Mental Health in the Pediatrician's Office

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Case Study

John (21 months) and Victoria (31 months) were siblings only 10 months apart, and their mother Leanne was quickly feeling incompetent in her efforts to manage their constant fighting. During a visit to their pediatrician, John hit Victoria, which prompted Victoria to hit John, which in turn resulted in their mother hitting Victoria. Leanne confessed to Dr. Myers that this was a daily routine, which was quickly stressing the health of her marriage and causing her to go to bed in tears each night. Additionally, though she had attempted to work a part time job, both children were asked to leave their nursery school due to behavior, forcing Leanne to quit the job. A three week intervention focused on alternative discipline strategies, and both children returned to nursery school.

Case Study

Caroline is 32 months old, and still wakes up nightly, crying and fussing until her parents respond to her. Additionally, she still drinks 4 bottles a day, and constantly has a pacifier in her mouth. She is obese, and her parents describe her as "bossy" and "defiant and aggressive," but note that she is "perfect" in her day care setting, and wonder what they are doing wrong. Lately, Caroline has been hitting her mother in response to limit setting. "Dr. Allen," they plead, "we've tried time out, spanking, and everything else, but nothing works. We never even leave the house anymore because her behavior is so horrible. Neither of us are speaking to our parents, because they just accuse us of spoiling her." Two sessions of intervention helped Caroline's parents to learn that they need to become more effective in setting limits with Caroline, so that she might learn frustration tolerance and coping skills. As a result, she was sleeping through the night, had given up her pacifier, and was down to one bottle a day, just before bedtime.

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These children's stories are not unique.

There is a growing recognition that millions of children in the United States experience emotional and behavioral problems, with early childhood a critical time for onset of these problems. Research on brain development during the earliest years has highlighted the importance of the relationships and environments that a young child experiences. Relationships that are characterized by empathic and reliable care giving, in an enriched learning environment, promote the neurological underpinnings for secure attachment, behavioral regulation, cognitive and linguistic development, and a sense of emotional well being.[1] Environments and relationships characterized by any less often contribute to significant difficulties later in development, including problems in children's social-emotional development, learning, and behavioral regulation.[2]

Researchers reviewing the effects of stress on the young brain tell us that:

> ***"The relationships children have with their caregivers play critical roles in regulating stress hormone production during the early years of life…children whose relationships are insecure or disorganized demonstrate higher stress hormone levels when they are even mildly frightened. This results in an increased incidence of elevated cortisol levels which may alter the development of brain circuits in ways that make some children less capable of coping effectively with stress as they grow up."*** [ibid.]

Given that current guidelines recommend fifteen well-child visits from birth through the child's third birthday, pediatricians are in a unique position for the earliest identification of mental health issues in both children and their families. Furthermore, pediatrics is a non-stigmatized and universally accessed setting, with recent estimates suggesting that at least 95% of children in the U.S. regularly visit a pediatrician.[3] While competencies around screening, addressing and referring a host of social emotional issues are not emphasized in pediatric training, the social emotional issues facing children and families today demand a great range of competencies of a practicing pediatrician if he or she is to be effective in meeting patient needs.

This article presents a clear framework for the ways in which pediatricians can begin to transform their practice to address social-emotional issues in infants and toddlers.

We begin by providing an overview of infant and toddler social-emotional development and one of the main risk factors for problems in this area: maternal depression (including post-partum depression). We then highlight different opportunities available to pediatricians for addressing mental health issues, followed by a discussion of ways to transform a practice, with a strong emphasis on screening for mental health issues. We conclude with some examples of best practice in this field as well as opportunities for pediatrician participation in advocating for a range of investments in early childhood mental health services.

Overview of Infant and Early Childhood Social and Emotional Development

The terms "infant mental health" and "social-emotional development" are often used interchangeably. Zero to Three, as part of their Infant Mental Health Resource Center, defines infant mental health as follows:

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Infant mental health is the developing capacity of the child from birth to age 3 to:

- ***experience, regulate, and express emotions***
- ***form close and secure interpersonal relationships; and***
- ***explore the environment and learn***

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Infant mental health is synonymous with healthy social and emotional development.[4] Researchers often adopt the terminology "social and emotional development" when speaking about older children. Because this article addresses children ages 0 – 6, the broader "social and emotional development" will be used throughout.

