

Characteristics of Children Presenting to Early Childhood Mental Health Systems of Care

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Early Childhood Systems of Care (EC-SOC)

- EC-SOCs develop services and supports for children aged birth to six years, and their families to:
 - promote positive mental health
 - prevent mental health problems, and
 - provide mental health interventions
- With a few notable exceptions, SOC communities have primarily addressed the mental health challenges and needs of older children and youths and their families
- A growing number of EC-SOCs are being supported, but little is known across communities about
 - demographic and background characteristics of these children
 - experiences that may have and continue to place them at risk for or protect them from psychiatric difficulties

Building EC Knowledge Base

- In response to the gap in knowledge, the five Phase V EC sites came together to:
 - work with the national evaluation team to modify/add appropriate data elements for EC population
 - select several common outcome measures so that more relevant longitudinal data could be gathered about young children
 - agree to share data to be aggregated across sites

Purpose of Presentation

- To present data pooled from three different SAMHSA CMHS funded EC-SOC communities to:
 - understand who are the young children aged birth to six years and their families served, and
 - report on factors that may have increased children's risk for social, emotional, and/or behavioral challenges or protected them from these difficulties
 - report on children's exposure to potentially traumatic events

Collaborating EC SOC's

- All three communities funded in 2005 (Phase V)
 - Six year initiatives (currently in Year 4)
- Range in ages served (birth through 11 years)
- Population of focus differs
- Intervention of focus differs
- Continuum of mental health services and supports are similar

New London Building Blocks

- An initiative of the Southeastern Mental Health System of Care (SEMHSOC)
- Partners include: Families United, The Department of Children and Families, Child and Family Services, United Community and Family Services, LEARN
- Children under six years with serious social, emotional, and mental health challenges and their families
- Serving all of New London County with areas of focus in the following towns: Groton, New London, Norwich; and underserved populations including military families, Hispanic/Latino families, teen parents, and homeless families
- 300 children and their families to be served



Rhode Island Positive Educational Partnership (RIPEP)

- Partnership among DCYF, RIDE, Sherlock Center, and early childhood systems
- Integration of RI PBIS statewide initiative, RICASSP SOC and continuum of children's behavioral health services, and early childhood systems
- Children aged birth through 11 years with serious social, emotional, and mental health challenges and their families
- 80 schools/ECE sites will be involved
- 700 children and families to be served



Sarasota Partnership for Children's Mental Health

- Comprised of representatives of the health department, mental health service agencies, school district, early learning and care community, and numerous other child serving organizations.
 - The population of focus includes children birth through age 8 and family members at risk of disrupted relationships due to
 - a) foster care placement or risk of placement,
 - b) prenatal exposure to alcohol and other substances,
 - c) risk of expulsion or exclusion from early learning environments, and/or
 - d) the presence of other environmental stressors (i.e., domestic violence, poverty, caregiver mental illness, homelessness).
- The children have a DC:0-3R or DSM-IV-TR diagnosis and prognosis that mental health challenges will last at least one year and require multi-agency interventions from at least two community service agencies.
- Approximately 400 children and families expected to receive care coordination

CMHS National Evaluation Core Studies

Core Study Component	Core Study Question(s)
Cross-Sectional Descriptive Study	<i>Who are the children and families served and what are their characteristics?</i>
Child and Family Outcome Study	<i>To what extent do child and family outcomes improve over time?</i>
Service Experience Study	<i>To what extent are system of care principles experienced by children and families?</i>
Services and Costs Study	<i>What services do children and families receive, and what are the service costs and utilization patterns associated with those services?</i>

Cross-Sectional Descriptive Study

- One core study required of all SOC communities
- Seeks to answer
 - Who are the children and families served by the program in the funded communities?
 - Does the served population change over time as systems of care mature?
- Data sources
 - Administrative records
 - Caregivers
 - Evaluators (for specific questions)

Cross-Sectional Descriptive Study (cont.)

