



Research-Informed **Social Emotional Health Strategies**

Assess the likely health equity impacts of public policies, including legislative, regulatory and administrative policies and provide recommendations to reduce identified impacts.

Require agencies involved in community or county strategic planning for transportation, land use and housing development to **link with public health agencies and identify potential health equity consequences of proposed actions. Decision makers should examine whether policies and practices limit access to services – either intentionally or not – or separate populations.**

Survey communities to understand the needs and develop services accordingly. Use strengths-based approach to planning and implementation.

Require training for state and local policy makers and other decision-makers on implicit bias, history of trauma, and racial equity. Leadership needs to understand and be able to talk about white privilege, systemic racism, systemic failings, and historically oppressive policymaking.

Work with state and local decision makers towards inclusiveness of all cultures in decision-making activities. Study and replicate instances of decisions successfully made with authentic engagement.

Develop a political pipeline of people of color and especially women who have experienced these challenges and specifically recruit people of color for key decision-making roles and positions. On local level, engage community and informal group leaders to identify and support people of color to run for office and have and give voice to concerns. Re-think who should be mandatory participants on boards, commissions with lens towards parents/families served.

Intentional examination of policy impacts on families (low-income, race, ability) and their needs, which impact in turn the long-term health of NC.

Integrate mental health, physical health and primary care. Integrated behavioral health care within the patient-centered medical home (PCMH) is a particularly promising strategy to reduce barriers and increase access to mental health care across pediatric populations.

Serve all children in medical homes.

Create referral protocols that allow mental health providers to be available quickly, eliminate repetitive intake processes, and enable effective and specific communication between pediatric and mental health providers.

Develop strong links between primary care providers and community mental health centers to assure continuity of care when more complex or intensive mental health services are warranted.

Do not silo out mental health services from physical health services.

Engage pediatricians and primary care providers in screening for general child behavioral issues, more specific social-emotional needs, social determinants of health, maternal depression, and parental strengths, and then talking systematically with parents about those results. Create billing codes as needed.

Increase use of paraprofessionals (e.g., family navigators, family support workers) in pediatric practices to facilitate access to care

Create child mental health access programs, in which a mental health team (eg, psychiatrists, psychologists) provides real-time consultation to pediatricians to support their implementation of mental health interventions.

Through additional training, increase the capacity of primary care providers and staff to address barriers to patient engagement in mental health care, including by increasing attention to social determinants of health (e.g., housing, neighborhood conditions).

Create training to increase primary care providers' comfort and competency in prevention, management, and treatment of frequently occurring and lower-acuity mental health conditions in childhood and adolescence, including medication management and knowledge of evidence-based mental health services.

Co-locate mental health providers within primary care practices.

Make programs where pediatricians educate parents about reading and interacting with their children universal.

Use a collaborative care model across child-serving systems to ensure attention to early childhood mental health is infused throughout. Build in increased cooperation between mental health providers and the health, education, family supports, and child welfare systems at the community, county and state levels to implement a comprehensive, shared framework for advancing young children's mental health and social-emotional development.

Create a state strategic plan to infuse infant and early childhood mental health (I-ECMH) into behavioral health, primary and public health, early learning and development, child welfare, home visiting including MIECHV, and Part C early intervention initiatives. An I-ECMH state plan should address the promotion, prevention, and treatment continuum and include several core components:

- Leadership.
- Financing.
- Systems integration.
- Improvement strategies.
- Professional development.
- Public awareness.

Establish cross-agency infant and early childhood mental health leadership to drive the strategic direction of statewide efforts. **Bring agencies together several times a year to brainstorm solutions and share how to access resources.**

Support the inclusion of ACEs screening and trauma-informed care across governmental agencies at the state and county levels and in all medical visits. Ensure availability of ACE screenings in high-poverty neighborhoods.

Review and align professional standards across sectors and make sure that infant and early childhood mental health is adequately addressed in training for child welfare, maternal-child health, MIECHV and other home visiting efforts, Part C early intervention, mental health, pediatric health, and early learning and development so that all of these professionals understand how to promote social-emotional development, how to recognize the risk factors and early signs of social-emotional problems and mental illness in infants and toddlers, and when a concern should be referred for appropriate follow-up. **Incorporate I-ECMH knowledge and competencies into higher education, personnel preparation, and workforce development initiatives across child development, early childhood special education, early intervention, social work, pediatrics, and related disciplines.**

Require child-serving state and local systems to measure children's outcomes and to include early childhood and family mental health measures.

Integrate supports for infant mental health consultation into the contexts where infants and toddlers are found, for instance, in parent education programs, child care and early education programs, well-child health services, home-based services, child- and family-serving agencies, WIC, etc.

Develop a Maternal Depression Screening and Response Program to ensure that maternal depression screening and response is embedded in the statewide home visiting system and in primary care, including as part of prenatal and postpartum care.

Develop centralized intake systems, designed to help families access multiple programs through a single entry point. Centralize core tasks that are common to most social services, such as outreach and identification of families, screening or assessment during intake, identification of needed services, and referral to services and programs.

Expand Help Me Grow partnership and integrate with 2-1-1. Parents need better referral systems.

Engage in ground-level parent education by equipping community agents (including doctors, mental health professionals, teachers, community, probation officers, police, clergy, guidance counselors, principals, employers, college instructors, etc.) to link parents to public health/referrals, provide resource program explanations and early-intervention options from birth.

