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Erin Ford

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Infants and Toddlers:
What They Teach Us About How to Help Preschool and Elementary School Students Regulate Behavior and Achieve Mental Health

By

Erin Ford

Mentor:
Lesley Koplow

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Abstract

Looking at early childhood mental health from a policy perspective, this thesis describes practices that support children's social and emotional development and mental health prevention, intervention, and treatment approaches that can be used in preschool and elementary school settings; looks at young students' unmet mental health needs in both of these settings; and explores how schools can better address students' problem behaviors and mental health needs. To do so, it describes the field of Infant Mental Health and the supporting research; provides an overview of what the literature suggests preschools and elementary schools can do to support young children's social and emotional development and mental health; documents preschool and elementary school students' unmet mental health needs; and includes observations of current practices from three New York City schools. This thesis finds that preschools and elementary schools are not doing all they can to support students' social, emotional, and mental health needs. The field of Infant Mental Health, which is a comprehensive, collaborative, holistic, and cross-disciplinary system of mental health care for young children, offers a model of how preschools and elementary schools can better address the problem behaviors and mental health needs of our youngest students.

Table of Contents

Rationale

Growing up, I was constantly exposed to discussions about children's mental health, as my mother is an advocate for children with special needs and my father is a child psychiatrist. Yet it was not until college, when I realized I wanted to be a teacher that I began to take an active part in these conversations. When I was a sophomore at Wellesley College I began to work in the two-year-old class at the preschool on campus. One of the primary tasks of two-year-olds starting school is to learn to say goodbye to a caregiver in order to form relationships with new adults and peers in a structured environment. For this reason, I became very interested in children's social and emotional development as well as their attachment relationships.

During my senior year at Wellesley, I enrolled in a course called Social and Emotional Learning (SEL) in Schools. This course introduced me to the idea that while social and emotional learning is increasingly overlooked as children get older, it continues to play a significant role in a child's experience in school and can even influence one's academic achievement. In this course, I also had the opportunity to see some elementary school programs designed to support children's social and emotional development in action in several schools in Massachusetts.

When I moved to New York to attend Bank Street, I began working as a policy assistant at the TeenScreen National Center, a non-profit health initiative affiliated with the Columbia University Division of Child and Adolescent Psychiatry. TeenScreen works in primary care, school, and community settings to expand access to adolescent mental health screenings in order to accurately identify signs of possible mental illness and risk of suicide in youth. In my position there, I had the opportunity to research mental health

policy and prepare background documents and fact sheets about adolescent mental health issues, such as "Youth Suicide and Prevention" and "Youth Mental Health and Academic Achievement." This work reinforced the concept I learned at the Wellesley preschool and in the social and emotional learning course, that mental health impacts every aspect of children's lives and is closely intertwined with all areas of development.

With this background and my three very distinct Bank Street student teaching placements (including an integrated class at an independent preschool with a social and emotional focus, an integrated co-teaching class at a public school, and a self-contained special education class in a public school with many students with emotional and behavioral needs), I started searching for information about early childhood mental health. While we discussed both social and emotional development and several emotional and behavioral disorders, such as Attention Deficit Hyperactivity Disorder (ADHD) in my early childhood special and general education classes at Bank Street, I was surprised by the lack of discussion about early childhood mental health.

When it came time for me to write my thesis, I knew immediately that I wanted to learn more about early childhood mental health and to explore its relationship to educational language and practice. When narrowing down my topic, I decided to explore what early childhood mental health interventions might look like in preschool and elementary school settings. I took this broader approach for several reasons: 1) during my student teaching placements, as someone with an early childhood background, I was struck by how differently children's social and emotional development and mental health needs were addressed in the preschool and elementary school settings, 2) most of my experience with mental health has been from a policy perspective across childhood and

adolescence, and 3) since I will be certified to teach children birth through 8 years of age, I wanted to look at mental health across the whole range of those ages. As I began my literature review, I quickly learned the Infant Mental Health field provided a natural way to frame mental health interventions and treatments for young children. While the infant/early childhood mental health approach seems to fit nicely into preschool settings, I became curious to know if it could inform teaching in elementary schools too. My thesis is therefore structured by the initial review of the literature, then observations from my three student teaching placements in New York City schools, and finally the implications of these findings for addressing the behaviors and mental health needs of young children in emotionally and developmentally supportive ways.

Introduction

The field of Infant Mental Health (IMH), with its foundations rooted in the developmental perspective and the child-parent relationship perspective, provides a model of a holistic, collaborative, and prevention-based system of mental health care. It is this author's contention that if this system were emulated or adopted, by preschools and elementary schools, these schools could better address young students' problem behaviors and mental health needs. IMH acknowledges that children develop within the context of their environment, relationships, experiences, and biological makeup. Thus, children's social, emotional, and behavioral challenges are viewed as unique to the individual and the result of a combination of these factors, which are often out of the child's control. The IMH view takes a collaborative, cross-disciplinary approach, incorporating the medical field as well as others to address all factors that may be impacting the child's development. Similarly, prevention and early intervention strategies

that build upon the child and their family's strengths and assist them in their areas of need are used to avoid or address problems before they become significant causes for concern. Individual, family, and community-level approaches are taken to help children of all levels of need regulate their behavior and achieve mental health.

In contrast, while individual schools may have focused views and systematic approaches to providing social, emotional, and behavioral support to young children and their families, there is not a unified, cross-disciplinary understanding of mental health that informs the way schools address problem behaviors and mental health needs of their students. This lack of uniformity is particularly striking when looking at how preschools and elementary schools differ in the way they think about and address students' mental health needs.

In preschool, children are primarily viewed from the developmental perspective. Teachers focus on the development of the whole child and recognize that development occurs within the context of their relationships, experiences, environments, and biological makeup. Social and emotional development is an important focus of preschool. Developmentally, children are expected to be exploring the changing nature of their primary attachment relationships as they form new relationships with teachers and peers. As a result, they are supported when they have strong feelings and are explicitly taught socially appropriate language and actions to use in those moments. As children grow and develop, there are greater expectations of their abilities to regulate both emotions and behavior, so the supports they are provided in this area decrease proportionately.

Yet, as children move into elementary school, the stated goal is suddenly different. Academic learning becomes the primary focus and the child's social and

emotional development becomes a support or a hindrance towards that goal, rather than a goal in itself. It is at this point that the critical connection between successful academic learning and social/emotional development are irrevocably and mistakenly split. Teachers' expectations of the child's ever-improving social and emotional skills continue to increase, while there is a disproportionate decrease in supports to help the child achieve social and emotional competence. Children's problem behaviors are then increasingly seen outside of the context in which they actually develop. Instead, they are often viewed as the child's fault and as a deficit because they are negatively impacting the achievement of the ultimate goal: academic learning. Students who develop significant mental health needs that impact their learning and success in school are then given a label from the medical model, "emotional disturbance," in order to receive special education services.

Use of terms from the medical model to describe students with the most significant social-emotional needs is common as children move from toddlerhood to preschool and school age. This may not be a problem in the context of a preschool or elementary school with a developmental approach to children's mental health that acknowledges that all children have a range of social and emotional skills and need support as these skills continue to develop. However, when these medical model terms are used only to describe the children with the most significant needs and not used in a context of a continuum of social and emotional skills, they may negatively influence the way children are viewed by their peers, their families, their teachers, and even themselves. By only using medical model, deficit-oriented language to describe children's social-emotional needs, schools may be exacerbating the stigma around mental

health supports for both parents and teachers, thereby narrowing the framework from which possible prevention, intervention, and treatment approaches may arise in support of both development and learning. In addition, referring to social and emotional needs in solely medical terms may give teachers the message that this area of development is beyond their scope and not their responsibility.

It is in the school's best interest to address a young child's problem behaviors and mental health needs in the earliest and most effective way possible, as good mental health not only improves the child's general well-being but also that child's social skills and academic achievement (Knitzer, 2000, p. 2). Emulating or adopting a comprehensive approach like IMH, with a clearly defined foundational perspective that informs the way providers and caregivers work with young children in their homes, their preschools, their elementary schools, and their pediatricians' office would be one way to ensure that the disconnect between goals and approaches in different educational settings do not have a detrimental effect on the learning and emotional well-being of our youngest students.

Literature Review

An Overview of Infant Mental Health

The Infant Mental Health (IMH) field provides a model of what a unified system of early childhood mental health care, which includes prevention, early intervention, and treatment services for individuals, families, and communities, can look like. IMH's holistic, collaborative, and preventive approach to mental health care stems from the nature of the underlying perspectives of the field: that children's development is influenced by a variety of factors, from biology to environment, and that of those factors relationships are of primary importance.

Fitzgerald and Barton (2000) described the defining goal of the field this way: "Infant mental health focuses on the social and emotional well-being of infants and their caregivers and the various contexts within which caregiving takes place" (p.4). While as with other mental health interventions, the child's emotional well-being is at the heart of this goal, IMH does not separate the child from his or her social and environmental contexts. Instead, IMH considers both risk and protective factors that may influence a child's development. Cathie Wright TAC (2002) stated: "From an infant mental health perspective it is important to address developmental pathways to competence and family resilience, as well as developmental pathways to disorders. Treatment needs to address both positive and negative influences on child and family social, emotional and behavioral health." (p.7). Fitzgerald and Barton (2000) wrote "Any event or set of events that affects infant/family well-being is an issue of appropriate concern for infant mental health" and listed these examples:

> premature birth, perinatal complications, inadequate prenatal care, infant morbidity and mortality (and parental grief), physical disability, mental retardation, poverty, undernutrition, single parenting, supplemental caregiving, parental psychopathology, parental stress, abusive parenting, parental substance abuse, and marital conflict. (p. 21)

For this reason, Raver & Knitzer (2002) explained that the IMH approach is closer to a public health model than a clinical or medical model.

The field of IMH also looks more like a public health model than a medical model because it combines education, prevention, and research strategies with the more typical mental health interventions and treatments (Fitzgerald & Barton, 2000, p. 22). The result

is a cross-disciplinary field that "acknowledges that early childhood mental health is an interagency responsibility, and that all service systems play a role in addressing the mental health needs of very young children" (Cathie Wright TAC, 2002, p. 1). This also means that:

> the designs typically combine several strategies; emotional and social skills learning may be paired with efforts to engage young children in more academic learning; parent-focused strategies may be joined with teacher-focused strategies; preventive interventions may be linked with more intensive strategies targeted to specific children already showing more problematic behaviors (Raver & Knitzer, 2002, p. 15).

Zeanah et al. (2005) described how a state could offer three levels of infant mental health care across a variety of settings:

- Primary prevention, or universal, approaches are aimed at improving child development, parenting knowledge and behavior, and infant mental health for all families within their service range. These approaches can take place in any setting, but primarily in health care, early childhood education and child care, and family support settings. Strategies generally include promotion, screening and assessment, education and guidance, and referral for more intensive services when needed.
- Focused, or targeted approaches are aimed at specifically identified groups considered at risk for developing potentially serious social or emotional problems. These approaches may be generated from any setting that serves individuals at risk. Examples include early intervention for premature or low birth weight

babies, home visiting services for first time mothers, or preventive interventions for abused or neglected children. Family support interventions include income assistance, adult basic and secondary education, parenting education to promote positive parent child interaction and interventions that address environmental risk factors like poverty.