- Provides local- and federal-level documentation of the number and the characteristics of youth and families who have received services
- Helps to determine whether the children/youths in the outcome study are representative of who is being served
- Allows communities to determine whether the desired youth and families are receiving services

Trauma Exposure

- Trauma is pervasive among children, youth, and families in the United States, particularly for children and youth involved in public systems (National Center for Children in Poverty, 2007)
- In a study of parent and partner violence in families with young children, Smith Slep and O'Leary (2005) found that in 90% of the 453 families studied, some type of physical aggression (adult-to-adult and/or parent-to-child) occurred in the past year
- Based on data from child protective services (CPS) agency investigations and assessments, approximately 906,000 children were victims of child abuse and neglect in 2003 (U.S. DHHS, 2005).
- Given the high rates of multiple victimizations, studies should assess for the range of potentially traumatic events.
- Need to understand young children's exposure to potentially traumatic events and how it impacts their social and emotional functioning.

Methods

- Data collection and sharing approvals
- Measures
- Procedure

Enrollment and Demographic Information Form (EDIF)

- Age
- Gender
- Race
- Date of entry into services
- Diagnosis
- Service planning
- Program and evaluation enrollment status
- EC-relevant data elements added

Traumatic Events Screening Inventory (TESI-PRR)

- Ghosh-Ippen, et al., 2002
- Assesses history of exposure to different types of traumatic events
 - children aged birth to six years
 - 24 items
 - accidents, natural disasters, death of someone close to the child, assault, attacks by animals, domestic violence, war, community violence, and sexual abuse
 - response categories: "yes", "no", or "unsure"
 - Additional information about each potentially traumatic event obtained (i.e., age first experienced)

Procedure

- Descriptive Data (demographic and diagnostic) must be collected at intake and submitted for . . .
 - All youth and families supported and served by the CMHS-funded system of care
- Data sources
 - Administrative records
 - Caregivers
 - Evaluators (for specific questions)
- Trauma data collected during the Child and Family Outcome Study (every 6 months)
 - Intake data reported on here
- Data source
 - Caregiver participating in Outcome study



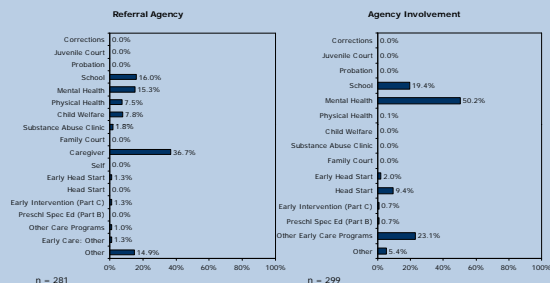
Findings

Participants Children under 6 years (N=299)

Demographics	
System of Care Community (n =299)	
New London Building Blocks (NLBB)	36.5%
Rhode Island Positive Educational Partnership (RIPEP)	11.7%
Sarasota Partnership for Children's Mental Health	51.8%

Demographics	
Gender (n = 299)	
Male	72.2%
Female	27.8%
Average Age at Intake (n = 299)	
Average Age	4.01 years
Age Group (n = 298)	
< 1 year	3.0%
1 year	6.0%
2 years	13.8%
3 years	22.1%
4 years	27.9%
5 years	27.2%
Race/Ethnicity (n = 287)	
American Indian or Alaska Native	.3 %
Black or African American	18.7%
White	66.6%
Other	10.4%
Hispanic/Latino Background (n = 287)	
Yes	16.7%

Intake Referral Information and Agency Involvement



DSM-IV Axis I and Axis II Diagnoses

Diagnosis (n = 299)	%
Attention-Deficit/Hyperactivity Disorders	9.7%
Oppositional Defiant Disorder	5.4%
Mood Disorders	3.3%
Adjustment Disorders	16.1%
PTSD and Acute Stress Disorder	4.0%
Pervasive Developmental Disorders	3.7%
Anxiety Disorders (not PTSD or Acute Stress Disorder)	5.7%
Learning, Motor Skills, and Communication Disorders	2.7%
Other	6.7%
Disruptive Behavior Disorder	11.4%
Mental Retardation	0.3%
Conduct Disorders	0.3%
Impulse Control Disorders	0.7%
Personality Disorders	0.0%
Substance Use Disorders[a]	0.0%
Schizophrenia and Other Psychotic Disorders	0.0%
V code[b]	0.3%
Substance Induced Disorders	0.0%

Because children/youth may have more than one diagnosis, percentages for diagnoses may sum to more than 100%.

[a] Substance Use Disorders include caffeine intoxication.

[b] V Code refers to Relational Problems, Problems Related to Abuse or Neglect, and additional conditions. Percentage excludes V71.09 (No Axis I or II diagnosis).