Increase adoption of electronic health records, and implement information systems for quality assurance, accountability, and data sharing across providers, agencies and counties. A system for sharing records facilitates joint planning and improves efficiency and quality of care.

Coordinate and integrate mental health services for high-need populations, such as those in foster care, jails, prisons, homeless shelters, and refugee resettlement programs. **Increase the availability of high-quality mental health services, providers and treatment capacity in education, juvenile justice, and child welfare settings.** Because racial and ethnic minorities are over-represented among these vulnerable, high-need populations, the introduction, expansion, and improvement of mental health services in settings where these groups are is critical to reducing mental health disparities.

Develop programs designed to **divert youth with mental health problems from the juvenile justice system.**

Create a robust system of referrals and connections among child- and family-serving programs and resources, including mental and physical health, early intervention, early

childhood education and more, and train referral agents to be culturally competent so children are connected to appropriate services.

Work with referral agents to ensure that they are knowledgeable about available services, including culturally specific services, and able to make referrals that would best meet the needs of youth.

Strengthen the relationship between the schools and childcare professionals **to align teaching practices to prepare children for kindergarten.**

Improve transition planning from IDEA Part C to IDEA Part B and from preschool to kindergarten for students with special needs.

Expand focus of early intervention to include social-emotional health.

Use data to track community needs, available services, and racial disparities in service provision and outcomes, and use the data to adjust provision of services appropriately.

Ensure accurate, timely information on community needs, and data on program participation by race and ethnicity, age, language spoken, and income level in programs serving children ages 0-3. Consistently collect comparable data across programs to get a full picture of whether access to quality services is equitable and whether enough services are available in a particular area.

Integrate and link data both horizontally and vertically (with preschool and K-12 systems) and compare the characteristics of the eligible population with the families who are actually receiving these services, in order to target services to those who need them.

Monitor racial disparities in the provision of mental health care and outcomes, in order to continually track progress and refine approaches.

Put oversight in place to ensure there is not a "dual-track" system. Research shows that youth of color are more likely to be diagnosed for behavioral disorders and prescribed psychiatric medication, and are less likely to receive counseling and psychotherapy, and spend less time in care. Ethnicity has found to be a significant predictor of behavioral disorder diagnoses, prescription treatment, decreased odds of receiving therapy, reduced length of stay in care, and outpatient care. It is also the only variable that predicted site placement, with Black youth more likely to be in a correctional placement and White youths in a psychiatric hospital.

Track progress on a broad set of social emotional health indicators.

Share data and do joint strategic planning among parts of the young child mental health system (CCNC, Early Intervention Part B, Early Intervention Part C) to better coordinate individual care and allow for population-level progress measurement.

Use qualitative data by helping people tell their stories anonymously, then connecting those stories to show systemic failings.

Data to show how flexible, paid parental time off work can decrease ACEs and improve child health and education outcomes.

Promote public awareness of the impact of early experiences on success in school and life. Emphasize the importance of social-emotional development for children to succeed in school, be healthy, and enjoy financial stability in adulthood.

Build community-wide awareness and support for families. Build community cultures that are pro-family. Educate on the role of housing and other concrete supports in providing stability necessary for children's social emotional health.

Parents of color must be supported to have a voice in policy advocacy efforts to educate policymakers on the need for investments in young children of color's health as part of any strategies to meet the triple aim (individual health improvement, community health improvement, and cost reduction). Medicaid managed care – both physical and mental health – must have powerful consumer advocacy voice at the table/parents of color. Nonprofit agencies engaged in parent leadership efforts should focus efforts on parents of color.

Ask legislators to spend time listening to and participating with the school systems and communities in their districts to try to shift the mindset of policymakers to value social-emotional learning and understand what families and children live with.

Make data related to SEL transparent to the public to shine a spotlight on conditions for learning that enable social and emotional development. There are several sources of data that states and LEAs may look to for this information: student surveys, observations of students and teachers, school quality reviews that assess practices within schools, and administrative data such as attendance and suspension rates.

Articulate a simple, well-rounded vision of student success that encompasses the multiple domains of students' development, including social and emotional development. Students need to be able to apply knowledge and skills to understand and manage their emotions, set goals, build positive relationships, and make responsible decisions.

Require dissemination and outreach of family-friendly written resources or technology-based applications that help caregivers better understand their children's health progress and needs, including the impact of ACEs on healthy development, by all governmental agencies serving young children, their parents or other primary caregivers. NC Foundations could be used to produce resources for parents. Improve **public awareness at all levels that parent education should be normal (i.e., for all parents), not just for "problem parents."**

Use word of mouth, schools, child's teacher, Facebook, local library, family or friends, doctor's office, newspaper or flyers, internet, text messages, community organizations, and

churches **to communicate with parents**. Do not use the radio, magazines, or Twitter. Lower income families prefer word of mouth referrals, community agency referrals, friends and family, and flyers/brochures, while higher income parents prefer word of mouth and online resources.

Use a variety of methods to educate parents about social-emotional health and child development, including parent meetings, playgroups, community support groups, ongoing classes, short workshops, parent education advisory groups, integrate with other classes, videos, library collections, trainings, technology, etc.

Create in-house parent education specialists at Division of Social Services (DSS) to normalize the need for information in raising a successful child. Address fears of parents who know they need mental health services but are afraid of contact with DSS.

Address stigma around mental health and disabilities and build trust in services, particularly in communities of color. Mistrust of mental health services deters many individuals from seeking treatment for mental illness.

