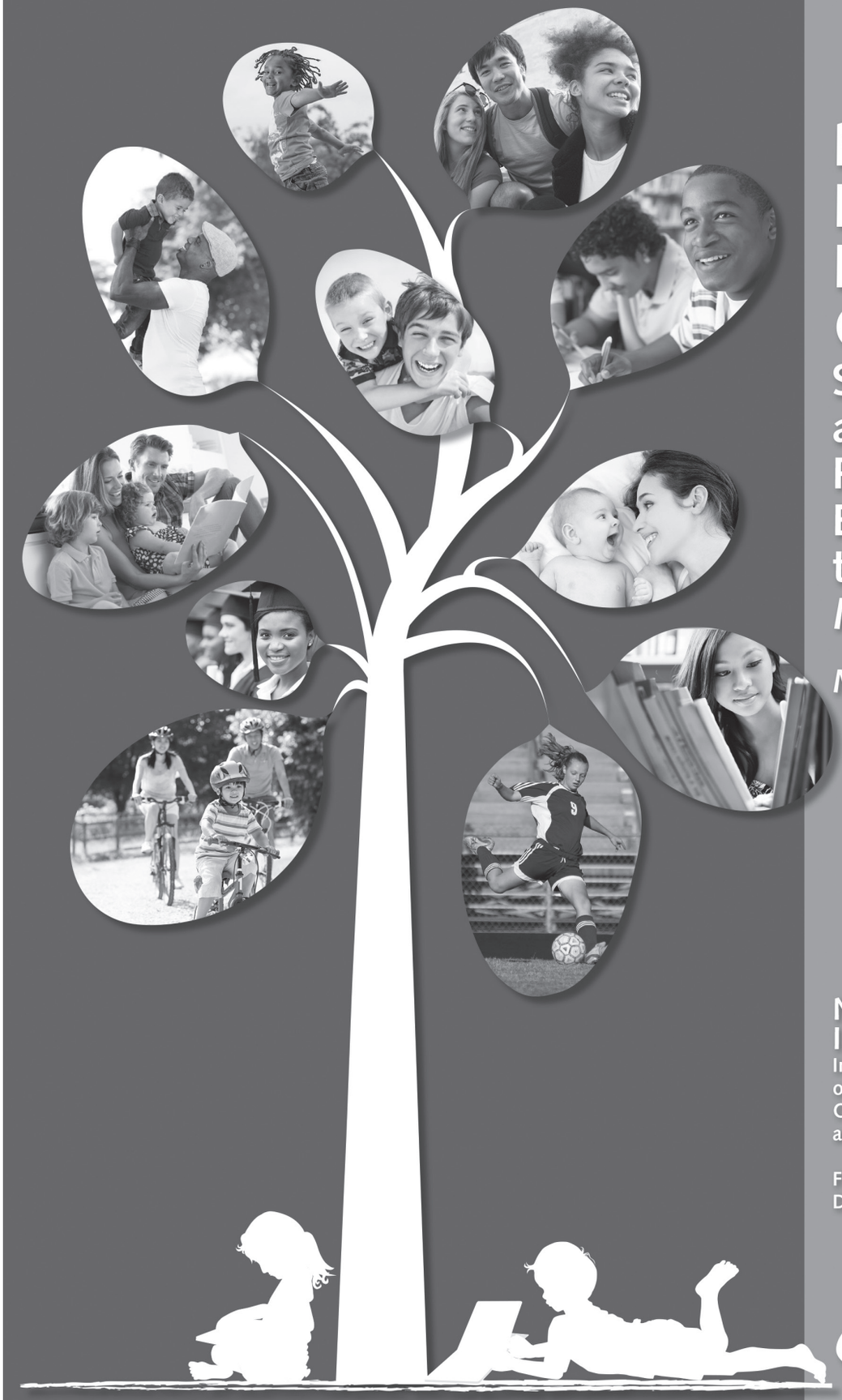

NCIOM Task Force on Essentials for Childhood:

Safe, Stable, and Nurturing Relationships and Environments to Prevent Child Maltreatment

March 2015

North Carolina Institute of Medicine

In partnership with the Division of Public Health within the North Carolina Department of Health and Human Services

Funded by the Centers for Disease Control and Prevention

NCIOM

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The Task Force was chaired by Kenneth A. Dodge, PhD, founding director of the Duke Center for Child and Family Policy, and Katherine V. Pope, Board of Directors for PCANC. The Task Force's work would not have been possible without their leadership. The NCIOM also wants to thank the members of the Task Force and Steering Committee who gave freely of their time and expertise over the past 14 months to address this important issue. The Steering Committee members provided expert guidance and content, helped develop meeting agendas, and identified expert speakers. For a complete list of Task Force and Steering Committee members, please see pages 7-9 of this report.

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NCIOM Task Force on Essentials for Childhood

Executive Summary

North Carolina's future growth and prosperity depends on our ability to foster the health and well-being of our children. Child maltreatment is a significant public health problem that negatively impacts North Carolina's future. Child maltreatment impacts health across an individual's lifespan and is associated with a broad range of problems including substance abuse, intimate partner violence, teenage pregnancy, anxiety, depression, suicide, diabetes, heart disease, sexually transmitted diseases, smoking, and obesity.[1]

In North Carolina, during 2013-2014, over 128,000 children were referred to local department of social services agencies for suspected abuse or neglect. Of these, over 36,000 children were recommended to receive additional services.[2] In 2012, 28 children in North Carolina died as a result of abuse or neglect by a parent or caregiver.[3] Significant adversity during childhood, such as child maltreatment, can cause toxic stress which can disrupt a child's brain development and other organ and metabolic systems. In the absence of protective factors, such as nurturing relationships with caregivers, these disruptions produce changes in the body and brain that can lead to difficulty learning and lifelong impairments in both physical and mental health. Additionally, child maltreatment has a significant financial impact on our medical and social services systems, with annual nationwide costs of child maltreatment estimated at approximately $80 billion, and $200,000 in total lifetime costs per victim.[4]

Child maltreatment is a problem that can be prevented if communities take steps to promote positive development of children and families.

Child maltreatment is a problem that can be prevented if communities take steps to promote positive development of children and families and prevent family violence. Research has shown that safe, stable, nurturing relationships and environments are fundamental to healthy child development, and that they reduce the occurrence of child maltreatment and can help protect children against the negative effects of child maltreatment and other adversity.[5]

To address the problem of child maltreatment, the Centers for Disease Control and Prevention (CDC) developed the Essentials for Childhood Framework, through which communities committed to preventing child maltreatment can help children thrive and develop safe, stable, and nurturing relationships and environments. The framework's foundation is that young children grow and develop through experiences and relationships with parents and other caregivers, and when children and their caregivers experience safe, stable, and nurturing relationships and environments they are able to mitigate the effects of potential stressors that could lead to child maltreatment.[5]

In 2013, North Carolina was one of five states to receive funding to implement the Essentials for Childhood Framework. As part of this work, the North Carolina Institute of Medicine (NCIOM), in collaboration with the North Carolina Department of Health and Human Services (DHHS) Division of Public Health (DPH), convened a statewide Task Force on Essentials for Childhood.

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The Task Force on Essentials for Childhood was tasked with studying and developing a collaborative, evidence-based, systems-oriented, public health-grounded strategic plan to reduce child maltreatment and secure family well-being in North Carolina. Using the CDC's Essentials for Childhood Framework, the Task Force developed a collective, evidence-based state plan for reducing child maltreatment and securing child and family well-being for our state. Additionally, the Task Force examined progress on recommendations issued by the 2005 NCIOM Task Force on Child Abuse Prevention,[6] and prioritized the services, programs, and policies needed to build on this progress.

The recommendations of the Task Force, if implemented, will ensure North Carolina has a comprehensive, coordinated system to support child and family well-being.

The Task Force on Essentials for Childhood was chaired by Kenneth A. Dodge, PhD, founding director of the Duke Center for Child and Family Policy, and Katherine V. Pope, vice chair and program and policy committee co-chair of the Board of Directors for PCANC. The Task Force was comprised of 48 members, including representatives from DHHS, the Department of Public Safety's Juvenile Justice section, the North Carolina General Assembly, health care providers, community-based service organizations, universities, and youth and parent organizations. The Task Force met 10 times between January and December 2014. The CDC's Essentials for Childhood lays out four goals that communities should strive to meet in order to promote safe, stable, nurturing relationships and environments between children and their caregivers. The Task Force on Essentials for Childhood used these goals as the organizing structure of their work and this report:

Goal 1: Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child maltreatment

Goal 2: Use data to inform actions

Goal 3: Create the context for healthy children and families through norms change and programs

Goal 4: Create the context for healthy children and families through policies

The Task Force reviewed each of the steps within the four goals and made recommendations to support the implementation of each step. Taken together, the recommendations of the Task Force, if implemented, will ensure North Carolina has a comprehensive, coordinated system to support child and family well-being.

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GOAL 1: Raise Awareness and Commitment to Promote Safe, Stable, Nurturing Relationships and Environments and Prevent Child Maltreatment

The Task Force on Essentials for Childhood envisions a statewide, collective effort for supporting North Carolina's children and families. This effort should build upon the success and promise of the many people currently working to ensure that North Carolina's children and families are healthy and productive. Current efforts to increase awareness and understanding of children's development provide the building blocks for expanded focus around the effects of trauma and adverse childhood experiences. Additionally, there is a need for coordinated leadership at the state level to build support for investing in North Carolina's children and families and to identify appropriate policy solutions.

Recommendation 3.1: Establish Coordinated State Leadership Efforts to Address Essentials for Childhood Through a Collective Impact Framework (PRIORITY RECOMMENDATION)

The North Carolina Department of Health and Human Services Division of Public Health (DPH), and Prevent Child Abuse North Carolina should establish membership and convene a Leadership Action Team, which will plan for and oversee investment in childhood and family programs to promote safe, stable, and nurturing relationships and environments and prevent child maltreatment.

Recommendation 3.2: Support the Establishment and Continuation of Trauma-Informed Practices and Communities (PRIORITY RECOMMENDATION)

The Leadership Action Team should establish a working group to examine research on brain development; the impact of trauma on development and behavior over the lifespan; and ways in which other states and communities have established trauma-informed practices in communities, schools, and among health care providers.

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GOAL 2: Use Data to Inform Actions

Data plays a critical role in achieving the goals of the Task Force on Essentials for Childhood both by raising awareness of child maltreatment and for measuring progress—or lack thereof—towards providing safe, stable, and nurturing relationships and environments for children and ensuring economic opportunity and security for North Carolina's families. Traditionally child maltreatment has been measured solely by data collected by Child Protective Services. Taking a public health approach to child maltreatment prevention requires a much broader view of child maltreatment. To get to this broader frame, data beyond the traditional measures of child maltreatment are needed. In order to better assess the well-being of children and families, more data is needed on their social-emotional, behavioral, and mental health, as well as on the community and societal contexts in which families live. Analyzing data from multiple sources will provide a clearer picture of child well-being and the systems that serve children, families, our communities, and our state.

Recommendation 4.1: Establish a Child Data Working Group of the Leadership Action Team to Identify and Support Data Collection and Collaboration

The Leadership Action Team should establish a child data working group tasked with reviewing existing child data systems, exploring options for integrating existing data systems, monitoring child maltreatment surveillance system efforts currently being piloted, and identifying critical data that is not currently collected. Additionally, the child data working group should identify indicators to be included in the Leadership Action Team's annual Essentials for Childhood report.

Recommendation 4.2: Gather Data on Social Norms around Children and Parenting

The child data working group of the Leadership Action Team should explore and identify the most appropriate mechanism and funding source by which to measure public opinion and social norms around parenting, children, and families, and report back to the Leadership Action Team.

Recommendation 4.3: Create an Online Data System for an Expanded Kindergarten Health Assessment

The North Carolina Department of Public Instruction, Department of Health and Human Services, North Carolina Pediatric Society, North Carolina Academy of Child Psychiatrists, North Carolina Academy of Family Physicians, and additional partners

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should develop an online data system for the Kindergarten Health Assessment that could be shared between health providers and schools and integrated into the Child Profile generated by the Kindergarten Entry Assessment. As part of this effort, the Kindergarten Health Assessment should be expanded to include prompts for addressing specific concerns, including developmental and behavioral concerns and health-related concerns.

GOAL 3: Create the Context for Healthy Children and Families through Norms Change and Programs

To provide support for families and children and prevent child maltreatment, the Task Force on Essentials for Childhood supports the promotion of the collective belief that we all share responsibility for children's well-being. Individual members of a community have a role in developing neighborhoods, activities, and programs where people gather, interact, and get to know each other. Relationships formed through neighborhood associations, faith communities, and other community organizations can link families and provide support. Communities can promote positive norms around early childhood development, family support, and effective parenting behavior. As part of this work, communities and policymakers can support the implementation of evidence-based programs that have been tested and proven effective and focus on effective parenting and behavior management skills for parents and caregivers.

Recommendation 5.1: Promote Positive Community Norms Around Child Development and Parenting (PRIORITY RECOMMENDATION)

The North Carolina Early Childhood Foundation should continue and expand their work on changing social norms through the First 2,000 Days campaign.

Recommendation 5.2: Foster Community Support for Healthy Children and Families

The North Carolina Department of Health and Human Services, Department of Public Instruction, Prevent Child Abuse North Carolina, and North Carolina Partnership for Children should work towards incorporating the Strengthening Families Framework in state and local child maltreatment prevention efforts.

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Recommendation 5.3: Support Implementation of Evidence-Based Programs to Prevent Child Maltreatment and Promote Safe, Stable, and Nurturing Relationships and Environments (PRIORITY RECOMMENDATION)

The Leadership Action Team should convene a state Essentials for Childhood Evidence-Based Programs working group to coordinate and align infrastructure across evidence-based programs serving children and develop sustainable funding strategies.

Recommendation 5.4: Assess Potential Funding Strategies to Ensure Adequate Investment in Evidence-Based Programs to Prevent Child Maltreatment

The Leadership Action Team should study existing alternative funding strategies for evidence-based program investment, examining the experience of South Carolina and other states.

Recommendation 5.5: Explore Incentivizing Outcomes Resulting from Evidence-Based Treatment Programs (PRIORITY RECOMMENDATION)

The North Carolina Division of Medical Assistance, in collaboration with Community Care of North Carolina, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Division of Public Health should identify opportunities to incentivize payment for outcomes resulting from evidence-based treatment programs, especially as quality of care is incentivized under reform of Medicaid in North Carolina.

Recommendation 5.6: Increase Funding for Evidence-Based and Evidence-Informed Programs Implemented by the Smart Start Network (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should increase appropriations by 5% per year to the Smart Start network targeted to support the implementation of evidence-based programs.

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GOAL 4: Create the Context for Healthy Children and Families through Policies

Public policies have strong influences on our communities and environment. National, state, and local policies create the context in which children and families function. As part of their work, the Task Force examined state and agency-level policies and how they may influence and promote safe, stable, and nurturing relationships and environments for North Carolina's children. The Task Force identified several areas in which policy approaches can enhance child development and educational success; reduce risk factors for child maltreatment and adverse childhood experiences; and improve families' economic security and job opportunities.

Recommendation 6.1: Ensure that Child Care Centers Provide a High Quality, Nurturing Environment (PRIORITY RECOMMENDATION)

The Division of Child Development and Early Education (DCDEE), in partnership with the Child Care Commission and the Department of Public Instruction Office of Early Learning, should continue to re-evaluate its quality star rating system and reimbursement system to identify high quality child care programs based on updated evidence and best practices. DCDEE, in partnership with others should continue work to grow a high quality and well-trained early care and education work force. The North Carolina General Assembly should enhance child care subsidies by ensuring a larger portion of eligible families receive subsidy payments.

Recommendation 6.2: Enhance Care and Reimbursement Standards to Promote Children and Families' Mental Health (PRIORITY RECOMMENDATION)

Community Care of North Carolina, and others, should establish guidelines for primary care clinicians for expanded screening of families with children for psychosocial risk factors and family protective factors. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Medical Assistance, and others should support current work to increase integrated behavioral health care under Medicaid reform.

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Recommendation 6.3: Ensure Economic Security for Children and Families (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should commission a non-partisan economic analysis of the impact of current North Carolina state tax policy on children and families, including impact on economic security, take home pay, and employment rates.

Recommendation 6.4: Enhance Career Training and Education Opportunities to Promote Economic Security for Families

The North Carolina Community College System and other education partners should provide additional support for workforce development and skill building programs that increase families' economic security and students' preparation for the workforce.

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Introduction

Chapter 1

In 2013, the Centers for Disease Control and Prevention (CDC) launched Essentials for Childhood, a framework designed to help communities create safe, stable, and nurturing relationships and environments (SSNRs and Es).

The CDC defines child maltreatment as "all types of abuse and neglect of a child under the age of 18 by a parent, caregiver, or another person in a custodial role that results in harm, potential for harm, or threat of harm to a child." This includes physical abuse, sexual abuse, emotional abuse, and/or neglect.[1] In North Carolina, during 2013-2014, over 128,000 children were referred to local department of social services agencies for suspected abuse or neglect. Of these, more than 36,000 children were recommended to receive additional services.[2] In 2012, 28 children in North Carolina died as a result of abuse or neglect by a parent or caregiver.[3] In addition, child maltreatment has a significant financial impact on our medical and social services systems, with total lifetime costs for one year of child maltreatment cases estimated at approximately $124 billion nationwide, and $210,000 per victim.[4]

The North Carolina Institute of Medicine (NCIOM), in collaboration with the North Carolina Department of Health and Human Services Division of Public Health (NCDPH), convened a statewide Task Force on Essentials for Childhood in order to develop a collective, evidence-based state plan for reducing child maltreatment and securing child and family well-being for our state.

The Task Force on Essentials for Childhood developed a collective, evidence-based state plan for reducing child maltreatment and securing child and family well-being for our state.

The Task Force on Essentials for Childhood

In early 2014, the NCIOM, in collaboration with NCDPH, convened a statewide Task Force on Essentials for Childhood, charged with studying and developing a collaborative, evidence-based, systems-oriented, public health-grounded initiative to address the issue of child maltreatment prevention and family well-being in North Carolina. Chaired by Kenneth A. Dodge, PhD, founding director of the Duke Center for Child and Family Policy, and Katherine V. Pope, vice chair and program and policy committee co-chair of the Board of Directors for PCANC, the Task Force on Essentials for Childhood sought to develop an integrated, comprehensive strategic plan to coordinate and prioritize the services, programs, and policies that will build on New Directions for North Carolina, a previous statewide plan for the prevention of child maltreatment, which was published in 2005 by the NCIOM. The Task Force explored work currently underway in North Carolina and examined ways to expand upon and enhance this work.