DC:0-3R Axis I Diagnoses

Clinical Diagnosis (n = 80)	%
Traumatic Stress	1.3%
Deprivation/Maltreatment	1.3%
Prolonged Bereavement/Grief	1.3%
Anxiety D/O of Infancy and Early Childhood	2.5%
Separation Anxiety D/O	6.3%
Social Anxiety D/O (Social Phobia)	2.5%
Generalized Anxiety Disorder	3.7%
Anxiety Disorder NOS	3.7%
Mixed Disorders of Emotional Expressiveness	3.7%
Adjustment D/O	33.8%
Regulation D/O of Sensory Processing	7.5%
Hypersensitive	1.3%
Hypersensitive Type A: Fearful	1.3%
Hypersensitive Type B: Negative/Defiant	7.5%
Hyposensitive	3.7%
Sensory Stimulation-Seeking/Impulsive	12.5%
Sleep Behavior D/O	3.7%
D/O of Relating/Communicating	1.3%
Other	2.5%

Because children/youth may have more than one diagnosis, percentages for diagnoses may sum to more than 100%.

DC:0-3R Axis II Diagnoses

Relationship Classification	
Parent-Infant Relationship Global Assessment Scale (PIR-GAS) (n=30)	
Well Adapted (91-100)	0%
Adapted (81-90)	0%
Perturbed (71-80)	10.0%
Significantly Perturbed (61-70)	23.3%
Distressed (51-60)	40.0%
Disturbed (41-50)	16.7%
Disordered (31-40)	10.0%
Severely Disordered (21-30)	0%
Grossly Impaired (11-20)	0%
Documented maltreatment (1-10)	0%

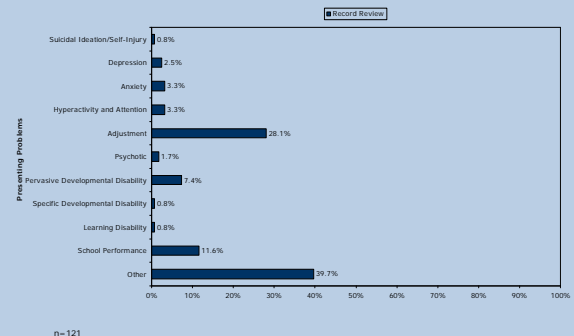
DC:0-3R Axis II Diagnoses

Relationship Classification

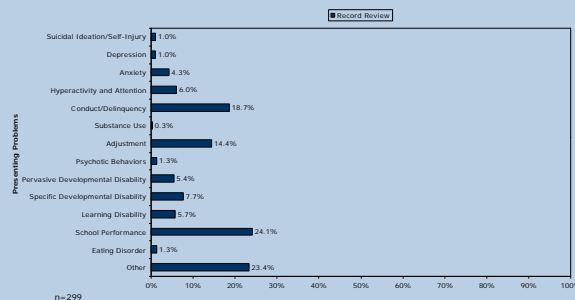
Relationship Problems Checklist (RPCL)

Relationship Quality	No evidence	Some evidence	Substantial evidence
Overinvolved (n=52)	51.9%	42.3%	5.8%
Underinvolved (n=54)	59.3%	27.8%	13.0%
Anxious/Tense (n=56)	25.0%	51.8%	23.2%
Angry/Hostile (n=57)	42.1%	45.6%	12.3%
Verbally Abusive (n=54)	72.2%	22.2%	5.6%
Physically Abusive (n=54)	81.5%	13.0%	5.6%
Sexually Abusive (n=54)	92.6%	3.7%	5.6%

Problems Leading to Referral

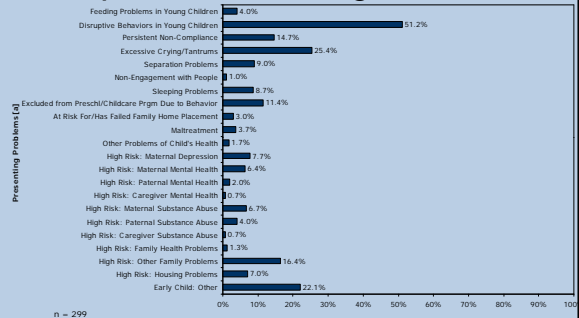


Presenting Problems Reported



[a] Because children may present with more than one problem, percentages may sum to more than 100%.