- Intensive, or tertiary services serve infants and caregivers experiencing current difficulties, and also attempt to prevent or lessen future problems. These services are most likely to come out of mental health programs, and may be provided for those infants currently experiencing suffering, such as those who have experienced significant trauma, or for whom there are significant parent-infant relationship problems. (pp. 11-12)

As is clear from this description, early childhood education and childcare can play a prominent role in IMH interventions and treatments. Zeanah et al. (2005) explained that early care and education providers could play a role in assessment, education, intervention, and care coordination for children with mental health needs:

> Like a child's health and health care, early care and education can have significant and long term impacts on a child's development and eventual life success. The quality of care in an ECE setting can directly support a child's development by providing a learning environment. Like pediatric providers, ECE providers often have relationships of trust with their clients, and this relationship creates the opportunity for ECE providers to impact parent-child relationships, as well as act as an entry point to a broad network of early childhood services. Therefore, it is important that ECE providers be equipped with the knowledge, skills, tools and

relationships to provide quality care nested within a community of resources. (p.20)

Research Supporting the Infant Mental Health Perspective

Terminology. When discussing the relationship between mental health and mental illness in *Mental Health: A Report of the Surgeon General* (1999), the U.S. Department of Health and Human Services (USDHHS) stated that the two "are not polar opposites but may be thought of as points on a continuum" (p. 4). The Report defined mental health as "a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity" and described it as "indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society" (p. 4). The Report defined mental illness as "all diagnosable mental disorders" (p. 4). The USDHHS also acknowledged that along the continuum, there is a range of "signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder," for which they used the term, "mental health problems" (p. 5).

While labeling and defining mental health and mental illness is difficult to do, it gets further complicated when we attempt to apply these terms to young children and fit them into the language of education and development.

What we know about infant mental health.

Terminology and definitions. While the broad definition of mental health included above can apply to young children, in order to make the definition a truly useful and applicable one it is important to adjust the definition to describe what developmentally appropriate abilities and behaviors would look like in young children.

Lieberman and Van Horn (2008) made a simple adjustment to acknowledge the developmental difference between adults and children when they wrote: "Freud defined mental health as the capacity to work well and love well. For infants and young children, mental health may be defined as the capacity to *grow* well and love well" (p.2). ZERO TO THREE (2004) created a more developmentally specific definition of mental health for young children:

> Early childhood mental health is the capacity of the child from birth to age five to experience, regulate and express emotions; form close and secure interpersonal relationships; and explore the environment and learn. Infant mental health refers to how these issues affect development in the first three years of life. Early childhood mental health is synonymous with healthy social and emotional development. (p. 1)

The last part of this quote raises the point that early childhood mental health is closely related to what the education and child development fields describe as social and emotional development. Again, the definition of social and emotional development is general and applies to both children and adults: "The core features of emotional development include the ability to identify and understand one's own feelings, to accurately read and comprehend emotional states in others, to manage strong emotions and their expression in a constructive manner, to regulate one's own behavior, to develop empathy for others and to establish and sustain relationships" (National Scientific Council on the Developing Child, 2004b, p. 2). This definition can be further adapted to include specific developmental milestones that are appropriate for young children:

The hallmarks of a positive developmental trajectory and early childhood mental health are evident in the young child's capacity to:

- Develop enduring relationships with primary caregiver
- Initiate, discover, play and learn
- Persist when discouraged and attend when distracted
- Cope with disappointment and recover from disruption
- Develop self-regulation and a range of emotional responses that match the social-cultural-developmental expectations of the situation. (Cathie Wright TAC, 2002, p. 2)

How infant mental health develops. It is now widely understood that children's emotional development is influenced by their biological makeup, their experiences, their environments, and their relationships. Recent brain research places increasing emphasis on the importance of these factors, as it has shown us that children's early emotional experiences influence the pathways of their future emotional and cognitive development:

> Emotional development is actually built into the architecture of young children's brains in response to their individual personal experiences and the influences of the environments in which they live. In fact, emotion is a biologically based aspect of human functioning that is "wired" into multiple regions of the central nervous system that have a long history in the evolution of our species. These growing interconnections among brain circuits support the emergence of increasingly mature emotional behavior, particularly in the preschool years. (National Scientific Council on the Developing Child, 2004b, p. 2).

The role of relationships in the development of infant mental health. Relationships play a crucial role in the development of children's mental health. Of particular importance, especially for infants and toddlers, is the early parent-child attachment relationship. The National Scientific Council on the Developing Child (2004a) stated: "The initial emotional duet created by mother and baby-with their complementary interweaving of smiles, gestures, and animated vocalizations in social play-builds and strengthens brain architecture and creates a relationship in which the baby's experiences are affirmed and new abilities are nurtured" (p.2). These type of nurturing and stable parent-child relationships have been associated with both emotional and cognitive competence in young children, as well as later in life, "which illustrates the connection between social/emotional development and intellectual growth" (National Scientific Council on the Developing Child, 2004a, p.2).

While the parent-child relationship is important, research show us that children can also benefit from nurturing and secure relationships with other caregivers and peers. For example, "the warmth and support of the caregiver in a child care setting also influence the development of important capabilities in children, including greater social competence, fewer behavior problems, and enhanced thinking and reasoning skills at school age" (National Scientific Council on the Developing Child, 2004a, p. 2). With their peers, particularly their friends, young children engage in social learning and problem solving. They "learn how to share, to engage in reciprocal interactions (e.g. taking turns, giving and receiving), to take the needs and desires of others into account, and to manage their own impulses" (National Scientific Council on the Developing Child, 2004a, p. 2).

Relationships, particularly parent-child relationships, also interact with other factors such as environment, experiences, and even biological makeup to influence children's emotional development.

The role of the environment in the development of infant mental health. Parents and caregivers play a large (but not isolated) role in shaping the environments in which young children are raised. For example, along with other factors such as socio-economic status, caregivers influence the home environment, such as the choices of toys, activities, and interactions within the family setting, which "is strongly related to early cognitive and language development, performance on IQ testing, and later achievement in school"(National Scientific Council on the Developing Child, 2004a, p.2). The same holds true for other early caregivers, such as preschool teachers, who design the classroom environment in which children will learn.

Parents and caregivers also have some control over children's nutrition and health, such as assuring they are adequately nourished and protected from exposure to toxins. The National Scientific Council on the Developing Child (2004a) stated that: "These influences contribute significantly to healthy brain development and depend upon the care and support provided by individuals in the community as well as in the family" (p. 3).

The role of experiences in the development of infant mental health. Research also shows that parents and caregivers play a crucial role in how young children respond to stressful events:

> The relationships children have with their caregivers play critical roles in regulating stress hormone production during the early years of life. Those who

> experience the benefits of secure relationships have a more controlled stress hormone reaction when they are upset or frightened. This means that they are able to explore the world, meet challenges, and be frightened at times without sustaining the adverse neurological impacts of chronologically elevated levels of hormones such as cortisol that increase reactivity of selected brain systems to stress and threat. (National Scientific Council on the Developing Child, 2005, p. 4)

Not only are children who have nurturing and supportive caregivers better able to regulate their reactions to stressful events in the moment, they are actually better able to cope with stress physically and mentally later in life as well (National Scientific Council on the Developing Child, 2005, p. 1).

The role of biological makeup in the development of infant mental health. Temperament, which is grounded in one's biological makeup, plays a role in the way a child expresses and regulates emotions. The "goodness of fit" between the child's natural temperament and the temperament and parenting style of the primary caregivers can also influence the child's emotional development (The National Scientific Council on the Developing Child, 2004b, p. 3).

What we know about infant and early childhood mental health challenges and mental illness.

Terminology and definitions. While mental illness is a medical model term, defined as any diagnosable mental disorder, there are a range of signs, symptoms, and behaviors that fall along the continuum of mental health to mental illness but do not meet the criteria for a mental disorder. The USDHHS (1999) termed these signs and symptoms

"mental health problems." Yet, it is important to note that terms like "mental illness," "mental health problems," and even "mental health" can be met with stigma, particularly when applied to children.

The early childhood education and child development fields look at challenging behavior within the context of children's social and emotional development. Even socially and emotionally competent children will present some challenging behaviors as they develop; provided that these behaviors are socially, culturally, and/or developmentally appropriate for the age of the child they are considered typical and addressed accordingly. Challenging behaviors may be labeled as problem behaviors and seen as more cause for concern when they are considered socially, culturally, or developmentally inappropriate for the age of the child or when they are repetitive, persistent behaviors that negatively impact aspects of the child's life or development.

When a child's emotional needs are significant enough that they interfere with learning and achievement in school, the medical model is used to inform eligibility for special education services. The Individuals with Disabilities Education Improvement Act (IDEA, 2004) governs the education of students with disabilities. Turnbull, Turnbull, and Wehmeyer (2010) explained:

> IDEA uses the term *emotional disturbance* to refer to a condition that is accompanied by one or more of the following characteristics over a long time and to a marked degree and that adversely affect a child's educational performance:
>
> - An inability to learn that cannot be explained by intellectual, sensory, or health factors

- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers
- Inappropriate types of behavior or feelings under normal circumstances
- A general, pervasive mood of unhappiness or depression
- A tendency to develop physical symptoms or fears associated with personal or school problems. (p. 184)

Etiology of infant and early childhood problem behaviors, mental health challenges, and mental illness.

Risk factors. As with mental health; biological makeup, genetics, relationships, experiences, and environment are all factors that can make children more vulnerable to mental health problems and place them at risk for mental illness. While being exposed to one risk factor may not impact a child's mental health, the type, timing, and duration of the risk factor, as well as exposure to a combination of multiple risk factors may influence the impact (USDHHS, 1999, p.129). It is also true that certain risk factors may stem from/contribute to other risk factors, making certain populations more vulnerable (Cathie Wright TAC, 2002, p. 7).

- Biological risks: Some biological risks for mental illness include: premature birth; prenatal exposure to alcohol, tobacco smoke, and drugs (APA's Task Force on Early Mental Health Intervention, 2003); individual temperament, particularly in interaction with stressful experiences and parenting and caregiving styles (National Scientific Council on the Developing Child, 2008, p. 6); low birth weight; developmental delays, disabilities, chronic illness (Cathie Wright TAC, 2002, p. 4); and cognitive difficulties (Raver & Knitzer, 2002, p. 8).

- Genetic risks: One prominent genetic risk is inherited predisposition to a mental disorder because of parental mental illness (APA's Task Force on Early Mental Health Intervention, 2003).
- Relationship risks: Some relationship risks include: insecure attachment to primary caregiver (National Scientific Council on the Developing Child, 2004a, p. 3; APA's Task Force on Early Mental Health Intervention, 2003, p. 4); limited maternal emotional availability (as determined by factors such as poverty, parenting skills, degree of social support, homelessness, domestic violence, teen parent status, and substance abuse) (Cathie Wright TAC, 2002, p. 6); unstable, inconsistent relationships or abandonment by parent (Cathie Wright TAC, 2007, p. 7), and high caregiver turnover and inadequate preparation of staff in child care setting (National Scientific Council on the Developing Child, 2004a, p. 2).
- Experiential risks: Some experiential risks include: early physical and sexual abuse and exposure to violence; living through environmental disasters; immigrant background (APA's Task Force on Early Mental Health Intervention, 2003); and maltreatment, including neglect, abuse, separation and loss (Cathie Wright TAC, 2002, p. 5). Stressful experiences like these can have a negative impact on children's physical and mental health throughout life when they are at toxic levels and even impact their brain architecture. The National Scientific Council on the Developing Child (2005) explained that: "Toxic stress refers to strong, frequent or prolonged activation of the body's stress management system. Stressful events that are chronic, uncontrollable, and/or experienced without the child having access to support from caring adults tend to provoke these types of

toxic stress responses" (p.1). It is also true that the timing of the exposure to stressors like these matters, as the "neural circuits for dealing with stress are particularly malleable (or 'plastic') during the fetal and early childhood periods. Early experiences shape how readily they are activated and how well they can be contained and turned off" (National Scientific Council on the Developing Child, 2005, p.2).

