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# ADDRESSING SOCIO-EMOTIONAL DEVELOPMENT AND INFANT MENTAL HEALTH IN EARLY CHILDHOOD SYSTEMS: *Executive Summary*

PAULA ZEANAH, PhD, MSN

GEOFFREY NAGLE, PhD, LCSW

BRIAN STAFFORD, MD, MPH

THOMAS RICE, MA

JOANNA FARRER, BA



UCLA CENTER  
FOR HEALTHIER CHILDREN,  
FAMILIES AND COMMUNITIES



ASSOCIATION OF MATERNAL  
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### ABOUT THE AUTHORS:

This executive summary was prepared by authors from the Tulane University School of Medicine and UCLA Center for Healthier Children, Families and Communities (CHCFC). Paula Zeanah, PhD, MSN is an Associate Professor of Psychiatry and Pediatrics at the Tulane University School of Medicine; Geoffrey Nagle, PhD, LCSW is an Assistant Professor of Clinical Psychiatry at the Tulane University School of Medicine and Director of the Institute of Infant and Early Childhood Mental Health; Brian Stafford, MD, MPH is an Assistant Professor of Psychiatry and Pediatrics at the Tulane University School of Medicine; Thomas Rice, MA is the program manager for the National Center for Infant and Early Childhood Health Policy at CHCFC; Joanna Farrer, BA is a research assistant for the National Center for Infant and Early Childhood Health Policy.

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## WHAT IS INFANT MENTAL HEALTH?

During the past three decades, there has been an increase in knowledge about early childhood development. Early experiences can function as either risk factors or protective factors for a child's future health and development. This has led to concern about how current health systems contribute to the quality of the earliest experiences of life. Specifically, knowledge about child development has led to a focus on mental health care services for young children. This report draws on existing research findings and makes policy recommendations for how to structure and implement mental health care systems that work with infants and families.

*Terminology:* Members of the health, mental health, and other disciplines refer to different age ranges when using the terms “infant” and “infancy.” In order to simplify the discussion, this report uses the term “infant mental health” or IMH to describe the social and emotional health and well-being of young children age 0-3 years.

This executive summary describes:

- Policy recommendations and strategies for implementation.
- What “infant mental health” means.
- How to develop systems for delivering IMH services.

## RECOMMENDATIONS

### Primary Policy Recommendation

#### 1 Integrate Infant Mental Health into all child and family service systems.

**Rationale:** Pediatric, early care and education, and family support providers have roles in providing education, conducting assessment, performing interventions, and care management. By utilizing the contributions of each group, state SECCS plans can maximize universally available services that promote social and emotional development, prevent IMH problems, and address problems that do occur.

### Additional Policy Recommendations

- 2 Identify mental health disorders in young children and their families early.
- 3 Expand system capacity through workforce development.
- 4 Assure that young children of highest risk receive comprehensive health and mental health services.
- 5 Provide access to mental health consultation and support early care and education providers.
- 6 Raise public and professional awareness about the importance of early social and emotional development.
- 7 Develop strategies for assessing outcomes and program evaluation.

## WHAT DOES INFANT MENTAL HEALTH MEAN?

Infant mental health specifically refers to the social and emotional health of a young child (Zero to Three, 2004). However, as a broader topic it has many implications for families and communities, early care and education, health and health care of individuals, and systems of health care delivery.

### Implications:

- *Families and communities* can become more aware of and active in their role in supporting the social and emotional health and development of all young children.
- *Early care and education settings* can be an ideal common ground where infants, parents, caregivers and health care professionals come together and provide appropriate support and services for IMH.
- *Health care professionals* can play many roles: they can learn about IMH and possible services and interventions, they can help educate children, families and the general public about IMH, they can provide specific IMH-promoting advice to parents, and they can act as links to services and information about IMH.
- *Systems of health care delivery* are the building blocks of the IMH service continuum (see **Figure 1**).