Conduct public health awareness and social marketing campaigns to help people understand normal child development, and identify symptoms and understand the potential causes of mental health issues.

Tailor public education efforts targeting shame, stigma, and discrimination to the languages, needs, and cultures of racial and ethnic minorities.

Provide culturally-appropriate and user-friendly information about the full range of available services and their potential outcomes. Provide minority communities with more information about the effectiveness of treatment and the possibility of recovery from mental illness.

Incorporate information about mental illnesses, ACEs, toxic stress and mental health services into health education programs and other settings to increase children's and parents' awareness of symptoms and interventions. Use PSAs, social media, and community providers like primary care doctors, schools, etc.

Expand education/outreach efforts. Especially to particularly vulnerable parent populations such as young, incarcerated, foster, homeless, undocumented, and/or non-English speaking parents. **Ensure that there are vehicles for their voices to be heard by policymakers.**

Involve consumers in services and governance at all levels of the system, including opportunities to provide peer support, participate as caregivers, and provide community services.

Engage consumers in treatment, by **providing opportunities for them to share information and build consensus regarding goals.**

Ask rather than tell. Build families' capacity through coaching. Engage families and youth in their own treatment planning and decisions. Family support and family-based treatment are critical to children and youth resilience. Reaching out to community stakeholders to increase their awareness and knowledge regarding EBPs will enhance youth and family engagement, which fosters treatment effectiveness.

Conduct outreach in partnership with culturally-specific community agencies (ex: churches and other communities of faith). Offer screenings/services in non-

traditional settings in communities to address distrust, for example: salons, barber shops, churches, etc. Use closed schools as community centers.

To build trust in mental health services, reduce racial and ethnic disparities in the quality of available services.

Reduce implicit bias in the system. It is easier for wealthy white parents to advocate for services/IEPs for their children and they are less likely to be perceived as disruptive.

Providers can **promote engagement in services** through establishing a receptive environment, practicing motivational interviewing, assessing barriers to treatment, fostering a strong, culturally sensitive therapeutic alliance, and explaining the process.

Caseworkers should take a coaching style of mutual respect, genuine listening, and concrete advice and support rather than a punitive stance that conveys stigma.

Black and Latina mothers being treated for post-partum depression gave advice to providers. Among the most common recommendations were for professionals to develop strong therapeutic alliances by (1) conveying knowledge and understanding of postpartum depression; (2) listening carefully to the mothers' concerns and empathizing with them; (3) offering validation and reassurance that the mothers' symptoms would improve; (4) providing emotional support; (5) building trusting relationships; and (6) establishing more services that are accessible, have flexible appointment times, and are parent- and child-friendly.

Incorporate a measure of family engagement in accountability systems.

Educate medical professionals on gender differences in how men and women approach health care and prevention.

Expand screening and early identification activities, using diagnostic and screening instruments that are valid for minority populations, to detect social-emotional problems in infants and toddlers, such as relationship disorders, depression, and self-regulation problems. **Include screening for family risk factors that might affect children’s social-emotional development**—for example, poverty, pre- and postnatal parental depression, family isolation, parental mental illness, or parental substance abuse.

Increase health literacy among parents, including helping parents identify the threshold for labeling a problem requiring professional mental health care.

Ensure that screening and evaluation tools are appropriate for literacy skills of parents.

After screening and assessment, **identify specific family needs and opportunities for support** through care coordination or targeted case management.

Increase practitioner surveillance, screening, and anticipatory guidance that focuses both on child and family issues.

Incorporate infant and family screening procedures into routine standards of care in mental health practice as well as in pediatric care and other child-serving settings, including early care and education. Screen for developmental delays, ACEs, trauma, including to reduce/eliminate expulsions from early care.

Ensure the standardized use of reliable screening tools by directing state agencies and their contractors/vendors to use such tools and requiring insurance, HMO and Medicaid contracts to include coverage for developmental and behavioral health screenings.

All medical providers should report results of the ASQ and ASQ-SE to the state (Department of Health and Human Services).

Maintain North Carolina’s high rates of health insurance for children and low-income children’s access to screening, diagnosis, and treatment through Medicaid under the Early and Periodic Screening, Diagnostic and Treatment program (EPSDT).

Continue to review primary care practice and county ABCD screening rates and expand investment in the ABCD developmental screening program to reach all Medicaid-eligible children participating in EPSDT-recommended well-child visits.

Comprehensive, coordinated system of universal screening, including for developmental delays, social-emotional health, at-risk circumstances, and maternal depression and referral to services.

Scale-up screening for and identifying families at risk of poverty and other social determinants of health from the first pre-natal visit and share screening data with pediatricians after birth to ensure connection to needed services.

Multicultural Assessment/Intervention Process model can be used at various points in the assessment/intervention process to emphasize the relevance of assessment instruments, increase the reliability and accuracy of clinical diagnoses, and foster the use of more credible and beneficial intervention services.

Ensure screenings and follow up treatment are available to children with disabilities/blind/deaf.

Screeners need to be trained on cultural issues when screening.

Pay attention to the needs of racial and ethnic minority families in assessment, diagnosis and treatment design, like using combined treatments or more case management services. **Implement effective treatment models for communities of color since current practice may be less effective.**

Identify families who are experiencing homelessness and focus on mental health needs of their children.

System to screen parents at different system entry points for ACEs, social determinants of health and protective factors and use that information to meet families' needs. Use Medicaid to pay for.

