Arkansas Early Childhood Comprehensive Systems

Social-Emotional Workgroup

Arkansas' Strategic Plan for Early Childhood Mental Health

2014-2015

Editors

Nicola Conners-Burrow, PhD

University of Arkansas for Medical Sciences, Department of Family and Preventive Medicine

Carol Amundson Lee, MA LPC AADC

Save the Children

Contributors

Patti Bokony, PhD

University of Arkansas for Medical Sciences, Department of Family and Preventive Medicine

Ashley Huddleston, LCSW

University of Arkansas for Medical Sciences, Department of Psychiatry

Joy Pemberton, PhD

University of Arkansas for Medical Sciences, Department of Psychiatry

Benjamin Sigel, PhD

University of Arkansas for Medical Sciences, Department of Psychiatry

Stakeholders

Organizations that participated in development of the plan through participation in the AECCS SE Workgroup:

Arkansas Access to Recovery

Arkansas Association for Infant Mental Health

Arkansas Department of Human Services, Divisions of Child Care and Early Childhood Education, Behavioral Health Services, Medical Services and Children and Family Services

Arkansas Head Start Collaboration Office

Arkansas Prevention Certification Board

Child and Adolescent Service System Program

Community Development Institute Head Start Serving Tri-Region Arkansas

Counseling Associates Inc.

Health Resources of Arkansas

Mid-South Health Systems

NAMI of Arkansas

Project PLAY

Southwest Arkansas Community Mental Health Center

University of Arkansas, Partners for Inclusive Communities

University of Arkansas at Little Rock, School of Social Work

University of Arkansas for Medical Sciences, Departments of Family Medicine, Pediatrics and Psychiatry

Zero to Three Safe Babies Court Team

Executive Summary

What is Early Childhood Mental Health?

Early childhood professionals often use the terms 'early childhood mental health' and positive 'social and emotional development' interchangeably. Social development involves skills like communicating needs, getting along with others and making friends. Emotional development involves skills like being able to be soothed when upset, recognizing feelings and expressing them appropriately, and beginning to understand that others have feelings too. When children experience healthy social and emotional development, they are able form satisfying relationships with others, play, communicate, learn and face challenges successfully. *These are the skills children need to succeed in school, and later in the workplace and in relationships.*

Why are Early Relationships so Important to Mental Health?

Young children develop social emotional health through their relationships with others, especially the adults they depend on for their care. In fact, nurturing relationships are crucial for the development of trust, empathy, compassion, generosity, and conscience. When children do not have a strong emotional tie to a caregiver (parent, parent-figure, other caregiver), or that relationship has been disrupted, they are at increased risk for social, emotional, and behavior problems. *The loss or disruption of important early relationships with caregivers can have negative effects on the developing brain and result in developmental delays and life-long physical and mental health problems*.

How Common Are Problems with ECMH?

A significant proportion of young children (i.e., birth to 5 years) suffer from mental health problems. In fact, the prevalence of such problems warranting a psychiatric diagnosis has been estimated to range from 10% to 20%, meaning that *one in every five to ten children under 5 experience significant difficulties* with behavior and emotions.

Why Be Concerned About Problems with ECMH?

Mental health problems can be temporary for some children, but for others these problems will persist and grow more severe. In fact, *without early intervention, about 50% of children with early problems will continue to have serious difficulties in later childhood and adolescence*. These children can be difficult to care for, resulting in high rates of preschool expulsion and child maltreatment. Although these problems are serious, the majority of mental health services are targeted to older children, with services for young children largely underdeveloped.

Very early mental health concerns that are not resolved provide fertile ground for the development of problems in the home, school and community. As children reach adolescence and adulthood, they are at high risk for problems such as substance abuse, risky sexual behavior, and criminality. These problems are taxing on many social service systems, and particularly demanding of medical and law enforcement/criminal justice resources. *The lifetime cost of an untreated high-risk youth has been estimated at between $1.7 and $4.4 million*.

Do These Problems Exist in Arkansas?

Studies of Arkansas children and families reveal that many children are showing signs of early problems, and their caregivers are struggling.

- 16% of children screened in AR pre-kindergarten programs have significant behavioral concerns
- 18% of Arkansas mothers have post-partum depression; 27% of mothers of pre-kindergarten reported depressive symptoms shown to negatively impact parenting
- In 2012 there were 1057 victims of abuse or neglect aged 0-1 and another 2780 victims aged 2-5 in Arkansas
- Arkansas is among a group of states with 4-7 expulsions per 1,000 preschoolers, a rate about three times higher than the rate in Kindergarten through 12th grade.
- High quality child care and early education programs are not available to all young children in need of services.
- Surveys of mental health providers reveal that most are not trained in evidence-based interventions for children 0-5.

Approaches to Supporting Young Children: What Does Science Tell Us?

Early interventions are much more cost effective and efficient than waiting until later in the child's life. This increased efficiency occurs for two major reasons: 1) Promoting healthy brain development from the beginning is easier than the more intensive work required to repair early damage and 2) As children age, their problematic behaviors, if unaddressed, frequently progress into more dangerous or costly behaviors.

Evidence-based clinical programs for early childhood mental health problems can occur at the level of prevention, early intervention, or intervention. *All of these programs focus on enhancing children's relationships with their caregivers* (including parents, foster parents, teachers or other caregivers), building the skills of the caregivers and creating supportive classroom and/or home environments.

Participation in high-quality child care and early education programs supports ECMH. In fact, studies of children who receive early intervention and support in a high quality preschool setting, reveal they are more likely to graduate from high school, more likely to become employed and earn more money, and less likely to have been incarcerated or receive welfare services.

What Was the Process and Who Developed this Plan?

The Social-Emotional Workgroup of the Arkansas Early Childhood Comprehensive Services Initiative identified the need to develop a comprehensive Arkansas State Plan for Children's Mental Health. The standing workgroup members identified and recruited key stakeholders to participate in the workgroup for at least one year to develop the plan. The group completed a series of tasks:

1. Developed a shared understanding of information presented in the 'Background' section;
2. Completed an environmental scan of existing programs that support ECMH in the state;
3. Identified gaps and issues to be addressed through the plan;
4. Identified 5 broad goals that focus on the gaps in existing programming in the state
5. Develop strategies under each goal
6. Emailed out for comment by workgroup members not present at final meeting

Arkansas' Strategic Plan for Early Childhood Mental Health Summary	
Long-Term Goals	Key Strategies:
1. The most at-risk families will be supported with services designed to keep families together.	Strategy 1: Embed family support services into settings where high risk families have been identified (e.g., early care and education, substance abuse/ mental health treatment).
	Strategy 2: Support family-centered court systems through the development and expansion of evidence-based, collaborative practices (such as the Safe Babies Court Team model).
2. Younger children and their families will be fully represented in state cross-systems initiatives to support mental health.	Strategy 1: Increase collaboration across key state agencies (Departments of Human Services, Health and Education) to identify and implement best practices for young children and their families.
	Strategy 2: Identify the young child and their family as a priority in our behavioral health systems, in alignment with best practice principles for serving young children with their families (evidence-based programs across the continuum of promotion, prevention and intervention services).
3. Evidenced based screenings for social-emotional problems in young children and serious family risks will be expanded and referrals to appropriate services will be enhanced.	Strategy 1: Increase routine screening to identify children at high risk for early onset of social-emotional difficulties based on their family risk factors (e.g. family substance abuse, domestic violence, mental illness).
	Strategy 2: Increase identification of children with early emerging social emotional problems through the expansion of routine standardized screening.
4. Early childhood mental health care providers and early care and education providers will receive the supports necessary to improve child social-emotional outcomes.	Strategy 1: Advocate for the rollout of the Early Childhood Mental Health (ECMH) graduate certificate for behavioral health providers to work with young children.
	Strategy 2: Invest in training opportunities in promising and evidence-based mental health services for young children and their families (e.g. Parent-Child Interaction Therapy, Child-Parent Psychotherapy) .
	Strategy 3: Invest in training and support for early care and education in order to improve child social-emotional outcomes.
5. Public awareness of the mental health needs of young children will be increased.	Strategy 1: Develop an ECMH toolkit of materials with simple messages about early childhood mental health designed for use with varied audiences.
	Strategy 2: Launch a public awareness campaign to promote the importance of early childhood mental health and ways to promote children's social and emotional development.

