

**EARLY CHILDHOOD SOCIAL AND EMOTIONAL WELL-BEING
TOPIC AREAS AND POTENTIAL RECOMMENDATIONS**

We will include something in the text about the need for multiple interventions that intervention at different levels of the socio-ecological model of behavior: interpersonal/family; clinical; community/environment; and policy.

Interpersonal/Family

Social media

Note: We will also include a statement in the text that supports the work of the ECAC in educating the public about the importance of early childhood brain development, the connection between social emotional health and success in school and on later success in work and in life, and the impact of alcohol and other substances on brain development in utero.

Rec. XXX. Social Marketing Campaign to Reduce the Use of Alcohol and Other Substances During Pregnancy

DMHDDSAS should use part of the SABG to fund a social marketing campaign aimed at reducing the use of alcohol and other substances during pregnancy.

Workforce Development

Note: We noted specific competencies below. However, this is probably too detailed for the recommendation—so we may put some of the details into the text of the report and leave the recommendation more generic. (In other words, everything that begins “including but not limited to...” would be included in the text of the report rather than the recommendation).

Rec. XXXX. Enhanced Training for Health and Behavioral Health Care Professionals (Physicians and other primary care providers, licensed mental health professionals, early intervention specialists, and other professionals who serve young children and their families)

- a) **AHEC, in collaboration with CCNC, NC Foundation for Advanced Health Programs, DMHDDSAS, DPH, and academic health centers should enhance the health professional training on health issues that affect the social, emotional, and physical health and well-being of young children and their families. Specifically, AHEC should partner with other organizations to ensure that health professionals have opportunities to increase their knowledge, skills and competencies on:**
 - i. **Parenting, caregiving, family functioning and parent-child relationships, including but not limited to: attachment issues, parenting as a developmental process, cultural issues in parenting and family development; strategies to facilitate change and growth process in families with significant problems in relationships**
 - ii. **Child development, including but not limited to: milestones of development; normative dyadic emotional development and implications for atypical dyadic emotional development; cultural variations in development and family expectations;**

- early childhood social relationships, communication and representational skills and executive function abilities for school readiness
- iii. Biological and psychosocial factors that impact development and relationships, including but not limited to genetics, prematurity, low birth weight, nutrition, substance exposure, trauma, service availability, and unaddressed stress in the infant, child, and/or parents.
 - iv. Risk and resiliency, including but not limited to risk factors, factors that support development of resilience, application of concepts of resilience to assessment and intervention, and modulation of intervention style and strategies in response to specific strengths and vulnerabilities of the infant, child, and family;
 - v. Observation, screening and assessment, including but not limited to multidimensional assessments that integrate information from observation, screening, and assessment tools, multiple settings, and other providers and caregivers; incorporation of health, physical, social, emotional, psychological, and cultural aspects in to assessment; stimulus for and process of referral.
 - vi. Diagnosis and intervention, including but not limited to linking of assessment to diagnosis and interventions, diagnosis systems for early childhood, symptoms and criteria for disorders of infants and toddlers, effective communication with caregivers and others, development of intervention goals, concrete assistance, developmental guidance, evidence-based therapeutic options, medication options and impact, monitoring of progress, and preventive interventions that address social-emotional-behavioral vulnerabilities.
 - vii. Interdisciplinary/multidisciplinary collaboration including but not limited to plan integration across all professional and caregiver team members, and prioritization of child and family needs.
 - viii. Ethics, including but not limited to scope of practice, boundaries, personal competence, professional development, and education of other professionals.
- b) AHEC and other partners should ensure that health and behavioral health professional students are trained in these topics in undergraduate and graduate academic health programs, as well as in clinical settings, and provide continuing education, learning collaboratives, learning communities, and mentoring for existing health professionals.

Rec. XXX. Early Childhood Mental Health Certification.

XXX, in conjunction with DMHDDSAS, DPH, universities, and other appropriate groups should work together to develop an early childhood mental health certification process. In so doing, the groups should explore existing certification programs in other states, to identify appropriate certification standards.

Clinical

Care management for high risk pregnant women, high risk children

Question: Do we need to change the definition that will enable individuals to get care manager to include socio-emotional risk factors?) Look at CC4C to see if this is targeted to high-risk and at-risk children. See if priority list includes both kids with physical health problems AND toxic stress. We need

clarification on this. Ask Kevin, Cheryl Lowe, and CCNC how this is going to work. How does this differ from CCNC. Is this just for high cost patients?

Question for group: Do we need something for parents who have questions/concerns who don't need clinical intervention?

Rec. XX

DMA, NCCCN, and DPH should ensure that children exposed to toxic stress (*define in text*) are included in the priority list for children receiving care management services.

- a) Any child who is referred to CCNC or CC4C by a health or behavioral health provider should be screened and assessed to determine if they have been exposed to toxic stress.
- b) If it is determined that the child has been exposed to toxic stress, the child and his or her caregiver should receive appropriate evidence-based treatment and support services.