In 2005, the NCIOM, in collaboration with Prevent Child Abuse North Carolina, convened a statewide Task Force on Child Abuse Prevention. Funded by The Duke Endowment and led by the Honorable Carmen Hooker Odom, then-Secretary of the North Carolina Department of Health and Human Services, and Marian Earls, MD, FAAP, then medical director of Guilford Child Health, Inc., the Task Force was comprised of 51 additional members

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representing entities directly involved in children and family welfare. The Task Force's primary goal was to develop a statewide plan that focused on preventing maltreatment before it occurs, and it issued 37 recommendations to enhance the capacity of North Carolina state- and community-based agencies to strengthen families and prevent child maltreatment. The culmination of the work is a report entitled *New Directions for North Carolina: A Report of the North Carolina Institute of Medicine Task Force on Child Abuse Prevention.*

The NCIOM revisited the Task Force recommendations in 2008 and found that progress had been made on implementing 75% of the original 37 recommendations in areas including public health leadership, mobilization of public-private partnerships, shared decision making, and increased replication of evidence-based programs.[5] Examples of fully-implemented recommendations included the establishment of a Child Maltreatment Prevention Leadership Team in 2006, which is dedicated to a public health approach to prevention; the creation of several work groups, including the Alliance for Evidence-Based Family Strengthening Work Group, which seeks to increase the number of evidence-based, effective programs available to children and families; and increased training of childcare providers to better understand and to assist parents in understanding stages of child development and age appropriate child behavior.

Substantial work is needed for the primary prevention of child maltreatment in North Carolina, as well as for improving the physical, social, and emotional well-being of all children and families.

In addition, North Carolina progressed in changing the narrative around child maltreatment prevention, moving the conversation to prevention of maltreatment rather than reaction after the fact. Stakeholders built important but limited infrastructure to support the implementation of evidence-based programs to support children and families, and established new partnerships across different disciplines and sectors to focus on prevention.

While additional progress has been made since 2008, we still face many challenges and recognize substantial work is needed for the primary prevention of child maltreatment in North Carolina, as well as for improving the physical, social, and emotional well-being of all children and families. The NCIOM sought to build upon this work with the 2014 Task Force on Essentials for Childhood.

The Task Force on Essentials for Childhood was comprised of 48 members, including representatives from the North Carolina Department of Health and Human Services, the North Carolina Department of Public Safety, the North Carolina General Assembly, health care providers, community-based service organizations, early child care and education, universities, and youth and parent organizations. The Task Force met 10 times from January to December 2014.

The Task Force used the four goals of the CDC's Essentials for Childhood Framework as an organizing structure for this work, and applied principles of collective impact to the Task Force process. The four goals of the CDC's Essentials for Childhood are:

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1. Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child maltreatment
2. Use data to inform actions
3. Create the context for healthy children and families through norms change and programs
4. Create the context for healthy children and families through policies

The Task Force on Essentials for Childhood was supported by a multidisciplinary Steering Committee comprised of senior program level staff from the North Carolina Department of Health and Human Services, including the Division of Public Health and the Division of Social Services, Benchmarks, North Carolina Partnership for Children, The Duke Endowment, and Prevent Child Abuse North Carolina. The Steering Committee met on a monthly basis between scheduled Task Force meetings and assumed responsibility for planning Task Force meetings, identifying issues of relevance for the Task Force, and arranging speakers to present expert research at Task Force meetings.

Organization of This Report

This report examines the scope of the issue of child maltreatment in North Carolina, the lifelong effects of adverse childhood experiences and trauma, and the importance of working with state, local, and other stakeholders to promote safe, stable, and nurturing relationships and environments. The report examines the ways in which North Carolina is working to address the four goals of the CDC's Essentials for Childhood and recommends action steps to enhance this work, implementing a collective impact framework.

This report contains seven chapters:

Chapter One: Introduction

Chapter Two: Overview: Child Maltreatment, Adverse Childhood Experiences, and the Socio-ecological Approach to Child Maltreatment Prevention

Chapter Three: Raise Awareness and Commitment to Promote Safe, Stable, and Nurturing Relationships and Environments and Prevent Child Maltreatment

Chapter Four: Use Data to Inform Actions

Chapter Five: Create the Context for Healthy Children and Families through Norms Change and Programs

Chapter Six: Create the Context for Healthy Children and Families through Policies

Chapter Seven: Conclusion and Outline of Task Force on Essentials for Childhood Recommendations

Appendix: Suggested Collective Impact Infrastructure

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Overview: Child Maltreatment, Adverse Childhood Experiences, and the Social-Ecological Approach to Child Maltreatment Prevention

Chapter 2

All children have the potential for positive development. However, adverse experiences, such as exposure to violence and neglect during childhood, increase the likelihood of poor physical and mental health throughout one's life. Traditionally, work regarding child maltreatment prevention took a reactive approach in which agencies and interested parties sought to address the problem after it had already occurred. As efforts to address child maltreatment have evolved, a proactive, public health-oriented approach has emerged.

Imagine a fast-flowing river at the bottom of a large waterfall, with many people scrambling to save those who are struggling in the water. Instead of only working to save people in the river at the bottom of the waterfall, it is important to both teach people to swim and to figure out why they are falling in at the top—and then work to prevent that fall in the first place.[1,2] Within a public health framework, solutions focus more on the prevention of child maltreatment by understanding the community context in which families live, supporting healthy environments for children and families, and reducing broader risk factors that can contribute to higher rates of child maltreatment, thereby addressing the factors upstream of the waterfall. We know that North Carolina's future growth and prosperity depends on our ability to foster the health and well-being of our children. Addressing the community and environmental context in order to prevent child maltreatment and create safe, stable, and nurturing relationships and environments will also allow for overall improvement in health, well-being, and security for our state.

North Carolina's future growth and prosperity depends on our ability to foster the health and well-being of our children.

Overview of Child Maltreatment

Child maltreatment is a far-reaching public health problem with damaging consequences to individual children, families, and communities. While common impressions of child maltreatment often bring to mind stories of horrific abuse, maltreatment actually encompasses a wide range of experiences. The Centers for Disease Control and Prevention (CDC) defines child maltreatment as, "any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child."[3] Acts of commission (also known as "child abuse") include words or actions that result in harm, potential harm, or threats of harm to a child, regardless of intention. Physical abuse, sexual abuse, and psychological abuse are acts of commission. Acts of omission (also known as "child neglect"), result in failure to meet a child's physical, educational, or emotional needs, or the failure to protect a child from harm. Examples of acts of omission include failure to provide (e.g. physical needs, emotional needs, medical/dental care, and education) and failure to supervise (e.g. inadequate supervision or exposure to violence).[4]

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Under North Carolina general statute, child maltreatment includes acts of commission or omission committed against a juvenile by a parent, guardian, custodian, or caretaker (generally defined to be an adult who is responsible for the health and welfare of the child within the home setting).[5] Children may experience multiple forms of maltreatment simultaneously or at distinct times. There is also a continuum of frequency and severity of child maltreatment, and it often overlaps with other forms of family violence and toxic stress.

Child maltreatment is a far-reaching public health problem with damaging consequences to individual children, families, and communities.

Incidence and Prevalence of Child Maltreatment

In 2013, the Children's Bureau of the US Department of Health and Human Services recorded 3.5 million reports of abuse or neglect from state and local child protective services (CPS) agencies. It was estimated that approximately 679,000 children (or 9.1 out of 1,000) were victims of one or more types of maltreatment.[6] Because these statistics rely on only the reported cases, the actual prevalence of child maltreatment may be higher. The National Incidence Study of Child Abuse and Neglect (NIS) aims to capture an accurate count of maltreated children using data from non-CPS sources, including public schools, health departments, hospitals, daycare centers, social service agencies, and shelters. NIS-4 data indicates approximately 39.4 per 1,000 children suffer from maltreatment.[7]

The Child Protective Services program of the North Carolina Division of Social Services investigated more than 64,000 reports of child maltreatment affecting more than 128,000 children in state fiscal year (SFY) 2013-2014.[8] Reports of abuse and some forms of neglect (including those involving a child fatality) are investigated through an investigative track with two possible findings: substantiated (indicating that the incident occurred and services were needed) and unsubstantiated (incident cannot be proven, but services may be needed).[9] Research has shown that children reported to social services without substantiation have similar developmental and behavioral outcomes as those with substantiated maltreatment.[10,11]

Neglect reports are investigated through the Multiple Response System (MRS) by local divisions of social services. The Multiple Response System, implemented statewide in 2006, utilizes a family-centered assessment approach called the Family Assessment Track, which aims to protect children and serve families by building partnerships and providing support services to address families' needs. Families with reports of neglect are investigated under the MRS and classified as "services not recommended;" "services recommended," meaning voluntary services are identified but the family can choose whether to use them; or "in need of services," which means services are mandated.[9] Of the more than 64,000 reports of maltreatment, more than 17,000 were recommended services.[8] In 2012, 28 children in North Carolina died as a result of abuse or neglect by a parent or caregiver.[12] North Carolina data show that victims of child maltreatment are also disproportionately very young children, with children

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ages 0-5 representing slightly more than half the children newly reported in each year.[8] Data also show that almost half of all children investigated each year had previously been reported to the system.

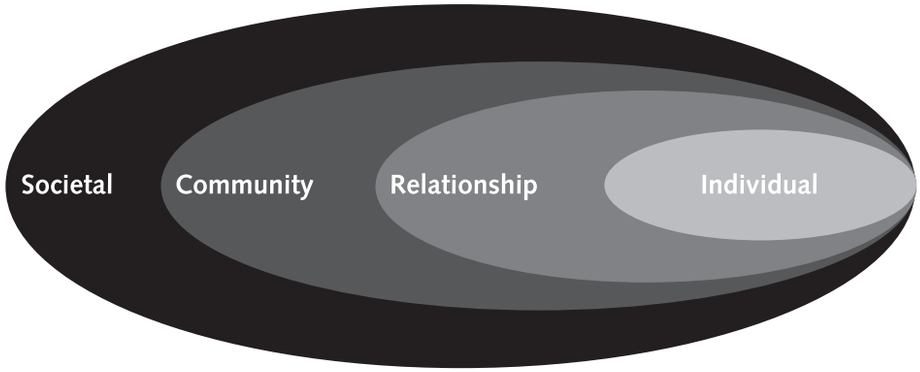
Child maltreatment has a significant economic impact. A 2012 economic analysis by Prevent Child Abuse America found that the annual nationwide cost of child maltreatment was over $80 billion. In North Carolina, the estimated annual cost of child maltreatment was approximately $2 billion.[13] This figure includes estimates of direct, short-term costs including medical treatment, mental/behavioral health care, and government-provided services such as child welfare and law enforcement, as well as estimates of long-term impact on special education, housing, medical care, mental health care, and juvenile/adult justice systems.[14] One of the largest costs, at both the national and state levels, is incurred by the child welfare system, estimated nationally at $29 billion.[13] On the individual level, the CDC estimates that victims of child maltreatment have lifetime costs of around $200,000, much of which comes from lost productivity once the child becomes an adult.[15]

In North Carolina, the estimated annual cost of child maltreatment was approximately $2 billion.

Factors Influencing Child Maltreatment

Preventing child maltreatment requires understanding the factors that influence violence and neglect. When examining various factors that influence child and family well-being and risks for maltreatment, this Task Force was guided by the social-ecological model of child maltreatment prevention. (See Figure 2.1.) Social-ecological models show how the well-being of the individual is influenced not only by the individual themselves, but also by their relationships with others and their broader community and environment. Many of the factors related to children's health and well-being are determined most immediately by the child's family, child care or school setting, and neighborhood. However, children and their families are also impacted by the community in which they live, attend school, and work; the public policies that govern them; and the broader social, cultural, political and economic environment.

Figure 2.1
Social-ecological Model of Child Maltreatment Prevention[16]



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Typically child maltreatment is thought of solely as a problem between a child and parent or other caregiver. The social-ecological model illustrates that, while abuse and neglect may happen within a family, there are many outside factors that can increase or decrease the likelihood of child maltreatment. At each level of the social-ecological model, there are protective factors that decrease the likelihood of maltreatment and risk factors that increase the likelihood of maltreatment. Protective factors are characteristics, events, and experiences strongly associated with improved health and social outcomes for children and families.[17] In contrast, risk factors are characteristics, events, and experiences associated with negative health and social outcomes for children and families. While protective factors do not remove risks, they can moderate the impact of risk factors. Risk and protective factors exist at all levels of the social-ecological model including individual, family, school, and community. (See Table 2.2)

It is crucial to remember that an individual, community, or family having any of these risk factors does not mean child maltreatment will always occur—rather, that a combination of individual, family, and community factors may contribute to an increased likelihood of child maltreatment. The interaction between types of risk and protective factors serves to emphasize the importance of a prevention-oriented, public health approach to reducing child maltreatment. Research has

Table 2.2
Risk and Protective Factors for Child Maltreatment Exist at All Levels[16,18]

Domain	Risk Factors (Child)	Risk Factors (Parent)	Protective Factors
Individual	• Younger than age 4 • Special needs (disabilities, mental health issues, chronic physical illness)	• Poor parenting skills • Parents' history of child maltreatment • Substance abuse • Mental health issues • Low socioeconomic status • Nonbiological transient caregivers in the home	• Nurturing parenting skills • Household rules and child monitoring • Positive parent-child interactions • Self-regulation and problem-solving skills
Relationship		• Social isolation • Partner violence • Parenting stress	• Stable family relationships • Parental employment • Social cohesion with friends and caring individuals
Community	• Community violence • High poverty • Poor social connections • High unemployment		• Strong social connections • Safe neighborhoods • Adequate housing
Societal	• Social and cultural norms • Health, economic, educational, and social policies that help to maintain economic or social inequalities between groups in society		• Access to health care and social services • Economic opportunities

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shown that when children and their caregivers experience safe, stable, and nurturing relationships and environments they are able to mitigate the effects of potential stressors that could lead to child maltreatment. By working within all levels of the social-ecological model of child maltreatment, stakeholders can aim to reduce both individual and community risk factors, promote protective factors, and potentially achieve an overall reduction in rates of maltreatment.

Consequences of Child Maltreatment

Early Brain Development and Toxic Stress

Child maltreatment has a significant impact on a child's growth and development. Because a high percentage of abuse and neglect occurs among very young children, there has been much research into the ways these experiences impact early growth, particularly brain development and other physiological responses.

Research indicates that exposure to toxic stress can have a significant impact on gene expression as a child grows, potentially leading to poor health outcomes.

Adverse experiences, such as abuse or neglect, typically elicit a stress reaction, including increased heart rate and breathing, the release of stress hormones (such as cortisol and adrenaline), and emotional responses such as fear or anger.[19] Reactions to stress are categorized in three ways: positive, tolerable, and toxic. Positive stress reactions are short, mild, and are tempered by assistance from a caring adult who provides a protective effect that helps the child's stress level return to normal. Experiences that provoke positive stress reactions may include normal experiences of frustration, new caregiver situations, or other common events. Tolerable stress reactions may occur when children experience an event that is out of the ordinary from their everyday experiences and is of greater negative significance, such as the death of a family member, serious illness, or a natural disaster. The effects of these experiences on the stress response are greatly tempered by caring adults who can help the child cope. Toxic stress responses generally result from repeated, strong stressors experienced without the protective factor of a caring adult to help the child cope and retain a sense of control. Examples of experiences that may provoke toxic stress responses include physical abuse, sexual abuse, psychological abuse, severe neglect, family substance abuse, family mental illness, and community violence.

Repeated and prolonged exposure to stress hormones, even when the responses might typically be positive or tolerable, can lead to negative effects on the brain. Changes in the brain's architecture as the result of toxic stress can contribute to problems with memory, contextual learning, and differentiating between danger and safety. These problems can lead to difficulties with language and emotional skills. Research indicates that exposure to toxic stress can have a significant impact on gene expression as a child grows, potentially leading to poor health outcomes.[20] For example, research has shown that exposure to toxic stress can affect the expression of the glucocorticoid receptor gene, which can have negative effects on brain development and lead to problems with mental health and emotional development.[21] In addition to negative

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effects on brain development, there are additional pronounced physiological and developmental effects that result from a child's experience of toxic stress including cardiovascular disease, depression, and asthma.[19]

Adverse Childhood Experiences

As research on the impact of child maltreatment grows, there has been an increasing emphasis on studying adverse childhood experiences (ACEs) and the ways in which individuals experiencing these negative events are affected by them not only in childhood, but also throughout their lives. The category of events or situations categorized as adverse childhood experiences is broad. Examples include child maltreatment (physical abuse, psychological abuse, sexual abuse, and/or failure to provide/supervise), as well as dysfunctional family characteristics such as intimate partner or other violence in the home, divorce or parent absence, mental illness, substance abuse, and incarceration of a family member.[22] ACEs are linked to heart disease, obesity, lung disease, diabetes, depression, anxiety, and substance addiction in adulthood. A 1998 Kaiser Permanente study surveyed adult patients on the following eight categories of adverse childhood experiences: child maltreatment including psychological, physical, or sexual abuse; violence against the mother; and living with household members who were substance abusers, mentally ill, suicidal, or ever had been imprisoned.[23] More than half of survey respondents reported having experienced at least one ACE, with one-quarter reporting two or more ACEs. This study also found a dose response relationship between the number of adverse childhood experiences reported by respondents and the adult characteristics relating to health status, disease, and risk behavior. That is to say, the more ACEs reported, the higher the likelihood of many disease outcomes.[23]

ACEs are linked to heart disease, obesity, lung disease, diabetes, depression, anxiety, and substance addiction in adulthood.

In 2012, the North Carolina Division of Public Health included questions about ACEs for the first time in the Behavioral Risk Factor Surveillance System (BRFSS) survey.[a,24] The following ACEs prevalence data reflect the responses of over 10,000 North Carolinians to the 2012 BRFSS survey. (See Figure 2.3)

These data show the importance of taking a public health oriented proactive approach to preventing child maltreatment. Although child maltreatment data show relatively small numbers of children are substantiated as victims of abuse and neglect, this data show that many North Carolinians grow up in households with abuse or other types of toxic stress. As these experiences may have distinct health, psychosocial, and personal impacts throughout childhood and adulthood, understanding and preventing child maltreatment is critical to ensuring the health and well-being of North Carolinians.

a Through random telephone surveys of state residents aged 18 and older, the BRFSS collects information on a variety of health behaviors and practices related to the leading causes of death and disability including cardiovascular disease, cancer, diabetes, and injuries.