## The Contexts of Infant Mental Health

Infant mental health can be described in terms of the many dynamic factors that influence infants' development. Four major sets of factors or "contexts" are discussed below. When developing and administering IMH programs, these factors need to be considered.

### *Biological Context*

The biological context includes all of the intrinsic factors that affect an infant's development: genetic influences, temperament, constitution, physical health, and physical attributes. Much of primary health care focuses on these biological factors, using interventions such as nutritional education, developmental surveillance, and other early intervention for various health and developmental problems.

Biological context is important for IMH because the most rapid period of brain development occurs from the third trimester of pregnancy through the second year of life. The overall *structural development* of the brain occurs prenatally, but the *functional development* is a result of prenatal and postnatal experiences. Functional development occurs at an incredibly rapid pace during the first three years of life, and is shaped by the interplay between biology and experience (Nelson & Bosquet, 2000; Shonkoff & Phillips, 2000).

### *Developmental Context*

The developmental context is important to IMH because early development sets the stage for later success. As the most rapid period of development in the life span occurs in the first three years of life, the effects of environment and biology on human development can significantly raise or lower a child's developmental trajectory. Research shows that infants who experience serious adversity (e.g., exposure to violence) are more likely to experience developmental problems, including abnormal patterns in the expression of emotions, unusual or deviant behaviors, distractibility and inattention, and delays in motor and language skills (Scheeringa & Gaensbauer, 2000).

Identifying positive and negative impacts on child development is complicated because the stages of early childhood development are not strictly scripted; rather, significant variation as to when children meet milestones occurs even within a normal range.

### ***Environmental Context***

The infant lives within a specific physical environment, and his care is influenced by familial, cultural, and ethnic influences. Poverty exerts a strong negative influence on the early experiences of many young children because of the myriad associated environmental and psychosocial stresses (Aber, Jones & Cohen, 2000; Evans, 2004). Availability of support for the family is also partly determined by aspects of the physical environment, such as geographic isolation or unhealthy living spaces.

The family exerts a strong influence on the day to day experience of the infant. Factors include parents' expectations, hopes, values, parenting practices, as well as the support that parents themselves receive. Cultural and ethnic influences affect parenting beliefs and behaviors, beliefs about infants and child care, expectations about the roles of mother, father, and extended family members.

### ***Relationship Context***

The *infant-caregiver relationship* is the most important experiential context for infant development (Shonkoff & Phillips, 2000; Zeanah & Zeanah, 2001). It is through this relationship that:

- The infant begins to understand his world, interact with others, and develop a sense of his competence and self-worth.
- The infant is exposed to risk and protective factors for later development.

A warm, nurturing, responsive, and consistent pattern of interactions between the infant and caregiver leads to a “secure” attachment (Bowlby, 1969). Conversely, interactions that lack these qualities lead to insecure or disorganized attachments. These patterns of interaction develop over time and in step with other developmental achievements, including motor and cognitive abilities.

It is important to consider the relationship context when designing assessment and intervention measures because the quality of attachment lies within the relationship and not the individual child or caregiver. For instance, exclusively treating depression in the mother ignores the impact her depression may have on the child, and the impact that the child may have on the mother's depression. Further, the focus on relationships in IMH is not limited to the parent-infant relationship, but includes positive working relationships between caregivers and service providers.

*The relevance of contexts:* Infant Mental Health describes the social and emotional well-being of a young child existing among all of these contextual factors. The four contexts described above are not mutually exclusive; relationships are affected by environmental factors, and development is influenced by biological factors. The emphasis in IMH is to study and learn from how all of the contexts function in unison, and develop systems that address how these contextual factors ultimately affect the mental health and well-being of young children.

### HOW CAN IMH SERVICES BE DELIVERED EFFECITVELY?

This report outlines a broad system of care that incorporates many existing strategies. It includes multiple service sectors and their providers, as well as three intensities of care, and four major areas of function in each. The report identifies roles for primary health care providers, for providers of early care and education services, and for family support providers.