Background and Context

What is Early Childhood Mental Health?

Early childhood professionals often use the terms 'early childhood mental health' and positive 'social and emotional development' interchangeably. Social development involves skills like communicating needs, getting along with others and making friends. Emotional development involves skills like being able to be soothed when upset, recognizing feelings and expressing them appropriately, and beginning to understand that others have feelings too. When children experience social and emotional wellness, they are able form satisfying relationships with others, play, communicate, learn, face challenges, and experience emotions. These are the skills children need to succeed in school, and later in the workplace and in relationships. To sum it up, early childhood mental health is the developing capacity of a child from birth to 5 years of age to form close and secure relationships; experience, manage, and express a full range of emotions; and explore the environment and learn (Cohen, 2009).

Why are Early Relationships so Important to Mental Health?

Young children develop social emotional wellness through their relationships with others. Healthy social-emotional development is achieved through the experience of safe, supportive and nurturing relationships with caregivers within the context of family, community, and culture. In fact, nurturing relationships are crucial for the development of trust, empathy, compassion, generosity, and conscience (National Research Council and Institute of Medicine, 2000). Adults support children's mental health in many ways through warm, sensitive, consistent caregiving within home, child care, and early educational settings. These dependable relationships create a "secure base" from which a child can explore the world. Some examples of safe, supportive, and nurturing caregiving include: 1) Responding to infant cues and listening to children; 2) Establishing predictable, safe, and developmentally appropriate routines; 3) Teaching and modeling social-emotional skills including emotion recognition and regulation, social skills, and problem solving skills; 4) Providing support when a child is stressed or challenged; and 5) Supporting opportunities for exploration and social play.

A secure emotional tie (or *attachment*) to one or more consistent caregivers supports the infant's exploration of their environment and provides the foundation for developing a sense of trust in others and an understanding of their place in the world. While biological parent(s) are usually the primary attachment figures for a child, other adults in the child's life, such as grandparents, can also be stable attachment figures. Evidence suggests that supportive relationships with early educators and/or other caregivers can also offer advantages for young children, who can benefit from attachment to more than one person (National Research Council and Institute of Medicine, 2000). Alternately, when children do not have a strong emotional tie to a caregiver, or that relationship has been disrupted, they are at increased risk for social, emotional, and behavior problems. **The loss or disruption of crucial early relationships can have negative effects on the developing brain, resulting in delays across all developmental domains** (Dicker & Gordon, 2004). Children without healthy early relationships are at higher risk for delinquency, substance abuse, and depression later in life (Melmed, 2011).

What Makes Young Children Vulnerable to Social-Emotional Problems?

Young children who are just learning how to regulate their emotions and behaviors can be profoundly affected by adversity and stress. Children with adverse childhood experiences are at

higher risk for long-term health and mental health problems, and these experiences can have detrimental effects on the body and brain that are carried into adulthood. Examples include poverty; exposure to domestic and/or community violence; abuse and/or neglect; parental mental health problems, substance abuse, and/or incarceration; and extremely poor childcare environments. These experiences, especially without the mitigating influence of a secure and supportive caregiving relationship, can result in "toxic stress". **Toxic stress actually damages the developing brain. This damage ultimately affects a child's cognitive functioning, ability to manage their emotions, and ability to develop social skills** (Center on the Developing Child, 2008). We now understand that this damage is associated with lifelong mental and physical health problems.

How Common Are Problems with ECMH?

A significant proportion of young children (i.e., birth to 5 years) suffer from mental health problems. Symptoms in an infant might include poor eye contact, excessive fussiness or little expression of emotion, inability to be soothed by caregiver, difficulty with bonding/attachment, and/or problems with feeding and sleeping. A toddler or preschooler might exhibit additional symptoms, such as tantrums, problems with attention and hyperactivity, opposition/defiance, aggression, anxiety, social withdrawal or other depressive symptoms, and difficulty with empathy and learning right from wrong.

In fact, the prevalence of such problems warranting a psychiatric diagnosis has been estimated to range from 10% to 20%, meaning that **one in every five to ten children under 5 experience significant difficulties with behavior and emotional regulation**. Furthermore, these rates are relatively consistent with rates of mental health problems in older children and adults (Egger & Angold, 2006). In Arkansas, universal pre-kindergarten screening has shown that 15% of children under 5 have "clinically elevated" indicators of emotional and/or behavioral symptoms on standardized measures (Conners-Burrow, 2012).

Why Be Concerned About Problems with ECMH?

Very early mental health concerns that are not resolved provide fertile ground for the development of problems in the home, school and community. Mental health problems can be temporary for some children, but for others these problems will persist and grow more severe without early intervention. **Studies of early childhood mental health problems reveal that 50% or more of these children will continue to have these difficulties in later childhood and adolescence** (Campbell & Ewing, 1990; Campbell, Ewing, Breaux, & Szumowski, 1986).

Educating and caring for young children with social and emotional problems can be challenging. In school settings, young children are expelled from preschools at three-times the rate of children in K-12 (Gilliam, 2005). Furthermore, young children, particularly those with emotional and behavior problems, difficult temperament, or problems with attachment, are also at higher risk for maltreatment. In fact, children under a year old have the highest rates of child maltreatment and four-fifths (81.6%) of all child fatalities occurred in children under age four (U.S. Department of Health and Human Services, 2012).

Despite a demonstrated need for early childhood intervention, the majority of mental health services are targeted to older children, with services for young children largely underdeveloped (Dicker, Gordon, & Knitzer, 2001). This is, in part, because many mental health providers have little formal training in early childhood development, assessment, and treatment of children in these age groups and, specifically, in evidence-based treatment approaches for young traumatized children and their

families (Osofsky & Lieberman, 2012). Furthermore, the policies and procedures within child-serving systems (e.g., mental health, health, child welfare, education and child care) and payment sources (e.g., Medicaid and private insurance) often are developed for older children and adults, and early childhood intervention is often not targeted or included. The significant difficulties that young children display and the lack of available early mental health intervention along with inadequate policies and payment sources may explain the dramatic increase in the prescription of psychoactive medication, including "off-label" use, and high rates of hospitalization used to treat young children's mental health problems (Gleason et. al, 2007).

What is the Cost of Problems with ECMH?

Children with mental health problems are at greater risk for a variety of health and social problems as they reach adolescence and adulthood, such as substance abuse, risky sexual behavior, and criminality (Caspi, Moffitt, Newman, & Silva, 1996; Fergusson & Woodward, 2000; Molina & Pelham, 2003). These problems are taxing on many social service systems, and particularly demanding of medical and law enforcement/criminal justice resources (Cohen, 1998; Leibson, Katusic, Barbaresi, Ransom, & O'Brien, 2001). **For example, the lifetime cost of an untreated high-risk youth has been estimated at between $1.7 and $4.4 million** (Cohen, 1998; Cohen & Piquero, 2009).

