provide specialized treatment protocols that are developmentally and trauma informed for infants and young children who have been exposed to chronic stress, neglect and/or abuse. Mentorship regarding interventions is ongoing.

New Mexico Infant Teams utilize various Infant Mental Health intervention options with families based upon the impact of trauma, assessment results, and team decisions (see Example of a Tiered Approach for Intensity of Services and New Mexico Infant Teams: Level of Engagement in Appendix 1). Interventions may be offered simultaneously or alone. Biological (and foster families who are interested) may be offered the 8-week Circle of Security DVD Parenting Program. The Program helps caregivers gain new insight into their infant’s behavior and aims to create the more secure attachment. The program implements decades of attachment research and is evidence-based. The learning objectives for the training include:

- Understand the theoretical foundation of the Circle of Security®
- Build a secure base/safe haven relationship with caregivers
- Shift caregiver focus from behavior management to enhancing the quality of relationship
- Understand specific steps to build self-reflection in caregivers
- Use video examples to support increased empathy in caregivers
- Identify new options to help caregivers manage emotions
- Learn step-by-step approaches for promoting secure attachment in children

A higher level of intervention and treatment intensity that may be offered is Child Parent Psychotherapy (CPP), which is an intervention for children from birth through age 5 who have experienced at least one traumatic event (e.g., maltreatment, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and parent or caregiver.
as a vehicle for restoring the child’s sense of safety, attachment, appropriate affect, and improving the child’s cognitive, behavioral, and social functioning.

Reports are generated prior to court hearings integrating the treatment goals, progress, challenges and recommendations from each of the team members working with a particular case in order to present the court with a unified document. In addition the Infant Team if possible attends court hearings and addresses the court if needed regarding services.

Finally, the Part C Provider designated staff and Infant Mental Health team members meet regularly with the Infant Team directors for consultation and training regarding shared infant custody cases. This includes both discussion of the process of working with challenging cases, as well as the content of family centered interventions. Consultation supports the development of reflective skills, techniques and tools needed for this challenging work. Didactic training furthers specialized diagnostics and treatment planning that addresses infant mental health competencies and difficult issues such as substance use, domestic violence, neglect or abuse in order to further build capacity of the Infant Team.

4. PRINCIPLES OF SERVICE DELIVERY

• Collaboration with the child and caregiver(s)
  Respect for and active collaboration with the child and his/her caregivers is the cornerstone to achieving positive developmental and infant mental health outcomes. Caregivers and children are treated as partners in the assessment and treatment process, and the planning, delivery, and evaluation of developmental and infant mental health services.

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

• Collaboration with others
  When children have multi-agency, multi-system involvement, the Infant Team contributes to integrating and coordinating a jointly established service plan that is collaboratively implemented.

• Accessible services
  Infants and young children have access to a comprehensive array of developmental and infant mental health services. When the service needs are outside the scope of the Infant Team (e.g. substance use, domestic violence and mental illness treatment), ancillary community service providers and programs are accessed to augment the Infant Team services and ensure that the child and caregiver(s) receive the treatment they need to be successful. Plans identify services to assist with reunification efforts and minimize stress during visits. It is critical that ancillary service providers coordinate interventions and communicate with the Infant Team and PS regarding parent’s treatment progress.

• Best practices
  Competent individuals who are adequately trained and supervised provide developmental and infant mental health services. They are delivered in accordance with evidence-based “best practice” and include state of the art, trauma and developmentally informed practices. Infant Team service plans identify and appropriately address relationship issues that are reactions to abuse or neglect, and substance abuse problems. They address the need for stability and corrective emotional experiences to promote permanency and resilience.
• **Most appropriate setting**
  Children are provided services in their home and community to the extent possible. Visitation recommendations are based upon the most natural setting appropriate to the child’s needs and safety.

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

• **Services tailored to the child and family**
  The unique strengths and needs of children and their caregivers dictate the type, mix, and intensity of developmental and infant mental health services provided. Caregivers are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking to reunify, and what services they think are required to meet these goals.

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

• **Respect for the child and family’s unique cultural heritage**
  Infant Team services are provided in a manner that respects the cultural tradition and heritage of the child and caregivers.

**GETTING STARTED**

**A. BEGINNING—INFANT TEAM TIPS**

1. Establish a Transdisciplinary Team (infant mental health, Part C –FIT, medical, etc.) in which members come together from the beginning to jointly communicate, exchange ideas and work together to come up with solutions to problems. A transdisciplinary approach is a framework for allowing members of an Infant Team to contribute knowledge and skills, collaborate with other members, and collectively determine the services that most would benefit a child, and includes representatives from every discipline that works with very young children in the child welfare system.

2. Conduct a community needs assessment. Review sample cases involving very young children in foster care to develop a baseline profile to inform the team’s work. Identify significant gaps in community services (e.g., services for parents with co-occurring mental health and substance abuse disorders) and work with public officials to remedy these gaps.

3. Conduct community awareness trainings to explain the Infant Team, research and benefits to judicial community, pediatricians, CYFD, Part-C providers, substance use counselors and mental health workers involved in child welfare cases.

4. Develop a project plan to begin implementation of Infant Team, complete CAPTA and Infant Mental Health Assessments, and initiate services. Educate all team members about Part C of the Individuals with Disabilities Act, which specifies that maltreated infants and toddlers are eligible for screening and services for developmental delays. Develop the community’s capacity to offer mental health interventions to parents and young children together.
5. Coordinate medical, developmental, and behavioral assessments of the child so service providers share information and develop a unified treatment plan that meets the child’s needs.

6. Ensure the case plan provides frequent, regular supported visits between parent and child. If limited access to transportation creates a challenge for parents to visit their children, consider strategies to help parents overcome this barrier.

7. Hold regular meetings of all individuals and organizations delivering services to infants and toddlers to review case progress. This should include biological family and foster parents; the CPS worker assigned to the case; attorneys for the parents, child(ren), and CPS; Infant Team members responsible for developmental and infant mental health services to child(ren) and caregivers; and a facilitator. At this meeting, discuss the family’s strengths and challenges and provide CPS worker with integrated report of all services provided, progress and challenges to present to the judge and the court.

8. Establish a monthly case review process that informs the judge about each family’s progress.

9. Collaborate across disciplines by offering transdisciplinary training, and encouraging team providers to participate at child and family provider meetings, conferences, and court hearings.

10. Identify staff to coordinate each case, prepare documents for court, oversee services and assure the process is progressing towards permanency.

11. Agree on how decisions will be made and how to resolve conflicts and reach consensus among team members.

12. Connect team members with their counterparts involved in successful Infant Teams in other communities.

13. Assure Infant Team members are provided with reflective supervision and avenues for consultation to avoid burn-out and activation as well as to discuss interventions.

14. Build knowledge about the impact of abuse and neglect on early development by providing training opportunities for project team members and other legal and child-serving professionals working with young children and families.

15. Educate foster parents about the trauma-informed needs of the children in their care.

16. Develop and share resource materials to guide project team members, birth parents, and foster parents.

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

B. INITIAL STEPS—BUILDING AN INFANT MENTAL HEALTH TEAM

1. Identify community partners and connect with additional expert resources.

2. Identify entry level training needs and capacities of community partners regarding the complexity of families in the CPS system, caregiver-infant assessment procedures, assessing parenting capacity, and trauma informed interventions.

3. Developing an Infant Team in the community may reduce maltreatment recidivism rates of infants referred to the CPS system.
4. Develop Memorandums of Agreements (MOAs) with community partners, and develop positive, productive working collaborations between protective services, infant mental health services, early intervention (Part C) and the judiciary, so that the entire system is working on behalf of the best interest of the infant (examples of MOAs in appendix).

5. Infant Teams can improve psychological/developmental care to infants in their community by providing a comprehensive assessment and coordinated services that are trauma and developmentally-informed.

6. Infant Teams improve the quality of information provided to courts regarding infants, biological parents, relatives, and foster parents as it pertains to the welfare of the infant by gathering and combining the information from all professionals involved and synthesizing observations and recommendations in a concise and relevant report.

7. Developing a coordinated process for assessment and treatment in order to promote permanency planning and positive developmental outcomes including protocols for assessment and intervention strategies, is an essential goal of the Infant Team.

8. Determine frequency of Infant Team Meetings, provider meetings with CYFD, and meetings with other collaborating service agencies that are realistic to ensure regularity of communication.

9. Develop network with other community Infant Mental Health Teams.

10. All Infant Team members should have ongoing Reflective Supervision or Consultation.

11. Evaluate progress and collect information for state database.

12. Make recommendations regarding what would be helpful for investigations regarding infant safety and well being, referrals to SCI and number of referrals prior to removal.

C. HOW TO DESCRIBE—INFANT TEAM AS A TRANS-AGENCY APPROACH

1. The Infant Team Represents a Collaborative Model where:
   • Team members work in partnership and pool resources.
   • All team members are involved in planning and monitoring goals and procedures, although each team member’s responsibility for the implementation of procedures may vary.
   • Team members jointly share ownership & responsibility for intervention objectives.
   • Designated team member(s) organize the team’s progress and challenges as well as additional supportive documents for the court and CYFD.

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

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

4. Incorporating Additional Infant Team Consultation Services are:
• Flexible to meet the individual needs of children and families in CYFD custody and to accommodate the variation in program structure.
• Vital co-collaborators with the core Infant team.
• Not required to be involved in monthly Infant Team meetings unless interested.
• Expected to share progress updates at the end of each month with service coordinator or with director(s) to be compiled for CYFD and court.
• New Mexico Children, Youth and Families Department has created a Community of Practice for its current and future Infant Teams. The teams meet face to face for quarterly meetings to discuss system, clinical and technical issues; have monthly COP calls and monthly reflective consultation calls.
CHAPTER 4

Questions and Descriptions of Roles on Infant Team

QUESTIONS ABOUT INFANT TEAM ROLES

A. DIRECTOR ROLE

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

2. How does the director represent the Infant Team at CYFD and in Court?
   • The director or another designated team member represents the Infant Team in Court if possible and is responsible for compiling monthly information from the Infant Team for use by CYFD and to inform the Court.

3. Is the director involved in completing the Infant Mental Health Assessments and Interviews?
   • The director participates in and/or oversees completion of the Infant Mental Health Assessments, Perception Interviews, Developmental Evaluations and reports.

4. Would CYFD and the Court use the detailed Infant Mental Health Assessment and monthly reports compiled by director in the permanency planning decision?
   • The Infant Mental Health Assessment and monthly reports are used to develop a Treatment Plan with CYFD, to evaluate progress and to assist in the Court’s permanency planning decision.
5. Does the director provide direct services to the child who is in state custody and part of the IMHT, along with the foster parent(s) and biological parent(s)?
   • The director may provide direct services to Infant Team families or provide consultation and supervision to Infant Team members implementing the direct services.

6. How often do the director meet with the Infant Team either individually or as a group?
   • The director of each New Mexico Infant Team will determine what is feasible in terms of frequency of team meetings, reflective supervision and consultation.
   • Respective infant teams meet at least once a month with state wide reflective consultants, meet quarterly in person with all the teams and meet once a month via phone with all teams.

7. Does the director or another appropriate person provide ongoing Reflective Supervision and consultation on service delivery to the Infant Team?
   • An important part of participating in an Infant Team is for its members to receive ongoing Reflective Supervision and consultation to assure the quality of service delivery.

B. INFANT MENTAL HEALTH THERAPIST ROLE
1. What is the role of Infant Mental Health Therapist on the infant team? and are they familiar with the unique challenges associated with providing services to maltreated children and their families?
   • The Infant Mental Health Therapist’s role is to provide dyadic and collateral mental health services to the biological parent(s) and to the child(ren) in custody as well as for the foster parents. This starts with a comprehensive assessment of the relationship and the respective capacities of the adult and the child.
   • The Infant Mental Health therapist should meet the competencies required for a level 3 or 4 endorsement through the New Mexico Association for Infant Mental Health, and, in addition, have specific training on assessment and intervention, trauma informed practice, familiarity with the child protective system, and be able to articulate in reports the progress and challenges related to the relational health and risks currently.

2. Are the Infant Mental Health Specialists responsible for completing the Infant Mental Health Assessments and Interviews?
   • Yes, the assigned Infant Mental Health clinician is the likely person to complete the IMH assessments.

3. How should Infant Mental Health providers write reports/contact notes and maintain confidentiality since they can be used in court?
   • The mental health provider keeps notes, records and reports in accordance with the governing licensure board they are under. Psychotherapy notes have a higher level of client confidentiality in regards to court.
   • The comprehensive, regularly submitted reports serve the purpose of sharing information with the court, CPS the client, GAL, respondent’s attorneys, children’s court attorneys and CASA workers so that there are no “surprises” in court.

4. Would CPS use the results of the Infant Mental Health Specialist’s comprehensive intake information or contact notes in the investigation decision?
   • No, any information gathered after the investigation cannot be used in the initial judiciary decision.

5. If the child is in state custody and part of the IMHT, should both the foster parent(s) and biological parent(s) receive Infant Mental Health Services?
   • This is ideal as all primary caretakers for the infant(s) benefit from knowing what supports the infant’s social, emotional and physical development.
   • It is also helpful for the caregivers to have support regarding their experiences during the custody process.
6. How should the Infant Mental Health Specialist consult with other Infant Mental Health Team members?
   • Ideally the Infant Team works collaboratively on all aspects of assessment, treatment and recommendations.
   • Infant Mental Health providers should use discretion regarding the sharing of personal content that is
     shared individual psychotherapy sessions. The mental health provider should be judicious and share what
     is relevant to treatment and recommendation decisions.
   • It is important to be respectful of adult clients confidentiality and trust in their primary therapist.

7. Should the Infant Mental Health Specialist receive ongoing Reflective Supervision from an Infant Team
   member or an outside source?
   • The important factor is that the infant mental health specialists receive reflective consultation from a
     competent professional.
   • Whether the individual is part of the team or an outside consultant depends upon the specific team set up
     and resources. Often teams will utilize both.

C. PART-C EARLY INTERVENTIONIST AND SERVICE COORDINATOR ROLE

1. What is the role of Early Intervention on the Infant Team, and are Part C providers familiar with the unique
   challenges associated with providing services to maltreated children and their families?
   • Support and enhance collaboration among public health agencies, the child protection system, and
     private community-based programs to provide child abuse and neglect prevention and treatment services
     (including linkages with education systems) and to address the health needs, including mental health needs,
     of children identified as abused or neglected, including supporting prompt, comprehensive health and
devvelopmental evaluations for children who are the subject of substantiated child maltreatment reports.
   • Many Part C providers are speech language therapists, occupational therapists and physical therapists, who
     may not be well prepared to address the special considerations required when working with maltreated
     children.
   • Receipt of Part C services is voluntary, so court-ordered services are not part of the culture for early
     intervention service providers.
   • Court-ordered involvement may cause parents or caregivers to view a service provider as an intrusion
     rather than as a source of assistance.
   • They may be suspicious of, or hostile towards, service providers.
   • The focus and role of Child Welfare Services is on protecting the child’s safety and dealing with the
     perpetrator and Part C’s focus and role is providing services to children with disabilities and their families.
   • Early interventionists must also be aware of the ways their own culture, “way of being” or professional
     agenda may influence a parent child dyadic relationship.
   • There are three dyadic relationships to consider when thinking about early intervention work in general,
     but specifically with IPMH (Infant-Parent Mental Health) work: caregiver-child dyad; caregiver-provider
     dyad; and provider-child dyad.

2. How should Infant Team Part C - FIT (Family, Infant, Toddler Program) providers write reports / contact
   notes since they can be used in court?
   • It is important that all materials be written clearly and should include factual statements rather than
     opinions.
   • The exception for this would be the informed clinical opinion of the team regarding the child’s eligibility.
   • The developmental evaluation report is not intended to be a professional assessment of the family’s
     functioning, as might occur in other types of service delivery settings or circumstances.
   • The voluntary developmental evaluation is intended to be a family-directed process to identify the family
     resources, priorities, and concerns related to enhancing their child’s development.
As part of the developmental evaluation process, the evaluator should discuss with the parent how the results of the family assessment should be documented, including what information should be included in the evaluation report (transparency).

Families can be informed that in case of a subpoena, the notes may be read in court.

Parents should also be informed that the role of the FIT providers is to record information regarding the early intervention supports and services provided and not to judge the parent(s).

Dates and times should always be recorded and the full name of the staff person who completed the notes/reports must be included.

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

4. If the child is in state custody, does the foster parent have the ability to say that the parents cannot receive FIT documents (evaluation report, IFSP, etc.) or participate in the early intervention services?
   - No, The foster parent cannot determine what documents the biological parent(s) receive and do not receive.

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

6. What responsibility does the Infant Team’s FIT provider have in reporting any information back to CPS on what they saw on the home visit?
   - The FIT provider should report to the director of the Infant Team any concerns related to the development of the child and the success of the FIT provider in providing effective early intervention supports and services with both the foster family and parents.
   - The director will communicate with the CPS caseworker on issues and concerns related to safety of the child.
   - The Infant Team and the FIT provider staff are mandated reporters for suspected abuse and neglect.

7. If the abuse/neglect investigation is substantiated but the child is not taken into state custody, how long will a CPS caseworker be involved with the family?
   - The initial investigation may remain open for 30 days or more in special cases.
   - If a court order is not filed, all ongoing involvement with the family is voluntary.
   - CYFD policies and procedures allow the department to work with a family on a voluntary basis for a 90-day period with a possible 90-day extension.
   - Not all substantiated cases are opened to CYFD - CPS for voluntary services.

8. Is the CPS caseworker involved in the development of the IFSP with the Infant Team, parents and foster family?
   - The CPS caseworker as a member of the Infant Team should be involved in the development of the IFSP with other team members and with both the parents and foster family.
9. Does the Infant Team FIT staff provide the CPS caseworker with a copy of all documents, including the initial evaluation, IFSP, case notes and progress reports?
   • For a child in the custody of CYFD, the Infant Team provides the CPS caseworker with the results of any evaluations conducted and the IFSP.
   • The director of the Infant Team compiles integrated monthly reports for CYFD and the court from all team service providers reflecting participation in services as well as progress and challenges with the child, foster family and parents.
   • If a child is not in the custody of the state, the child's parents/guardian must authorize the release of any information to CYFD (Non-Substantiated Referral).

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

11. Is the Infant Team required to testify in court, and can reports and contact notes made by FIT providers be part of the testimony?
   • Yes. The Infant Team director(s) attend all court hearings of their assigned families as representatives of the team.
   • The court is provided with the compiled, integrated monthly reports from the Infant Team service providers, that includes all evaluations and progress/contact notes in the child's record.
   • The monthly reports are written in a way that is clear, factual and objective.
   • The court can subpoena the director(s) of the Infant Team to provide additional information and psychoeducation related to work with a particular child and family.

12. Do all children being referred through CAPTA to the Infant Team need a full developmental evaluation or can they be screened?
   • It is more cost effective to move straight to the comprehensive multidisciplinary developmental evaluation rather than screen first.
   • The Infant Team's developmental evaluation is then part of a comprehensive Infant Mental Health Assessment of the child and family that provides the foundation for determining appropriate services and treatment goals.

13. How can the Infant Team FIT provider and CYFD Case workers promote good communication with each other?
   • The Infant Team's FIT service coordinator should give feedback to the CPS caseworker regarding the referral and should inform the caseworker of the results of the developmental evaluation.
   • The CPS caseworker should be invited to the IFSP meeting.
   • If the CPS caseworker is unable to attend, due to scheduling, the Infant Team FIT service coordinator should inform them of the early intervention supports and services to be provided to the child and family.
   • A copy of the IFSP should be sent to the caseworker if the state has custody or if parents authorize such a release of information.
   • The Infant Team FIT provider should update the caseworker as the child's developmental information changes and informs the caseworker of any difficulties in carrying out the IFSP.
   • The Infant Team FIT service coordinator and the CPS caseworker should remain in regular contact throughout the child's eligibility for the FIT Program as long as CYFD has the authority to be involved with the child.
   • The CYFD caseworker should inform the director(s) of the Infant Team and the team's FIT service coordinator if there is a change in caseworkers assigned.
14. What should the Infant Team FIT provider do if the family refuses to attend and/or participate in early intervention?
   - If the family does not allow the Infant Team FIT staff to enter their home or does not attend early intervention at another planned location, the FIT service coordinator needs to inform the director(s) of the Infant Team who will communicate with the CYFD - CPS caseworker.

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

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

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

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

EXAMPLE OF NEW MEXICO INFANT TEAM ROLE DESCRIPTIONS

1. DIRECTOR
   - Provide developmental consultation and reflective supervision to team members
   - Conduct developmental evaluations and provide complete transdisciplinary reports
   - Conduct Crowell Procedures and contribute to report
   - Oversee completion of the reports for court with other co-director
   - Review of all referrals
   - Develop evaluation procedures and report formats to integrate developmental and infant mental health components
   - Oversee the provision of Infant Mental Health collateral and dyadic treatment
   - Develop specific and innovative developmental interventions for families and team members that incorporate somatosensory, self-regulatory, relational and cognitive strategies
   - Engage in data management and support
   - Participate in meetings to build capacity and service initiation in the First Judicial District
2. INFANT TEAM COORDINATOR
   - Point person with CPS regarding identifying information, visitation schedules, meeting schedules, transitions and disposition of cases
   - Schedules 1x a month meetings with CYFD personnel involved with Infant Team
   - Schedules Crowells, Perception Interviews and other meetings regarding cases
   - Provides the visitation schedule and determines coverage options with other Infant Team members
   - Oversees documentation for files and data collection of Infant Team services provided to bio- and foster family, and child(ren)

3. INFANT MENTAL HEALTH THERAPIST
   - Responsible for conducting Crowell Caregiver-Child Interaction Procedure and Perception Interviews
   - Assigned to a biological parent or foster parent(s)
   - Offers COS-DVD Parenting Program to client(s)
   - Conducts Infant Mental Health Treatment that includes Collateral (Collateral is individual face-to-face instruction and treatment by the therapist to a biological parent working towards reunification with their child or with the foster parent(s)) sessions and Dyadic work with a biological parent and child
   - Participates in Reflective Supervision and Infant Team meetings
   - Provides monthly progress notes to be included in comprehensive reports written by co-directors for CYFD and Court
   - Attends Provider Meetings, Family Centered Meetings, IFSP Meetings, Transition Meetings in addition to any other special meetings called by CPS when possible
   - Training and ongoing supervision with an infant mental health specialist/expert is vital for relationship-based developmental services.

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

5. EARLY INTERVENTIONIST, OCCUPATIONAL THERAPIST, PHYSICAL THERAPIST AND/OR SPEECH-LANGUAGE THERAPIST
• Provides developmental services as documented in the IFSP and according to Part-C state regulations
• Integrates Developmental Goals with Infant Mental Health Goals
• Provides developmental support during visits with biological parent(s) and supports foster parents
• Writes progress notes to be included in monthly reports written by co-directors for CYFD and Court
• Develops activities used to support developmental progress and relationship building to be utilized by all team members
• Visits infants and young children in childcare to offer support and training to staff
• Attends Training and ongoing Reflective Supervision with an Infant Mental Health Specialist/Expert who is knowledgeable about trauma-informed, relationship-based developmental services.
1. INTRODUCTION
Competencies and interactions that are normal in ordinary parent-child interactions are often strained, impaired or absent when there is undue stress and/or situations where there has been child maltreatment in the form of abuse or neglect.

As a result, we bring a trauma informed and developmental lens to our work with the caregiver (which can be the biological parent(s), the foster parent(s), grand-parents, kinship or other primary caregiver for the infant). The Dyadic work focuses on the relationship between the child and the adult and the transactions that take place when they are together. Therefore, in infant-parent and Child Parent (CPP) psychotherapy, the relationship and interactions become the focus, on behalf of the child, for the therapeutic work.

The therapeutic work is based on attachment theory, but also integrates developmental, psychodynamic, psychoeducational, and trauma informed practices as well.

The purpose of this model is to bring the parent’s awareness to the infant’s experience and needs in a way that is protective and supports the development of secure attachment. This is done by addressing the adult’s history and experience, their reflective functioning, working model and specific behavioral interactions with the child.

As in Child-Parent Psychotherapy, the targets of the infant team intervention include caregivers’ and young child’s maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child’s mental health. (Lieberman, 2005)
The infant team mental health goal is to:

**Have the adult(s):**

- Develop and maintain a therapeutic relationship with the infant mental health therapist. This involves developing a therapeutic alliance and often dealing with “institutional transference”;  
- Demonstrate capacity for reflective functioning;  
- Understand the impact of traumatic events on the child  
- Take responsibility for the impact of their behavior on their child and for assuring the child’s safety;  
- Understand the developmental and emotional needs of their child.

**2. TULANE MODEL**

The New Mexico Infant Teams have utilized the Tulane Model. The Tulane Mental Health Assessment and Treatment Phase is articulated by following excerpts from the body of work by Julie Larrieu, PhD, Charlie Zeanah, MD and Neil Boris, MD:

**Clinical Context and Evaluation**

- Young children’s development is powerfully affected by their relationships with important caregivers  
- Developing a secure attachment relationship to caregivers is essential for young children  
- Young children may have vastly different kinds of relationships with different caregivers  
- Infants are strongly biologically predisposed to form attachments to caregiving adults;  
- Attachment develops gradually over the first several years of life, based upon relationship experiences with caregivers;  
- The Majority of abused or neglected children have difficulty developing a strong healthy attachment to a caregiver;  
- Under usual rearing conditions, infants develop “focused” or “preferred” attachments in the second half of the first year of life;  
  ~ Separation protest;  
  ~ Stranger wariness.

**Importance of Attachment**

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

**Attachment Disruptions**

- Disrupted attachments in early years have long been believed to be harmful;  
- Increasing numbers of disruptions are associated with increased risk for clinical problems, including disorders of attachment;  
- Children who have experienced complex trauma often have difficulty identifying, expressing, and managing emotions, and may have limited language for feeling states;  
- From child’s perspective, disruptions are impossible to understand;  
- We work to minimize attachment disruptions.

**Attachment Essentials**

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

3. SPECIAL FEATURES OF THE INFANT TEAM
   • Multimodal services
   • Relational, infant mental health perspective;
   • Focus on the Impact of Trauma on Relationships and Development
   • Naturalistic and clinic settings and structured and unstructured assessments;
   • Integrated treatment plans;
   • High intensity, low volume case load;
   • Address countertransference;
   • Systems focus;
   • Program/funding partnerships;

Case Evaluation Process
   • Home visits (Biological and foster parents);
   • Clinic visits;
   • Childcare Center visits;
   • Part C Developmental Services;
   • Ancillary measures;
   • Case conferences;
   • Parent conferences;
   • Court letters;
   • Treatments employed;
   • Individual psychotherapy;
   • Dyadic psychotherapy;
   • Infant-parent psychotherapy;
   • Child-parent psychotherapy;
   • Interaction guidance;
   • Parent-child interaction therapy;
   • Circle of Security®;
   • Trauma informed treatment, including Part C developmental services;
   • Therapeutic visitation;
   • Visit coaching;
   • Couples psychotherapy;
   • Family psychotherapy;
   • Sometimes includes extended family, kin, foster parents.

Assessment of Relationship
Considerations:
   • Focus on patterns of interaction between caregivers and infants to obtain information about healthy or disturbed aspects of the relationship;
   • Parent’s ability to understand and respond to infant’s special needs;
   • Focus on the impact of trauma on the attachment relationship;
   • Consider objective and subjective experiences of infant and caregiver, which include caregivers’ history, culture, and community.
**Essentials**

- Experts who have not seen caregiver and child together are not able to comment on the quality of their relationship;
- Understanding that the quality of the relationship of the caregiver and child is an essential tool in making decisions regarding “best interest” of child.

4. THE PROCESS

What Do We Do With the Results?

**Our goal is to facilitate safe enough parenting:**

- Focus on strengths;
- Remediate concerns (e.g., help parent address own issues which get in the way of seeing the child clearly and keeping the child safe).

How Do We Use Relationship Assessments?

**Permanency planning decisions:**

- Visitation issues;
- To understand confusing/complex behaviors in a child;
- To understand child’s developmental and emotional needs;
- Treatment planning;

What are Predictors of Recidivism?

**Treatment Goals:**

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

5. VISITATIONS

**Attachment and Visitation**

- Adults, but not young children, are capable of sustaining attachment relationships across time and space;
  - Adults should bear the burden of difficulties, not young children;
- Who visits whom?
- Travel and familiarity of setting;
- Biological relatedness does not trump stability (Zeanah, 2001)

**Visitation with Biological Parents**

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

**Principles of Visitation**

- Child’s well-being is primary concern;
- Must have an attachment figure present if child is more than 6 months old;
• Child can sustain a relationship with parent without parent being an attachment figure;
• As parents progress towards reunification, frequency and length of visits should increase;
• Relationships with foster parents should continue after reunification whenever possible.
• Attachment building efforts begin after parents:
  ~ Have accepted responsibility for children’s maltreatment;
  ~ Have begun recovery from mental health/substance abuse problems;
  ~ Are making progress towards reunification

Considerations for Collaborative Visitation
• Visiting without attachment figure (foster parent) causes undue stress on child (separation) by second half of first year;
• Presence of foster parent can improve quality of visit for biological parent:
  ~ If biological parent understands rationale and can be supported;
  ~ If foster parent can support child without undermining biological parent.
• Goal of visit with biological parents need not be developing attachment (especially initially);
• Child’s best interest ought to be paramount in any visitation plan;
• Child must be able to tolerate stress of visit; otherwise, modify visitation schedule.

7. INTERVENTIONS
Interventions Aim to Change Systems
• Infants and families are embedded within powerful and complex systems of care:
  ~ Child Welfare
  ~ Legal
  ~ Mental Health, Substance Abuse, Developmental Disabilities
  ~ Healthcare
  ~ Education
  ~ Other Community Resources

Goals of Systems Intervention
• Change how the system understands and deals with young children:
  ~ Developmental differences;
  ~ Time frame differences;
  ~ Importance of caregiving relationships, culture, community;
• Enhance access to services;
• Improve integration and coherence of services.

3 Levels of System Intervention
• Proximal, immediate clinical context:
  ~ Infant-parent relationship;
  ~ Child care setting;
  ~ Child protective services;
• Legal system:
  ~ Juvenile or family court judge;
  ~ Attorneys for protective services, children, parents;
  ~ CASA workers;
• Other, larger systems.

The intensive treatment phase involves implementation of the court-ordered case plan for the family. The intervention team attempts to define explicit treatment goals and to design specific interventions to help
parents achieve those goals within a time frame that is reasonable for the children. The sine qua non of treatment goals is helping parents accept responsibility for their children’s maltreatment. From this overarching goal, all other specific goals and interventions derive. Among other components, the intensive treatment phase often includes individual psychotherapy with parents, dyadic psychotherapy with parents and young children, medication, and crisis intervention. In keeping with our explicitly relational approach, we attempt to identify and remove barriers to what we believe is a biological predisposition for infants’ attachment to their parents and for parents’ caregiving behavior directed toward their young. In this preliminary evaluation of the outcome of this intervention, we address three major questions.

First, we determined whether the intervention changed types of permanent plan outcomes of young children in foster care. Second, we determined whether the intervention reduced the length of time that young children spent in foster care. Third, we determined whether the intervention reduced maltreatment recidivism, that is, subsequent incidents of maltreatment in the same child or in siblings. (Zeanah, 2000) (Bold and italics added)

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

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

The use of reflective practice and supervision/consultation is an essential component of the New Mexico multi-disciplinary Infant Teams and must take place at a consistent and committed time for all team members.

Heffron and Murch (2010,) provide us with a rich resource in their publication of Reflective Supervision and Leadership in Infant and Early Childhood Programs. They state that Reflective supervision builds staff member’s skills in reflective practice. Reflective practice refers to a way of working that spans disciplines and encourages staff members to (a) consider the possible implications of their interventions while in the midst of their work; (b) slow down, filter their thoughts, and more wisely choose actions and words; (c) deepen their understanding of the contextual forces that affect their work; and (d) take time afterward to consider their work and the related experiences in a way that influences their next steps (pg 6).

Please see the definition for on the nmaimh.org website for a lengthy description and further details.