The first level of care addresses the universal need for optimizing the healthy development of young children; the second level addresses the particular needs of populations that are at increased risk for developing problems; the third level of care is directed at the treatment of children who have developed identifiable social and emotional health conditions.

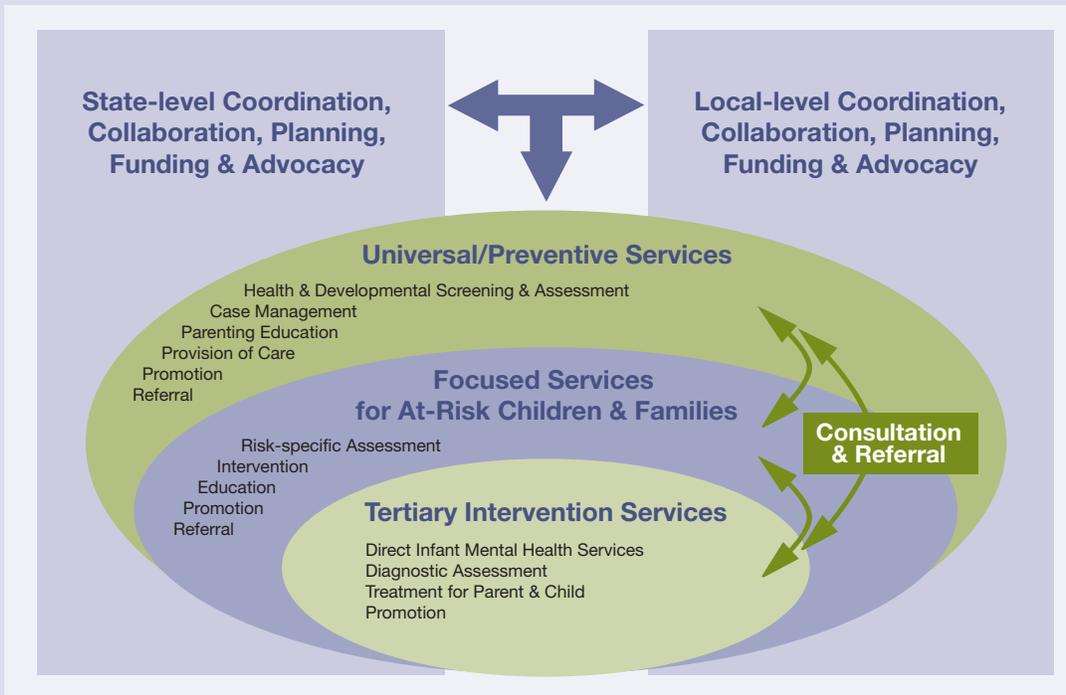
Within each level of care, activities include assessment, educational services, intervention services, and care coordination. The type of services and the roles of different service providers are based on the provider's knowledge, skills, resources, and tools.

- *Assessment*—includes obtaining and integrating information obtained via parent report, parent-child observations, child behavior assessments, developmental monitoring, psychosocial screening, and information from other service providers.
- *Educational services*—includes anticipatory guidance regarding normal development and child behavior, the parent-infant relationship, and developmental issues, parenting education, and specific instruction.
- *Intervention services*—includes services such as office-based counseling, telephone hot lines, home visitation, and psychotherapeutic services.
- *Care coordination*—facilitating referrals for diagnostic or specialty care (Halfon & Regalado et al, 2003).

This model of a system of care is held together at the state and local levels by integrative planning, coordination, funding, and advocacy. More information about this model is available in **Appendix A**.

Integration of appropriate IMH strategies into all early childhood service settings enhances the likelihood that substantial contributions to the social and emotional development of young children will occur. Individual state activities will depend on: organizational structure, federal, state and local resources, community needs, and available expertise. **Figure 1** describes the types of services that could be available along the continuum.