- Social environment risks: Social environment risks can include the environment of the child's immediate family, as well as those of the child's neighborhood and community. Some examples of risks include: disrupted family composition (i.e. divorce); low mother education and income; chaotic relationship history; exposure to discrimination (APA's Task Force on Early Mental Health Intervention, 2003); growing up in poverty and receiving public assistance; having unemployed or teenage parents (Masi & Cooper, 2010); exposure to family violence (National Scientific Council on the Developing Child, 2004a, p. 3); exposure to toxins, such as drugs or lead; inadequate nutrition or iron deficiency anemia (Cathie Wright TAC, 2002, p.4) ; and placement in institutional or foster care. ZERO TO THREE (2004) explained that children in foster care are often subject to multiple risk factors: "Nearly 80% are prenatally exposed to substance abuse, 40% are born prematurely and/or low birth weight, and all of them experience repeated and often traumatic separation from caregivers, placing them at risk for future mental health disorders" (p. 8). Finally, the mental health of parents and caregivers can also disrupt parenting and affect their child's mental health. ZERO TO THREE (2004) stated that "[i]nfants of

clinically depressed mothers often withdraw, ultimately affecting their language skills, as well as physical and cognitive development" (p.5). They also estimated that "[m]aternal depression, anxiety disorders, and other forms of chronic depression affect approximately 10% of mothers with young children" (p.1).

Protective factors. As described above, exposure to a risk factor (or even multiple risk factors) does not mean that a child will develop mental health problems. This is particularly true if they have access to some protective factors. This is where the importance of secure, supportive attachment relationships can have a huge impact: "sensitive and responsive caregiving from a parent or a child care provider can serve as a powerful buffer against stress hormone exposure, even in children who might otherwise be highly vulnerable to stress" (National Scientific Council on the Developing Child, 2005, p. 4). Cathie Wright TAC (2002) also explained that supportive environments, characterized by "responsive emotional engagement, protection from overstimulation, alleviation of distress, encouragement of persistence, and development of self-efficacy," serve as protective factors, along with access to shelter, food, and health care (p.7).

Interestingly, supportive family environments appear to improve mental health outcomes for children, even when they are genetically at risk. A study by Pekka Tienari et al. (2004) compared a sample of Finnish adoptees at high-genetic-risk of schizophrenia with adoptees without this genetic risk to see if the adoptive families' environment impacted the children's development of the disorder. The study found evidence of genotype-environment interaction, as adoptees in the high-genetic-risk group were more sensitive to problems in the rearing environment (i.e. there was a significant association between more disordered rearing and adoptee's higher frequency of expression of

schizophrenia-spectrum disorders). But the study also found that the reverse was true, as the high-genetic-risk group had rates of schizophrenia-spectrum outcomes consistent with those without genetic risk when they were reared in 'healthy' adoptive families.

Problem behaviors, mental health problems, and mental illness can present in infancy and toddlerhood. While, as Zeanah emphasized, psychiatric disorders in the infancy and toddler periods are "less clearly differentiated and less well validated" (as cited in Cathie Wright TAC, 2002, p. 3) than those in adolescence and adulthood, research has found that infants and toddlers can experience "enduring emotional difficulties and mental-health problems that may be more severe than earlier generations of parents and clinicians ever suspected" (National Scientific Council on the Developing Child, 2004b, p. 3). It is now known that infants and toddlers can have clinically significant psychiatric disorders, such as depression, attachment disorders (ZERO TO THREE, 2002, p. 3), anxiety and post-traumatic stress disorder (National Scientific Council on the Developing Child, 2004b, p. 4-5).

When looking at mental illness in young children, it is important to understand that while their mental health challenges may share biological and behavioral characteristics with those of older children and adults, early childhood is a period of special vulnerability. Some reasons for this include: 1) young children are uniquely influenced by their environment of relationships, 2) young children are still developing the ability to display, think about, and manage their emotions, so the way they respond to emotional experiences and traumatic events is different from adults and adolescents, and 3) early childhood is a period of rapid growth and development, characterized by a broad range of individual differences (National Scientific Council on the Developing Child,

2008, p. 2). As a result of these differences between mental health challenges and mental illness in young children compared to those in older children and adults, identification and diagnosis can be difficult.

Symptoms of mental health challenges and mental illness in infants and toddlers. Infants and toddlers are still learning to display, manage, and communicate about their emotions. As a result, they have a fairly limited range of ways to respond to stress and trauma and display and manage their emotions. These responses often look quite different from those of older children, adolescents, and adults and may include physical and behavioral symptoms. ZERO TO THREE (2004) described what emotional problems might look like in infants and toddlers: "Early mental health disorders might be reflected in physical symptoms (poor weight gain, slow growth, constipation), overall delayed development, inconsolable crying, sleep problems, or in older toddlers, aggressive or impulsive behavior" (p. 5). According to Cohen (2005), additional behaviors that warrant concern in infants and toddlers include: inconsolable "fussiness" or irritability, extreme upset when left with another adult, inability to adapt to new situations, easily startled or alarmed by routine events, and inability to establish relationships with other children or adults (p. 5).

Overview of infant mental health prevention, intervention, and treatment approaches.

Overview of infant mental health prevention approaches. Some common early childhood mental health prevention approaches include: focusing on at-risk groups to reduce risk factors and enhance protective factors, offering early childhood developmental and mental health screenings at pediatric primary care visits, and

designing high quality preschool and childcare programs that promote social and emotional competence.

As described above, standardized screening and assessment tools offer an opportunity for early identification of mental health problems and prevention of the development of clinically significant mental disorders. ZERO TO THREE (2004) recommends that child and family practitioners use screening and assessment tools to document need for infants, toddlers, and young children. They also stated that "[s]creening and assessment of parental mental health, stress and support systems are equally important in enabling providers to document the needs of parents" (ZERO TO THREE, 2004, p. 5).

While general, routine screening and assessments are beneficial, providers can also opt to use screenings and developmental assessments within at-risk populations. For example, the National Scientific Council on the Developing Child (2007) recommended that providing developmental assessments for children in the child welfare system would be a compelling and promising place to start. (p. 8) Other prevention strategies also focus on identifying and reducing risk factors and enhancing protective factors for children at-risk. ZERO TO THREE (2004) identified children in foster care as a group at-risk and in need of comprehensive mental health services (p.7).

Overview of infant mental health intervention and treatment approaches. There is a wide range of intervention and treatment approaches for young children with emotional and behavioral needs. Some are early interventions, designed to address problems before they become more serious, others are designed to address more significant mental disorders. Some take place in specialty mental health settings, while

others are offered in the places where young children live and learn. Some work with children individually or children in group contexts with their peers or family members, while others work with children's caregivers, such as their teachers and parents.

The APA's Task Force on Early Mental Health Intervention (2003) highlighted several types of early mental health interventions, including: parent-focused and parent-child focused interventions, child-focused interventions (such as counseling sessions, outpatient cognitive behavioral treatment, and manual-based treatment), group-based interventions (such as classroom-based approaches), multicomponent interventions (such as home visiting and center-based day care, children and parents approaches, and parent and teacher approaches), and finally, pharmacotherapeutic interventions.

Interventions and treatments that are particularly useful for the youngest of children with emotional and behavioral problems are those that focus on their early relationships, particularly their attachment relationships. Some intervention and treatment approaches include family members in order to receive and share information about how to best help the child. The National Scientific Council on the Developing Child (2008) stated: "to understand the reasons that young children may be at risk for mental health impairments, how best to provide assistance, and strategies for preventing these problems from arising, it is important to look at the quality of their early relationships "(p.1). One specific strategy that allows providers to foster relationships with families, gather information about the home environment, and provide context-based suggestions for parents is home visiting.

Other approaches specifically aim to help make changes in the parent-child relationship. Knitzer (2000) stated: "Practice wisdom, although not yet rigorous

evaluation, suggests that more intensive family- and child-focused interventions explicitly designed to repair damaged relationships can help young children exposed to multiple risk factors" (p. 3). Koplow (2007) offered some reasons why parents may not be able to be active relationship partners in their young child's developmental process:

> The parents themselves may be experiencing a crisis during their child's infancy and toddlerhood that exhausts their inner resources and diminishes responsive parenting. There may by depression or other mental health issues that intrude on the parenting process. There may be intergenerational patterns of abuse and neglect that the parent is not consciously aware of, but which threaten to surface as the young child's oppositional or provocative behavior evokes the parent's childhood experience. (p. xvi)

Given that these types of challenges may impact the parent-child relationship, it is clear that families should be involved in young children's mental health treatment. Yet, sometimes designing supports and treatments for the parents themselves is the most important and helpful way to improve emotional and behavioral outcomes for their children.

Thus, this approach has implications for providers who are designing mental health interventions for children and also those providers who work with adults. The National Scientific Council on the Developing Child (2008) described the systemic barriers that may prevent this type of coordination: "most funding approaches to mental health services are client-specific rather than family-focused, and most programs aimed at such "adult" problems as poverty, domestic violence, or substance abuse do not take into consideration the emotional well-being of the children affected by them" (p. 8). They

added the recommendation that: "mental health services for adults who are parents of young children would have broader impact if they routinely included attention to the needs of the children as well" (p. 8).

Similarly, in much of the literature, there are calls for statewide, policy-level approaches to early childhood mental health interventions and treatments. In *Achieving the Promise: Transforming Mental Health Care in America*, the President's New Freedom Commission on Mental Health (2003) called for building upon systems already in place, such as primary care and school health services. ZERO TO THREE (2004) recommended that infant and early childhood mental health be integrated into all child-related services and systems, such as child care centers, maternal and child health programs, and community health programs (p. 2).

Preschool Programs Can and Do Support Students' Mental Health

Preschool-aged children are in a period of rapid growth in all areas of development. As a result, many preschool settings consider whole child development when planning instruction and designing classroom environments and activities. Children's physical, cognitive, adaptive, communication, and social and emotional skills are seen as equally important. Instruction is often planned with individual children's developmental needs and interests in mind. In this way, while preschool teachers are informed of "typical" child development milestones, the end goal of preschool education is individual children's progress towards developmental goals that are tailored specifically to their strengths and needs at the time of instruction.

The social and emotional milestones of the preschool years. As children grow, they "rapidly develop their abilities to experience and express different emotions, as well

as their capacity to cope with and manage a variety of feelings"(National Scientific Council on the Developing Child, 2004b, p. 1). Even by the time they reach toddlerhood or preschool, children's emotional states are much more complex. Children this age also become more aware of the feelings and actions of others: "They depend on their emerging capacities to interpret their own personal experiences and understand what others are doing and thinking, as well as to interpret the nuances of how others respond to them" (National Scientific Council on the Developing Child, 2004b, p. 2).

Benefits of early childhood mental health and well developed social and emotional skills. The young child's ability to regulate emotions and collaborate and interact productively with others impacts that child's current relationships and well-being: "differences in how young children understand and regulate their own emotions are closely associated with peer and teacher perceptions of their social competence, as well as with how well-liked they are in a child-care setting or preschool classroom" (National Scientific Council on the Developing Child, 2004b, p. 3).

In addition to their current relationships, these skills can impact the development of young children's emerging cognitive skills:

> The pathways that develop when children exercise emotional regulation not only allow for emotional maturation but are also needed to engage with other circuits, such as those governing the brain's "executive functioning" and cognitive mastery. In order for children to solve problems, use good judgment, plan their actions, and engage in higher level symbolic thinking, they need to be able to express and regulate emotions. (Koplow, 2007, p. xv).

Instructional strategies that support preschool students' social and emotional

competence and mental health. Since preschool children are in a period of significant social and emotional growth and because the impact of that growth is so significant, many preschool programs purposefully use instructional strategies that are conducive to children's success in this area. For example, they may: set up situations that foster these skills, such as collaborative pretend play and small group activities, such as cooking projects; model and scaffold children's learning as they begin to use socially appropriate language and actions; encourage children's exploration and discussion of strong feelings; and simply provide structure and consistency with a daily routine so that children can feel secure enough to learn these social and emotional skills. Preschools may also offer advice to parents in order to help them promote the development of their children's social and emotional skills at home.