Treatment (outpatient, residential for pregnant women, perinatal)

Rec. XXXX. Residential Treatment Services.

- a) DMHDDSAS, in collaboration with DMA, DHHS Housing specialists, and the NC Housing Finance Agency should examine options to expand the array of residential perinatal treatment services for women with substance abuse or postpartum depression, or for other families with young children that require residential treatment services.
- b) These agencies should explore the impact of the Affordable Care Act, when implemented, on payment for residential treatment services.
- c) DMHDDSAS et. Al, should bring recommendations to the **XXX** committee about resources needed to address the needs, no later than **XXX**.

Rec. XXX. Reimbursement for Screening, Assessment and Treatment.

The task force discussed the need to reimburse pediatricians for postpartum screen (depression, parent-child dyad), and OB-GYNs or other physicians during prenatal visit.

Note: Is this recommendation necessary given the upcoming changes in the ACA?

- The ACA requires all health plans (with limited exceptions) to provide coverage for mental health and substance abuse services in parity with other health problems (Sec. 1311(j) of the ACA—applies to individual and small group plans offered in the exchange, parity already applies to employers with 50 or more employees; 42 USC 1396u-7(b)(6) in Sec. 2001 of the ACA (Medicaid benchmark plan for newly eligibles).
- The ACA also requires all plans to include certain preventive health services (Sec. 1001 of the ACA, amending 42 USC 300gg, et. seq, and adding a new 2713). Preventive services will include:
 - “evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force.” (Sec. 2713(a)(1)) [Note: USPSTF includes:
 - “with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health

Resources and Services Administration.” (Sec. 2713(a)(3))[Note: this is the American Academy of Pediatrics Bright Futures screening and periodicity schedule, and includes psychosocial/behavioral assessments of children at each visit; age-specific observations of the parent-child interaction, etc.]

- *“with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.” (Sec. 2713(a)(4)). [Note: these women’s health guidelines were just promulgated, and did NOT include screening for postpartum depression].*
- *Most parents will have access to insurance coverage in 2014, so women/parents could be screened directly for post partum depression or other mental health/substance abuse problems that affect the parent-child interaction; rather than bootstrapping coverage for parents as part of treatment for the child. Note: One reason given for asking for reimbursement for pediatricians for assessment of the mother is that many mothers don’t attend the post-partum visit. So, they aren’t screened by their own providers. Ideally parents would be screened by their own provider. However, there may be indicators parental MH problems in the parent-child interaction that would not be as easily picked up in an evaluation of only the parent.*

Community/Environment

Education for child care workers, social workers, DSS, foster parents, courts

Note: We built in specific competencies. Again, this is probably too detailed for the recommendations—so we may put some of the details into the text of the report and leave the recommendation more generic. (In other words, everything that begins “including but not limited to...” would be included in the text of the report rather than the recommendation).

Rec. XXXX. Enhanced Training for Child Care Workers, Social Workers, DSS, Foster Parents, Courts

- a) **DSS, DMHDDSAS, DPH, DCD, AOC, NCPC, and academic centers should enhance the training of staff involved in the care of young children on issues that affect the social, emotional, and physical health and well-being of young children and their families. Specifically, these organizations should partner with other organizations to ensure that staff involved in caring for young children have opportunities to increase their knowledge, skills and competencies on:**
 - i. **Parenting, caregiving, family functioning and parent-child relationships, including but not limited to: the importance of caregiver modeling and caregiver availability on development; adjusting routines to child temperament and cues; support of the parent-child relationship as the primary; boundaries in working with families; and cultural sensitivity.**
 - ii. **Child development, including but not limited to: milestones, peer and group interactions, importance of healthy relationships, cultural variations in expectations, and impact of and interaction between environments.**
 - iii. **Biological and psychosocial factors that impact development and relationships, including but not limited to self-regulation, nutritional needs, feeding methodologies, brain development, challenging behaviors, neglect, abuse, and trauma.**

- iv. Risk and resiliency, including but not limited to risk and resilience factors, application of concepts of risk and resilience to interaction with children, and recognition and support of families' cultural beliefs and practices.
- v. Observation, screening and assessment, including but not limited to use of screening tools, how and when to refer for evaluation, engaging families, observational skills.
- vi. Diagnosis and intervention, including but not limited to relating to and interacting with young children, providing emotional support and positive/negative feedback, intervention skills and strategies, effective communication with other caregivers, and development and implementation of parent training programs.
- vii. Interdisciplinary/multidisciplinary collaboration including but not limited to community resources, communication with caregivers regarding use of resources, team work, and integration.
- viii. Ethics, including but not limited to state and agency regulations, professional code of ethics, and impact of personal cultural and educational background and values.

Support of Evidence-Based Programs: Screening Tools, Assessment Instruments, and Treatment Options.