Doctors should follow up with parents to be sure they could access recommended or referred services.

Allot funding to counties based on needs identified by screenings.

Ensure equitable access for linguistically and culturally diverse children and families and children with special needs to a system that includes health care, home visiting, early intervention and high quality early care and education, and a comprehensive array of services from prevention to treatment.

Embed the Protective Factors framework in child- and family-serving state systems and invest in programs that build protective factors:

- Parental resiliency.
- Parental knowledge of child development.
- Concrete services in times of need
- Positive relationships and peer support for parenting roles.
- Developmental activities for young children with peers and playmates.

There is growing evidence that programs that are successful in strengthening these protective factors have long-lasting impacts upon healthy child development.

Early intervention programs can ensure that students of color can receive appropriate educational services without special education placement.

Target services geographically. Innovative strategies for training providers, delivering services, creating incentives for providers to work in underserved areas, and strengthening the public health safety net promise to provide greater geographic access to mental health services for those in need. Services delivered within a targeted geographic region, sometimes called hubs or zones, offer states and communities an opportunity to consolidate administrative activities, share financial resources, identify common goals, align activities and standards, and build working relationships across agencies while providing a continuum of services to a key population. Geographic targeting cuts down on duplicative efforts across sectors and frees up resources to increase service capacity, ultimately reaching more families and children in need.

Increase interventions in community locations, including services co-located with other key service systems (such as primary care, education, child welfare, and juvenile justice).

Ensure that mental health services are available within high poverty areas or consider opportunities for **providing transportation to services in other locations.**

Ensure access to services for rural communities, including loan forgiveness and other programs to get providers and specialists to rural areas. Promote regional hubs for specialists that travel to remote areas and fund travel expenses. Build mental health infrastructure like build any other - nurture interest, support financially, etc.

Review policies and procedures to ensure that uninsured children are able to access mental health services when needed, and ensure access to services for children who are not eligible for Medicaid. Private insurance does not cover all services that Medicaid covers.

Ensure continuous, coordinated, accessible health services for children, including more emergency mental health services and home-based mental health options.

Reduce Barriers in Managed Care. Managed mental health care is perceived by some racial and ethnic minorities as creating even greater barriers to treatment than fee-for-service plans. However, more systematic assessment of the treatment experiences, quality, and out-come of racial and ethnic minorities in managed care may help to identify opportunities for using this mechanism to improve access and quality of services.

Support care coordination for young children with health problems, developmental issues or who are living with toxic stress who may not be eligible for Part C or Part B services, with the goal of improving children's health outcomes and reducing costs.

Provide high quality early education programs, particularly for children of low-income parents, to enable parents to work while children learn.

Ensure that children's social-emotional health and development is not overlooked when **developing individual treatment plans through IDEA Part C.**

Working with the North Carolina Interagency Coordinating Council, explore feasibility and cost for expanding eligibility parameters of IDEA Part C to include children at risk of conditions based on the current science of trauma and toxic stress.

For children in low-income families, programs that are family driven, target children in their natural contexts, incorporate evidence-based interventions, and take a comprehensive approach to treatment that addresses relevant social determinants (e.g., housing or food insecurity) may be associated with greater therapeutic changes, decreased treatment attrition, and increased engagement.

Ensure that children who have experienced maltreatment, substance abuse and domestic violence receive priority for mental health services, and fund services and follow-up for children and families involved with the child welfare system and for families seeking drug and alcohol addiction services. Support the full implementation of new CAPTA and IDEA provisions, which require states to develop policies and procedures for referring children under age 3 who are involved in a substantiated abuse or neglect case to Part C of IDEA. These policies and procedures might include funding a pilot study to shape an effective process for referrals and data sharing, directing your state's Interagency Coordinating Council for Part C to develop procedures for referrals or

mandating that interagency contracts be established between all relevant state agencies to fully implement federal requirements.

Train state and local providers and build capacity on the use of evidence-based programs, including parent education, home-visiting and others. Expand doctor home-visit programs (i.e., example in Durham). Fund only what works.

Identify statewide gaps in support (informal and formal, education) and advocacy system for families with children with special needs. Clarify what services are available and how to access.

Families with children with disabilities need more accessibility to services, advocacy, translators, and child care. Adults with disabilities can advocate to families with children to share what's needed/like to lead a life with disabilities.

Get more information to parents about services available in the community, including using parent mentors, using language parents understand and helping parents negotiate the system.

Increase availability of high quality foster parents.

Offer year-round support for children with IEPs, not just limited to school year. Currently, year-round services are available for birth to 3, but not after 3 years of age.

Ensure one diagnosis (i.e., intellectual disability) doesn't limit services for other learning issues children may have.

Improve access for parents and expectant parents to screening, services and supports for substance abuse and addiction, family violence, depression, and other adult mental health disorders, including by using two-generation strategies.

Ensure access to trauma-informed medical care and mental health supports to keep parents and expecting parents healthy, including smoking cessation, addiction treatment, post-partum depression care and general health care.

Help parents with stress management.

Require the use of high quality screening tools for identifying parent mental health concerns and their coverage by state insurance, HMOs and Medicaid.

Expanding maternal depression screening and access to services and target services to pregnant women and new mothers, women most at risk of maternal depression:

Partner with CCNC and health researchers to determine, as data is now becoming available:

- The extent to which mothers are being screened for maternal depression at infant well-baby visits.
- The sufficiency and effectiveness of needed services.
- The extent of racial/ethnic and/or geographic disparities in screening and service delivery to mothers with post-partum depression.