The positive impact of "quality" preschool programs on young children's social and emotional competence and mental health. Much of the literature focuses on the role that supportive, quality early childhood programs can play in the development of young children's social and emotional competence and the prevention of problem behaviors turning into more serious mental health concerns. While the term "quality early childhood care" is somewhat subjective and hard to measure, a study conducted by Burchinal, Peisner-Feinberg, Bryant, and Clifford (2000) supported this observation:

> aspects of child care quality that can be regulated, such as teacher training, teacher-to-child ratio, and compliance with safety codes, have clearly demonstrated that low-income children in high-quality child care settings are significantly better off, cognitively and emotionally, than similar children in poor-quality settings. (as cited in Raver & Knitzer, 2002, p. 13)

Other literature describes "quality" programs as: programs that are nurturing, caring, and stimulating; programs that provide family support and developmentally appropriate practices (Knitzer, 2000, p. 3); programs that are marked by close teacher-student relationships, low levels of problem behaviors, and opportunities for positive social interaction; programs that offer more center-based experience; and programs with warm teachers and a predictable, stimulating atmosphere (Raver & Knitzer, 2002).

While program quality plays an important role in the mental health of preschoolers, there is much more that early childhood programs can do to promote emotional well-being among their students. Some of these tasks are preventive, such as providing early childhood teachers with training and access to help in dealing with children who are experiencing or at risk for emotional and behavioral problems (Raver & Knitzer, 2002, p. 4). Other approaches are more closely aligned with intervention and treatment and will be described below.

School-related intervention and treatment approaches. Raver & Knitzer (2002) explained that there are three types of interventions that can be implemented for young children:

- universal, prevention-oriented interventions aimed at child care and preschool classrooms as a whole;
- early interventions designed to help children experiencing greater risks for poor emotional and behavioral development; and
- mental health services and related support services beyond the classroom to help the most troubled young children and their families. (p. 14)

Yet, within these three types of interventions there is a range of approaches that can be used in the classroom. Some of these interventions can be used with the whole class, while others target individual children, families, and teachers. Some examples are listed below:

- Social skills curricula: Some preschools and elementary schools use social skills curricula targeted to all students in a classroom in order to "promote young children's decision-making, prosocial behavior, impulse control, and emotional-problem solving" (Raver & Knitzer, 2002, p. 14). The benefits of these types of programs are that they can be offered "universally" to all children in a classroom, at a relatively low cost (Raver & Knitzer, 2002, p. 14). Preliminary research on the impact of social skills curricula in preschool classrooms is promising but involve very limited samples (Raver & Knitzer, 2002, p. 4).
- Mental health consultants: One strategy that appears in much of the literature about school-based strategies is the use of mental health consultants in early childhood programs. Knitzer (2000) explained: "Early childhood mental health consultants bring mental health expertise to where the children and families are in the same way that school-based mental health services bring mental health expertise to where older children are" (p. 5). Knitzer also explained that consultants can be connected to individual early childhood programs or to a network of programs and that they can do a range of tasks to help schools support children's mental health, such as:
    - Help early childhood staff observe and understand behavior.

- Team with early childhood staff to design classroom interventions to promote emotional strengths and strong relationships, including social skills building.
- Provide information about what to expect in infants, toddlers, and preschoolers, and the importance of early relationships for them.
- Increase staff competencies in dealing with children with challenging behaviors or problematic emotional development.
- Help staff work more effectively with families, individually or through parent support groups.
- Help staff know when children or families need more specialized help.
- Help staff address cultural or other work-place tensions.
- Help children, staff, programs, and communities respond to community or family violence or other crises. (p.5)

Thus, the benefits of the consultation approach are that:

> the consultant can and often does develop a continuum of interventions, from classroom-focused interventions serving all children, to more intensive classroom and sometimes home-linked interventions for more high-risk young children, to referrals for those who need more specialized services. The model can be effective for infants and toddlers as well as preschoolers. Further, consultation approaches emphasizing linkages between parents and teachers encourage both sets of adults in a child's life to develop a sense of shared responsibility and support in addressing the

> child's emotional and behavioral difficulties. (Raver & Knitzer, 2002, p. 16)

- Parent guidance strategies: Building upon the research that parent-child relationships play a large role in children's social and emotional development, early childhood programs can offer support and resources to families, especially those who face many of the risks described above. Parent-training strategies can come in the form of more formal approaches, such as offering parenting classes or workshops (Raver & Knitzer, 2002, p. 15), to more informal interventions, such providing a parents' room, parents' groups, and parent-child days (Koplow, 2007, pp. 231-240).
- Play therapy strategies: While play therapy can be used in individual or group therapy settings, Lesley Koplow (2007) suggested that preschools can also incorporate play therapy strategies into the classroom when working with children with emotional and behavioral needs. Koplow defined play therapy "as a process of using play symbols to establish a connecting dialogue between child and therapist as well as between the child's conscious and unconscious experience" (p.65). Koplow described the benefits of using play therapy in the preschool setting this way:

> > When therapy takes place within the context of the early childhood program, children are able to experience attention to their dependency needs and use relationships to deepen their symbolic capacities. This allows them to use play to resolve difficult developmental and life experience issues, and to do so in the company of an attuned adult who

> can bear witness to their struggles and their growing integration. Parents may feel relieved to know that their children's emotional difficulties can be addressed in the trusted and familiar school setting. (p.77)

- Therapeutic techniques into the classroom: In addition to play therapy techniques, it is also possible to incorporate other types of therapeutic techniques into the classroom when working with children with mental health needs. Koplow (2007) stated: "Therapeutic techniques are available to all staff members who work in preschools for use at appropriate moments. These are moments when traditional management strategies and intervention models fall short of what is meaningful for emotionally fragile children" (p. 79). In *Unsmiling Faces: How Preschools Can Heal*, Koplow (2007) described a variety of techniques that can be incorporated in the classroom, in addition to a broader therapeutic curriculum design, including: therapeutic language (purposeful, communicative language, characterized by a genuine affect, a lack of moral judgment, and a reliance on observational comments); reflective techniques (which "help clients clarify and connect to their own thoughts and feelings" (p. 80)); techniques that invite expression (including "symbolic play, drawing, painting, playdough or clay" (p. 84)); containing techniques (ranging from daily routines to firm and consistent teachers, who reassure children that they will still care for them even when they have strong feelings); "modified" behavior modification programs (behavioral techniques that are used in addition to other more developmentally appropriate techniques, rather than in isolation, and ones that help children acknowledge their hurtful behavior and socially appropriate behavior, as well as become aware of

patterns in their behavior over time), interpretations (statements which are offered to help a child see an experience in a different way, gain insight about an experience, and/or make social-emotional cause and effect connections), and drawing (which is used to help children process their emotional experiences).

Preschool Students' Unmet Mental Health Needs

Despite the fact that preschools can, and often do, implement many of these strategies to promote children's social and emotional competence and prevent social, emotional, and behavioral problems from impairing children's continued growth and development; the literature also suggests that preschools, along with other child serving systems, may not best serve children who exhibit problem behaviors or more significant mental health needs.

Overview of preschool students with the greatest mental health needs.

Prevalence of problem behaviors among preschoolers. Since young children are still learning how to express and manage their emotions and play cooperatively with their peers; behaviors, such as hitting, kicking, biting, and threatening, can often be seen in preschool classes. In their study, Willoughby, Kupersmidt, and Bryant (2001) found that 40% of preschoolers exhibit at least one antisocial behavior each day but that some of these behaviors may no longer be seen by the time the children enter elementary school (p. 177). This suggests that many of these behaviors are simply signs of these children's emerging social and emotional development and will be expressed in more socially productive ways as the children develop greater self-regulation and awareness of their emotions. The National Scientific Council on the Developing Child (2008) discussed how educators and providers might assess the severity of early behavior problems:

> Generally speaking, clinical experts advise greater concern when children exhibit constellations of problems (e.g., persistent irritability, eating and sleeping problems, combined with defiance) that lead to significant impairments (especially in age-appropriate behavioral skills and relationships). Nevertheless, in the absence of more extensive evidence on the natural history of many mental health disorders, the "when to worry" problem remains a challenge. (p. 5)

Brauner and Stephens (2006) estimated that the prevalence of more significant emotional/behavioral problems in children (0-5 years of age) is in the range of 9.5 and 14.2 percent (p. 307). Boys show a greater prevalence of behavior problems that girls and young children from households with lower levels of family income are more likely to experience behavioral problems that negatively impact their development (Cooper, Masi, and Vick, 2009, p. 3-4).

Prevalence of mental illness among preschoolers. The USDHHS (1999) reported that one in five children (ages birth to 18) have a diagnosable mental disorder, "but only about 5 percent of all children experience what professionals term 'extreme functional impairment'" (p. 193). The rates of clinically significant mental illness are much lower for younger children than older children and adolescents. Raver & Knitzer (2002) reported that research finds that most young children with serious emotional and behavioral problems are either not identified or misidentified (2002, p. 10).

When looking at younger children in isolation, the National Center for Children in Poverty (NCCP) reported that between 4 and 6 percent of preschoolers have serious emotional and/or behavioral disorders (as cited in ZERO TO THREE, 2004, p. 6). The APA's Task Force on Early Mental Health Intervention (2003) reported that among

preschooler referred for psychiatric evaluation, the most common psychopathology was ADHD (86%), disruptive behavioral disorder (61%), mood disorders (43%), and anxiety disorders (28%) and that co-existing disorders were common (p. 10).

Prevalence of mental illness among young children at-risk. As expected, rates of clinically significant mental illness are higher when children and their parents are exposed to multiple risk factors. Whitaker, Orzol, and Khan (2006) found that children's behavior problems increased with maternal risk factors. Children with exposure to 3 risk factors were two to three times more likely than children without exposure to family risk factors to experience problems with aggression (19% vs. 7%), anxiety and depression (27% vs. 9%) and hyperactivity (19% vs. 7%)" (p. 551).

Prevalence rates of mental health challenges are particularly high for children exposed to certain risk factors, such as parental mental illness. Rates of child psychiatric diagnosis among children of parents with mental illness range from 30% to 50%, compared with an estimated rate of 20% in the general child population (Nicholson, Biebel, Hiden, Henry & Steir, 2001, p. ii). Howell (2004) reported that 19% of low-income children (ages 6 through 11) have mental health problems (p. 5). Burns et al. (2004) found that 48% of children and youth (ages to 2 through 14) in the child welfare system have a diagnosable mental illness (p. 960).

Symptoms of mental health challenges and mental illness in early childhood. As children move into the older toddler and preschool years, their response to stress and trauma may become less physical and more behavioral, such as aggressive or impulsive behavior, defiance, or overactivity. Additional behaviors that warrant concern in preschoolers include: engagement in compulsive activities (e.g. head banging); throwing

wild, despairing tantrums; withdrawal; showing little interest in social interaction, displaying repeated aggressive or impulsive behavior, difficulty playing with others, little or no communication, lack of language, or loss of earlier developmental achievements (Cohen, 2005. p. 5).While these behaviors may not necessarily indicate mental illness in young children, they are signs that parents, caregivers, and educators should monitor.

The impact of exposure to stressful events during early childhood. Long-term or repeated exposure to stressful events can have serious developmental consequences, which can last beyond the time of the events themselves, "alter the function of a number of neural systems, and even change the architecture of regions in the brain that are essential for learning and memory (The National Scientific Council on the Developing Child, 2005, p. 3). The impact of these stress exposures is particularly severe when the individuals affected are genetically more vulnerable to stress, which can lead to the emergence of later mental health challenges and even mental illness (National Scientific Council on the Developing Child, 2008, p. 1).