Please refer to references in Appendix 1
CONSIDERATIONS FOR OBSERVATIONS, ASSESSMENTS AND INTERVENTIONS

1. Promoting Physical Health
   • Initial health information gathering
   • Ensure necessary health care and birth records and consents are available

2. Addressing Early Mental Health and Developmental Needs
   • Ensure the comprehensive mental health and developmental observations, assessments and evaluations are initiated soon after referral
   • Ensure the emotional and mental health needs of the parent(s) are assessed
   • Determine the intensity and type of services required to meet the family’s needs
   • Develop Infant Team, CPS service plan and FIT Infant-Family Service Plan
   • Ensure a continuum of services are provided
   • Determine if infant and parent would benefit from Child-Parent Psychotherapy, Circle of Security and/or Interaction Guidance or other appropriate intervention
   • Ensure services respond to the needs of different ethnic and cultural groups
   • Ensure frequent sibling contact when appropriate
   • Carefully consider the availability and quality of Early Child Care

3. Achieving Permanency
   • Plan for permanency from day one
   • Consider the rapid and multifaceted development of the infant when determining permanency goals
   • Assess whether the issues that caused the infant’s removal are being addressed
   • Order additional services or reasseessments when needed
   • Evaluate safety and risk factors when planning to transition infant to return home
   • Be part of preliminary protective hearings, disposition and case planning, hearing reviews, permanency hearings, and determination of post-permanency support
   • Include Guardian ad Litems, and CASA workers in collaborative interactions
EXAMPLES OF INSTRUMENTS TO CHOOSE FROM

1. Child
   • *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised 2005 (DC:0-3R) * undergoing current revisions
   • Trauma Informed Inventories from Child Trauma Academy and Child Parent Psychotherapy scales and measures
   • DIR Profiles to assess Developmental Capacities and Individual Differences
   • Infant Toddler Developmental Assessment
   • NCAST Feeding Scale
   • Hearing and Vision Screening
   • Neurosequential Model of Therapeutics
   • Bayley Scales of Infant Development
   • Infant Toddler Developmental Assessment
   • Progress In Treatment Assessment (PITA) (included in appendices)
   • COS Parent Progress Consideration (included in appendices)

2. Parent
   • Trauma Informed Life Stressors Checklist
   • Depression Scale
   • Angels Checklist
   • COSI (Circle of Security Interview) and Working Model of the Child

3. Dyad(s)
   • CROWELL (Caregiver-Child Structured Interaction Procedure)
   • DIR Profile and FEAS (Functional Emotional Assessment Scale) to assess Relationship
   • Videotaping Procedures

EXAMPLES OF INTERVENTION AND TREATMENT OPTIONS

1. Child
   • Trauma Informed Interventions recommended by Child Trauma Academy
   • Developmental and Specialized FIT Services
   • DIR Model – Functional Emotional Developmental Levels

2. Parent
   • Circle of Security®
   • Substance Use Treatment Recommendations
   • Adult Mental Health Referrals
   • Collateral Infant Mental Health Services

3. Dyad(s)
   • Child Parent Psychotherapy (CPP)
   • DIR Model - Floortime
   • Infant-Parent Psychotherapy
   • Interaction Guidance
   • Videotaping Procedures
EXAMPLES OF INFANT TEAM QUESTIONS

1. What are the Infant's/Child's Overall Needs?
   • What are the Relational, Self-Regulatory, Somatosensory and Cognitive needs of this infant/child?
   • What are the Medical, Developmental, Emotional and Attachment needs of this infant/child?
   • What challenges does this caregiver(s) face that could impact his or her capacity to parent this infant/child?
   • What resources are available to enhance this infant/child's healthy development and prospects for permanency?
   • What is interfering with this infant's/child's ability to interact and relate in a social capacity? What is the solution?
   • What are the parent(s) capacity for comprehending the effects of maltreatment on the infant/child; reflection; resource utilization; and, accessing social support?

2. What are the medical needs of this infant/child?
   **The Medical Checklist**
   • What health problems and risks are identified in the infant's/child's birth and medical records (e.g., low birth weight, prematurity, prenatal exposure to toxic substances)?
   • Does the infant/child have a medical home?
   • Are the infant's/child's immunizations complete and up-to-date?
   **Common Medical Diagnoses Seen in Infants/children in Foster Care**
   • Fetal alcohol syndrome
   • Congenital infections (e.g., HIV, hepatitis, syphilis)
   • Growth failure, failure to thrive
   • Shaken baby syndrome
   • Lead poisoning
   • Respiratory illness
   • Hearing and vision problems

3. What are the developmental needs of this infant/child?
   **The Developmental Checklist**
   • What are the infant's/child's risks for developmental delay or disability?
   • Has the infant/child had a developmental screening/assessment?
   • Has the infant/child been referred to the Early Intervention Program?
   **Developmental Red Flags**
   • Premature birth
   • Low birth weight
   • Abuse or neglect
   • Prenatal exposure to substance abuse

4. What are the attachment and emotional needs of this infant?
   **The Emotional Health Checklist**
   • Has the infant/child had an infant mental health assessment such as a Crowell or NCAST?
   • Does the infant/child exhibit any red flags for emotional health problems?
   • Has the infant/child demonstrated attachment to a caregiver?
   • Has concurrent planning been initiated?
Emotional Health Red Flags
• Chronic sleeping or feeding disturbances
• Excessive fussiness
• Incessant crying with little ability to be consoled
• Multiple foster care placements
• Failure to thrive

5. What challenges does this caregiver face that could impact his or her capacity to parent this infant?

The Caregiver Capacity Checklist
• What are the specific challenges faced by the caregiver in caring for this infant/child (e.g., addiction to drugs and/or alcohol, mental illness, cognitive limitations)?
• What are the learning requirements for caregivers to meet the infant’s/child’s needs?
• What are specific illustrations of this caregiver’s ability to meet the infant’s/child’s needs?

Caregiver Capacity Red Flags
• Noncompliance with the infant’s/child’s scheduled health appointments and medication or therapeutic regimens
• Caregiver substance abuse and noncompliance with psychiatric treatment and medications
• Confirmed instances of child abuse or neglect
• Incomplete immunizations and infant’s/child’s poor growth or arrested development

6. What resources are available to enhance this infant’s healthy development and prospects for permanency?

The Resource Checklist
• Does the infant/child have Medicaid or other health insurance?
• Is the infant/child receiving services under the Early Intervention Program?
• Has the infant/child been referred to Early Head Start or another quality early childhood program?

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

NEW MEXICO INFANT TEAMS
EXAMPLE OF REFERRAL PROCESS AND SERVICES

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

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

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

Post-Adjudication
- Begin Infant Mental Health Services with Bio-Parents and Foster Family
- Add Infant Team to Treatment Plan at Disposition Hearing
- Collaborate with other services outside of Infant Team assigned to this family
- Provide Monthly Progress Reports of Developmental and Infant Mental Health Services to CYFD
• Attend FCMs and Provider Meetings as well as any others affecting the well-being of child and family
• Attend Court Hearings when Possible
• Move some of the Visits outside of CYFD when possible
• Support transitions and all other changes affecting the best interest of the child
• Provide reflective supervision to Infant Team
• Get Progress Reports to CYFD – Permanency Planning Worker (PPW) by designated time agreed upon by
  PPW and team members

**What would be helpful?**
• For CPS to complete update form weekly if possible
• For CPS to share monthly calendars for families with Infant Team

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

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

**EXAMPLE OF NEW MEXICO INFANT TEAM REFERRAL PROTOCOL**

**PROTECTIVE SERVICES**

**Upon legal filing on any child age 0-3:**
PS Worker will initiate a staffing with the PS County Office Manager to determine whether or not the case is
eligible for IT (Infant Team).

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

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

**Upon transfer of the case to Permanency Planning:**
PS Worker will staff the case for eligibility and services with the IT.

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

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

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

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

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

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

—Developed by Jolene Torrez, Las Cruces, CYFD

### EXAMPLE OF CAPTA REFERRAL FORM

<table>
<thead>
<tr>
<th>CAPTA Referral Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Child Abuse Prevention and Treatment Act (CAPTA) – the Keeping Children and Families Safe Act of 2003 (P.L. 108-36) requires states to refer infants and toddlers birth to three with substantiated abuse or neglect to the Family Infant Toddler (FIT) Program.</td>
</tr>
</tbody>
</table>

#### 1. CHILD INFORMATION

<table>
<thead>
<tr>
<th>Referral Date:</th>
<th>*Child’s Last Name:</th>
<th>*Child’s First Name:</th>
<th>MI:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>*DOB:</th>
<th>Gender:</th>
<th>*Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*City:</th>
<th>*State:</th>
<th>*Zip:</th>
<th>County:</th>
</tr>
</thead>
</table>

#### 2. CHILD LIVES WITH

<table>
<thead>
<tr>
<th>*Caregiver</th>
<th>Relationship:</th>
<th>*Home Phone if Available:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(                         )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Phone:</th>
<th>Other Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(           )</td>
<td>(           )</td>
</tr>
</tbody>
</table>

Best Way to Contact Caregiver?

Primary Language / Mode of Communication?

Surrogate parent needed?

#### 3. REASON FOR REFERRAL

Presenting Concerns: Referral of child birth to three for (check one):

- [ ] Substantiated abuse / neglect
- [ ] 0-3 year old
- [ ] sibling

Are there any developmental concerns and/or medical conditions?

- [ ] yes
- [ ] no

Explain:

Worker Safety/Security Precautions?

- [ ] YES (attach details)
- [ ] NO

Is the Child Currently in the Hospital?

- [ ] YES
- [ ] NO

Criminal Domestic Violence?

- [ ] YES
- [ ] NO

#### 4. Referral Source / CPS Caseworker

CPS

- [ ] Assessment Worker
- [ ] Permanency Planning Worker
- [ ] In-home Service Worker

Name: County Office:

Address: City: State:

ZIP: Phone: ( ) Fax: ( )

Email Address: CPS Worker Signature Date: [ ] Non-Substantiated Referral [ ] Substantiated Referral

Consent For Evaluation Signature

#### 5. FIT Program Action Taken:

Name: FIT Provider Agency:

---

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

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

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

—Developed by Jolene Torrez, Las Cruces, CYFD
# Example of New Mexico Infant Team Referral

## Please Attach Affidavit Report

<table>
<thead>
<tr>
<th>DATE AND TIME OF REFERRAL</th>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
</table>

### Referrer Details

<table>
<thead>
<tr>
<th>Name of CYFD/CPS Worker:</th>
<th>Job Title:</th>
<th>Tel No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPTA Referral to FIT Program:</td>
<td>Yes □ No □</td>
<td>Date Sent:</td>
</tr>
</tbody>
</table>

### Referral Information

#### Child/ren's Details

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Gender</th>
<th>Social Security #</th>
<th>Medicaid #</th>
<th>In Childcare Y/N</th>
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Primary Language:  
Medical Needs:

#### Parent(s) / Foster Caregiver(s) Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Home Number</th>
<th>Cell Number</th>
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</table>

### Legal Dates

<table>
<thead>
<tr>
<th>Date of Custody</th>
<th>10-Day Hearing</th>
<th>Adjudicatory Hearing</th>
<th>Other Court Dates</th>
<th>Other Meeting Dates</th>
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</thead>
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</tbody>
</table>

### Legal Assignments

- Guardian Ad Litem (GAL)
- CASA Worker
- Respondent’s Attorney (Mother)
- Respondent’s Attorney (Father)

**Other**

Please include any additional information:
MEMORANDUM OF AGREEMENT
EXAMPLE BETWEEN NEW MEXICO INFANT TEAM AND CHILD PROTECTIVE SERVICES

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

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

Agreements
Child Protection Services/CYFD
1. Infants, age’s birth-to-3, who have been taken into Child Protective Custody are identified by the CYFD Investigator and a CAPTA referral is faxed to the Part C/FIT agency as per federal regulations with Attention: Infant Team on cover sheet or top of form.
2. The CAPTA referral is made after the **initial investigation** and faxed within 48 hrs. following the FCM/decision making meeting to the Part C/FIT agency.

3. A **separate** Infant Team Referral form is completed, faxed and sent to the Infant Team (IT) at the time of the 10-day hearing.

4. Following the 10-day hearing and the referral to the Infant Team a comprehensive Infant Mental Health and Relationship Assessment with the family will be scheduled and CPS notified of the dates and times.

5. When possible, designate specific staff from CPS to be on infant team. Continuity of staff is critical.

6. Designated CPS Infant Team staff agree to attend meetings and commit to a collaborative decision making process.

7. CPS team and the Infant Team will jointly formulate specific recommendations and a proposed treatment plan for the infant and caregivers related to services and interventions (identify specific collaborative community providers for other services needed) within the 30 days prior to adjudication and disposition hearing.

8. CPS and the Infant Team clinicians will agree on treatment outcome measures. CPS will provide the Infant Team with dates of meetings, mediations and court hearings. The Infant Team will provide a comprehensive report to PS 8 days prior to the court hearing.

9. CPS will provide Infant Team with or access to review pertinent history and documentation (such as investigative reports, treatment plans, psychological reports, medical reports, etc.).

10. CPS and Infant Team will collaboratively convene monthly team meetings of service providers to clarify shared goals, expectations, additional supports or expertise needed.

11. CPS and Infant Team will convene meeting with caregivers and provide integrated feedback on progress and/or change in treatment goals.

12. When possible, CPS will provide the Infant Team with a designated observation room for providing supervised visitations, developmental services and infant or child-parent psychotherapy as well as a room for collateral sessions with caregiver.

13. CPS will provide the IT Coordinator with weekly updates on cases (form will be provided).

**New Mexico Infant Team**

1. Upon receipt of CAPTA referral, the Infant Team will coordinate with the Part C/FIT team to expedite the CAPTA developmental evaluation, schedule the IFSP (Infant Family Service Plan), and initiate developmental services with the child(ren).

2. Upon receipt of the Infant Team Referral Form (at time of 10-day hearing), the Infant Team will schedule the Infant Mental Health assessment protocol. Upon completion of the assessment procedures, or inability to complete due to client non-participation, a comprehensive report will be completed summarizing the assessment and including recommendations, strengths and concerns.

3. Upon adjudication, Infant Team will oversee direct infant mental health and developmental intervention and treatment services for the infant/family and will collaborate with intervention and treatment provided by other agencies so as to avoid duplication.
4. Within reason, the Infant Team staff will participate in meetings as requested by CPS to include provider meetings, staff meetings, court hearings, etc.

5. The Infant Team will provide direct services which include supervising therapeutic visits, dyadic infant–parent psychotherapy, Circle of Security Parenting, developmental services through Part C, and other services as specified by the team.

6. The Infant Team will provide CPS with monthly progress summaries and comprehensive reports for court hearings (with the requisite 8 days notification).

7. The Infant Team will meet on a regular basis (monthly or every other month) with CPS staff to discuss procedures, planning and strategies for optimal service provision.

8. The Infant Team will track progress and challenges through provider and CPS reports and will compile information into update reports as per contract requirements from CYFD.

Signed______________________________________  
Title________________________________________  
Child Protective Services/CYFD

Signed______________________________________  
Title________________________________________  
New Mexico Infant Team
EXAMPLE
MEMORANDUM OF AGREEMENT
BETWEEN NEW MEXICO INFANT TEAM AND PART-C FIT SERVICES

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

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

Agreements
Part-C FIT Agency

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

2. The CAPTA referral is made after the initial investigation and faxed within 48 hrs. following the FCM/decision making meeting to the Part C/FIT agency.

3. The CAPTA referral is given to identified Infant Team Part-C Service Coordinator to schedule developmental evaluation and subsequent IFSP meeting.

4. The IFSP meeting includes PPW, Foster Parent(s) and Biological Parent(s) who collaborate on developmental goals through a trauma-informed lens. All parties sign the IFSP document.

5. IFSP goals will be integrated with Infant Mental Health goals and reflected in the Treatment Plan and Court Documents.

6. Fit Service providers will provide a brief monthly update outlining progress and challenges to the co-directors of the Infant Team to be included in the report for CYFD and the court.

7. Fit service providers will attend Infant Team supervision and training meetings when possible.
**Infant Mental Health Process**

8. A separate Infant Team Referral form is completed, faxed and sent to the Infant Team (IT) office.

9. Following the 10-day hearing, the Infant Team Referral will be completed and faxed to the Infant Team in order to begin a comprehensive Infant Mental Health and Relationship Assessment with the family. All meetings will meet ASFA guidelines in order to support the CPS team time lines and planning.

10. When possible, designate specific staff from CPS to be on infant team. Continuity of staff is critical.

11. Designated CPS Infant Team staff agree to attend meetings and commit to a collaborative decision making process.

12. CPS team and the Infant Team will jointly formulate specific recommendations and a proposed treatment plan for the infant and caregivers related to services and interventions (identify specific collaborative community providers for other services needed) within the 30 days prior to adjudication and disposition hearing.

13. CPS take the lead in designating time lines for reports/updates due and agree on outcome measures. CPS will allow at least 8 days from notification to provide a comprehensive report to the courts.

14. CPS will provide Infant Team with or access to review pertinent history and documentation (such as investigative reports, treatment plans, psychological reports, medical reports, etc.).

15. CPS and Infant Team will collaboratively convene monthly team meetings of service providers to clarify shared goals, expectations, additional supports or expertise needed.

16. CPS and Infant Team will convene meeting with caregivers and provide integrated feedback on progress and/or change in treatment goals.

17. When possible, CPS will provide the Infant Team with a designated observation room for providing supervised visitations, developmental services and child-parent psychotherapy as well as a room for collateral sessions with caregiver.

**The New Mexico Infant Team**

1. Upon receipt of CAPTA referral, the Infant Team will coordinate with the Part C/FIT team to expedite the CAPTA developmental evaluation, schedule the IFSP (Infant Family Service Plan), and initiate developmental services with the child(ren).

2. Upon receipt of the Infant Team Referral Form (at time of 10-day hearing), the Infant Team will schedule and complete the Infant Mental Health assessment and evaluation protocol. The protocol will be taped and a comprehensive report completed summarizing the assessment and including recommendations, strengths and concerns.

3. Upon adjudication, the Infant Team will oversee direct Infant Mental Health and Developmental Intervention and Treatment services for the infant/family and will oversee intervention and treatment provided by other agencies so as to avoid duplication.

4. Within reason, the Infant Team staff will participate in meetings as requested by CPS to include provider meetings, staff meetings, court hearings, etc.
5. The Infant Team will provide direct services, which include supervising therapeutic visits, dyadic infant–parent psychotherapy, Circle of Security Parenting, developmental services through Part C, and other services as specified by the team.

6. The Infant Team will provide CPS with monthly progress summaries and comprehensive reports for court hearings (with the requisite 8 days notification).

7. The Infant Team will track progress and challenges through provider and CPS reports and will compile information into update reports as per contract requirements from CYFD.
Examples of Treatment Goals and Tulane’s Assessment of Progress

NEW MEXICO INFANT TEAM
TREATMENT GOALS AND OBJECTIVES

1. Assess biological parent(s) capacity for engagement in services (see decision tree regarding challenges and barriers).

2. Provide appropriate level of intervention, i.e. COS, Infant Parent or Child Parent Psychotherapy to explore past and current trauma.
   a. Help caregiver to understand the reasons for PS involvement and parenting issues related to this such as inappropriate reversal of roles displayed in her/his relationship with infant, and change her actions that result in that behavior.
   b. Support caregiver to be able to carry the emotional responsibility for the relationship with infant.
   c. Support and assist caregiver in setting appropriate limits and boundaries with infant.
   d. Support and strengthen caregiver’s ability to be a safe and protective parent.
   e. Assist both caregiver and infant in integrating the difficulties associated with removal, change in placement, CYFD involvement and visitations, in order to increase feelings of safety, trust and competence.

3. Give caregiver basic information about the critical role of attunement, affect-arousal regulation, security, exploration, and play in brain development.
   a. Educate and expand caregiver’s awareness of concepts and interactions that support brain development and social-emotional well-being in vivo during moment-to-moment interactions.
   b. Determine caregiver’s learning style and best way to impart information to help with generalization.

4. For caregiver to become aware of the infant’s arousal dysregulation and behavioral disorganization during specific situations or differing environments, and to reduce her/his own arousal in order to expand her/his ability to read infant’s nonverbal communications.
   a. Learn strategies for reading and anticipating infant’s autonomic and behavioral cues that signal hypo- or hyperarousal and stress to modulate for social engagement.
b. Learn strategies for supporting and anticipating infant’s nonverbal engagement cues, subtle and potent, to match affect through prosody, tone of voice, facial expressions, eye contact, gestures, touch, and rhythmic movements.

c. Learn strategies to support infant’s vestibular, proprioceptive and tactile sensory processing to provide foundation for arousal regulation, contingency, and social-emotional engagement.

d. Learn strategies to support infant’s ability to regulate behavior and enter into shared attention while being interested in a wide range of sensations (sounds, sights, smells, touch, own movement patterns and imposed, rhythmic movement patterns).

e. Become aware of and learn strategies to modulate caregiver’s own arousal dysregulation and emotional states so that infant will not mirror dysregulation and be less available for social-emotional engagement.

f. Help support caregiver as he/she attaches affective meanings to situations, and provides social expectations and values related to infant’s specific emotional responses.

5. For caregiver to recognize infant’s disengagement and withdrawal behaviors as a cue to not increase but decrease her/his stimulation and give infant more interpersonal space.

a. Learn strategies for reading, responding to and anticipating infant states of behavior or states of consciousness, distress behaviors and subtle and potent disengagement cues.

b. Learn to recognize changes in motor tone and organization, eye contact, breathing, vocalizations, and color changes that communicate infant’s inability to interact fully in the moment.

c. Help infant with managing and communicating strong emotions, distress or overstimulation, and allowing different comforting strategies by caregiver.

d. Help support caregiver to manage stimulation within a comfortable range for infant and help alter her/his behavior if it is intrusive, aversive or insensitive to infant’s coping behaviors.

e. Help support caregiver to be able to pace their interactions within a comfortable range, give infant a break when “I’ve had enough” is communicated nonverbally, and pause to allow infant to respond to social overtures.

f. Help caregiver be aware of her/his own unconscious cues that adults give when under some sort of stress, be it positive or negative.

g. Help support caregiver understand how she/he attaches affective meanings to situations with infant, and provides social expectations and values related to infant’s specific emotional responses that may indicate role reversals or unreasonable projections.

6. Help caregiver engage in nonintrusive play by following infant’s lead and amplifying infant’s states of regulated positive arousal.

a. Learn play strategies and activities at infant’s developmental level and be able to interact with appropriate developmental expectations and anticipate and support the next level of development.

b. Help caregiver be able to support infant’s ability to take turns in a reciprocal interaction and amplify infant’s states of regulated positive arousal.

c. Support caregiver to be emotionally available and an active participant in moment-to-moment interactions following the infant’s lead.

d. Develop caregiver’s ability to interpret infant’s experiences; develop action schemes; support infant’s cognitive organization; support motivation, attentional skills and persistence; and, provide eternal support or co-regulation in the establishment of emotional and self-regulation.

7. Include ongoing assessment of child’s capacities, progress and challenges and recommendations.

8. Include ongoing assessment of parental capacity to take responsibility, progress, challenges and recommendations.
9. Work with CYFD to determine visitation schedule and additional supports needed in the best interest of the infant; participate in provider and family-centered meetings; and, support visitations with biological parents and family.

10. Educate and guide the court based on Infant Team evaluations and interventions in order to make informed placement decisions in the best interest of the infant.

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

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**Tulane Infant Team**

Tulane University School of Medicine

New Orleans, Louisiana

Name: ______________________ Date: __________________

Clinician: ____________________

### Progress in Treatment Assessment (PITA)

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<tr>
<td>1. Degree of responsibility parent assumes for state of child (the fact that the child has been maltreated)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>2. Sustained awareness demonstrated by parent of the need to change his/her own behavior</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>3. Evidence that parent can put the needs of their child ahead of their own needs</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>4. Does not blame the child for his/her maltreatment</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5. Recognition by parent of need to address personal, marital, relationship problems to improve parenting</td>
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<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>6. Recognition by parent of need to address substance abuse issues to improve parenting</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>7. Recognition by parent of need to address psychiatric disorder in order to improve parenting</td>
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<td>1</td>
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<td>8. Willingness and/or capacity to cooperate with involved professionals in process of treatment</td>
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<td>9. Potential for change, flexibility, and willingness to try different approaches within a time frame appropriate to child</td>
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<td>3</td>
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<td>10. Makes use of available community resources needed to assist family</td>
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1. **Degree of responsibility parent assumes for state of child (the fact that the child has been maltreated)**

0 = parent accepts no responsibility for child’s condition (e.g., does not think neglect/abuse has occurred; does not feel child has been impacted; blames others [i.e., system, reporter, etc] for contact with system)

1 = parent accepts limited responsibility for child’s condition (e.g., admits some problems may exist, does not feel child was impacted)

2 = parent recognizes that child was impacted by behavior and begins to accept personal responsibility

3 = parent accepts personal responsibility for child’s abuse/neglect and can provide convincing detail about ways in which child was impacted

2. **Sustained awareness demonstrated by parent of the need to change his/her own behavior**

0 = parent demonstrates no awareness of need to change his/her own behavior (e.g., feels unjustly accused, ‘picked on’)

1 = parent demonstrates limited awareness of need to change his/her own behavior (e.g., begins to voice awareness of problematic behavior)
EXPERT TESTIMONY IN JUVENILE COURT

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

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

C. Look and act prepared and professional.

II. COURTROOM PROCEDURE
A. Direct vs. Cross exam
   1. Purpose of cross is to undermine and rebut direct evidence;
   2. Re-direct can clarify and explain
B. Objections

C. Rules of evidence
   1. Leading questions
   2. Hearsay
   3. Laying a foundation

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

III. PRESENTATION IN COURT
A. Listen to the question

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

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

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

E. Common tactics on cross examination:
   1. Mispronouncing names of witnesses;
   2. Suggestive questions;
   3. Friendly counsel;
   4. Condescending counsel;
   5. Badgering, belligerent;
   6.Demanding “yes” or “no” answers
   7. Demanding percentages, statistics.

F. Post-hearing feedback
   1. Watch others testify;
   2. Review with attorney
GENERAL RULES AND TIPS ON TESTIFYING

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

CROSS EXAMINATION: GENERAL RULES AND TIPS

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

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

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

### MONTHLY PROVIDER UPDATE FORM

**Month and Year of Update:**

<table>
<thead>
<tr>
<th>Child:</th>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB:</td>
<td>Discipline:</td>
</tr>
<tr>
<td>Biological Parents:</td>
<td>Agency:</td>
</tr>
<tr>
<td>Foster Parents:</td>
<td>Services Provided:</td>
</tr>
<tr>
<td>Custody Entry:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Services Began:</th>
<th>Dates of Sessions and who was present:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancellations:</td>
<td>No Shows:</td>
</tr>
<tr>
<td>Collateral Meetings and Other (e.g. Provider, Video-Case Study, Court):</td>
<td>Length of Sessions:</td>
</tr>
</tbody>
</table>

**Treatment Goals:**

**Progress:**

**Challenges:**

**Best Interest of Child:**

**Risk of Return:**

**Plans/Recommendations to Further or Change Goals:**

Please attach copies of your family notes.
Central Register: The central registry is a list of individuals identified as having been responsible for child abuse or neglect following an investigation either by law enforcement, CYD, or both.

Central Registry: Data pertaining to child abuse or neglect.

Child Maltreatment: Maltreatment occurs when a child age birth to through 17 is physically, emotionally, or sexual harmed.

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

**Neglect:**
• Emotional neglect: Information which indicates that the child is suffering or has suffered severe negative effects due to a parent’s failure to provide the opportunities for normal experience which produce feelings of being loved, wanted, secure and worthy. Lack of such opportunities may impair the child’s ability to form healthy relationships with others.
• Physical neglect: The failure of the parent to provide for the basic needs, or provide a safe and sanitary living environment for the child.
• Medical Neglect of Handicapped Infant; the withholding of medically indicated treatment (appropriate nutrition, hydration and medication) from a disabled infant with life-threatening conditions. Exceptions include those situations in which the infant is chronically and irreversibly comatose; the provision of this treatment would merely prolong dying or not are effective in ameliorating or correcting all of the infant’s life-threatening conditions, and the provision of the treatment itself under these conditions would be inhumane.

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

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

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

**Intake:** The process of documenting all Child Welfare related contacts with CYFD/CPS. Intake includes the activities associated with the receipt of a referral, the assessment of screening, the decision to accept, and the referral of individuals or families to services. In New Mexico this occurs when reporters call Statewide Centralized Intake (SCI) located in Albuquerque and staffed 24 hours. SCI staff complete assessment and other structured decision making tools to determine how CYFD or other agencies will respond based on the information provided.
**Initial Investigation:** The gathering and analyzing of information in response to reports of suspected child abuse or neglect, to determine which families need further intervention. During this phase the CPS worker is primarily concerned with child safety. The CPS worker determines if child maltreatment did occur, determines the level of risk, and arranges services as necessary to protect the child.

**Perpetrator:** The person who was found to have committed an offense, as in abuse or neglect of a child.

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

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

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

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

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

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

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

**Adjudication and Disposition:** (also called the adjudicatory hearing) This hearing is held within 120 days of the initial custody hearing. The court will rule on whether the child has been abused or neglected and may order services for the family and continued custody.
Judicial Review: This hearing is held between the adjudicatory hearing and the initial permanency hearing for all parties to the case in order to review the progress in alleviating the causes and conditions that led to the court ordering the child into state custody.

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

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

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

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

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

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

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

Permanency: Each child in care is assigned one of five potential permanency plans that will guide services to ensure the child is achieves the goal of placement in a safe, loving and permanent family environment. Unless the state proves unusual circumstances in a case at the adjudicatory hearing a child’s first permanency plan is always reunification, sometimes also referred to as returnhome. Other permanency plan options include: adoption, permanent guardianship, placement with a fit and willing relative or planned permanent living arrangement. Permanent plans are recommended by CYFD and approved by the court. A permanent plan for all children entering care is expected to be finalized within 24 months of entering care.
**TPR/ Termination of Parental Rights:** In some cases children are abandoned by their parents or cannot return to their care. In some of these cases the state may recommend the state pursue a termination of parental rights trial. During these trials the court will rule on evidence presented to the court as to whether a parent's legal rights to their children should be terminated. The courts may subsequently establish another legal parent-child relationship by means of adoption. Parents may appeal the district courts decision regarding termination of parental rights. There are currently no laws or regulations regarding time frames for higher court decisions. Appeals place children in legal-limbo, until a decision by the appeals court is made.

**“It Depends”:** This statement is used widely in child welfare services. Just as all individuals and families are unique, circumstances and situations related to all child protective services cases are variable and differ widely. Each case presents its own unique set of issues, weaknesses, strengths and opportunities. Situations and circumstances are different in the case of every child we serve so we must respond to each child, family and case differently to preserve families, protect each child’s best interests and achieve permanency for all children.
Annual Review: IFSP team meeting held each year to evaluate and, as appropriate, revise the child’s IFSP.

Assessment: An ongoing process including the use of tests and tools to identify your child’s or family’s needs and strengths.

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

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

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

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

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

Cultural Competence: Respect for the beliefs, interpersonal styles, attitudes, and behaviors both of families who access or are referred to early intervention services and the staff who provide them. Early Intervention policy, administration and practices reflect this competency.

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

Due Process Hearing: A hearing involving a hearing officer who rules on evidence related to a disagreement between a parent and an early intervention provider’s professional judgment.

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

Early Intervention Services: The early Intervention system contains entitled services and access to other available services designed to meet the developmental needs of each eligible infant or toddler with disabilities and the needs of the family related to enhancing the development of their infant or toddler.
**Entitlement**: Benefits of a program granted by law to persons who fit within the defined eligibility criteria. Entitlement through Early Intervention ACT includes services coordination and development of the (IFSP) Individual Family Services Plan.

**Family**: Parent(s) guardian(s), and/or other person identified by the family.

**IFSP**: The Individual Family Service Plan is a process for providing early intervention services which results in a written plan for the provisions of those services that includes goals, outcomes, location duration and intensity of each service provided.

**IDEA**: The Individuals with Disabilities Education Act: A federal law that establishes the Part C Early Intervention Program for Infant and Toddlers with a disabilities.

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

**Mediation**: A way to settle a conflict so that both sides win. Parents and other professionals discuss their differences and, with the help of a trained and independent mediator, reach a settlement that both sides accept.

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

**Natural Environments**: Settings that are natural or normal for the child’s age peers, who have no disabilities and include the home, childcare and other community settings.

**Outcomes**: Statements of changes you want for your child and family that are documented in your IFSP (in situations where there is no other person to act as parent at the IFSP).

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

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

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

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

**Transition**: The process of planning for support and services for when your child will leave the Family Infant Toddler Program or if you move to a new community.