Approaches to Supporting Young Children: What Does Science Tell Us?

Young children need positive relationships, meaningful learning opportunities and safe environments. Enhancing the quality of a child's environment and relationships is essential for improving long term health and social outcomes for young children, particularly for those who are experiencing adversity and stress. This may be accomplished through a wide variety of interventions and supports, both formal and informal, across multiple environments, depending on family need. These interventions and supports should be guided by early childhood mental health principles and coordinated across all systems of care (e.g., health, mental health, childcare/early education, parent education, and child welfare) with the goal of promoting positive relationships in the critical first years (National Scientific Council on the Developing Child, 2008).

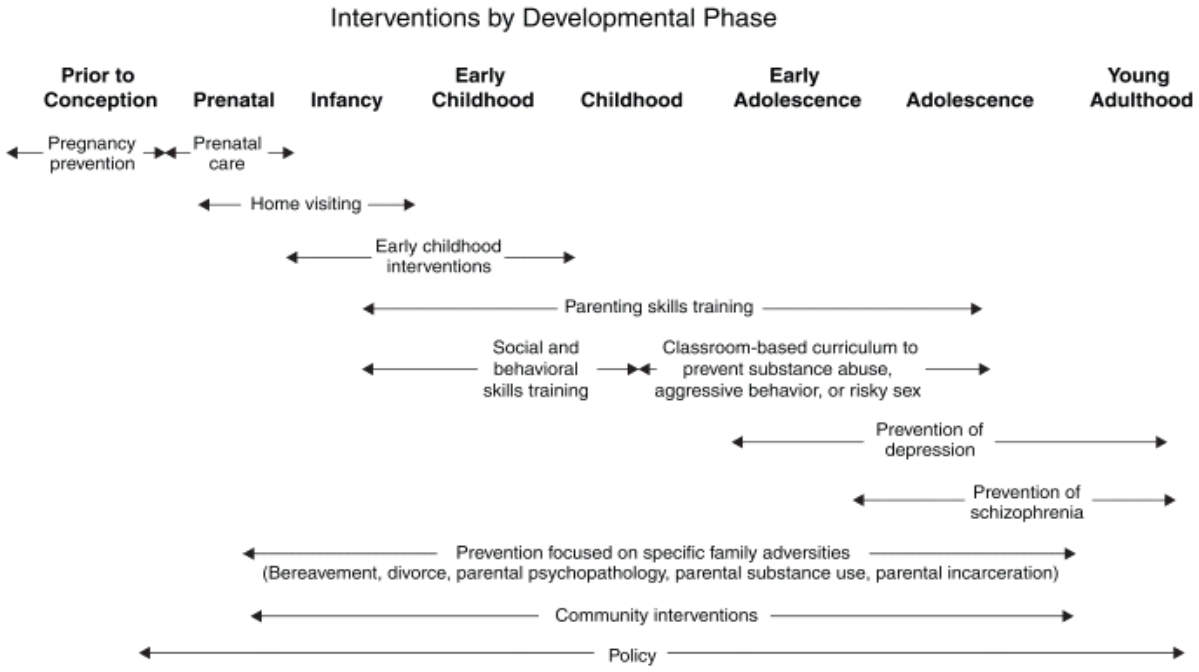
This coordination must include high quality child care programs that feature a safe physical setting, qualified and well compensated personnel, small group sizes with low adult-child ratios, and developmentally appropriate curricula that promote a language-rich environment and ensure consistently high levels of child participation. There is growing evidence that low cost, low quality programs are not effective (National Scientific Council on the Developing Child, 2008). They have been demonstrated not only to fail in promoting ECMH, but in some cases to actually undermine the mental health of the child, particularly the child who is more vulnerable to toxic stress. These poorer-quality programs can serve to increase expenses by increasing children's risk for later problems (National Research Council and Institute of Medicine, 2000; Vandell et al., 2010). A recent review of a longitudinal program with high-risk children indicates that participation in a high-quality, two year preschool program has an even greater positive impact on social-emotional development than cognitive development, and that early behavior and social skills, rather than intelligence, predict success later in life. The children who received early intervention and support in a high quality preschool setting, despite adversity, were more likely to graduate from high school, more likely to become employed and earn more money, and less likely to have been incarcerated or receive welfare services (Heckman, Moon, Pinto, Savelyev, and Yavitz, 2010).

In terms of clinical interventions, **effective programs must operate with the key principle that early childhood mental health develops in the context of relationships**. These clinical interventions should address the caregiver-child relationship, whether the caregiver is a parent, child care provider, foster parent, or other. Studies have shown that attachment-promoting parenting can be fostered among the most troubled parents with good success through early clinical intervention (Cicchetti, Rogosch and Toth, 2006; Dozier et al., 2006). Evidence-based clinical programs for early childhood mental health problems can occur at the level of prevention, early intervention, or intervention. These include screening and treatment for early child and parent risk factors (e.g., difficult temperament, emotional/behavioral difficulties, parental substance abuse or mental health problems), consultation, parent education, home visiting programs, and clinical treatments (e.g., Child-Parent Psychotherapy, Parent-Child Interaction Therapy, Trauma-Focused Cognitive Behavioral-Therapy). Services should be available to families in both the clinic and home environments to increase access to services for families at risk and prevent attrition. These kinds of evidence-based programs have proven long-term success at improving caregivers skill and reducing problems with behavior and emotions in young children (Eyberg et al., 2001; Lieberman, Ippen & Van Horn, 2006; Silverman, Ortiz & Viswesvaran, 2008).

Unfortunately, barriers to early intervention exist, including providers' difficulties serving the youngest children, who may not yet qualify for a diagnosis. It is vital that these barriers be addressed, because these **early interventions are much more cost effective and efficient than waiting until later in the child's life. This increased efficiency occurs for two major reasons: 1) Promoting healthy brain development from the beginning is easier than the more intensive work required to repair early damage and 2) As children age, their problematic behaviors, if unaddressed, frequently progress into more dangerous or costly behaviors**.

How Does This Fit Within a Prevention Framework?

Prevention, early education and mental health professionals do not always use the same terminology. However, the prevention framework dovetails nicely with strategies suggested by those with expertise in infant and early childhood mental health. Recent Institute of Medicine Prevention Reports have a strong emphasis on prevention through strengthening families. This is accomplished by providing prevention services to at-risk populations, including families living in poverty, those exposed to community violence, families with parental substance use and/or mental health problems, and children with aggressive behavior. These families are taught effective parenting skills to improve areas such as communication and management of disruptions or adversities. Clinical interventions are provided as needed. The figure below illustrates the variety of forms effective prevention can take. The approaches and interventions described above (e.g., high quality childcare, evidence-based clinical interventions) fall into a variety of the categories described. For example, high quality childcare is likely to include experiences that assist children's social and behavioral skill development, while evidence-based clinical interventions nearly always include parenting skills training. When implemented at the appropriate developmental phase by effectively trained personnel, these methods and interventions can improve children's developmental trajectories, prevent future problems, and promote child and family strengths.



National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions; O'Connell ME, Boat T, Warner KE, editors. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Washington (DC): National Academies Press (US); 2009.

What Are Common Policy Recommendations Based on These Core Concepts?