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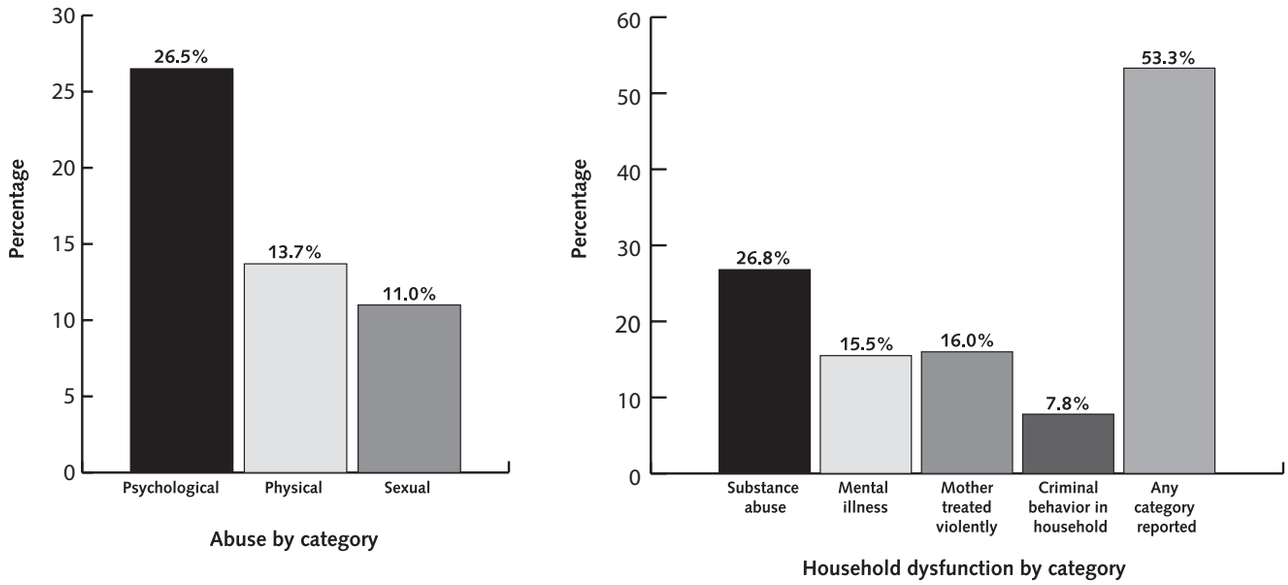
Figure 2.3
Prevalence of childhood exposure to abuse and household dysfunction, %
Category of childhood exposure[24]



Child Maltreatment Prevention: Essentials for Childhood and Strengthening Families

Research has shown that children and families are able to thrive when communities invest in building a robust infrastructure of protective factors. The Task Force on Essentials for Childhood used two frameworks to help orient our work towards creating the local and statewide infrastructure needed to support healthy children and families. The North Carolina Division of Public Health (NCDPH) has adopted the Centers for Disease Control and Prevention's (CDC's) Essentials for Childhood Framework in planning around child maltreatment prevention and in working with this Task Force. The CDC's Essentials for Childhood Framework provides core values as well as specific steps to achieving safe, stable, and nurturing relationships and environments. The North Carolina Division of Social Services (NCDSS) has already begun efforts to orient their work around the principles outlined in the Center for the Study of Social Policy's Strengthening Families Protective Factors Framework™. Strengthening Families is an approach organizations can use to find universal, non-punitive, and non-judgmental ways to prevent child maltreatment. Both the Essentials for Childhood Framework and the Strengthening Families Framework were embraced in the current work because this Task Force aims to align the efforts of NCDPH and NCDSS, as well as other state and local agencies that work with children and families, so that they are all working together to build and support a robust infrastructure of protective factors for North Carolina's families.

Strengthening Families is an approach organizations can use to find universal, non-punitive, and non-judgmental ways to prevent child maltreatment.

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CDC's Essentials for Childhood Framework: Steps to Create Safe, Stable, and Nurturing Relationships and Environments for All Children

A few years ago, the CDC launched Essentials for Childhood, a framework through which communities committed to preventing child maltreatment can help children thrive. The framework's foundation is that young children grow and develop through experiences and relationships with parents and other caregivers, and when children and their caregivers experience safe, stable, and nurturing relationships and environments they are able to mitigate the effects of potential stressors that could lead to child maltreatment.[4] Through a focus on communities and overall environmental well-being, this framework also addresses the fact that increasing children's and families' well-being also contributes to the overall health, security, and growth of our communities and state.

Increasing children's and families' well-being also contributes to the overall health, security, and growth of our communities and state.

The CDC defines safety, stability, and nurturing as follows:[4]

- Safety: The extent to which a child is free from fear and secure from physical or psychological harm within their social and physical environment.
- Stability: The degree of predictability and consistency in a child's social, emotional, and physical environment.
- Nurturing: The extent to which a parent or caregiver is available and able to sensitively and consistently respond to and meet the needs of their child.

The NCIOM Task Force on Essentials for Childhood used the CDC's Essentials for Childhood Framework goals as the organizing structure of their work and this report. The Task Force reviewed each of the steps within the four goals and made recommendations to support the implementation of each step. Taken together, the recommendations of the Task Force, if implemented, will ensure North Carolina has a comprehensive, coordinated system to support child and family well-being.

Center for the Study of Social Policy's Strengthening Families Protective Factors Framework™

The Strengthening Families approach focuses on early childhood (ages 0-8) because young children are particularly vulnerable to abuse and neglect. It is not a curriculum or program but instead provides a framework of five research-based protective factors that support effective parenting, encourages optimal child development, and reduces the likelihood of child maltreatment.[25] Strengthening Families focuses on all interactions with children and families, with an emphasis on building family strengths instead of only addressing deficits. Inherent in its design is recognition that all families need support. The approach helps agencies and programs to identify their current activities that promote the building of protective factors. It also illuminates small but

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The steps to achieving safe, stable, and nurturing relationships and environments are embedded in four goals recommended by the CDC:[4]

Goal 1: Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child maltreatment

- Adopt the vision of "assuring safe, stable, and nurturing relationships and environments for every child and preventing child maltreatment"
- Raise awareness in support of the vision
- Partner with key stakeholders to unite the vision

Goal 2: Use data to inform actions

- Build a partnership to gather and synthesize relevant data
- Take stock of existing data
- Identify and fill critical data gaps
- Use the data to support other action steps

Goal 3: Create the context for healthy children and families through norms change and programs

- Promote the community norm that we all share the responsibility for the well-being of children
- Promote positive community norms about parenting programs and acceptable parenting behavior
- Implement evidence-based programs for parents and caregivers

Goal 4: Create the context for healthy children and families through policies

- Identify and assess which policies may positively impact the lives of children and families in the community
- Provide decision-makers and community leaders with information on the benefits of evidence-based strategies and rigorous evaluation

significant changes to practice needed to build a stronger set of policies and programs. This approach also recognizes that everyday actions to build protective factors can be done in multiple settings by many people, including parents, professionals, and community members.

The Strengthening Families approach emphasizes small but significant changes in the daily interactions that service providers have with families, as well as changes in systems and policies at the practice and organizational level. These shifts in policy and practice support families in building protective factors that

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promote optimal child development and reduce the likelihood of child abuse and neglect. Employing the Strengthening Families approach involves providing families with opportunities and experiences to build their protective factors, including parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. These protective factors are interrelated conditions that simultaneously prevent or mitigate the effect of exposure to risk factors and stressful life events, while also building family strengths and a family environment that promotes optimal child development. The Strengthening Families Framework provides simple, concrete steps that organizations and agencies can take to integrate building these five protective factors into their work through "everyday actions."

One of the strengths of the Strengthening Families approach is that it can be used to reframe and engage partners who previously may not have viewed themselves as having a role to play in the prevention of child maltreatment, including early care, education, and home visiting. Although child maltreatment prevention is a primary goal of the Strengthening Families approach, the principles can be embraced by any organization or agency as a strategy for promoting healthy families. Implementing the Strengthening Families Framework across all child and family serving agencies in North Carolina would help ensure that our systems and services are working at all levels in coordination to promote protective factors and support healthy families. Additional discussion of Strengthening Families and recommendations regarding implementation will be reviewed in Chapter 5.

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Raise Awareness and Commitment to Promote Safe, Stable, Nurturing Relationships and Environments and Prevent Child Maltreatment

Chapter 3

The Task Force, using the Essentials for Childhood Framework, focused on the importance of raising awareness and commitment to promote safe, stable, and nurturing relationships and environments. In order to accomplish this, communities should first adopt the vision of assuring safe, stable, and nurturing relationships and environments for all children. Next, communities should raise awareness and build public buy-in in support of this vision; and, finally, communities should partner with key stakeholders to unite the vision and work toward preventing child maltreatment and ensuring child and family well-being.[1]

The Task Force envisions a statewide, collective effort for completing these steps and supporting North Carolina's children and families. This effort should build upon the success and promise of the many people currently working to ensure that North Carolina's children and families are healthy and productive. The Task Force identified the importance of a statewide leadership effort to build public will for investing in North Carolina's children and families; to support evidence-based programs with demonstrated and sustained impact; and to identify appropriate policy strategies to assure safe, stable, and nurturing relationships and environments for children and families. In addition, the Task Force identified the need to increase awareness and understanding of children's development and the effects of trauma and adverse childhood experiences.

Uniting the Vision Through Leadership in North Carolina

North Carolina stakeholders have long been involved in work to address child maltreatment prevention. In 2005, as a result of the NCIOM Task Force on Child Abuse Prevention, North Carolina leaders in child health, development, and maltreatment prevention were successful in creating and convening a Child Maltreatment Prevention Leadership Team in 2006. The Leadership Team was a multidisciplinary, interagency collaboration designed to oversee the implementation of recommendations from the NCIOM Task Force on Child Abuse Prevention.

The Leadership Team was charged with the undertaking of several of the Task Force's recommendations, including working with state partners to pilot and evaluate additional evidence-based programs to address child maltreatment prevention and treatment programs; working with the Early Childhood Comprehensive Systems Initiative in the development of an integrated and comprehensive early childhood system to promote the health and well-being of young children; working to enhance the capacity to provide behavioral health care to children in need; creating work groups as needed to address various issues in more depth (such as maternal depression screening and

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maltreatment surveillance); and also to monitor much of the work tasked to other organizations and entities as part of the Task Force's recommendations.

Building on the work from the 2005 Task Force on Child Abuse Prevention, the 2014 Task Force on Essentials for Childhood explored opportunities to improve leadership around addressing this complex set of issues, in order to best recommend ways for North Carolina to move forward. The goals of the Task Force include the establishment of a statewide Leadership Action Team, to be comprised of state and local leaders in child maltreatment prevention, philanthropy, law enforcement, state agencies, nonprofit organizations, private organizations, pediatrics, behavioral and mental health, business, education, and academia. Convened by the North Carolina Division of Public Health, within the North Carolina Department of Health and Human Services (DPH) and Prevent Child Abuse North Carolina (PCANC), the Leadership Action Team will provide oversight, guidance, and expert consultation throughout the course of the initiative. The Leadership Action Team will consist of high level leaders with broad decision-making power, who are invested in the collaborative process, and who will be responsible for selecting a backbone organization to oversee subsequent work that results from the Task Force recommendations. As outlined in the recommendations throughout this report, the Leadership Action Team will also have the primary responsibility of establishing several working groups to address the statewide work of the Essentials for Childhood initiative.

The Task Force recognized the need for cross-sector collaboration toward meeting these needs and identified a collective impact process as a way of creating more impactful partnerships.

Currently, multiple organizations work independently to meet the physical health, mental health, social, and emotional needs of children and families. These agencies include DPH; North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS); North Carolina Division of Social Services (DSS); North Carolina Division of Child Development and Early Education (DCDEE); North Carolina Division of Medical Assistance (DMA); North Carolina Department of Public Instruction (DPI); North Carolina Partnership for Children (NCPC); PCANC; philanthropic partners; corollary local agencies; service delivery providers; and academic institutions.

These and other organizations have implemented a wide variety of programs to help meet the specific mental health and social-emotional needs of young children and their families. While these programs provide much needed services and supports, they sometimes focus on very narrow and specific needs of young children and their families (i.e. small service array and restricted eligibility). Programs and services often exist in silos, and separate children's physical, cognitive, and social-emotional development, or carve out even smaller distinctions rather than treating children's development components and family needs as integrated and interdependent. The Task Force recognized the need for cross-sector collaboration toward meeting these needs and identified a collective impact process as a way of creating more impactful partnerships.

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Collective Impact: Process and Implementation

Collective impact is a method of multi-stakeholder collaboration that meets the following criteria:[2]

Common agenda:
Participating organizations have a shared goal and understanding, and a commitment to using agreed-upon solutions for addressing problems and challenges. Differences between organizations in definitions of problems and desired outcomes are discussed and resolved.

Shared measurement system:
Consistent data collection and measurement across systems and organizations maintains common goals and ensures consistency. While organizations' different activities may require different types of measures, common data collection and measurement systems allow organizations to review and learn from each others' outcomes.

Mutually reinforcing activities:
Collective impact requires coordination of goals and outcomes, and organizations' different program activities serve to support other programs' work. Activities are consistent with the common agenda and are supported by shared measurement.

Continuous communication:
Multiple meetings and communication between meetings is necessary to develop trust, support coordinated efforts, and maintain commitment to the common agenda.

Backbone support organization:
In order to have the greatest success, a collective impact process must have a dedicated organization and staff to serve as the infrastructure through the course of the initiative. The backbone organization must commit to handling the logistic and administrative work of the collective impact process, as well as mediate conflicts and oversee technical issues, inter-organization communication, data collection, and analysis/reporting.

In order to have the greatest success, a collective impact process must have a dedicated organization and staff to serve as the infrastructure through the course of the initiative.

Backbone organizations generally assume the following roles:[3]

1. Guide vision and strategy
2. Support aligned activities
3. Establish shared measurement practices
4. Build public will
5. Advance policy
6. Mobilize funding

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There are many types of organizations that can serve as appropriate backbone organizations. Government agencies, nonprofit organizations (either new or existing), and funder-based organizations can all be effective backbone organizations, and there are pros and cons to each type of entity fulfilling this role, including varying levels of transparency, neutrality, sustained funding, and existing infrastructure. Backbone organizations also generally require at least three dedicated staff positions: a project director/manager, a data manager, and a facilitator.[4]

The process of selecting and establishing a backbone organization varies, and often depends on the stage of the collective impact effort during which it occurs. The process can be open, with a team selecting the backbone organization through a request for proposal and interview process, often of the "usual suspects" in the field. The selection can be semi-open, with an "early backbone" guiding the initial activities of the initiative, with the early backbone organization subsequently made either permanent or the selection opened to other organizations. The selection process can be predetermined, with funders, advisors, or other early participants selecting the backbone organization. Regardless of which selection process is undertaken, the backbone organization should be considered a neutral convener with strong expertise in the subject area, ease with facilitation and communication, and ability to secure funding for the initiative.[4]

In order to facilitate leadership efforts to address Essentials for Childhood, the Task Force recommends:

Recommendation 3.1: Establish Coordinated State Leadership Efforts to Address Essentials for Childhood Through a Collective Impact Framework (PRIORITY RECOMMENDATION)

The North Carolina Department of Health and Human Services (DHHS) Division of Public Health (DPH), and Prevent Child Abuse North Carolina (PCANC) should establish membership and convene a Leadership Action Team, which will plan for and oversee investment in childhood and family programs to promote safe, stable, and nurturing relationships and environments and prevent child maltreatment. Using a selection process as defined by best practices in collective impact, the Leadership Action Team will select an appropriate backbone organization to facilitate the collective impact work of state and local communities, guide the strategic vision, and ensure adequate funding support. The Leadership Action Team should:

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1) **Include organizational leadership with broad decision-making power from DPH, PCANC, Division of Social Services, and North Carolina Partnership for Children. Organizational leadership should also include additional leaders from the philanthropic community, state agencies, nonprofit organizations, private organizations, business, education, and academia.**

2) **Provide oversight, guidance, technical assistance, and expert consultation for activities to promote child and family well-being.**

3) **Establish working groups to address shared planning, implementation, and accountability of state and local efforts to serve families and children. The working groups should serve as collective impact teams and consist of additional partners who can provide expert consultation and guidance. Working groups should identify opportunities to support efforts in existing state and local systems and serve families and children. Working group topics should include but not be limited to: trauma-informed training and community support; using data to inform action; implementation of evidence-based programs for treatment of child maltreatment and promotion of parenting skills; and exploration of alternative funding strategies for evidence-based programs. Additional details on working groups are laid out in other recommendations.**

4) **Establish membership, select backbone organization, and create/staff working groups, as discussed above, by the end of 2015.**

5) **Produce an annual report, starting in FY 2016, to be sent to the Governor, Secretaries of Health and Human Services and Education, and the Joint Oversight Committee. The report should also be made publicly available. The report should include updates on working group activities, policy recommendations, and additional progress toward both the broad and specific goals of Task Force on Essentials for Childhood.**

Promoting the Vision Through Trauma-Informed Communities

As experts gain an improved understanding of the impact of childhood trauma and adverse childhood experiences (ACEs) on growth and development, they are increasingly exploring how working toward trauma-informed communities can be beneficial for individual children and community growth as a whole. The Task Force examined the prevalence of child maltreatment and adverse

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childhood experiences and the negative long-term physical and psychosocial effects of these experiences (discussed in chapter 2). Given that half of adults report at least one adverse childhood experience, and one-quarter report two or more, the Task Force determined that it is appropriate to raise awareness of the negative life-long effects of child trauma and related adverse experiences, including ACEs , and the effects of child traumatic stress on developing brains, and to work toward the development of trauma-informed communities within North Carolina.

Past traumatic experiences can affect current health, behaviors, and attitudes.

For the purposes of this report, the Task Force used the definition of trauma provided by the Substance Abuse and Mental Health Services Administration (SAMHSA): "trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being."[5]

"Trauma-informed" care or practice, in turn, refers to a commitment to provide care and environments that are not harmful to individuals, while also acknowledging the high prevalence of trauma among individuals and identifying effects of trauma and ways to address these effects.[6] It also includes an understanding of the ways in which past traumatic experiences can affect current health, behaviors, and attitudes, and takes the traumatic experiences into account during all interactions.[6]

The SAMHSA funded National Child Traumatic Stress Network defines a trauma-informed child- and family-service system as, "one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family."[7]

While there are specific psychiatric diagnoses in youth related to the experience of trauma, including post-traumatic stress disorder, depression, anxiety, and disruptive behavior disorders, trauma-informed practice acknowledges the potential negative effects of all traumatic stress and adverse experiences, including those that may not result in a diagnosable mental health problem.[a] In addition, trauma-informed care ensures that individuals and relationships are approached with an understanding of resilience, coping, and the adaptive strengths of trauma survivors as they move through their development.[9]

a Amaya-Jackson, L. Associate Director, UCLA-Duke National Center for Child Traumatic Stress, Duke University Medical Center. Written (email) communication. February 15, 2015.

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Figure 3.1
SAMHSA's Trauma-Informed Approach:[7,8]

Trauma-Informed Child- and Family-Service System:

Programs, agencies, and service providers:

1. routinely screen for trauma exposure and related symptoms;
2. use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms;
3. make resources available to children, families, and providers on trauma exposure, its impact, and treatment;
4. engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma;
5. address parent and caregiver trauma and its impact on the family system;
6. emphasize continuity of care and collaboration across child-service systems; and
7. maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.

SAHMSA's Key Principles of a Trauma-Informed Approach:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

Ten Implementation Domains for a Trauma-Informed Approach:

1. Governance and leadership
2. Policy
3. Physical environment
4. Engagement and involvement
5. Cross-sector collaboration
6. Screening, assessment, and treatment services
7. Training and workforce development
8. Progress monitoring and quality assurance
9. Financing
10. Evaluation

Community Involvement and Workforce Development

The development of a trauma-informed community requires extensive multi-sector commitment, including widespread state and community engagement. Involved sectors may include, but not be limited to, physical and behavioral health providers, early care and education, K-12 education, juvenile justice, first responders, and social services agencies. It is imperative that a trauma-informed approach takes into account the ways that trauma affects not only individuals, but also families, institutions, and communities, as well as the workforce that provides services.