In infants, one of the most important hallmarks of mental health is the ability to regulate their own emotions and to form secure attachments (see Box 1). In preschoolers and older children, healthy social and emotional development allows for pro-social interactions with both their peers and with adults. Research makes clear that children's social and emotional skills build a foundation for early academic achievement. Children with poor social-emotional development demonstrate: higher risk of poor academic achievement; higher rates of school failure; higher levels of delinquency; and lower levels of interaction with both teachers and peers.[5] Difficulties in dyadic regulation in early childhood may also have significant impact on later mental health, predicting rates of depression, anxiety, and global psychopathology.[6] Intervention in early childhood has also been shown to have a beneficial effect of rates of criminal arrests and illicit substance use (rates cut in half compared to a control group).[7]

BOX 1—Attachment

- **Attachment theory was developed by Bowlby and Ainsworth:** from the parent-child bond, children develop an "internal working model" of how relationships function. This model serves as a guide for future relationships.
- **Types of attachment:** (These are typically measured using Ainsworth's Strange Situation, in which a parent and child are separated for a brief amount of time, and the child's behavior upon reunion is analyzed.)
  - **Secure**—The parent serves as a secure, constant base for the child from which to explore.
  - **Avoidant**—Babies are more unresponsive to the parent when the parent is present.
  - **Resistant**—While these babies seek closeness to the parent, they will not use the parent as a base from which to explore.
  - **Disorganized/disoriented**—This is the highest level of insecurity, in which after separation, the baby responds to the parent in a confused, contradictory fashion.
- **Attachment can be affected by multiple factors.** These include maternal deprivation, the quality of caregiving and "in-tuneness" between the mother and child, the infant's characteristics and temperament, and contextual factors, such as the family's socio-economic status.

The prevalence rates of social and emotional issues among infants and young children make these issues impossible to ignore. Estimates of national prevalence rates of young children with psychosocial problems are between 10% and 21% (depending on the sample studied), while rates specifically for externalizing problems (i.e. "acting-out" behaviors) can be as high as 25%.[8] While many children go undiagnosed and untreated, in 1997 there were, nonetheless, almost 120,000 preschoolers (1 out of 200) between the ages of birth and six who received mental health services.[9] The expansive impact of early childhood mental health problems is illuminated by the alarming rate of expulsion in preschool; in a study using data from the National Prekindergarten Study, Gilliam found that children in state-funded prekindergarten programs were 3 times as likely to be expelled as K-12 students (6.7 per 1,000 as compared to 2.1 per 1, 000 enrolled).[10] While the reasons teachers gave for expulsions are not explicitly stated, expulsion is typically the result of extreme behavior problems that result in classroom disruption.

Researchers have identified multiple risk factors for poor early childhood social-emotional development (see box 2). One method for categorizing these risk factors is: demographic risk factors, family risk factors, child risk factors, and environmental risk factors. Demographic and family risk factors include the context that the child was born into, such as the family's poverty status, having a single parent, a teen parent, lack of social support, punitive discipline strategies, low parental education levels, parental depression, and the presence of substance abuse or domestic violence in the home. Child risk factors are those that the child brings with him and are often apparent to parents right from the time of the child's birth. These include developmental or health delays or emotional and behavioral disorders. Finally, environmental risk factors include homelessness and placement in the foster care system.

BOX 2— Risk Factors For Poor Social-Emotional Health

- Poverty
- Single Parent
- Low Parental education levels
- Teenage parent
- Substance abuse in the home
- Domestic Violence in the home
- Homelessness
- Foster Care System
- Developmental Delays

Risk factors often lead to a need for referral, and common referral reasons for infants and toddlers include [11]:

- *Early onset language delay*
- *Concerns regarding autism*
- *Regulatory issues, such as sleep, feeding, and toilet training problems*
- *Externalizing behavior problems, including tantrums, biting, and hitting*
- *Developmental delay*
- *Concerns regarding parental mental health*
- *Concerns regarding the interaction between parents and their child*
- *Harsh and punitive discipline*

Overview of Maternal Depression and Post-Partum Depression

We know that maternal depression, including post partum depression[1], affects millions of families. Depression may be especially pernicious among mothers of young children: while the rates of major depression disorder at any given time in the general adult population are around 7%, rates of depression among mothers of young children have been found to range between 12 and 50%, depending on the study. This risk appears to be exacerbated for mothers of young children who are living in poverty. For example, in the Early Head Start Research and Evaluation Project, 48% of the mothers reported enough depressive symptoms to be considered depressed at the time of enrollment in the study.[13] Similarly, post-partum depression has been found to affect 14% of new mothers, and that rate rises to 25% for young and socioeconomically disadvantaged mothers.[14]

1 While post-partum depression is defined in the DSM-IV-TR as depression with onset within 4 weeks of childbirth, that definition is often found to be too narrow, and the term is often used in practice for onset up to a year after childbirth.