**Surrogate Parent**: Means the person appointed in accordance with these regulations to represent the eligible child in the IFSP Process when no parent can be identified or located or the child is a ward of the state. A surrogate parent has all the rights and responsibilities afforded to a parent under Part C of IDEA.
EXAMPLE OF TIERED APPROACH FOR INTENSITY OF SERVICES
ADAPTED FROM CONVERSATIONS WITH DR. JULIE LARRIEU, TULANE INFANT TEAM

Tier 1
- CAPTA (Child Abuse Prevention and Treatment Act) Referral fulfilled
- Infant Team Intake and Determination for Level of Service Intensity
- Infant Mental Health Assessments and Report (helps to determine Level of Service)
- Observations of Visits
- Developmental Services if Recommended
- Recommendations given to Permanency Placement Worker (PPW) and Court

Tier 2
- Progress/Challenges and Recommendations given to PPW and Court
- COS (Circle of Security – P) DVD-Parenting Program
- Therapeutic/Dyadic Visitation Support
- Possible Co-Visits between IMH and Developmental Services
- Progress Reports for Court

Tier 3
- Infant Mental Health Treatment—Dyadic and Collateral (may include Parent-Infant Psychotherapy (PIP), Child Parent Psychotherapy (CPP) and COS (Circle of Security) Treatment methods) or other approved intervention.
- Video Intervention Therapy
- Therapeutic/Dyadic Visitation Support
- Progress Reports for Court
New Mexico Infant Teams: Level of Engagement

**NO**

- Bio-Parent not engaging in IMH Individual Therapy, IMH Dyadic Treatment or in Developmental Services
  - (NO ENGAGEMENT)
  - Challenges documented and efforts recorded in Integrated Report for Court Hearings
  - IMH and Developmental Services available to Bio-Parent when he/she indicates a readiness
  - IMH and Developmental Services offered to Foster Parents

**Visits observed and Recommendations given to PPW**

**YES**

- Bio-Parent engages in Infant Team Services
  - Progress and Challenges documented in Integrated Report for Court Hearings
  - Progress and Challenges discussed at Provider Meetings
  - If unable to complete assessment process and initiate work towards IMH Treatment Goals, discontinue attempts until Bio-Parent indicates a readiness to join in parallel process.
  - If Bio-Parent misses three consecutive IMH Individual Therapy sessions, discontinue attempts until he/she indicates a willingness to resume consistency of therapeutic visits.

**Visits observed and Recommendations given to PPW Developmental Guidance continues to be provided during visits**

- Bio-Parent engages in Developmental Services but not engaging in IMH Treatment (dyadic and individual)
  - (LOW INTENSITY)
  - Progress and Challenges discussed at Provider Meetings
  - If appropriate, Developmental Services continue to be available when Bio-Parent is open, and IMH Individual Therapy available when Bio-Parent indicates a willingness to engage in the work

**COS and CPP Treatment modalities along with Developmental Guidance offered within Dyadic Framework**

- Bio-Parent engages in IMH Dyadic Treatment during visits but not available for IMH individual Therapy or Developmental Services
  - (LOW INTENSITY)
  - Progress and Challenges documented in Integrated Report for Court Hearing
  - Progress and Challenges discussed at Provider Meetings

- If appropriate, Developmental Services continue to be available when Bio-Parent is open, and IMH Individual Therapy available when Bio-Parent indicates a willingness to engage in the work

**COS and CPP Treatment modalities along with Developmental Guidance offered within Dyadic Framework**

- Bio-Parent engages in Developmental Services and IMH Dyadic Treatment during visits but unavailable for IMH Individual Therapy
  - (MEDIUM INTENSITY)

- Bio-Parent available for IMH Individual and Dyadic Treatment and for Developmental Services
  - (HIGH INTENSITY)
  - Progress and Challenges documented in Integrated Report for Court Hearings
  - Progress and Challenges discussed at Provider Meetings

- COS and CPP and/or Video Intervention Therapies implemented along with Developmental Support or Therapy(ies)
Infant Team Referral initiated by CPS

If Infant Team Referral not received

Part C - Developmental Evaluation Completed and Support Given to Foster Family

In Process or Completed

New Mexico Infant Mental Health Teams: Track Recidivism and Permanency

YES

NO

Complete Multidisciplinary Evaluation

Contact Bio-Parent(s) and/or Foster Family

FIT Program not integrated with Infant Team

Evaluation Previously Completed and no Services recommended

Evaluation Previously Completed and Services being provided

Contact Service Providers and determine any additions to IFSP needed

No additions needed

IFSP Amended and Reviewed with Bio-Parent(s) and Foster Family

FIT Part C Services continue with revisions to include services

Developmental Services not needed

FIT - Part C Services initiated with Bio-Parent(s) and Foster Family

Fit re-assessment to determine whether Services are needed with Placement Disruption

FIT - Part C Services initiated with Bio-Parent(s) and Foster Family

Review

Complete Multidisciplinary Evaluation of Child

FIT - Part C IFSP developed with CPS, IT, Bio-Parent(s) and Foster Family and Evaluation interpreted

FIT - Part C Services initiated with Bio-Parent(s) and Foster Family

New Mexico Infant Teams: CAPTA Referral Process

Chapter Nine 2016
New Mexico Infant Teams: Working with Substance Abusing Parents

**Bio-Parent with Substantiated Substance Use**

- **Part of Allegations that brought Child into Custody**
  - **YES**: Under Medical Care (e.g. Suboxone/antabuse Treatment Program)
  - **NO**: Consult with Recovery Program about Plan before beginning Assessment Process
- **Not Part of Treatment Plan but may be Suspected**: Continue with IT Assessment Process
- **Progress and Challenges documented in Integrated Report**: Bio-parent Adheres to Prescribed Dose and Engagement is documented with Recovery Program
- **Denial of Substance Abuse but Evidence of Active Use**: Under Medical Care (e.g. Suboxone/antabuse Treatment Program)
  - **YES**: Bio-parent Adheres to Prescribed Dose and Engagement is documented with Recovery Program
  - **NO**: Consult with Recovery Program about Plan before beginning Assessment Process

**Substance Abuse and Co-Morbid Condition with Mental Illness**

Recommend Appropriate Outside Professional Evaluation to determine Treatment Needs

Infant Team Recommends No Visits if Parents are Impaired and Challenges documented and given to PPW (Permanency Planning Worker)

Following documented engagement with IOP Recovery Program, IT Assessment Process begins

**Bio-parent with Substantiated Substance Use**

- **Under Medical Care (e.g. Suboxone/antabuse Treatment Program)**
  - **YES**: Bio-parent Adheres to Prescribed Dose and Engagement is documented with Recovery Program
  - **NO**: Consult with Recovery Program about Plan before beginning Assessment Process

**Bio-parent Adheres to Prescribed Dose and Engagement is documented with Recovery Program**

- **YES**: Continue with IT Assessment Process
  - **NO**: Consult with Recovery Program about Plan before beginning Assessment Process
New Mexico Infant Teams:
Working with Bio-Parents who have History of Domestic Violence (DV)

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

Part of Allegations that brought Child into Custody

Not Part of Treatment Plan but may be Suspected
- Progress and Challenges documented in Integrated Report

Domestic Violence identified in Affidavit
- Affidavit Reviewed in Intake Process
- Mandated Group and Individual Domestic Violence Program on Treatment Plan and Court-Ordered

Bio-Parents wish to remain a Couple
- Begin Intake Process and Determine Safety and Impact on Child(ren) of Co-Visits
  - Documented Engagement and Participation in Group and Individual Domestic Violence Program
    - Following Assessment Process, offer Infant Mental Health (IMH) Co-Treatment as a Couple along with Dyadic Relationship Therapy with Child and Collateral Therapy to work on Parenting

Bio-Parents separated and may have Restraining Order
- Begin Intake Process and Determine Safety and Impact on Child(ren) of Visits
  - Documented Engagement and Participation in Group and Individual Domestic Violence Program
    - Following Assessment Process, offer each parent IMH Dyadic Relationship Therapy with Child along with Collateral Therapy to work on Parenting

Bio-Parent(s) Denial of Domestic Violence but Evidence of Active Abuse
- Begin Intake Process and Challenges Documented and Given to PPW
- Determine Safety and Impact on Child(ren) of Visits
  - Recommend Separating Parents for Visits with Child until Documented Engagement and Participation in Group and Individual Domestic Violence Program
  - Begin Assessment Process when Documentation is Available

Co-Existing DV, Substance Use and/or Mental Illness
- Begin Intake Process and Determine Safety and Impact on Child(ren) of Visits
  - In Addition to Group and Individual Domestic Violence Program, a Substance Abuse Assessment and Inpatient or Intensive Outpatient Recovery Program along with Appropriate Psychiatric or Neuropsychological Evaluation be added to Treatment Plan
  - Assessment Process will proceed with Documented Engagement and Participation in Recovery Programs and Professional Evaluation Results to determine Treatment Needs
Questions for Parents

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

Focus on self

Why are you here?

Focus on others

Deflects responsibility from self onto others

“`I’m here because my ex-husband is trying to get back at me so he blamed me that my baby got hurt when he was the one watching her.”`

Takes responsibility

“`I’m here because I was stupid. If I hadn’t left my baby she wouldn’t have gotten hurt. I feel so bad that she got hurt because I wanted to go party.”`

Shows empathy (esp. for child)

“`My ex-husband is a screw-up and doesn’t watch the kids like he should.”`

Blames others

What impact does “X” have on your child?

Dismiss, minimize, or justify behavior

“`She is fine. I broke my arm twice when I was a kid, and anyway I wasn’t even there when it happened”`

Show empathy and understanding for child

“`Her arm is fine, but I think the whole thing was scary for her. I remember when I broke my arm as a kid and I was scared to death.”`

How could this have been prevented?

Change in behavior

Sees isolated mistakes rather than a pattern

“I shouldn’t have left her with my ex-husband.”

Shows understanding of adequate supervision

“I shouldn’t have left her with my ex-husband. I mean I know he isn’t careful and he has a temper. I need to not leave her with people I don’t trust.”

Shows insight into the big picture

“I don’t know that it could be prevented. Accidents just happen sometimes. What are the odds that she would have broken her arm falling off the couch?”

Change in facts

Sees problem as a one time event or fluke

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REFERENCES ON INFANT MENTAL HEALTH
With Contributions from Julie A. Larrieu, Ph.D.

OVERVIEW OF INFANT MENTAL HEALTH: DEFINITIONS AND DEVELOPMENT


**CHILD CARE: OVERVIEW, OBSERVATION, AND CONSULTATION**


**TRAUMA IN CHILDREN AND HEALTH PROBLEMS**


**ASSESSMENT IN INFANT MENTAL HEALTH**


**TREATMENT IN INFANT MENTAL HEALTH**


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


MALTREATED INFANTS AND CAREGIVERS: ASSESSMENT AND TREATMENT


**Websites:**

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

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

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

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

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

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

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

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Abstract
This article focuses on the experience of “Desirae,” a young mother who participated with her children in services at The Children’s Ark, an attachment-based intervention for families in foster care. The story of Desirae and her children highlights both the sometimes paradoxical truths about families fractured by addiction, abuse, and neglect and the nature of lasting change that challenge the current child welfare system. Informed by attachment theory and other psychodynamically oriented perspectives as well as Buddhist psychology and mindfulness, the authors stimulate further thinking about how professionals can manage challenges with creativity and compassion by keeping relationships at the center of care for families in crisis.
To him. She seemed to have the most difficulty responding to his cries, when he needed her the most. The first night that Jacob spent at The Ark (after being in foster care for more than a year), Desirae took free time and was gone for the evening, leaving Jacob without her in his new surroundings.

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

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

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

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

Abandonment or avoidance was an issue from the beginning with David. There was little interaction between them. She often placed him facing away from her, sat with her back to him, and spent long periods of time not speaking with Jacob. Life became even more complicated for Desirae. Unbeknownst to us, she was pregnant when she left The Children's Ark. She married her boyfriend and soon was also parenting one of his children from a previous relationship. The state of Washington then placed in their custody her sister’s three children, so suddenly there were seven.

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

Although we worked hard to discourage reunification after Desirae left The Children’s Ark, we worked equally hard to stay in relationship with her, and not ambush, mislead, or abandon her. I visited occasionally during the first 2 years or so, when I was able to keep track of an address. On occasion, they would contact us, usually when their backs were against the wall. Then one Halloween, Desirae, her husband, and all of the children arrived on our doorstep, and this began a tradition of a visit each year.

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

The Lessons

Desirae’s reflection on her own experience coupled with Janet’s insight and interpretation has helped to frame the following lessons and their implications for practice. In its initial conceptualization, The Children’s Ark was informed and influenced by attachment theory (Bowlby, 1969/82). As reflected in the following, our thinking is also influenced by other psychodynamically oriented perspectives (Fosha, 2000; Heineman & Ehrensaft, 2006; Richo, 2008) as well as by work in Buddhist psychology and mindfulness (Bayda, 2006; Richo, 2008). These history-in-the-moment experiences informed and influenced our thinking and are thereby an integral component of our work at The Children’s Ark.

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

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

Decades of research show that the intergenerational forces operating on one’s parenting are powerful, that even when parents intend to care for their children differently they often find themselves repeating what they experienced. Researchers and clinicians have described how the parent, once they think, feel and are, they will not come out from behind their protective walls. These history-in-the-moment experiences powerfully color, shape, and drive parents’ behavior even when they have some insight into them. Desirae stated to her Ark therapist, “I feel like I’m living with my mother and nothing I say matters, and it is never good enough.” This emotional reenactment with me of her own experience threw Desirae into a protective, defensive stance that felt critically necessary to her survival on some level, but from which she could not possibly parent with any sensitivity.

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

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

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

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

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

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

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

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

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

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

Over one of the Christmas holidays at The Children’s Ark, the mothers were sharing stories. Desirae started talking about how many agencies “adopted” her family at Christmas when she was little, and how as each stranger arrived bearing gifts, the pile of toys and goodies under the tree grew larger and larger. But then as her mother, who was an addict, fell into more depression and desperation—along with her own painful ghosts from the past—the pile began diminishing. As Christmas approached Desirae witnessed kids in the neighborhood riding “her” bike and playing with “her” doll. Tears rose in Desirae’s eyes as she described the shame, humiliation, and deep pain of watching others with gifts intended for her because her mother put her next drug fix before her children.

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

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

Lesson 4: Real change takes time.

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

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

**The Implications**

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

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

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

Parents and children may well also benefit from individual treatment in conjunction with the relationship-based treatment. Two factors are important to remember regarding any treatment. One is that change is optimized within in the context of a safe relationship; and so, whenever possible, therapists and treatment providers should remain constant. For example, The Children’s Psychotherapy Project, started by a nonprofit organization called A Home Within, developed the following model for its work with children and youth in foster care: “One child. One therapist. For as long as it takes” (Heineman, 2006, p. 3). This approach grew out of a consistent finding in research and clinical work: “The single most important factor in the lives of children and youth in foster care is a stable and lasting relationship with a caring adult” (Heineman, p.11).

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

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

Finally, relationships between biological families and foster families or relatives should be encouraged and facilitated, not discouraged (Ehrensaft, 2006). Not only do the children benefit from all their caretakers working together, but foster families and relatives can often be the best resource for a family in crisis. Foster families are entitled to information about the children in their care specifically, and they should be better trained about the needs of children facing significant loss and trauma generally (Bass, Shields, & Behrman, 2004; Dozier et al., 2009). A well-intended, well-informed, well-supported foster or relative family can be a critically important member of the team and a caring bridge between parents and children at risk (Harrison, 2004). Had Desirae and I not been able to tolerate each other’s imperfections enough to stay connected over time, she would never have been able to use what The Children’s Ark had to offer.

**Conclusion**

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

**Learn More**

Circle of Security Early Intervention Program
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A Home Within
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More of Desirae’s Story

Just as Desirae maintained enough connection to ultimately access the softer, wiser part of herself, so David held, on some level, the “knowing” of another way to be in relationship. One day, about 2 years after the family had left The Children’s Ark, I encountered Desirae, David, and the new sibling (who was now 2 years old) at a nearby park. David was playing in the wading pool. Desirae called him to his sister, tousled her hair, and remarked, “You don’t know me, do you?” as she stared at me. Quite appropriately, he first peaked out from behind his mother’s skirt, then ran off to play on the climbing equipment with his sister. As I left the park I walked by where David was playing up on a platform and stood eyeball to eyeball with him. I said hello to his sister, tousled her hair, and remarked, “You don’t know me, do you?” as she stared at me with a bit of apprehension. David, however, was staring intently into my eyes. I said quietly, “But you don’t, do you?” David nodded, slowly, almost imperceptibly, without taking his eyes off me. Finally he fell into my arms and held on tight and long. Even after 2 years something in his deeply rooted, perhaps unconscious, memory system allowed him to trust the safety and connection in my arms. That moment in the park floated through my mind recently as I stood with Desirae on the sidelines of the now-14-year-old David’s football game, cheering him on.

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

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Authors’ Note

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

References

A GUIDE TO PRACTICAL INTERVENTIONS TO HELP CHILDREN AFFECTED BY TRAUMA
Acknowledgements

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

Additional thanks go to the Multiplying Cross System Training Institute and Steering Committee who carefully reviewed and edited the content of the guide and to Suzanne Cohen for publishing the guide in a user friendly format.
A GUIDE TO PRACTICAL INTERVENTIONS TO HELP CHILDREN AFFECTED BY TRAUMA

Introduction

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

- *Techniques* (behavioral and structural changes you can make when interacting with children),
- *Activities* (focused interactions with children designed specifically to help them cope with their responses to trauma and any trauma triggers present in the environment), and
- *Environmental changes* (ways you can rearrange your office, classroom, etc to make it calmer and more secure for children)

With a little practice, all of these strategies can easily be implemented and integrated into your daily work and they do not require any special clinical training.
Since childhood trauma is “any physical or physiological threat or assault to a child’s physical integrity, sense of self, safety or survival or to the physical safety of another person significant to the children” (MC definition – BTI), the overall goal of all of these interventions is to increase a child’s sense of self, safety, stability, and positive connections with others.

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

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

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

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

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

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

**ATTUNED:** asks you to be aware of children’s non-verbal signals: body language, tone of voice, emotional state. These signals tell you how much and what types of activity and learning the child can currently handle. These signals are also constantly shifting, so being attuned to children requires constant vigilance. Furthermore, children affected by trauma experience both life and their trauma in the midbrain, or the implicit, sensory part of the brain rather than in the “thinking/learning” neocortex. (Steele, p. 14). Consequently, you must connect with the child(ren) on an emotional, sensory level before moving to a cognitive level.
**PRESENT:** requires that you focus your attention on the child(ren) you are with, that you be in the moment. All children can sense when you are not truly engaged or focused on them; to compound this intuition, a “pervasive mistrust of the adults with whom they interact” (Bath, p. 6) is a key characteristic of children who have experienced trauma. Despite their wariness, these children need to and, with support, can form secure relationships with loving adults.

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

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

TECHNIQUES

CREATE EMOTIONAL/PHYSICAL SAFETY

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

**CAPPD Concepts:** predictable, attuned, calm

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

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

PROVIDE CHOICE AND CONTROL

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

**CAPPD Concepts:** predictable, attuned, present

**What It Is:** It is normal and necessary for children to go through a demanding/controlling phase of development, but trauma exacerbates it. For chil-
Children who have been traumatized, many of their life experiences involve control being taken away from them; they need to regain a sense of control. For demanding/controlling/stubborn kids, give them control over small things. For example, say to them “For snack, you can have A or B” or “Which activity would you like to do, A or B?”. Cheer children on as they try new things and try to accomplish things independently.

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

**COMMUNICATE RESPECT/TRANSPARENCY:**

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

*CAPPD Concepts:* predictable, attuned, present

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

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

**BE NURTURING**

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

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

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

PROVIDE STABILITY

Age: 0–5  Applicable To: Groups or Individuals

CAPPD Concepts: predictable

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

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

Age: 0–5  Applicable To: Groups or Individuals

CAPPD Concepts: attuned, present

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

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

MODEL OPEN DISCUSSION

Age: 3–5  Applicable To: Groups or Individuals

CAPPD Concepts: attuned, present

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

Why It Helps: Open discussion helps kids learn generally to talk openly and develop good conversation skills. Open dialogue will also help children feel more comfortable discussing difficult issues. When children have the truth and the facts, it decreases their impulsivity and aggression. Open discussion also communicates respect for the children, which helps build their self-esteem.
**Age:** 1–5  
*Applicable To:* Groups or Individuals

**CAPPD Concepts:** calm, attuned, predictable, don’t...

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

Think about the causes of a child’s behavior before giving disciplining. Try to make the experience something from which they can learn. Try to select consequences that address the causes of the behavior and that are logical. Also keep in mind that children who have experienced trauma often need adults to react to their developmental age, not their biological age (i.e. – a 5 yr old throwing a tantrum like a 2 yr old may need to be rocked and held, not sent out to time out). Give choices, if possible, for consequences.

Children affected by trauma are very sensitive to displeasure, so err on the side of under-reacting, when possible. Don’t criticize or shame children for regression (i.e. – a potty-trained child starts wetting his pants again after trauma); regression is a normal response to trauma. Try to ensure that the consequence will not trigger a trauma response, for some children discipline strategies such as isolated time out may be very retraumatizing if they have been neglected or abandoned in the past. It is NEVER acceptable for children’s services professionals caregiver to use hitting, spanking, verbal abuse or yelling as a consequence for a child’s negative behavior.

Give warm, abundant praise as much as you can (ratio of praise to criticism should be at least 6:1). In other words, make more effort to catch and acknowledge children doing “good” things. Make sure to use “labeled” (specific) praise. For example, instead of giving vague encouragement like “Good job,” praise the specific behavior or action – “I really like
how quickly you stopped playing the game when I said it was time to go inside" or “I really like how you used many different colors to draw your butterfly today”

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

**ACTIVITIES**

**MAKE A SAFETY PLAN**

*Age: 2–5 Applicable To: Groups and individuals*

*CAPPD Concepts:* attuned, predictable

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

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

Age: 3–5  
Applicable To: Groups or Individuals

CAPPD Concepts: calm, present

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

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

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

**Age:** 3–5  
**Applicable To:** Groups or Individuals  

**CAPPD Concepts:** calm, present

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

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

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

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**POSITIVE IMAGERY**

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

**CAPPD Concepts:** calm, present

**What It Is:** Ask children to close their eyes if they want to (for some children who experienced trauma closing their eyes can be frightening and/or a trauma trigger) and imagine a nice place in their minds. They can imagine some place they’ve been or some place that is very familiar and comfortable. Ask them to take 3 deep breathes and imagine any ‘bad’ thoughts they are having drifting away as they breathe out. Tell them to think about their nice place and imagine it with all their senses. What does it feel/smell/look/sound like? They should enjoy being in the place and notice
how being there makes them feel. When they are ready, they should slowly let go of this image and bring themselves back to the room.

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

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

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**CREATIVE ACTIVITIES**

*Age: 6 mo–5 Applicable To: Groups or Individuals*

*CAPPD Concepts: calm*

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

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

Age: 6 mo–5  Applicable To: Groups or Individuals

CAPPD Concepts: calm, present

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

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

READ STORIES

Age: 0–5  Applicable To: Groups or Individuals

CAPPD Concepts: calm, predictable

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

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

Age: 0–5  Applicable To: Groups or Individuals

CAPPD Concepts: calm, present

What It Is: Give children time for unstructured play.

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

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

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

*Applicable To:* Groups or Individuals

*CAPPD Concepts:* attuned

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

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

Age: 3–5  Applicable To: Groups or Individuals

CAPPD Concepts: attuned

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

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

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

Age: 4–5  Applicable To: Groups or Individuals

CAPPD Concepts: calm, present

What It Is:

Lead the children through the following:

- sit comfortably and relaxed; breathe deeply
- look around and name 5 pleasant objects you see
- breathe slowly and deeply
- name 5 pleasant sounds you hear
- breathe slowly and deeply
- name 5 pleasant things you can physically feel
- breathe slowly and deeply
- name 5 colors you see in the room
- breathe slowly and deeply

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

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

TREASURE HUNT

Age: 2–5  Applicable To: Groups or Individuals

CAPPD Concepts: predictable

What It Is: Have children look for certain objects (yellow star, etc) around the room. Repeat the activity often.
**Why It Helps:** Finding items where you expect them to be, and repetition in general, provides predictability, which decreases hyper-arousal. Repetition is also necessary for the brain to build new pathways and leads to competence and skill development.

**I SPY**

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

*CAPPD Concepts:* attuned

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

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

**INTERACTIVE STORY TELLING**

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

*CAPPD Concepts:* attuned, present

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

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

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

*CAPPD Concepts:* present, predictable, calm

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

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

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**EMOTIONAL MATCHING**

*Age: 3–5  Applicable To: Groups or Individuals*

*CAPPD Concepts:* attuned

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

*Why It Helps:* Children affected by trauma have trouble accurately identifying emotional states; they often over-interpret people’s displeasure or upset. For example, they have difficulty differentiating between neutral, sad and angry expressions and may interpret even the slightest sign of annoyance as threatening to them; i.e. expression of fury. The activity provides the opportunity to practice accurately identifying emotional expression and builds neural pathways.

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**DRAMATIC PLAY**

*Age: 3–5  Applicable To: Groups or Individuals*

*CAPPD Concepts:* calm, attuned

*What It Is:* Using props, have children pretend that the police come to help a girl who is lost (assign roles to the children), etc (other dramas might
involve the hospital, social workers, firefighters – anything with which the child might have had negative experiences).

*Why It Helps:* Children who have experienced trauma are often afraid of the police (or other people/situations) and often naturally re-enact their trauma through their play. This activity helps them reframe their experiences with police (or others) to learn that police help maintain safety in the community. Research shows that developing ‘stories’ about their experiences is a crucial part of the recovery process (Bath, p.7). By interacting calmly with children as they do these re-enactments, you will help them manage their stress and create perspectives that go beyond their traumatic experiences.

**ENVIRONMENTAL CHANGES**

**LIMIT TV**

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

*CAPPD Concepts:* calm, present, attuned

*What It Is:* If possible, don’t allow children to watch TV at all, but especially programming that exposes them to traumatic events (disaster, murder, accident, death, etc.). If you do watch media on trauma or violence with children, actively engage them and talk about what’s happening while watching it and after the program is over.

*Why It Helps:* TV hinders healthy brain development, especially in very young children (0–3). The rapid movement from scene to scene on TV keeps children’s brains on high alert, and interferes with the development of a normal attention span and with children’s ability to follow story lines. Being continuously re-exposed to a traumatic event, especially in the sensationalized format of TV can worsen trauma for children. If children do see reminders of trauma they have experienced on TV, discussing it with them is an excellent way to remain attuned and be present for them and to help them make sense of the trauma.
COZY CORNER

Age: 2–5  
Applicable To: Groups or Individuals

CAPPD Concepts: calm, attuned

What It Is: Create a cozy area where children can go when stressed, angry, sad, or fearful. Make the area as warm and homelike as possible – soft blankets, soft chairs, beanbag chairs, cushions, stuffed animals, etc.

Why It Helps: Two major problems children affected by trauma experience are an absence of feeling safe and the inability to self-soothe, particularly when they are operating in a hypervigilant state. Providing them with a calm, cozy area can provide them with a safe retreat when they feel overwhelmed or unsafe and gives them the opportunity to practice self-soothing and regulating their emotions.

PLAY BACKGROUND MUSIC:

Age: 0–5  
Applicable To: Groups or Individuals

CAPPD Concepts: calm, present, attuned

What It Is: Play soft, classical/instrumental music in the background.

Why It Helps: This technique can help create a soothing environment. The rhythms of music help bring brain functioning from hyperactive or disassociated states to “normal”, which promotes neurological development.
APPENDIX I

Recommended Books and Music for Infants and Toddlers

(Taken from Helping Children Rebound)

BOOKS

Black and White Illustrations

*Baby Animals: Black and White* by Phyllis Limbacher Tildes

*Black on White* by Tana Hoban

*What is That?* by Tana Hoban

*White on Black* by Tana Hoban

*Who Are They?* by Tana Hoban

Bold Illustrations

*Animal Noises* by Stephan Cartwright


*Color Farm* by Lois Ehlert

*Pet Animals* by Lucy Cousins

*My Car* by Byron Barton

Baby Faces

*Baby Face* by Phyllis Limbacher Tildes

*Eat (Baby Faces series)* by Roberta Grobel Intrater

*How Sweet It Is To Be Loved by You (MotownBaby Love Board Book series)* by Charles R. Smith, Jr.

*Peekaboo Baby (Look Baby! Series)* by Margaret Miller
Books For Toddlers

A You’re Adorable by Buddy Kaye, Fred Wise, and Sidney Lippman

Baby Dance by Ann Taylor

Busy Fingers by C.W. Bowie

Can I Have a Hug? by Debi Gliori

Counting Kisses: A Kiss and Read Book by Karen Katz

Goodnight Moon by Margaret Wise Brown

Hear Are My Hands by Bill Martin, Jr.

Hush Little Baby by Sylvia Long

I Love You Baby from Head to Toe! by Karen Pandell

Just Like Me by Miriam Schlein

“More, More, More,” Said the Baby by Vera B. Williams

Pretty Brown Face by Andrea Davis Pinkney

The Runaway Bunny by Margaret Wise Brown

Ten Little Fingers by Annie Kubler

Ten, Nine, Eight by Molly Bang

Tickly Under There by Debi Gliori

Toes, Ears and Nose!: A Lift-the-Flap Book by Marion Dane Bauer


Where is Baby’s Belly Button? by Karen Katz

Will You Carry Me? by Heleen van Rossum
MUSIC

Lullabies

* A Child's World of Lullabies * by Hap Palmer

* Dream a Dream * by Mary Stahl

* Lullabies for Little Dreamers * by Kevin Roth

* The Baby Record * by Bob McGrath

* Wee Sing Nursery Rhymes and Lullabies * by Pamela Conn Beall and Susan Hagen Nipp

Gentle Music

* Baby's First Classics, Volume 1,2,and 3 * by various artists, St. Clair Records

* Baby's First Guitar Music * by various artists, St. Clair Records

* Quiet Places and Seagulls * by Hap Palmer

Playful Songs and Nursery Rhymes; Recordings

* Babysongs * and * More Babysongs * by Hap Palmer

* Early, Early Childhood Songs * by Ella Jenkins

* Peek-A-Boo * and * So Big * by Hap Palmer

* Songs and Games for Toddlers * by Bob McGrath

* Tiny Tunes * by Carole Peterson

* Wee Sing and Pretend * by Pamela Conn Beall and Susan Hagen Nipp

* Wee Sing Children’s Songs and Fingerplays * by Pamela Conn Beall and Susan Hagen Nipp

* Wee Sing for Baby * by Pamela Conn Beall and Susan Hagen Nipp
Songs and Nursery Thymes: Resource Books for Caregivers

*I Love You Rituals* by Becky A. Bailey

*The Book of Bounces* by John M. Feierabend

*The Book of Simple Songs & Circles* by John M. Feierabend

*The Book of Tapping and Clapping* John M. Feierabend

*The Book of Wiggles and Tickles* John M. Feierabend
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*Head Start School Intervention Project*. Southwest Michigan Children’s Trauma Assessment Center.


Perry, Bruce. *Trauma Up to Age Five*. Video #4 in Film Series: *Childhood Trauma*. VB 9.08

HOW I STAY CAPPD

To stay Calm I ________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

To be Attuned I ________________________________
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To be Present I ________________________________
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To be Predictable I ________________________________
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_______________________________________________________________________________________

So I Don’t escalate I ________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
**Multiplying Connections** is a cross-system initiative funded by the **William Penn Foundation** to build the capacity in Philadelphia’s public children’s service system to

- Provide developmentally appropriate and trauma informed services for all children;
- Understand and respond to children suffering from trauma in ways that “do no further harm;” and
- Support ways to expand the quality and quantity of children’s relationships, and nourish their healthy development.

**The Health Federation of Philadelphia** is home to **Multiplying Connections**. Our steering committee public system partners include the **School District of Philadelphia**, **Early Childhood Education Program** and the **City of Philadelphia’s Departments of Human Services, Public Health, Maternal Child Family Health Division, and Behavioral Health, Children’s Division**. We are also proud to partner with the **Institute for Safe Families**, **The Center for Non-violence and Social Justice**, **The Children’s Crisis Treatment Center**, **The Behavioral Health Training and Education Network** and the **Pennsylvania Council for Children Youth and Family Services**.

To learn more about Multiplying Connections visit our website: **[www.multiplyingconnections.org](http://www.multiplyingconnections.org)**
For Supporting this project, special thanks to:

The William Penn Foundation

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This publication was co-authored by the National Scientific Council on the Developing Child and the National Forum on Early Childhood Policy and Programs, which are both initiatives of the Center on the Developing Child at Harvard University. The content of this paper is the sole responsibility of the authors and does not necessarily represent the opinions of the funders or partners. Copies of this document, as well as more information about the authors and the Center, are available from www.developingchild.harvard.edu.

The authors gratefully acknowledge the contributions of Kamila Mistry, Ph.D.; Anne Riley, Ph.D.; Sara Johnson, Ph.D.; Lisa Dubay, Ph.D.; Cynthia Minkowitz, M.D., M.P.P.; and Holly Grason, M.A., of the Women’s and Children’s Health Policy Center, Johns Hopkins Bloomberg School of Public Health.