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There are several prerequisites for achieving a system that successfully incorporates the principles of trauma-informed care, including:[6]

1. Administrative commitment to change
2. Universal trauma screening
3. Staff training and education
4. Hiring practices
5. Review of policies and procedures

Essential partners to the development of trauma-informed practice and communities are the medical, mental, and behavioral health professional and social services (including child welfare and juvenile justice) education sectors, as well as the public education (early education and K-12) sector. School systems in some states have been incorporating trauma-informed practice in the classroom, with promising results in dropout and suspension reduction.[10,11] In North Carolina, the Area Health Education Center (AHEC) programs recently offered a continuing education program centered around training in trauma-informed care for physicians, nurses, mental health providers, therapists, counselors, and other health care professionals.[12] The University of North Carolina at Chapel Hill School of Social Work provides a certification in trauma-informed behavior management for social workers and foster parents that focuses on the foundation of trauma and related behavior, and helps encourage behavior management and prevention systems that use principles of trauma-informed care.[3,13]

The promotion of trauma-informed practices can also benefit from the support and enhancement of integrated care and coordinated care. Trauma integrated care refers to the full integration of physical health, mental and behavioral health, and trauma awareness and treatment into one setting. (see Chapter 6 for additional information on integrated care).

In 2011, DSS was awarded grant funding for "Project Broadcast: Disseminating Trauma-Informed Practices to Children in the North Carolina Child Welfare System." This five-year project set out to develop a trauma-informed workforce in nine counties, including social workers, resource parents, and system of care providers; increase the number of mental health clinicians providing trauma-informed, evidence-based treatment; develop trauma-informed policies and procedures; and collaborate more effectively across child serving systems, particularly by sharing information to improve child well-being. By the end of the project, a plan for statewide dissemination will be established. [14,b]

b Preisler, J. Project Broadcast Coordinator. North Carolina Department of Health and Human Services. Written (email) communication. November 24, 2014.

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The Task Force focused its recommendations around raising awareness of the effects of childhood trauma and adverse childhood experiences and in building public will, through multiple sectors, to develop trauma-informed practices and communities. The Task Force recommends:

Recommendation 3.2: Support the Establishment and Continuation of Trauma-Informed Practices and Communities (PRIORITY RECOMMENDATION)

The Leadership Action Team should convene a working group to examine research on brain development, the impact of trauma on development and behavior over the lifespan, and ways in which other states and communities have established trauma-informed practices in communities, schools, child welfare systems, and among health care providers. The working group should explore additional strategies to disseminate knowledge of brain development, trauma, and adverse childhood experiences. Potential strategies may include social marketing and public awareness campaigns around the impact of trauma on children and their developing brain and neurobiology; work with professional associations in multiple fields, including health, education, first responders, faith community, justice system, and social and community services; focused training for these groups and others in trauma-informed practices and community development; and support for integrated behavioral and mental health services.

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Use Data to Inform Actions

Chapter 4

Informed action requires data. Data plays a critical role in achieving the goals of the Task Force by both raising awareness of child maltreatment and measuring progress towards providing safe, stable, and nurturing relationships and environments for children and ensuring economic opportunity and security for North Carolina's families. Traditionally child maltreatment has been measured solely by data collected by Child Protective Services (CPS). Unfortunately there are significant limitations to this data. Data from CPS only includes caregiver maltreatment cases as understood by authorities. We understand that many cases of maltreatment do not get reported to authorities and may not be known to non-perpetrating adults in a child's life. Furthermore, and perhaps more importantly, children may be exposed to numerous types of trauma that would not be considered maltreatment, and all children will best thrive in the context of safe, stable, and nurturing relationships and environments. In order to better assess the well-being of children and families, we need to better understand their social-emotional and mental health, as well as the community and societal contexts in which families live. Analyzing data from multiple sources will provide a clearer picture of the systems that serve children and families in our communities and our state. In order to evaluate if North Carolina is meeting the Task Force goals, a more expansive set of measures is needed, in addition to greater coordination and linked analysis of data.

In order to better assess the well-being of children and families, we need to better understand their social-emotional and mental health, as well as the community and societal contexts in which families live.

Measuring the Problem of Child Maltreatment

North Carolina does not have a comprehensive monitoring system to estimate the magnitude of the child maltreatment problem. Currently the majority of data collected on child maltreatment is available from the UNC County Report Experiences website, which includes data from all 100 local child protective services agencies.[a] This website houses abuse and neglect data (i.e. data on child abuse and neglect investigations), Child and Family Services Review (CFSR) data (federal measures to assess safety and permanency outcomes), foster care caseload data, and experiences report data (i.e. data on child placement immediately following entry into custody/placement authority).

There are other sources of data which could help more accurately measure the incidence of maltreatment. Some of the CPS data is captured in an automated system and aggregate summary data is available on the UNC Management Assistance/UNC County Report Experiences website mentioned above. Additional aspects of CPS, such as assessments of family risk, strengths, and needs for all families subject to an assessment (investigative or family) are currently not captured in an automated system. This information will be captured in the North Carolina Families Accessing Services through Technology (NC FAST) case management system as part of NC FAST project 4, which will have child protective services as its primary focus.

a http://ssw.unc.edu/ma/

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Other data that could be used to create a comprehensive monitoring system include hospital administrative data, death certificate data, law enforcement data, Child Advocacy Center data, juvenile justice system data, and child and family welfare data. Although this data is already collected, it currently resides in different systems. Bringing data from different systems together in a common system takes time, technical expertise, and financial resources. The agencies and organizations involved must agree to share data, resolve legal and privacy challenges, agree on data management, and identify the resources needed for linking and managing data.

A comprehensive child maltreatment surveillance system would include data from the more than 20 public agencies in North Carolina that work with children and families.

In 2011, Wake County and the North Carolina Division of Public Health, through a $259,000 grant from the John Rex Endowment, began work to create a comprehensive child maltreatment surveillance system in Wake County. Currently the system has linked CPS records, emergency department data, and medical examiner records. They are working on establishing partnerships so they can link law enforcement data and Child Advocacy Center data into the surveillance system. The Wake County Child Maltreatment Surveillance System is the first step towards the type of child maltreatment surveillance system that the Task Force on Essentials for Childhood envisions for the state and all 100 counties. Integrated, real-time data will be used to meet both surveillance/population level information needs and case management needs.

Measuring Safe, Stable, and Nurturing Relationships and Environments for Children and Economic Opportunity and Security for North Carolina's Families

As envisioned by the Centers for Disease Control and Prevention (CDC), the Essentials for Childhood Framework included a selection of shared measures by each state. The CDC compiled a list of "indicators of impact" for the Essentials for Childhood Initiative. The indicators cover a wide range of topics including: impact on equity in health and well-being; health services; intermediary determinants; socioeconomic position; socioeconomic and political context; and social organization.[1]

As part of the Essentials for Childhood grant, the Leadership Action Team (LAT) is responsible for selecting a set of shared indicators that all partners in this work would use to measure their collective impact and inform decisions in order to affect future outcomes and track progress towards the goal of safe, stable, nurturing relationships and environments for all children and families.

Building on the work to create a child maltreatment surveillance system and the work required in the Essentials for Childhood Framework, the Task Force on Essentials for Childhood recommends that the state develop an integrated data system that would allow the LAT and others to identify outstanding needs and treatment gaps, modify priorities for funding, monitor the effectiveness of interventions, and work to improve population health.

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As part of the Race to the Top Early Learning Challenge grant[b] (RTT-ELC), the state is working to build the North Carolina Early Childhood Integrated Data System (ECIDS). The ECIDS will integrate data on early care and education, health, and social services from multiple state agencies. ECIDS will link into North Carolina's longitudinal data system for pre-K to age 20 that is being built as part of North Carolina's Race to the Top grant.[c] The goals of the ECIDS are similar to those the LAT would have for an integrated data system: to provide state agencies, policy makers, and the public with unduplicated counts of children being served and to provide information about current programs and services to better address areas of need and effective practice within systems.[2]

As the ECIDS focuses on young children and does not include comprehensive information about older children, it will not meet all of the goals for the LAT. Nonetheless, it may provide a platform that could be expanded.

A comprehensive child maltreatment surveillance system would include data from the more than 20 public agencies in North Carolina that work with children and families. A number of states have systems that do this to varying degrees. The LAT should build on the experiences of other states and on what is already being done in North Carolina. Linked data should be used to identify outstanding needs and treatment gaps, modify priorities for funding, monitor the effectiveness of interventions, and work to improve population health. Finding a way to integrate data systems from all of these agencies into a single system that would allow information exchanges among agencies could help target and improve services for children and families, as well as provide crucial population level data about child maltreatment in our state. Therefore, the Task Force recommends:

Recommendation 4.1: Establish a Child Data Working Group of the Leadership Action Team to Identify and Support Data Collection and Collaboration

a) The Leadership Action Team (LAT) should establish a data working group composed of experts from the North Carolina Division of Public Health (DPH) (e.g. Office of the Chief Medical Examiner, State Center for Health Statistics, Women and Children's Health Section, and Injury and Violence Prevention Branch); Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Division of Social Services; Department of Public Instruction; State Bureau of Investigation; local police departments; North Carolina Partnership for Children; NC Child; Prevent Child Abuse North Carolina; academia; and others. The data working group should be tasked with:

b In 2011, North Carolina was awarded a federal Race to the Top Early Learning Challenge grant of approximately $70 million. More information on the grant is available online at http://earlylearningchallenge.nc.gov/.

c More information on North Carolina's Race to the Top Grant is available online at http://www.ncpublicschools.org/rttt/.

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1) **Identifying existing data systems in North Carolina for measuring the physical, socio-emotional, and mental health of children and families.**

2) **Making recommendations on improving and sustaining these systems.**

3) **Exploring options for integrating existing systems or developing new functional, interoperable data systems for tracking and evaluating children's and families' well-being.**

4) **Identifying data critical to assessing child well-being that are not currently measured and developing a plan to collect these data.**

b) **The LAT should designate staff from the Chronic Disease and Injury Section of DPH to lead the data working group and report back to the LAT at regular intervals.**

c) **The data working group should identify indicators from the CDC's indicators of impact report as well as additional data from the North Carolina Child Fatality Prevention Program data; Child Protective Services reports; emergency department and hospital discharge data; vital records; and criminal justice data to be included in the LAT's annual report on Essentials for Childhood.**

d) **The data working group should monitor the progress of the Wake County Child Maltreatment Surveillance System and, if successful, make recommendations to the LAT on steps to expand the system to include all 100 counties.**

e) **The data working group should monitor the progress of the ECIDS and explore the possibility of expanding the ECIDS to include data on older children and other data sets relevant to child maltreatment surveillance.**

f) **The data working group should examine existing case management operations and explore how data can be used at the population health level to improve services and child welfare. The data working group should examine ways to utilize child maltreatment surveillance data to improve case management services and child well-being at the population level.**

Assess Social Norms and Indicators of Child and Family Well-Being

While North Carolina's many agencies that work with children and families all collect data, there are few data sources with information collected from parents and children. Data from parents and youth about mental health, social-emotional development, and familial relationships help provide a fuller picture of children and families' well-being than administrative data alone can provide.

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The North Carolina Child Health Assessment and Monitoring Program (CHAMP) and the Youth Risk Behavior Survey (YRBS) each provide crucial data to assess the well-being of children and their families.

CHAMP: The CHAMP survey measures the health characteristics and behaviors of children ages 0-17. CHAMP is administered by the North Carolina State Center for Health Statistics (SCHS) with a new survey every other year. Questions on CHAMP cover a wide variety of health-related topics. Modules can be added to the CHAMP survey (or the Behavioral Risk Factor Surveillance System (BRFSS), CHAMP's parent survey) to answer questions of critical interest to state agencies or organizations as funding and space on the survey permit. CHAMP data are available online through the SCHS.[3]

Youth Risk Behavior Survey: The YRBS is a national survey to monitor six types of health risk behaviors that contribute to the leading causes of death and disability among youth and adults. In North Carolina, the survey is administered by school districts in high schools and middle schools. The survey includes questions about alcohol, tobacco, and other drug use and behaviors that contribute to unintentional injuries and violence, as well as other topics. Data from the North Carolina YRBS are available online through the North Carolina Department of Public Instruction and the North Carolina Healthy Schools website.[4]

CHAMP and YRBS provide a wealth of data that are not available from other datasets. Many of the measures included in these surveys are on the CDC's list of "indicators of impact" that could be used to track progress toward the goal of safe, stable, nurturing relationships and environments for all children and families. Funding and participation levels for both CHAMP and YRBS are often at risk of being too low to field the surveys and get enough responses to provide valid statewide estimates. It may be possible (if space and funding permit) to add a rotating bank of questions to CHAMP to assess social norms around parenting in North Carolina.

Data from parents and youth about mental health, social-emotional development, and familial relationships help provide a fuller picture of children and families' well-being than administrative data alone can provide.

Recommendation 4.2: Gather Data on Social Norms around Children and Parenting

The child data working group should explore and identify the most appropriate mechanism and funding source by which to measure public opinion and social norms around parenting, children, and families, and report back to the Leadership Action Team. This work should assess attitudes and knowledge about parenting; punishment and discipline techniques; safety net programs including Medicaid and nutrition programs; and risk and protective factors for child maltreatment. Once identified, the survey mechanism should:

1) **Include baseline and follow-up surveys to be completed at five year intervals.**

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2) **Produce results to be used by the North Carolina Division of Public Health, the North Carolina Early Childhood Foundation, and community organizations to inform social norms approaches to increasing safe, stable, nurturing relationships and environments.**

The health assessment can help identify health and developmental problems that may interfere with the child's performance in school, and also provides an opportunity to open up the conversation about health, development, and education between families, health care providers, and schools.

Improving the Kindergarten Health Assessment

Each child entering kindergarten in North Carolina public schools must have a health assessment.[d] The Kindergarten Health Assessment (KHA) is a form that the child's doctor completes and the parent then delivers to the school. The health assessment can help identify health and developmental problems that may interfere with the child's performance in school, and also provides an opportunity to open up the conversation about health, development, and education between families, health care providers, and schools.

The KHA includes a developmental screening section. There is limited space for comments and there is no guidance for health care providers what kind of comments (such as social-emotional assessment) might be included for the school. The KHA is a paper form and it is unclear to health care providers how the forms are used in schools and if teachers review them to help inform instruction. Furthermore, the data from the KHA is not aggregated for a population-based assessment of child health and development at school entry. Health care providers on the Task Force reported that physicians have concern about the number of forms that come through doctors' offices, the lack of instruction around completing forms, and the lack of information about how forms are used.

Currently the Department of Public Instruction's (DPI) Office of Early Learning is testing a new developmentally appropriate, individualized assessment tool called the K-3 assessment, in response to legislation passed by the North Carolina General Assembly,[e,f] and in order to meet the requirements of the Race to the Top Early Learning Challenge grant (RTT-ELC). The development of the assessment was guided by the Office of Early Learning Think Tank, a group of educators and scholars from across the state. The K-3 assessment includes a kindergarten entry assessment (KEA). The KEA must be completed within the first 60 days of kindergarten and must "address the five essential domains of school readiness: language and literacy development; cognition and general knowledge; approaches toward learning; physical well-being and motor development; and social and emotional development."[e] Data from the KEA will be used to generate a Child Profile to inform the instruction of each child. The KEA is on schedule to be implemented statewide in the fall of 2015.

d North Carolina General Statute §130A-440-18.
e North Carolina General Statute §115C-83.1E.
f North Carolina General Statute § 115C_174.11.

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As part of their work, the K-3 North Carolina Assessment Think Tank (a collaboration of DPI's Office of Early Learning and the Center for Child and Family Policy at Duke University) has discussed ways to incorporate information from the KHA into the Child Profile that teachers will use to help guide instruction. The first step to integrating information from the KHA into the Child Profile is creating an online platform for the KHA so that the information is gathered electronically and can be integrated with other data collected by schools. Creating new data systems can be costly; however, the RTT-ELC included funding for new data systems, with a focus on integrating data across systems, and the K-3 assessment. Creating an online platform for the KHA would meet the RTT-ELC goals of integrating data systems and having a comprehensive Child Profile to help inform individualized instruction. Therefore, the Task Force recommends:

Recommendation 4.3: Create an Online Data System for an Expanded Kindergarten Health Assessment

a) DPI, Department of Health and Human Services (DHHS), North Carolina Pediatric Society, North Carolina Academy of Child Psychiatrists, North Carolina Academy of Family Physicians, and partners should develop an online data system for the KHA that could be shared between health providers, schools, and parents or guardians and integrated into the Child Profile generated by the KEA. Investment in the new system may be supported by the RTT-ELC, but development of the system and ongoing maintenance will require DPI and DHHS investment or legislative appropriations.

b) To improve our knowledge of the well-being of children as they enter school, DPI and DHHS should expand the KHA's comments section to include prompts for addressing specific concerns, including developmental, behavioral, social-emotional, and health-related concerns, as well as provide space for physicians to detail specific recommendations for teachers and school staff on addressing individual children's needs appropriate to their scope of practice. To be effectively utilized, DPI and DHHS will need to invest in educating health care providers and school personnel in the use of the KHA as an essential communication tool between health homes, schools, and families.

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Create the Context for Healthy Children and Families through Norms Change and Programs

Chapter 5

To support families and children and prevent child maltreatment, the Task Force on Essentials for Childhood promotes the shared belief that we all share responsibility for children's well-being. Individual members of a community have a role in developing neighborhoods, activities, and programs where people gather, interact, and get to know each other. Relationships formed through neighborhood associations, faith communities, and other community organizations can link families and provide support. Communities can promote positive norms around early childhood development, parenting support, and effective parenting. For example, communities can emphasize that teaching parents positive parenting skills is a process that benefits the whole community by helping create stronger families and reduce child maltreatment. Community organizations can also help parents who may need extra support to use new parenting skills and knowledge about child development, especially when these skills are different from those practiced by other family or community members.

In North Carolina, there is strong support for investments in early childhood education and development.

As part of this work, communities can support the implementation of evidence-based programs that have been tested and proven effective, such as programs that focus on effective parenting and behavior management skills for parents and caregivers. Many programs have succeeded in helping establish and promote safe, stable, and nurturing relationships and environments for North Carolina's children, and in coordinating these programs to better fit local community needs. Communities already investing in parenting and other family support programs should review the programs they are using to ensure they are evidence-based. If they are not, it may be necessary to redirect funds from strategies that are not evidence-based or to enhance infrastructure to ensure capacity for evaluation, implementation support, and program fidelity. It may also be necessary to increase the use of a statewide, coordinated approach to selection and investment in programs.

The Task Force on Essentials for Childhood examined current, local social norms and public perceptions around parenting, child development, behavior, and family support, and the ways in which shaping social norms and implementing evidence-based programs can help to strengthen families and support children.

Changing Social Norms to Build a Supportive Environment For Children and Families

Social norms are defined as a group or community's common values, beliefs, attitudes, and/or behaviors.[1] The Centers for Disease Control and Prevention, in the context of the Essentials for Childhood Framework, encourages the promotion of positive community social norms for children and families. These norms should address the need for a community to contribute to and support children's well-being and also to promote positive parenting behaviors and techniques that can contribute to strong families and healthy children. In

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this way, stakeholders can apply a public health-oriented prevention approach to child maltreatment. By examining the social norms in existence around early childhood development, parenting techniques, and knowledge of risk and protective factors for children, the Task Force sought to move forward the notion of community responsibility for children in order to enhance children's development in these crucial years.