The impact of difficulty managing emotions and behavior during early childhood. Social and emotional development is tied to other areas of growth and development, including physical growth and health, communication and language development, and cognitive development. Children who exhibit problem behaviors and experience mental health challenges in early childhood may also struggle in other areas. One area of particular interest to educators is the relationship between social and emotional development and academic achievement, which can be impacted in several different ways.

Brain research has shown that the development of emotion and cognition are interrelated. The National Scientific Council on the Developing Child (2004b) summarized the connection this way:

> When feelings are not well managed, thinking can be impaired. Recent scientific advances have shown how the interrelated development of emotion and cognition relies on the emergence, maturation and interconnection of complex neural circuits in multiple areas of the brain…The circuits that are involved in the regulation of emotion are highly interactive with those that are associated with 'executive functions' (such as planning, judgment and decision making), which are intimately involved in the development of problem-solving skills during the preschool years. In terms of basic brain functioning, emotions support executive functions when they are well regulated but interfere with attention and decision making when they are poorly controlled. (p. 3)

The impact of difficulty managing emotions and behavior during early childhood. In addition to actually impacting cognitive development, language development, and brain functioning, children's social and emotional skills have an effect on their social functioning, participation, and success in preschool. Research shows that young children who struggle with regulating their emotions are: less likely to be accepted by their teachers and peers, less likely to be perceived as socially competent by their teachers and peers (National Scientific Council on the Developing Child, 2004b, p. 3), less likely to participate in classroom activities and work collaboratively with peers, less likely to receive instruction and feedback from teachers (even in preschool), and less

likely to be perceived as cognitively competent by their teachers (Raver & Knitzer, p. 3, 8).

The impact of mental illness during early childhood. Young children with mental illness experience many of the same impacts as children with difficulties regulating their emotions and behaviors, though the levels of impairment and the consequences for their future may be more enduring and severe. ZERO TO THREE (2004) explained that mental illness in young children may influence their future behavior and mental health status:

> Early attachment disorders predict subsequent aggressive behavior. Some early mental health disorders have lasting effects and may resemble conditions of later life, including withdrawal, sleeplessness or lack of appetite due to depression, anxiety, and traumatic stress reactions (p. 5).

Rates of access to care among preschoolers. While a smaller percent of preschoolers are identified as needing mental health services as compared to older children and adolescents (4% for preschoolers vs. 11% for adolescents) (NHIS as cited in Ringel & Sturm, 2001, p. 323); the percentage of young children who receive any type of mental health services is striking low. Ringel & Sturm (2001) reported: "Only 1% to 2% of preschool-aged children use mental health services, whereas the rate is 6% to 8% for the group aged 6 to 11 and 7% to 9% for the group aged 12 to 17" (p. 322).

Barriers to treatment. There is a wide range of reasons why people, particularly young children, may not have easy access to mental health services. The APA's Task Force on Early Mental Health Intervention (2003) cited these reasons: stigma and hesitation to label young children, insurance reimbursement rarely offers parity for

mental health services in the same way as it does for physical health, lack of professionals with early childhood focus, fragmentation of services, and disparities in utilization of child mental health services among particular racial/ethnic and socio-economic groups (p. 25). As this list makes clear, failure to provide mental health services to children can happen at two stages: the identification stage and the treatment stage.

As mentioned previously, early emotional and behavioral problems are often missed or misidentified, which prevents children and families from accessing needed services (Knitzer, 2000, p. 3). Using developmental and mental health screening tools during primary care check-ups is an important opportunity for the early identification and prevention of mental health problems in young children and their parents (i.e. maternal depression screening). These tools provide primary care doctors, who may feel in unfamiliar territory when looking at early childhood mental health, a straightforward way to screen for children's mental health problems. They also create opportunities for discussions with parents about their children's mental health. This opportunity is crucial, as research by Horowtiz et al. showed that "parents of children with social, emotional and behavioral problems were less likely to discuss these problems with a health care professional than parents of children with other developmental problems (20% vs. 80%)" (as cited in Cooper, Masi, Vick, 2009, p. 8). Despite these benefits, many providers do not use these screening tools to screen young children for developmental delays or their mothers for maternal depression.

In addition to lack of identification of mental health needs, there is also evidence that many young children with identified need do not receive services. Even when parents

of children with social, emotional, and behavioral problems reported concerns to their health care providers, Horowitz et al. found that "they were still less likely to access needed services than parents of children with other developmental problems (38% vs. 91%)" (as cited in Cooper, Masi, & Vick, 2009, p. 8).

Early childhood mental health prevention, intervention, and treatment approaches are effective. The figures about low access and barriers to mental health services are disheartening, especially when considering the fact that early identification and treatment can improve outcomes for young children with mental health challenges. In the report, *Achieving the Promise: Transforming Mental Health Care in America*, the President's New Freedom Commission on Mental Health (2003) recommended that early mental health screening, assessment and referral to service become common practice in order to improve the detection of mental health problems. In *Mental Health: A Report of the Surgeon General,* the USDHHS (1999) recommended early detection and intervention in order to prevent mental illness before any mental health problems "are established and become more refractory" (p. 132). The USDHHS then went on to explain that: "The field of prevention has now developed to the point that reduction of risk, prevention of onset, and early intervention are realistic possibilities" (p. 133).

The National Scientific Council on the Developing Child (2008) also called attention to the benefits of prevention and early intervention:

> If young children are not provided appropriate help, emotional difficulties that emerge early in life can become more serious disorders over time. Early prevention strategies and efforts to identify and treat emergent mental health problems are likely to be more psychologically beneficial and cost-effective than

> trying to treat emotional difficulties after they become more serious at a later age…many disorders can be prevented before they begin through developmentally appropriate, high-quality early care and education, systems of support that assist parents and caregivers to provide warm and secure relationships and detect emotional problems before they become more resistant to change, and public policies that help to ameliorate the physical, social, and economic conditions that cause some families to struggle. (p. 4)

In addition to prevention, "there are indications that early intervention can have a profound positive effect on the trajectory of emotional or behavioral problems as well as improve outcomes for children with serious disorders, be they psychological or genetic in origin" (National Scientific Council on the Developing Child, 2008, p. 1). There is also a range of effective treatments that "exist to help children and youth with mental health problems to function well in home, school, and community settings" (Masi & Cooper, 2006, p. 3).These interventions and treatments can even be effective in high-risk populations, such as young children exposed to violence, parental abuse or neglect (as cited in National Scientific Council on the Developing Child, 2004b, p. 4-5), and other significant early stresses (National Scientific Council on the Developing Child, 2005, p. 5).

Unmet mental health needs in preschool programs. The fact that students with greatest need are often not receiving sufficient support in preschool programs is evidenced by the fact that many preschoolers are expelled for behavior problems. For example, Gilliam (2005) found that "the prekindergarten expulsion rate is 3.2 times the rate for K-12 students" (p. 1). Another study by Cutler and Gilkerson found that 42% of

child care programs surveyed asked families to withdraw their infants and toddlers because of social-emotional problems (as cited in Knitzer, 2004, p. 1).

Preschool teachers and programs may not be able to help children with significant needs regulate their emotions and achieve mental health for a variety of reasons. First, teachers may not have received training on how to effectively address problem behaviors and identify mental illness. Second, they may not have the time or means to address these types of needs on their own. As Judith Feber (2007) explained, when a teacher takes on the role of the therapeutic teacher, her role expands: "She is many things to the child, including teacher, surrogate caregiver, therapist, and limit setter" (p. 56). Ferber also explained that this teacher has to balance these many roles with her role as the facilitator of the collective group (p. 63). Koplow (2007) also acknowledged that caring for children with significant emotional and behavioral challenges can have an impact on the adult who is involved:

> The behaviors of traumatized children and the awareness of their traumatic experiences can provoke a range of feelings in the adults who take care of them. This phenomenon of countertransference refers to the conscious or unconscious emotional reactions in the therapist or teacher that are evoked by the child's affects, behaviors, and issues. Countertransferential reactions can be powerful and sometimes confusing to the early childhood professional. (p. 187)

Third, preschools may not have the appropriate resources or supports to help teachers provide this type of instruction. Teacher supports, such as mental health consultants, decrease children's expulsion rates, as consultants can provide classroom-based strategies for dealing with students' challenging behaviors. In fact, a study found that "the lowest

rates of expulsion were reported by teachers that had an ongoing, regular relationship with a mental health consultant"(Gilliam, 2005, p. 12). Fourth, the poor quality of programs in general may impact their ability to provide socially and emotionally beneficial experiences to young children, much less to at-risk children, as they are characterized by "high caregiver turnover, poorly designed programs, or inadequate preparation of staff" (National Council on the Developing Child, 2004b, p. 1). Finally, Koplow (2007) explained that some programs may be shifting away from the goal of whole child development, in order to focus on academic achievement earlier: "there has been increasing pressure on early childhood programs to withdraw social supports and focus on academic performance in order to "prepare" children to succeed on standardized tests in the early grades" (p. xvii).

Unmet Mental Health Needs in Elementary School Settings

There is much less literature about the importance and possible methods of addressing students' metal health needs in elementary school. This is because as children enter elementary school academic learning becomes the primary goal of education. While some programs may still attempt to teach the whole child, activities that promote social and emotional development and physical development often get pushed to the side or pushed out of the school day in order to make room for academic learning. Chip Wood (2007) wrote of this: "Sadly, our classrooms have returned to an almost singular focus on the core three r's of readin,' ritin,' and 'rithmetic and we're in a period of endless testing of these skills, almost to the exclusion of critical social, cultural and civic learning" (p. 4). Thus, instead of promoting social and emotional competence, many schools react to problem behaviors and social and emotional needs once they begin to disrupt the learning

process or a child receives a label of "emotional disturbance" to access special education services. Similarly, when schools do address problem behaviors, they often begin with behavior modification plans, such as sticker charts and token systems, instead of looking more closely at the behavior to understand the underlying cause and context. Koplow (2007) said of these types of programs:

> Evidence shows that continual use of external rewards may interfere with the intrinsic motivation that underlies successful learning in early childhood. Children who organize themselves around earning rewards may become less involved in the actual learning activities and processes. Programs that routinely use behavior modification techniques to extinguish negative behaviors may neglect to address the source of the difficulties and may find that the child finds another undesirable means of expressing his or her distress after the target behavior has been extinguished. (p. 87)

Similarly, Nelson, Olive, Donovan, and McEvoy (1999), described these as "cookbook" approaches that respond to the "form" of a challenging behavior, rather than considering the form and the function of the behavior (p. 6).

As with preschool students, suspension and expulsion rates show that the current elementary school education system is not serving children with social and emotional needs as well as it could be. In fact, Masi & Cooper (2006) stated that: "Children and youth in elementary school with mental health problems are more likely to be unhappy at school, be absent, or be suspended or expelled" (p. 2).

The Need for Reforms Promoting the Support of Students' Social and Emotional Development and Mental Health in Elementary School

This lack of prevention and early intervention is inappropriate because even typically developing elementary school children have much learning to do about connecting with others and regulating their emotions.

The social and emotional and mental health milestones of the early elementary years. While the developmental leaps are not as rapid as they were during the preschool years, elementary school children are still in the process of exploring and fine-tuning their skills in many areas. The National Scientific Council on the Developing Child (2004b) explained that by the end of preschool, children with strong emotional foundations can use their social and emotional skills to better manage everyday social interactions, use language to communicate how they feel and to ask for help, and to "inhibit the expression of emotions that are inappropriate for a particular setting" (p. 2). Lightfoot, Cole, & Cole (2009) went on to describe the major social and emotional milestones of ages 5 to 7. Some of the things they listed included: stage of industry vs. inferiority (success in coping with increased expectations for maturity result in positive self-esteem), emergence of playing games with rules, moral behavior regulated by social relationships, emergence of clearly defined peer social structures, gendered-type behaviors increase, increasing proficiency at making and keeping friends and dealing with interpersonal conflicts, and emergence of social comparison (p. 382). This list of skills suggests that elementary school students still need teacher support and guidance as they navigate the complexities of interacting and collaborating with their peers.