Levels of Infant Mental Health Care



**Universal/Preventive Services** are aimed at improving child development, parenting knowledge and behavior, and infant mental health for all families within their service range. Strategies generally include promotion, screening and assessment, education and guidance, and referral for more intensive services when needed.

**Focused Services** are aimed at specifically identified groups considered at risk for developing potentially serious social or emotional problems that could lead to infant mental health problems. These approaches may be generated from any setting that serves individuals at risk. Examples include home visiting services for first time mothers, or preventive interventions for abused or neglected children.

**Tertiary Intervention Services** serve infants and caregivers experiencing current difficulties, such as recent significant trauma, and also attempt to prevent or lessen future problems. These services are most likely to come out of mental health programs.

Implementation Strategies

Bridging the *cultural differences* between the diverse stakeholders in planning and policy initiatives is a key component to integrating IMH into current mental health care systems. The keystone report in the “Building State Comprehensive Systems” series outlines general principles of early childhood systems development and key strategies for SECCS grantees to use as they build their strategic plans (Halfon et al, 2004). **Appendix B** in this report describes the elements of a comprehensive and continuous system of care.

continued

The current mental health care system is the most likely system that primary care providers turn to for tertiary (specialized, intensive) services for children and families. Collaboration between the different health sectors and the mental health system is essential to assure a full range of early childhood services. For the SECCS initiative to be most effective, it is important to be aware of the challenges as well as opportunities most likely to be encountered in the mental health system. **Table 1** describes three key challenges and opportunities that could influence IMH system development.

**TABLE 1**

## Challenges and Opportunities

### 1. FUNDING

**Challenges:** Some state policy makers may lack information or understanding about the importance of early childhood development and IMH. Parents' and children's eligibility standards may differ. Funding for tertiary services may be problematic.

**Opportunity:** States have wide discretion in the administration of Medicaid and State Child Health Insurance Programs (SCHIP). Also, there are other funding sources, including Part C of IDEA, welfare reform (TANF) funds, and the Substance Abuse and Mental Health Services Administration (SAMSHA) funds.

### 2. WORKFORCE DEVELOPMENT

**Challenges:** Most child and adult mental health practitioners do not have adequate knowledge or skills to perform developmentally appropriate, relationship-based assessment and treatment for young children or their caregivers. There is a lack of child mental health professionals in general, and specifically, there are very few child psychiatrists (AACAP, 2003).

**Opportunity:** Expand current pediatric residency requirements to provide more focus on child development, awareness and use of validated and reliable screening tools, and referral resources. Similar training should be available for practicing pediatricians and child psychiatrists. Likewise, training for new and existing child care professionals can improve their abilities to recognize and respond to IMH issues. Training should emphasize use of evidence-based interventions.

### 3. OUTCOMES AND EVALUATION

**Challenges:** There remains a lack of epidemiological information about the number of children in need of direct IMH services, including baseline data to determine the number of children at risk for problems or in need of services, and longitudinal outcomes studies.

**Opportunity:** As state MCH programs and their partners consider how to design new programs, it is important to look to model programs with a proven history of success and to build in evaluations that are likely to add to the evidence base. Therefore, continued research and analysis in the field of IMH is necessary.

## POLICY RECOMMENDATIONS AND STRATEGIES

The following policy recommendations and accompanying strategies reflect the issues discussed throughout the Infant Mental Health report and the 2004 Zero to Three Fact Sheet on Infant Mental Health (Zero to Three, 2004).<sup>1</sup>

### 1. *Integrate Infant Mental Health into all child and family service systems.*

*Enhancing relationships between infants, parents, caregivers, and service providers through supportive child and family service systems is a key to success in IMH.* Pediatric, early care and education, and family support providers have roles in providing education, conducting assessment, performing interventions, and care management. By utilizing the contributions of each group, state SECCS plans can maximize universally available services that promote social and emotional development, prevent IMH problems, and address problems that do occur. Attention should be given to bringing those children and families that do not access these care providers into the system.