Ensure widespread access to screening and treatment services.

Treat parents with three or more ACEs and educate state and local child and family service systems on where to refer parents with ACEs. Process is currently county-specific and or system-specific.

Expand family centered, dyadic intervention programs for families impacted by opioid addiction that incorporate health, mental health, child development and social support. Ensure that state policy includes a focus on multi-generational family impact, neonatal addiction, child welfare implications and service needs, and pregnancy prevention.

Provide funding for drug treatment for parents, including drug take-back days, needle exchange programs, Narcan dispensing/training and treatment programs that offer at least 30 days of services and are accompanied by mental health services.

Provide advocacy services and strategies for domestic violence victims, including smaller arenas where victims can feel safe.

Improve caregiver access to services when they can't pay, don't have insurance, but child is in treatment.

Develop standard of care for pregnant incarcerated women. Women currently can be shackled in childbirth, for example.

Ensure access to high quality parenting programs, adult education and workforce training supports.

Use two-generation approaches and programs, including screening/assessment/treatment for children and parents, early education for children, and family supports and education for parents. **Bring to scale proven strategies like Harlem Children's Zone that help children meet their potential through strengthening parental knowledge.**

Provide parents with job training and help finding employment. Fund healthy free meals and childcare when training is provided in the community.

In parent training and employment preparation programs, target the development in adults of specific skills that are needed for adaptive coping, sound decision-making, and effective self-regulation, including executive functions such as inhibitory control, planning, and cognitive flexibility. Learning these skills as an adult requires appropriate coaching, scaffolding and practice.

Include practices shown to improve parent-child interactions in state- and community-funded parenting support programs.

Expand parent education and home visiting programs across the state, particularly offering information for new parents.

Provide parent groups for education/engagement, job training, skill building in childcare centers and community health centers.

Incorporate financial/economic literacy programs in parent education.

Improve access to health insurance for children and parents and ensure that children's insurance and Medicaid payment policies provide coverage for developmental screening, including screening for social- emotional health, payment for preventive services, and payment for appropriate treatments.

Maintain North Carolina's high rate of insured children and increase health insurance coverage rates for parents and other adults.

Expand Medicaid in NC.

Eliminate disparities in access to health insurance, and ensure mental health parity. On the federal level: Reauthorize CHIP, expand Medicaid and strengthen ACA.

Create financing and monitoring and development structures, particularly within Medicaid, that ensure that practitioners who move beyond their traditional medical role, including screening for developmental delays and disabilities, to effectively connect families and their children to other early childhood systems supports, are enabled to and rewarded in doing so as part of the mainstream system, rather than as add-ons or additions to their work. Ensure that insurance providers include trauma-informed practitioners in their networks.

Benefit packages for behavioral health should include:

- Language to make it clear that infants and toddlers (e.g., "children from birth on ...") are included in definitions of "serious emotional disturbance."
- Language to support the use of developmentally sensitive, evidence-informed diagnostic criteria such as DC:0-3R and crosswalks between DC:0-3R and ICD or DSM codes for billing purposes.
- A definition of "medically necessary services" to include prevention, diagnosis, and treatment of I-ECMH impairments.
- A requirement for evidence-based approaches appropriate for infants, toddlers, and their families, such as treating parents and young children together and delivering I-ECMH services in primary care settings and via home visits.

Create a payment system that supports preventive or health-promoting interventions and fits the mental health service needs of infants, toddlers, and their families through dyadic or two-generation treatment. Enable providers to treat and receive Medicaid reimbursement for dyadic therapy by adding definitions such as Individual and Family Therapy. Current child mental health payment practices are generally based on individually based treatment models responding to diagnoses appropriate to older children.

Address barriers in covering infant and early childhood mental health services, including:

- Requirement of a diagnosis to provide payment.
- Lack of appropriate infant-toddler diagnostic criteria.
- Lack of diagnostic and treatment codes that qualify for insurance reimbursement.
- Lack of a range of approved treatments suitable to the age group, especially dyadic and family treatments.
- Barriers to infant mental health service providers in being approved to receive insurance or Medicaid payments.

In order to bill Medicaid for treatment, create a crosswalk between the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood—Revised Edition and the Diagnostic and Statistical Manual of Mental Disorders diagnostic codes.

Create an infant mental health endorsement to enable Medicaid to recognize and reimburse for infant and early childhood mental health. **Ensure that the Medicaid waiver covers I-ECMH home-based services.**

Promote 12-month health insurance eligibility periods, and make it easy for individuals who experience changes in circumstances that would affect their eligibility to move from one form of coverage to another without experiencing a lapse in coverage.

Allow for state Medicaid plans to reimburse for screenings, assessments, referrals and treatment (including through early intervention) for children with, or at risk of, social, emotional and behavioral health issues. Providing reimbursement for at-risk children will allow for identifying and intervening early, with the greatest impact. Risk categories could include concerns such as severe relationship disorders and disruptions to the development of the nervous system, and environmental risks such as parental drug abuse, child abuse, poverty, or homelessness.

Assure quality inter-conception and prenatal care.

Create a modifier for coding positive vs negative screening results.

Policies to incentivize doctors/dentists to accept Medicaid patients, including small family practices.

Broader training for parents on their rights under Medicaid, WIC and other supports.