This teacher support is even more important for children who may be coming into school with social and emotional delays or mental health needs and those exposed to risk factors that may impact their social and emotional development. This is a significant

number of students, as data from the U.S. Department of Education's Early Childhood Longitudinal Study, Kindergarten (ECLS-K) indicated that 31 percent of young children entering kindergarten have one risk factor such as low family income, low maternal education, single-parent status, or parents for whom English is a second language and 16 percent have two or more socio-demographic risks (Zill & West, 2001, p. 17).

The impact of social and emotional competence and mental health in the early elementary years. Research has shown that a focus on social and emotional development in elementary school can have a positive impact on students' personal, social, and academic well-being. One study on social and emotional programing in schools found that it raised achievement test scores by 11 to 17 percentile points (Payton et al., 2008, p. 7). Similarly, research by McClelland, Morrison, and Holmes (2000) showed the social and emotional adjustment of young children made a difference in predicting their academic achievement at school entry in kindergarten and the end of 2nd grade, even after varying levels of family resources and cognitive skills were taken into account (p. 308). In addition, strong social and emotional skills in early childhood establish the foundation for children's ability to be productive members of society:

> As a person develops into adulthood, these same social skills are essential for the formation of lasting friendships and intimate relationships, effective parenting, the ability to hold a job and work well with others and for becoming a contributing member of a community. (National Scientific Council on the Developing Child, 2004b, p. 1)

The impact of difficulty managing emotions and behavior during the early elementary years. In contrast, delayed social and emotional skills and unmet mental

health needs have been found to impact children as they transition to elementary school, affecting perceptions of their school readiness and their academic achievement. Knitzer (2000) reported: "Estimates are that between one-quarter and one-third of young children are perceived as not being ready to succeed in school. For a significant number of these children, concerns center around emotional development" (p. 3). Young children who have difficulty regulating their emotions and behavior are "more likely to do poorly on academic tasks and to be held back in the early years" (Raver & Knitzer, 2002, p. 3).

The impact of mental illness during the early elementary years. Hurwitz and Weston (2010) looked at the direct and indirect costs childhood mental disorders can have for the individual and society:

> Childhood mental disorders — such as depression and anxiety — persist into adulthood and often worsen if left untreated, thereby increasing the length and associated direct cost of treatment. Such delays can also encumber the individual with indirect costs that come with increased risk of school dropout, underemployment, incarceration, substance use, and co-morbid illness. The indirect costs of failing to appropriately address mental health issues early affect not only the individual, but society as well. The heavy toll placed on systems of health care, welfare, education, business, industry, justice, and public safety by unmet mental health needs cause society to absorb significant costs. Finally, considering that the average lifespan of an adult with mental illness is more than 25 years less than the average for an adult without mental illness, failure to provide prevention and early intervention allows for unconscionable human costs and suffering. (p. 7)

Finally, for children at-risk, early mental illness can have an even more significant impact. For example, in the child welfare system, children receiving special education services under the classification of emotional disturbance are less likely to be placed in permanent homes than children without any special education classification or with another special education classification (Smithgall et al, 2005, p. 22).

Prevention, intervention, and treatment options for elementary students with mental health needs. As with infants, toddlers, and preschoolers, there are a variety of prevention, intervention, and treatment options available for elementary school students. Unlike younger children, elementary school children may be old enough to more successfully participate in child-focused interventions, such as counseling sessions, outpatient cognitive behavioral treatment, and manual-based treatment. Similarly, elementary school students are more likely to receive pharmacotherapeutic treatment approaches. The National Scientific Council on the Developing Child (2008) reported that:

> There has been a dramatic increase in the use of psychoactive drugs for young children with behavioral or mental health problems, despite the fact that neither the efficacy nor safety of many of these medications has been studied specifically in children at these early ages. A recent report from the National Survey of Children's Health, for example, reported that children age 4-8 were more likely to be taking medication for attention deficit/hyperactivity disorder than older children and adolescents. (p. 7)

While there is less literature on school-based interventions for elementary school children than preschoolers, many of the strategies could apply to elementary schools as

well. Some examples include: implementing social skills curricula, using a mental health consultant, and incorporating play therapy into the classroom. In fact, Garry Landreth (2002) described how play therapy could be used in elementary school settings "to meet a broad range of the developmental needs of all children" (p. 36). Landreth stated that when used in elementary schools, play therapy is "an adjunct to the learning environment, an experience that helps children maximize their opportunities to learn" (p. 36).

Summary

This literature review has demonstrated that the IMH field offers a promising approach to early childhood mental health care, as: it is built upon a unified understanding of early childhood mental health, it combines multiple approaches to mental health interventions (with a focus on prevention), and it is cross-disciplinary, collaborative, and holistic. In contrast, while preschool and elementary school settings, as well as other child serving systems for these age groups, do some work to promote children's social and emotional development and prevent early childhood mental health problems and mental illness, there is still a significant amount of preschool and elementary school-aged children with unmet mental health needs. Through greater collaboration, better defined and shared mental health goals, and a holistic approach to children's development, schools and other child serving systems, could make better use of the available effective prevention, early intervention, and treatment options for young children and their families and in turn, have a profound impact on children's social, emotional, and academic success.

Addressing Students' Problem Behaviors and Mental Health Needs in Preschool and Elementary School: Observations from Three New York City Schools

All schools will encounter students with a range of emotional and behavioral needs. How they help these children will depend on the school's individual philosophy, resources, cultural influences, teacher training and capacity, and views on mental health, as well as the age range and the associated developmental expectations of their students. While two preschools may look very different on many levels, there is likely to be some cross-over in their approaches simply because they educate children of a certain age, who are facing similar developmental goals. These observations are presented to serve as a window into current practices in preschool and elementary school settings.

Observations from an Independent Preschool in New York

This section will describe observations from a student teaching placement in an integrated 4's class at an independent preschool in Lower Manhattan. As the description of this school will highlight, the preschool setting and philosophy facilitate the students' social and emotional development in many ways but, as with any setting, there is room for growth.

Overview of the school. This preschool is a small, independent preschool in Lower Manhattan. The school is progressive and focuses on the "whole child." The program is integrated, which means that it serves children with special needs as well as typically developing children in the same setting. There are four classes for children ages two through five. Each class has at least one head teacher with a master's degree in education and at least one assistant teacher. The co-directors of the school meet with each classroom team weekly and visit the classrooms on a regular basis. There is an on-site

speech therapist and Special Education Itinerant Teachers (SEITs) provide special education services for the students with special needs. The classroom teams also have weekly meetings with all service providers for the children with special needs. Teachers check-in with parents and caregivers daily and have two formal parent teacher conferences, complete with a written narrative to take home, twice a year. There is also a parent's night, a curriculum night, a school auction, and an end of the year potluck. While the school offers some financial aid, most of the families are upper middle class. The majority of the students are white or Asian American.

The 4's class that is being described has one head teacher, two assistant teachers, a SEIT, and a student teacher. There are 20 students in the class. One student in the class has a disability. The majority of the students in the class are white, though there are four Asian American students, one African American student, and one Indian American student.

An anecdote that characterizes this preschool's approach to students' social and emotional and mental health needs. Two boys in this class, "Kyle" and "Nate," had been "best friends" since they were two. Their parents often socialized and encouraged the boys to spend time together after school. Kyle was an outgoing child, who was well liked by many of the children in the class because his collaborative play skills were quite well developed. Nate was a shy child, who was only successful playing collaboratively when he was playing with Kyle. The teachers suspected that this was because Kyle often told Nate exactly what to do. When Kyle would play with other children in the class, Nate would get furious, sit in the corner of the room with his arms crossed and his brow furrowed, and refuse to talk to anyone. He would growl, mutter

things like, "I hate Kyle!," and throw things in Kyle's direction, while he watched Kyle's every move. Eventually, he would get up from his corner and tell Kyle that he hated him and that he was not his friend. Kyle would get very upset when Nate said things like this and often checked in with Nate, even when they were playing together cooperatively, "You're my friend, right? I will give you all my movies that I have in my house!" When Nate would say "No," Kyle would often tell a teacher, "Nate said he isn't my friend."

Because this happened at least once every day, the teachers in the class observed Kyle and Nate's interactions very closely. They checked in with each other daily about what they had observed, talked to the directors of the school about Kyle and Nate during the weekly classroom meeting and brainstormed strategies to try to help both boys. These included: offering Kyle regularly scheduled one-on-one time with a teacher, so that he could be reassured that everything was okay and so that Nate could have time to interact with classmates without Kyle there; updating both boys parents about the situation on a regular basis; drawing social stories to remind both boys that sometimes friends play apart and to help Nate process what made him angry; reading books about people being angry, friends playing apart, and friends saying "I'm not your friend."

One day, a teacher heard Nate tell Kyle, "I'm not your friend." Then when Kyle said, "You're my friend, right? Can I come over to your house?," Nate said, "Well, you can come over to my house and we can kill my mom." Since he was not talking to her, the teacher did not feel comfortable jumping in at that moment but encouraged Nate to come to storytelling to see what he would say there. Nate drew a picture and she recorded his words. His story was about a boy named Nate who had to kill a monster. The teacher then let Nate act his story out in front of the class. Nate got to be the character that killed

the monster and the director of the acting, who could tell Kyle what to do. Thus, this activity was beneficial for two reasons: the dynamic in the boys' relationship was shifted, at least temporarily, and the teacher was able to follow up on the concerning comment she heard Nate make.

Implications. This anecdote illustrates that the teachers in this classroom were paying close attention to the complicated dynamics of Nate and Kyle's friendship. They identified some concerning patterns and behaviors, which they viewed as their responsibility to address because they were disrupting both boys' learning, engagement, and relationships in school. To help promote both boys' social and emotional development, the teachers collaborated with each other, the directors of the school, and the parents. The teachers tried different types of interventions at the same time, such as parent education and more therapeutic approaches that invited expression. In doing so, they actively created a safe space in which the boys could process their feelings, navigate the complexities of their relationship, and continue to develop and learn.

Strengths in terms of supporting students' social and emotional development. While this school focuses on the whole child, the teachers place great emphasis on the children's social and emotional development.

Classroom environment. The 4's classroom is structured and consistent. The classroom is organized and stimulating but not overwhelming. Materials, such as blocks and dramatic play clothes, are stored in attractive, consistent, and easily accessible ways. There is a meeting area with a rug that turns into a dramatic play area, a block area, a sand table, and two large tables that can be turned into an art area, a manipulative area, or a lunch table as needed. Children's presence and place in the classroom is honored, as

children's paintings are displayed on the wall under their name. Children have their own cubbies to store their jacket, materials from home, and their family pictures. The daily classroom routine is generally the same every day and indicated on a picture schedule at the children's eye level. On days that the classroom routine changes, such as when a music teacher comes to play guitar and sing with the children, the change is indicated on the schedule.

Classroom experiences. Classroom experiences are also well organized and structured. Each morning when the children enter the room they move a picture of themselves from the "Home Box" to the "School Box." During circle time, teachers show the children which students and teachers are absent by pulling their pictures out of the "Home Box." They also show who is at school. This process welcomes children to the classroom and provides a routine way to acknowledge changes in the classroom. During work time, children are allowed to make a choice from several activities, such as blocks, playdough, snack, dramatic play, and painting. Some activities are collaborative, such as dramatic play, while others are solitary, such as painting. Once a week teachers also work with children in small groups to do cooking activities. Children choose an activity by placing their picture next to their choice on a felt board. Each choice can hold a set number of students, which is indicated by corresponding pieces of tape. When children are done at an activity they can make a new choice. Teachers give children a five-minute warning before it is time to put toys away, empathize with them if they are disappointed, and brainstorm with them if they created important work that they do not want put away, such a block structures.