As previously described, the relationship environment is of paramount importance related to early childhood brain development, and the impact of maternal depression is often quite significant. Parents who are depressed are less able to engage in the daily activities of parenting. One study of maternal depressive symptoms at 2 to 4 months post-partum found that mothers with depressive symptoms were less likely to: continue breastfeeding, show picture books, play and talk with their infants, and follow daily routines.[15] A study assessing the cost of depression found that 50% of depressed parents report that depression hinders their ability to participate in their child's daily activities, and 30% of depressed individuals report using sick days because they are unable to work.[16] Parental depression manifests itself in child outcomes, as well. Infants with depressed mothers show difficulties in engaging in social interactions as well as in their ability to regulate their states (i.e., calm themselves when upset), and new evidence has emerged to suggest that infants as young as 4 months old can also be diagnosed with depression, most often in the context of maternal depression.[17,18] As children grow older, having a depressed mother puts them at increased risk for both internalizing and externalizing behavior issues, and at risk for suffering as victims of child abuse.[19]
Researchers at Child Trends explain: ***"Consider one possible scenario: A mother is struggling to support her family or is in a difficult personal relationship or has health problems; this situation makes her feel depressed; being depressed causes her to act harshly toward her child; in the presence of harsh parenting, the child is more likely to misbehave"***.[20]

Despite the profound impact of maternal depression on child and family functioning, research suggests that pediatricians are not addressing this issue on a regular basis and need further education on depression and post-partum depression (see Box 3).

In a study of over 500 primary care pediatricians[21],

- 57% felt it was their responsibility to recognize maternal depression,
- but only 21% reported using a screening instrument for family psychosocial issues,
- and a full 23% could not recall a single recent case of maternal depression.

Box 3— Pediatrician's Knowledge of Post-Partum Depression

One survey of over 300 pediatricians found:

- 49% reported little or no education about PPD
- 51% underestimated the incidence of PPD
- 35% thought there were adequate treatment resources in their community for PPD
- 31% thought they would be able to recognize PPD in mothers of their patients
- 7% were familiar with available tools for screening, but 58% said they would use a brief screening tool if available

Wiley, C.C., Burke, G.S., Gill, Pa., & Law, N.E. (2004). Pediatricians' views of postpartum depression: A self-administered survey. Archives of Women's Mental Health, 7, 231-236.

The Physician's Role in Mental Health

The first and most fundamental way in which a pediatrician can address mental health issues is by **striving to provide a true medical home.** The American Academy of Pediatrics defines a medical home as a place that provides care that is **"accessible, continuous, comprehensive, coordinated, compassionate, and culturally effective."[22]** By providing a medical home, pediatricians address multiple points along the continuum of wellness, from promotion, to prevention, to treatment and referral.

The notion of promotion is perhaps best encapsulated in the *Bright Futures* guidelines: "The foundation of Bright Futures health supervision is health promotion-not just preventing or treating illness or injury but actively promoting the physical, emotional, mental, and social well-being of children, adolescents, and their families."[23] To this end, the guidelines stress the ways in which pediatricians can actively engage in promoting health and wellness.

It is also incumbent upon pediatricians to be knowledgeable in the areas of social-emotional issues to facilitate effective diagnosis and treatment or, when necessary, referral to an appropriate treatment source. Pediatricians are making progress on this front: from 1979 to 1996, clinician-identified social-emotional problems increased from 6.8% to 18.7% of all pediatric visits among 4- to 15-year-olds.[24] However, researchers stress that, "the vast majority of children with emotional or behavioral problems still go undiagnosed and untreated."[25]

While increased diagnosis of social-emotional issues is an important first step, this must be followed by increased treatment and referral options.

Pediatricians routinely complain that it is difficult to make community referrals for mental health issues. One solution to this is to build in-house mental health capacity, either by having a mental health provider in the office or by co-locating with a variety of services and supports to offer families a type of "one-stop shopping". One advantage of this approach is that families can access behavioral health services at the same time as making regular pediatric visits, reducing the stigma associated with seeing a mental health provider in the outside community. In-house services also allow for "teachable moments" between the mental health provider and the pediatric staff, including front-desk receptionists, nurses and physicians.