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Health is more than merely the absence of disease—it is an evolving human resource that helps children and adults adapt to the challenges of everyday life, resist infections, cope with adversity, feel a sense of personal well-being, and interact with their surroundings in ways that promote successful development. Nations with the most positive indicators of population health, such as longer life expectancy and lower infant mortality, typically have higher levels of wealth and lower levels of income inequality. In short, children’s health is a nation’s wealth, as a sound body and mind enhance the capacity of children to develop a wide range of competencies that are necessary to become contributing members of a successful society.1,2

Adverse events or experiences that occur early in childhood can have lifelong consequences for both physical and mental well-being. That is to say, developmental and biological disruptions during the prenatal period and earliest years of life may result in weakened physiological responses (e.g., in the immune system), vulnerabilities to later impairments in health (e.g., elevated blood pressure), and altered brain architecture (e.g., impaired neural circuits). For example, exposure of expectant mothers to highly stressful environments can influence the birth weight of their babies, and lower birth weight has been linked to substantially increased risk for obesity, diabetes, and cardiovascular disease later in life. Traumatic experiences during childhood, such as physical abuse or the adversities that accumulate for children reared in deep and persistent poverty, are also capable of disrupting the neurobiological systems that guide physiological and behavioral responses to stress, potentially for the remainder of an individual’s life. Altering these regulatory mechanisms (e.g., setting the stress response system on a “short fuse”) can permanently increase the risks of acute and chronic disease, and even a shortened life span, by undermining the normally adaptive response of the body to the challenges and stressors of everyday life. These alterations to developing biological systems can lead to greater susceptibility to a wide range of illnesses well into the adult years, even in the absence of any conscious memory of early trauma.

Beyond its effect on individuals, poor health early in life also imposes significant societal costs that are borne by those who remain healthy. For example, when large numbers of children become ill because they did not receive their immunizations, the entire population becomes vulnerable to epidemics of infectious diseases. Similarly, the consequences of adversity and poor health in childhood can lead to higher rates of chronic diseases in adults, such as diabetes, hypertension, cardiovascular disease, and various forms of cancer, as well as depression, anxiety disorders, addictions, and other mental health impairments. These conditions affect all of society by reducing the productivity of the workforce and increasing the incidence of disability, the demand on medical facilities, and the costs of medical care. Thus, a focus on health promotion in the early childhood period—where an extensive body of evidence supports the promise of effective prevention programs that can change the trajectory of children’s lives—can help reduce the social and economic burdens of illness, not only in childhood but also throughout the adult years. This connection between early life experiences and the health of a nation underscores the importance of strategic investments in the care and protection of pregnant women, infants, and young children, and it suggests that most current attempts to prevent adult disease and create a healthier workforce may be starting too late.
Reconceptualizing the Health Dimension of Early Childhood Policy

The knowledge base summarized in this document presents a compelling rationale for fundamentally rethinking the health dimension of early childhood policy. Science tells us that meeting the developmental needs of young children is as much about building a strong foundation for lifelong physical and mental health as it is about enhancing readiness to succeed in school. This insight points to the importance of viewing a broad array of policies and programs—beyond the provision of medical services—as potentially important vehicles for reducing the social burdens, human capital consequences, and medical-care costs of health impairments in the adult years. In other words, significant progress in lifelong health promotion and disease prevention could be achieved by reducing the burden of significant adversity on young children—and this progress could be accelerated through science-based enhancements in a wide range of policy domains, including child care and early education, child welfare, public assistance and employment programs for low-income parents, housing policies, and community development initiatives, to name just a few.

Driven by converging evidence from neuroscience, molecular biology, genomics, and advances in the behavioral and social sciences, this call for a broader perspective on health promotion and disease prevention is guided by the following three overarching concepts:

- Experiences are built into our bodies (for better or for worse) and significant adversity early in life can produce physiological disruptions or embedded biological “memories” that persist far into adulthood and lead to lifelong impairments in both physical and mental health.
- Genes and experiences interact to determine an individual’s vulnerability to early adversity and, for children experiencing severe adversity, environmental influences appear to be at least if not more powerful than genetic predispositions in their impact on the odds of having chronic health problems later in life.
- Health promotion and disease prevention policies focused on adults would be more effective if evidence-based investments were also made to strengthen the foundations of health and mitigate the adverse impacts of toxic stress in the prenatal and early childhood periods.

This new scientific knowledge compels us to think and act creatively to enhance the healthy development of young children by reducing the disruptive effects of significant adversity on developing biological systems. Progress toward this goal will be most effective if innovative actions are guided by an understanding of four interrelated dimensions that together comprise a new framework for improving physical and mental well-being: (1) the biology of health; (2) the foundations of health; (3) caregiver and community capacities; and (4) time and commitment.
capacities to promote health and prevent disease and disability; and (4) public and private sector policies and programs that can influence health outcomes by strengthening caregiver and community capacities.

The biology of health is defined by advances in science that explain how experiences and environmental influences “get under the skin” and interact with genetic predispositions, which then result in various combinations of physiological adaptation and disruption that affect lifelong outcomes in learning, behavior, and both physical and mental well-being. These findings call for us to rethink current, adult-focused approaches to health promotion and disease prevention by incorporating an understanding of the early childhood origins of lifelong illness and disability.

The foundations of health refer to three domains of influence that establish a context within which the early roots of physical and mental well-being are either nourished or disrupted:

• A stable and responsive environment of relationships. This domain underscores the extent to which young children need consistent, nurturing, and protective interactions with adults that enhance their learning and behavioral self-regulation as well as help them develop adaptive capacities that promote well-regulated stress response systems.

• Safe and supportive physical, chemical, and built environments. This domain highlights the importance of physical and emotional spaces that are free from toxins and fear, allow active exploration without significant risk of harm, and provide supports for families raising young children.

• Sound and appropriate nutrition. This domain emphasizes the foundational importance of health-promoting food intake, beginning with the future mother’s pre-conception nutritional status and continuing into the early years of the young child’s growth and development.

Caregiver and community capacities to promote health and prevent disease and disability refer to the ability of family members, early childhood program staff, and the social capital provided through neighborhoods, voluntary associations, and the parents’ workplaces to play a major supportive role in strengthening the foundations of child health. These capacities can be grouped into three categories: (1) time and commitment; (2) financial, psychological, and institutional resources; and (3) skills and knowledge.

Public and private sector policies and programs strengthen the foundations of health through their ability to enhance the capacities of caregivers and communities in the multiple settings in which children develop. Relevant policies include both legislative and administrative actions that affect systems responsible for public health, child care and early education, child welfare, early intervention, family economic stability (including employment support for parents and public assistance), community development, housing, and primary health care, among others. It is also important to underscore the role that private-sector practices as well as government-sponsored programs can play in strengthening the capacities of families to raise healthy and competent children. Workplace policies related to parental leave, flexible working hours, and time off to care for a sick child or attend a parent-teacher conference are a few examples.

This framework suggests a new way of conceptualizing policies and practices in multiple sectors, all of which affect the early childhood origins of lifelong health. The goal is to catalyze informed investments and creative innovations that build on a shared scientific base to achieve significantly improved outcomes for children and society above and beyond the impacts of existing efforts. Although the framework can be adapted to address challenges facing all nations, the policy and program context for this document is focused on current circumstances and opportunities in the United States.
Understanding the Biology of Health in the Early Years of Life

In order to understand how policies and programs strengthen the capacities of families and communities to promote the foundations of health, it is essential to begin with an understanding of how personal experiences, environmental conditions, and developmental biology work together in early childhood to influence the roots of lifelong physical and mental well-being. Early childhood is a time of rapid development in the brain and many of the body’s biological systems that are critical to sound health. When these systems are being constructed early in life, a child’s experiences and environments have powerful influences on both their immediate development and subsequent functioning. These effects may appear early and be magnified later as children grow into adolescence and adulthood. Some have compared a child’s evolving health status in the early years to the launching of a rocket, as small disruptions that occur shortly after take-off can have very large effects on its ultimate trajectory. Thus, “getting things right” and establishing strong biological systems in early childhood can help to avoid costly and less effective attempts to “fix” problems as they emerge later in life.

Physiological Adaptations or Disruptions in Early Development

An extensive body of scientific evidence now shows that many of the most common chronic diseases in adults—such as hypertension, diabetes, cardiovascular disease, and stroke—are linked to processes and experiences occurring decades before, in some cases as early as prenatally. For example, longitudinal studies have demonstrated that lung disease in adulthood is commonly associated with a history of respiratory illness in childhood, particularly among premature infants and young children exposed to tobacco smoke. Chronic, life-threatening cardiovascular disease in adulthood can also be linked to nutritional deficits and growth impairments occurring as early as the prenatal period.

Early experiences or exposures can affect adult health in two ways—by the chronic wear and tear of repeated damage over time or by the biological embedding of specific physiological disruptions during sensitive developmental periods. If a physiological maladaptation occurs in response to cumulative exposure to adverse social and/or physical conditions, then an ensuing chronic disease can be seen as the consequence of repeated encounters with psychologically or physically toxic environments. When damaging exposures occur during sensitive periods in the early development of specific biological processes, the resulting disruptions can become biologically embedded and subsequent adult diseases appear as the latent (or delayed) outcomes of early environmental assaults. In either case, science shows that there can be a lag of many years, even decades, before early harm is expressed in the form of overt disease.

Cumulative Exposures to Adverse Childhood Experiences

An extensive and growing body of research demonstrates multiple linkages between childhood adversity and health impairments in the adult years. The Adverse Childhood Experiences (ACE) Study, for example, documents strong associations among multiple instances of traumatic or abusive childhood events (as recalled...
in adulthood) and an extensive array of conditions later in life, including cardiovascular disease, chronic lung disease, cancer, depression, alcoholism, and drug abuse.\textsuperscript{13,14} Individuals reporting more adverse childhood experiences also had substantially greater risks for life-threatening psychiatric disorders,\textsuperscript{13} overlapping mental health problems,\textsuperscript{15} teen pregnancies,\textsuperscript{16} obesity, physical inactivity, and smoking.\textsuperscript{17} Other longitudinal studies have found comparable linkages between early stressful life events and adult disease.\textsuperscript{18,19,20} In all cases the pattern has been the same—the greater the number of adverse experiences in childhood, the greater the likelihood of health problems later in life.

Research on the biology of adversity illustrates how the body’s physiological equilibrium breaks down under cumulative conditions of chronic stress (or what has been called “allostatic load.”)\textsuperscript{21} The activation of stress management systems in the brain results in a tightly integrated repertoire of responses involving the secretion of stress hormones, increases in heart rate and blood pressure, elevation in blood sugar and inflammatory protein levels, protective mobilization of nutrients, redirection of blood flow to the brain, and the induction of vigilance and fear.\textsuperscript{22} The normal, healthy, temporary activation of these systems represents a “positive stress response” and is protective, even necessary, in the face of an acute threat. A “tolerable stress response” is a more serious and sustained activation that is mitigated by supportive adults, who help the child develop adaptive coping responses. A “toxic stress response” in early childhood can weaken developing brain architecture and recalibrate the threshold for activating the stress response system for life. It occurs under circumstances of chronic or overwhelming adversity without the buffering support of caring, consistent, and supportive relationships.\textsuperscript{3,23} Animal studies indicate that toxic stress also can have direct, negative, and persistent effects on brain circuits that control reward and motivation. For example, research on rodents has demonstrated that profound neglect during early development increases drug-seeking behavior in adult rats.\textsuperscript{24}

Recently documented patterns of allostatic load that parallel racial disparities in health outcomes suggest that chronic physiological stress may play a role in the premature and disproportionate burden of physical and mental illness experienced by African-Americans and other groups that experience discrimination.\textsuperscript{25} African-Americans, for example, sustain earlier deteriorations of health compared with whites, leading to racial health disparities that increase with age and resulting in a life expectancy for blacks in the United States that is four to six years less than for whites.\textsuperscript{26} This finding is consistent with research suggesting that the “weathering” of the body under conditions of chronic stress reflects an acceleration of normal aging processes.\textsuperscript{25,27,28}

**BIOLOGICAL EMBEDDING DURING SENSITIVE PERIODS OF DEVELOPMENT**

During sensitive periods of early growth and development, the evolving architecture of the brain (as well as the maturation of other organ systems) is highly receptive to a wide range of environmental signals or cues, whether positive or negative.\textsuperscript{29} A considerable body of research suggests that adult disease and risk factors for poor health can be biologically embedded in the brain and other organ systems during these sensitive periods, with resulting health impairments appearing years, or even decades, later. Biological embedding as a function of malnutrition, toxic stress response, or exposure to damaging chemicals can occur in various ways, including mechanisms that change the regulation of genes that affect brain and body development.\textsuperscript{30} For example, poor living conditions in early life (e.g., inadequate nutrition or recurrent exposure to infectious diseases) are associated with increased rates of chronic cardiovascular, respiratory, and psychiatric diseases in adulthood.\textsuperscript{10,31,32} Also, lower birth weight is associated with several risk factors for later heart disease, such as hypertension, central body fat distribution, insulin resistance, metabolic syndrome, and diabetes.\textsuperscript{9,33,34}

These findings are supported by evidence from a variety of animal and human studies. For example, lower birth weight in rats has been associated with higher blood pressure,\textsuperscript{35} and studies in humans have linked poor growth \textit{in utero} to later problems with heart disease\textsuperscript{36} and hypertension.\textsuperscript{37} Research investigating the underlying mechanisms that explain these associations have found linkages between early experiences of child maltreatment and evidence of heightened inflammatory responses in
adulthood that are known risk factors for the development of cardiovascular disease, diabetes, asthma, and chronic lung disease, as well as new evidence of elevated inflammation as early as age 12 in children experiencing maltreatment and depression, regardless of their socioeconomic status.

THE PHYSIOLOGICAL CONSEQUENCES OF SOCIAL AND ECONOMIC DISADVANTAGE

Children who grow up in families or communities of low socioeconomic status appear to be particularly vulnerable to the biological embedding of disease risk. Researchers have hypothesized that this association may be the result of excessive stress related to high rates of neighborhood risk factors such as crime, violence, boarded-up houses, abandoned lots, and inadequate municipal services. Economically disadvantaged children also tend to live in housing that is crowded, noisy, and characterized by structural defects, such as leaky roofs, rodent infestation, and inadequate heating, and they are exposed to greater air pollution from traffic, industrial emissions, and caregiver smoking. Children raised in low-income environments, on average, also experience less and lower-quality parental responsiveness, and are more likely to experience conflictive and punitive parenting behavior. Together, these adverse conditions create repeated physiological and emotional disruptions that can have long-lasting effects on health and development.

Socioeconomically patterned differences in children’s emotional, cognitive, and social experiences have been linked to several aspects of brain development, particularly within those areas of the brain that are tied most closely to the regulation of emotion and social behavior, reasoning capacity, language skills, and stress reactivity. Children from lower socioeconomic backgrounds are more likely to show heightened activation of stress response systems, and some emerging research suggests that differences in caregiving related to income and education—such as responsiveness in parent-child interaction—can alter the maturation of selected brain areas such as the prefrontal cortex. Animal models of early, stress-related changes in brain circuitry show that such modifications can persist into adult life, altering emotional states, decision-making capacities, and bodily processes that contribute to substance abuse, aggression, obesity, emotional instability, and stress-related disorders.

The biology of early health and development illustrates how complex interactions among genes, environmental conditions, and experiences produce either positive adaptations or negative disruptions in basic biological systems—with lifelong consequences for both physical and mental health. There is much that society can do to ensure that children’s environments provide the conditions that their biological systems need to produce positive health outcomes. Three critically important foundations invite careful scrutiny: a child’s environment of relationships; the physical, chemical, and built environments; and sound and appropriate nutrition.

CREATING A STABLE AND RESPONSIVE ENVIRONMENT OF RELATIONSHIPS

Human infants are unique among all species in their prolonged period of extreme dependence on adult care and protection for their survival and healthy development. The care that infants receive, whether from parents, extended family members, neighbors, or child care professionals, lays the groundwork for the development of a wide range of basic biological processes that support emotion regulation, sleep-wake patterns, attention, and ultimately all psychosocial functioning. Stable, responsive, and
nurturing caregiving early in life is also associated with better physical and mental health, fewer behavior problems, higher educational achievement, more productive employment, and less involvement with social services and the criminal justice system in adulthood.54,55 In biological terms, a child’s environment of relationships can affect lifelong outcomes in emotional health, regulation of stress response systems, immune system competence, and the early establishment of health-related behaviors.

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Thus, supports for families and appropriate training for providers of early care and education across all types of care, including informal arrangements as well as established centers, can improve health outcomes throughout the life course as well as enhance the current quality of life for young children and the adults who care for them.

Secure attachments. One important way in which responsive caregiving has long-lasting effects on physical and mental well-being is through the formation of strong, positive bonds between young children and the important adults in their lives. Securely attached infants show more positive emotion and less anxiety in early childhood and have an easier time establishing relationships with teachers and peers at school.56,57 Attachment patterns develop over the first few years of life and can influence mental health and psychological functioning throughout childhood and the adult years.36,38,39 Caregivers struggling with overwhelming problems such as depression may be unable to be sufficiently responsive to a young child during that early period when the foundations of attachment relationships are developing.60,61 This lack of consistent responsiveness disrupts what has been called the “serve and return” interaction between infants and adults that is fundamental to the development of healthy brain architecture. When appropriate responses are missing, this can lead to a range of poor outcomes, including physical and mental health problems later in life.62

Effective self-regulation and sleep cycles. Another way in which the caregiving environment affects the health of young children is the extent to which the consistency, quality, and timing of daily routines shape their developing regulatory systems. Beginning in the earliest weeks of life, the predictability and quality of these experiences influence the most basic biological rhythms related to waking, eating, eliminating, and sleeping.63,64 For example, infants who are exclusively breast-fed through about 3 months of age ingest levels of nutrients and hormones that reflect the mother’s circadian rhythm (i.e., her 24-hour sleep-wake cycle) and appear to assist in establishing better sleep patterns and sleep efficiency.65

Early experiences stimulate a wide variety of nerve transmissions that activate different parts of the brain and other body systems. When positive experiences are repeated regularly in a predictable fashion, the complex sequences of neural stimulations create pathways that become more efficient (i.e., “neurons that fire together wire together.”) For example, infants who learn that being soothed and comforted occurs shortly after they experience distress are more likely to establish more effective physiological mechanisms for calming down when they are aroused and are better able to learn to self-soothe after being put down to sleep.63,64 In contrast, when eating and being put to bed occur at different times each day and when comforting occurs unpredictably, the organization and consolidation of sleep-wake patterns and self-soothing responses do not develop well, and biological systems do not “learn” healthy routines and self-regulation.66

This finding highlights the importance of secure, stable housing with quiet and predictable sleeping areas for babies. Although children differ in how much sleep they require, inadequate amounts lead to disruptive behavior problems, diminished cognitive performance, and greater risk for unintentional injuries.68,69 Growing evidence also suggests that poor sleep is associated with obesity in later childhood and early adulthood.66,70,71,72 Given that babies’ internal clocks do not initially differentiate day from night, how
Promoting the Foundations of Healthy Development

Healthy stress response systems. Just as early experiences affect the architecture of the developing brain, they also shape the development of other biological systems that are important for health. For example, responsive caregiving plays a key role in the normal maturation of the neuroendocrine system. A wealth of animal research that is now being replicated in humans demonstrates that caregiving behavior also shapes the development of circuits that regulate how individuals respond to stressful situations. Specifically, variations in the quality and quantity of maternal care that a mother received in her own early life can affect how genes are turned on or off in her own offspring. Genes involved in regulating the body’s stress response are particularly sensitive to caregiving, as early maternal care leaves a signature on the genes of her offspring that carry the instructions for the development of physiological and behavioral responses to adversity. That signature (known as an epigenetic marker) is a lasting imprint that affects whether the offspring will be more or less likely to be fearful and anxious later in life. Consequently, early overloading of the stress response system can have a range of adverse, lifelong effects on learning, behavior, and both physical and mental health.

Immunologic responsiveness. Regulatory mechanisms that manage stress also influence the body’s immune and inflammatory responses, which are essential for defending against disease. Young children cared for by individuals who are available and responsive to their emotional and material needs develop well-functioning immune systems that are better equipped to deal with initial exposures to infections and to keep dormant infections in check over time. Some protections, such as maternal antibodies, are passed directly from mother to fetus through the placenta or from mother to infant through breast milk. These protections confer important passive immunity until the infant's own antibody response is developed. Thus, caregiving practices such as breastfeeding not only provide important opportunities for social bonding but also help the baby develop a more competent immune system. Conversely, inadequate caregiving and limited nurturance very early in life can have long-term (and sometimes permanent) effects on immune and inflammatory responses, which increase the risk of chronic impairments such as asthma, respiratory infections, and cardiovascular disease.

Learned health-promoting behaviors. Another way in which early caregiving practices matter is the extent to which young children develop behavioral routines and patterns that influence long-term health trajectories. These early behaviors include a wide variety of domains: tooth brushing, television viewing, routine levels of physical activity, and risk-taking behaviors, among many others. One example is the type, amount, and frequency of foods offered to infants and toddlers, which together shape the processes that affect their taste and texture preferences and their developing dietary likes and dislikes. Increasingly persuasive scientific evidence shows that early learning of both food preferences and routine levels of physical activity affect the risk for obesity.

Safe and Supportive Chemical, Physical, and Built Environments

Unsafe environments are not only a threat to the immediate physical well-being of young children but also jeopardize their future health and development. These threats can manifest themselves in a variety of forms, many of which are amenable to effective preventive actions that simply await the political will required for widespread implementation.

Chemical exposures. Environmental toxins pose a significant threat to immature biological systems, as low-level exposures before or shortly after birth often produce more damaging and longer-lasting harm than exposures at higher levels in later childhood or adult life. At the same level of exposure, embryos, fetuses, and children absorb much larger doses of toxins relative to their body weight than adults, which is another reason why the adverse impacts are greater in the prenatal period and early in life, when important developmental processes are
underway. Of all the body’s organ systems, the brain is especially vulnerable to environmental toxicity, as even small injuries can produce significant effects on future health, learning, and behavior. Early chemical exposures also may prompt changes in other organs and tissues, resulting in structural malformations or greater susceptibility to diseases that may even be passed on to subsequent generations. For example, prenatal exposure to diethylstilbestrol (DES), a drug prescribed for many pregnant women until the 1970s, has been linked to reproductive cancers in young women whose mothers were medicated while pregnant. 

In contrast to the long latency of adverse effects for many chemical exposures, the health impacts of some toxins are apparent much sooner. For example, lead ingestion is a well-established risk factor for cognitive deficits across the life course, largely because lead disrupts neurotransmitter regulation of synaptic development in the brain. Although most lead exposure is related to lead-based paint, soil, and dust, recent problems have been detected from contaminated consumer products, including toys.

**Physical and built environments.** The danger of toxic chemical exposures as an environmental threat to child health is easy to understand. Less immediately apparent is the growing evidence that the way a child’s physical environment is designed, built, and maintained can also significantly affect the risk of disease, disability and injury. Beyond the safety of homes and child care settings, the “built” environment offers multiple opportunities to influence health-related behaviors. The availability of food choices and options for healthy eating illustrates one important example. This can be seen in many low-income, urban communities that are less likely to have grocery stores that stock healthy foods such as fresh fruits or vegetables and more likely to have multiple fast-food outlets and liquor stores, all of which undermine good nutrition.

Neighborhoods designed with parks, green space, sidewalks, and playgrounds away from traffic offer children and their families an opportunity to play and socialize with friends and other caregivers, as well as encourage greater physical activity, reduce child pedestrian injuries, and increase social ties. Children living in such communities tend to be more physically active and have a lesser risk for obesity than those who live in neighborhoods with fewer recreational facilities. Neighborhood features such as parks and sidewalks also influence social interactions: people can come together and develop a sense of mutual trust and responsibility for the community and its inhabitants, which often leads to a willingness to intervene on behalf of the common good. This neighborhood-level phenomenon, called “collective efficacy” or social capital, has been linked to lower rates of childhood obesity, better adult mental health, and reduced crime rates. Thus, zoning laws and regulations that influence the built environment can have an important influence on the well-being of children and caregivers, which contributes to the overall health of a community.

**Sound and Appropriate Nutrition**

Health at every stage of the life course is influenced by nutrition, beginning with the mother’s pre-conception nutritional status, extending through pregnancy to early infant feeding and weaning, and continuing with diet and activity throughout childhood and into adult life. Adequate intake of both macronutrients (e.g., protein, carbohydrates, and fats) and micronutrients (e.g., vitamins and minerals) is particularly important in the early months and years of life, when body growth and brain development are more rapid than during any other period. In this context, nutrition serves as an important example of how early influences contribute to developmental patterns of health over time.

Although levels of severe hunger and malnutrition that persist in many of the world’s poorest countries are rarely found in the United States, food insecurity remains a problem for a subset of the population that lacks access to sufficient food to meet their basic needs because of inadequate financial resources. That said, the growing epidemic of both childhood and adult obesity in the United States is receiving far more public attention than concerns about poor growth. The relation between nutrition and health in childhood is broadly understood. The extent to which the nutritional status of a pregnant woman can influence the long-term growth and health of her child is less well appreciated. Inadequate maternal nutrition during pregnancy is associated with a range of undesirable
outcomes in the offspring, including obesity in childhood and adulthood as well as subsequent hypertension and cardiovascular disease.\textsuperscript{9,33} When mothers do not receive adequate calories and nutrients while pregnant, their fetuses develop in anticipation of “making do” with fewer nutritional resources. This response is beneficial if the post-natal environment provides minimal calories. However, if the post-natal environment offers access to sufficient nutrients, the infant’s prior adaptation becomes a liability, predisposing children to obesity and other diseases of excess because they were prepared for a world of scarcity.\textsuperscript{33} Children born at very low birth weight also show marked insulin resistance and other changes that put them at risk for diabetes.\textsuperscript{34}

Maternal nutrition also affects the development of the fetal and infant immune system, as the adversity of under-nutrition can stimulate the release of maternal stress hormones that impair thymus development in the fetus.\textsuperscript{105} The thymus gland is important, because it plays a key role in the development of the immune system by incubating immature immune cells, and decreased thymus size in infancy is associated with higher rates of infection and mortality.\textsuperscript{106} Indeed, a smaller thymus has been linked to poor immune responsiveness from the neonatal period through adolescence.\textsuperscript{105,107} As a result, adults who experience prenatal and early childhood under-nutrition are 10 times more likely to die from an infection than others.\textsuperscript{106}

Successful public health efforts to improve maternal nutrition, even prior to conception, have had beneficial effects on the health of both expectant mothers and their children. For example, maintaining adequate levels of folate for women in their child-bearing years has important implications for both pregnancy and the health of the newborn,\textsuperscript{108} with folate fortification of foods leading to a 20 to 30 percent reduction in neural tube defects.\textsuperscript{109,110} Nevertheless, iron deficiency and inadequate levels of vitamins A and D remain significant health concerns for many children, who need increased levels of these nutrients to support the rapid growth of blood cells, bones, and other tissues. These types of deficiencies early in life can have adverse impacts on a wide range of cognitive, motor, social-emotional, and neurophysiological development and behavioral outcomes as well as lead to chronic medical conditions such as osteoporosis, asthma, and diabetes.\textsuperscript{111,112,113}

**Strengthening the Capacities of Caregivers and Communities to Promote the Health of Young Children**

The multiple, interrelated capacities of caregivers and communities are essential promoters of the foundations of child health. Thus, policies and programs designed to promote the well-being of young children will be more effective if they bolster these capacities. The influences of caregivers and communities are played out in a wide variety of settings and contexts, including neighborhoods, parents’ workplaces, early care and education settings, health care facilities, and, of course, in the home. When caregiver and community capacities reinforce each other in positive ways, the foundations of health are strong. When they function at cross purposes, or collectively in the wrong direction, child health is threatened and society’s future is at peril.

**CAREGIVER CAPACITIES**

Because young children develop in an environment of relationships, it is critically important that adult caregivers interact with them in a consistent and responsive manner. All parents and other adults (both within and outside of the family) bring a range of capacities to the care and support of young children. These include
(1) time and commitment (i.e., the nature and quality of time spent with children and on their behalf); (2) resources—both financial (i.e., economic ability to purchase goods and services) and psychological, emotional, and social (i.e., physical and mental health and parenting style); and (3) skills and knowledge (i.e., human capital acquired through education, training, interactions with child-related professionals, and personal experiences). Extensive documentation of the important impacts of these capabilities on child health and development is provided throughout this paper.

The fact that the majority of young children in the United States currently live in families with working parents provides a clear illustration of the importance of this issue. The pressures and demands of balancing parenting and work responsibilities, along with other changes in family structure and social roles, lead to considerable strain on time for parenting and other caregiver capacities across the socioeconomic spectrum. That said, most policies and programs for families with young children in the United States are focused on either parenting education or financial support for those with limited income. The fact that relatively limited attention is focused on addressing the shortfalls in time and/or psychological resources that overwhelm many parents across all social classes threatens the healthy development of many children, with the greatest burdens on those whose families and communities are impoverished and those whose children have special needs.

COMMUNITY CAPACITIES

Just as children develop in an environment of relationships, families function within a physical and social environment that is influenced by the conditions and capacities of the communities in which they live. In the context of community capacities, commitment is evident when child health and developmental outcomes are monitored, and responsibility for their promotion is assigned and accepted, such as through enforcement of legislation and regulations that affect child well-being. Resources at the community level include services and organizations dedicated to the promotion of children’s healthy development as well as the availability of supportive structures such as parks, child care facilities, schools, and after-school programs. Finally, skills comprise both political and organizational capabilities that can be leveraged to accomplish strategic goals. Thus, community capacities can range from enforcement of standards for child safety seats to the availability of high-quality markets selling affordable fresh fruits and vegetables and the presence of local leaders and organizations that can mobilize collective action.

Communities vary widely in their collective commitment, resources, and skills. For example, while there is strong evidence regarding the link between quality child care and positive child health and developmental outcomes, not all communities have the same level of resources to ensure access to affordable, quality options. Moreover, although problems in affordability and access to quality child care are an important issue for low-income neighborhoods, they also present significant challenges for middle-income communities where parents are employed but do not qualify for public subsidies.

To summarize, although both individual caregivers and communities as a whole can influence the foundations of child health, not all have the same capacities. When necessary resources are not available, effective policies and programs can fill the gaps by building those under-developed or missing capacities. Healthy children are raised by people and communities, not by government and professional services—but public policies and evidence-based interventions can make a significant difference when caregivers and neighborhoods need assistance. It is also important to note the potential impacts of private-sector actions, above and beyond the effects of public policies, to address unmet needs. Creative, new strategies from multiple sources represent vital and highly promising contributions to community-wide health that are likely to produce substantially greater returns across the lifespan.
Rethinking the Health Implications of a Broad Range of Policies and Programs in the Public and Private Sectors

Building on the framework presented in this document, a science-based approach to the promotion of health and prevention of disease would be well served by strategic investments that build the capacities of communities and families to strengthen the foundations of healthy development in young children. This broader focus does not in any way diminish the importance of primary health care for all children and high-quality medical treatment for those who are ill. It does, however, underscore extensive and growing evidence that many of the major threats to the health of children cannot be addressed effectively in a hospital or a physician’s office. In fact, the origins of health-related behaviors and many adult diseases can be found in the environments and experiences of early childhood.

The time has come to view primary health care as one important component of a multidimensional approach: building the capacities of communities and caregivers to strengthen the foundations of lifelong health during the prenatal period and early childhood years. With this goal in mind, two strategies for investment are worthy of attention. First, sufficient resources should be allocated to assure that all eligible children and families are served by existing policies and programs with demonstrated effectiveness factors that strengthen each of the three foundations of health. Second, a consistent portion of expenditures should be invested in the design and evaluation of new approaches to health promotion and disease prevention that are grounded in rigorous science. The need for innovative interventions across a wide range of sectors is particularly important for young children who are at greatest risk for early physiological disruptions that lay a foundation for later stress-related physical and mental health impairments.

Examples of policies and programs that focus on each of the three foundations of health—stable and responsive relationships; safe and supportive environments; and sound nutrition—are described below. Collectively, they cover a range of informal family supports, voluntary community efforts, private sector actions, and publicly funded policies and programs. Some are well-documented initiatives that deserve broader implementation. Others represent promising new directions that are grounded in sound scientific reasoning yet await formal testing and evaluation. Both strategies are worthy of investment.

**Policies and Programs That Promote Stable and Responsive Relationships**

The goal of strengthening parent-child relationships is central to many existing policies and services for families with young children. Parents who are raising children in environments with multiple stressors and few supports comprise a critical constituency for such assistance. Working parents in well-functioning families with low incomes constitute another important target group. The need for relationship-strengthening support is particularly compelling for families whose economic security depends on low-wage jobs, often during non-standard working hours, and for working parents whose children have chronic health problems or special developmental needs that require multiple medical and therapeutic appointments, skilled child care, and a variety of other supports.
of specialized interventions. In the absence of sufficient support for families facing such circumstances, many young children are subjected to excessive stresses that can have lifelong effects on their physical and mental health. These adverse effects incur substantial costs, for affected individuals personally and for society as a whole, that could be reduced by more timely and appropriate intervention early in life.

The following four policy/program domains are excellent candidates for re-examination through this new lens of health promotion and disease prevention.