A number of policy recommendations have been developed by national research and advocacy group focused on the needs of young children (e.g. National Center for Children in Poverty, Zero to Three). The recommendations are based on the key concepts previously discussed, especially the centrality of early relationships. These commonly include: 1) Infusing early childhood mental health into behavioral health, maternal-child health, child welfare, home visiting (including the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program), and Individuals with Disabilities Education Act Part C early intervention initiatives; 2) Incorporating a social-emotional component to screening, referral, and intervention requirements in home visiting programs (including MIECHV programs), child welfare, and other early learning and development programs, as well as pediatric and prenatal health care; 3) Inclusion of early childhood mental health screening, assessment, and treatment in state Medicaid and behavioral health plans; 4) Building capacity and competence in early childhood mental health practice through professional development for child care and mental health providers through degree programs and through ongoing continuing education; 5) Promoting the use and expansion of evidence-based clinical interventions, parenting education, and family support (e.g. home visiting); 6) Increased access to early childhood mental health consultation in child care and early education settings; 7) Expansion and use of evidence-based caregiver mental health and substance abuse treatments and programs; 8) Increased efforts to serve children and families involved in child welfare, as these children often have the greatest amount of early adversity; and 9) Expansion and use of evidence-based practices for the children's mental health problems that span the full continuum from prevention to early intervention to treatment (National Center for Children in Poverty, 2011; Smith et al., 2008; Cohen, 2009).

As part of the process for the development of this strategic plan, we reviewed Arkansas' strengths and needs relative to the policy recommendations above. Our proposed goals and strategies address many of the policy recommendations identified, especially in areas where we identified Arkansas has particular gaps or needs.

Need for Support for Arkansas Children, Parents and Service Providers

As described above, many national studies point to the need for increased efforts to support early childhood mental health by promoting positive relationships between young children and their caregivers. Below we provide evidence of the need among Arkansas children and their caregivers.

Evidence of Challenges for Young Children

Early-emerging behavior problems are a serious concern. Without help, about 50% of children with early problems will go on to have more serious problems in later childhood and adolescence.

Behaviors in Pre-K Settings: In a study of 1448 children enrolled in Arkansas Head Start and Arkansas Better Chance Pre-K programs, 16% of children had clinically elevated behavioral screening results. Behaviors were reduced in sites with access to routine mental health consultation (Conners-Burrow, 2012).

Behaviors for High Risk Children: Behavior problems are more common among children with major family risk factors. For example, among preschool children whose mothers were in substance abuse treatment in Arkansas, 55% of had clinically elevated behavior problems according to teacher-report (Conners-Burrow et al, 2013).

Evidence of Stressors for Parents

Parenting Stress: High levels of parenting stress are a risk factor for child abuse and other problems in parenting. In a study of Arkansas Head Start parents, 28% surveyed had high levels of parenting stress (Whiteside-Mansell et. al, 2007); Stress levels were much higher (52%) among Head Start parents that screened positive for substance use problems in the family.

Maternal Depression: Symptoms of depression are common among mothers with young children, and are a major risk factor for problem in parenting and poor child outcomes. Screenings of Arkansas mothers in Head Start reveal 6% with a strong probability of major clinical depression and 21% reporting lower level depressive symptoms (51% among Head Start parents screening positive for substance use problems in the family). In studies of Arkansas families, even lower-level depressive symptoms have been shown to increase home safety risks and decrease learning opportunities in the home (Conners-Burrow et.al, 2013).

Data from the Pregnancy Risk Assessment Monitoring System (PRAMS*)* indicates a postpartum depression rate of 17.7% among Arkansas women. Postpartum depression is more common in mothers younger than 20 years of age, smokers, and among mothers with stressful life events (e.g. moving, divorce) and family risk factors (e.g. financial strain, unsupportive partner).

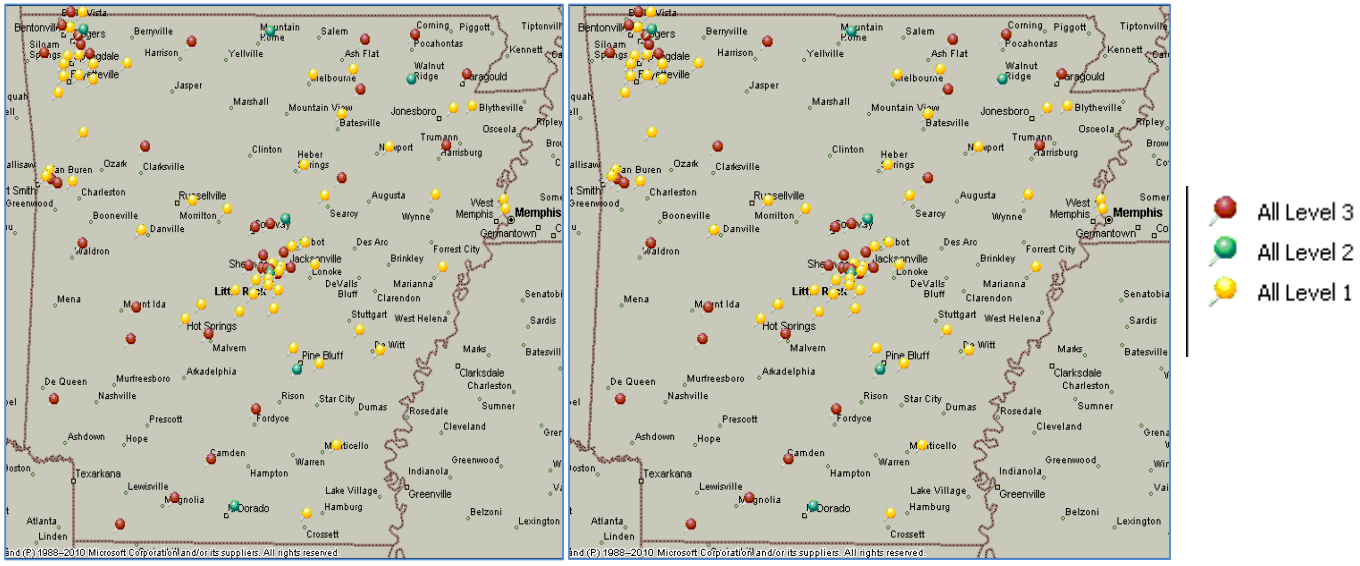
Child maltreatment: Children who experience abuse and neglect are at high risk for problems with mental health. In 2012 in Arkansas there were 1057 victims of abuse or neglect aged 0-1 and another 2780 victims aged 2-5. In the same year, there were 3,317 children aged 0-5 living in foster care in Arkansas (Arkansas Department of Human Services, 2012).

Lack of Widespread Access to High Quality Child Care

High quality child care supports social-emotional development, while children in low quality care are more likely to have problems with behavior and to fall behind on school readiness indicators. Unfortunately, many Arkansas children do not have access to high quality care. Arkansas has a relatively new quality rating improvement system for child care providers, called Better Beginnings. It is a tiered, 3 level system, with higher levels representing greater quality. Participation in the quality rating system is voluntary, and programs may choose to meet only the minimum licensing standards. Arkansas consistently ranks at or near the bottom of states for the quality of our licensing standards although we rank high for enforcement of the standards that exist (Child Care Aware of America, 2013). There is an effort underway to revise licensing standards in an effort to remedy this situation.

In 2012, there 774 rated facilities (586 Level 3, 33 Level 2, and 155 Level 1), and the majority (535) were Arkansas Better Chance (ABC) /Head Start facilities. These facilities are for pre-kindergarten age children and have income eligibility requirements. As shown on the maps below, there are large parts of the state with no quality-rated program, especially for children (including infants and toddlers) that are not eligible for Head Start or ABC programs.