Two sites from the *Best Beginning* study highlight the potential value of in-house services. This is a mode in which the mental health professional is located in the same setting as the pediatrician. While co-location is often sited as the ideal model for integrating early childhood and parental mental health into pediatric practice, we recognize that this may not be feasible in many situations. For those practices, the ability to make facilitated referrals is vital. A facilitated referral is defined as a trusting and ongoing relationship between a member of a primary care clinical team, the family, and the community, for the purpose of successfully referring a patient to community-based services and supports. This is similar to the function of the physician described in the AAP's definition of the medical home. It is differentiated from more traditional linkage referrals, in which a family might simply get a list of names. It involves becoming truly embedded in the community and using those linkages to serve children and families. For example, at Foster Care Pediatrics in Monroe, NY, the staff find that "everybody knows we're here," and as a result their charts are voluminous and comprehensive.

Infusing a pediatric practice with an awareness and attention to social-emotional issues in both children and parents is not an easy or trivial task. Horwitz and colleagues surveyed a random sample of 832 members of the AAP.[26]

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When pediatricians were asked about barriers to addressing children's psychosocial issues, the following items were most commonly endorsed:

- *Lack of time to treat mental health (MH) problems*
- *Long waiting periods to see MH providers*
- *Lack of training in treatment of MH problems*
- *Lack of confidence to treat MH problems with counseling or medication*
- *Lack of referral options for children with MH issues*

When pediatricians were asked about barriers to addressing maternal depression, the following items were most commonly endorsed:

- *Lack of training in treatment*
- *Lack of time to treat*
- *Concerns about liability*
- *Unfamiliarity with screening instruments*
- *Lack of time to identify*
- *Inadequate time to contact community MH providers*
- *Too few community MH resources*

Opportunities to Transform your Practice

Perhaps the centerpiece of any attempt to transform a practice into one that truly addresses social-emotional issues in young children is the implementation of a screening protocol.

The American Academy of Pediatrics defines screening as a "brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment".[27] The most basic argument for more comprehensive developmental screening (when conducted appropriately, see Box 4) is that it can lead to early identification of social-emotional and biological problems. That identification could lead to a referral for preventive or treatment interventions by behavioral health and medical specialists.

Pediatricians are a natural fit for implementing screening protocols: they see families on a frequent basis and have the ability to intervene early. Additionally, the presence of parents in the primary care setting suggests a key opportunity to use a "two-generation approach" for health.[28]

Not only do pediatricians have the opportunity, but research finds that parents want screening from pediatricians, and they want follow-up. The Commonwealth Fund's nationally representative Survey of Parents with Young Children (1996) revealed that parents are anxious for more information about common social-emotional issues such as discipline, toileting, sleep, and crying. While parents were satisfied with pediatricians' attention to medical concerns, they were less satisfied with attention to developmental and behavioral concerns, as only a little more than half the 2000 parents interviewed felt satisfied with their pediatrician's guidance on social emotional and behavioral issues.[29] One focus group study of young mothers found that mothers are open to discussing stress and depression with their child's pediatrician, provided a trusting relationship has already been established.[30] Yet, in a American Academy of Pediatrics survey, only 29% of pediatricians reported spending time discussing parental substance abuse and/or emotional support for parents.[31]

New guidelines from the American Academy of Pediatrics recommend developmental screening at the 9-, 18-, and 30-month visits.[32] For positive screens, this is followed by referrals for evaluation and intervention. The guidelines also recommend developmental surveillance at every well-child visit, followed by screening, if warranted.

Box 4 SAMHSA Screening Guidelines

The Substance Abuse and Mental Health Services Administration (SAMHSA) statement on screening and early detection highlights several principles that communities and providers should adhere to in implementing screening programs. These include:

- "do no harm,"
- Screening must be voluntary, with parental consent (in the case of children),
- Screening instruments used must be valid and reliable, and the person administering them must be qualified and trained,
- Screening must be done in a culturally competent manner,
- Screening should never be used to make a diagnosis, but should, instead, be followed by in-depth assessment, and,
- Confidentiality must always be ensured.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2005). *SAMHSA background paper on screening and early detection of mental health problems in children and adolescents.* Rockville, MD.