Parenting education and home visiting programs, with their origins in public health nursing, occupy a growing niche within the broad array of existing programs designed to ensure that primary caregivers have the knowledge and skills required to provide the kinds of safe environments and learning experiences that young children need. Research has demonstrated the extent to which higher levels of staff training and expertise predict the effectiveness of these kinds of services in such areas as developmental progress and reduction of child maltreatment. Even so, an important subgroup of families who face considerable hardship needs more assistance than parenting education and social support alone can provide. Science suggests that highly skilled personnel with the training and programmatic resources needed to reduce the impacts of these specific stressors on the home environment (whether related to severe poverty, maternal depression, substance abuse, or family violence) will improve the long-term physical and mental health of the children.

Parental leave policies are designed to promote the enhanced bonding and responsive caregiving needed to build a strong foundation for healthy development by providing families with sufficient time to adjust to the birth or adoption of a new child. Although universal family leave arrangements with varying levels of income replacement are part of the policy environment in virtually all economically developed nations in the world, the United States remains a highly conspicuous outlier. Continuing debate on this issue in both the public and private sectors could be informed by a greater understanding of its implications for child well-being and long-term human capital development. Although relevant empirical evidence on the merits and costs of paid leave is limited because of the paucity of studies that have been conducted in the United States, we do know that children of mothers who have the financial support to delay their return to work receive more timely well-child care and are more likely to be breastfed and for longer durations. Job-protected, paid leave also has also been shown to be associated with lower rates of infant mortality and low birth weight. Although several states have begun to implement parental leave initiatives, evaluation data are currently limited. Both government and the private sector continue to face the important responsibility of determining how to respond to the reality that all parents need time to adjust to the arrival of a newly born or adopted child.

Income supports and “make work pay” programs are designed to augment the capacity of low-income families to provide basic necessities and positive learning environments for their children, thereby enhancing their developmental outcomes, and a growing body of program evaluation research has confirmed this expectation. While the effects of these programs on health have not been studied, research on the biology of adversity suggests that reducing serious, sustained stress in the lives of families with young children should in theory help to reduce the higher rates of stress-related chronic diseases that are consistently documented in low-income populations.

Expanded professional development for early care and education providers offers another strategy for strengthening the relationships that young children have with the important adults in their lives. This is particularly important for children who exhibit emotional difficulties or behavioral problems that present a challenge in out-of-home settings. Expanded access to expert assistance in identifying and treating emergent mental health problems could provide much-needed support for program staff to strengthen their capacity to help young children who exhibit excessive fear, withdrawal, aggressive behavior, or difficulties with attention, impulsivity, and hyperactivity—all common problems for which considerable new knowledge has been generated but access to evidence-based services remains markedly limited.
POLICIES AND PROGRAMS THAT ASSURE SAFE AND SUPPORTIVE CHEMICAL, PHYSICAL, AND BUILT ENVIRONMENTS

Two major studies by the Institute of Medicine have reviewed evidence on the influences of biology and the environments in which children spend most of their time.1,129 Both reports agree on the following clear and consistent conclusions. First, health outcomes are profoundly influenced by a range of factors beyond children’s biological endowment and the medical care they receive. Second, since these influences are rooted in the social and physical environments in which families and children live, learn, work, and play, enhancing these environments is necessary to both improve child health generally and to reduce disparities in outcomes related to socioeconomic disadvantage.

Health and safety requirements for early care and education programs represent an important reference point for measuring the extent to which a community takes responsibility for protecting the well-being of its children. This issue is broadly relevant to the nearly 75 percent of children under the age of 5 in the United States who are enrolled in early child care and education programs in a variety of settings (including center-based and family child care as well as informal care provided by family members, friends, and neighbors). Recent reviews of state regulations show that one-half to two-thirds of the states fail to require even minimally acceptable care130 and that many care providers operate legally beyond the purview of state licensing laws.131 Children who attend child care facilities of poor quality receive less of the individualized attention that is necessary for healthy development, and they incur increased risk of exposure to multiple communicable diseases and a variety of potential injury hazards, including unsafe playground surfaces and equipment, missing or broken child safety gates, unattended window-blind cords, and a variety of equipment (such as cribs and bedding) and toys that do not meet current safety codes.132 In the absence of national standards for monitoring the quality of the child care environment, each state currently formulates its own regulations and criteria. Although some guidance is available from professional organizations, such as the American Academy of Pediatrics’ National Health and Safety Performance Standards,133 widespread deficiencies in this highly fragmented diversity of settings are well known to child care directors and program staff.

Physical features of a community (e.g., sidewalks, bicycle trails, and parks that are safe from crime134 and neighborhood resources (e.g., grocery stores that sell fresh fruits and vegetables) are selected examples of what is meant by the “built” environment. These features are heavily influenced by community zoning laws and land use policies, which provide a promising vehicle to facilitate the development of health-enhancing characteristics and to limit the proliferation of those that are health-endangering. Examples of the former include parks that provide a place for physical activity and for parents to engage in positive interactions with their children as well as opportunities for caregivers to meet and interact with other adults to enhance their network of social support and thereby facilitate positive mental health.103 Examples of the latter include pollution-generating factories, an abundance of fast-food restaurants and liquor stores, and congested, unsafe walkways. Zoning laws and land use policies that protect green space and limit the density of fast-food outlets also encourage neighborhood awareness of the health-related benefits of these decisions, and thus embed health-enhancing behaviors in the fabric of the community. Together, these kinds of policies strengthen the capacities of caregivers and communities to support the foundations of child health and improve well-being across the lifespan.

Laws and safety regulations for commercial products provide another illustration of how state policies and standards can not only protect the healthy development of children directly but can also build caregiver and community capacities to assure a safer physical environment. For example, motor vehicle injuries are the leading cause of death among children in the United
States, and both serious injuries and fatalities can be reduced by more than half through the use of age-appropriate and size-appropriate child safety and booster seats. Standards for child restraints serve to strengthen individual caregiver capacity by increasing awareness about the importance of safety measures. At the state level, the establishment and enforcement of standards can increase community capacity by creating a marketplace for child seats and boosters, implementing hospital discharge policies requiring approved safety seats, and supporting child restraint checks by law enforcement officials. The enforcement of regulations mandating maximum temperatures on residential hot water tanks is another example of a characteristic of the built environment that reduces threats to child health, as scald burns represent one of the more common household injuries.

**Policies that regulate the chemical environments in which children grow and develop** include lead paint laws, emissions restrictions that require filtering of mercury, guidelines on the use of bisphenol A (BPA) in plastic baby bottles, and restrictions on the use of toxic insecticides near playgrounds, schools, and child care centers. As described in greater detail in a previous working paper, the decreased prevalence of lead poisoning is an example of an effective public policy that has reduced exposure to one of the most widely recognized neurotoxins. Another example is the use of organophosphate pesticides, on which the U.S. Environmental Protection Agency imposed new restrictions in 1999-2000, largely because of concerns about the potential exposure of young children. Subsequently, the percentage of food samples with detectable residues of these pesticides declined from 29 percent in 1996 to 19 percent in 2001. Although progress has been made in reducing environmental levels of some toxins, policies that could restrict the exposure of embryos, fetuses, and infants to other chemicals whose neurotoxicity is well documented, such as mercury and other industrial organic compounds, have fared less well. Beyond the compelling moral responsibility to reduce known threats to the health of young children, there are also persuasive economic arguments for greater attention to the value of prevention, both as a strategy for reducing the continuously escalating treatment costs of disease and disability and as an investment in human and economic development.

Specifically, one study, using a widely accepted measure of basic cognitive skills, calculated that, for every decrease equivalent to a 15-point drop on an IQ test, an individual’s earnings were 20 percent lower a decade later.

Among the most significant environmental toxins that affect lifelong health, the exposure of pregnant women, fetuses, and young children to tobacco smoke, is particularly important. Maternal smoking during pregnancy continues to expose about half a million newborns to this toxic substance. Although exposure of nonsmokers to environmental smoke decreased substantially beginning in the 1990s, due in large part to policies affecting workplaces and commercial and public spaces, the median exposure level of children age 4 to 11 years has remained twice as high as that of adults. Numerous reports conclude that between one-quarter and one-half of all preschool age children are exposed to smoke. The health consequences of these exposures include increased risk of low birth weight, increased hospitalization, and serious respiratory disease, and the direct medical costs of all pediatric diseases attributable to parental smoking is estimated to be $7.9 billion (in 2006 dollars).

**POLICIES AND PROGRAMS THAT PROMOTE SOUND AND APPROPRIATE NUTRITION**

Community actions that affect child nutrition range from zoning laws that favor stores selling nutritious foods over fast-food restaurants, to guidelines for healthful snacks and lunches that are served in early care and education programs. Until recently, the health-related nutritional problems facing children living in low-income families were largely manifested in iron deficiency anemia and poor growth. Currently, the major problem facing U.S. children across all social classes (with low-income populations still affected disproportionately) is the phenomenon of increasing obesity and its associated health complications, most prominently in the form of increasing rates of type 2 diabetes. Given what science now shows about how early experiences can biologically embed vulnerability to diseases later in life, much greater attention to maternal and prenatal health is clearly needed.
in order to address the early childhood roots of obesity. Other public and private sector policies that affect nutrition and health include the following examples.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a good example of a long-standing federal-level program (implemented at the state and local levels) that is designed to build the capacities of families to provide appropriate nutrition for their children by providing financial support (i.e., cash for food purchases) and strengthening knowledge and skills (i.e., health education and nutrition counseling, including the promotion of breastfeeding). Since 1972, WIC has grown to serve about 45 percent of all pregnant women in the United States and over 25 million children annually.152 Concerns about the quality and appropriateness of the WIC food package have been addressed in recent years by including fresh fruits and vegetables, legumes and alternative proteins, and culturally appropriate foods. Conflicting claims have been made about the health benefits of the program, with good evidence that it prevents iron deficiency anemia in low-income infants but conflicting data on its effectiveness in reducing low birth weight.153,154,155,156 Despite these differences, a Congressional report found that, for every dollar spent on WIC, the government saved $3.50 on reduced payments for Medicaid, Supplemental Security Income, special education, and unneeded medical costs in the first year of life.157

Private sector policies that support breastfeeding by working mothers represent a promising, non-governmental example of promoting community and caregiver capacities that enhance infant nutrition and strengthen mother-infant relationships. Approximately 60 percent of the mothers of children under the age of 6 are employed full- or part-time.158 Research shows that full-time work has a significant negative effect on breastfeeding initiation and duration,159,160,161 as many women wean their babies early in anticipation of returning to work or dealing with the difficulties of balancing work and breastfeeding.162 Preliminary evidence suggests that corporate lactation programs—including the provision of worksite lactation rooms and lactation counselors—bolster caregiver and community capacities and enable women to maintain breastfeeding for at least 6 months, with rates equivalent to those of mothers not employed outside the home.163,164 The potential health benefits of breastfeeding include fewer

Reducing the number and severity of early adverse experiences and strengthening relationships that mitigate the effects of toxic stress on young children will decrease the prevalence of a wide range of stress-related physical and mental health problems.

Although public interest in health promotion and disease prevention programs for adults is high, public understanding of the relation between early childhood experiences and adult illnesses remains low. Even expert understanding of the broad array of factors and conditions that either support or compromise child health is constrained by the “silos” of existing domains of policy and practice that make it difficult to test creative, new ideas that cross sectors.

A rich and growing body of epidemiological evidence and research in neuroscience, molecular biology, and genomics indicates that reducing the number and severity of early stressful and traumatic experiences, such as child maltreatment, family violence, parental mental illness and substance abuse, and the adversity associated with significant economic hardship, will decrease the prevalence of a wide range of stress-related physical and mental health problems. Guided by this scientific knowledge, multiple policies and programs outside the jurisdiction of the medical sector offer promising opportunities to improve health outcomes by mitigating the impact of adversity on young children. The examples presented in each of the
following policy sectors illustrate some of many potential options.

Public Health. The time has come in the continuing debate over spiraling health care expenditures to look beyond strategies for limiting the costs of hospitalization and medication and to invest in policies that keep people healthy. The impacts of current health promotion and disease prevention efforts that begin in the adult years are limited by three important constraints. First, they are burdened by the increasing difficulty of changing behavior and lifestyles as people get older. Second, they face the difficult challenge of overcoming the biological vulnerabilities that remain from early adverse experiences, which could have been prevented by intervening earlier to change the environments in which children live. Third, by addressing adult behaviors only, without also addressing the conditions faced by families of young children, they shift the focus toward individuals whose health risks have been shaped already and away from the circumstances that shaped them. Thus, science suggests that a more effective approach to health promotion would invest more resources in the reduction of significant adversity during the prenatal and early childhood periods, in contrast to the current disproportionate emphasis on campaigns to encourage more exercise and better eating habits in middle-aged adults.

Early Care and Education. Programs designed to promote readiness to succeed academically in school (such as Early Head Start, Head Start, and pre-kindergarten) serve large numbers of young children and their families and offer a rich infrastructure for testing innovative approaches to address the stress-related roots of disparities in learning, behavior, and health. As child development experts work on new teaching strategies to enhance learning outcomes for vulnerable young children, neuroscience and genomics suggest that further decreases in disparities in educational achievement will require both the provision of rich learning experiences and the reduction of significant adversity that disrupts the developing architecture of the brain. Research on the biology of stress further demonstrates that such adversity also threatens the function of other organ systems, leading to higher rates of hypertension, obesity, and diabetes. Thus, early care and education programs that incorporate efforts to reduce toxic stress in the service of promoting healthy brain circuitry—for example, by addressing sources of serious family stress, including economic instability, maternal depression, or family violence—offer the possibility of considerable returns, not only in stronger academic gains but also in better health well into the adult years. In this context, the current approach to funding child care of variable quality through the Temporary Assistance for Needy Families (TANF) program illustrates a striking example of an important gap between what we know from research and what we do in policy and practice. Despite persistent resistance to the enforcement of quality standards, science indicates that TANF funds for child care should be viewed as an opportunity to invest in high-quality programs that promote the healthy development of vulnerable, young children and not simply as an obligatory expense to facilitate mandated maternal employment.

Child Welfare. For more than a century, child protective services have focused on issues related to physical safety, reduction of repeated injury, and child custody. Now, recent scientific advances are increasing our understanding of the extent to which the toxic stress of abuse, neglect, or exposure to family or community violence can produce physiological changes in young children that increase the likelihood of mental health problems and physical disease throughout their lives. Based on this heightened risk of stress-related illness, science suggests that all investigations of suspected child abuse or neglect should include a comprehensive assessment of the child’s cognitive, language, emotional, social, and physical development, followed by the provision of effective therapeutic services as needed. This could be accomplished
through regularized referrals from the child welfare system (which is a mandated service in each state) to the early intervention system for children with developmental delays or disabilities (which provides services under an entitlement established by federal law). Although the most recent federal reauthorizations of the Keeping Children and Families Safe Act and the Individuals with Disabilities Education Act both included requirements for establishing such linkages, sufficient funding has not been provided, and the implementation of these requirements has moved slowly. The availability of new, evidence-based interventions that have been shown to improve outcomes for children in the child welfare system underscores the compelling need to transform “child protection” from its traditional concern with physical safety and custody to a broader, more science-based focus on health promotion and disease prevention. The Centers for Disease Control and Prevention has taken an important step in advancing this issue by promoting the prevention of child maltreatment as a public health concern.

**Mental Health.** In view of the many advances that have been made in the development of evidence-based treatments for a range of child mental health problems, the limited availability of appropriate therapeutic services for young children and families dealing with toxic stress requires urgent attention. Reports of youngsters with disruptive behaviors being expelled from preschool programs and the dramatic rise in off-label prescription of antipsychotic medications for very young children underscore the extent to which this situation has reached crisis proportions. Timely access to specialists in the identification, assessment, and clinical treatment of young children with serious mental health problems within existing early childhood programs could enhance their capacity to address unmet needs without creating a separate mental health system for young children. Because of the close association between children’s emotional well-being and the mental health of their caregivers, mental health services for parents would have a broader impact if they routinely included attention to the needs of their children as well.

Finally, more effective treatment of stress-related problems in early childhood is likely to reduce the prevalence of a wide range of stress-related health disorders later in adulthood.

**Primary Health Care.** The association between an expectant mother’s preconception health and the subsequent well-being of her baby is well documented, but there are few policies or programs that connect these periods explicitly in the delivery of primary health services. The absence of attention to the mother-child relationship in the treatment of depression in women is another striking example of the gap between science and practice, given extensive evidence of the negative impact of diminished maternal responsiveness on the development of young children. Payment mechanisms that provide incentives for coordinating child and parent medical services (e.g., automatic coverage for parent-child intervention linked to reimbursement for the treatment of maternal depression) offer one promising strategy for addressing this problem.

The most striking challenge related to the role of primary health services in promoting child well-being is reflected in a longstanding debate within the pediatric health care community about the possibilities and limitations of well-child care within a comprehensive health system. For at least half a century, this debate has focused on the need for family-centered approaches to address the concerns of children with developmental impairments, behavioral difficulties, and chronic health problems, along with the complex challenge of providing more effective interventions for children living in highly adverse environments. Despite longstanding calls for an explicit community-focused, primary care strategy, a recent national study of pediatric practices identified the persistent inability to achieve better linkages with community-based resources as a major challenge. A parallel survey of parents also noted the limited communication that exists between pediatric practices and community-based services such as WIC programs, child care providers, and schools. Moreover, both groups agreed that pediatricians cannot be expected to meet all of a child’s needs.

Notwithstanding this broad accord, history tells us that continuing calls for reduced fragmentation among community-based services will have little impact. The time has come for bold and innovative leadership to develop new
strategies for coordination that are:
• grounded in a shared science base;
• able to leverage the benefits of new information technologies for sharing information more effectively while protecting confidentiality; and
• genuinely committed to trying new models of working collaboratively across disciplines and sectors.

Recommendations for providing a “medical home” for all children within the provisions of the Patient Protection and Affordable Care Act of 2010 offer a promising starting point. However, successful transformation to a more effective model of primary health care will require deeply committed attention to a wide range of factors, including strong leadership, financial resources, personal and organizational relationships, engagement with families, management expertise, health information technology, support for care coordination, and staff development as well as the extent to which practitioners in the medical, educational, and social services worlds are truly ready to work together (and to train the next generation of practitioners) in new ways.

A Call for Innovation

The stability, prosperity, and sustainability of a society depend on the healthy development of its population. Knowing this, a recent analysis of data from the United States and six other countries (Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom) raises serious concerns that require thoughtful attention. In addition to noting that the U.S. health care system ranks last or next-to-last on four dimensions associated with high performance (quality, access, efficiency, and equity), the report also indicated that the United States ranks last on mortality amenable to health care, last on infant mortality, and second-to-last on healthy life expectancy at age 60. The fact that the U.S. spends more money per capita on medical care than any other industrialized nation makes these findings particularly problematic. Extensive evidence that effective health promotion and disease prevention depend on more than simply assuring the availability and affordability of high-quality medical care further underscores the need for creative, new strategies to improve our nation’s health.

As we look to the scientific community for new ways to address this challenge, advances in neuroscience, molecular biology, and genomics are converging on three compelling conclusions: (1) early experiences are built into our bodies; (2) significant adversity early in life can produce physiological disruptions or embedded biological “memories” that undermine the development of the body’s stress response systems and affect the developing brain, cardiovascular system, immune system, and metabolic regulatory functions; and (3) these physiological disruptions can persist far into adulthood and lead to lifelong impairments in both physical and mental health.

These broadly accepted scientific principles send two clear and powerful messages to decision-makers who are searching for more effective ways to improve the health of the nation. First, health promotion and disease prevention policies focused on adults would be more effective if evidence-based investments were also made to strengthen the foundations of health in the prenatal and early childhood periods. Second, the increasing prevalence of chronic disease across the life course could be lowered by reducing the number and severity of adverse experiences threatening the well-being of young children and by strengthening the protective relationships that help mitigate the harmful effects of toxic stress.

Although much important research still remains to be done, sufficient knowledge to address these challenges more effectively is already available. Disjointed medical care in the crucial periods of preconception, pregnancy, and early childhood demands better coordination, as do a broad range of policies that affect families with young children who are facing significant adversities that threaten their physical and mental well-being. These policies include early care and education, child welfare, early intervention, workforce development, housing, urban planning, economic development, and environmental protection, among many others.
Simply calling for a more comprehensive approach to the challenges facing disadvantaged young children and their parents, however, offers nothing new. Equally important, enhanced coordination across systems that are guided by disparate values and disconnected bodies of knowledge is unlikely to produce sufficiently greater impact. What is needed instead is creative new thinking about how to apply a unified science base about the early childhood origins of health, learning, and behavior across multiple sectors.183

The framework presented in this document is offered in the spirit of attempting to catalyze such innovative policymaking and creative interventions. Promising ideas include the following:

- Child welfare agencies can help prevent long-term adult impairment, not just provide immediate child protection.
- Zoning laws and land development policies can facilitate healthy lifestyles, not just generate commercial profit.
- Alternative child care arrangements for young children whose mothers are mandated to work as a condition of receiving public assistance provide an opportunity to build foundations for healthy development, not just support maternal employment.
- High-quality early care and education programs can promote health and prevent disease, not just prepare children to succeed in school.

Dramatic advances in the biological sciences are transforming the diagnosis and treatment of illness—and the products of these efforts will undoubtedly improve the effectiveness of medical care as well as increase its cost. It is equally important to note that these same advances could also be mobilized to transform the way we address the promotion of health, prevention of disease, and reduction of disparities related to social and economic disadvantage. Every system that touches the lives of children—as well as mothers before and during pregnancy—offers an opportunity to strengthen the foundations and capacities that make lifelong healthy development possible. Investments in the early reduction of significant adversity are particularly likely to generate strong returns.

**Every system that touches the lives of children offers an opportunity to strengthen the foundations and capacities that make lifelong healthy development possible.**
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Humans are social creatures. We live, work, and grow up in social groups. For the vast majority of the last 200,000 years, humans have lived in multigenerational, multifamily hunter-gatherer bands characterized by a rich and continuous relational milieu; the concept of personal space and privacy is relatively new. Child mortality during our history was high; children were highly valued by the band and in these groups of 40–60 members, there were roughly four developmentally more mature potential caregivers for each child under the age of 6. This enriched relational ratio helped the group protect, nurture, educate, and enrich the lives of each developing child.

These living groups were the source of safety and sustenance for individuals in a dangerous world. Survival depended upon the ability to communicate, bond, and share with and receive from other members of the band. Then, as today, the presence of familiar people projecting the social–emotional cues of acceptance, understanding, compassion, and empathy calmed the stress response of the individual. We feel safest in the presence of familiar and nurturing members of our family and com-
munity. These powerful regulating effects of healthy relational interactions on the individual—mediated by various key neural networks in the brain—are at the core of relationally based protective mechanisms that help us survive and thrive following trauma and loss. Individuals who have few positive relational interactions—a child without a healthy family/clan—during or after trauma have a much more difficult time decreasing the trauma-induced activation of the stress response systems. The result is an increased probability of developing trauma-related problems. Further, children in a relationally impoverished setting will likely be unable to recover or heal from these effects without a change in the relational milieu. Positive relational interactions regulate the brain’s stress response systems and help create positive and healing neuroendocrine and neurophysiological states that promote healing and healthy development both for the normal and the maltreated child.

There is another aspect to the interconnectedness of the stress response and relational neurobiology. Human history, to this very day, is characterized by clan on clan, human on human competition for limited resources. Indeed the major predator of humans has always been other humans. In our competitive, violent past, encounters with unfamiliar nonclan members were as likely to result in harm as harmony. As the infant becomes the toddler and the toddler becomes the child, the brain is making a catalogue of “safe and familiar” attributes of the humans in his or her clan; the language, the dress, the nonverbal elements of communication, the skin color of the family and clan become the attributes of “safe and familiar,” which, in future interactions with others, will tell his or her stress response networks to be calm. In contrast, when this child interacts with strangers, the stress response systems activate; the more unfamiliar the attributes of these new people, the greater the activation. In some cases, a clan’s beliefs may have exacerbated this response; if the child grows up with ethnic, racial, or religious beliefs and values that degrade or dehumanize others, the stress activation that results in an encounter with different peoples can be extreme. In this case, relational interactions activate and exacerbate trauma-related stress over activation. A recent study by Chiao and colleagues (2008), for example, has shown that fear-related social cues from individuals from one’s own group/ethnicity have greater “power.” We are more tuned into people in our own “group.” Fear of a member in our group will induce greater amygdalar activation than similar cues from nongroup members.

The social milieu, then, becomes a major mediator of individual stress response baseline and reactivity; nonverbal signals of safety or
threat from members of one’s “clan” modulate one’s stress response. The bottom line is that healthy relational interactions with safe and familiar individuals can buffer and heal trauma-related problems, whereas the ongoing process of “tribalism”—creating an “us” and “them”—is a powerful but destructive aspect of the human condition that only exacerbates trauma in individuals, families, and communities attempting to heal.

THE IMPACT OF CHILDHOOD EXPERIENCES

The experiences of early life have the profound ability to shape the infant, child, adolescent, and ultimately the adult. Each child has his or her own unique genetic potential, yet this potential is expressed differentially depending upon the nature, timing, and patterns of developmental experience (see Perry, 2001, 2002). An understanding of how early experiences shape neurodevelopment is imperative if we seek to impact the lives of children with whom we live and work. This is especially true in the case of children growing up in homes plagued by violence, maltreatment, and neglect.

For many, childhood is a very violent time; for others, childhood is permeated with unpredictability, chaos, threat, and other forms of adverse developmental experience. There is a wealth of research describing the negative impact of childhood trauma on the physical, behavioral, cognitive, social, and emotional functioning of children (Perry & Pollard, 1998; Bremner & Vermetten, 2001; Read, Perry, Moskowitz, & Connolly, 2001; Malinosky-Rummell & Hansen, 1993; Fitzpatrick & Boldizar, 1993; Graham-Berman & Levendosky, 1998; Margolin & Gordis, 2000; Sanders-Phillips, 1997; Berenson, Wieman, & McCombs, 2001; Anda et al., 2006). Children exposed to trauma have increased neuropsychiatric problems (e.g., posttraumatic stress disorder [PTSD], depression, dissociation, conduct disorders), school and academic failure, involvement with the juvenile justice system, drug and alcohol use, antisocial behaviors, and engagement in high-risk sexual behavior and teenage pregnancy. The impact of early trauma is so profound because it occurs during those critical periods when the brain is most rapidly developing and organizing. Because the experiences of early life determine the organization and function of the mature brain, going through adverse events in childhood can have a tremendously negative impact on early brain development, including social and emotional development.
Buffering the Impact of Childhood Trauma

The Human Brain and the Impact of Trauma

The brain of a newborn is composed of billions of neurons and glial cells that, from conception, have been changing—dividing, moving, specializing, connecting, interacting, and organizing. This organization takes place from the bottom, simplest area (brainstem) to the highest, most complex (cortex). The various functions of the brain parallel this structure: The brainstem regulates the simplest reflexive functions (e.g., body temperature and heart rate), and the cortical areas mediate complex functions such as abstract thought and language (Perry, 2001). The brain is a use-dependent organ that changes in response to patterned, repetitive activity. Thus the more any neural network of the brain is activated, the more that part will change. Among other things, this process is the basis for memory, learning, and development.

All experience, therefore, changes the brain—even if in the subtlest, microscopic ways. Yet experiences in childhood have disproportionate power in shaping the brain. Early in life the brain organizes at an incredible rate, with more than 80% of the major structural changes taking place during the first 4 years. Experiences that take place during this window of organization have a greater potential to influence the brain—in either positive or negative ways. Because the majority of brain growth and development takes place during these first years, early developmental trauma and neglect have a “disproportionate influence on brain organization and later brain functioning” (Perry & Hambrick, 2008; see also, Perry, 2008). Unfortunately, traumatic experiences that take place during this critical window impact the brain in multiple areas and can actually change the structure and function of key neural networks, including those involved with regulating stress and arousal (Perry, 2008). These stress response systems in the brain are designed to sense and respond to threats, either from internal (body) or external sources. Thus, the end effect is that children who are exposed to chronic threat develop overactive and overly reactive stress response neural systems. In short, they live in a persistent state of fear. Although these neuronal changes are useful and protective when the child is living in an abusive environment, they lead to problems in other settings. For example, a hyperaroused child is often preferentially alert to nonverbal cues, which is adaptive with an unpredictable, violent parent but maladaptive in a classroom where the child will miss much of the verbal information presented by a teacher.

As the brain develops in a use-dependent manner, it requires stimulation at specific times in order for the systems to function at their best.
THE EXTENT OF THE PROBLEM

(see Perry, 2001; Perry & Szalavitz, 2007). If these sensitive periods of development are missed, “some systems may never be able to reach their full potential” (Perry & Szalavitz, 2007, p. 85). Inconsistent, abusive, or neglectful caregiving in early childhood alters the normal development of neural systems involved in both relationships and the stress response. It is through patterned, repetitive neural stimulation provided by consistent, nurturing, predictable, responsive caregivers that the infant’s brain receives what is needed to develop the capacity for healthy attachment and self-regulation capabilities. The caregiver becomes the external stress regulator for the infant. However, if the caregiver is depressed, stressed, “high,” inconsistent, or absent, these two crucial neural networks (relational and stress response) develop abnormally. The result is a child more vulnerable to future stressors and less capable of benefiting from the healthy nurturing supports that might help buffer stressors or trauma later in life.

These early developmental experiences with caregivers create a very literal template or set of associations for the child’s brain about what humans are. The brain of a child growing up in a home with attentive, attuned caregivers will create a template of humans as safe, predictable, and a source of sustenance, comfort, and pleasure. The brain of a child living in a home plagued by domestic violence and whose primary caregiver is preoccupied and chaotically neglectful will create a template in which humans are unpredictable and a source of fear, chaos, pain, and loss. Children carry these templates created by their initial caregiving experiences into all future relational interactions, either increasing or decreasing their capacity to benefit from future nurturing, caring, and invested adults. Relationships in early childhood, then, can alter the vulnerability–resilience balance for an individual child. Negative or neglectful primary caregiving relationships have the capacity to increase the likelihood that the child will have a more vulnerable, dysregulated stress response network and a less receptive relational capacity to buffer and heal following trauma as the child grows.

SOCIAL AND EMOTIONAL DEVELOPMENT

Understanding healthy social and emotional development in children underscores why disruptions to, or disorganization in, early attachment has such far-reaching implications. Attachment is defined as an enduring relationship with a specific person that is characterized by soothing, comfort, pleasure, and safety. It also includes feelings of intense distress
when faced with the loss, or threat of loss, of this person. By far the most important attachment relationship is that of mother and infant. Even before birth, the emotionally healthy mother begins the process of attaching to her baby as she grows attuned to its patterns of movement and the way it responds to stimuli such as sound (Greenspan & Wieder, 2006). Bowlby (1969) describes maternal–infant attachment as a reciprocal relationship. Greenspan and Wieder (2006) note that “the rhythmic, near-synchronous patterns of movement and vocalization between infant and caregiver enable the infant to begin attending to and appreciating the world” (pp. 14–15). In fact, many have aptly described this mother–infant relationship as a dance, the moves of which will be used with many partners throughout the child’s life.

The importance of healthy attachment has been extensively studied. Research in this area has identified four categories of attachment: secure, insecure-resistant, insecure-avoidant, and insecure-disorganized/disoriented. Securely attached children feel a consistent, responsive, and supportive relation to their mothers even during times of significant stress. Children with insecure attachment feel inconsistent, punishing, unresponsive emotions from their caregivers and feel threatened during times of stress. Ainsworth, Blehar, Waters, and Wall (1978) posited that the type of attachment a child develops is dependent on the kind of caregiving received during the first year of life. A solid and healthy attachment with a primary caregiver predicts healthy relationships with others as the child grows.

Development in many other areas is rooted in the development of a healthy attachment to a primary caregiver. These areas include development of emotional, social, cognitive, and self-regulatory capabilities. These first relationships, including those formed with other significant people during early childhood, “are the prism through which young children learn about the world, including the world of people and of the self” (Thompson, 2002, p. 10). These early experiences literally provide the organizing framework for the infant/child. Regulation of the infant’s emotional states develops through the repeated appropriate responses of an attentive, attuned caregiver to the baby’s changing emotional states (e.g., fear, anger, distress). Through this consistent, predictable, and repetitive nurturing the child develops the capacity to self-regulate these emotional states as well as to communicate his or her emotions (Emde, 1998). These nurturing behaviors also provide feelings of safety and security. According to Lyons-Ruth and Spielman (2004), a mother’s capacity to regulate her infant’s distress and fear is vital to the child’s ultimate sense of security.
The timing of relational interactions is critically important for the development of attachment and social–emotional functioning. An absence of nurturing during the first 3 years of life can lead to disorganization of the neural systems that mediate social–emotional functioning (Perry, 2002). Without the vitally important relational input from caring, attuned caregivers, children may develop as if the entire world were a cold, dangerous place. Not surprising, many studies have found that maltreated infants exhibit disturbed or insecure attachment (Carlson, Cichetti, Barnett, & Braunwald, 1989; Crittenden, 1985; Lamb, Gaensbauer, Malkin, & Schultz, 1985; Schneider-Rosen, Braunwald, Carlson, & Cichetti, 1985). Children who have experienced abuse and neglect in infancy and early childhood are at greater risk for developing maladaptive behaviors and mental health problems as they get older.