Note: The text will note some of the evidence-based community based programs, including but not limited to: Nurse Family Partnership, Parent Strengthening, Promoting healthy social behaviors, Incredible Years, DECA, or Circle of Security (promising programs).

Question for group: Should we ask NC foundations and/or state to invest in a particular program (like state is doing around NFP, or in a small group of EBPs—given that we don't have the resources to provide necessary infrastructure for unlimited number of EBPs.) If so, which one(s) does the task force want to support? Who will take the lead? What is the priority for staging EBPs in NC to address the largest needs?

Question for group: is it reasonable to require that any program funded by the state involve implementation of an e-b program AND demonstration that program supports (technical assistance, staff training, on-going evaluation, etc) are in place to ensure implementation with fidelity.

Should we recommend that the state redirect existing funding for parent-child programs into EBP?

Rec. XXX. Ensuring Successful Implementation of Evidence-Based Programs

- a) North Carolina philanthropic organizations, state and local agencies should focus new funding in evidence-based programs, or if unavailable, evidence-informed programs that support and strengthen the social and emotional wellbeing of young children and their families.
- b) **XX** should provide funding to **XXX** to build the necessary infrastructure to ensure that evidence-based programs are implemented with fidelity to the program. Specifically, funding should be provided to support:
 - a. Management and staff training
 - b. Technical assistance, including coaching, quality improvement activities, and evaluation.
 - c. Resources, including any programmatic resources necessary for successful program implementation.

- c) **Funding should be provided to evaluate evidence-informed programs to determine the impact on the social and emotional health and wellbeing of young children and their families.**

Note: The text will also identify some evidence-based screening, assessment and treatment options:

- *Screening tools: Edinburgh postnatal depression scale (Postpartum depression), ages and stages questionnaire-social emotional component, ABCD, **others?***
- *Assessment instruments: parenting stress index, screening for exposure to trauma for children and adults. **Others?** Should include screening for exposure to trauma for children and adults.*
- *Treatment options: Parent and Child Interactive Therapy (PCIT), trauma-focused cognitive behavioral therapy (TF-CBT), Attachment & BioBehavioral Catchup ABCPositive Parenting Program (Triple P), **Others?***

Rec. XXXX. Financial Incentives for the Use of Evidence-Based Screening Tools, Assessment Instruments and Treatment

- a) **The North Carolina Division of Medical Assistance in collaboration with CCNC, DMHDDSAS, and DPH should explore value-based Medicaid and NC Health Choice payments that would provide additional reimbursement to providers who:**
- Complete approved training programs that focus on the identification, referral, and treatment for women of childbearing years on substance use and abuse; perinatal and postpartum maternal depression and other parental/caregiver mental health or substance use disorders; fetal alcohol spectrum disorder, adult or child exposure to trauma, and early childhood social and emotional wellbeing.**
 - Obtain early childhood mental health certification from **XXX****
 - Consistently use state-approved evidence-based screening and assessment instruments to identify people with one or more of these conditions.**
 - Consistently offer evidence-based treatment including but not limited to evidence based programs delivered in the home.**
 - Report process and outcome measures, as defined in subsection b) below.**
- b) **DMA, CCNC, DMHDDSAS, and DPH should work collaboratively to define appropriate behavioral health process and outcome measures on which to tie performance-based incentive payments.**

Data

Rec xxxx: Data system to monitor and evaluate changes in early child mental health system

- a) **ECAC, in collaboration with DHHS, DPI, and NCPC should ensure that data are available and utilized for on-going assessment of the status of social-emotional health of young children and their families by:**
- Defining the data required for measuring social-emotional health,**
 - Identifying sources of data elements that are currently collected,**
 - Developing a plan to collect data for elements not in existing data systems,**
 - Creating the legal and physical infrastructure, as well as the linking methodology required for storing new data elements with data elements from the linked sources of existing data,**
 - Establishing an on-going monitoring system to measure population-based changes in social-emotional health, and**
 - Instituting safeguards to ensure data security and protection of privacy.**

- b) Data should also be collected to assess the availability, affordability and accessibility of evidence-based treatment and support services for early childhood mental health at the state and county levels.
- c) Data should be used to identify outstanding needs and treatment gaps. As this information become available, it should be used to modify priorities for funding for new EBP to address the largest unmet needs. Data should also be used to monitor effectiveness of interventions.

OTHER OUTSTANDING QUESTIONS BASED ON TASK FORCE DISCUSSIONS:

Foster children

- **NOTE: Consider children in Child Protective Services too – not much different than children in foster care] Train foster parents and kinship care about attachment and emotional needs of traumatized children.**
 - Need to work with DSS to reduce number of moves, particularly for young children
What will this entail?

Question for group: Child Care. Do we want a recommendation about requirements for Star Ratings around addressing emotional wellbeing of young children.