One of the first steps is to understand what the social norms are, and the differences between actual social norms and *perceived* social norms. In many areas of parenting and child development, parents and communities have different ideas about what their communities' social norms and expectations are than what they actually are. Researchers have attempted to assess social norms around parenting and child development, and to identify differences between actual and perceived norms. The Positive Community Norms Project to reduce child maltreatment in Wisconsin found that most respondents (70%) agreed that protecting children from neglect and abuse improves healthy brain development, and 82% agreed that reducing neglect and abuse saves public money in the long term.[2] The survey also found that while 84% of adults strongly agreed that children should not grow up in fear of their caregivers, only 53% of respondents felt that other adults agreed with this. Two-thirds of respondents strongly or mostly agreed with providing additional financial support for poor children, but only 55% believed other adults felt the same way. Most respondents also supported paying more taxes in order to increase support and services for children, but many felt that others disagreed with this.[2] Because of the common gap between community norms and the perception of community norms, it is important that work on addressing social norms also establishes an understanding of possible misperceptions.

Experts in child maltreatment and early child development agree that corporal punishment, or spanking, is not effective as a long-term discipline strategy.

Social Norms around Child Development in North Carolina

The Task Force sought to identify social norms around child development, parenting, and community support for families in North Carolina. However, very little information was available. The Task Force was able to identify a few examples of the type of information needed to identify social norms around discipline, parenting techniques, early childhood development, and community/connection for families and education that are common in North Carolina, but much more information is needed.

In North Carolina, there is strong support for investments in early childhood education and development. A recent survey sponsored by the North Carolina Early Childhood Foundation and the First Five Years Fund found that 86% of respondents felt that "making sure children get a strong start in life so they perform better in school and succeed in their careers" is important or extremely important.[3] Most respondents (85%) thought that improving public schools is important or extremely important. In addition, 83% of respondents believed that investing in early childhood education would have a positive impact on

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North Carolina's economy, and a majority supported investments in quality preschool programs, home visiting programs, and teacher training.[3]

While many North Carolinians support investments in early childhood, there are also social norms in many of our communities that are harmful for children. Experts in child maltreatment and early child development, as well as the American Academy of Pediatrics, agree that corporal punishment, or spanking, is not effective as a long-term discipline strategy (particularly for children under 18 months old), reduces the effect of other discipline techniques (such as time-outs or removal of privileges), and has a high likelihood to escalate in intensity.[4] However, recent national studies have established that, while rates of corporal punishment have been decreasing over the past several decades, spanking remains common, particularly for very young children. In North Carolina, rates of spanking for children under 2 years old were estimated (based on reports by mothers) at 30% in a one-year period, with increased rates associated with increasing age up to age 2.[5] For older children, national rates of spanking (within a one-year period) were estimated at 79% for children ages 3-5, 60% for children ages 6-8, and 52% for children ages 9-11 (95% CI).[6] The American Academy of Pediatrics recommends that parents should be encouraged and assisted in developing other, more effective techniques and skills to address their children's behavior.[7]

The First 2,000 Days Initiative frames its messages around the first 2,000 days of a child's life—the approximate time between birth and starting kindergarten.

Other aspects of social norms around early child development and parenting techniques require further assessment. Such information is critical to evaluate the impact of any campaigns to address social norms, particularly in regards to the negative effects of toxic stress and adverse childhood experiences (such as corporal punishment) on the developing brain and body. There is increasing awareness and commitment around addressing these effects among physicians and the health and education sectors, but it is unknown how much information has reached families and the greater public (see recommendation in Chapter 4 regarding data collection on public opinion and social norms in North Carolina).

The Task Force recognized that preconception and early parenthood are crucial times to address attitudes around discipline strategies, parenting skills, and family and individual protective factors in order to begin to engage families and communities around these social norms. The Task Force identified promising programs and campaigns for influencing individual and community social norms.

Promising Programs to Address Social Norms Change for Families, Communities, and Children

One promising North Carolina program is the First 2,000 Days Initiative, created and implemented by the North Carolina Early Childhood Foundation. The First 2,000 Days Initiative frames its messages around the first 2,000 days of a child's life—the approximate time between birth and starting kindergarten.

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This initiative, a combination of social marketing and direct community engagement, emphasizes the connection between a child's early development, lifelong health, and community strength. The initiative also maintains that improving a child's early development can lead to greater national security and economic stability.[8]

The campaign uses research-informed best practices for influencing public opinion to support policy change. These best practices include: 1) redefining the issue, 2) involving new actors, and 3) creating greater issue salience and heightened media and public attention. The campaign engages many distinct stakeholders in early childhood development, as well as groups that traditionally have not worked in this field, including business leaders, the faith community, and law enforcement. Participating organizations can access social marketing tools including infographics, brochures, social media messages, slide presentations, and logos that engage audiences with the First 2,000 Days message and raise awareness about early childhood development. An independent evaluation found that the First 2,000 Days Initiative increased stakeholder knowledge of early childhood issues and the importance of early childhood investments. The stakeholders with the greatest knowledge gains were those with the least early childhood experience, including the business, faith, and law enforcement communities.[a]

An independent evaluation found that the First 2,000 Days Initiative increased stakeholder knowledge of early childhood issues and the importance of early childhood investments.

The First 2,000 Days has focused on the effects of quality early childhood education and other positive messages. There is opportunity for the campaign to also shape public awareness about the negative effects of toxic stress on children's development and lifelong health and influence the ways families, educators, and communities engage with children and increase protective factors around adverse childhood experiences.

There is great opportunity to engage the goals of the First 2,000 Days through the Strengthening Families Protective Factors Framework as well (as discussed in Chapter 2). Strengthening Families focuses on all interactions with children and families with the goal of building on agencies' current activities and providing a bridge between programs that are highly relevant to the First 2,000 Days work. The Strengthening Families approach emphasizes small but significant changes in the daily interactions that service providers have with families, as well as changes in systems and policies at the practice and organizational level, in order to support families in building protective factors and greater resilience. First 2,000 Days can build on its existing messaging and tools to create targeted messaging and outreach efforts for families, incorporating the Strengthening Families approach. First 2,000 Days can also build upon its current work with purveyors of evidence-based programs that support families. For example, First 2,000 Days messaging is being used now by the state Nurse Family Partnership (NFP) program to build understanding of and support for NFP by starting with

a Perry-Manning S. Executive Director, North Carolina Early Childhood Foundation. Written (email) communication. Dec. 3, 2014.

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First 2,000 Days messages about early brain development and relevance to other issues (such as economic development and national security).[b]

In order to address social norms around parenting and child development, the Task Force recommends:

Recommendation 5.1: Promote Positive Community Norms Around Child Development and Parenting (PRIORITY RECOMMENDATION)

The North Carolina Early Childhood Foundation should continue and expand their work on changing social norms through the First 2,000 Days campaign. Specifically, the North Carolina Early Childhood Foundation should:

1) **Partner with stakeholders including the North Carolina Department of Health and Human Services (DHHS) Division of Child Development and Early Education, the Division of Public Health, the Department of Public Instruction, Prevent Child Abuse North Carolina, Child Care Services Association, North Carolina Pediatric Society, North Carolina Partnership for Children, and North Carolina Academy of Family Physicians to identify professional and community organizations and opinion leaders and conduct trainings on how to promote the First 2,000 Days and effectively educate their members and stakeholder groups on brain development, toxic stress, and early childhood development, and organize/lead community engagement around the campaign.**

2) **Seek funding support from North Carolina and national funders (public and private) to develop and implement future phases of the First 2,000 Days campaign, including social marketing and public awareness efforts, community events, parent/teacher workshops, and other activities centered around:**

    i) **Increasing awareness of brain development, the effects of toxic stress, and the importance of "the First 2,000 Days" as a critical phase for intervention for children's health and well-being.**

    ii) **Expanding outreach to parents and supporting the convening of community and opinion leaders at the practice level (school administrators, teachers, pediatricians, faith leaders, child care workers, etc.) who can influence social norms around parenting and families.**

b Perry-Manning S. Executive Director, North Carolina Early Childhood Foundation. Written (email) communication. Dec. 3, 2014.

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Recommendation 5.2: Foster Community Support for Healthy Children and Families

The North Carolina Department of Health and Human Services (DHHS), North Carolina Department of Public Instruction, Prevent Child Abuse North Carolina, and North Carolina Partnership for Children should partner with the Center for the Study of Social Policy to identify steps for implementing the Strengthening Families Framework in North Carolina and work towards incorporating the Strengthening Families Framework in state and local child maltreatment prevention efforts. The implementation should focus on evidence-based program implementation, mandated reporter trainings, home visiting models, community-based programs, and other DHHS-wide initiatives that focus on direct services to children and families, as well as efforts aimed at economic security and workforce development.

1) **The Division of Child Development and Early Education, in partnership with stakeholders listed above, should convene a working group to examine current family engagement and parent leadership strategies in early care and education, and social services settings. This working group should define best practices and develop a strategy around parent and caregiver engagement.**

2) **Coordination and planning should include the development of shared outcomes and implementation of evaluation and accountability processes.**

Supporting the Implementation of Evidence-Based Programs

Within the context of Essentials for Childhood, evidence-based programs are those programs which have proven success, through studies with experimental or quasi-experimental designs, in reducing child risk factors, promoting protective factors, treating children and families suffering from trauma, and ultimately preventing child maltreatment.[c] Evaluation research is critical in examining a program's success and determining the best direction of future investments.[9]

In addition to evidence-based programs, some organizations consider evidence-*informed* practices when making funding and implementation decisions. Programs and evaluations fall on a spectrum of evidence, and individual organizations often decide to pursue programs that are currently under evaluation and may not (or may not yet) meet the criteria to be considered evidence-based. Figure 5.1 explains the criteria for both evidence-based and evidence-informed programs, and addresses the continuum between the two. Evidence-informed programs are similar to evidence-based programs, but the research base is generally not as strong, with evidence currently emerging.

c NOTE: Evidence-based programs are defined as a "set of practices or a curriculum that is bundled together as a whole." This type of program is intended to be implemented with all of its pieces or "core components" in place. Evidence-based practices are "individualized practices that can be implemented on their own, individually, or grouped with other practices."[14]

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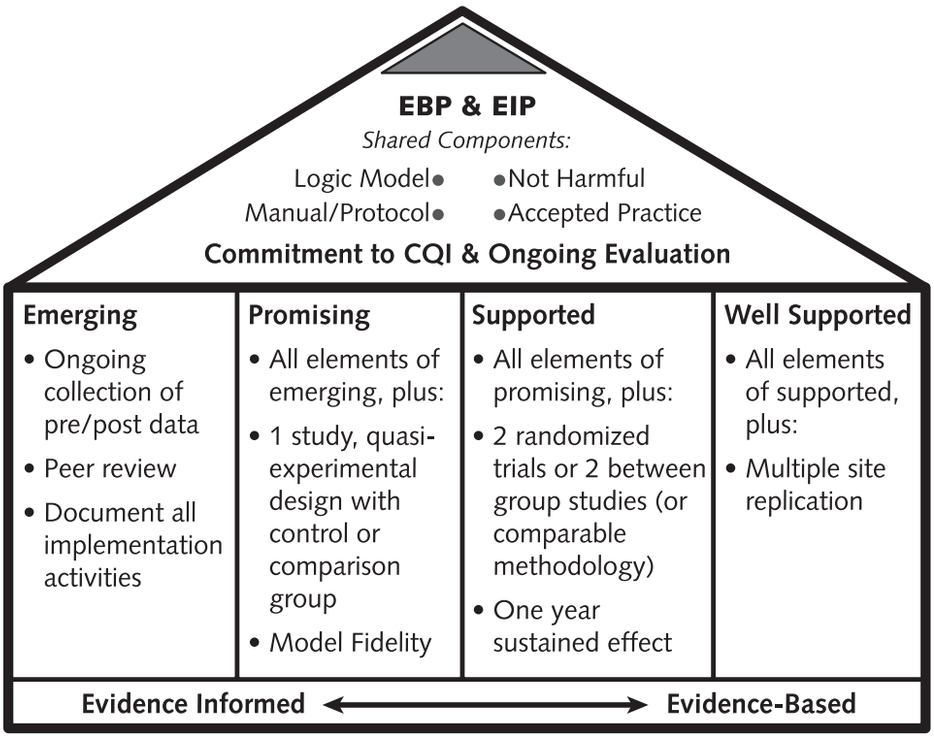
Figure 5.1
Evidence-Based and Evidence-Informed Programs[10]



Evidence-based programs are those programs which have proven success, through studies with experimental or quasi-experimental designs, in preventing child maltreatment.

For both evidence-based and evidence-informed programs, programs must be shown to be not harmful, be generally accepted, utilize a logic model, have a written protocol, and have a commitment to evaluation and continuing quality improvement.[10] Organizations may choose to implement an evidence-informed program rather than an evidence-based program for a variety of reasons, including cost, target population, availability of evidence-based alternatives for program objectives, and organizational needs and culture.

Two high quality resources to help organizations in identifying appropriate evidence-based and evidence-informed programs are the California Evidence-Based Clearinghouse for Child Welfare and the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices.[11,12]

Examples of Evidence-Based and Evidence-Informed Programs

In a 2014 environmental scan of programs serving North Carolina's children and families, Prevent Child Abuse North Carolina identified 579 programs dedicated to serving and strengthening families, implemented through 237 agencies. Of these programs, PCANC identified 59% as evidence-based or promising, with an additional 26% identified as evidence-informed.[13] These

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programs are categorized as group-based, home visitation, case management, multi-strategy, or other.[d,13]

Group based programs are those in which a community location is used to provide multiple caregivers with facilitated education or skills training or support. Group-based parenting skills programs generally focus on improving parenting techniques and increasing awareness of child development and appropriate behavior for individual parents and families. Several of these programs have demonstrated success in improving children's school readiness, increasing parents' use of appropriate discipline techniques, and decreasing problem behaviors.[14-16]

As evidence-based programs require significant financial resources for proper planning, implementation, and evaluation, North Carolina must also address ways to adequately fund such programs.

Home visiting programs provide services to families in their homes. This type of program has demonstrated success in child and family outcomes, including reduction in child maltreatment and improved infant and maternal health. Programs in which nurses or other health care professionals visit parents and children in their homes to assess health and other family status can also reduce parental stress, improve families' economic self-sufficiency, and decrease medical costs for families.[17,18]

Case management programs assess and coordinate families' need for services. Multi-strategy programs use a variety of methods, including home visiting, group programs, and case management, among others. Programs categorized as "other" used program methods including play groups, peer support interventions, and parent workshops and seminars.

For parents and children with persistent social-emotional and mental health challenges, who often need more comprehensive, individualized, intensive treatment, treatment-based programs may prove effective. Parent Child Interaction Therapy (PCIT) is an evidence-based parent-focused behavioral training clinical intervention that has been shown to improve parenting skills, child-parent relationships, behavior problems, and the incidence of physical abuse.[19] Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based mental health treatment for children and families who have experienced serious trauma, including physical abuse, sexual abuse, and domestic violence. TF-CBT has been shown to reduce depression, post-traumatic stress disorder, anxiety, and externalizing behaviors in children and to improve parents' mental health and parenting practices.[20]

d **Evidence-based models included**: Early Head Start, Healthy Families, Incredible Years BASIC, Nurse-Family Partnership, Strengthening Families Program 10-14, Strengthening Families Program, and Triple P.
Promising models included: 1-2-3 Magic!, Adolescent Parenting Program, Family Connects, Guiding Good Choices, Parent to Parent/FSN, Parenting Wisely, Parents as Teachers, Partners for a Healthy Baby, and Staying Connected With Your Teen.
Evidence-informed models included: 1,2,3,4 Parenting, Active Parenting for Stepfamilies, Active Parenting Now, Active Parenting of Teens, Circle of Parents, Families and Schools Together (Pre-K), Incredible Years Toddler, Nurturing Parent Program, and Pregnancy Care Management.
Models not able to be rated included: 24/7 Dad, Cooperative Parenting and Divorce, Healthy Start/Baby Love Plus, Incredible Years Advance (11 sessions), Love and Logic, Making Children Mind Without Losing Yours, New Parent Support Program, Parenting Matters, Parents Matter!, Positive Discipline, and Scream Free Parenting.

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Many obstacles exist in providing appropriate evidence-based programs for children and families, including a shortage of trained behavioral and mental health professionals in many parts of North Carolina, a lack of health care coverage for these services, and stigmas around receiving behavioral and mental health treatment. There are efforts in North Carolina to expand the number of clinicians trained in evidence-based treatments for children and families that have been shown to reduce child maltreatment and improve child and family outcomes, as well as efforts to integrate behavioral and mental health services with primary care (discussed more thoroughly in chapter 6).

Strategies for Funding Evidence-Based Programs

As evidence-based programs require significant financial resources for proper planning, implementation, and evaluation, North Carolina must also address ways to adequately fund such programs. Using a combination of public and private dollars, alternative funding strategies, and cost-benefit analyses, policymakers and practitioners may ensure that programs have the necessary resources to have their intended impact.

A cost-benefit model should incorporate the full cost of program implementation, including supports for fidelity.

Local and state government, as well as philanthropic, investment strategies should be made based on anticipated benefit. The benefit is usually measured in dollars, which is not the only way to consider benefit but does help policymakers compare the relative benefit from a variety of investment strategies. Ideally, cost-benefit models should incorporate real program costs and actual savings in North Carolina. A cost-benefit model should incorporate the full cost of program implementation, including supports for fidelity. Replication of the cost-benefit model should include strong leadership and commitment from executive and legislative branches, adequate and streamlined data collection and analysis, and reinvestment of savings from cost effective programming into communities.

The Results First model was developed by the Washington State Institute for Public Policy and has been implemented in six states. Through a systematic review of evidence relevant to policy alternatives, cost estimates for projected impact and needed resources, and predictions of net costs and benefits, the initiative enables states to apply a customized, cost-benefit approach to policy and budget choices.

In 2013, several states demonstrated significant success with the Results First model, particularly around directing funds to evidence-based programs; analyzing programs and policy proposals; and establishing legislative frameworks for using the Results First approach in policymaking.[21] New Mexico has used Results First to direct $49.6 million in funding to evidence-based criminal justice and early childhood programs.[1,22] In 2012, Iowa's Public Safety Advisory Board assessed mandatory minimum terms for lower-risk drug offenders and found that the state would reduce the prison population and save taxpayers $1.2 million over 10 years if policymakers eliminated these terms and reinvested a portion of the savings in evidence-based treatment programs.[21] In comparing long-term costs and benefits, models for the six states that implemented Results First predict

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that for every $1 spent on Results First-identified programs, the states will see a return of $38 over 7-10 years.[23]

Pay for Success financing (a method of financing sometimes known as "social impact bonds") is also increasingly being explored by state and local governments as an alternative method of funding public sector programs that seek to have a social and/or public health impact. Originally pioneered in the United Kingdom, Pay for Success financing utilizes private investments in public programs, with the goal of achieving improvements in agreed-upon outcomes and saving public money. A portion of these savings are then given back to the private investors as a return on their investment.[24] This method of financing is considered particularly useful for its potential in prevention programs: an upfront investment in effective prevention can make a large difference in outcomes and in increasing public sector savings on treatment and other services later in life, including medical care, education, social services, and criminal justice.

Policymakers in several states are examining the role of Pay for Success financing in addressing social issues.