CASE 1: CAREGIVER ISSUES IMPACTING BONDING AND ATTACHMENT

Mark, age 2, was brought to our clinic by his adoptive mother due to concerns that he may have an attachment disorder. He had been adopted at 10 months of age from a small Eastern European orphanage, where he had been placed at birth. His adoptive mother, Sarah, had no knowledge of Mark’s biological parents but reported that the orphanage seemed “better than most,” as Mark had relatively stable caregivers to whom he appeared attached and areas in which he could explore and play. She reported that her difficulties with Mark began almost immediately upon returning home. According to Sarah, he would not look her in the eyes, didn’t enjoy being held, and didn’t engage in exploratory play. In an effort to strengthen the attachment bond, she had taken Mark to multiple therapists specializing in attachment. Further, she had been trained in holding therapy and had read countless books on the subject.

In an effort to get to know Sarah and Mark better, clinicians observed their interaction over the course of the first two interview sessions. During the initial interview Sarah sat and talked with the lead clinician while Mark explored the room. Mark quickly discovered that he could climb from the chair to the desk, and within minutes he was happily walking on top of the desk and onto the adjoining table. The observing clinicians watched in dismay as Sarah continued the interview with no acknowledgment of her son’s precarious situation. Only
when the suggestion was made that Mark might fall and injure himself did she remove him from the table.

During the second interview, Sarah offered to demonstrate the activities she was currently implementing to increase her son’s attachment to her. She picked Mark up and held him tightly in her arms, her hand under his chin, in an effort to force him to look directly into her face. The child squirmed and fought to get loose; eyes closed, he turned his head violently in an effort to avoid her gaze. The more he fought and screamed the more resolute she became. Finally, she looked at the clinician and said, “See, this is exactly what I’ve been dealing with.” However, to the clinician, Mark’s reaction was not a surprise. When infants or young children are distressed due to pain, pervasive threat, or a chaotic environment, they will have difficulty participating in even a supportive caregiving relationship (Perry & Pollard, 1998)—which this obviously was not.

A second clinician participated in the third session with the family. While the primary clinician talked with Sarah about healthy development, the second clinician sat on the floor with Mark, who was playing with a large plastic dinosaur. The second clinician engaged in parallel play with another dinosaur. Within a short time, Mark had moved close to the clinician, interjecting his dinosaur into her play. He interacted easily with the clinician, making appropriate eye contact and happily describing the dinosaur’s activity. In subsequent sessions it became clear that the issue was not centered in the child but in the parenting behavior. Sarah had experienced abuse at the hands of her own mother as a child. Relationships, it seemed, had been difficult for her throughout her adult life, but her hope was that by adopting a child she would fill this relational void. Unfortunately, it is not uncommon that caregivers who themselves experienced trauma or maltreatment as children carry these experiences into their own maternal–child relationships. The frightened or frightening behaviors of such a caregiver often creates a contradiction that is impossible for the child to resolve: The caregiver is both the source of, and solution to, the child’s distress (Main & Hess, 1990). Without an acknowledgment of the impact that their own childhood experiences have on their parenting, these caregivers are unlikely to change their behavior. This was the case with Sarah. Attempts to help her better understand how her own trauma history impacted her ability to respond to her son’s needs and to teach her appropriate nurturing activities ultimately were unsuccessful, leading ultimately to her decision to relinquish her parental rights. Mark was later adopted by
another family who was more open to understanding the impact of his early experiences and to providing the necessary reparative experiences that would allow him to grow into a healthy happy child.

**CASE 2: THE DEVASTATING IMPACT OF MALTREATMENT ON SOCIAL–EMOTIONAL DEVELOPMENT**

Sydney never knew her biological parents. She had been removed from their care at birth due to the severe physical abuse of her three older siblings by her mother and father. Sydney was fortunate. She was placed in a loving home with foster/adoptive parents who cared for her as if she were their own child. Sydney thrived in the care of these nurturing, attentive, and attuned caregivers. In her mind, they were her mommy and daddy, and that’s what she called them. Tim and Jan thought of Sydney as their child even though they had been reminded, time and time again by her caseworker, that there was no guarantee that they would be able to adopt her. Despite torturing their older children, the parental rights of Sydney’s parents had not been terminated. The Child Protective Services (CPS) caseworker was concerned about the ethnic differences between the foster parents and Sydney, although that difference was only noticeable to those who didn’t know them. They were a very happy family.

Then when Sydney was 3 years old the judge made a surprising decision. Her biological parents had completed all of the requirements placed upon them by CPS, including parenting classes, anger management classes, and domestic violence and drug and alcohol counseling. It now seemed that after several years they had finally gotten their act together and were once again ready to parent their four children. Sydney did know her brothers and sister; they had monthly visits during their time in foster care, although the infrequency of the time together did little to forge a sibling bond. Her parents, on the other hand, had rarely made the parental visits. However, this made little difference as the judge handed down his decision. They were her biological parents and that’s what mattered. Tim and Jan hired an attorney, and they fought Sydney’s removal from their home with all they had—but biology won out. On a crisp February morning, Sydney was taken from them. Jan later described how Sydney’s screams haunted her day and night.

But that was just the beginning of the trauma for Sydney. She had been taken from her mommy and daddy and given to two people whom
she didn’t know. They said that they were her “real” mommy and daddy, but she knew that wasn’t true, so she called them by their names. That was only one of the things that infuriated them about her. Within a short period of time, the torture began: beatings, burning with cigarettes, being locked in her room, and denied food. Sydney’s world had completely changed and her 3-year-old mind couldn’t begin to understand why.

Thankfully, Tim and Jan never gave up. They were not able to see Sydney but, based upon the reports when her siblings initially came into care, they could only imagine what she was going through. They continued to fight. They told Sydney’s story to the media and sought the help of children’s rights groups. But ultimately it was a neighbor who put an end to Sydney’s suffering. She had seen Sydney only on rare occasions over the year and a half that the children had been back in the home. The older children went to school and played in the neighborhood park, but not Sydney. One day she witnessed the father kicking Sydney as she tried to walk out onto the front porch. The neighbor immediately called the police. When they arrived with CPS there was little doubt of the abuse suffered by this child. She was rushed to the hospital. Both parents were arrested, and her brothers and sister were once again placed in foster care.

When Jan and Tim entered the hospital room, they barely recognized their little girl. Her once beautiful hair was now matted to her head and was completely gone in some places. Her eyes, once so sparkling and full of life, stared right through them. She didn’t speak. Ultimately the results of days of tests and X-rays told the horrible truth. Sydney had suffered countless beatings that ended in broken bones that were never treated. She would have to endure multiple surgeries to chip away the calcium deposits that had formed on the healed bones in her legs. She had regressed in every developmental domain, and she exhibited severe PTSD.

It wasn’t until she returned home that the healing could begin. Her room was just as she left it—the consistent, nurturing, and safe home was waiting for her. She would need hours of physical and occupational therapy and the efforts of therapists experienced in working with traumatized children. Most important, she needed the love and care of her family to provide the patterned, repetitive, and reparative experiences that would help build the developmental capacities that anger and cruelty had stolen from her. Ultimately Sydney did heal from all this early trauma because of her strong spirit and the parents who never gave up on her.
CASE 3: NEGLECT IN INFANCY
AND THE DEVELOPMENTAL CONSEQUENCES

Haley was adopted from an orphanage outside of the United States when she was 9 months old. While the information her adoptive parents had about her past was minimal, they did know that she had spent the first 2 months of her life with her biological mother, who was a known alcoholic. At the time she was placed, Haley had a serious illness and several bruises on her legs, and she spent at least a month in the hospital. Haley’s adoptive parents had an opportunity to tour the facility, which they described as a “typical” orphanage—a cold place with large rooms filled with rows of cribs or beds and only a few caregivers.

Upon returning home with their new baby, the parents were surprised by her behavior. She cried very little during the day; she would often just sit and stare into space. At night, however, she would wake several times screaming uncontrollably. No matter what they tried, they were rarely able to comfort or soothe her when she was upset. She didn’t like to be touched or held, and her eating was always rushed, as if she hadn’t eaten in days and didn’t know when she would eat again. Haley would often hurt herself by banging her head or pulling her hair until it came out, and she would also try to hit or bite anyone who tried to hold her.

Haley’s adoptive parents, Kristy and Sam, worked to make home a safe place. Kristy quit her job to stay home with her daughter. They hired a psychologist to come into their home and teach them appropriate attachment techniques such as cuddling, gentle holding, and rocking. They worked very hard to build routines and predictability into Haley’s day. Over time, Haley’s self-injurious behaviors began to diminish, although they did not completely go away. However, following an outing to visit family out of state, Haley’s behaviors regressed significantly. Once again she was rageful, hitting everyone within reach, touch averse, and exhibiting severe sleep disturbances. Only through limiting her exposure to those outside of the family and not venturing outside the home did her behaviors get better.

Haley seemed to be making progress. A massage therapist had worked with the family and now both parents used massage as a way to help soothe and calm their daughter. They built rocking and music and movement into their daily routine. They followed every recommendation to the letter—they were doing everything right. But without warning, Haley’s behaviors began to escalate into severe mood swings. Her
parents describe her as exceptionally gentle and loving one minute and
defiant, rageful, rejecting, and hurtful the next. Despite all of the empa-
thy, patience, and nurturing, Haley did not seem to be getting better.
What Sam and Kristy didn’t know was that the absence of critical orga-
nizing experiences during Haley’s neglectful first 8 months was a major
contributing factor to the devastating developmental problems they wit-
nessed on a daily basis.

THE POWER OF RELATIONSHIPS TO HEAL

Understanding the power of traumatic events to shape the brain helps us
to better determine what a child needs to heal. Although negative early
life relational experiences have the ability to shape the child’s devel-
oping brain, relationships can also be protective and reparative (see
Figure 3.1). The cases of Mark and Syndey are examples of the power
of relationships both to injure and to heal. There exists a wide body
of research suggesting that social connectedness is a protective factor
against many forms of child maltreatment—including physical abuse,
neglect, nonorganic failure to thrive—as well as a means of promoting
prosocial behavior (Belsky, Jaffee, Sligo, Woodward, & Silva, 2005; Cal-
iso & Milner, 1992; Egeland, Jacobvitz, & Sroufe, 1988; Rak & Patterson,
1996; Travis & Combs-Orme, 2007; Chan, 1994; Coohey, 1996; Guadin,
Polansky, Kilpatrick, & Shilton, 1993; Hashima & Amato, 1994; Pascoe
& Earp, 1984; Altemeier, O’Connor, Sherrod, & Vietze, 1985; Benoit,
Zeanah, & Barton, 1989; Crnic, Greenberg, Robinson, & Ragozin, 1984;
Gorman, Leifer, & Grossman, 1993). Sydney’s early experiences had
taught her that home was a place where she was safe and loved. Her
foster/adoptive parents and their extended family supplied her with the
emotional connections, healthy interactions, and nurturing that pro-
vided a strong basis for surviving the horrors of life with her biological
parents. We can only infer that Mark had something similar built in by
his first caregivers in the orphanage that helped buffer the experiences
with his first adoptive mother.

Haley, unfortunately, missed out on the nurturing, touch, and love
that she needed in order to grow into a healthy, secure little girl. Her
brain, literally, was a reflection of the severity of her neglect, likely com-
combined with some type of physical maltreatment. Her stress response sys-
tem overly active, Haley spent most of her time either hyperaroused or
dissociating when her little system could take no more. Also, not surpris-
Interestingly, the strategies that helped her survive in the environment of the orphanage made it more difficult for her to “take advantage of good-quality, loving and responsive” caregiving in her new home (Howe & Fearnley, 2003, p. 372). Experience in her earliest caregiving relationships had taught her that adults were frightening, hurtful, unpredictable, and confusing. Children with early neglect histories and subsequent attachment-related problems rarely feel safe when placed in new, healthy caregiving situations. Instead, they work to avoid close relationships, often becoming aggressive and controlling as a way to protect themselves from further hurt. Howe and Fearnley (2003) aptly describe the situation this way.

**FIGURE 3.1.** Relational health during development is protective. This graph is from research with a group of maltreated children. A retrospective measure of the presence, quality, and number of relational supports during each child’s development was obtained as part of a clinical assessment (Relational Health: Development) using an approach called the Neurosequential Model of Therapeutics (NMT; Perry, 2009). This is plotted against a measure of the development and functional capabilities of 28 brain-mediated functions (NMT Brain Organization [org] Score). A clear relationship between the relational health scores and overall quality of brain organization and functioning is seen.
Close relationships are the one thing these children avoid. Their developmental agenda is to control and not to engage people. This denies them exposure to the very experiences they need. So long as they remain unable to relinquish control and relate fully and accurately with their carers and therapists, the children make little emotional or developmental progress (p. 380).

Sydney’s case, in particular, provides an example of how healthy caregiving and strong attachments can help protect children from the lasting impact of traumatic events. That is not to say that all of the scars disappear or that the memories of trauma no longer exist, only that the reestablishment of predictable routines, reconnections with attentive, attuned, committed caregivers, and solid therapeutic treatment provide the opportunity for children to heal.

**PRACTICE AND POLICY IMPLICATIONS**

Our current mental health, child welfare, and judicial systems, as well as child-placing agencies deal with traumatized and maltreated children as if they were completely unaware of these essential findings in development, attachment, and trauma. We have few metrics to measure the number, quality, and patterns of healthy (or unhealthy) relational interactions; we move traumatized children from therapist to therapist, school to school, foster home to foster home, community to community. Indeed our systems often exacerbate or even replicate the relational impermanence and trauma of the child’s life (see Figure 3.2). We expect “therapy”—healing—to take place in the child via episodic, shallow relational interactions with highly educated but poorly nurturing strangers. We undervalue the powerful therapeutic impact of caring teacher, coach, neighbor, grandparent, and a host of other potential “cotherapists.”

Future effective therapeutic interventions—both preventive and healing—must be developmentally informed and trauma sensitive. There is much to learn, yet we know enough now to begin to evaluate and modify our current therapeutic practices, programs, and policies to take full advantage of the biological gift of the healing power of relationships.


**FIGURE 3.2.** Positive relational interactions: Typical and foster child. These two figures are representative 24-hour relational contact maps examining the number of positive relational interactions in two children. Arrows represent positive interactions (as rated by observer and child); arrows ending in the inner circle represent interactions with family; additional circles represent friends, then classmates/acquaintances. Arrows outside the circle represent interactions with strangers. The figure on the right is based on a 10-year-old boy in foster care who was moved in the middle of the school year to a new foster home away from extended family and community. This figure is the best 24-hour map for a 2-week period for this child. Several days were completely devoid of any positive relational interaction. The relational poverty played a major role in this child’s inability to progress; symptoms related to trauma and neglect persisted and increased while he was in relationally impoverished settings. Once in a stable placement with positive relationships created in school and the community, he stabilized and improved.

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Buffering the Impact of Childhood Trauma


Buffering the Impact of Childhood Trauma


A convergence of compelling evidence has linked traumatic early childhood adverse experiences with a lifetime trajectory of serious mental and physical health problems. Advances in the understanding of trauma such as the landmark Adverse Childhood Experiences Study (Anda et al., 2004) compel early childhood professionals to re-examine traditional systems and practices and bring a trauma lens to the work with young children and families. Nowhere is the need to rethink services more apparent than in the Part C Early Intervention System (which we will refer to as EI), a federal program designed to serve infants and toddlers with disabilities or delays, or who are at high risk of risk of delay. Federal legislation now requires the child welfare system to refer all infants and toddlers with substantiated abuse or neglect to the EI system for an evaluation of need for EI services. Within the diversity of groups eligible within each state’s definition, EI also serves other groups of children—such as low birth weight babies and young children with established disabilities—who are at elevated risk for abuse and neglect (Spencer, Wallace, Sundrum, Bacchus, & Logan, 2006; Sullivan & Knutson, 2000) and infants and toddlers with disabilities who may have experienced medical trauma from repeated hospitalizations and painful procedures.

Abstract
Federal directives require that any child less than 3 years old with a substantiated case of abuse be referred to the early intervention (EI) system. This article details the need and presents a vision for a trauma-informed EI system. The authors describe two exemplary program models which implement this vision and recommend steps which the field can take to move toward a trauma-informed EI.

Although EI providers are well-trained to address developmental disabilities and general developmental delay, they are not typically trained to consider the impact of trauma on development and
on relationships. For example, intervention for a language delay in a child who has experienced complex trauma calls for a very different approach than a language delay related to cerebral palsy. Although there are models for trauma-informed child welfare, health care, education, mental health, and juvenile justice, there is not yet a model for trauma-informed EI. In this article, we describe the national policies that link the child welfare system to EI and create the need for states to build trauma-informed EI systems. We briefly review the tenets of trauma-informed systems, present a vision for trauma-informed EI, and describe two program models which illustrate what trauma-informed EI can look like in practice. The article concludes with recommendations to the field to infuse a trauma perspective and trauma expertise into EI.

Policies Supporting Trauma-Informed Early Intervention


Part C Early Intervention and CAPTA

The original intent and the legislative language of Part C EI provide the basis for a collaborative and comprehensive system of services to eligible infants, toddlers, and their families. Part C requires states to serve children who have established conditions or disabilities (e.g., spina bifida, Down Syndrome), but gives states flexibility in defining the criteria for the amount of “delay” necessary for services. As a result, states differ in the amount of delay necessary for EI eligibility, ranging from 20% to 35% delay in one or more areas (Ringwalt, 2012). States are are encouraged but not required to serve children at “high risk” of substantial delay. Only six states currently serve at-risk children, despite compelling evidence of the likelihood of delay when multiple risk factors are present (Ringwalt, 2012).

Evidence confirms that infants and toddlers in child welfare are at higher risk for developmental delays. National data shows that 38-65% of infants and toddlers encountered by child welfare have delays (Barth et al., 2008) and up to 82% of maltreated infants will have attachment problems (Goldsmith, Oppenheim, & Wanlass, 2004). A national longitudinal study found that 35% of infants and toddlers needed EI services at the time of contact with child welfare (meeting the strict criteria of 2 standard deviations of delay; Casanueva, Cross, & Ringeisen, 2008). This high incidence of developmental delays and the potential benefits of EI for children encountering the child welfare system were so compelling that the federal government amended both CAPTA and IDEA to address this unmet need.

CAPTA now requires that states develop “provisions and procedures for referral of a child under age 3 who is involved in a substantiated case of child abuse or neglect to EI services funded under EI of the Individuals with Disabilities Education Improvement Act” (Sec. 106(b)(2)(A)(xxvi); IDEA, 2004). While the definition of “substantiated case” varies from state to state, it typically means that an incident of child abuse or neglect is believed to have occurred. Part C EI contains parallel language to that included in CAPTA and requires that states “…must include a description of state policies and procedures that require the referral for EI services ...of a child under the age of 3 who (A) is involved in a substantiated case of child abuse or neglect, or (B) is identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure (Sec. 637 (a)(6)).” CAPTA and EI both require that a child with substantiated abuse or neglect be referred to EI to determine the child’s eligibility for EI services; neither federal law requires the child’s automatic eligibility for EI. The determination of eligibility for services remains the responsibility of the EI system and follows the dictates of the state’s EI eligibility criteria.

Challenges and Successes in Implementing CAPTA Requirements

The parallel requirement in child welfare and EI for referring children with substantiated abuse or neglect for developmental services creates opportunities to strengthen ties between the two programs while presenting challenges to each system. To better understand the challenges from the child welfare perspective, ZERO TO THREE and Child Trends conducted a survey of state child welfare agencies. Data from 46 agencies responding identified the following barriers in implementation: (a) birth parents’ lack of familiarity with EI services and lack of training in identifying developmental needs, (b) need and cost of EI services exceeds that available through current funding, (c) EI staff’s inability to engage children and families in the child welfare system, and (d) transportation and other access-related issues.

The survey found that child welfare agencies are addressing these challenges by: (a) collaborating with EI agencies to implement requirements of federal, state, and local laws (36 states); (b) formal information sharing about each system’s policies/procedures (28 states); and (c) clearly delineating the roles/responsibilities of EI and child welfare staff (24 states; Changing the Course for Infants and Toddlers, 2013).

In 2008, a survey of EI state administrators shed light on the experiences of EI staff with referrals of children under the CAPTA requirements (IDEA Infant Toddler Coordinators Association [IITCA], 2008). Thirty states responded to the survey,
The study (Gilkerson et al., 2011) found that the potential for retraumatization exists from the EI experience itself for traumatized children when there is a lack of knowledge of a trauma-sensitive approach (e.g., abrupt separation of a child from caregivers to complete an assessment task when that child had recently been removed from the home, asking biological or foster parents to leave the room so the provider can work with the child alone, or routine procedures that can be intrusive such as an oral exam of a child’s mouth if conducted without awareness of a child’s trauma experience). Barriers to considering trauma were identified: (a) belief that infants and young children are too young to be affected by trauma experiences; (b) reticence of parents to talk about trauma and mental health concerns (and providers reticence to ask) because of the associated stigma and fear their child may be taken away; and (c) lack of preparation and supervision in professionals to address the social-emotional domain in general, not just trauma-related responses and, for some, part of their role. In addition to an absence of appropriate tools or processes for trauma screening, respondents reported that the approved tools for eligibility determination were not adequate for quantifying social-emotional delays, especially those related to attachment issues, trauma, or both.

**Collaborative, Integrated Approach to Addressing Trauma in EI**

The requirements in EI and CAPTA provide new opportunities for child welfare and EI to work together to infuse developmental perspectives into child welfare and trauma-informed approaches into EI. Identified positive outcomes of the CAPTA requirements include increased attention to the developmental needs of maltreated infants and toddlers, greater dialogue between EI and child welfare lead agencies, increased opportunities for professional development and training across systems, and most important, more children identified who can benefit by receiving EI services (Herman, 2007; Keller-Allen, 2007).

The EI system offers infants and toddlers referred through CAPTA a reliable system with predictable responses and timetable for referrals, home-based services easily accessible for families, interventions from a range of disciplines and linkages with other services in the community; and lastly, EI “often goes the extra mile to help a child or family” (Gilkerson et al., 2011).


Issued in partnership with the Administration for Children and Families, Centers for Medicare & Medicaid Services, and Substance Abuse and Mental Health Services Administration, the letter acknowledged the impact of trauma on health and development, affirmed the collaborative approach to effectively address complex trauma, and provided essential financing information to state program directors. The stage was set for a new integration of a trauma-informed approach with the philosophy and practices of EI.

**Vision for a Trauma-Informed EI System**

The National Child Traumatic Stress Network (NCTSN) defined a trauma-informed child- and family-service system as:
expose to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family. (NCTSN Trauma-Informed Service Systems Working Group, 2012).

NCTSN described the characteristics of trauma-informed systems as:

1. Routinely screen for trauma exposure and related symptoms;
2. Use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms;
3. Make resources available to children, families, and providers on trauma exposure, its impact, and treatment;
4. Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma;
5. Address parent and caregiver trauma and its impact on the family system;
6. Emphasize continuity of care and collaboration across child-service systems; and
7. Maintain an environment of care for staff that addresses, minimizes, and treats adverse traumatic stress, and that increases staff resilience.” (NCTSN Trauma-Informed Service Systems Working Group, 2012)

Building on these characteristics of a trauma-informed system and the focus group study of EI and child welfare (Gilkerson et al., 2011), Gilkerson (2012) presented a vision for the elements of a trauma-informed EI system. The first two essential elements relate to the philosophy of EI which guides the approach for all children in EI; the remaining elements are trauma-specific.

**FOR CHILDREN EXPOSED TO TRAUMA AND THEIR FAMILIES**

- **Unique Needs:** Views children who are impacted by trauma as having unique needs which must be considered at each phase of the EI process. EI recognizes and responds to the special impact of trauma—both interpersonal and medical trauma—on an infant or toddler’s development and uses a trauma-sensitive lens and adequately trained professionals to understand (a) risks to the child’s development and family relationships and (b) how to intervene to promote developmental growth.

- **Broad Eligibility:** Uses a definition of EI eligibility broad enough to include infants and toddlers with developmental delays associated with trauma exposure and with multiple environmental risks; formal procedures for informed clinical opinion are in place and used to help with eligibility determination.

- **Trauma Screening:** Routinely screens for trauma exposure and related symptoms at intake and throughout the EI process; medical trauma is assessed at intake and again when hospitalizations and painful procedures occur. Providers respect the family boundaries around trauma and seek to create a safe, trusting relationship in which trauma experience can be shared, understood, and considered in the EI process.

- **Priority on Emotional Safety:** Places priority to the child’s emotional safety and the need for co-regulating caregivers during all aspects of EI: intake, assessment, and service provision; avoids retraumatizing the child; and helps the child gain or regain competence derailed through trauma.

- **EI Trauma Specialists:** Includes professionals in EI with trauma-specific expertise such as infant mental health specialists with trauma-training; these specialists can provide trauma-informed evidence-based services to infants, toddlers, and families; collaborate with other EI providers to integrate trauma-related and developmental services; and help develop the capacity of other providers to work from a trauma-informed perspective.

- **Trauma Training, Consultation, and Reflective Supervision:** Infuses and sustains a trauma awareness, knowledge, and basic skills in all EI professionals through training, reflective supervision, and consultation; training is not one-time but over time with opportunities for reflective supervision and case consultation; at a minimum, all managers, service coordinators, and providers receive awareness training in trauma and trauma-informed practices; follow-up training, consultation, reflective supervision, or a combination of these are provided by trauma-trained, infant mental health specialists or consultants. Because trauma affects regulation, cognition, and language, special provisions...
Trauma-Informed EI in Practice

In this section, we describe two existing programs which illustrate the vision for trauma-informed EI. The first model, in Baltimore, Maryland, describes the effort of an EI program to infuse a trauma-informed, infant mental health framework into its screening, assessment, and referral practices. The second model, the New Mexico Infant Team approach, exemplifies a comprehensive interagency, transdisciplinary, collaborative model which fully merges EI and mental health in collaboration with child welfare and the court system.

Baltimore Infants and Toddlers Program

Beginning in 2011, Baltimore City Department of Health, the lead agency for EI in Baltimore, has made the integration of EI and early childhood mental health a priority. This priority led to the development of a trauma-informed EI program which is a partnership between Baltimore Infants and Toddlers Program (BITP), an interagency EI program serving more than 900 infants and toddlers in Baltimore City, and the University of Maryland School of Medicine’s Taghi Modarressi Center for Infant Study (CIS)/Secure Starts program, an agency with a long history of providing infant mental health training, consultation, and direct services to young children and families. Developed by Toby C. Hairston-Fuller, BITP coordinator of evaluation and assessment, and Jessica Lertora, associate director from CIS, the model integrates trauma screening into the eligibility process for all children referred to EI, including those referred through CAPTA. On the basis of screenings and assessment, referrals are made for infant mental health consultation or treatment depending upon need. A central feature of the Baltimore program is the strong foundation that the EI professionals have in trauma and infant mental health. The EI services are funded by the EI agency; the infant mental health services are funded by EI funds via a contract with the CIS Program.

STAFFING

The BITP program includes the director, service coordinators, and the full array of EI disciplines with the addition of a developmental pediatrician. The coordinator of evaluation and assessment oversees the evaluation process and integrity of referral process. CIS provides a trauma-trained, infant and early childhood mental health consultant who has provided consultation with the EI program in different capacities over the past 5 years. Her role includes providing staff training, participating in the review of the trauma screenings, and providing referral sources and services to the CAPTA-referred EI families who need infant mental health consultation or treatment. She also participates in a special evaluation team which focuses on helping to assess children with specific social–emotional concerns.

Through the partnership with CIS, all service coordinators have been trauma trained. They understand how trauma affects development, can recognize the symptoms of trauma, and are confident with helping families through the referral process. The CIS and the University of Maryland School of Medicine’s Department of Child and Adolescent Psychiatry also offers an Early Childhood Mental Health Certificate Program which highlights trauma as a vital part of the core curriculum. All the EI administrative staff and team leaders have received this certification, which allows everyone on the staff to aid the service coordinators around family and child needs and with next steps in referrals when the CIS therapist is not present.

REFFERAL TO SERVICES

Baltimore has a single point of entry for all children referred to EI, inclusive of those in the foster care system. The foster care children referred through CAPTA receive a developmental evaluation using the Battelle Developmental Inventory, 2nd edition (Newborg, 2004). If they are eligible for Part C, they receive an Ages and Stages: Social Emotional Questionnaire (ASQ: SE; Squires, Bricker, & Twombly, 2003) and a six-question trauma screen.

TRAUMA SCREENING

The program developers reviewed a range of trauma screeners and chose a two-part screener, adapted from the Young Child PTSD Screener (Sheeringa, 2011) for use in the EI evaluation process. The screening assesses the child’s exposure to trauma and the trauma impact. To assess trauma exposure, the service coordinator asks the current caregiver (e.g., biological parent, grandparent, foster parent) a series of questions about trauma (e.g., has the child been a witness to violence [inside or outside the house], had a severe adjustment to illnesses, been attacked by an animal, or experienced natural disasters). To assess the impact of trauma on the child, the service coordinator asks the following six questions, each scored on a 3-point scale from none, a little, to a lot.
1. Does the child have intrusive memories of the trauma? Does s/he bring it up on his/ her own?
2. Is your child having more nightmares since the trauma occurred?
3. Does s/he get upset when exposed to reminders of the event(s)?
4. Has s/he had a hard time falling asleep or staying asleep since the trauma?
5. Has your child become more irritable, or had outbursts of anger, or developed extreme temper tantrums since the trauma?
6. Does your child startle more than before the trauma? (For example, if there’s a loud noise or someone sneaks up behind him/her, does s/he jump or seem startled?)

(Scheeringa, 2011, p. 1)

For very young children, the service coordinators review the medical passport from the Department of Social Services and talk with foster parents to understand the child’s exposure to trauma and its impact. At this point, the trauma screening is provided only at the initial eligibility; follow-up screening is not currently provided. Providing routine follow-up screening at the 6 month IFSP reviews would ensure that each child is rescreened, avoiding the likelihood of missing a child affected by trauma. Repeated screening would also help uncover how a child’s symptoms are affected through developmental gain or regression, in addition to perhaps identifying the possibility of new traumas occurring.

SERVICES PROVIDED
On the basis of the screening scores, the impact of the trauma is categorized in three tiers, each with a different referral response.

• Tier 1: Child passes trauma screen and ASQ: SE (Squires et al., 2003) — Child receives follow-up service coordination and relevant EI services
• Tier 2: Child fails ASQ: SE and passes trauma screen — Child may receive up to 6 sessions of consultation visits from a CIS infant mental health therapist and relevant EI services
• Tier 3: Child does not pass ASQ: SE and has positive endorsement for trauma screen — The child is referred to CIS therapist for infant mental health intervention services, including — but not limited to — mental health consultation (6–8 sessions), or infant mental health treatment (up to 1–2 times/week until the child ages out of EI), or referral to a more intensive mental health intervention or program.

Although EI providers are well-trained to address developmental disabilities and general developmental delay, they are not typically trained to consider the impact of trauma on development and on relationships.

Information is sought from the EI providers in efforts to attain a fuller picture of the child within the context of the family. However, the EI and infant mental health providers do not interact regularly, but can co-treat if needed.

NICOLE’S STORY
Nicole was a 14-month-old toddler, part of a sibling group who were referred to child welfare for neglect and abandonment. Nicole was in the care of a foster mother who had strong concerns about her inconsolability; Nicole cried endlessly and, after 2 months, she had not shown any connection to her foster mother. Nicole was referred to BITP and found eligible for EI because of delays in adaptive behavior with feeding problems (e.g., she would not take textured solid foods) and social–emotional concerns, as she did not pass the ASQ: SE (Squires et al., 2003).

The trauma questionnaire was completed by the foster mom, who reported that Nicole had difficulty with sleeping and significant hypersensitivity to noise. These findings cued the EI service coordinator to contact protective services and learn more about Nicole’s early birth history as well as the months just prior to placement. Nicole’s history revealed significant periods of abandonment, including the children being found alone.