#### Strategies:

- **Build** the capacity of existing early childhood systems to address infant mental health and serve more children by overcoming difficulties that caregivers and providers encounter when interfacing with individual systems and attempting to bridge systems. (e.g., parents accessing ECE; ECE providers communicating with Part C).
- **Link** early intervention programs and public mental health services at the state and local levels. For instance, involve high-level state mental health participation in the development and coordination of early intervention and prevention programs (i.e., participation in Part C interagency coordinating council), and encourage cooperation between local mental health and intervention programs (i.e., facilitate referrals between agencies).
- **Enhance** the capacity of the early childhood system by addressing funding challenges. Maximize the abilities of EPSDT, SCHIP and Medicaid to fund IMH assessment and intervention services.

### 2. *Identify mental health disorders in young children and their families early.*

*Establishing systems that are capable of providing screening and early identification services are a key component of an IMH infrastructure.*

#### Strategies:

- Equip and train early childhood service providers with validated and reliable screening and assessment tools.
- Improve the financing of IMH services by making full and appropriate use of existing diagnostic procedures, tools and billing codes (i.e., Zero to Three's Diagnostic Classification, (Zero to Three, 1994)).
- Expand billing options to allow caregivers and children to receive treatment together.

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<sup>1</sup>Further details on additional best or promising practice examples for each of the recommendations can be found in the Zero to Three fact sheet. [www.zerotothree.org](http://www.zerotothree.org)

### ***3. Expand system capacity through workforce development.***

The ability of the system to respond to the mental health needs of young children and their families depends on how the system is structured and the abilities of the workforce. Medical, early childhood education, and family support providers need the knowledge, skills, and resources to effectively support early social and emotional development.

#### **Strategies:**

- Partner with state, regional, and local universities, colleges, and other training organizations to enhance the training and education of future providers.
- Enhance the knowledge and skills of existing providers through continuing education programs.
- Encourage professional and regional associations to build resource networks.
- Build the capacity of caregivers to support their children's social and emotional development through education programs for all adults.
- Provide IMH consultation for pediatric practices, early care and education providers, and family support providers.

### ***4. Assure that young children of highest risk receive comprehensive health and mental health services.***

Extremely vulnerable children include those in foster care, children of substance abusing parents, children of parents with severe mental illness, and children exposed to violence (Harden, 2004; Knitzer, 2000; Halfon et al, 2002). Comprehensive programs for this population are critical because they are less likely to receive regular health care; often have had significantly disrupted relationships and are more likely to have experienced abuse or neglect; and they are more likely to display behaviors and have conditions that will seriously impede their lifelong learning and life success.

#### **Strategies:**

- Develop comprehensive programs that identify and serve high-risk children.
- Ensure that professionals serving these children and their families have appropriate training and supervision.
- Provide education and support for high-risk children, as well as their families and child and health care providers.

### ***5. Provide access to mental health consultation and support to early care and education providers.***

Early care and education providers (center and non-center based) can provide early learning opportunities and ways to promote the social and emotional development of young children. Previous recommendations and strategies addressed the role of workforce development, and this recommendation addresses direct involvement of appropriately trained mental health providers in early care and education settings to provide on-site, tailored education and technical assistance to staff, and some direct psychotherapeutic services to children and families. State MCH programs are well-placed to advocate for such services due to their experiences and success implementing the Healthy Child Care America program. Evidence-based programs are described in further detail in the main body of the report. These programs can serve as a reference point for other projects.

#### **Strategies:**

- Develop linkages between early care and education providers and infant mental health care providers and services.
- Provide education for early care and education providers about the available IMH resources and referrals.

- Provide education for both early care and education professionals and IMH providers about the unique needs of young children in out-of-home child care settings.