Ensure that health care institutions are welcoming and respectful to people of different races and ethnicities by providing culturally and linguistically competent staff, curriculum, and policies. Attention to providers' cultural and language competence leads to improved mental health outcomes and greater adoption of effective practices.

Conduct ongoing reviews of agency procedures, referrals, and services to explore whether services are provided in an equitable and appropriate fashion across youth from different racial/ethnic backgrounds. Providers can undertake self-assessments to determine whether programs, resources and practices are culturally relevant and linguistically appropriate, whether operating hours and location provide barriers to treatment for some, whether transportation is accessible and clients are made aware, etc.

Train providers and staff in equity, cultural and linguistic competence, trauma, resilience and ACEs, and provide coaching to build respect, acceptance, sensitivity, commitment to equity, openness, humility and flexibility. Training on implicit bias will include identifying your bias, reviewing policies and brainstorming next steps that work.

Incentivize and support **interventions, such as coaching teams, to reduce negative provider attitudes towards minority youth, train providers in culturally-specific treatments, and enhance adoption of evidence-based treatment in community healthcare systems, tailored to the age, race, gender, and culture of the individual. Provide training to ensure that all service personnel are aware of the existing regulations and policies pertaining to the provision of services to diverse populations.** There are cases in which services are denied to racial and ethnic minority individuals in need of serious help because of a lack of knowledge or misunderstanding of the services that can and should be provided to such persons (e.g., the undocumented, the uninsured).

Make information available to advocates who do not primarily speak English or who work with communities that do not primarily speak English and **translate documents to other languages.** All printed and electronic outreach and educational materials should be produced in multiple languages and at a literacy level that is easily comprehensible.

Provide interpretation services, including for all clinical encounters, and **provide help in multiple languages to individuals submitting applications,** whether the process is done by phone, in person, or via the Internet.

Doctors should ask parents about family needs and what they need to support their children's health. Individual health practices should have parent advisory groups. Providers should receive training in family engagement skills.

Expand engagement with families to facilitate service access, including logistical barriers and emotional support for undocumented immigrants, rural, poor, and families of color.

Supplement current assessment and diagnosis approaches **to incorporate a clinical review of culturally relevant factors**.

Align treatment options with what families of color value. Develop interventions that reflect family's explanations of the causes of mental health issues, incorporate cultural values throughout the intervention, engage youth and families in the process, and build on the cultural strengths each family brings.

Evaluate the role of different sources of care (e.g. schools and/or community agencies) in service delivery to help minority families become more receptive to mental health treatments. Design programs, including after school preventive programs, that address ethnic and racial minority families' competing demands and linguistic capacity to help surmount barriers to mental health services.

Expand the use of alternative medicine and non-Western approaches, including training providers about these practices and working with insurance providers to increase coverage of services.

Given significantly lower treatment completion rates among African Americans and Latinos, **explore interventions such as enhanced access to medications and 'virtual' interventions (telephone, computers) which provide anonymity and are less burdensome to complete.**

Develop and implement strategies for **linking youth and family members to natural supports** within the community.

Recruit, train and retain mental health providers of color

Increase staff diversity by recruiting and training providers who represent the racial/ethnic diversity of the community.

Ensure that loan forgiveness is adequately distributed to students of color who are interested in medical and healthcare professions. Also those willing to serve in under-served areas.

Government, private entities, and foundations should **invest in and strategically fund programs, including public universities, community colleges and scholarships, including at traditionally black colleges and universities, that build and maintain medical and healthcare professions pipeline programs for minority students.** Studies show that physicians of color are more likely to work in communities of color. Create specialized projects in colleges and universities, including at traditionally black colleges and universities, to recruit and graduate mental health professionals, including early childhood mental health specialists.

Ensure that licensing and certification requirements in professional development for agency staff do not create unnecessary barriers.

Target high schools that are predominantly students of color and encourage higher education with specific focus on mental and physical health fields. Ensure access to counselors for college planning early in high school.

Hold LME-MCOs accountable for working with providers of color, since they choose who can provide services. Approach as a small business issue.

Build capacity and competence in infant and early childhood mental health practice among providers that serve young children and families by expanding professional development.

Train providers who work with young children on NC's infant and young child mental health competencies.

Create a system of cross-sector trauma-informed professional development.

Ensure that undergraduate, graduate, and continuing professional education programs include content on infant mental health. This may involve including mental health experts in training programs, co-precepting with mental health professionals in residency continuity clinics, and increasing the amount of time allocated to training in mental health within pediatric residency programs.

Create I-ECMH competencies to provide a framework for core knowledge and skills, infuse the competencies into training programs, and create endorsement systems to acknowledge various levels of I-ECMH expertise and build capacity for service delivery. IECMH core competencies help to upgrade professional standards, provide guidelines for higher education and other training programs, recognize IECMH within Medicaid and other health financing systems, and increase recognition of IECMH as a field of practice.

Work closely with state mental health agencies and associations to identify training and professional development strategies.

Take advantage of federal programs to build the early childhood mental health workforce established in the Affordable Care Act, including a loan repayment program for pediatric health care specialists (including mental health) and a psychology workforce development program.

Recruit and retain more clinicians for infant and toddler mental health.

Cross-train home visitor providers in medicine, social-emotional health, early intervention, as well as literacy.

Expand NC Child Treatment Program, ensuring an equity focus.

Address social-emotional health and social-emotional learning in schools, including building social-emotional skills and capacities of children, parents, teachers, service providers and school leaders.