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Developmental surveillance includes five components:

- **listening to and addressing parents' concerns**
- **maintaining a developmental history**
- **making accurate and informed observations of the child**
- **identifying risk and protective factors**
- **documenting the surveillance activities via medical charts (paper or electronic)**

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Screening all patients and families in the social emotional domain can seem daunting, however, there are time efficient screeners that can respect the time limitations of the typical pediatric visit while ensuring that the mental health of children is paramount. The box provides a list of sources pediatricians can use for identifying a screening tool appropriate for their office. (Box 5). It is important to note that, in some cases, asking only a few questions can accurately identify families in need of follow-up and referrals. Glascoe (1997) found that a two-question measure of parents' concerns was a highly sensitive predictor of developmental problems and that the absence of concerns was also generally associated with typical development, leading her to conclude "…parents' concerns can be safely recommended for use as a screening tool."[33] This also holds true for maternal depression. A review of evidence, conducted for the U.S. Preventive Services Task Force, finds that asking two questions ("Over the past 2 weeks, have you felt down, depressed or hopeless?" and "Over the past 2 weeks, have you felt little interest or pleasure in doing things?") can be as effective as using a longer screener.[34]

The AAP acknowledges that it is much easier to find a general screening tool than it is to find screeners that specifically address social-emotional and behavioral concerns.

Box 5---Identifying Screening Tools

- **For information on choosing a screening tool**: Bergman, D. (2004). *Screening for behavioral developmental problems: Issues, obstacles, and opportunities for change*. Portland, ME: National Academy for State Health Policy.
- **For *Bright Futures* developmental tools:** http://www.brightfutures.org/tools/index.html
- **For information on the screening tools used by practices/programs in the *Best Beginning* study**: Rosman, E.A., Perry, D.F. & Hepburn, K.S. (2005). *The Best Beginning: Partnerships between primary health care and mental health and substance abuse services for young children and their families*. Washington, D.C.: Georgetown University National Technical Assistance Center for Children's Mental Health. Retrieved January 30, 2007 from http://gucchd.georgetown.edu/files/products_publications/TACenter/bestbeginfinal.pdf
- **For the Center for Epidemiologic Studies Depression Scale (commonly used for maternal depression)**: http://patienteducation.stanford.edu/research/cesd.pdf

Possible Screening Tools Suggested by AAP[35]:

- ***Temperament and Atypical Behavior Scale,***
- ***Child Behavioral Checklist***
- ***Carey Temperament Scales,***
- ***Eyberg Child Behavior Inventory,***
- ***Pediatric Symptom Checklist,***
- ***Family Psychosocial Screening,***
- ***Ages and Stages Questionnaire: Social-Emotional** (discussed below)*

Another tool frequently mentioned by pediatricians is the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE).[36] The ASQ:SE is available for ages 6 to 60 months, takes only 10-15 minutes to complete, is written at a 5th grade reading level, and is available in English and Spanish. Each questionnaire is age specific, and has its own empirically derived clinical cut off score, at or above which children should be assessed further (based on answers provided by the parents, each questionnaire is scored to derive a total score). In addition, there are more open-ended questions where parents are asked to share any concerns not already addressed. Question content relates to self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. The ASQ:SE has a sensitivity ranging from 70.8% to 80.0% and a specificity ranging from 89.5% to 98.2%.[37] Parents report that the questionnaire is easy to understand, takes little time to complete, and has appropriate question content.[38] Building on the research cited above which suggests that parental report is in fact predictive of developmental delay, the ASQ:SE is one example of a screener which acknowledges the parents' expertise and makes parents active participants in the screening process. Programs using the ASQ:SE in pediatric practice have shown that use of the ASQ:SE greatly enhances the ability to identify language, learning, and regulatory problems in children ages 6-36 months, and to identify general behavior concerns in older toddlers (ages 2-3).[39]

In a report "Spending Smarter A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness, Authors: Kay Johnson and Jane Knitzer stated "Research on early brain development makes a powerful case for investing in strategies to promote healthy early relationships, intervene early when there are signs of problems, and provide intensive treatment for troubled young children and families to improve school-linked outcomes.", and suggest the following strategies for investing in improving social-emotional outcomes; many of which can be implemented in the pediatric screening.

Promotion and prevention strategies targeted to all children, but especially low-income children. Many of these strategies focus on improving the skills of parents, other caregivers, and front-line providers. Screening, in a variety of settings, with follow-up advice and support for caregivers, is core to promotion and prevention.