ABC/Head Start Facilities by Level 2012 **Non ABC /Head Start Facilities by Level 2012**



Facilities are mapped by zip code. One pin may represent more than one facility at that level within the same zip code. Generated by UAMS Better Beginnings Evaluation Team in February 2013 using DCCECE data.

Evidence of Stressors for Early Care and Education Providers

Caregiver Stress and Depression: A recent survey of 1040 Arkansas ECE providers revealed that 8% of preschool teachers reported depressive symptoms consistent with a likelihood of major clinical depression, while another 23% reported lower-level depressive symptoms (Bokony, 2013).

Similarly when this same group of teachers were asked items about stress, including whether 'difficulties were piling so high that they could not overcome them', 8% reported this feeling 'fairly or very often', while another 26% reported feeling this 'sometimes' (Bokony, 2013).

Teacher Turnover: Nurturing relationships with caring and consistent adults, including teachers, are essential for children's development. Teacher turnover is a concern because high levels of turnover prevent children from developing meaningful relationships. While teacher turnover rates are not routinely tracked, two recent reports have documented a 34-40% six-month teacher turnover rate in private child care centers (Conners-Burrow et al., 2012, 2013). This is a major concern, as children cannot develop critical attachment relationships with unstable caregivers.

Preschool Expulsion: Preschool expulsion is a serious concern, not only because it disrupts their educational experience, but because it labels them as a 'problem child' before they even ready school age. Arkansas is among a group of states with 4-7 expulsions per 1,000 preschoolers, a rate about three times higher than the rate in Kindergarten through 12th grade. Expulsion rates were lower where teachers had access to mental health consultation services (Gilliam, 2005).

Lack of Capacity among Mental Health Professionals

Mental health problems among young children and their families can be successfully addressed through evidence-based programs. However, both nationally and in Arkansas, our mental health workforce is not adequately trained to provide evidence-based interventions to young children and their caregivers. Many mental health professionals lack training in early childhood development, assessment and intervention. Among 179 mental health professionals attending an Arkansas training on an evidence-based treatment approach for children, survey results revealed:

- Only 9% of providers currently provide therapy services for children 0-3 who have experienced trauma (such as abuse or neglect)
- Only 28% of providers worked in an agency where at least one staff member was trained to provide an evidence-based treatment for traumatized children 0-3.
- Only 12% of provider indicated they would feel comfortable to complete a mental health assessment for a child under age 3 (43% were comfortable completing for a child 3-5).
- **84% were interested in receiving additional training on mental health interventions for children under the age of 5**.

Strategic Planning Process and Intended Use of the Plan

What Kind of Plan was Intended?

The proposed plan utilizes a Public Health Approach that balances a focus on children's mental health problems and maximizing children's positive mental health (see Miles, et al., 2010). This approach envisions a children's mental health plan that provides a full continuum of services and supports: mental health is promoted; problems are prevented; and when problems occur, they are treated and health is reclaimed. Such an approach requires collaboration among an array of systems, agencies, organizations and disciplines as well as public and private partnerships. **No one system is responsible for children's mental health.**

The public health approach addresses the four categories shown in Figure 2. Promotion (supporting optimal mental health) and prevention (addressing problems before they occur) require knowledge and understanding of the determinants of positive and negative mental health outcomes in our state. Interventions emphasize a system of care that builds an infrastructure to support a full continuum of individualized and community-based care (e.g., wrap-around services). Reclaiming supports optimal health, not just alleviating mental health symptoms.

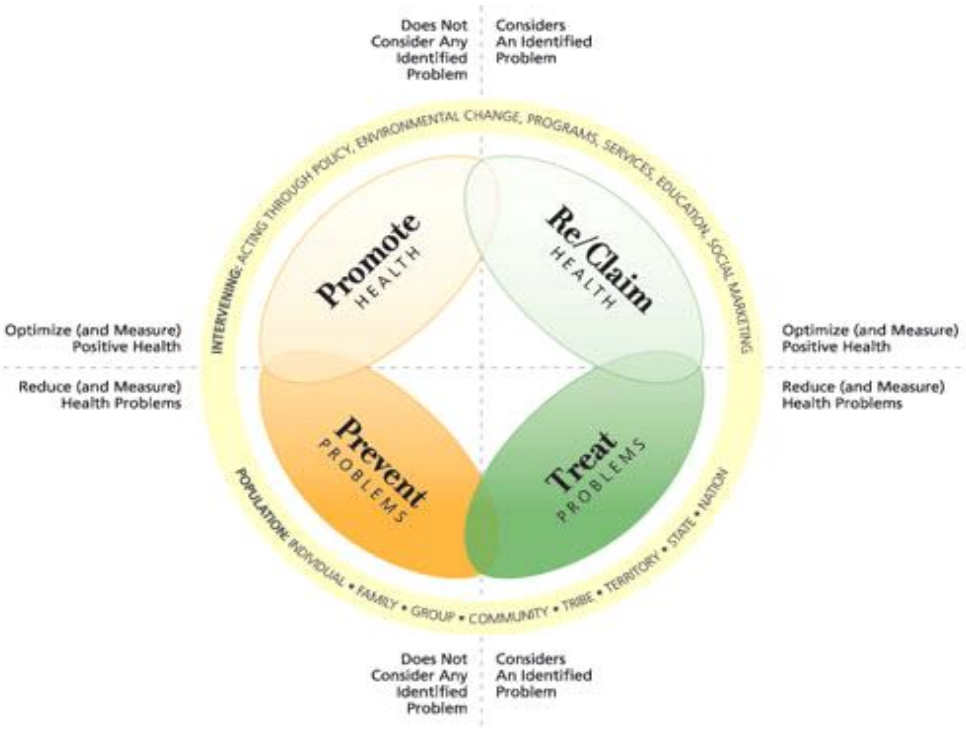


Figure 2. Intervention Model for Children's Mental Health (Miles et al., 2010).

Arkansas System of Care (SOC) principles also guided the development of this early childhood plan. This plan is built on the concept of keeping children in their homes and communities. Young children are seen in context of their relationship with their parents/caregivers and the child care

and education programs that serve them. *It is understood that success in early child care and education settings is primary prevention.* The Arkansas system seeks the development of developmentally appropriate interventions for the individual child, family and community. It recognizes that community based, culturally appropriate and collaborative decision making requires the participation of representatives from both the public and private sectors. In order to ensure that evidence informed practices are used to manage the state's resources, research and data collection both must be ongoing practices.

What Was the Process and Who Developed the Plan?

The Social-Emotional Workgroup of the Arkansas Early Childhood Comprehensive Services Initiative identified the need to develop a comprehensive Arkansas State Plan for Children's Mental Health. The standing workgroup members identified and recruited key stakeholders to participate in the workgroup for at least one year to develop the plan. The group completed a series of tasks:

1. Developed a shared understanding of information presented in the 'Background' section of this document;
2. Completed an environmental scan of existing programs that support ECMH in the state;
3. Identified gaps and issues to be addressed through the plan;
4. Identified 5 broad goals that focus on the gaps in existing programming in the state
5. Develop strategies under each goal
6. Emailed out for comment by workgroup members not present at final meeting

During the development of the plan, the workgroup came to decisions about what would and would not be feasible to include in the plan. The group decided not to include methods for evaluating and monitoring the success of the plan, though we recommend that evaluation and monitoring occur within the agencies that choose to implement elements of the plan. The group also decided to keep the focus on identification of strategies needed to support ECMH in Arkansas, while leaving detailed discussions of financing for a later time.

How Should the Plan Be Used?