Because Nicole did not pass the ASQ: SE (Squires et al., 2003) and had a trauma history with significant symptoms, she was considered a Tier 3 referral. In addition to EI occupational therapy services for oral motor and feeding skills, she received a referral to an intensive feeding clinic which required daily attendance for 6 weeks. A referral to the CIS infant mental health specialist for home-based infant mental health services was made to address the attachment and relationship concerns and to facilitate Nicole’s ability to interact with her peers. The foster parent and child were involved in each of the sessions with the infant mental health specialist, who used a Child–Parent Psychotherapy approach (Lieberman & Van Horn, 2008) to this family’s needs. Treatment focused on goals which included reducing the child’s inconsolability, increasing the foster parent’s feelings of effectiveness in caring for Nicole, and psycho–education around the effects that neglect may have had in Nicole’s life, all in the context of play and focusing on building the dyadic relationship between caregiver and child. After receiving EI, including infant mental health services for 9 months, Nicole was functioning at her developmental level and was no longer eligible for special education services when she turned 3 years old. Nicole was adopted by her foster mother and has maintained regular visits with her siblings. Follow-up with her adoptive parent after Nicole turned 3 revealed that Nicole continues to attend weekly playgroups at the local library and interacts with her peers with ease. Her mother reports that Nicole is loving, affectionate, and seems to never get enough of “Mommy’s Love.” It was noted that Nicole does take time to warm up to strangers, but looks to Mom for reassurance that all is well.
SUCCESS OF THE MODEL

The model provides a universal trauma screening for all children referred to EI. Because all children in foster care are screened, the program ensures the likelihood that no trauma experienced from a substantiated case of abuse or neglect will be unattended. Children receive EI developmental services depending on their individual needs and, as appropriate, they receive infant mental health services or referrals to address attachment relationship and social/emotional/behavioral concerns. This is the CAPTA and IDEA legislation in action. The commitment of the Department of Health has been instrumental in the success of this program, first prioritizing the integration of EI with infant mental health and then standing behind their priority with funding for staff training in infant mental health, trauma screening, and contracting with CIS for infant mental health services to supplement EI. The partnership with CIS has provided EI with the expertise in infant mental health which was integral to implement the Department’s vision for integrated services. While the program is funded by the Part C allotment to the state, these funds do not fully cover special projects that are designed to enhance service provision. Special projects, like the trauma screening and follow-up infant mental health home visiting services, are vulnerable to budget cuts when resources tighten and funds are needed to provide basic EI services mandated by law. Again, strong lead agency support is key to the sustainability of the model.

New Mexico Infant Team

New Mexico is one of the six states whose EI eligibility includes an at-risk category. If an infant or toddler does not qualify with the requisite percentage of delays, New Mexico providers have an option to qualify children who are in protective custody for EI through the state’s at-risk criteria. Since 2009, New Mexico has implemented an interagency, transdisciplinary, Infant Team model program linking EI with three other state systems: (a) child protection, (b) behavioral (mental) health, and (c) the family courts. The goal of the New Mexico Infant Teams is to provide infants in state custody with a coordinated, trauma-informed, and developmentally based process for assessment, early developmental intervention, and mental health treatment to promote safety, permanency planning, and positive developmental outcomes (Clarke & Harris, 2013). Funding for the Infant Teams is provided by the New Mexico Department of Children, Youth and Families where Child Protection is housed. EI services are funded by the Department of Health through a Memorandum of Agreement that specifies the mutually agreed-upon responsibilities and collaborative protocols for the model.

Like the Baltimore model, the New Mexico Infant Teams were developed by leaders, Deborah Harris and Jane Clarke, who had extensive experience in EI and infant mental health. Guided by the principles of infant mental health and developmental intervention, the Infant Team model does not infuse one approach into the other; rather, the model conceptualizes the fields of early developmental intervention and infant mental health treatment as two equal parts that together create a sum greater than the individual components.

STAFFING

Although the staffing differs by region, typically the Infant Team includes: (a) a director(s) with a background in infant mental health and early intervention who supervises all aspects of the Infant Team, including providing clinical and reflective supervision, (b) a coordinator who is the liaison with Child Protective Services, (c) infant mental health specialists who provide the infant and parent mental health treatment, and (d) EI providers assigned to the Infant Team: a service coordinator, developmental specialist, and occupational therapist or speech and language pathologist. The EI providers have specialized training and reflective supervision focused on trauma-informed care.

REFERRAL TO SERVICE

Referral to the Infant Team starts with the CAPTA referral from Child Protective Services which goes simultaneously to the Infant Team coordinator and to the EI program. The EI developmental evaluation is put on a fast track and is completed by the Infant Team EI staff within 1 to 2 weeks of the referral. By federal guidelines, EI evaluations can take up to 45 days from referral. The shortened time frame for an evaluation responds to the infant’s needs during a stressful period and provides important, timely information to Child Protective Services and the courts during the initial adjudicatory process. Rapid response to the CAPTA referral, prompt development of the IFSP, and immediate initiation of services are critical to address the effects of trauma and essential to trauma-informed EI.

SERVICES OFFERED

The Infant Team provides a braided array of developmental and mental health services including:

- Developmental assessment provided by Infant Team EI providers.
- EI service coordination provided by the Infant Team EI service coordinator, including facilitation of IFSP development with the child protective worker, foster parent(s), biological parent(s), and infant mental health specialist and mid-year/annual IFSP reviews. The service coordinator has an expanded role and is part of the Child Protection and Infant Team meetings, provides input into the monthly court report, and works in tandem with the infant mental health specialist to coordinate developmental services through a trauma-informed lens.
- Parent–child relationship assessment conducted after the EI developmental assessment by Infant Team infant mental health specialists. The assessment includes the Crowell Parent-Child Interaction Procedure (Crowell, Feldman, & Ginsberg, 1988), parent perception and reflective functioning interviews such as the Working Model of the Child Interview (Zeanah & Benoit, 1995), and other protocols (e.g., Traumatic Events Screening Inventory–Parent Report Revised; Gosh-Ippen et al., 2002; and the Neurosequential Model of Therapeutics Metrics; Perry, 2006).
- EI developmental services as outlined in the IFSP are offered by the EI providers and include co-treatment with the infant mental health specialist.
- Parent–child dyadic psychotherapy with the biological parent(s) and child provided by the infant mental health specialist. The IFSP developmental interventions addressing the child’s specific needs are incorporated into the dyadic work with primary caregivers as well as provided in separate sessions with the parent, foster parent, and child.
- Therapeutic supervision of visits may also be included.
- Family Court education and liaison provided by the infant mental health professionals.
specialists; this includes educating the judges about infant’s response to trauma, family risk factors, and the current needs of the particular infant in custody (e.g., relationship and interaction patterns, placement recommendations, visitation arrangements, EI services, and medical condition and medical needs). The team provides regular reports to the court and expert witness testimony on behalf of the infant.

- Infant Team liaison with Child Protective Services: The Infant Team works closely with Child Protective Services on treatment plan development and case coordination. The Infant Team coordinator provides regular and comprehensive reports to Child Protective Services in addition to monthly provider meetings (specific to each case) and ongoing contact about status of each case.

The Infant Team meets twice a month for 3 hours to discuss organizational issues, staff and assign cases, and participate in reflective supervision.

**TWEETY’S STORY**

Tweety was a toddler who came into custody when she was 14 months old. Tweety, a nickname her parents gave her, and her younger sister, who was 4 months old at the time, were removed from their parent’s home because of unexplained injuries to the infant. During the initial investigation, the mother disclosed an extensive history of domestic violence and substance abuse by the children’s father. The girls were placed in kinship foster care.

During initial visits and assessments, Tweety cried, whined, and grunted continuously, looking down or into space but not making eye contact with the staff or either of her parents, who visited separately. She sucked vigorously on a pacifier much of the time and did not respond to most of the attempts that her parents or other caregivers made to soothe, engage, or distract her. She was so distressed that the initial EI developmental evaluation could not take place and was rescheduled for a later time at the foster home. Tweety’s inconsolability and disengagement were difficult for her parents as well as her foster parents and challenged the professionals who attempted to evaluate her. All of the adults—parents, foster parents, grandparents, Infant Team Staff, Child Protective Services staff, Court-appointed Special Advocate workers, and other involved parties—experienced personal activation regarding the children’s situation. Both of these very young girls had experienced trauma in a number of forms and were demonstrating significant signs of distress and dysregulation. How to address and intervene when the adults are also distressed and dysregulated became a focus of the Infant Team staffings for Tweety and her infant sister.

During the EI developmental evaluation, Tweety showed delays in motor, language, and social–emotional and regulatory domains. In the infant mental health interactive evaluation session with her mother, Tweety was not engaged and did not use any language at 17 months old. She did not show particular interest in the toys or activities. She did not look at her mother for much of the procedure, nor did she explore the environment. For most of the session, Tweety was stationary or lay in her mother’s lap. When her mother began to talk to the Infant Team staff about her situation and upcoming court appearance, Tweety became very focused on her mother’s tearful face and sucked more intensely on her pacifier as she continued to watch her mother. The mother was sharing her sorrow and guilt at not protecting her children from the domestic violence and her fear of future repercussions. When the mother occasionally looked down at Tweety, the little girl covered her face with her blanket or looked away.

The Infant Team’s service plan was to integrate social–emotional, relational, and developmental services for Tweety with the therapeutic supervised parent visits and parent–child psychotherapy for Tweety and her caregivers. The services included occupational and speech and language therapy as well as infant mental health. The goals for the work with Tweety’s parents were three-fold: (a) help them to see and to acknowledge their children’s developmental and emotional challenges, (b) explore and manage their own dysregulation and distress in response, and (c) make behavioral changes in their responses to and support of their daughter’s needs. All team members were trained in the advanced Circle of Security or the Circle of Security DVD-P® (2010) and used the terminology and imagery of Circle of Security with the parents to help the parents observe and communicate about their child’s needs.

Developmental and infant mental health goals were integrated into a treatment plan. The occupational therapist worked closely with the speech–language consultant and the infant mental health supervisor to develop strategies that would help both the parent(s) and the child with their arousal system activation, which was interfering with the parent(s) and child’s capacity for mutually responsive and satisfying interactions. The misattunement between the parents and child, in turn, was not supporting Tweety’s developmental progress. The next section outlines the kinds of interventions designed to address Tweety’s trauma-related dysregulation and to promote attuned interactions between the parent(s) and child. These goals and interventions blend developmental, relational, psychotherapeutic, and body-based approaches.

- Provide Tweety with patterned, repetitive somatic activities to entrain more rhythmic regulation. Tweety’s frustration, stress reactivity, inattention, and...
sleep disturbances originate from problems in the brainstem and diencephalon likely due to her ongoing exposure to intense domestic violence and stress. Because cognitive interventions do not change lower areas of the brain, rhythmic interactions through movement and music will provide Tweety with the patterned, repetitive stimulation these brain areas need.

- Tweety may have distorted templates and biases about what nonverbal cues mean. The brain makes new memories only for novel experiences. In order to help Tweety build a sense of safety in her relationship with her father, the team supported her father to create new experiences with Tweety that allowed her to feel safe, confident, and appreciated; build awareness of Tweety’s regulatory and emotional needs; and suggest new shared experiences and support the father with pacing, tone of voice, and sharing in play.

- The most effective communication is synchronous verbal and nonverbal, a combination of words connected to affect and matching actions. When words do not match the facial expression, Tweety will trust the facial expression. When Tweety experiences inconsistency between the words, affect, and the actions, she will feel confused. Help her parents understand how to communicate with their eyes, smiles, touch, voices, and the consistency of their actions.

- Help parents to learn how to narrate their actions and become a “play-by-play” announcer, showing her how to put words to Tweety’s and their own actions, feelings, and thoughts.

- Novelty activates the stress response and because of Tweety’s experiences, even the tiniest little stimulation causes her to have a big reaction. Help her to become less reactive through using smooth movements, clear facial expressions, calm speech, and slow actions to help her to lower her high arousal level.

These intricate interventions are not a simple matter in the best of circumstances and a very complicated order when considering individual histories of trauma and high levels of activation and arousal due to the current traumatic situations (e.g., injuries, removal, court hearings, separations, conflict, and substance abuse and domestic violence issues). For example, the team had a lengthy discussion about Tweety’s constant use of her pacifier and about the strong desire on the part of EI team members to discourage the use of the pacifier in order to promote speech development. During reflective supervision, the team was able to discuss their own “presses” around the use of a pacifier as well as the meaning or need for Tweety to use her pacifier as a regulatory tool at this time.

Both of Tweety’s parents successfully completed their individual court-ordered programs (domestic violence and substance abuse treatment); they each individually completed the Circle of Security DVD Parenting (2010) and repeated it as co-parents. Both Tweety and her younger sister made significant developmental gains in motor, regulatory, and social–emotional domains. Both girls and were reunified with their parents, who agreed upon a co-parenting plan, and the case was deemed a “wonderful success” by the family court judge.

SUCCESS OF THE MODEL

The Infant Team has received positive recommendations from all parties, including the biological parents, guardian ad litem, children’s court attorneys, and Court Appointed Special Advocate. All have stated that since the Infant Team has been involved, the nature of the legal cases has changed and the information regarding the infant’s experience and needs are now brought to the forefront during court hearings. Initial evaluation of the model shows fewer no-shows, more involvement with EI services, and in New Mexico more voluntary relinquishments (vs. court-ordered termination of parental rights). The Children, Youth and Families Department has developed a new database to track outcomes which will help the Infant Teams assess progress and challenges. New Mexico now has Infant Teams in four judicial districts. The Children, Youth and Families Department has developed a new database to track outcomes which will help the Infant Teams assess progress and challenges. New Mexico now has Infant Teams in four judicial districts. The Children, Youth and Families Department has developed a new database to track outcomes which will help the Infant Teams assess progress and challenges. New Mexico now has Infant Teams in four judicial districts.

IMPLEMENTING THE VISION

Both of the Baltimore and New Mexico programs exemplify the vision for a trauma-informed EI system and the promising outcomes achieved. The programs embrace a relationship-based approach to EI and have complemented the developmental expertise of EI with trauma-informed expertise in infant mental health. EI staff receive training in trauma and reflective supervision to support the integration of the new concepts into practice. Community collaborations play a central role in helping families receive the specialized services needed. Clearly, the leadership from the funding agencies is essential in making trauma-informed EI a reality.

Summary and Recommendations

Just as EI has benefited from major paradigm shifts over the years—from child-centered to family-centered, relationship-based practices; from medical models to natural environments—advances in the understanding of trauma compel professionals and policymakers to once again rethink EI policies and practices. This article has proposed a vision for a trauma-informed EI system—building on the federal policies that link the child welfare system to EI and frameworks around trauma-informed systems. The impressive work of the NCTSN in developing resources for trauma-informed systems and the pioneering work of the New Mexico Infant Team and the BITP provide inspiring examples of what is possible for children and families when trauma is assimilated into EI systems. The wealth of science and promising practices can guide the next steps.

Experience from previous paradigm shifts also provides the wisdom to know that system change is not quick, nor easy; that it has to come from top down and bottom up; and that all aspects of the system must share the vision. When a system or program takes the step to become trauma-informed, every component is assessed and potentially modified to include a new trauma lens. At the program level, professionals can begin by simply asking the question: “Have I considered whether trauma has played a role in the child’s development and behavior?”

At the system level, there are also steps that could lead to a more trauma-informed system. Some of these might include:

- NCSTN might develop a work group on trauma and EI, creating a toolkit for a trauma-informed EI system similar to their valuable materials for trauma-informed child welfare systems.
- Council for Exceptional Children Division for Early Childhood might include a trauma perspective in their revision of the Recommended Practices in Early Intervention/Early Childhood Special Education (Sandall, Hemmeter, Smith, & McLean, 2005).
ZERO TO THREE, in partnership with other national organizations, could provide direction for policy action steps for trauma and EI in a document such as the policy recommendations made in A Call to Action on Behalf of Maltreated Infants and Toddlers (American Humane Association, Center for the Study of Social Policy, Child Welfare League of America, Children’s Defense Fund, & ZERO TO THREE, 2011).

The U.S. Department of Education Office of Special Education Programs (the federal agency responsible for Part C), and the U.S. Department of Health and Human Services Administration for Children, Youth and Families (the agency responsible for child welfare policy) might jointly convene key stakeholders from federal and state government, parent advocacy and professional associations, national experts, and interested foundations to identify issues, review relevant data, and identify areas of innovation and joint recommendations for the field related to trauma and EI.

Federal agencies funding trauma-related projects can specifically include Part C EI in their requests for proposals; training and research initiatives funded by the Office of Special Education Programs could include projects related to early childhood trauma.

Part C Statewide Training Systems can offer foundational training in trauma for EI service coordinators and providers; they can develop reflective consultation groups for EI providers facilitated by infant mental health specialists with trauma training.

State Early Intervention Interagency Coordinating Councils can review the vision for Trauma-Informed Part C presented here and begin to assess the needs and opportunities at the local and state levels to move toward a trauma-informed system.

Creating a new vision, a trauma-informed vision, for Part C EI has already begun. Federal legislation, state policies, and program practices are beginning to acknowledge the impact of adverse early experiences, and trauma research. We hope that by sharing examples of what trauma-informed care looks like in practice, and by proposing a trauma-informed framework for Part C EI, this vision will become more of a reality for the many infants and toddlers affected by trauma and who could benefit greatly from EI. The need is compelling; the science irrefutable; and the opportunity is at hand to elevate trauma-informed practices into EI systems.

LINDA GILKERSON, PhD, LSW, professor, Erikson Institute, directs the Irving B. Harris Infant Studies Program, the Infant Mental Health Certificate Program, and is founder and executive director of the Fussy Baby Network®, a national model preventive intervention program. Dr. Gilkerson has served on Illinois’ State Early Intervention Coordinating Council, co-lead a state-wide initiative to add a social-emotional component to the Illinois EI system, and directed multiple federally funded training and research grants related early intervention policy. Dr. Gilkerson is on the Board of Zero to Three.

MIMI GRAHAM, EdD, is director, Florida State University (FSU) Center for Prevention & Early Intervention Policy. Dr. Graham specializes in policy, training, and special projects for vulnerable infants and toddlers including: The Harris Infant Mental Health Training Institute, FSU Early Head Start, The Young Parent Project, Child Welfare Community Collaboration, and the Partner’s For A Healthy Baby Home Visiting Training Institute. Dr. Graham is president of the Florida Association for Infant Mental Health and is spearheading “baby” court teams to address the trauma of young children in the state. She is a fellow of ZERO TO THREE: National Center for Infants, Toddlers, and Families.

DEBORAH HARRIS, MSW, Endorsed Infant Mental Health Mentor, created and directs the First Judicial District Infant Team and trains and consults with the New Mexico Infant Team initiative. Deborah has a master’s degree in social work from the University of California, Berkeley. She trained in infant–parent psychotherapy at the Infant Parent Program, started by Selma Fraiberg. Deborah completed a post-graduate fellowship in family therapy and is certified in the advanced Circle of Security (COS) assessment and treatment protocol and is an Endorsed COS DVD trainer and consultant. Deborah has completed the 3-year Train the Trainers Neurosequential Model of Therapeutics developed by Dr. Bruce Perry. She is a graduate Fellow of the ZERO TO THREE Leadership Development Initiative. She is endorsed through the New Mexico Association for Infant Mental Health as a level 4 Infant mental health mentor and practice leader.

CINDY OSER, RN, MS, is director of Infant-Early Childhood Mental Health Strategy, ZERO TO THREE Policy Center. Ms. Oser has more than 30 years of experience in pediatric nursing, public health, early intervention for infants and toddlers with disabilities, and early childhood policy. She has been with ZERO TO THREE since 1998 and currently staffs the DC:0–3R Revision Task Force as well as providing technical assistance to state early childhood systems. She is the author of many publications, including America’s Babies: The ZERO TO THREE Policy Center Data Book (2003), Making It Happen: Overcoming Barriers to Providing Infant-Early Childhood Mental Health (2012) and most recently, Nurturing Change: State Strategies for Improving Infant and Early Childhood Mental Health (2013). Ms. Oser also served on the national board of the Division for Early Childhood (DEC), Council for Exceptional Children, from 2008–2011, and she continues to lead the DEC Policy Special Interest Group (SIG).

JANE CLARKE, PhD, is the co-director of the First Judicial District Infant Team. Jane has a master’s in speech/language pathology and a doctorate in special education specializing in early childhood language/learning disabilities. She has done post-graduate work at Fielding University and at the University of Massachusetts in Infant Mental Health with Dr. Ed Tronick as mentor, and is a trainer of the Bruce Perry Neurosequential Model of Therapeutics.

TODY C. HAIRSTON-FULLER, MS, coordinator of evaluation and assessment, Baltimore City Infants and Toddlers Program, has more than 20 years of experience in early intervention. She received her certification in early childhood mental health from the University of Maryland’s Department of Child and Adolescent Psychiatry and currently directs the mental health component for the local Part C Program.

JESSICA LERTORA, MSW, LCSW-C, is the associate director and lead clinician for the Taghi Modarresi Center for Infant Study (CIS); Secure Starts program. Over the past 8 years she has been providing early childhood mental health therapeutic and consultation services to families with infants, toddlers, and preschoolers in Head Start, Early Head Start, Part C and outpatient clinical settings specializing in trauma and grief and loss. Jessica is a National Endorsed Trainer for Child Parent Psychotherapy and has completed training as a Parent Coach for the Attachment, Bio-BehavioralCatch-Up model.
References


CASE EXAMPLE (Introduction):

Heather is the clinician for Sam, a five-year-old girl who, with her sister, was placed in foster care one year ago because of the severe abuse and neglect they suffered in the care of their biological parents. Due to extreme behavioral issues, Sam and her sister have had five placements. Heather began seeing Sam when she arrived at her current foster home and now has been subpoenaed to testify at a hearing to discuss a permanency plan. The attorney representing the child welfare agency told Heather that she would ask about Sam’s diagnosis, her trauma exposure, the effect of the trauma on Sam, and Heather’s recommendations regarding the child’s needs in terms of placement and permanency.

Heather, although nervous about testifying, feels confident that she has reviewed the case, has some idea of what she will be asked in court, and has met with her supervisor Josh on several occasions. Josh, who has testified in court many times, reminded her that testifying will be a chance for Heather to educate the court on Sam’s traumatic events and their effects and how Sam exhibits common traits seen in children who have suffered from early childhood traumatic experiences. Josh also encouraged Heather to engage in self-care activities to help manage her stress level through the court process.

WHAT TO EXPECT IN COURT

Despite all the unknowns of a court hearing, the process of testifying follows a predictable, predetermined path. Just as we prepare our clients for a court hearing, preparing yourself by knowing what to expect can help you feel more confident in your testimony and ease anxiety.

“Testifying in court can be a difficult and stressful experience for clinicians. But judges and lawyers are not experts in child development or the impact of trauma on children. The knowledge clinicians bring to bear is essential if the legal system is to have any hope of making sound decisions that will serve children’s interests. By educating the court through testifying, clinicians provide an invaluable service to the legal system and, most importantly, to children.”

Frank E. Vandervort
Clinical Professor of Law
University of Michigan Law School
1. **Direct examination**: The attorney who called you as a witness questions you. Generally, you will be asked first about your qualifications, education, and work history and second about your client and your treatment. You then may be asked to give recommendations or opinions based on your professional knowledge and treatment of the client. The attorney will ask open-ended questions and ask you to elaborate on your responses.

2. **Cross-examination**: The opposing attorney will ask you questions designed to bring out points in your testimony that may be favorable to his or her client’s case or that may appear contradictory. These questions typically will be short, closed-ended questions requiring a “yes” or “no” answer.

3. **Objections**: Sometimes an attorney will interrupt a question by saying, “Objection.” If this happens, stop talking. If the judge sustains (approves) the objection, you should not answer the question. If the judge overrules (denies) the objection, you will be asked to answer the question.

4. **Examination by the judge**: At any point in the proceeding, the judge may question you.

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**Self-Care Tips for Managing Anxiety during the Hearing**

- Be prepared to wait; expect frequent delays in court. Bring an activity (e.g., a book, knitting, crossword puzzles) to occupy you while you wait your turn on the witness stand.

- Remember to breathe! This can decrease your anxiety, give you an opportunity to pace the question and answer process, and permit you to pause and think before you respond.

- Use relaxation strategies (e.g., muscle relaxation, grounding techniques) or positive affirmations to stay calm and focused when you are on the witness stand.

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After cross-examination, the attorney who originally called a witness has two options: (a) to “redirect” the witness’ testimony by asking follow-up questions to further develop or clarify a certain point, or (b) to decide the concerns raised during the cross-examination were not significant to warrant further questioning. The latter may leave the witness feeling frustrated or misunderstood; however, the attorney’s decision is not a reflection of the content or value of the witness’ testimony, but rather a judgment based on legal strategy.
TYPES OF CASES

The following are four types of cases in which clinicians may be asked to testify about the impact of trauma on children.

Criminal

A criminal case involves the charging and prosecution of an individual for actions that violate state or federal law (e.g., child abuse or maltreatment, child sex trafficking)—a “crime.” There are two named parties to the case: the defendant and the state (or US), which is represented by the prosecution. In criminal trials, clinicians may be called to testify as a fact or expert witness about the child victim of the accused. At trial, this testimony may be used to determine whether a crime took place. During sentencing, this testimony may be used to influence the defendant’s sentencing (See below for more information about types of witnesses.).

Delinquency

A delinquency case is the charging of a juvenile for a delinquent act (behavior by a minor that would be criminally punishable if committed by an adult) or status offense (an act that is only illegal if committed by a juvenile and not an adult, such as truancy or running away). Youth tried in the juvenile delinquency court are treated differently than adults in the criminal court, as juvenile court is intended to provide rehabilitation for offenders, while adult criminal court is intended to provide sentencing. The parties involved in a delinquency case are the juvenile defendant and the prosecution.

In delinquency cases, clinicians may be called to testify on behalf of a juvenile victim or a juvenile offender. Testifying for the victim will be similar to testifying for a victim in the adult criminal court. However, a clinician may also testify for the juvenile offender by offering insight into his or her past mental, physical, and behavioral histories, providing context for the juvenile’s action. Fact and expert witness testimony may be used in either of the two phases of a delinquency case: adjudication and disposition. During an adjudication hearing, the judge or jury will determine the culpability of the defendant; while the disposition hearing determines how the youth will be sentenced (i.e., treatment, training, or services.)

Dependency

A dependency, or child welfare, case is a proceeding that addresses alleged neglect or inadequate care by parents or guardians of the children in their charge. Although parental abuse and neglect may be severe enough to warrant the filing of separate criminal charges, a dependency case is NOT a criminal case. The parents and the child welfare agency are parties to the case. Children may also be parties, depending on the jurisdiction, and may also be represented by an attorney, who advocates for the wishes of the child, or a guardian ad litem, who advocates for the best interests of the child. Clinicians may be called by any of these parties to support that party’s position (e.g., removal of the child, return of custody, permanency placement). Clinicians will be called to give their opinion of the child’s social-emotional, mental, and behavioral well-being.
**Family Law**

*Family law* cases involve a wide range of issues relating to marriage, divorce, and the care of children, including custody, guardianship, and adoption. A *custody* case is a proceeding that determines the legal and physical custody of a child. *Guardianship* grants a non-parent physical custody as well as the power to make significant decisions about the child’s upbringing. *Adoption* is a judicial order that creates a legal parent-child relationship. In any of these cases, there may be only one party, e.g., the person seeking uncontested adoption, or there may be multiple parties, e.g., parents or other relatives contesting the custody or adoption of a child. Sometimes the child has his or her own legal representative, such as a guardian *ad litem*. In all of these cases, the judge must determine which placement and custody arrangement is in the best interests of the child. Parties will often call clinicians as fact or expert witnesses to inform the court’s decision.

**TYPES OF WITNESSES**

A clinician’s testimony may be used either as an “expert witness” or a “fact witness.” The following describes these different roles:

**Expert Witness**

An *expert* witness is an individual qualified by knowledge, skill, experience, or training to provide a scientific or other specialized opinion about evidence that is beyond the common knowledge of the jury. The expert witness provides clarifying information for the judge or jury on a substantive topic area. The expert witness gives testimony based on facts and materials provided to him or her by one of the parties to the case, and she or he is not required to meet with or evaluate the client. Examples of expert testimony are information on child development, childhood traumatic stress, and the behavioral characteristics of abused children. Expert witnesses must be qualified by the judge in order to testify in this role, but the rules for qualifying as an expert witness vary by jurisdiction.

**Fact Witness**

More often, a clinician will be called to testify as a *fact* witness (also known as a lay witness) whose testimony is restricted to providing information based on his or her firsthand knowledge or observations, rather than providing expert testimony on a particular subject. This opinion is based on his/her “rational perceptions.” While a clinician has specialized training that makes him or her an expert in the field, this differs from an expert witness who must be qualified by the court. The court may ask the clinician as a fact witness to give his or her professional opinion of the client, but it is still based on firsthand knowledge and facts gathered during interactions with the client. For example, a clinician testifying as a fact witness may be asked to speak about a client’s attendance, the assessments conducted, or treatment goals. Interpretation and opinion related to a client’s treatment needs and progress may be included in this testimony. As a fact witness, the clinician can only speak about his or her client, and cannot extrapolate as to other parties to the case with whom he or she has not interacted. The determination between fact versus expert witness may vary based on jurisdiction. Be sure you understand the requirements for the jurisdiction in which your testimony will be used. It is also possible that a judge may decide on his or her own to qualify you as an expert during your testimony, allowing you to testify as an expert witness.
TESTIFYING EFFECTIVELY

To testify successfully, simply convey information as you would in your practice as a clinician and in your personal life: use a confident, firm, controlled, and calm, yet alert demeanor.

1. Maintain a respectful attitude. Avoid speaking at the same time as others.

2. Listen carefully to the question asked. Make sure you understand each part of the question. Ask for clarification or for the question to be repeated, if you do not fully understand.

3. When you answer, speak directly to the judge or to the jury (in a jury trial), not to the person who asked the question. The judge and jury are the ones who need to understand your responses.

4. Speak slowly and thoughtfully. Answer only the question asked. Do not volunteer extra information. Provide short, succinct answers; answer “yes” or “no” if possible. If you must explain your answer, or cannot answer “yes” or “no,” be brief.

5. Be prepared to answer questions about the number of times you interacted with the child/family, length of service, treatment methods, your clinical qualifications and training. (For more information on how to prepare, see Tip Sheet on How to Prepare for Court.)

6. Respond directly and honestly to the questions asked of you.

7. Do not add comments or opinions.

8. Limit your testimony to what you know, and do not guess or speculate.

9. Do not allow yourself to become defensive or argumentative when being questioned.

Your Rights as a Witness

- You have the right to ask for a glass of water, to go to the bathroom, to consider a question or request, to have the question repeated, or to speak to the attorney who has called you to court.

- You have the right to look at a document (including your own reports) to which the attorneys or judge are referring while you are a witness.

- You have the right to say that you cannot give an opinion, because you do not have the necessary data. If you do not know the answer to a question or feel that you are asked something that is out of the scope of your knowledge or expertise, say so.

Trauma Talking Points

You will want to be prepared to define, discuss, give examples, and explain how the following apply to your client:

- Types of trauma (physical and psychological)

- Acute, chronic, and complex trauma and how the appropriate type applies to your client’s experience

- DSM criteria for PTSD, depression, and other trauma-related diagnoses, and methods used to diagnose and monitor the client’s symptoms, including results of standardized measures pre- and post-treatment for your client
- Trauma stress reactions and their role in the client’s life
- Impact of trauma on the child’s social development and ability to form healthy, secure relationships
- “Evidence-Based Practice” and supporting research for selected interventions
- Trauma-specific treatment provided and what that treatment addresses
- Client’s progress with the selected treatment model
- Caregiver involvement in treatment, impact on the client of the caregiver’s willingness and ability to participate in treatment

### Behaviors and Symptoms Commonly Explained in Testimony

The following chart lists behaviors demonstrated by children with traumatic stress. Note that this is not an exhaustive list, nor do traumatized children fit neatly into these descriptions. They may display more than one behavior.

<table>
<thead>
<tr>
<th>Behaviors Displayed</th>
<th>Possible Contributing Factors from a Trauma Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger, irritability, defiance, oppositionality with authority</td>
<td>Emotional/mood dysregulation (depression/anxiety), hyperarousal, survival strategies, getting needs met</td>
</tr>
<tr>
<td>Lying or profound distrust of authority</td>
<td>Negative beliefs about self, caregivers and world view based on traumatic experience</td>
</tr>
<tr>
<td>Running away</td>
<td>Survival (fight/flight), hypervigilance, hyperarousal</td>
</tr>
<tr>
<td>High risk behavior (e.g., substance use, promiscuity, rule breaking, self-mutilation)</td>
<td>Pain numbing, attempts to increase sense of power, control, and self-worth</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>Impact on brain development, hyperarousal (fight/flight response)</td>
</tr>
<tr>
<td>Difficulty falling asleep or staying asleep</td>
<td>Re-experiencing, hyperarousal</td>
</tr>
<tr>
<td>Distractibility, difficulty following through with tasks, poor concentration, daydreaming</td>
<td>Difficulty regulating attention and cognition (problem solving), re-experiencing, hyperarousal, dissociation (pre frontal cortex “off line”)</td>
</tr>
<tr>
<td>Denying experiences of harm/trauma, avoiding talking about history</td>
<td>Primary symptom of trauma (avoidance); strategy for managing overwhelming emotions</td>
</tr>
<tr>
<td>Avoiding activities, isolating from others</td>
<td>Poor self-concept, anxiety and/or depression</td>
</tr>
</tbody>
</table>
CASE EXAMPLE (conclusion)

Heather initially felt uncertain and unsure of herself when she got on the stand, but was able to breathe, manage her anxiety, and focus herself. Because Cindy, the attorney representing the child welfare agency, asked the questions she said she would, Heather felt prepared with good answers. After Heather testified, she experienced a common reaction—relief—but with some uncertainty about her testimony. She felt slightly anxious about whether her testimony was ultimately helpful to Sam and concerned about how the information she presented in her testimony would be interpreted. She felt slightly better after Cindy, the attorney representing the child welfare agency, thanked her and talked to her about the hearing. Cindy pointed out that her testimony was helpful in explaining to the court that Sam’s behaviors were common to children that are abused and helped the court understand the dynamics of trauma and abuse and the purpose of Heather’s treatment. Heather decided to take her supervisor’s advice and take care of herself by watching a funny movie after she got home.