Advance a social-emotional learning framework, such as the Pyramid Model to promote the social and emotional development of infants and young children, in birth through third grade settings statewide.

Add Social-Emotional Foundations for Early Learning (SEFEL), Teaching Pyramid Observation Tool (TPOT) or Classroom Assessment Scoring System (CLASS) to all programs birth through eight, to measure interactions between teachers and children and categories of socio-emotional health. For early care settings, tie the results to a center's child care license.

Address implicit bias, cultural awareness, ACES and resilience, child development and social-emotional learning in early childhood and K-12 settings/ teacher and administrator pre-service and in-service training and make them requirements for licensure and renewal.

Add case managers under the Department of Public Instruction who are the hub of integrated care teams (ICTs) that connect everyone associated with the child. Expand trauma-informed knowledge and practice in school systems. Alternatives for preschool to prison pipeline – mindfulness, implicit bias training, meditation rooms. Add ACEs screening into KEA and K-3 formative assessment.

Identify evidence-based social emotional learning interventions as a school improvement strategy.

Align standards and educational practices during the infant and toddler years and K-12. Aligning standards and education creates a continuous pathway of learning and development that reduces gaps or unnecessary redundancies in early learning and difficult adjustments for children moving from one level to another. Communities are approaching standards alignment by replicating effective standards and regulations from existing high quality programs; initiating efforts to improve the quality of available settings, including informal care received from family, friends, and neighbors; and identifying developmental benchmarks that children should achieve from birth through their formal education.

Train teachers in practices that support social-emotional learning (SEL) like:

- Student-centered discipline.
- Teacher language that encourages student effort and work.
- Responsibility and choice given to students in the classroom.
- Warmth and support shown by teachers and peers.

- Cooperative learning strategies, such as supported group work.
- Classroom discussions.
- Self-reflection and self-assessment.
- An appropriate balance between direct instruction, group learning, and independent work.
- Academic press and high expectations for students.
- Competence building—instruction includes modeling, practicing, feedback, and coaching.

Educate teachers about normalizing differences in ability, race, gender, etc.

Recruit and retain more teachers who look like the students in their classroom and incentivize them to work in high-need schools.

Train teachers in Mental Health First Aid.

Regular and special education teachers are being trained on effective Language and Literacy and Social-Emotional Health teaching practices for tiered social-emotional support strategies in NC schools (MTSS Tier 1). Should expand this training to 0-8 and expand to training on effective teaching practices for MTSS Tiers II and III as well.

Create a welcoming environment and support opportunities for parents to form relationships with school staff, engage in respectful, two-way communication with parents, practice shared decision-making in planning student services, and recognize and build parent strengths, learning, and leadership.

Train teachers and school leaders to work effectively with parents and the community.

Explicitly target adult skill-building (parents and teachers) to improve the quality of adult-child relationships in order to improve life outcomes for vulnerable children. Teach parents techniques like mindfulness, meditation, etc.

Implement a standardized approach to providing assessments and therapeutic services for very young children with mental health needs and their families who are at risk of expulsion from early care and education settings. Increase access to infant and early childhood mental health consultation within early childhood programs.

Early Childhood Mental Health Consultation is a preventative intervention that places ECMH consultants in early childhood settings to build social-emotional competence in programs and classrooms. Consultants also partner with families to address a child's individual needs and/or provide information, training, and resources to all families.

In early care and education programs, target the development in young children of specific skills that are needed for adaptive coping, sound decision-making, and effective self-regulation, including executive functions such as inhibitory control, planning, and cognitive flexibility.

Leverage Title IV Student Support and Academic Enrichment Grants to implement SEL strategies in schools.

Implement evidence-based family support programs like Strengthening Families, Triple P, Incredible Years, Nurse-Family Partnership, etc.

Systematically incorporate new research and North Carolina guidance around the important role of play in early education and kindergarten settings for developing young children's social-emotional health.

Strengthen school-based health interventions, including screenings, telehealth programs, recess and physical activity, school health and mental health professionals, and school health clinics. **Allow school providers to bill Medicaid for services.**

Prevent bullying and treat children dealing with increased bullying related to race/ethnicity, religion, immigration status.

Ensure access to licensed school counselors, guidance counselors, school nurses and other school support staff, particularly for children with identified social-emotional concerns and for children in families dealing with immigration concerns. **Provide in-home support for more intensive needs.**

Employ Social Emotional Coaches within all schools based on results of Adverse Childhood Experiences (ACE) surveys that are conducted with all families. Set an established ratio of social-emotional coaches to number of families with high ACE scores and also require social emotional curriculum.

Eliminate suspensions and expulsions in early education (0-5 and K-3). Instead, assess, identify needs, address needs when possible, screen for disabilities, refer for supports including for parent/caregiver. Train teachers in cultural competence and awareness of disproportionate use of discipline with children of color to handle behavioral issues.

Create policies across sectors that collectively lower the burden of stress on families due to the often interrelated threats of poverty, crime, mental illness, substance abuse, discrimination, and community violence, and support parents and other caregivers in their roles as nurturers and providers.

Maintain and strengthen a set of proven policies known to support the health and well-being of low-income families with young children, including subsidized parental leave policies, access to affordable and high-quality early care and education services, community recreation and support activities, home-visiting programs that coach new parents on how to interact positively with their children, behavioral and physical health services, income supports, nutrition programs, housing policies, and employment policies that promote good parenting during the child's earliest years, to reap benefits to society throughout the child's lifetime.