Presenting Problems Reported for Young Children



[a] Because children may present with more than one problem, percentages may sum to more than 100%.

History of Potentially Traumatic Events

Has your child ever... (n = 164)	%
been in serious accident (n=164)	10.4%
seen serious accident (n=163)	8.0%
been in serious or natural disaster (n=163)	4.3%
experienced severe illness or injury of someone close	22.6%
experienced the death of someone close (n=162)	16.0%
undergone any serious medical procedure or had life threatening illness (n=164)	22.6%
been separated from you or another person who your child depends on for love or security (n=164)	37.8%
someone close to your child ever attempted suicide or tried to harm him or herself (n=163)	5.5%
experienced physical assault (hitting, kicking) (n=157)	9.6%
experienced direct threats of physical harm (n=157)	7.6%
experienced mugging or theft (n=163)	1.8%
experienced kidnapping (n= 164)	3.0%
been attacked by an animal (n=164)	6.1%
seen, heard, hear about people getting physically assaulted (n=161)	31.7%

History of Potentially Traumatic Events (cont).

Has your child ever... (n = 164)	%
seen, heard someone directly threaten someone in your family with physical harm (n=161)	23.6%
known, seen family that was arrested, jailed, imprisoned, taken away (n=162)	24.7%
Seen, heard, hear about people outside the family being physically assaulted (n=160)	11.3%
been directly exposed to war, armed conflict, terrorism (n=163)	.6%
seen or heard acts of war or terrorism on tv or radio (n=57)	10.2%
experienced someone making him/her do something sexual (n=151)	3.3%
Been present when someone was being forced to engage in any sort of sexual activity (n=154)	1.9%
experienced repeatedly being told s/he was no good, yelled at in scary way, had someone threaten to abandon (n=157)	7.0%
Gone through period of time when s/he lacked appropriate care (n=160)	13.1%
experienced other stressful things (n=160)	31.9%


Young Children's Trauma Exposure

Future Directions

- Examine the role of developmental processes in the impact of trauma on young children's mental health adjustment:
 - Temperament, self-regulation, attachment, protective factors
- Examine the role of family characteristics and processes in the impact of trauma on young children's mental health adjustment:
 - Caregiver depression, substance use/abuse, stress and strain
- Assess trauma contextual factors (age at first exposure, etc.)
- Examine developmental trajectory of trauma exposure (outcomes over time)
- Examine broader array of potential outcomes
 - Peer functioning, functional outcomes, resilience



Thank You!



Risk Factors and Change in 6- Month Outcomes for Children Receiving Services within Early Childhood Systems of Care

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Background

- Systems of care for children with severe emotional and behavioral difficulties have typically served a school-aged population (Manteuffel, Stephens & Santiago, 2002).
- There is clear evidence that intervening when emotional and behavioral difficulties begin to emerge makes a difference in the cost of the intervention and its probable success (Strain & Timm, 2001; Kazdin, 1995).
- Research has shown that early childhood services that include home visiting and parenting education result in parents who are able to be more emotionally supportive and have more positive interactions with their children (e.g., Love, et al., 2002).
- The literature regarding the risk factors that put young children at risk for severe emotional and behavioral challenges is still limited.

Methodology

- The 2005 cohort of SAMHSA's Comprehensive Community Services for Children and their Families Program includes 5 communities that focus on the early childhood (EC) population.
- Since the National Evaluation of the SAMHSA program is geared toward a school-age population, a number of the EC communities began to identify measures appropriate for the younger population.
- Data in this paper has been gathered by 3 of these EC communities (Connecticut, Florida and Rhode Island).

Population

- This analysis focused only on those children who were enrolled in the outcome study (n = 136).
- The children in this sample are on average 4.1 years of age and are predominantly boys (75.7%).
- Two-thirds (69%) are Caucasian, 18% African American/Black, and 11% Other.