Prior to the Day of the Hearing

- Call the attorney who subpoenaed you to make sure the hearing is scheduled and that you are still expected to appear.
- Find out the name of the judge and the courtroom where the hearing will take place.
- Make sure you have the phone number of the attorney or the court in case of an emergency on the day of the hearing.
- Make sure the Court has your contact information in case there are changes in the schedule.
- Engage in self-care activities and arrive rested.
- Check in with the attorney or wait outside the courtroom until you are called in. Do not discuss your information with other witnesses.
NEW MEXICO INFANT TEAM FORMS
New Mexico Infant Team uses specific forms for data documentation and evaluation of progress. Examples of forms to use for intake, assessment, treatment, progress and discharge are shown on the following pages.
# Referring Source

Person making referral: ___________________________  Position: ___________________________  Date of referral: __/__/____

Phone: ___________________________  Ext: ___________________________  Note/Remarks: ___________________________

# Client and Foster Parent Information

Child(1) First Name: ___________________  Last: ___________________  M.I.: ___________________  DOB: ____/____/____  SS#: ______________________

Child(2) First Name: ___________________  Last: ___________________  M.I.: ___________________  DOB: ____/____/____  SS#: ______________________

Child(3) First Name: ___________________  Last: ___________________  M.I.: ___________________  DOB: ____/____/____  SS#: ______________________

Child(4) First Name: ___________________  Last: ___________________  M.I.: ___________________  DOB: ____/____/____  SS#: ______________________

Foster Parent(s) Name (current placement): ___________________________  Relationship to child: ___________________________

Foster Parent(s) Address: ___________________________  Phone/Cell: ___________________________

# Biological Parent / Adoptive Parent / Legal Guardian Information

1. BP/AP/LG Name: ___________________________  Relationship to child: ___________________________
   Address: ___________________________  Phone(s): ___________________________

2. BP/AP/LG Name: ___________________________  Relationship to child: ___________________________
   Address: ___________________________  Phone(s): ___________________________

3. BP/AP/LG Name: ___________________________  Relationship to child: ___________________________
   Address: ___________________________  Phone(s): ___________________________

Are translation services needed?  No  Yes: ___________________________

Are there any specific cultural needs (such as cultural connections or resources, hearing, vision, developmental, disability, or other considerations)?

# Legal Information

Guardian ad Litem: ___________________________  Phone: ___________________________

Respondent Attorney for Parent #1: ___________________________  Phone: ___________________________

Respondent Attorney for Parent #2: ___________________________  Phone: ___________________________

Respondent Attorney for Parent #3: ___________________________  Phone: ___________________________

Are there Orders of Protection / Restraining Orders in place?  No  Yes - Describe: ___________________________

Are there other Legal or Safety Considerations?  No  Yes - Describe: ___________________________

# CPS Actions

What are the initial family safety concerns and current risk factors / reason for CPS involvement?: ___________________________

Date of 10-day Custody Mediation: ____/____/____  Date of 10-day Custody Hearing: ____/____/____  Judge: ___________________________

Affidavit Attached to Referral?:  Yes  No  Ex Parte Custody Order Attached to Referral?:  Yes  No

What is the Current Permanency Plan: ___________________________
New Mexico Infant Mental Health Teams

RELEASE OF PROTECTED HEALTH INFORMATION (R.O.I.)

<table>
<thead>
<tr>
<th>CLIENT/PARENT NAME</th>
<th>D.O.B.</th>
<th>CLIENT #</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS:</td>
<td>PHONE:</td>
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<tbody>
<tr>
<td>ADDRESS:</td>
<td>PHONE:</td>
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LEGAL GUARDIAN (if client is under age 18 or has a legal trustee):

I __________________________ hereby authorize the Gila Regional Medical Center Infant Mental Health Court Team, Brian Reeves, MA, LPCC and Adriana Bowen, MA, LMHC

☐ to release information to (as specified below): ☐ to obtain information from (as specified below):

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

(Name and address of individual, agency or organization sending/receiving information)

Specific information client authorizes to be released:

☐ CYFD Service Planning Records ☐ Clinical Intake and Assessments/Assessment Scales/Inventories
☐ Treatment Plan/Updates ☐ Progress Notes ☐ Crisis Plan ☐ Psychological /Psychiatric Evaluations
☐ Court Reports/Documents ☐ Medication Record ☐ Discharge Plan/Summary ☐ CASA Reports
☐ Developmental Evaluations and Service Plans ☐ Other:________________________
☐ Other:____________________

For the following specific purpose(s):

☐ Infant Mental Health Court Team Intake, Service planning and Treatment provision.
☐ Other purpose:

I understand that:

a. This authorization is voluntary and I may refuse to sign it without affecting my health care or eligibility for current services, or that of my child.

b. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).

c. This authorization may also include disclosure of alcohol and/or drug abuse information which is protected by provisions in the Code of Federal Regulations (42 CFR, part 2) and may also include disclose of HIV Test results which are protected by provisions set forth in New Mexico House Bill Chapter 227 “Human Immunodeficiency Virus Test Act” of 1989. This authorization may include any or all mental health records.

d. Unless withdrawn by me, this consent will expire in one hundred and eighty (180) days from the date shown below. I understand that I may withdraw this consent at any time by giving written notice to Gila Regional Medical Center Infant Mental Health Court Team, Brian Reeves, MA, LPCC or Adriana Bowen, MA, LMHC unless action has already been taken on the consent to release or obtain information. I release the releasing party from liability and claims of any nature pertaining to the disclosure of requested information in my medical record.

<table>
<thead>
<tr>
<th>Client</th>
<th>Date</th>
<th>Parent/Guardian (for youth &lt;18)</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Client</td>
<td>Date</td>
<td>Parent/Guardian (for youth &lt;18)</td>
<td>Date</td>
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</tbody>
</table>

NOTICE TO THE RECIPIENT OF CLIENT RECORDS AND INFORMATION:

Information pursuant to this authorization has been disclosed to you from records which may be protected by Federal confidentiality rules (42CFR Part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient.
# New Mexico Infant Mental Health Teams

**CHART CONTENTS**

[ ☑ Indicates required documentation - ✓ when completed ]

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<td>☑ Consent to Services</td>
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<td>☑ Notice of Privacy Practices</td>
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Faxes / Communications / Letters
Other: ____________________________
Other: ____________________________

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<tr>
<th>Section 2 - CYFD-PS and JD6 COURT ORDERS</th>
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<td>☑ CYFD Affidavit</td>
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<td>☑ CYFD ex Parte Custody Order</td>
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<td>☑ Court Order Appointing CASA Worker</td>
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<td>☑ CYFD Treatment Plan</td>
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<td>☑ Court Orders – 10 Day, Adjudications, Reviews</td>
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<tr>
<td>Other CYFD/JD6 Document: ____________________________</td>
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<td>☑ SED Screen</td>
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<td>☑ MHSF-III</td>
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<td>☑ PC-PTSD Screen</td>
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<td>☑ SSI-SA Screen</td>
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<td>☑ WAST</td>
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<td>Other Screen: ____________________________</td>
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<th>Section 4 - ASSESSMENT and EVALUATION</th>
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<td>☑ Parent Perception of the Child Interview</td>
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<tr>
<td>☑ Crowell / Baby Crowell (&lt;12 mo.)</td>
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<tr>
<td>☑ NCAST Feeding and/or Teaching Scale (&lt;6 mo.)</td>
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<tr>
<td>☑ ASQ-3 ☑ ASQ-SE</td>
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<tr>
<td>Psychiatric / Medication Evaluation</td>
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<td>Psychological / Neuropsychological Evaluation</td>
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<td>Adult Medical Reports / Evaluations</td>
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<td>Pediatric Medical Reports / Evaluations</td>
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<td>Other Evaluation or Assessment: ____________________________</td>
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<td>Other Evaluation or Assessment: ____________________________</td>
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<td>Psychosocial Assessment: ____________________________</td>
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<thead>
<tr>
<th>Section 5 - TREATMENT PLANS and SERVICE NOTES</th>
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<tr>
<td>☑ Service/Progress Notes</td>
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<tr>
<td>☑ Team meeting Notes / Sign-ins</td>
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<tr>
<td>☑ Treatment Plans</td>
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<td>☑ Discharge Plans</td>
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<th>Section 7 - FOSTER PARENTS</th>
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<td>☑ Parent Perception of the Child Interview</td>
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<td>☑ Crowell / Baby Crowell</td>
<td></td>
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<tr>
<td>☑ Consent to Videotape – Dates: ____________________________</td>
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<th>Section 8 - COURT and STATUS REPORTS</th>
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<td>☑ Court Reports</td>
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<td>☑ Provider Status Reports</td>
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<tr>
<td>Other Report / Update: ____________________________</td>
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New Mexico Infant Mental Health Teams

INFANT MENTAL HEALTH INTAKE

<table>
<thead>
<tr>
<th>DATE OF INTAKE:</th>
<th>/ / PERSON(S) COMPLETING INTAKE:</th>
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<tbody>
<tr>
<td>NAME OF CHILD (1):</td>
<td>FIRST:</td>
</tr>
<tr>
<td>NAME OF CHILD (2):</td>
<td>FIRST:</td>
</tr>
<tr>
<td>NAME OF CHILD (3):</td>
<td>FIRST:</td>
</tr>
<tr>
<td>NAME OF CHILD (4):</td>
<td>FIRST:</td>
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<tr>
<td>CURRENT PRIMARY CAREGIVER(s) (FOSTER):</td>
<td>RELATIONSHIP TO CHILD:</td>
</tr>
<tr>
<td>GUARDIAN AD LITEM NAME AND PHONE:</td>
<td>CASA VOLUNTEER NAME AND PHONE:</td>
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<tr>
<td>PRIOR TO CPS CUSTODY, THE CHILD WAS LIVING WITH:</td>
<td>BOTH BIOLOGICAL PARENTS</td>
</tr>
<tr>
<td>PARENT(S) IS/ARE:</td>
<td>MARRIED</td>
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<tr>
<td>MOTHER/GUARDIAN A:</td>
<td>DOB:</td>
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<tr>
<td>HOME PHONE:</td>
<td>CELL PHONE:</td>
</tr>
<tr>
<td>HOUSEHOLD COMPOSITION:</td>
<td>NAME, AGE, RELATIONSHIP:</td>
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<td>NAME, AGE, RELATIONSHIP:</td>
<td>NAME, AGE, RELATIONSHIP:</td>
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<tr>
<td>MOTHER’S EMERGENCY CONTACT INFORMATION</td>
<td>(NAME, RELATIONSHIP, PHONE(S):)</td>
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<tr>
<td>MOTHER’S HEALTH-RELATED CONDITIONS, ALLERGIES, MEDICATIONS:</td>
<td>PRIMARY CARE PHYSICIAN/PHONE:</td>
</tr>
<tr>
<td>MOTHER’S CURRENT OR PENDING LEGAL ISSUES (COURT CASES, ARRESTS, INCARCERATIONS, JPO, CPS, DWI):</td>
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<tr>
<td>FATHER/GUARDIAN B:</td>
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<td>HOME PHONE:</td>
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<td>NAME, AGE, RELATIONSHIP:</td>
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<tr>
<td>FATHER’S EMERGENCY CONTACT INFORMATION</td>
<td>(NAME, RELATIONSHIP, PHONE(S):)</td>
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<td>FATHER’S HEALTH-RELATED CONDITIONS, ALLERGIES, MEDICATIONS:</td>
<td>PRIMARY CARE PHYSICIAN/PHONE:</td>
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<td>FATHER’S CURRENT OR PENDING LEGAL ISSUES (COURT CASES, ARRESTS, INCARCERATIONS, JPO, CPS, DWI):</td>
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</table>

GRMC-INTAKE 5/27/14

NAME OF CHILD/REN & DSOB:
Notice of Privacy Practices

This notice describes how personal health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

As therapist with Gila Regional Medical Center’s Infant Mental Health Court Team, we respect confidentiality and only release personal health information about you in accordance with the New Mexico state and local laws and federal HIPAA policies.

Uses and disclosure of protected health information

In order to effectively provide you care, there are times when we will need to share your personal health information with others. This includes for:

- Treatment: With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others in a consultation setting or potential referral sources.
- Payment: Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company to verify insurance coverage and/or benefits, to process claims and for billing and collection services.
- Healthcare Operations: We may use or disclose, if necessary, information about you in order to coordinate treatment procedures and conduct business activities. Information may be used for certification, compliance, and licensing activities.

Information disclosed without your consent

Under New Mexico and federal law, information about you may be disclosed without your consent in the following circumstances:

- Emergencies: Sufficient information may be shared to address an immediate emergency where the client is unable to give permission to release appropriate information.
- As Required by Law: This would include situations where we have received a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.
- Governmental Requirements: We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure.
- Criminal Activity or Danger to Others: If a crime is committed on our premises or against a staff member, we will share information with law enforcement, as requested. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may occur to someone.
- Research: We may disclose your health information to researchers if you have agreed to participate in a research study and have consented to that study.

Participant rights

You have the following rights under New Mexico and federal law:

- Copy of Record: You are entitled to inspect and obtain a copy of your clinical record. This request must be submitted in writing, and we may charge a reasonable fee for supplies, copying and mailing your record.
This Comprehensive Assessment and Recommendations report is based upon the following individual evaluations, assessments and interviews conducted between (client) and (provider):

___Infant Mental Health Intake and Screening Instruments
   ___Intake
   ___Adverse Childhood Experiences Screen (ACEs)
   ___Beck Depression Inventory (BDI)
   ___Primary Care PTSD Screen (PC-PTSD)
   ___Woman Abuse Screening Tool (WAST)
   ___Child Serious Emotional Disturbance Checklist (SED Checklist)
   ___Simple Screening Instrument for Substance Abuse (SSI-SA)
   ___Mental Health Screening Form (MHSF-III)
   ___Ages and Stages Questionnaire-3 (ASQ-3)
   ___Ages and Stages Questionnaire – Social Emotional (ASQ-SE)
___Parent Perception of the Child Interview (WM)
___Circle of Security® Interview (COSI)
___Crowell Caregiver-Child Interaction Procedure
___Baby Crowell Caregiver-Child Interaction Procedure
___Strange Situation Procedure, Modified (SSP,M)
___NCAST Teaching Scale
**CONSENT TO VIDEOTAPE**

<table>
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<tr>
<th>DATE OF CONSENT:</th>
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<th>PERSON(S) COMPLETING CONSENT:</th>
<th>CLIENT #</th>
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<th>CLIENT(S) NAME(S)</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>DATE OF BIRTH</th>
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<td>LAST FIRST M.I.</td>
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<tr>
<td>1. CHILD:</td>
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<td>2. PARENT/GUARDIAN:</td>
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<td>2. PARENT/GUARDIAN:</td>
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</table>

I, ______________________________________, understand that this:  
Assessment:________________________________________
Evaluation:________________________________________
Treatment:________________________________________

session will be videotaped and is therefore not confidential. I understand that this videotape will provide personal information about my life to the examiner. I may be asked about my relationship to my child, as explained to me by the evaluator. I give permission to release the content of this video for educational purposes. This video recording may be used for training purposes.

You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office and requesting that the revision be sent to you in the mail or by asking for one at the time of your next appointment.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**CONSENT TO VIDEOTAPE**

1. The information above has been reviewed with me: Yes No

2. I give permission to release the content of this video for educational and training purposes: Yes No

Client: __________________________ Date: ________________

Client: __________________________ Date: ________________

**PROVIDER SIGNATURE:**

**LICENSE #:**

**DATE:**
Primary Care PTSD Screen (PC-PTSD)
Prins, Ouimette, & Kimerling, 2003

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?  
   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?  
   YES / NO

3. Were constantly on guard, watchful, or easily startled?  
   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?  
   YES / NO

Scoring and Comments:

In most circumstances the results of the PC-PTSD Screen should be considered positive if a patient answers “yes” to any 3 items. Positive screens should be assessed with a structured interview for PTSD.

Score:_______

Clinician comments:____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Clinician Signature:_________________________ Date:_________________________
New Mexico Infant Mental Health Teams

Simple Screening Instrument for Substance Abuse (SSI-SA)
Published by S.A.M.H.S.A. / CENTER FOR SUBSTANCE ABUSE TREATMENT

## During the last 6 months:

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, marijuana, methamphetamine, cocaine, heroin or other opiates, uppers, downers, hallucinogens, or inhalants.)
   *For example, have you:
   - Had blackouts or other periods of memory loss?
   - Injured your head after drinking or using drugs?
   - Had convulsions or delirium tremens (“DTs”)?
   - Had hepatitis or other liver problems?
   - Felt sick, shaky, or depressed when you stopped using or drinking?
   - Felt a crawling or itching feeling under the skin during or after drug use?
   - Been injured after drinking or using?
   - Used needles to shoot drugs?

2. Have you felt that you use too much alcohol or other drugs?
   - Yes
   - No

3. Have you tried to cut down or quit drinking or using alcohol or other drugs?
   - Yes
   - No

4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors or a treatment program.)
   - Yes
   - No

5. Have you had any health problems? (Check √ all that apply.)
   - Yes
   - No

## The next questions are about your lifetime experiences:

6. Has drinking or other drug use caused problems between you and your family or friends?
   - Yes
   - No

7. Has your drinking or other drug use caused problems at school or at work?
   - Yes
   - No

8. Have you been arrested or had other legal problems? (Bouncing bad checks, DUI, theft, or drug possession.)
   - Yes
   - No

9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?
   - Yes
   - No

10. Do you need to drink or use drugs more and more to get the effect you want?
    - Yes
    - No

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?
    - Yes
    - No

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?
    - Yes
    - No

13. Do you feel bad or guilty about your drinking or drug use?
    - Yes
    - No

### For Office Use Only:

Questions 1 and 15 are not scored. For the remaining questions, score 1 for each Yes and 0 for each No.

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**Total Score:**

### Preliminary Interpretation of Results

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<tr>
<th>Score</th>
<th>Degree of Risk for Alcohol or Other Drug Abuse</th>
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<tbody>
<tr>
<td>0 – 1</td>
<td>None to Low</td>
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<tr>
<td>2-3</td>
<td>Minimal</td>
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<tr>
<td>≥ 4</td>
<td>Moderate to High: Possible need for further assessment</td>
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**Clinician Comments:**

**Clinician Signature:**

**Date of Scoring:**

196
While you were growing up, during your first 18 years of life:

<table>
<thead>
<tr>
<th></th>
<th>Score 1 for Yes, 0 for No</th>
<th>Child/ren</th>
<th>Parents/Gs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Recurrent Emotional Abuse</strong></td>
<td>Did a parent or other adult in the household often or very often: Swear at you, insult you, put you down, or humiliate you? Or, act in a way that made you afraid that you might be physically hurt?</td>
<td>c1 c2 c3 c4 p1 p2</td>
<td></td>
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<tr>
<td>2. <strong>Recurrent Physical Abuse</strong></td>
<td>Did a parent or other adult in the household often or very often… Push, grab, slap or throw something at you? Or, ever hit you so hard that you had marks or were injured?</td>
<td>c1 c2 c3 c4 p1 p2</td>
<td></td>
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<tr>
<td>3. <strong>Contact Sexual Abuse</strong></td>
<td>Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? Or, attempt or actually have oral, anal, or vaginal intercourse with you?</td>
<td>c1 c2 c3 c4 p1 p2</td>
<td></td>
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<tr>
<td>4. <strong>Emotional Neglect</strong></td>
<td>Did you often or very often feel that … No one in your family loved you or thought you were important or special? Or, your family didn’t look out for each other, feel close to each other, or support each other?</td>
<td>c1 c2 c3 c4 p1 p2</td>
<td></td>
</tr>
<tr>
<td>5. <strong>Physical Neglect</strong></td>
<td>Did you often or very often feel that … You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? Or, your parents were too drunk or high to take care of you or take you to the doctor if you needed it?</td>
<td>c1 c2 c3 c4 p1 p2</td>
<td></td>
</tr>
<tr>
<td>6. <strong>One or No Parent</strong></td>
<td>Were your parents ever separated or divorced?</td>
<td>c1 c2 c3 c4 p1 p2</td>
<td></td>
</tr>
<tr>
<td>7. <strong>Mother is Treated Violently</strong></td>
<td>Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or, sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or, ever repeatedly hit at least a few minutes or threatened with a gun or knife?</td>
<td>c1 c2 c3 c4 p1 p2</td>
<td></td>
</tr>
<tr>
<td>8. <strong>An Alcoholic and/or Drug Abuser in the Household</strong></td>
<td>Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?</td>
<td>c1 c2 c3 c4 p1 p2</td>
<td></td>
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<tr>
<td>9. <strong>Someone who is Chronically Depressed. Mentally Ill. Institutionalized, or Suicidal</strong></td>
<td>Was a household member depressed or mentally ill, or did a household member attempt suicide?</td>
<td>c1 c2 c3 c4 p1 p2</td>
<td></td>
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<tr>
<td>10. <strong>An Incarcerated Household Member</strong></td>
<td>Did a household member go to prison?</td>
<td>c1 c2 c3 c4 p1 p2</td>
<td></td>
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</tbody>
</table>

ACE SCORES: __________________________

CLINICIAN: ____________________________ DATE OF SCORING: ________________
New Mexico Infant Mental Health Teams

Woman Abuse Screening Tool (WAST)
(To be used for both women and men)

1. In general, how would you describe your relationship?
   - A lot of tension
   - Some tension
   - No tension

2. Do you and your partner work out arguments with:
   - Great difficulty
   - Some difficulty
   - No difficulty

3. Do arguments ever result in you feeling down or bad about yourself?
   - Often
   - Sometimes
   - Never

4. Do arguments ever result in hitting, kicking, or pushing?
   - Often
   - Sometimes
   - Never

5. Do you ever feel frightened by what your partner says or does?
   - Often
   - Sometimes
   - Never

6. Has your partner ever abused you physically?
   - Often
   - Sometimes
   - Never

7. Has your partner ever abused you emotionally?
   - Often
   - Sometimes
   - Never

8. Has your partner ever abused you sexually?
   - Often
   - Sometimes
   - Never

Scoring and Comments:
Score:_______ (0-24)
Clinician comments:_________________________________________
_______________________________________________________________________
Clinician Signature: ___________________________ Date:_____________
New Mexico Infant Mental Health Teams

MENTAL HEALTH SCREENING FORM (MHSF-III)


<table>
<thead>
<tr>
<th>DATE OF SCREEN:</th>
<th>/</th>
<th>PERSON COMPLETING SCREEN:</th>
<th>CLIENT</th>
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</thead>
<tbody>
<tr>
<td>NAME: FIRST:</td>
<td></td>
<td>LAST:</td>
<td>MIDDLE:</td>
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</table>

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? 
   
   YES   NO

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? 
   
   YES   NO

3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? 
   
   YES   NO

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? 
   
   YES   NO

5. Have you ever heard voices no one else could hear or seen objects or things which others could not see? 
   
   YES   NO

6. (a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? 
   
   YES   NO

   (b) Did you ever attempt to kill yourself? 
   
   YES   NO

7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic / terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? 
   
   YES   NO

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? 
   
   YES   NO

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property? 
   
   YES   NO

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? 
    
    YES   NO
CONSENT TO SERVICES

<table>
<thead>
<tr>
<th>DATE OF CONSENT:</th>
<th></th>
<th>PERSON(S) COMPLETING CONSENT:</th>
<th>CLIENT #</th>
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<tr>
<th>LAST NAME(S)</th>
<th>FIRST NAME(S)</th>
<th>M.I.</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>DATE OF BIRTH</th>
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HOME ADDRESS(ES) | CITY | STATE | ZIP CODE
1. | | | |

I, ________________________, give consent to participate in assessment, screening and treatment services with the Gila Regional Medical Center Infant Mental Health Court Team. I understand that by giving my consent I am agreeing to the confidentiality standards outlined by HIPAA, which mandates that clinicians maintain strictest confidentiality in terms of what is shared during assessment and treatment sessions. Assessment may include clinician observations through the CYFD observation window during child visitations. Limitations to confidentiality include reports of abuse, neglect or exploitation, reports of intent to severely harm or kill self or others and reports required by the NM Children, Youth and Families Department and the NM Sixth Judicial District Court. A full description of Client Rights and the Limitations to Confidentiality has been reviewed with me within the Notice of Privacy Practices.

CONSENT TO SERVICES

1. The information above has been reviewed with me: Yes No

2. I have been given a copy of the NOTICE OF PRIVACY PRACTICES and it has been reviewed with me: Yes No

3. I am voluntarily seeking services for myself and/or my child; and I give my consent for the Gila Regional Medical Center Infant Mental Health Court Team to provide services: Yes No

Client: ______________________ Date: ________________
Client: ______________________ Date: ________________

PROVIDER SIGNATURE: ______________________ LICENSE #: ______________________ DATE: ______________________
### Service/Progress Notes

**New Mexico Infant Mental Health Teams**

**CONFIDENTIAL INFORMATION**: Per US and New Mexico Protected Health Information Codes, disclosure of this information without client/guardian consent or statutory authorization is prohibited by law.

---

#### Client Information

- **Client Name:**
- **DOB:** / / 
- **Client #:**

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#### Codes

- CYFD-0003 – Family Counseling/Training
- CYFD-0004 – Family Training/Support
- CYFD-0005 – Group W/Child/Parent
- IMHG – CYFD-GRMC IMMH Grant

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#### Service/Progress Notes

<table>
<thead>
<tr>
<th>DATE</th>
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**Notes Must Include:**
- Service Type/Location
- Attendees
- Risk Assessment (Low, Moderate, High)
- DAP
- Clinician Signature

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**GRMC-SERVICE/PROGRESS NOTES – 10/14/13**

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201
New Mexico Infant Mental Health Teams

CSA-IMH
Team Meeting Agenda

Family 1: ___________________________ Allotted Time: ________________
Family 2: ___________________________ Allotted Time: ________________
Family 3: ___________________________ Allotted Time: ________________
Family 4: ___________________________ Allotted Time: ________________
Family 5: ___________________________ Allotted Time: ________________
Family 6: ___________________________ Allotted Time: ________________
Family 7: ___________________________ Allotted Time: ________________

a. Current Strengths
b. Current Struggles
c. Foster placement Strengths and Struggles
d. Progress on CYFD Treatment Plan: Visitation – Supervision - Transportation – Providers / Needs
e. Upcoming Court Hearings and Team Meetings
f. Needed Reports

General Discussion: Concerns, Communication, Logistics, etc. between CYFD and IMH
New Mexico Infant Mental Health Teams

MONTHLY PROVIDER UPDATE FORM

Month and Year of Update: Date Form Completed:

<table>
<thead>
<tr>
<th>Child:</th>
<th>D.O.B.</th>
<th>Date child entered custody:</th>
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<tr>
<th>Biological mother:</th>
<th>Biological father:</th>
<th>Foster parent(s):</th>
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<tr>
<th>Provider name:</th>
<th>Agency:</th>
<th>Discipline:</th>
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Date services began (at time of intake):

CURRENT (REPORTING) MONTH SESSION DATES↓

<table>
<thead>
<tr>
<th>Session date:</th>
<th>Who was present:</th>
<th>Length of session:</th>
<th>Service provided:</th>
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Date(s) of cancelled appointments / rescheduled:

Date(s) of no-show appointments / no-contact:

Treatment Goals (Broad/General, from Tx./Service Plan):

Progress/Strengths:
# INFANT MENTAL HEALTH STATUS REPORT / PITA
## (PROGRESS IN TREATMENT ASSESSMENT)

**DATE OF REPORT:**
**PERSON(S) COMPLETING REPORT:**

<table>
<thead>
<tr>
<th>NAME OF CHILD:</th>
<th>MIDDLE:</th>
<th>LAST:</th>
<th>(NICKNAME):</th>
<th>DOB:</th>
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<td>FIRST:</td>
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<table>
<thead>
<tr>
<th>NAME OF CAREGIVER IN RELATIONSHIP TO CHILD:</th>
<th>DOB:</th>
<th>RELATIONSHIP TO CHILD:</th>
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<td>FIRST:</td>
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**REPORTING PERIOD:**

**Note:** *The following information is an overall assessment that pertains to the past 10 weeks of this parent’s participation in the GRMC Infant Mental Health Court Team Program.**

1. The parent has attended **XX** out of **XX** sessions (**XX%**) scheduled during this reporting period:

**REPORTING PERIOD: JUNE 18 – AUGUST 23, 2013**

<table>
<thead>
<tr>
<th>Session date</th>
<th>Session location</th>
<th>Who was present</th>
<th>Length of session</th>
<th>Service provided</th>
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<td>CYFD office</td>
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**Date(s) of cancelled appointments / rescheduled:**

**Date(s) of no-show appointments / no-contact:**
# New Mexico Infant Mental Health Teams

## INFANT MENTAL HEALTH DISCHARGE/TRANSITION PLAN

<table>
<thead>
<tr>
<th>DATE OF DISCHARGE:</th>
<th>PERSON(S) COMPLETING DISCHARGE:</th>
<th>CLIENT #</th>
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<tr>
<th>NAME OF CHILD:</th>
<th>MOTHER/GUARDIAN A:</th>
<th>FATHER/GUARDIAN B:</th>
<th>MOTHER/GUARDIAN A:</th>
<th>FATHER/GUARDIAN B:</th>
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<td>FIRST:</td>
<td>DOB:</td>
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<td>MIDDLE:</td>
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**CYFD PLACEMENT PLAN AT TIME OF GRMC-IMH DISCHARGE OR TRANSITION:**

<table>
<thead>
<tr>
<th>CURRENT PRIMARY CAREGIVER(S) (FOSTER):</th>
<th>RELATIONSHIP TO CHILD:</th>
<th>ADDRESS:</th>
<th>PHONE:</th>
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**GUARDIAN AD LITEM NAME AND PHONE:**

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<tr>
<th>CASA VOLUNTEER NAME AND PHONE:</th>
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**RESPONDENT ATTORNEY (A)/PHONE:**

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<tr>
<th>RESPONDENT ATTORNEY (B)/PHONE:</th>
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**REASON FOR GRMC-IMH DISCHARGE OR TRANSITION:**

<table>
<thead>
<tr>
<th>TREATMENT PLAN</th>
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<td>TX.GOAL #</td>
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<td>TREATMENT GOAL</td>
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<tr>
<td>DATE GOAL MET</td>
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**NARRATIVE SUMMARY** - Include summary of presenting problems, course of treatment, barriers to treatment, treatment goals completed.

<table>
<thead>
<tr>
<th>NAME OF CHILD:</th>
<th>DOB:</th>
<th>CLIENT #</th>
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<tbody>
<tr>
<td>DC:0-3R DIAGNOSIS UPON DISCHARGE / TRANSITION:</td>
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IMH TEAM DATA DOCUMENTATION
The Infant Team Data System is designed to reflect the flow of the Infant Team process and to capture the key activities of the infant team and the involvement of many individual and systems in the child’s course toward permanency.

See next page for flow chart.
IMH TEAM DATA DOCUMENTATION

Children Taken into custody

Register case with adults and children who are receiving services
- Bio Parent(s)
- Child(ren)
- Other non bio primary caregiver(s)

Basic demographics:
- Ethnicity/race
- DOB
- County of residence
- CAPTA

Infant Team Case Activities

Document services:
- Court hearings
- Coordination with court and CYFD
- Supervised visits
- COS-D/D training with bio-and foster parents
- Therapy
- Other relevant services or coordination of other services

Document individuals involved in the case in different activities:
- GAL
- CASA
- FPW and other CYFD personnel
- Other therapists

Infant Team Other Activities

Document non-client related activities (e.g. training with community partners about trauma-informed and developmentally informed services)

Comprehensive IMH Assessment

Enter required assessment information:
- DC:0-3R axis V, IV, II – rating for V an II, and age of onset (in months) for relevant items
- PIR-GAS rating
- Baseline PITA
- Working Model and Crowell, or CoS interview

Document other services such as FIT services

Treatment Goals and Progress

Document treatment goals and outcomes of goals

Assess treatment progress with PITA

Permanency Outcome

Permanency decision:
- Voluntary relinquishment/adoption
- Termination of parental rights
- Reunification

Agreement with infant team recommendation:
- Agreement – court
- Agreement – CYFD
- Disagreement – court
- Disagreement – CYFD

Re-referral to CPS:
- 6 months
- 12 months
- > 12 months
- No re-referral