Based on the participation of stakeholders in the workgroup, the plan provides a shared vision for Arkansas. The Arkansas ECMH Plan is a guide for Arkansas' public and private agencies and universities to best support the development of a comprehensive system that supports early childhood mental health. Recommendations target interagency collaborations, education and training opportunities, infrastructure development, and investments of time and resources.

Broad goals are intended to be long-term (5 years or greater). Specific strategies include short-term opportunities (1-3 years). The plan should be revisited to recognize progress and develop new strategies toward the long-term goals. As portions of the plan are implemented and adopted, the success of the implementation and its planned outcomes should be evaluated.

Goal 1: The most at-risk families will be supported with services designed to keep families together.

Strategy 1: Embed family support services into settings where high risk families have been identified.

A. Resources to support evidence-based and promising parenting education and support programs will be developed. New implementation will prioritize programs with proven positive outcomes in the state, including those implemented through support from the Substance Abuse Mental Health Services Administration then discontinued due to a lack for funding. Programs must address a continuum of varying child development and family needs.

B. Parenting education and evidence-based mental health interventions will be made available in settings that serve children considered to be at high risk. These settings include Community Mental Health Centers (CMHCs), Regional Prevention Providers (RPPs), substance abuse programs, publically funded pre-kindergarten programs (Head Start and Arkansas Better Chance) for low-income families, Developmental Day Treatment Clinic Services (DDTCS), Child Health Management Services (CHMS), homeless shelters, domestic violence shelters, Community Health Centers (CHCs), home visiting and child welfare (including biological parents, foster parents, potential adoptive parents and therapeutic foster parents). Services should also be made available to families identified as needing supports through the DCFS differential response program.

C. Develop resources to identify and reduce barriers to accessing parenting education and mental health interventions. Many families most in need of these services are also in need of basic dependable transportation, child care and other supports.

Strategy 2: Support family-centered court systems through the development and expansion of evidence-based, collaborative practices.

A. Increased utilization of existing Arkansas Safe Babies Court Team resources will be used in order to raise awareness of the needs of young children and their families in other court systems (e.g. drug courts, criminal courts).

B. The successful Pulaski County Safe Babies Court Team model will be replicated in court systems across the state.

C. A cross system partnership between court systems and the Arkansas Department of Human Services (DHS) Division of Child and Family Services (DCFS), Division of Youth Services (DYS) Division of Child Care and Early Child Education (DCCECE), Division of and Division of Behavioral Health Services (DBHS) will develop policies and

procedures that address how mental health and substance abuse providers work with families toward improved outcomes.

Goal 2: Younger children and their families will be fully represented in state cross-systems initiatives to support mental health.

Strategy 1: Increase collaboration across key state agencies to identify and implement best practices for young children and their families.

A. An identified staff member within DHS will work across DCCECE, DBHS, DCFS, DDS and the Arkansas Department of Health and Department of Education to provide staff education, ensure best practice, and build alliances and support for ECMH initiatives.

B. Policies and procedures should be developed to support collaboration across agencies and systems.

Strategy 2: Identify the young child and their family as a priority in our behavioral health systems, in alignment with best practice principles for serving young children with their families.

A. A full continuum of services must be available, to include promotion and prevention (e.g. parenting/caregiver education), early intervention and supportive services (e.g. social skills curriculum, classroom supports) and treatment (e.g. mental health services such as parent-child interaction therapy). This is compatible with the current DHS DBHS focus on Primary, Secondary and Tertiary strategies.

B. The utilization of evidence-based treatments for children (0 to 5) with their caregivers (e.g. parent-child interaction therapy, child-parent psychotherapy, trauma-focused cognitive behavioral therapy) will be optimized.

C. The following principles should guide planning:
   - Developmentally appropriate assessment must be emphasized.
   - A focus on young children should be encouraged, recognizing that evidence-based treatments are available to support high-risk parent-child dyad as early as infancy and continuing throughout early childhood.
   - Young children are best served in their natural settings. Interventions should support the maintenance of children in their homes and preschool programs.
   - Because early childhood mental health is dependent on early relationships, parent/caregiver involvement is necessary for intervention.

D. The state Child and Adolescent Service System Program (CASSP) council and local CASSP and Care Coordination Council teams will seek to increase the engagement of young child serving entities and prioritize effective young child interventions.
    - The DCCECE and the Head Start Collaboration office will encourage state funded Early Care and Education provider representations on local councils.

E. Young children that meet current Multiple Agency Planning (MAP) and Wraparound criteria (e.g. serious diagnosis, multi-agency involvement) should have the full array of all appropriate SOC services and supports available to them, their family and the early childhood programs that serve them.

F. Data development through the DHS Division of Medical Services will facilitate the understanding of the involvement of young children and families receiving behavioral health services at the higher levels. Data collection should include age, educational/care enrollment, diagnosis, identified developmental delays, services, supports and functional assessments.

G. The development of referral uniformity is critical. It is necessary to identify key providers of young child mental health services and referral gaps, including referral gaps based on geography. Disparities will be addressed through education and training efforts that include information on available services and supports.

Goal 3: Evidenced based screenings for social-emotional problems in young children and serious family risks will be expanded and referrals to appropriate services will be enhanced.

Strategy 1: Increase routine screening to identify children at high risk for early onset of social-emotional difficulties based on their family risk factors.

A. Providers of services to pregnant women will screen to identify mothers at highest risks for problems in parenting.

B. Screening for pregnant women and mothers of young children will include mental illness, substance abuse, domestic violence, catastrophic events, exposure to environmental toxins, chronic illness and child welfare involvement. Women with deployed or incarcerated partners will be a targeted population.

C. The use of screening tools with a prior history of successful implementation in AR should be encouraged (e.g. The Family Map to identify a range of family risks, the Patient Health Questionnaire for depression and the CAGE for substance use.) Primary care, home visiting and early education and Developmental Day Treatment providers will screen to identify high risk families in order to both provide intervention but also to increase protective factors.

Strategy 2: Increase identification of children with early emerging social emotional problems through the expansion of routine standardized screening.

A. Standardized questionnaires (e.g. Pediatric Symptom Checklist, Ages and Stages Questionnaire – Social emotional, Devereux Early Childhood Assessment) will be adopted to identify young children age with early social-emotional problems by pediatricians and primary care physicians, home visiting and early education and childcare providers.

B. The results of screenings completed outside of physician offices will be communicated with the child's health care provider. This protocol will build on the model developed by the state's previous Ages and Stages (ASQ) pilot project.

C. In coordination with DHS, monitoring systems will be developed to ensure that groups of children identified as being at high risk receive screening on a recommended schedule. This identified group includes children in foster care, children of depressed or alcohol- or drug-dependent parents and children with chronic health conditions.

D. Reimbursement incentives for screening and preventive mental health services will be provided and the funding mechanism of other states will be reviewed.

E. Guidelines for referral for assessment, prevention services, or treatment will be generated using existing guidelines (such as maternal depression toolkit being prepared for roll-out by the DCCECE).

Goal 4: Early childhood mental health care providers and early care and education providers will receive the supports necessary to improve child social-emotional outcomes.

Strategy 1: Continue to advocate for the rollout of the Early Childhood Mental Health (ECMH) graduate certificate for behavioral health providers to work with young children.

A. Increased collaboration between Arkansas Higher Education and behavioral health and early childhood education training programs must take place that support current and future workforce development and provide internships in birth to five settings.

B. State behavioral health licensing boards (Social Work, Counseling and Psychology), AAIMH, providers and DHS will work with Arkansas Universities to support the full implementation of the graduate ECMH certificate program. (ECMH standards were developed previously through the AECCS SE Workgroup in coordination with a state and private higher education representatives.)