Policymakers in several states are examining the role of Pay for Success financing in addressing social issues. In 2012, Massachusetts and New York were the first states to launch Pay for Success programs. Massachusetts sought proposals from potential investors and service providers in the areas of juvenile justice and chronic homelessness. The state also established a Social Innovation Financing Trust, in order to guarantee that funds would be available to return to investors upon a successful social program outcome.[25] New York City received $9.6 billion over four years to fund a program to decrease prison recidivism by at least 10%. The funding was provided by Goldman Sachs and partially guaranteed by additional funding from Bloomberg Philanthropies.[25] If New York City reaches the 10% goal, it will return the $9.6 billion to Goldman Sachs. If the program reduces recidivism by a greater percentage, Goldman Sachs will receive a higher return; if 10% is not reached, guaranteed funds from Bloomberg Philanthropies will cover a portion of the investment. Similar programs are under proposal or underway in Utah (early childhood investments), South Carolina (Medicaid), Indiana (social services), and at the federal level. This investment strategy has bipartisan support, though domestic experience is still limited.[26]

There is also opportunity to identify ways in which payments can be incentivized for providers who deliver evidence-based mental health treatment for pediatric patients. Funders, state agencies, and key stakeholders should collaborate to develop payment mechanisms and/or differential rates for the delivery of high-fidelity, evidence-based child mental health treatment to children enrolled in the North Carolina Medicaid and Health Choice programs. These differential rates should support the delivery of high-fidelity treatment by a network of mental health service providers who: 1) demonstrated successful completion of an EBT-specific training program that meets national and/or state standards; 2) engage in ongoing fidelity support and/or clinical consultation activities that meet national and/or state standards; 3) monitor clinical performance (fidelity)

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per national and/or state standards; 4) monitor pre-treatment and post-treatment clinical assessment outcomes per national and/or state standards; and 5) achieve acceptable clinical performance (fidelity) per national and/or state standards. Several managed care organizations from across the state are piloting differential payment strategies (e.g. a case rate) for mental health clinicians meeting the above criteria.[e]

Evidence-Based Programs: Implementation

Key to the process of achieving outcomes through evidence-based programs is substantial investment in implementation. It is not enough to simply identify a problem and intended outcomes, or to select a particular evidence-based program and hope to achieve intended results. Instead, organizations and funders must commit significant resources to ensuring that implementation is adequately supported. The National Implementation Research Network (NIRN), based in Chapel Hill, has identified five interrelated stages of successful implementation: exploration, installation, initial implementation, full implementation, and program sustainability.[27]

Key to the process of achieving outcomes through evidence-based programs is substantial investment in implementation.

As part of the exploration phase, stakeholders should begin with a common definition of evidence-based programs. As indicated in Figure 5.1, evidence-based programs must meet specific criteria for proven success, and also have both a sustained effect and successful replication. Use of a common set of definitions will allow funders and local programs to work from a shared understanding. It will also facilitate the use of shared language across requests for proposals issued by funding agencies which will allow local programs to work across agencies in program planning and funding. Additionally, organizations should specify the types of evidence-based programs that will help them reach their intended outcomes, evaluate capacity for implementation (including funding and commitment), and understand the necessary resources for fidelity, adaptation, and sustainability.[28]

Evidence-based programs must meet specific criteria for proven success, and also have both a sustained effect and successful replication.

As part of installation, organizations should establish an implementation team, tasked with promoting engagement with the program, ensuring financial and organizational preparation, providing technical assistance, and monitoring outcomes, fidelity, and barriers to success. An implementation team can work at the level of an individual evidence-based program, or as a body that helps others with implementation of a variety of programs. They are accountable for process and outcomes.[29]

Once implementation begins, there is both an initial implementation phase, when the innovation or program is being used for the first time, and a full implementation phase, defined as 50% of staff or practitioners utilizing an innovation and achieving intended outcomes and maintaining fidelity. During

e Steinberg J., Director of Clinical Implementation Strategies. Center for Child and Family Health. Hagele, D., Assistant Professor of Social Medicine and Pediatrics, University of North Carolina at Chapel Hill. Written (email) communication. December 4, 2014.

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this phase, it is the role of the implementation team to continue technical assistance; ensure that providers and staff are maintaining fidelity to the program model and/or adapting the program as appropriate; and continue planning for sustainability.[27]

A program that is funded in the short term and not supported by ongoing investment will not serve communities or the state well.

A program that is funded in the short term and not supported by ongoing investment will not serve communities or the state well. Indicators of program sustainability function on three levels: continued benefits for individuals, particularly among new consumers or intended recipients; continuation of specific organizational activities with intended outcomes (often termed "institutionalization" or "routinization"); and continued capacity for program delivery (particularly within the context of a collective/community implementation).[23]

Factors that influence a program's sustainability include characteristics of the program design, organizational factors, and community/environmental factors, including economic and political influences. During planning, developers and funders should examine the value of ensuring institutionalization of a program, establish sustainability planning early in a project's planning phase, and plan for evaluation at intervals that can influence continued funding and organizational capacity.[23]

During planning, developers and funders should establish sustainability planning early in a project's planning phase.

Currently, few North Carolina programs serving children and families have sufficient infrastructure to ensure implementation with fidelity, and none have the full implementation structure identified by NIRN and described above.[13] Smart Start is a network of 76 local nonprofit partnerships, established and funded by the state and administered by North Carolina Partnership for Children (NCPC). NCPC and Smart Start local partnerships are able to leverage these state funds to garner local and federal funds to use within their communities to address further needs. Using this combination of federal, state, local, and private resources, Smart Start provides an example of a promising infrastructure to integrate programs with community needs. Smart Start works in local communities to identify and administer evidence-based, evidence-informed, and promising programs that serve families and children. Smart Start promotes quality early care and education; supports families through parenting and family engagement programs; promotes early literacy; and advances access to health care and improved nutrition. Through a statewide infrastructure, Smart Start also aligns additional federal, state, and local programs with community needs and provides an example of successful integration of programs. Recent cuts in Smart Start funding at both the state and local level have impacted programming.[30]

The Task Force considered several successful evidence-based programs and examined the funding structure and capacity of state and philanthropic funding sources. The Task Force acknowledged the difficulties in ensuring sufficient funds for planning, implementation support, and sustainability. The resulting recommendations center on workable strategies for successful planning,

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funding, implementation, and sustainability of programs intended to secure safe, stable, and nurturing relationships and environments for North Carolina's children. The Task Force recommends:

Recommendation 5.3: Support Implementation of Evidence-Based Programs to Prevent Child Maltreatment and Promote Safe, Stable, and Nurturing Relationships and Environments (PRIORITY RECOMMENDATION)

The Leadership Action Team (LAT) should convene and staff a state Essentials for Childhood Evidence-Based Programs working group, comprised of public and private funders, committed to funding and scaling evidence-based programs. The working group should be charged with coordinating and aligning the implementation infrastructure across those programs, advising the backbone organization, and reporting to the LAT on an annual basis. The working group should ensure:

1) **A standard definition of evidence-based and evidence-informed programs and practices, and identify high-quality clearinghouses to reference in Requests for Proposals (RFPs).**

2) **Development of an RFP process that operates on a common cycle, with shared outcomes and evaluation requirements. RFPs should be informed by implementation science, and should provide multiyear funding with attention to sustainability and fidelity.**

3) **Planning grants to foster and sustain interagency collaboration and collective impact work in local communities. Subsequent grant cycles should give preference to communities that successfully carried out planning process.**

4) **Technical assistance to communities and organizations during planning, implementation, and on an ongoing basis.**

Recommendation 5.4: Assess Potential Funding Strategies to Ensure Adequate Investment in Evidence-Based Programs to Prevent Child Maltreatment

The Leadership Action Team (LAT) should study existing alternative funding strategies for evidence-based program investment, examining the experience of South Carolina and other states. Funding strategies should prioritize spending based on community need, determination of scope/reach, best practices, evidence-base of programs' outcomes, and availability of implementation support for such programs. The LAT

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should explore the application of cost-benefit models to inform policymaking and public investments in evidence-based programs, as well as North Carolina's current data capacity to apply such a model.

Recommendation 5.5: Explore Incentivizing Outcomes Resulting from Evidence-Based Treatment Programs (PRIORITY RECOMMENDATION)

The North Carolina Division of Medical Assistance, in collaboration with Community Care of North Carolina, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Division of Public Health should identify opportunities to incentivize payment for outcomes resulting from evidence-based treatment programs, especially as quality of care is incentivized under reform of Medicaid in North Carolina. Agencies listed above should:

1) **Identify evidence-based or evidence-informed child maltreatment and trauma treatment programs, particularly programs that have or could have implementation infrastructure in North Carolina.**

2) **Define age-appropriate, validated behavioral health and social, emotional, and mental health process and outcome measures on which to tie performance-based incentive payments for implementing organizations. These measures should align with those chosen by the child data working group (as described in Chapter 4) to measure progress and outcomes around child maltreatment and safe, stable, nurturing relationships and environments for children in North Carolina.**

3) **Develop value-based Medicaid payments that would provide additional reimbursement to professionals who credential to provide evidence-based or evidence-informed treatment protocols, including models such as Trauma-Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy.**

Recommendation 5.6: Increase Funding for Evidence-Based and Evidence-Informed Programs Implemented by the Smart Start Network (PRIORITY RECOMMENDATION)

The General Assembly should increase appropriations by 5% per year to the Smart Start network to support their work in promoting and implementing a range of evidence-based and evidence-informed programs to support and strengthen families and contributing to improved school readiness, long-term educational success, and lifelong well-being. Appropriation increases should continue until statewide capacity is developed to meet assessed needs.

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Create the Context for Healthy Children and Families through Policies

Chapter 6

Guided by the Social-Ecological Model of Child Maltreatment described in Chapter 2, the Task Force examined state- and agency-level policies and how they may influence and promote safe, stable, and nurturing relationships and environments for North Carolina's children. Goal 4 of the Centers for Disease Control and Prevention's (CDC's) Essentials for Childhood Framework focuses on the development of policies to ensure children lead healthy and safe lives. Involvement of both the public and private sectors is essential for policy development. Policy stakeholders may include legislators, state and local health departments, media, business leaders, schools and child care providers, faith-based organizations, and community organizations. The Task Force identified several areas in which policy approaches can enhance child development and educational success, reduce risk factors for child maltreatment and adverse childhood experiences, and improve families' economic security and job opportunities.

Early Child Care and Education

Early childhood is a key developmental period, with infants, toddlers, and preschoolers rapidly acquiring new knowledge, developing skills and language, and making new neuronal connections. Stimulating environments with stable and nurturing relationships can improve brain development and language acquisition, in contrast to environments in which children experience toxic stress and the accompanying adverse effects.[1,2]

Early childhood is a key developmental period, with infants, toddlers, and preschoolers rapidly acquiring new knowledge, developing skills and language, and making new neuronal connections.

A broad research base has taught us that infants acquire a range of abilities related to language, human interaction, counting, spatial reasoning, causality, and problem solving. There is some data to support specific types of stimulation for infant development in some areas. For example, preschool language skills and vocabulary size have been related to the amount that parents talk to infants and young children.[3]

Speech qualities including explaining, giving choices, and listening are more predictive of language development than sheer volume of talking.[3] In a large study of 5 year olds followed over time, vocabulary comprehension at age 5 ranged from that of a typical 2 year old to that of a typical 10 year old, and these differences persisted over time.[4] One study demonstrated that 5 year old children of low socioeconomic status (SES) had lower language test scores and lower development of a brain region highly involved in language known as Broca's area.[5] The authors postulated that it was not SES per se that 'caused' Broca's area to be less developed, but that this was due to decreased opportunities to learn. Children of low SES backgrounds may have fewer such opportunities in early childhood. As children's academic success at age 5 serves to predict future academic achievement, early care and education provide key opportunities for intervention.

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As children's academic success at age 5 serves to predict future academic achievement, early care and education provide key opportunities for intervention.

High quality, center-based care can augment the social and developmental nurturing provided in the home, and improve school readiness and future academic and workplace success. This is particularly important for low-income families that may not have the same resources or skills to provide an enriching academic home environment. For example, families with low socioeconomic status have been shown to have fewer children's books in the home.[6] However, high quality child care is in short supply in many communities and the cost of high quality, center-based care may be prohibitive to many families. Though many poor and near poor families may be eligible for child care subsidies, subsidy wait lists preclude many needy families from the opportunity for high quality, center-based care. The Task Force determined that both improving the quality of center-based care and improving access to this care were key priorities for North Carolina's children and families.

Second to the home, the early care and education environment is the place where children ages 0-5 spend the most time. In 2011, approximately 24% of children ages 0-5 were enrolled in licensed care in North Carolina in any given month. Many more children spend some portion of the year moving in and out of care as parents' work schedules change.[a] Nationally, 83% of children spend some time in non-parental care or education arrangements and 64% of children spend some time in formal early care or education the year before kindergarten.[7] Because so many young children spend time in formal child care or preschool arrangements, these settings are important opportunities for learning, nurturing, and early brain development.

Though many poor and near poor families may be eligible for child care subsidies, subsidy wait lists preclude many needy families from the opportunity for high quality, center-based care.

Early care and education settings are able to influence children's development through nurturing and stimulation. For example, the state can set caregiver ratios, teacher education requirements, a behavioral support system, and a curriculum in center-based care. The state can also set criteria for quality ratings that focus on social and emotional development, language acquisition, and teacher/child interactions. The Task Force examined the current quality rating system in North Carolina and focused on policy recommendations around improvement and enhancement of this system.

Research on Early Care and Education

There has been substantial research on the impact of high quality child care programs on early childhood development and academic success. The sentinel studies, the Perry Preschool Project, the Abecedarian Project, and the Head Start Impact Study merit special attention.

The Perry Preschool Project randomized 123 low-income African-American children in Ypsilanti, Michigan in high quality center-based care or control conditions (usually home or relative care). Children have been followed through age 40. Children who were in centered-based care were enrolled in

a Pat Hansen, MPH. Project Manager, Shape NC, The North Carolina Partnership for Children, Inc. Email communication. January 18, 2013

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full-time child care for two years from approximate ages 3-5. Most teachers had a master's degree and all had completed training in child development. There were no more than 16 children in a class and two lead teachers as well as a teacher's assistant. The preschool classes followed one of three specific theory-based curricula. Children were matched on gender, intelligence quotient (IQ), and socioeconomic status. The average IQ for children in both groups when starting the study was 79. The IQ for children in the treatment group rose to 102 (control 83) after one year in the preschool and was 92 at age 10 (controls 85). As adults, children who participated in the preschool program have higher incomes, are more likely to have jobs, more likely to have completed high school, and have committed fewer crimes than those in the control group.[8]

The Abecedarian Project followed four cohorts of children enrolled in full-time early care and education from ages 0-5 in Chapel Hill, North Carolina. Children had individualized educational programs and low teacher ratios. The curriculum focused on education as play in the curricular areas of social, emotional, and cognitive development, with a special emphasis on language skills. Children were followed through age 21. Children in the intervention group had higher IQs starting as toddlers through age 21, higher academic achievement in reading and math through young adulthood, were more likely to attend college, and were more likely to have their first child at a later age. Not only are the results of this program impressive for the young children, but mothers of intervention preschoolers were more likely to go further in school and have better employment than controls.[9]

Early care and education settings are able to influence children's development through nurturing and stimulation.

The Head Start Impact Study was a large scale attempt to evaluate the Head Start national program that serves many low-income children. In the 2012-2013 academic year, 1,130,000 children were served by Head Start for at least some time during the year. Head Start serves mostly 3 and 4 year olds from low-income families.[10] The Head Start Impact Study included 4,667 newly entering 3 and 4 year olds. There were modest gains over the course of the year in cognitive and socio-emotional development; however,

findings generally did not persist beyond the Head Start year. This study highlights real world challenges of large scale implementation of early care and education. Compared to the smaller Abecedarian and Perry Preschool projects, the quality was less consistently high. In the Head Start Impact Study, 70% of children were in high quality programs, 60% with curriculum that emphasized language and math, and 60% of children had teachers with an associate's degree or bachelor's degree.[10]

The sum of evidence from these and other studies on formal early care education indicate that earlier child care (ages 0-2) has more short- and long-term impact on cognitive development and school performance. Furthermore, full-time child care, longer-term child care, low teacher ratios, high quality, specific curriculum emphasizing math and literacy, and higher teacher education all support school readiness and long-term academic success.

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Quality of Care in North Carolina

Since 1999, North Carolina has used a star rating system to rate child care quality. All licensed child care programs received a star rating from 1-5 stars based on program standards and education standards. The program standards are rated using an observation scale [Early Childhood Environment Rating Scale (ECERS), Infant/Toddler Environment Rating Scale (ITERS), and Family Child Care Environment Rating Scale (FCCERS)]. These rating scales include observations of sufficient space, variety of play materials, clean and comfortable play area, interactions between adults and children, interactions between children, and interactions of children with activities and material. The education standards component of the star rating includes education and experience of lead administrators and the level of education and experience of classroom teachers.[11]

Research on formal early care education indicates that earlier child care (ages 0-2) has more short- and long-term impact on cognitive development and school performance.

The rating system was significantly revised in 2005. Since moving to a more rigorous system in 2005, most licensed facilities have improved in quality and are now licensed as 4 or 5 star centers or family child care homes (see Table 7.1).

Figure 7.1
North Carolina Child Care Program Star Ratings[11]

	Center (Number/%)	Home (Number/%)
*	85 (2%)	390 (16%)
**	37 (1%)	282 (11%)
***	946 (20%)	748 (30%)
****	1,153 (24%)	716 (29%)
*****	1,929 (41%)	326 (13%)
Other[b]	570 (12%)	12 (1%)
Total	4,720	2,474

Child care programs include licensed child care centers and family child care homes.[c]

Subsidies

Child care subsidies are administered through a local agency, often a department of social services. The subsidies are from a combination of state and federal funds and are administered based on a legislatively determined allocation formula. If a local agency has more eligible applicants than funds allow, the local agency can establish priorities for allocation of funding. Parents are allowed to use the child care subsidies to support their needs for child care in any arrangement that is most appropriate for their family, so long as the child care service provider accepts subsidies. Regulated care must be of 3, 4, or 5 star quality to receive child care subsidies. Child care subsidies are only available to families that meet situational and income criteria. Families must meet one or more of the following: parents working, looking for work, or in a job training program; children receiving child protective services or child welfare services; or children have an identified developmental need.[12]

b Other ratings include those which have probationary, provisional, religious, special, and temporary permits.

c Pat Hansen, MPH. Project Manager, Shape NC, The North Carolina Partnership for Children, Inc. Written (email) communication. January 18, 2013.

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In 2014, several changes were made to the subsidy eligibility requirements. The income limit for families with children 5 and under and children with special needs changed from 75% of the state median income (SMI) to 200% of the federal poverty guideline (FPG). For children ages 6-12, the maximum income limits changed from 75% of SMI to 133% of FPG.[13] In addition, beginning January 1, 2015, the child care subsidy eligibility requirements changed to include step-parents and non-parent relative caretakers (and non-parents' spouses and children, if applicable) in the accounting of the family "income unit" used to determine eligibility, if a child's parent does not live in the household.[d] These changes to the eligibility requirements have resulted in some children in relative care arrangements no longer being eligible for child care subsidies.[14]

Child care subsidies offer an opportunity for children who may be at risk for low school readiness to participate in high quality center-based care.