Strengthen/Keep policies that support low-income families and maximize enrollment of eligible parents and families in federally-funded and reimbursed supports such as TANF, WIC, SNAP, and Medicaid coverage.

Expand family-friendly employment policies to all NC employees. Employment policies that improve the stability of working hours, give parents more control over their work times, promote bonding and attachment, and improve conditions for young low income parents, including paid family leave for the birth of a child, paid sick leave, pregnancy and lactation accommodations, predictable scheduling, time to address domestic violence/sexual assault, and time to attend meetings at child's school.

- Add domestic partners
- Family and medical and adult dependent children
- Cannot leave behind low wage workers/people of color (full time, part time)
- Paid sick days and kin care

Provide respite to parents caring for children with special needs.

Offer necessities like diapers, financial services, child care, transportation, or low-interest emergency loans.

Modernize and streamline North Carolina's benefits eligibility applications and process, including bundling and integrating formal family support services and eliminating barriers to re-entry into programs and services. **Address the cliff effect in eligibility for public benefits by offering graduated support as family income increases.**

Link work requirements for receiving cash assistance through Temporary Assistance for Needy Families (TANF) directly to the availability of high-quality child care.

Provide convenient access to the highest quality programs for families of color experiencing poverty.

Locate services where families can access them using public transportation, and ensure access to services in rural counties. Ensure affordable, accessible, dependable transportation, especially in rural communities.

Expand availability for walk-in services and expand hours beyond 9-5.

Fund providers to respond to social determinants. In order for child health practitioners to better respond to social determinants of health and produce greater health equity, they will need to change their current practices and most will need support to do so. Not only does this require support for innovators, but it also requires training, technical assistance, and support to enable others to become early adopters.

Create child welfare policies that work with families to build strengths, reduce sources of chronic stress in their lives and provide therapeutic services to strengthen vulnerable relationships before the removal of children becomes necessary. **Create policies that support mothers in child welfare system staying home with infants.**

Provide support for incarcerated families during and after incarceration, including treatment of incarcerated mothers during childbirth, allowing bonding and pumping to provide breastmilk. Use deferred programs that help keep families together while sentence served for crime.

Provide wraparound supports in schools to meet family and community needs. Use schools as community resource hubs for parents and children - job training, laundry, etc.

Incorporate “nonmedical factors” into community health assessments, report on nonmedical factors as part of health benchmarking, and incentivize health care providers through the reimbursement process to address nonmedical factors that affect health.

Build family support settings and programs for ease of use:

- Produce materials in a variety of formats and make them clear and easy to read.
- Relate content of services to individual needs.
- Create organizational tools such as checklists and reminders that will help people manage the demands on their lives.
- Break down tasks into incremental steps.
- Incorporate technology into family support settings.

Create refundable tax credits for working families.

Drive responsible economic development and job growth, matched to sector-specific opportunities, that offers parents work income to adequately support their families.
Embrace multiple economic strategies, including tax policy. Ensure a living wage.

Expand evidence-based home visiting programs across the state.

Improve access to affordable fresh foods to reduce food insecurity, including creating a universal school breakfast program, supporting the statewide system of food banks, community gardens, summer lunches for school kids. Incentives for grocery stores. Healthy Corner Store initiative.

- Consider barriers to transportation.
- Change criteria to receive services, harder to raise matching funds in poorer counties.

Increase support for grandparents raising grandchildren.

Provide books, in English and Spanish, for parents to read with children at home, to help prepare them for kindergarten and for summer learning.

Equalize educational funding across all settings, high- and low-poverty. Develop educational funding policies that promote integrated, high quality educational settings (birth-age 8), by race and income.

Increase availability of childcare subsidies, high quality childcare and preK, including non-traditional hours. Assistance for operators opening high quality centers in low-wage areas. Increase eligibility and simplify application process for subsidies. Update the star system to focus on quality rather than just health, safety, payment. Increase compensation for early educators.

Reform juvenile justice and justice system to address preschool-to-prison pipeline, particularly for black boys.

Focus on the physical spaces children spend time in and invest in neighborhoods, including revitalization and beautification initiatives, civic engagement, sister communities, community gardens, parks and green spaces, transportation and walkability, community policing. Provide monetary incentives for business development in high-poverty areas.
Build neighborhood social capital through programs like Circle of Support. Address issues linked to community gun violence.

Increase access to affordable housing – home loans, funding for housing trust fund, increased Section 8, development plans that include affordable housing requirements -- with supports. **Integrate affordable and low-income housing into suburban**

communities. Expand homeownership. Improve conditions of current housing while simultaneously encouraging creation of more diverse communities.

More funding for mental illness prevention and treatment. In the absence of sufficient mental health system funding, blend funding sources by centralizing program delivery and creating processes and relationships that establish early childhood systems that can leverage the various funding opportunities.

Communities that have had success with this approach typically **offer a mix of services—such as health care, child care, and home visiting—that work collaboratively** to support children across programs over time.

Blend funding. Take advantage of federal funding sources, state funding sources, and philanthropic and private partnerships in order to support the continuum of infant and toddler services to expand access to high-quality programs.

Allow Title I funds to be used flexibly, determined by the local needs.

Fund more prevention, intervention and treatment services for children and adults, including more mental health supports for children through schools.

Eliminate lead hazards and other toxic substances in housing, child care locations, schools, and water.