#### **6. *Raise public and professional awareness about the importance of early social and emotional development.***

This includes information about the legitimacy of mental health disorders in young children and their connection to the mental health of caregivers. The report in this series *Framing Early Childhood Development: Strategic Communications and Public Preferences* (Gilliam & Bales, 2004) provides information about strategies, including:

##### **Strategies:**

- Craft public awareness messages.
- Build constituencies with political influence.
- Provide consistent messages regarding parenting across agencies and providers.
- Explore the rationale that keeps isolated children and families from engaging with the service system; explore options for inviting families into the service system in a culturally appropriate manner; develop multiple strategies and relationships to assist families to resolve challenges that prevent them from accessing services.

#### **7. *Develop strategies for assessing outcomes and program evaluation.***

In order to determine the effectiveness of programs, it is important to have baseline data as well as consistent and reliable outcome data.

##### **Strategies:**

- Partner with universities to develop sound methodologies and approaches for program evaluation.
- Partner with other agencies to develop methods of data collection that can reduce redundancy and cost, and can improve understanding of how programs impact problems.
- Replicate well-designed, evidence-based programs; if changes are made to implementation of such programs, carefully evaluate impact.

**IMH can and should be integrated into every aspect of a comprehensive early childhood system.** The short and long term results of improving the social and emotional experience of young children impact all aspects of development, and lay the groundwork not only for school readiness, but for later healthy, productive functioning.

APPENDIX A

TABLE 2

Continuum of Socioemotional Services within Primary Care

| Type of Service              | Level of Problems   |   |  |
|------------------------------|---|---|--|
|                              | LEVEL 1:<br>None or “typical”   | LEVEL 2:<br>Mild or subclinical   | LEVEL 3:<br>Identified problem   |
| <b>ASSESSMENT</b>            | Clinical history/intake/<br>parent report<br>Psychosocial/<br>environmental screen<br>Developmental screening<br>Parent-child<br>observations | Problem-specific<br>assessment for parent<br>or child<br>Periodic re-assessment                                   | Ongoing monitoring<br>for improvement and/or<br>emerging or associated<br>problems                             |
| <b>EDUCATION</b>             | Anticipatory guidance<br>Specific education<br>or instruction   | Problem-specific<br>information   | Problem-specific<br>information  |
| <b>INTERVENTION</b>          | Support/interest<br>Reinforce positive<br>Counseling for<br>“typical” problems<br>Routine follow-up   | Problem-specific<br>counseling<br>Home visit<br>Increased monitoring  | Problem-specific<br>interventions (e.g.,<br>mental health referrals)<br>Increased and/or<br>ongoing monitoring |
| <b>CARE<br/>COORDINATION</b> | None or<br>Refer for additional<br>educational or support<br>services   | Refer for speciality<br>diagnostic services<br>Refer to focused services<br>Link to ancillary<br>support services | Treatment planning and<br>coordination of care with<br>specialty and/or support<br>services                    |

**Authors’ analysis**

Level 1 represents “baseline” services that all children, with or without problems, should receive. Level 2 incorporates services for children and families for whom there are significant risks present, and/or when there are mild or sub-clinical problems in socioemotional development or parent-infant relationships. In these situations, additional assessment and intervention is warranted to avert adverse outcomes. Level 3 represents the situation when overt problems are present and require specialized treatment, for example a child who experiences post-traumatic stress disorder after a serious car accident. The pediatric provider is likely to be the one to identify the child as having a maladaptive response to the event and refer for diagnostic assessment and treatment. While the problem-specific treatment may be performed by a mental health provider, the pediatric provider remains involved with the family, may provide increased monitoring, support and information, and will be involved in treatment planning and coordination of care with other providers and services as needed.