There are currently approximately 398,000 children statewide (ages 0-11) who meet the eligibility requirements to receive subsidies.[15-17] However, available subsidies do not adequately meet the need. According to the Division of Child Development and Early Education's (DCDEE's) Subsidized Child Care Reimbursement System, in October 2014 (the last month for which data is available), 76,297 children in North Carolina received child care subsidies. There were an additional 29,806 children on the wait list.[18] Child care subsidies offer an opportunity for children who may be at risk for low school readiness to participate in high quality center-based care. Some counties have chosen to incentivize quality by offering higher subsidy rates to higher quality centers. One drawback to this approach is that it inevitably means there will be fewer subsidized child care slots without commensurate increase in resources. The Task Force concluded that the solution must focus on both increased quantity of care and better quality care. However, the Task Force emphasized that the ultimate goal is not to put more money into subsidies, but to improve families' financial independence, thereby decreasing the number of eligible families and children.

The Task Force emphasized that the ultimate goal is not to put more money into subsidies, but to improve families' financial independence, thereby decreasing the number of eligible families and children.

Workforce Development

A professional workforce is critical to the delivery of high quality child care. Credentials and ongoing training have been strongly associated with teacher quality and academic success in child care and early education. Training takes place in university and community college settings across the state. The quality star rating system incentivizes centers to encourage teachers to get ongoing education. However, only about half of child care teachers in North Carolina have a two or four year degree and many make minimum wage.[19] With low salaries and benefits, even for teachers with advanced degrees, it is hard for an individual teacher to justify ongoing education and investment in early childhood education as a profession.[20]

d North Carolina Session Law 2014-100.

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The Child Care WAGE$ Project supports ongoing education, draws more highly-educated teachers to participating centers, and decreases teacher turnover by providing a salary supplement to teachers.

The North Carolina Child Care Services Association runs two important programs to support workforce development of teachers: T.E.A.C.H. Early Childhood Project and the Child Care WAGE$ Project. The Teacher Education and Compensation Helps (T.E.A.C.H.) Early Childhood Project is federally funded and provides a partial scholarship to child care teachers for college coursework in early education and provides a cash bonus upon completion. In return, the teacher commits to continued work in the field of early childhood education for 6-12 months depending on the scholarship. In 2011-2012, 3,831 teachers received T.E.A.C.H. scholarships.[21]

Funded by DCDEE, the Child Care WAGE$ Project supports ongoing education, draws more highly-educated teachers to participating centers, and decreases teacher turnover by providing a salary supplement to teachers based on ongoing education, center quality, and partnership with the local Smart Start. As a teacher advances his or her education, WAGE$ salary supplements increase.[22] Local Smart Start agencies are critical partners in these child care workforce development efforts.

In order to ensure higher quality and greater access to early child care and education for North Carolina's children, the Task Force recommends:

Recommendation 6.1: Ensure that Child Care Centers Provide a High Quality, Nurturing Environment (PRIORITY RECOMMENDATION)

Research shows that high quality early care and education is associated with better social-emotional development of children and less maltreatment. The Task Force on Essentials for Childhood strongly believes that the right answer is more AND better early care and education. The long-term goal in early care and education should be that all children from families who want early education can afford it and that it be of high quality. North Carolina should seek to maximize its investment in early care and education initiatives, and leverage federal and foundation resources to enhance the child care workforce and allow more children to attend high quality care and education programs.

a) The Division of Child Development and Early Education (DCDEE), in partnership with the Child Care Commission and the Department of Public Instruction Office of Early Learning, should continue to re-evaluate its quality star rating system and reimbursement system to identify high quality child care facilities based on updated evidence and best practices. As part of this work, DCDEE should revise the star rating system to include:

1) Criteria that consider the program's focus on learning to support children's social and emotional development, executive function, language skills, and health.

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2) **Quality measures focused on teacher/child interactions and teacher education and criteria on continuous quality improvement.**

b) **DCDEE should work with the North Carolina Rated License Assessment Project to revise its policies and procedures for implementation of rating scale assessments to reflect these criteria changes.**

c) **The North Carolina General Assembly (NCGA) should enhance child care subsidies by:**

1) **Adjusting subsidy funding to increase percentage of eligible children receiving subsidies per year by 1% points.**

2) **Increasing subsidies for infant and toddler care, expanding both the number of available child care slots as well as improving access to and affordability of higher quality care.**

3) **Allocating additional recurring funding for child care subsidies and, in conjunction with DCDEE and the Social Services Commission, examining eligibility requirements including household income, employment/education, and redetermination periods in order to ensure children's continuity of care and allow parents to remain in the workforce, weather family transitions, and increase families' economic security without jeopardizing short-term subsidy eligibility.**

4) **Excluding the income of a "non-parent relative caretaker" from the definition of the family income unit so that grandparents and other extended family members can continue to care for their children and support their learning opportunities.**

d) **DCDEE, in partnership with the North Carolina Department of Public Instruction, Office of Early Learning and community stakeholders including child care resource and referral agencies, community colleges, Head Start, Smart Start partnerships, and child care providers, should continue to work towards adequate wages and/or wage support, benefits (especially health insurance), education and training, and career advancement opportunities to continue to grow a high quality and well-trained early care and education work force. DCDEE and partner organizations should:**

1) **Continue ongoing evaluation of professional child care workforce development on a bi-annual basis, using the Child Care Services Association workforce study evaluation model. Evaluation should provide county-specific data.**

2) **Allocate sufficient funding for statewide WAGE$ salary supplementation for eligible child care workers and other workforce development programs. Funding should also support targeted resources and technical assistance for the workforce, in order to improve early education quality, as well as a continuous quality improvement frame.**

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Primary Care Screening for Psychosocial Risk Factors and Protective Factors

Within a primary care setting, particularly in prenatal and pediatric care, there is great opportunity to enhance screening for psychosocial risk and protective factors and identify children and families at greater risk for child maltreatment and those who may need additional resources to help them establish safe, secure, and nurturing relationships and environments. Research has shown that identifying children and families at risk for child maltreatment through the pediatric setting can reduce the rate of additional maltreatment among these families.[23] Parents' physical, emotional, and social health; social circumstances; and child-rearing practices are essential determinants of child health and well-being. It is in the interest of supporting that health and well-being that children's medical homes are invested in screening for psychosocial risk and protective factors and facilitating referrals to services when appropriate.[24]

Research has shown that identifying children and families at risk for child maltreatment through the pediatric setting can reduce the rate of additional maltreatment among these families.

As approximately 13-20% of children and adolescents in the United States experience mental and behavioral health issues, pediatricians play an important role in addressing behavioral health issues.[25] In one North Carolina study, researchers found that pediatric residents identified at least one psychosocial concern in nearly 40% of their pediatric patients.[26] Screening can provide an entry into conversation with parents about family risk and protective factors, regardless of whether the screen is positive or negative. When a screening indicates risk, next steps can include more specific secondary screening, connection to a mental health provider, case management, referral to community based-services and supports, or co-management of the problem.[e]

Using psychosocial screening to identify those in need of behavioral health services, and integrating behavioral health into primary care can also reduce health care costs for families and payers.[27] In addition, establishing screening practices for families and children also presents an opportunity for health professionals to discuss child development and parenting skills, to identify family strengths, and to identify areas in which improved early care and education can be beneficial, particularly for at-risk children.[28] As of January 2015, brief behavioral and emotional screening procedures are reimbursable under Medicaid and the North Carolina Health Choice Health Insurance Program for Children.[29]

The Task Force examined existing psychosocial risk and protective factor screening structures and identified policy approaches to address the importance of psychosocial screenings to increase child and family well-being.

Examples of Screening in Practice

Originally launched in 1990 by the Maternal and Child Health Bureau of the Health Resources and Services Administration, Bright Futures is a comprehensive

e Earls, M. Leading pediatric consultant, Community Care of North Carolina. Written (email) communication.January 24, 2015.

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set of evidence-based guidelines and toolkits developed by pediatricians and child development experts. The guidelines are designed for use from the prenatal period through age 21, in order to improve health care quality and outcomes for children.[30] Bright Futures encourages a community approach to health and acknowledges the importance of healthy parents, families, and environments in promoting healthy children.[31]

The Bright Futures model encourages pediatricians to use several screening tools during their child health visits. These tools include developmental screenings for children, maternal depression screening, and pediatric behavioral and psychological assessments.[30] The Bright Futures guidelines recommend screening mothers for depression at baby's 1, 2, and 6 month visits. The Affordable Care Act mandates that all private insurance plans (except for those that are considered "grandfathered plans") must provide coverage of the Bright Futures clinical preventive services for infants, children, and adolescents without any cost sharing. Bright Futures also encourages the routine application of these screenings, use of anticipatory guidance to approach safety and health issues, and the establishment of a medical home for children and families, in order to promote continual, high-quality preventive care and integration with other services.[32]

Bright Futures encourages a community approach to health and acknowledges the importance of healthy parents, families, and environments in promoting healthy children.

The Safe Environment for Every Kid (SEEK) parent screening questionnaire is one of many screening tools used by Bright Futures to identify families at risk for child maltreatment or other problems. It asks parents and caregivers about general home safety practices and several common family stressors, including financial problems, child's behavioral problems, parental depression or mental illness, substance abuse, and domestic violence.[33] The questionnaire is a component of a larger comprehensive model of pediatric primary care. The SEEK model also utilizes expanded health professional training, motivational interviewing, additional parent engagement, integrated behavioral and mental health care, and direct services to children and families in need of additional help. Additional screening tools include the Kemper-Kelleher screen, which includes questions about the parents' childhood experiences with risk factors, as well as current experience with depression, substance abuse, and social support systems. The Survey of Wellbeing of Young Children (SWYC) includes questions about substance use (including tobacco), food availability, depression, and domestic violence. The Edinburgh screen is used to identify postpartum depression.[f] The Strengthening Families approach also provides a potential tool for protective factor screening; this tool asks parents about their feelings toward child care responsibilities and challenges, as well as their general outlook on parenting and life events.

Launched in 2011, Community Care of North Carolina's (CCNC) pregnancy medical home model provides a useful example of psychosocial risk factor

f Earls, M. Leading pediatric consultant, Community Care of North Carolina. Written (email) communication. January 24, 2015.

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screening in an obstetric care setting. The CCNC pregnancy medical home is a partnership between the Division of Medical Assistance (DMA), Division of Public Health (DPH), CCNC, and other state maternity providers. The program provides case management to Medicaid recipients with medical or psychosocial risks to their pregnancy. Women are served by case management during their pregnancy and afterwards until 60 days postpartum. The pregnancy medical home consists of an obstetrician or primary care provider who works with a care manager (nurse or social worker) to coordinate the patient's care. The project's primary goals are to improve birth outcomes, increase quality of maternity care, and reduce costs of health care in the Medicaid population through healthier babies. Over 1,600 providers in 380 practices participate in the CCNC pregnancy medical home.[34]

CCNC's pregnancy medical home model provides case management to Medicaid recipients with medical or psychosocial risks to their pregnancy.

Work is also being done with the CCNC pregnancy medical home to develop systems for routine communication between the obstetric care managers and care managers with Care Coordination for Children (CCNC's population health management program for at-risk infants and children) regarding infants at risk of toxic stress due to maternal risk factors (depression, substance use, domestic violence, homelessness), as well as communication with the infant's medical home.[35] Sharing patient information between providers, while keeping within the confines of privacy laws, can improve the quality of care for patients as well as reduce unnecessary costs.

The Assuring Better Child Health and Development (ABCD) Program, launched in 2000 and initially sponsored by the Commonwealth Fund and the National Academy for State Health Policy, is a quality improvement initiative that has successfully developed and maintained a system of implementation for developmental and autism screenings within pediatric care. ABCD works through the CCNC network and utilizes a state advisory group made up of representatives from key agencies and convened by the Office of Rural and Health and Community Care.[28,36] ABCD is also supported by some local Smart Start partnerships and has received additional Race to the Top funding since 2012, allowing it to expand statewide. The Race to the Top expansion project is led by the North Carolina Partnership for Children and implemented regionally in close collaboration between CCNC, Smart Start local partnerships, and early intervention agencies.[g] North Carolina was found to be successful in implementation of screening practices, with 90% of primary care practices implementing screening procedures, and 85% of Early and Periodic Screening, Diagnosis, and Treatment claims including age-appropriate developmental screening.[37]

While ABCD's original focus was on developmental screening for children, lessons learned from the success of the project have been applied to increase

g Oberleithner, A. Health and family support program officer, Smart Start. Written (email) communication. August 24, 2014.

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psychosocial screening as well. Successful components of the ABCD model include the use of care managers, application of data collection and evaluation techniques to inform quality improvement, integrating screening and surveillance into the office workflow, and identifying community supports and referral partners for additional behavioral health needs (including Head Start, home nurse visiting programs, community mental health services, and family support groups).[37] ABCD aims for practices to help parents learn more about developmental milestones and age-appropriate behavior, which can benefit all families, not just those families identified as needing additional services.

Integrated Care

An inherent challenge in the expansion of screening for psychosocial factors within the primary care setting is a potential lack of behavioral and mental health services for those patients identified as high risk. Communities may lack the resources to provide adequate services, or stigmatization of mental illness or substance abuse may decrease patients' willingness to seek out or participate in services. Behavioral and mental health services may also be cost-prohibitive for many families. Integrating behavioral and mental health with primary care has been associated with improved quality, improved outcomes, improved patient and provider satisfaction, and decreased cost.[38] The quality and consistency of treatment in primary care settings, and the integration with referral specialty services for behavioral health care, are essential to improved behavioral health treatment for children and families.

Integrating behavioral and mental health with primary care has been associated with improved quality, improved outcomes, improved patient and provider satisfaction, and decreased cost.

Integrated care refers to either the delivery of behavioral and mental health and substance abuse services in a primary care context, or the delivery of primary care in behavioral health care settings (sometimes referred to as reverse integration or reverse co-location). The Task Force recommendations around integrated care generally apply to integrating behavioral health care into pediatric, family medicine, and obstetric primary care settings.

The American Academy of Pediatrics has recently called for increased access to mental and behavioral health services for children, specifically through integrating mental and behavioral health services into the pediatric setting.[39] In a fully integrated system, the relationship with the provider is continuous (as with primary care), although the episodes may be time limited. For example, a patient in a primary care setting may have episodic depression during times of stress, and may occasionally need care by a behavioral health specialist. The behavioral health specialist in the integrated setting has an ongoing relationship. Because pediatric health providers often have strong, ongoing relationships with children and families, there is an opportunity to use the fundamental skills of these providers to identify and address children's and families' mental and behavioral health needs.[39]

Common strategies of high quality, successfully integrated care include: active management by a primary care clinician, collaboration with a mental health professional, adherence monitoring, treatment response assessment using a

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symptom checklist, active support for patient self-management skills, and integrated treatment lasting at least 16 weeks.[40] Mental and behavioral health treatment for children and adolescents may include interventions such as cognitive behavioral therapy, case management, home-based interventions, and other family-focused treatments, which have been shown to be particularly effective.[39]

In the pediatric setting, integrated care may help prevent lost costs due to absenteeism of parents with children in need of mental health services.

Such integrated care has also proven cost effective. Because the management of behavioral health conditions accounts for as much as half of the time of primary care clinicians, integrated care can ensure that the right provider cares for the right condition at the right time. A meta-analysis of 57 studies showed an average cost savings of 20% with integrated care.[27] In the pediatric setting, integrated care may have the additional advantage of helping prevent lost costs due to absenteeism of parents with children in need of mental health services.[39] Close collaboration or full integration can still take place even if there are few behavioral health specialists available in a community. This can occur through the use of available part-time behavioral health specialists, consultations with behavioral health providers, or the use of tele-behavioral health.

The current discussion around Medicaid reform in North Carolina represents an opportunity to invest in integrated care in our state. Specifically, the Governor's proposed plan for Medicaid reform recognizes both the improved quality and potential for cost savings with integrated care. Accountable Care Organizations can choose to invest in primary care-behavioral health integration as a means of improving health outcomes and lowering overall health care costs.[41] However, there is currently no requirement for integrated care. As the Medicaid reform proposal is reviewed by the North Carolina General Assembly and implemented, partners involved in primary care such as Community Care of North Carolina and experts in integrated care such as the North Carolina Center of Excellence for Integrated Care should work with policymakers and DMA to best support the delivery of integrated care and the technical challenges of such integration in pediatric and obstetric practices.

The Task Force recommends:

Recommendation 6.2: Enhance Care and Reimbursement Standards to Promote Children and Families' Mental Health (PRIORITY RECOMMENDATION)

a) Community Care of North Carolina (CCNC), should work with the North Carolina Division of Public Health (DPH), the Division of Medical Assistance (DMA), the North Carolina Pediatric Society, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), the North Carolina Medical Society, and the North Carolina Academy of

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Family Physicians, to establish guidelines for primary care clinicians for expanded screening of families with children for psychosocial risk factors and family protective factors, using Bright Futures as a model. Guidelines should be applicable to all populations, regardless of payer. Expanded screening guidelines should include/address:

1) Increased referrals, when appropriate, to existing mental health and social services, and improve care coordination and information sharing among health care (primary care and mental health) and social service providers.

2) Ongoing evaluation by DMA, including frequency of and intervals between implementation, quality of existing mental health and social services, and receipt of referred services.

3) Evaluation of payment policies to incentivize universal screening and services provided (prenatal, postnatal, children, new parents). DMA should explore the establishment of incentive structure for primary care providers who reach expected goals for screening (i.e. percentage of parents screened), assessment, referral, and treatment protocol for children and families, as well as development of a data collection process by which to track services and outcomes.

4) CCNC should ensure transfer of patient information from psychosocial risk screening done as part of pregnancy medical home to infants' pediatric medical provider and other medical services.

b) DMH/DD/SAS, DMA, the North Carolina Foundation for Advanced Health Programs, CCNC, North Carolina Pediatric Society, and the North Carolina Academy of Family Physicians should support current work to increase integrated behavioral health care under Medicaid reform. DMA and DMH/DD/SAS should build in methods to facilitate and establish integrated behavioral health within their practices (i.e. onsite mental health providers, social workers, etc.).

Ensuring Economic Opportunity and Security for North Carolina's Families

There is a well-documented link between poverty and health outcomes. Poor children fare worse in almost every indicator of health, including birth outcomes, access to care, health-risk behaviors, and mortality. Through the recent recession, more than 160,000 children in North Carolina entered poverty for a total of more than half a million children in poverty.[42,43] In 2013, the percentage of poor children increased from 19.5% of the child population in 2007 to 24.9%—nearly one in every four children.[42] Poverty and financial stress have a negative impact on children's cognitive development, impair their

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In 2013, the percentage of poor children in North Carolina increased from 19.5% of the child population in 2007 to 24.9%—nearly one in every four children.

ability to learn, and can contribute to behavioral, social, emotional, and health problems later in life. Poverty has also been associated with greater risk for child maltreatment, particularly neglect.[44,45] The risks posed by poverty are greatest among children who experience poverty during their earliest developmental years (before age 5), as well as those who experience persistent and deep poverty.[43,46] In contrast, increased household income during early childhood has been positively associated with better health outcomes, as well as higher wages and increased work hours once the child reaches adulthood.[47] Working to ensure economic opportunity and financial security for North Carolina's families and children is an investment that will reap great rewards.