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Promotion and prevention strategies include:

- Screening all pregnant women for depression in public health clinics and community health centers.
- Routinely screening all young children for developmental risk factors in the context of primary health care.
- Training all community providers working with low-income families in how to help parents "read" the cues of their babies.
- Assuring social-emotional screening and anticipatory guidance in pediatric practices and/or supporting child development specialists in pediatric practices.
- Implementing a social skills curriculum for preschoolers in prekindergarten programs.

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On the most practical level, the question remains of how to continue to support a practice financially while adopting a mental health focus. Pediatricians recognize that it is vital to "know the codes" (*CPT* codes): 96110 for developmental testing, limited, used for developmental screening and 96111 for developmental testing, extended, used for developmental testing.[40]

Finally, sites that have participated in the Healthy Steps for Young Children program provide examples of how practices can address social-emotional needs in their patients. The Commonwealth Fund launched Healthy Steps in 1994 as a national demonstration project, and The Robert Wood Johnson Foundation and a group of over 100 funding partners later continued it. The project was designed to determine the efficacy of embedding a developmental specialist into pediatricians' offices as a strategy for improving access to high quality preventive, developmental services. Each participating office/practice has a Healthy Steps Specialist, who can be a new team member or a nurse, child development specialist or social worker who is already working in the practice. Specialists have training in child development and work to address behavioral and developmental issues. Fifteen sites participated in the three-year Healthy Steps evaluation. Evaluators found that families who participated in the Healthy Steps evaluation were more likely to: be highly satisfied with the care they received; discuss more than six anticipatory guidance topics; receive timely well-child visits and vaccinations; and remain at the practice for twenty months or longer; and, for those mothers at-risk for depression, to discuss their feelings with someone at the practice. They were also less likely to use severe discipline with their children.[41]

There are also a range of practical, time-efficient ways to start the process of ensuring that your practice begins to address the social emotional needs of children and families. Among them are; showing videos around early learning and behavior management in your waiting room, materials including posters and brochures that address social emotional concerns, including maternal depression, an available list of community resources, attendance at CME focused on social emotional issues, and the use of screening tools to address social emotional concerns as part of your routine visits (brief screens, questions, consider having parents fill out questionnaires in waiting room or sent out pre-visit.

Resources for Handouts and Professional Support:

www.zerotothree.org

www.healthysteps.org

www.aap.org

Advocacy Resources:

American Academy of Pediatrics: www.aap.org

Docs For Tots: www.docsfortots.org A nationwide network of Doctors advocating for young children can link you to core advocacy groups in your area and provide technical support for advocacy opportunities.

Mental Health Resources:

Mental Health America: http://www.nmha.org/

National Center for Children in Poverty: http://www.nccp.org/

Beyond Clinical Walls: Pediatrician's Engagement in Advocacy for Early Childhood and Maternal Mental Health

The World Health organization states that "The key to continue the momentum on mental health is to step up advocacy efforts."

- Children's doctors can be extraordinarily influential voices for children, and polling data indicate that physicians are particularly effective messengers for early childhood issues.
- Early Childhood mental health is an area requiring increased investments and changed approaches combined with extensive education campaigns to the public, policy makers and within professional settings.
- There is tremendous opportunity to increase awareness, screening, funding and access for early childhood mental health services.
- In addition to transforming your practice, pediatricians can participate in state coalitions advocating for mental health services, contact your elected officials, submit articles to parent magazines and newspapers about the issue as well as participate in CME or organize educational opportunities around this issue.
- As the early childhood movement takes hold throughout our nation, with increasing recognition that in order to raise a generation of healthy and successful citizens, our policies need to support the overwhelming brain research that acknowledges the critical window of opportunity for learning and intervention in the earliest years.
- Your involvement in advocacy can range from the smallest time commitments that can be effective in lending your credible voice as a messenger to more extensive or funded opportunities.

Mounting evidence makes it clear that early childhood is a crucial time in children's development, that children's social-emotional development matters, and that parents' social-emotional health matters, for it dictates the environment within which children's brains develop. Pediatricians, given the timing and frequency with which they typically see young families, are in a unique position to truly take the lead on addressing social-emotional issues. There are multiple ways that pediatricians can infuse social-emotional issues into the day-to-day activities of a practice, from promotion practices, to screening, to creating strong linkages with the mental health community.

These steps are vital to truly serving the whole child and family.

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