TABLE 3

## Elements of Creating a System of Care

|                                       |  |
|---------------------------------------|--|
| <b>Access</b>                         | <ul style="list-style-type: none"> <li>▪ Infants and their families should be able to access services at multiple entry points, including health, educational, and social services.</li> <li>▪ Use existing pathways for outreach, information dissemination, and services, such as clinics, child care centers, and community centers.</li> </ul>   |
| <b>Continuum of Services</b>          | <ul style="list-style-type: none"> <li>▪ A continuum of services ranging from basic prevention to tertiary services is available.</li> <li>▪ Identify and prioritize the needs of various at-risk populations, including those who may need immediate services.</li> </ul>   |
| <b>Staff Training</b>                 | <ul style="list-style-type: none"> <li>▪ The current lack of appropriately trained providers negatively affects the availability of needed services and available capacity in all settings.</li> <li>▪ Staff should be adequately trained, and use best-evidence approaches for assessment and interventions.</li> </ul>   |
| <b>Program Design</b>                 | <ul style="list-style-type: none"> <li>▪ Cultural, ethnic, and community values need to be acknowledged and incorporated into any programmatic effort.</li> <li>▪ Parents should be involved in the development of initiatives to ensure their concerns are being addressed.</li> </ul>  |
| <b>Partnerships and Collaboration</b> | <ul style="list-style-type: none"> <li>▪ Partnerships are needed to provide the type and range of care because emotional and mental health needs of young children and families are often complex and cross traditional care boundaries.</li> <li>▪ Leaders who possess expertise (e.g., university experts, mental health and education professionals, existing community programs, child advocates) and those empowered to create change (e.g., state officials) must build and sustain alliances in order to develop programs.</li> <li>▪ State and local partnerships can work together to:               <ul style="list-style-type: none"> <li>▪ Provide support, training, technical assistance, materials and other resources to interested parties, other counties, state offices, etc.</li> <li>▪ Coordinate efforts for personnel and program development.</li> <li>▪ Expand integrated services.</li> <li>▪ Identify effective screening and assessment measures.</li> <li>▪ Provide community education regarding early socioemotional development.</li> <li>▪ Enhance training for health and mental health professionals.</li> <li>▪ Facilitate increased interdisciplinary interagency collaboration.</li> <li>▪ Evaluate outcomes for children, families, and service providers.</li> </ul> </li> </ul> |
| <b>Planning and Sustainability</b>    | <ul style="list-style-type: none"> <li>▪ Top down strategic planning begins at the state level, and includes identifying priorities, establishing outcomes and evaluation techniques, developing effective alliances, and ensuring that the needs of the population are being met.</li> <li>▪ Bottom up strategies include developing coalitions with local community-based organizations and service providers from sectors involved in providing services to infants and their families, identifying critical gaps and prioritizing local needs, and gaining community investment in early childhood programs.</li> <li>▪ Leverage funds by collaborating with programs targeting similar problems (e.g., maternal depression, parenting education, early childhood development).</li> </ul>   |

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**CONTACT INFORMATION:**

Institute of Infant and Early Childhood Mental Health, Tulane University School of Medicine, Department of Psychiatry and Neurology, Tidewater Building, TB-52, 1440 Canal Street, New Orleans, Louisiana 70112-2715. Phone: Geoffrey Nagle (504) 988-8241. Fax: (504) 587-4264. E-mail: [gnagle@tulane.edu](mailto:gnagle@tulane.edu). Web site: [www.infantinstitutione.org](http://www.infantinstitutione.org)

UCLA Center for Healthier Children, Families and Communities, 1100 Glendon Avenue, Suite 850, Los Angeles, California 90024. Phone: (310) 794-2583. Fax: (310) 794-2728. Email: [chcfc@ucla.edu](mailto:chcfc@ucla.edu). Web site: [www.healthychild.ucla.edu](http://www.healthychild.ucla.edu)

*UCLA Center for Healthier Children,  
Families and Communities*

1100 GLENDON AVENUE, SUITE 850

LOS ANGELES, CALIFORNIA 90024

PHONE: (310) 794-2583

FAX: (310) 794-2728

EMAIL: [chcfc@ucla.edu](mailto:chcfc@ucla.edu)

WEB SITE: [www.healthychild.ucla.edu](http://www.healthychild.ucla.edu)