Intake Information

Referral Agency:

- 43.4% - self referred/caregiver
- 15.4% - school
- 11.8% - mental health agency/provider
- 10.3% - other
- 7.4% - physical health care agency/provider
- 5.1% - child welfare
- 1.5% - substance abuse agency/provider

Procedures

- All families presenting to these SOC's are invited to participate in the longitudinal outcome study.
- Families are interviewed at entry into services and then every 6-months for 3 years. Families are compensated for their participation in these interviews.
- IRB approval was given by the universities that employ the evaluation principal

Measures

- Risk Factors:
 - **Child Exposure to Traumatic Events**
 - Sum of potentially traumatic events
 - Traumatic Events Screening Inventory- Parent Report – Revised (TESI-PRR) (Ghosh-Ippen, et al., 2002)
 - **Maternal Depression**
 - Clinical score
 - Center for Epidemiology Depression Scale (CES-D) (Radloff, 1977)

Measures

- Child Outcomes:
 - **Child Problem Behaviors**
 - Internalizing T Score & Externalizing T Score
 - Child Behavior Checklist for Ages 1.5-5 (Achenbach & Rescorla, 2000)
 - **Strength-Based or Resilience Behaviors**
 - Total Protective Factors T Score
 - Devereux Early Childhood Assessment – Clinical Scale (DECA-C) (Devereux & Nuri-Hodkin, 1999)

Analyses & Results I

- A multivariate multiple regression examined the relationship between the risk factors and child outcome variables at intake.
- Sum of traumatic events was related to internalizing problem behaviors and resilience behaviors.
- Caregiver depression was significantly positively related to internalizing behaviors. Conversely, caregiver depression was negatively related to resilience behaviors.
- Externalizing problem behaviors was not significantly related to either the sum of traumatic events or caregiver depression.

Multiple Regression

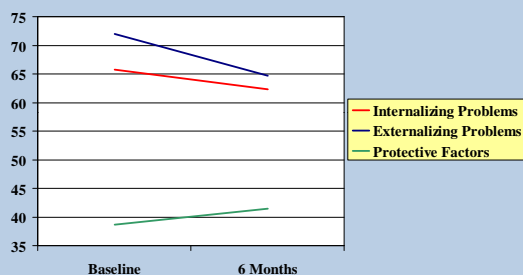
Risk Factors / Outcomes	β	S.E.
# Traumatic Events		
Internalizing Problems	.18*	.32
Externalizing Problems	.09	.43
Protective Factors	.35***	.38
Maternal Depression		
Internalizing Problems	.18*	.07
Externalizing Problems	.15	.09
Protective Factors	-.19*	.08

* $p < .05$, ** $p < .01$, *** $p < .001$

Analyses & Results II

- A paired samples t-test was conducted to examine change in the outcome variables from intake to 6-month follow-up.
- CBCL internalizing scores significantly decreased from intake into system of care services to six months following service entry
[$M = 65.77$, $SD = 8.92$ to $M = 62.33$, $SD = 10.72$, $t(56) = 3.30$, $p < .01$].
- CBCL externalizing scores also significantly decreased from intake to six months later
[$M = 71.98$, $SD = 12.90$ to $M = 64.63$, $SD = 12.76$, $t(56) = 4.72$, $p < .001$].
- The change in DECA Total T scores, measuring a child's resilience behaviors, from intake to six months later approached significance
[$M = 38.63$, $SD = 10.69$ to $M = 41.48$, $SD = 10.66$, $t(59) = -1.88$, $p =$

t-test: Improvement in first 6 months



Implications

- Overall the children served by these systems of care have experienced a significant improvement in functioning 6-months after services were initiated.
- The results also highlight some predictors of social/emotional health for young children with severe emotional and behavioral issues.
 - The findings suggest that children whose caregivers report high levels of depression demonstrate higher levels of internalizing problems and lower levels of resilience behaviors.
 - Children with higher levels of trauma exposure are reported to experience more internalizing problems and also to exhibit higher levels of resilience behaviors perhaps suggesting that these children have adapted their coping mechanisms in response to trauma.

Future Work

- The collaboration between these early childhood SOC communities has the potential to influence the field.
- We will have a sample of nearly 1,000 children and families and will be able to identify the risk and protective factors that impact the trajectory of young children with social emotional issues.
- Given that each of the communities are implementing a different evidence-based practice we will have the opportunity to examine the differential efficacy of services for different sub-populations.