C. Evidenced based practices as related to the young child and their family are infused throughout behavioral health education and training both in University and continuing education.

D. Workforce development needs will be addressed in the Arkansas application for Federal Race to the Top-Early Learning Challenge.

Strategy 2: Invest in training opportunities in promising and evidence-based mental health services for young children and their families.

A. CMHCs will provide early childhood liaisons in local communities as required by contractual agreement with DHS DBHS. These positions will be supported through ongoing DHS Divisional supports and training.

B. Professional development training needs (e.g. typical and atypical development) for public and private providers will be identified and supported through DHS interdivisional supports.

C. The appropriate role of mental health in the treatment of autism spectrum disorders requires definition (e.g. Medicaid) and training (DHS DDS DBHS). Work with AFMC and Medicaid will seek resolution of inconsistencies between private insurance and Medicaid.

D. The network of mental health professionals serving young children will be expanded in a partnering effort with DHS, AAIMH, NAMI, AR BEST and others to expand the network of mental health professionals focused on young children.

- The expansion of Arkansas tele-health sites can be used to expand training, consultation and the AAIMH network in all geographical areas.
- The AAIMH will work to expand its network of stakeholders, including the CMHC liaisons, in order to increase awareness of its mission, educational opportunities and promote involvement.

E. Current in-state trainings and evidence based mental health treatments for young children with their parents will be fortified through strategic investments. These include:

- The DCCECE 40 hour Pre-Kindergarten Social-Emotional Learning training for ECE providers and the abbreviated version for mental health professionals require promotion and expansion.
- The AECCE SE Workgroup developed guidelines for the process of obtaining at DCCECE Certificate for ECMH Consultation to Child Care (a child care consultation specific certificate, different from the graduate certificate previously described). All Project PLAY team members must obtain their certificate; the state should invest to ensure the certification process, including training, mentoring and supervision, stays open to other mental health professionals.
- Training for clinicians in evidence-based treatment approaches for young children with their parents, such as Parent-Child Interaction Therapy, Child-Parent Psychotherapy and Trauma-Focused Cognitive Behavioral Therapy require the support of DHS, public and private providers and institutions of higher education. Two UAMS initiatives provide models for successful dissemination, Arkansas Building Effective Services for Trauma and the Arkansas Network for Early Stress and Trauma.

Strategy 3: Invest in training and support for early care and education providers in order to improve child social-emotional outcomes.

A. Stronger minimum training requirements for childcare providers as part of minimum licensing standards, supported by the DCCECE, will be provided before a childcare provider enters the classroom. Basic training includes appropriate schedule and routines, developmentally appropriate practices and strategies to support social and emotional development and manage challenging behaviors.

- Increased usage of distance learning and on-line training modules are needed.

B. Standardized Social-Emotional curriculums (ages 3-5) will be encouraged for adoption in every preschool classroom and required for state funded programs including DDTCs.

- Curriculums require review and the establishment of state recommendations based on evidence of effectiveness, a continuum of capacity, cost and ease of implementation.

C. Project Play will be the model used for expanding AR Early Childhood Mental Health Consultation services.

- Consultation services should be available in every region of the state.
- Protocols for increasing coordination and communication between consultants and behavioral specialists, Part C and Part B providers must be identified, with communication to early care and education providers about the roles of each.
- Expanding consultation services for family day care home needs exploration.

D. The existing AR Department of Education Behavior Interventionist Program requires expansion and increased coordination with CASSP and CCC teams.

Goal 5: Public awareness of the mental health needs of young children will be increased.

Strategy 1: Develop an ECMH toolkit of materials with simple messages about early childhood mental health designed for use with varied audiences.

A. The AR Infant Mental Health Association, Arkansas Department of Health (ADH) and the DHS/Division of Behavioral Health Services (DBHS) will collaborate to develop targeted messaging points.

- Enhanced Screening efforts will be accompanied with materials designed to facilitate the reduction of stigma related to screening. Materials will provide education as to benefits of screening, risk avoidance and the importance of early interventions.

B. Developed materials will target the general public as well as behavioral health professionals, physicians and other medical providers and educators.

C. Cost effective materials will use existing professional resources (e. g. Zero to Three) and customized to Arkansans.

Strategy 2: Launch a public awareness campaign to promote the importance of early childhood mental health and ways to promote children's social and emotional development.

A. DHS, ADH will collaborate with the AR Infant Mental Health Association and Arkansas Advocates for Children and Families and interested foundations to turn targeted messaging points into radio spots, television spots, web-based videos, newspaper ads, etc.

- The DHS/Division of Early Childcare and Early Child Education (DECECE) will provide support for filming and access to radio and newspaper advertisements statewide through the AR broadcasting group.
- Support from the DHS, UAMS and ADH communication departments will be sought to support this ongoing campaign

B. Spokespersons/advocates at state and local levels will be identified and recruited to effectively deliver messages to diverse audiences.

- A "train the trainer" format will prepare for an expansion of advocates across the state, available to use the ECMH toolkit in their community with diverse audiences
- Assistance will be sought from Arkansas Advocates for Children and Families and the Kids Count Coalition.

C. Toolkit materials will be disseminated and training made available to legislators, policy makers, medical professionals, ADH, school, churches, civic groups, and libraries. 'Letters to the editor' campaigns in local communities will be used.

D. Collaboration with DHS/Division of Behavior Health Services will incorporate messaging materials into Mental Health Awareness Month events.

E. Collaboration with other mental health, family organizations and family support programs such as the National Alliance on Mental Health (NAMI) will expand messaging within related efforts

F. Partnering with UAMS/DFPM will support the inclusion of messaging in Naptime Academies for early child care providers.

G. Continuing Medical Education(CME) events for the medical community will be developed in conjunction with AFMC, AR medical associations and UAMS/Department of Family and Preventive Medicine/Continuing Medical Education Division and Arkansas Children's Hospital

References

Arkansas Department of Human Services, Division of Children and Family Services (2012). SFY Annual Report Card. Available at: http://humanservices.arkansas.gov/dcfs/Pages/StateFederal-Reports.aspx

Bokony, P. (2013). Survey of Arkansas Preschool Teachers. Unpublished data.

Campbell, S. B. and Ewing, L. J. (1990), Follow-up of Hard-to-Manage Preschoolers: Adjustment at Age 9 and Predictors of Continuing Symptoms. *Journal of Child Psychology and Psychiatry*, 31: 871–889. doi: 10.1111/j.1469-7610.1990.tb00831.x

Campbell, S. B., Breaux, A. M., Ewing, L. J., & Szumowski, E. K. (1986). Correlates and predictors of hyperactivity and aggression: A longitudinal study of parent-referred problem preschoolers. *Journal of Abnormal Child Psychology*, *14*(2), 217-234.

Caspi, A., Moffitt, T. E., Newman, D. L., & Silva, P. A. (1996). Behavioral observations at age 3 years predict adult psychiatric disorders: Longitudinal evidence from a birth cohort. *Archives of General Psychiatry*, *53*(11), 1033.

Center on the Developing Child, Harvard University, *In Brief: The Science of Early Childhood Development.* NGA Center for Best Practices, National Conference of State Legislatures, and Center on the Developing Child, Harvard University, 2008, www.developingchild.harvard.edu

Child Care Aware of America (2013). *2013 State of Child Care Centers in Arkansas*. Available at: http://www.naccrra.org/sites/default/files/default_site_pages/2013/arkansas_wcdb_2013.pdf
Cohen, J. (2009) *Laying the Foundation for Early Development*. Zero to Three. Available at: http://www.zerotothree.org/public-policy/policy-toolkit/mentalhealthbriefweb1-13-13.pdf

Cohen, M. A. (1998). The monetary value of saving a high risk youth. *Journal of Quantitative Criminology, 14*, 5-33.