In addition to the daily activities, there is also a yearlong curriculum in which children learn about themselves and document how much they have grown. Over the course of the year: they share pictures of themselves when they were babies; measure how long they were when they were born in string; have their parents come read their favorite story from when they were babies and their favorite story now; participate in interviews about what they were like when they were babies and what they are like now; and tell stories about growing up that the teachers dictate. This curriculum leads to many questions from the children, which teachers explore as they come up. For example, one boy with long hair shared with the class that he was a boy. When the children said he could not be a boy because he had long hair, the teacher created a chart about boys and girls; every child got to place their picture under the appropriate label, "boy" or "girl." They then had a conversation about what is different and what is the same between boys and girls.

Strategies for teaching social and emotional skills. In addition to designing a classroom environment and experiences that will help children develop social and emotional competence, the teacher in this class uses many strategies to help children work through their emotions. For example, she: uses drawing to help children reflect on an experience in the classroom; makes books to help talk to children about important events or changes in their life (such as a parent going on a trip or a pet dying); labels, mirrors, and validates children's emotions, sings songs and reads stories that have characters experiencing many different emotions, sets limits and establishes logical consequences when needed, gives children outlets for their strong emotions (such as pounding playdough), and talks about her own feelings with the children. In addition, the

teacher and directors provide information for parents about social and emotional development, in the form of written notes about child development (on topics such as aggression in preschool), in-person conversations about individual needs and concerns, and workshops on topics like limit setting.

Room for growth in terms of supporting student's social and emotional development. While this school places a particular focus on children's social and emotional development and, like many other preschools, focuses on the whole child, the teachers are not explicitly trained in addressing serious problem behaviors or recognizing mental health issues. While the directors, SEITs, and specialty service providers act as consultants and supports for the classroom teachers, there is nobody who specializes in mental health that comes to the school on a regular basis.

Observations from Two Public Elementary Schools in New York

What follows are observations from student teaching placements in two New York City public elementary schools. The first is a 2nd grade collaborative team teaching (CTT) class in a public school on the Upper East Side. The second is a self-contained kindergarten and 1st grade special education class in a public school on the Lower East Side. Both are included, as the first is more traditional, while the other attempts to incorporate progressive teaching strategies into the academic focus of elementary school.

Observations from a public elementary school on the Upper East Side.

Overview of the school. This school has about 750 students in grades prekindergarten through 5th grade. The student to teacher ratio is 14:1. All head teachers have a master's degree in education. Many classrooms have co-teachers, even ones that do not have children with special needs. Some students with special needs are assigned

paraprofessionals who are in class specifically to help them throughout the day. There are bi-weekly staff meetings. The principal of the school occasionally stops in the classrooms to observe teachers' lessons. The main focus of the school is academic achievement on standardized tests and the school does well on these. The school also participates in the Teachers College Reading and Writing Program, so they have a systematic approach to teaching reading and writing in school. Teachers are available to talk with parents over email and through appointment. There are two parent teacher conferences during the year, as well as a curriculum night, a family reading day, a family math day, an open school week, and several parent workshops. Most families who send their children to school here are upper middle class and live in the neighborhood around the school. Twenty percent of students at the school receive free lunch. The majority of the students are white (70 percent) and Hispanic (13 percent).

The 2nd grade class that is being described is a CTT class with a special education teacher, a general education teacher, a paraprofessional, and a student teacher. Both teachers have been teaching elementary school for less than five years. There are 20 students in the class. Eight students in the class have disabilities. The majority of the students in the class are white. There are two Hispanic students, two Asian American students, and one African American student.

Anecdotes that characterize this school's approach to students' social and emotional and mental health needs. There are two anecdotes that characterize this school's approach to students' social and emotional and mental health needs. In this classroom, children often worked in silence and were not allowed to get up from their seats during designated times. One day a girl, "Jasmine", asked the special education

teacher if she could go to the bathroom during silent reading. The teacher said she could not. Next Jasmine asked general education teacher who also said, "No". At the end of silent reading Jasmine refused to get up from her seat to move to the rug with the group. A teacher yelled at her to come to the rug. When the student teacher went over to see why Jasmine would not move, Jasmine whispered that she had peed in her pants and did not want anyone to see. When the student teacher asked her if she had any clothes to change into Jasmine said she did not, so the student teacher asked the special education teacher if there were any extra clothes the girl could borrow. The special education teacher went into the hall with Jasmine and the student teacher to explain where they could get extra clothes in the lost and found. Right then, the principal walked by and asked what had happened. The special education teacher explained and the principal said in front of Jasmine, "Isn't she a little too old to be having accidents?"

Another general education student, "Lola", often raised her hand during class and eagerly nodded her head when her teachers asked questions. One day the special education teacher told Lola, in front of the entire class, to stop answering all of the questions. From that day forward, Lola did not raise her hand in class for the rest of the year.

Implications. These anecdotes illustrate that the teachers' main goal was academic learning; they pursued this goal with a single-minded determination at the expense of children's social and emotional well-being and mental health. The first example of the accident during silent-reading showed that the child's physical comfort and emotional well-being were ignored to maximize academic instruction time. Then, after the child was

in an emotionally vulnerable state, she was criticized for failing to live up to the principal's age expectations, rather than supported at a time of need.

The second example of the eager student illustrated that by interacting with the students in ways that ignored their emotional needs in order to maximize academic instruction time, the teachers actually negatively impacted students' academic engagement and achievement.

Strengths in terms of supporting students' social and emotional development.

Classroom environment. This class is well organized and structured. The class is decorated with children's self-portraits, a New York City alphabet they made as a class, and many strategy charts for reading, writing, and math. There is a main meeting area with a rug, another rug area for small group work next to it, and a small computer station. The children's desks are arranged in five clusters of four students; children always sit at the same desk, unless their cluster changes, which happens every couple of months. Children hang their backpacks on personal hooks in the closet. The classroom routine is always similar but changes depending on the "specials" of the day, such as music, physical education, or science. The daily schedule is posted on the wall near the meeting area.

Classroom experiences. The daily activities are always well-organized and clear. Children begin the day by meeting the teachers on the playground and walking up to class. They have time to put their backpack and folders away and then sit down at their desk. Then the class moves to the rug for morning meeting. Students have daily jobs, which include things like reading the schedule, taking attendance, describing the weather, saying the date, and counting the days of school. Reading and writing workshops are

always in the same format. The students get into their groups and then have a mini-lesson with one of the teachers on the rug. They review what they have learned and then move to their desks for independent reading or writing. At the end, they share what they read or wrote with their neighbor and then the class. Math activities usually involve a formal lesson at the rug and then breaking into groups to complete a worksheet using manipulatives. On Friday afternoons children have choice time. Options include: board games, drawing on dry erase boards, making books, playing on the computer, or reading. Students meet with "reading buddies" from an older class once a month.

Strategies for teaching social and emotional skills. The teachers in this class often select stories to read aloud to the class that encourage group discussions about social issues, such as judgment and exclusion. When a child gets upset one of the teachers usually talks with that child in a private place about what happened. Desk clusters get "table points" when they pay attention, get ready for the next activity quietly, or answer questions right. At the end of the week, the cluster with the most points gets to pick a prize, which is usually a small toy or lunch with the teachers. The class also has a compliment jar. When other teachers in the school compliment the class, they get a token. When the jar of tokens is full, the class gets a party.

Room for growth in terms of supporting students' social and emotional development. This school places little emphasis on social and emotional development. While in some ways the students' presence and belonging in the classroom is recognized by the fact that they have their own desks and backpack hooks and their self-portraits are on the wall, the backpack hooks are very close together so students cannot easily access their stuff. The children's pictures are not up in the classroom but pictures of the

teachers' class from the year before are the screensaver on the computers. The student-teacher relationship feels formal, as teachers go by their last names. At the beginning of the year there were not any getting to know you activities. As a result, many students do not know each other's names.

There is very little variation in classroom activities. Teachers focus on reading, writing, and math because these are the subjects that matter for the standardized tests. Yet, children do receive music, science, and physical education outside of the classroom. There is also very limited student choice within activities and meaningful collaboration among students. While the teachers read relevant stories, there is no broader social and emotional curriculum.

When children get in trouble they get time off recess, rather than logical consequences for their actions. The teachers' style is somewhat authoritative. Children often work in silence and are not allowed to get up from their seats during designated times.

While the CTT setup inherently encourages a special education teacher and a general education teacher to work together and the teachers do work with other grade level teachers, there is limited teacher communication about issues other than lesson planning. Finally, the school has a school social worker and a nurse but there is nobody else who specializes in mental health that comes to the school on a regular basis.

Observations from a public elementary school in the Lower East Side.

Overview of the school. This school has about 300 students. There are students in prekindergarten through 5th grade. Many classes are mixed age level (i.e. classes with prekindergarten and kindergarten students). The student to teacher ratio is 12:1. All

teachers have a master's degree in education and many have a master's degree in special education. Many classes have two head teachers. There are also paraprofessionals and classroom aides in most classes. There are bi-weekly staff meetings at the school and grade level meetings every week during the teachers' lunch. The principal observes teachers' lessons frequently and is often on the playground during recess. The school has a progressive approach to education, so the curriculum includes hands-on projects, play, trips, and cooking. Teachers have a significant amount of choice in choosing curricula and planning lessons. Teachers communicate with parents at drop-off and pick-up, they also have two parent teacher conferences a year. Parents are invited to attend class trips and visit the school. There are also several parent workshops and events throughout the school year. While many of the families are middle class, 40 percent of the students receive free lunch. The school is fairly diverse: 40 percent of the students are white, 28 percent are Hispanic, 17 percent are African American, and 14 percent are Asian American. The school is in the process of expanding its special education program. Many classes are integrated with students with special needs and general education students in the same class. There are also several self-contained special education classrooms.

The combined kindergarten/1st grade class that is being described is a self-contained special education class. There is a head teacher with a master's degree in early childhood special education, a paraprofessional who works specifically with one child, a classroom aide, and a student teacher. The head teacher has worked as a teacher for more than five years and taught preschoolers with special needs before teaching elementary school students. There are 11 students with special needs in the class. The majority of

them qualify for free lunch. There are ten Hispanic students, one African American student, and one white student in the class.

An anecdote that characterizes this school's approach to students' social and emotional and mental health needs. In this class, there was a student, "Elizabeth", who often broke down crying when she did not get something right or she got in an argument with a classmate. Elizabeth had a sister, whose teachers suspected she was being sexually abused and had called Child Protective Services. One day, Elizabeth suddenly began crying and fled the room during music, her favorite class. When the teacher brought Elizabeth back to the classroom, he asked her what happened but did not have time to have a full conversation with her because he was about to start a lesson. During the transition, Elizabeth drew a picture of a girl holding a knife and standing over a man who was lying on the ground. In an effort to get children to the rug, the teacher told Elizabeth to put the paper away. He did not look closely at it and she ripped it up before he could see. When a student teacher described what Elizabeth had drawn to him later in the day, he seemed concerned but never followed up with Elizabeth.

Two days later, the school social worker came to do a presentation about private parts to the class because several boys had been playing a game where they touched each other's private parts in the bathroom and one boy had told his mother, who called the school. After reading a book about private parts and explaining that nobody should touch you in these places, the social worker asked for questions. Elizabeth raised her hand and said, "I have a question…" but then stuttered and began crying. The teacher had the teacher's aide go into the hallway with Elizabeth to help her calm down, while he and the social worker stayed in the classroom to help the class with a follow up activity. When

asked about it later, the teacher said that he thought Elizabeth was just having a hard day and her upset had nothing to do with the social workers' presentation.