Translating Research into Practice: Strategies for Implementing a Public Health Approach to Early Childhood Mental Health

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Paper presented at the 22nd Annual Research Conference-A System of
Care for Children's Mental Health: Expanding the Research Base,
March 2, 2009, Tampa, FL

Public Health Themes for Mental Health



- Population based – organized, interdisciplinary, scientific data drives decisions
- Promotion of mental health and prevention of challenges or illness. Interventions to improve and enhance the quality of life.
- Engages the whole community to assure the optimal physical and mental health of children and families.
- Promotes social and emotional well-being and the optimal mental health for all.
- Creates supportive and nurturing environments.
- Develops skills and knowledge.
- Promotes mental health and prevents and intervenes early in the pathways to mental illness.
- Comprehensive, evidence based, integrated.
- Seeks to eliminate disparities.
- Cross systems and multi-disciplinary.

"Caring for Every Child's Mental Health"

All children, youth and their families live, learn, work and participate fully in communities where they experience joy, health, love and hope.

Citation: National TA Center for Children's Mental Health Topical Conference Call, January 17, 2008
guchd.georgetown.edu/files/conference_calls/TACenter/Jan08/New%20Directions.ppt

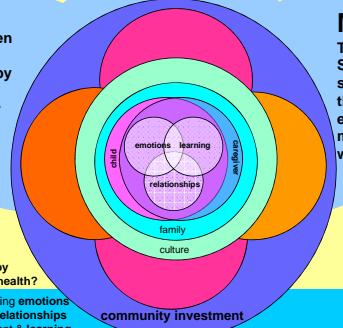
Sarasota Early Childhood Mental Health Partnership

VISION

All young children & their families are healthy, happy & thriving in Sarasota County communities

MISSION

To strengthen Sarasota's system of care that supports early childhood mental health & well-being

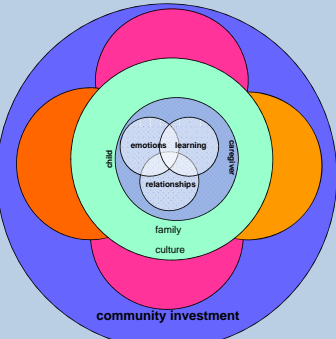


...so what do we mean by early childhood mental health?

- Experiencing & expressing emotions
- Forming close, secure relationships
- Exploring the environment & learning

- With primary caregivers
- In a family
- In a cultural context
- In a community

Early Childhood Mental Health



- Experiencing & expressing **emotions**
- Forming close, secure **relationships**
- Exploring the environment & **learning**

- With **primary caregivers**
- In a **family**
- In a **cultural context**
- In a **community**



A Public Health Approach to Early Childhood

- Promotion of positive mental health through comprehensive service delivery
- Prevention of conditions commonly associated with emotional disorders, including exposure to trauma, to preserve young children's mental health.
- Earliest possible identification and intervention in mental health problems, to restore positive functioning and well being.
- The approach focuses on both strengthening services and supports for children with serious emotional disorders and their families, and on prevention and early intervention strategies for all children.
- To achieve this public health approach, cross-system partnerships are needed within communities to implement and sustain such services.



Public Health Implications

- Enhance Early Childhood System of Care Eligibility
 - Imminent risk
- Resilience-informed approach
 - Focus: promote resilience
 - Goal: reduce negative outcomes
- Future directions
 - Explore additional risk factors
 - Identify/design screening tools

Early Childhood Community of Practice Diagnosis and Eligibility Workgroup

- Convened at Early Childhood Pre-Conference meeting in New Orleans, July 2007
- Draft Concept Paper presented to the Early Childhood Community of Practice participants at the Training Institutes in July, 2008 in Nashville



Imminent Risk

- Cumulative risk screening that may help focus preventive intervention where it will be most efficient and effective (e.g. based on number of risk factors experienced, occurring after risk exposure and before development of problems, in the context of service resources, etc.).
- Appropriate screening tools can be used to identify children and get them into the services they need to prevent young children from developing more severe and persistent disorders.

Criteria for Imminent Risk of a Mental Health or Serious Emotional Disorder

All infants/young children must meet **ONE** of the **FIVE** following **Criteria**:

1. The infant/young child is or has been determined to present **at least two of the following seven Risk Factors**:

- a) The infant/young child of a parent/caregiver who is unable to meet his or her basic needs (access to food, clothing, transportation);
- b) The infant/young child of a parent/caregiver who is at or below the poverty level.
- c) The infant/young child of a parent who is socially isolated/has limited natural supports, or child of a family in the military;
- d) A infant/young child who has been a witness to domestic violence;
- e) The infant/young child of a parent with a history of mental illness requiring treatment or hospitalization;
- f) The infant/young child of a mother who, upon knowledge of pregnancy, used tobacco, alcohol, and/or drugs; or,
- g) The infant/young child of a mother who received little to no pre-natal care (less than five visits)

Criteria for Imminent Risk of a Mental Health or Serious Emotional Disorder (cont.)