Cohen, M. A., & Piquero, A. R. (2009). New evidence on the monetary value of saving a highrisk youth. *Journal of Quantitative Criminology, 25*, 25-49.

Conners-Burrow, N.A. & Whiteside-Mansell, L (2012). Project PLAY Annual Evaluation Report. Unpublished report. Available at: www.projectplay.uams.edu

Conners-Burrow, N.A., Whiteside-Mansell, L., McKelvey, L., Amini-Vermani, E., & Sockwell, L. (2012). Improved Classroom Quality and Child Behavior in an Arkansas Early Childhood Mental Health Consultation Pilot Project. *Infant Mental Health Journal,* Vol. 33(3), 256–264 DOI: 10.1002/imhj.21335

Conners-Burrow, N.A., Fussell, J., Johnson, D.L., McKelvey, L., Whiteside-Mansell, L., Bokony, P., Kraleti, S. (2013) Maternal Low and High Depressive Symptoms and Safety Concerns for Low Income Preschool Children. *Clinical Pediatrics* 52 (2), 167 - 173. Doi: 10.1177/0009922812473776

Cicchetti D, Toth SL, Rogosch FA. The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment and Human Development* 1999;1:34-66.
Dicker, S. and Gordon, E. (2004), *Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges Advocates and Child Welfare Professionals.* Zero to Three. Available at http://www.nycourts.gov/ip/justiceforchildren/PDF/Infant%20Booklet.pdf

Dicker, S., Gordon, E., & Knitzer, J. (2001). *Improving the odds for the healthy development of young children in foster care.* New York, NY: National Center on Children in Poverty.

Dozier, M., Peloso, E., Lindhiem, O., Gordon, M. K., Manni, M., Sepulveda, S., Ackerman, J., Bernier, A. and Levine, S. (2006), Developing Evidence-Based Interventions for Foster Children: An Example of a Randomized Clinical Trial with Infants and Toddlers. *Journal of Social Issues*, 62: 767–785. doi: 10.1111/j.1540-4560.2006.00486.x

Egger, H. L., & Angold, A. (2006). Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry*, *47*(3-4), 313-337.

Eyberg SM, Funderburk BW, Hembree-Kilgin TL, McNeil CB, Querido JG, Hood KK. Parent-child interaction therapy with behavior problem children: One and two year maintenance of treatment effects in the family. *Child Fam Behav Ther* 2001;23(4):1-20.

Fergusson, David M., Lianne J. Woodward, and L. John Horwood. (2000) Risk factors and life processes associated with the onset of suicidal behaviour during adolescence and early adulthood. *Psychological medicine* 30 (01) 23-39.

Gilliam, Walter S. *Prekindergarteners left behind: Expulsion rates in state prekindergarten systems*. Foundation for Child Development, 2005.

Gleason, Mary, et al. (2007) Psychopharmacological treatment for very young children: contexts and guidelines." *Journal of the American Academy of Child & Adolescent Psychiatry* 46 (12)1532-1572.

Heckman, J. J., Moon, S. H., Pinto, R., Savelyev, P. A., & Yavitz, A. (2010). The rate of return to the HighScope Perry Preschool Program. *Journal of Public Economics*, *94*(1), 114-128.

Lieberman AF, Ghosh Ippen C., Van Horn P. (2006) Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *J Am Acad Child Adolesc Psychiatry*, 45:913-918.

Leibson CL, Katusic SK, Barbaresi WJ, Ransom J, O'Brien PC.(2001) Use and costs of medical care for children and adolescents with and without attention-deficit/hyperactivity disorder. *JAMA* 285: 60–66.

Miles, J., Espiritu, R.C., Horen, N., Sebian, J., & Waetzig, E. (2010). *A Public Health Approach to Children's Mental Health: A Conceptual Framework*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Molina, Brooke SG, and William E. Pelham Jr. (2003) Childhood predictors of adolescent substance use in a longitudinal study of children with ADHD." *Journal of abnormal psychology* 112 (3) 497.

NACCRA, 2012

National Research Council and Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Jack Shonkoff and Deborah A.Phillips, eds. Washington, DC: National Academy Press, 2000.

National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions; O'Connell ME, Boat T, Warner KE, editors. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Washington (DC): National Academies Press (US); 2009. Available from: http://www.ncbi.nlm.nih.gov/books/NBK32781/

National Scientific Council on the Developing Child (2008). Mental Health Problem in Early childhood Can Impair Learning and Behavior for Life: Working Paper #6. Available at: http://www.developingchild.net.

Melmed ME. A call to action for infants and toddlers in foster care. *Zero to Three* 2011;31:29-34.

Osofsky JD, Lieberman AF. (2012) A call for integrating a mental health perspective into systems of care for abused and neglected infants and young children. *Am Psychol* 66(2):120-128.

Smith, Stagman, Blank, Ong, and McDow (2011). *Building Strong Systems of Support for Young Children's Mental Health: Key Strategies for States and a Planning Tool*. National Center for Children in Poverty. Available at: www.nccp.org/publications/pdf/text_1016.

Silverman WK, Ortiz CD, Viswesvaran C et al. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *J Clin Child Adoles Psychol* 37(1):156-183.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). *Child Maltreatment 2011*. Available from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment.

Vandell, D. L., Belsky, J., Burchinal, M., Steinberg, L., Vandergrift, N. and NICHD Early Child Care Research Network (2010), Do Effects of Early Child Care Extend to Age 15 Years? Results From the NICHD Study of Early Child Care and Youth Development. Child Development, 81: 737–756. doi: 10.1111/j.1467-8624.2010.01431.x

Whiteside-Mansell, L., Bradley, R. H., Conners, N. A., & Bokony, P. A. (2007). The Family Map: Structured interview to identify risks and strengths in head start families. *NHSA Dialog: A Research-to-Practice Journal for the Early Intervention Field, 10*, 189-209.

Acronyms

AAIMH: Arkansas Association for Infant Mental Health

ABC: Arkansas Better Chance preschool programs

ADH: Arkansas Department of Health

AECCS SE Workgroup: Arkansas Early Childhood Comprehensive Systems Social Emotional Workgroup

AFMC: Arkansas Foundation for Medical Care

AR BEST: Arkansas Building Effective Services for Trauma

AR NEST: Arkansas Network for Early Stress and Trauma

ASQ: Ages and Stages Questionnaire

CASSP: Child and Adolescent Service System Program

CCC: Care Coordinating Council

CHC: Community Health Center

CHMS: Child Health Management Services

CMHC: Community Mental Health Center

CME: Continuing Medical Education

DHS: Department of Human Services

- DCCECE: Division of Child Care and Early Childhood Education
- DCFS: Division of Children and Family Services
- DBHS: Division of Behavioral Health Services
- DMS: Division of Medical Services
- DYS: Division of Youth Services

DDTCS: Developmental Day Treatment Clinic Services

ECMH: Early Childhood Mental Health

IMH: Infant Mental Health

MAP: Multiple Agency Planning

MIECHV: Maternal, Infant and Early Childhood Home Visiting program

NAMI: National Alliance on Mental Illness

PRAMS: Pregnancy Risk Assessment Monitoring System

PRC: Prevention Resource Center

Pre-k: Pre-Kindergarten

UAMS: University of Arkansas for Medical Sciences

DFPM: Department of Family and Preventive Medicine