Implications. This teacher missed several opportunities to talk with Elizabeth about possible sexual abuse because he was overwhelmed. While there was some collaboration among classroom teachers and the school social worker, these collaborations were not used as effectively as they could have been. For example, even though the school social worker was in the room when Elizabeth got upset, she too decided to stay in the room for the follow up activity and not to talk with Elizabeth. Instead, the classroom aide, the teacher with the least amount of training to support a student with possible exposure to a risk factor like sexual abuse was left with the upset child.

Strengths in terms of supporting students' social and emotional development.

Classroom environment. This classroom has many developmentally appropriate materials for children and balances supporting the development of the whole child with the external pressure to succeed on academic testing. There is a class meeting area with a rug, a block area, a dramatic play/calm-down area, a sand table, a reading bench, and two tables which can be turned in to work stations, lunch tables, or art areas as needed. The students are welcomed and acknowledge in this classroom. Students' art is hanging on the wall. Children have their own cubbies with their pictures on them. They also have their own rug spots, which are identified by different shapes. While the daily routine changes depending on the "specials" for the day, such as Spanish, physical education, and music and movement, there is a daily schedule on the board. The children drew the pictures on the activity cards for the schedule.

Classroom experiences. The children begin the day in a very predictable way. They hang up their coat and backpack and then find their handwriting journal and do the pages the teacher has individually selected for them. When they finish they can color in their notebooks. When all the children have arrived, they get a warning before clean up time and then go to the rug for meeting. During meeting children have jobs such as reading the schedule, reading the note from the teacher, saying the date, and describing the weather. Classroom lessons are almost always done in small groups, though sometimes they begin as a whole group and break up into smaller groups. Within the groups, the children usually work at their own pace and then get to play or draw when they are finished. Children eat lunch in the classroom with at least two of the teachers sitting with them. During this time they talk to their teachers and peers. At the end of everyday they have work time. Children are offered several choices of activities. These often include: balance beam, sand table, playdough, painting, pretend play, or games.

Strategies for teaching social and emotional skills. The teacher in this class talks about emotions with the students and models socially appropriate ways to handle strong emotions. The teacher validates children's emotions and encourages them to display these emotions in healthy ways, such as punching a bean bag. The teacher also created a space in the classroom (with a rug, a tent, and a bean bag) for children to go to when they needed to calm down, be alone, or in rare instances, catch up on sleep. Similarly, the school has a "peace room" where students can go with a teacher to calm down and talk about what happened in emotionally charged incidents. The teacher in this class also uses a significant amount of behavior modification plans. When a student hits or displays off task or disruptive behavior, the teacher talks with that student about what happened and

has the student sit out for a few minutes. Sometimes the teacher waits until the end of the day and has the student sit out before work time while the other students start playing. The teacher also gives children stickers if they behave during an activity. When students fill a sheet with stickers, they get to pick a prize at the end of the week, which is usually a toy. When using individual behavior modification plans, the teacher shares information with the parents' about the child's day.

Room for growth in terms of supporting students' social and emotional development. The teacher in this class deals with different challenges than the teachers in the other classes. Several of the students in the class face difficult circumstances at home, such as physical abuse, hunger, poverty, and parental drug use. Several students also display significant emotional and behavioral challenges. The teacher is often out of the classroom, talking to parents, the children's doctors and psychiatrists, the school social worker, and the school principal. As a result, he is often not in the classroom to follow through on the emotional supports he has designed. This means that the classroom paraprofessional and the classroom aide are often in the classroom alone with the children, dealing directly with the emotional and behavioral issues that come up. The paraprofessional and classroom aide have limited training in teaching students with special needs and a different, more authoritative management style than the head teacher. They often yell, sit children out, or take away recess or work time without any discussion of emotions or processing of events when children misbehave.

To make matters more difficult, the classroom team never has formal meetings at which they can discuss challenging incidents or even plan instruction. Similarly, the principal has relatively little experience with students with special needs, so the only real

resource for the teacher is other special education teachers in the building. These teachers do nice job of supporting each other, such as covering for each other and designing the "peace room" for their students to calm down in.

While this teacher is communicating with people from other fields, such as the students' doctors and psychiatrists and the school social worker, he is doing so during classroom time. He is also completely overwhelmed and does not have someone with formal mental health training consulting him on how to support the children with significant emotional and behavioral challenges in his classroom.

Summary

Preschool and early elementary school students are both at stages of rapid social and emotional development. Both groups require developmentally appropriate levels of adult support and guidance as they gain increasing competence with regulating and expressing their emotions and interacting and forming relationships with their peers. These observations from three New York City schools reveal the range of ways schools can and do support young children's social and emotional development. Some examples from the observations include: designing organized, inviting classroom environments; setting up activities that promote collaboration among students; welcoming parents and students to the school; explicitly talking about emotions and how to regulate them with children; validating children's emotions by acknowledging them, giving them socially appropriate ways to express them, and reading/singing about characters who have similar emotions.

In some ways, preschool settings are more suited for addressing social and emotional development, as preschool teachers often focus on the whole child, plan for

specific children's interests and needs, and have frequent communication with parents. Yet as these observations show, elementary school teachers can incorporate many of these approaches into their classrooms if they consciously decide to do so. Elementary teachers may also have more resources available to them, such as the school social worker, to help them plan activities and manage their classrooms in emotionally supportive ways.

Yet these observations also demonstrate that many schools often miss opportunities to support children's social and emotional development and do not have systems in place to meet the needs of children with more significant emotional and behavioral needs. Collaboration and communication among teachers, parents, administrators, and specialists from other fields is clearly an area in which schools are struggling. Elementary schools could benefit from using more explicit emotional and social supports, such as those used in the preschool described above, when working with children with significant social and emotional challenges. Preschools and elementary schools need to expand their view of social and emotional development and their range of prevention, intervention, and treatment supports to meet the needs of children with significant mental health issues.

Implications

What Schools Can Learn from the Infant Mental Health Field

School plays a unique role in a child's life. Aside from home, it is the place where the child spends the majority of the day and where an adult other than a family member knows the child well. This has implications for mental health prevention, intervention, and treatment approaches, as it is an ideal location for accessing a large number of young

children and because it provides families with increased opportunities to access services for their children (Hurwitz & Weston, 2010, p. 6).

While schools, particularly preschools, do often actively promote social and emotional development, it is clear from the observations above as well as expulsion rates in both preschools and elementary schools, that schools do not always take advantage of available opportunities to address students' social and emotional needs or adjust instruction and practice for children with more significant mental health needs. In part, this failure to really support students who display significant problem behaviors and mental health needs in schools stems from the fact that mental illness, or as it is described in the education field, "emotional disturbance," is not seen by teachers as a component along the continuum of social and emotional developmental skills and needs. Instead mental illness, like its stigma-laden name, is seen as belonging to the medical field and thus not part of the purview of the field of education. Thus, teachers and schools assume they cannot or do not need to have a role in treatment, or even prevention or early intervention of mental illness in the young children they work with; despite the fact that this intervention will not only improve their social/emotional development but also their academic achievement. Rather, they choose to "manage" the resulting behavior and hope that the child learns in spite of having mental health needs. This unrealistic and uninformed thinking occurs to a greater extent in elementary school, where the goal of education becomes academic achievement only, so that even activities promoting social and emotional competence are withdrawn or decreased.

IMH addresses this problem by grounding mental health and mental illness in a developmental and relationship-based context. Since a child's development is viewed as

being informed by his or her environment, relationships, experiences, and biological makeup, professionals from the medical field play one role in a web of prevention, intervention, and treatment services available to help improve the social and emotional outcomes for that child. Everyone, from the child's parents, to the child's teachers, to the child's neighbors, is a resource that can help that child achieve mental health and social/developmental success.

If schools adopted this wider IMH perspective and expanded their view of social and emotional development towards the recognition of a continuum that includes mental health and mental illness, they would better serve children with significant problem behaviors and mental health needs do so earlier, and ultimately also improve academic outcomes. Here are some recommendations of changes preschool and elementary school settings could make to move toward the IMH approach and better support their students:

Integrating infant mental health approaches into preschool settings. In many ways most preschools are closely aligned with the goals and underlying perspective of IMH. For example: most preschools' teaching methods are already informed by a developmental perspective and acknowledge the importance of the early attachment relationship for a child's growth and development. Similarly, preschool teachers and administrators often work closely with parents to address risk factors and acknowledge resilience factors that may influence a child's development. They also work to provide supportive, developmentally appropriate environments and experiences that promote social and emotional development.

In order to better address problem behaviors and mental health needs in the classroom, preschools could adopt additional strategies from the IMF field, such as:

1) Invest in parent, teacher, and administration education about identification of mental illness in young children, prevention and intervention strategies to use in the classroom and at home, and resources for outside assessment, intervention, and treatment services; and

2) Collaborate with professionals from other disciplines and agencies to provide resources to parents and teachers (this may be in the form of mental health consultation, assistance for poverty or substance abuse, etc.).

Integrating infant mental health approaches into early elementary school settings. While elementary school settings are not as closely aligned with the values and goals of IMH, they are already doing some work that IMH suggests, such as collaborating with professionals from other fields and agencies and looking at/addressing risk and resilience factors that influence development. For example, public schools provide children with free or reduced lunch if their family's income makes them eligible. Teachers refer children to the school social worker or suggest referrals to outside specialists when they worry that children's development is being affected by outside factors. Similarly, teachers are mandated reporters who are required to call Child Protective Services when they suspect child abuse.

These collaborative efforts would be much more effective if they were embedded within a larger framework of cross-disciplinary prevention, intervention, and treatment. In order to better address problem behaviors and mental health needs in the classroom, elementary schools could incorporate other strategies from the IMF field, such as:

1) Adopt a developmental and relationship-based framework and value system that views promoting whole child development as the best way to reach academic achievement goals;
2) Attempt to understand the underlying cause and context of problem behaviors before addressing them; and
3) Invest in parent, teacher, and administration education about identification of mental illness in young children, prevention and intervention strategies to use in the classroom and at home, and resources for outside assessment, intervention, and treatment services.

Summary

The IMH field takes a holistic, collaborative, and prevention based approach to early childhood mental health. This approach is developed from years of research about the nature of the social, emotional, and behavioral development of infants and toddlers. At the core of this research is the recognition that infant and toddler development is profoundly and uniquely influenced by children's contexts, particularly their early relationships, and is characterized by wide ranges of individual differences and rapid growth and development. Adopting or emulating the IMH approach to the prevention, intervention, and treatment of early childhood mental illness would require significant changes in the underlying perspectives of preschools and, even more dramatically, elementary schools. These changes would require major paradigm shifts in the goals of education, the role of schools in addressing early childhood mental illness, and the range of possible approaches to promote social and emotional learning; it is this author's

assertion that these changes would improve mental health, social and emotional outcomes, and ultimately academic success for young children.

By developing a better coordinated infrastructure for providing early childhood mental health services, preschools and elementary schools could more efficiently and effectively address students' problem behaviors and mental health needs. Adopting a unified perspective on early childhood social and emotional development and mental health would assure that prevention, intervention, and treatment strategies were developmentally appropriate, consistent, and informed by the research. Designing a system and services that promote collaboration among families, communities, and various disciplines would help reduce fragmented and inconsistent mental health services and encourage all adults involved in a child's life to see their role in the promotion of that child's mental health and social and emotional competence. Thus, there would likely be more opportunities to use prevention and early intervention strategies to promote positive mental health outcomes before mental health concerns turn into serious and debilitating problems.

While preschool and elementary schools may not see early childhood mental health as within the scope of their responsibilities, it is clear that they are already reacting to and addressing a wide range of students' mental health needs on a daily basis, albeit not very effectively. Choosing to prevent behavioral and mental health problems and to intervene early and appropriately when they do arise could only ensure greater positive outcomes for the young child in all areas. In turn, these positive outcomes, such as improved mental health, well-being, and academic success, would directly support schools' underlying goals: whole child development and academic learning.

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