2. The infant/young child of a parent/caregiver who is or has been a victim of domestic violence.
3. The infant/young child of a parent/caregiver suffering from mental illness, peri-natal depression, maternal depression, or substance abuse problems.
4. The infant/young child is the subject of an abuse/or and neglect report made to child protective services that did not result in a court order into foster care/shelter care or protective supervision.
5. The infant/young child who has suffered from a single traumatic event or a series of connected traumatic events, or chronic, enduring stress, but does not yet meet the criteria for a Posttraumatic Stress Disorder.
6. The infant/young child who has had a total of three or more disruptions from a home, foster or relative home, or child care setting within a 12 month period.



Screen for Emotional or Behavioral Problems

- Criteria for emotional or behavioral problems found to be in the significant/clinical range as measured by the Behavioral Assessment of Baby's Emotional and Social Style (BABES) for ages birth to three and the Strengths and Difficulties Questionnaire (SDQ) for ages 3 to 9.



The Behavioral Assessment of Babies Social and Emotional Style (BABES)

- Screening tool developed by K. Finello and M. Poulsen
- Completed by parents
- Yields information about the parent's experience of the child's behavior and the parent-child relationship.



Strengths and Difficulties Questionnaire (SDQ)

- Paper and pencil questionnaire completed by a parent and teacher in about 10 minutes to identify social-emotional delays or disorders in children 3 to 16 years of age.
- Includes 20 or more attributes (positive and negative) across five scales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and pro-social behaviors.



Resilience-Informed Approach

- Combination of high risk-status and inadequate protective factors compound to intensify the detrimental effect on a child's functioning and emotional well being. The results of our research highlight the relevance of risk and resilience to early childhood mental health.
- Since children are impacted greatly by adult risk behaviors (i.e., mental illness, drug abuse, criminal activity), a complementary focus on strengthening protective factors and promoting resilience within the family may help reduce the negative outcomes of current and future risk exposure.



Family Resource Scale

(Dunst & Leet, 1987)

- Measures the adequacy of different resources in households with young children
- 30 items, each rated on a 5-point scale ranging from *not at all adequate* (1) to *almost always adequate* (5).

Family Resource Scale
Carl J. Dunst and Hope E. Leet

This scale is designed to assess whether or not you and your family have adequate resources (time, money, energy, and so on) to meet the needs of your family as a whole as well as the needs of individual family members. For each item, please circle the response that best describes how well the need is met on a consistent basis in your family (that is, month-in and month-out).

To what extent are the following resources <i>adequate</i> for you and your family?	Does Not Apply	Not at All Adequate	Seldom Adequate	Sometimes Adequate	Usually Adequate	Almost Always Adequate
Food for two meals a day	NA	1	2	3	4	5
House or apartment	NA	1	2	3	4	5
Money to buy necessities	NA	1	2	3	4	5
Clothes for your family	NA	1	2	3	4	5
Heat for your house/apartment	NA	1	2	3	4	5
Indoor plumbing/water	NA	1	2	3	4	5
Money to pay monthly bills	NA	1	2	3	4	5
Good job for yourself or spouse/partner	NA	1	2	3	4	5
Medical care for your family	NA	1	2	3	4	5
Public assistance (SSI, AFDC, Medicaid, etc.)	NA	1	2	3	4	5
Dependable transportation (own car or provided by others)	NA	1	2	3	4	5
Time to get enough sleep/rest	NA	1	2	3	4	5
Furniture for your home or apartment	NA	1	2	3	4	5
Time to be yourself	NA	1	2	3	4	5



Summary and Next Steps

- Study results support using trauma exposure and protective factors to identify children at imminent risk for emotional and behavioral problems.
- Early intervention efforts should focus on strengthening protective factors and promoting resilience, which may reduce the negative outcomes of current and future risk exposure.
- Future directions should include the development and application of screening tools to identify risk and resilience for early childhood mental health.
- Ongoing research should investigate additional risk factors (e.g., prenatal tobacco, alcohol, and/or drug use, caregiver strain, poverty) that may place children at imminent risk for emotional and behavioral problems.