Tax Policy

Over the last several years, as our nation and state has suffered the negative impact of a years-long recession, policymakers' focus has turned to exploring ways to achieve fiscal balance and advance economic opportunity for North Carolina. In 2013, the North Carolina General Assembly adopted several tax policy reforms. These reforms included a shift to a flat rate personal income tax of 5.75%.[48,49] The child tax credit was also changed from $100 per child for adjusted gross income under $60,000 to a progressive rate of $100 per child for adjusted gross income over $40,000 and $125 per child for adjusted gross income under $40,000.[50,51] The child tax credit was eliminated for households earning above $100,000.[51]

On both sides of the aisle, policymakers claim their policies will have the greatest benefit for the state, but broad, non-partisan analysis is necessary to understand the full scope of impact, particularly on low-income families.

The 2013 tax reform also removed the state earned income tax credit (EITC) for North Carolina's families. The state EITC was a small tax credit, on average $116 per year, for working low to moderate income families. Nearly one million families received the state EITC in 2011. The EITC was available to families earning between $38,000-$52,000 per year (based on marital status and number of children), with the greatest benefits to families earning between $10,000-$22,000 per year.[52] For very low-wage workers, the credit expanded with higher income, with the aim of encouraging greater work hours. The EITC is most often temporary assistance, with most recipients no longer eligible after one to two years, or after they have increased work hours and/or wages.

It remains unclear what affect these policies have had or will have on the economic security of North Carolina's families and children. On both sides of the aisle, policymakers claim their policies will have the greatest benefit for the state, but broad, non-partisan analysis is necessary to understand the full scope of impact, particularly on low-income families.

Higher Education and Workforce Development

Developing and maintaining a strong workforce is important in ensuring economic security for North Carolina's families. The Task Force examined programs which aim to assist individuals as well as businesses in developing skills and training necessary for job growth and workforce strength.

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The North Carolina Community College System (NCCCS), a statewide network of 58 community colleges, is heavily involved with workforce development within their respective communities. SuccessNC is a planning initiative of NCCCS that aims to increase the percentage of students who transfer, complete credentials, or remain continuously enrolled from a six-year baseline of 45% in 2004 to 59% in 2014. SuccessNC has multiple components, including Career and College Promise pathways, which offers dual enrollment programs for high school students wishing to earn college transfer credit and technical education certification.[53] NCCCS also works with the North Carolina Department of Public Instruction (DPI) to administer the North Carolina High School to Community College Articulation Agreement, which provides opportunities for students to receive community college credit for proficiency in high school courses in the same subject.[53]

NCCCS works directly with business and industry to develop career training and job readiness programs tailored specifically to the businesses' workforce needs.

NCCCS works directly with business and industry to develop career training and job readiness programs tailored specifically to the businesses' workforce needs. Through the Customized Training Program, NCCCS focuses on job growth and productivity for local businesses. The program provides community college representatives who collaborate directly with local businesses to determine and coordinate the kinds of assistance they need. Offered services include training needs assessment, curriculum design and development, orientation development, and lab and computer training.[54] NCCCS also administers the Small Business Center Network, which provides resources and assistance for small business owners and employees, including business development, marketing, bookkeeping and taxes, and assistance with networking.[55] To this end, federal grant money has recently been allocated toward linking community colleges directly with business and industry associations and expanding on-the-job training through apprentice programs.[56]

Other innovative programs aimed at increasing college attendance and promoting economic security are also being implemented across the state. DPI, in partnership with North Carolina New Schools, the State Board of Education, North Carolina Independent Colleges and Universities, NCCCS, and the University of North Carolina, has invested in the early college high school initiative since 2004. The early high school college initiative establishes high school programs on the campuses of two- or four-year colleges, and allows high school students to simultaneously complete their high school education while also earning two years of transferable college credit or an associate's degree.[57] Many of the early college programs also partner with local employers to provide specified training, internships, and other exposure to career development.[58,59]

Many early college programs partner with local employers to provide specified training, internships, and other exposure to career development.

As of the 2013-2014 school year, there were 77 early college high school programs in North Carolina, serving more than 15,000 students, and with a combined graduation rate of 96.2%.[58] This program provides support for students during what is typically the most difficult part of a college program, particularly for low-income students, and also provides these two years tuition-free, helping

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low-income students and others who are underrepresented in higher education gain a foothold in the education system and expand their future economic opportunities.[58] In November 2014, North Carolina New Schools received a $20 million federal Department of Education grant to expand their work on the early college initiatives. After raising matching funds in order to finalize the grant funding, North Carolina New Schools will be able to expand early college work by creating new stand-alone schools, applying strategies in traditional high schools, and working with other states to promote the early college model.[59]

The Task Force recommends:

Recommendation 6.3: Ensure Economic Security for Children and Families (PRIORITY RECOMMENDATION)

The North Carolina General Assembly (NCGA) should commission a non-partisan economic analysis of the impact of current North Carolina state tax policy on children and families, including impact on economic security, take home pay, and employment rates. This analysis could be conducted by the North Carolina Center for Public Policy Research, the Fiscal Research Division of the NCGA, or a similar non-partisan policy analysis firm. The NCGA should use findings from this analysis to inform future policies to address economic opportunity and security for families and children.

Recommendation 6.4: Enhance Career Training and Education Opportunities to Promote Economic Security for Families

The North Carolina Community College System and local education agencies should work with local industry to enhance career training opportunities consistent with the needs of local industry. These programs should apply best practices from apprenticeship models, job certification programs, and early college integrated programs.

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Conclusion

Chapter 7

North Carolina's future growth and prosperity depends on our ability to foster the health and well-being of our children. Child maltreatment is a significant public health problem that negatively impacts North Carolina's future. Research has shown that safe, stable, nurturing relationships and environments are fundamental to healthy child development, and that they reduce the occurrence of child maltreatment and can help protect children against the negative effects of child maltreatment and other adversity.[1] If communities take steps to promote the positive development of children and families and prevent family violence, child maltreatment can be prevented and families can be strengthened.

The Centers for Disease Control and Prevention's (CDC's) Essentials for Childhood Framework can help communities develop safe, stable, and nurturing relationships and environments. The Framework's foundation is that young children grow and develop through experiences and relationships with parents and other caregivers, and when children and their caregivers experience safe, stable, and nurturing relationships and environments they are able to mitigate the effects of potential stressors that could lead to child maltreatment.[1]

In 2013, North Carolina was one of five states to receive funding to implement the Essentials for Childhood Framework. As part of this work, the North Carolina Institute of Medicine (NCIOM), in collaboration with the North Carolina Department of Health and Human Services, Division of Public Health, and Prevent Child Abuse North Carolina, convened a statewide Task Force on Essentials for Childhood. Using the CDC's Essentials for Childhood Framework, the Task Force has developed a collective, evidence-based, state plan for reducing child maltreatment and securing child and family well-being for our state. Additionally, the Task Force examined progress on recommendations issued by the 2005 NCIOM Task Force on Child Abuse Prevention,[2] and prioritized the services, programs, and policies needed to build on this progress.

The Task Force on Essentials for Childhood used the primary goals of the CDC Essentials for Childhood Framework as the organizing structure of their work and this report:

Goal 1: Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child maltreatment

Goal 2: Use data to inform actions

Goal 3: Create the context for healthy children and families through norms change and programs

Goal 4: Create the context for healthy children and families through policies

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Goal 1: Raise Awareness and Commitment to Promote Safe, Stable, Nurturing Relationships and Environments and Prevent Child Maltreatment

Recommendation 3.1: Establish Coordinated State Leadership Efforts to Address Essentials for Childhood through a Collective Impact Framework (PRIORITY RECOMMENDATION)

The North Carolina Department of Health and Human Services (DHHS) Division of Public Health (DPH), and Prevent Child Abuse North Carolina (PCANC) should establish membership and convene a Leadership Action Team, which will plan for and oversee investment in childhood and family programs to promote safe, stable, and nurturing relationships and environments and prevent child maltreatment. Using a selection process as defined by best practices in collective impact, the Leadership Action Team will select an appropriate backbone organization to facilitate the collective impact work of state and local communities, guide the strategic vision, and ensure adequate funding support. The Leadership Action Team should:

1) **Include organizational leadership with broad decision-making power from DPH, PCANC, Division of Social Services, and North Carolina Partnership for Children. Organizational leadership should also include additional leaders from the philanthropic community, state agencies, pediatrics, mental and behavioral health, nonprofit organizations, private organizations, business, education, and academia.**

2) **Provide oversight, guidance, technical assistance, and expert consultation for activities to promote child and family well-being.**

3) **Establish working groups to address shared planning, implementation, and accountability of state and local efforts to serve families and children. The working groups should serve as collective impact teams and consist of additional partners who can provide expert consultation and guidance. Working groups should identify opportunities to support efforts in existing state and local systems and serve families and children. Working group topics should include but not be limited to: trauma-informed training and community support; using data to inform action; implementation of evidence-based programs for treatment of child maltreatment and promotion of parenting skills; and exploration of alternative funding strategies for evidence-based programs. Additional details on working groups are laid out in other recommendations.**

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4) Establish membership, select backbone organization, and create/staff working groups, as discussed above, by the end of 2015.

5) Produce an annual report, starting in FY 2016, to be sent to the Governor, Secretaries of Health and Human Services and Education, and the Joint Oversight Committee. The report should also be made publicly available. The report should include updates on working group activities, policy recommendations, and additional progress toward both the broad and specific goals of Task Force on Essentials for Childhood.

Recommendation 3.2: Support the Establishment and Continuation of Trauma-Informed Practices and Communities (PRIORITY RECOMMENDATION)

A working group, as convened by the Leadership Action Team, should be established to examine research on brain development, the impact of trauma on development and behavior over the lifespan, and ways in which other states and communities have established trauma-informed practices in communities, schools, and among health care providers. The working group should explore additional strategies to disseminate knowledge of brain development, trauma, and adverse childhood experiences. Potential strategies may include social marketing and public awareness campaigns around brain development and trauma; work with professional associations in multiple fields, including health, education, first responders, faith community, justice system, and social and community services; focused training for these groups and others in trauma-informed practices and community development; and support for integrated behavioral and mental health services.

Goal 2: Use Data to Inform Actions

Recommendation 4.1: Establish a Child Data Working Group of the Leadership Action Team to Identify and Support Data Collection and Collaboration

a) The Leadership Action Team should establish a child data working group composed of experts from the North Carolina Division of Public Health (DPH) (e.g. Office of the Chief Medical Examiner, State Center for Health Statistics, Women and Children's Health Section, and Injury and Violence Prevention Branch); Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Division of Social Services; Department of Public Instruction; State Bureau of Investigation; local police departments; North Carolina Partnership for Children; NC Child; Prevent

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Child Abuse North Carolina; academia; and others. The child data working group should be tasked with:

1) **Identifying existing data systems in North Carolina for measuring the physical, socio-emotional, and mental health of children and families.**

2) **Making recommendations on improving and sustaining these systems.**

3) **Exploring options for integrating existing systems or developing new functional, interoperable data systems for tracking and evaluating children's and families' well-being.**

4) **Identifying data critical to assessing child well-being that are not currently measured and developing a plan to collect these data.**

b) **The Leadership Action Team should designate staff from the Chronic Disease and Injury Section of DPH to lead the child data working group and report back to the Leadership Action Team at regular intervals.**

c) **The child data working group should identify indicators from the CDC's indicators of impact report as well as additional data from the North Carolina Child Fatality Prevention Program data; Child Protective Services reports; emergency department and hospital discharge data; vital records; and criminal justice data to be included in the Leadership Action Team's annual report on Essentials for Childhood.**

d) **The child data working group should monitor the progress of the Wake County Child Maltreatment Surveillance System and, if successful, make recommendations to the Leadership Action Team on steps to expand the system to include all 100 counties.**

e) **The child data working group should monitor the progress of the Early Childhood Integrated Data System (ECIDS) and explore the possibility of expanding the ECIDS to include data on older children and other data sets relevant to child maltreatment surveillance.**

f) **The child data working group should examine existing case management operations and explore how data can be used at the population health level to improve services and child welfare. The data working group should examine ways to utilize child maltreatment surveillance data to improve case management services and child well-being at the population level.**

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Recommendation 4.2: Gather Data on Social Norms around Children and Parenting

The child data working group should explore and identify the most appropriate mechanism and funding source by which to measure public opinion and social norms around parenting, children, and families, and report back to the Leadership Action Team. This work should assess attitudes and knowledge about parenting; punishment and discipline techniques; safety net programs including Medicaid and nutrition programs; and risk and protective factors for child maltreatment. Once identified, the survey mechanism should:

1) **Include baseline and follow-up surveys to be completed at five year intervals.**

2) **Produce results to be used by the North Carolina Division of Public Health, the North Carolina Early Childhood Foundation, and community organizations to inform social norms approaches to increasing safe, stable, nurturing relationships and environments.**

Recommendation 4.3: Create an Online Data System for an Expanded Kindergarten Health Assessment

a) **Department of Public Instruction (DPI), Department of Health and Human Services (DHHS), North Carolina Pediatric Society, North Carolina Academy of Child Psychiatrists, North Carolina Academy of Family Physicians, and partners should develop an online data system for the kindergarten health assessment (KHA) that could be shared between health providers, schools, and parents or guardians and integrated into the Child Profile generated by the kindergarten entry assessment . Investment in the new system may be supported by the Race to the Top – Early Learning Challenge Grant, but development of the system and ongoing maintenance will require DPI and DHHS investment or legislative appropriations.**

b) **To improve our knowledge of the well-being of children as they enter school, DPI and DHHS should expand the KHA's comments section to include prompts for addressing specific concerns, including developmental, behavioral, social-emotional, and health-related concerns, as well as provide space for physicians to detail specific recommendations for teachers and school staff on addressing individual children's needs appropriate to their scope of practice. To be effectively utilized, DPI and DHHS will need to invest in educating health care providers and school personnel in the use of the KHA as an essential communication tool between health homes, schools, and families.**

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Goal 3: Create the Context for Healthy Children and Families through Norms Change and Programs

Recommendation 5.1: Promote Positive Community Norms around Child Development and Parenting (PRIORITY RECOMMENDATION)

The North Carolina Early Childhood Foundation should continue and expand their work on changing social norms through the First 2,000 Days campaign. Specifically, the North Carolina Early Childhood Foundation should:

1) **Partner with stakeholders including the North Carolina Department of Health and Human Services Division of Child Development and Early Education, the Division of Public Health, the Department of Public Instruction, Prevent Child Abuse North Carolina, Child Care Services Association, North Carolina Pediatric Society, North Carolina Partnership for Children, and North Carolina Academy of Family Physicians to identify professional and community organizations and opinion leaders and conduct trainings on how to promote the First 2,000 Days and effectively educate their members and stakeholder groups on brain development, toxic stress, and early childhood development, and organize/lead community engagement around the campaign.**

2) **Seek funding support from North Carolina and national funders (public and private) to develop and implement future phases of the First 2,000 Days campaign, including social marketing and public awareness efforts, community events, parent/teacher workshops, and other activities centered around:**

    i) **Increasing awareness of brain development, the effects of toxic stress, and the importance of "the First 2,000 Days" as a critical phase for intervention for children's health and well-being.**

    ii) **Expanding outreach to parents and supporting the convening of community and opinion leaders at the practice level (school administrators, teachers, pediatricians, faith leaders, child care workers, etc.) who can influence social norms around parenting and families.**

Recommendation 5.2: Foster Community Support for Healthy Children and Families

The North Carolina Department of Health and Human Services (DHHS), Department of Public Instruction, Prevent Child Abuse North Carolina, and North Carolina Partnership

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for Children should partner with the Center for the Study of Social Policy to identify steps for implementing the Strengthening Families Framework in North Carolina and work towards incorporating the Strengthening Families Framework in state and local child maltreatment prevention efforts. The implementation should focus on evidence-based program implementation, mandated reporter trainings, home visiting models, community-based programs, and other DHHS-wide initiatives that focus on direct services to children and families, as well as efforts aimed at economic security and workforce development.

1) **The Division of Child Development and Early Education, in partnership with stakeholders listed above, should convene a working group to examine current family engagement and parent leadership strategies in early care and education, and social services settings. This working group should define best practices and develop a strategy around parent and caregiver engagement.**

2) **Coordination and planning should include the development of shared outcomes and implementation of evaluation and accountability processes.**

Recommendation 5.3: Support Implementation of Evidence-Based Programs to Prevent Child Maltreatment and Promote Safe, Stable, and Nurturing Relationships and Environments (PRIORITY RECOMMENDATION)

The Leadership Action Team should convene and staff a state Essentials for Childhood Evidence-Based Programs working group, comprised of public and private funders, committed to funding and scaling evidence-based programs. The working group should be charged with coordinating and aligning the implementation infrastructure across those programs, advising the backbone organization, and reporting to the Leadership Action Team on an annual basis. The working group should ensure:

1) **A standard definition of evidence-based and evidence-informed programs and practices, and identify high-quality clearinghouses to reference in Requests for Proposals (RFPs).**

2) **Development of an RFP process that operates on a common cycle, with shared outcomes and evaluation requirements. RFPs should be informed by implementation science, and should provide multiyear funding with attention to sustainability and fidelity.**

3) **Planning grants to foster and sustain interagency collaboration and collective impact work in local communities. Subsequent grant cycles should give preference to communities that successfully carried out planning process.**

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4) **Technical assistance to communities and organizations during planning, implementation, and on an ongoing basis.**

Recommendation 5.4: Assess Potential Funding Strategies to Ensure Adequate Investment in Evidence-Based Programs to Prevent Child Maltreatment

The Leadership Action Team should study existing alternative funding strategies for evidence-based program investment, examining the experience of South Carolina and other states. Funding strategies should prioritize spending based on community need, determination of scope/reach, best practices, evidence-base of programs' outcomes, and availability of implementation support for such programs. The Leadership Action Team should explore the application of cost-benefit models to inform policymaking and public investments in evidence-based programs, as well as North Carolina's current data capacity to apply such a model.

Recommendation 5.5: Explore Incentivizing Outcomes Resulting from Evidence-Based Treatment Programs (PRIORITY RECOMMENDATION)

The North Carolina Division of Medical Assistance, in collaboration with Community Care of North Carolina, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Division of Public Health should identify opportunities to incentivize payment for outcomes resulting from evidence-based treatment programs, especially as quality of care is incentivized under reform of Medicaid in North Carolina. Agencies listed above should:

1) **Identify evidence-based or evidence-informed child maltreatment and trauma treatment programs, particularly programs that have or could have implementation infrastructure in North Carolina.**

2) **Define age-appropriate, validated behavioral health and social, emotional, and mental health process and outcome measures on which to tie performance-based incentive payments for implementing organizations. These measures should align with those chosen by the child data working group (as described in Using Data to Inform Actions) to measure progress and outcomes around child maltreatment and safe, stable, nurturing relationships and environments for children in North Carolina.**

3) **Develop value-based Medicaid payments that would provide additional reimbursement to professionals who credential to provide evidence-based or evidence-informed treatment protocols, including models such as Trauma-Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy.**

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Recommendation 5.6: Increase Funding for Evidence-Based and Evidence-Informed Programs Implemented by the Smart Start Network (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should increase appropriations by 5% per year to the Smart Start network to support their work in promoting and implementing a range of evidence-based and evidence-informed programs to support and strengthen families and contributing to improved school readiness, long-term educational success, and lifelong well-being. Appropriation increases should continue until statewide capacity is developed to meet assessed needs.

Goal 4: Create the Context for Healthy Children and Families through Policies

Recommendation 6.1: Ensure that Child Care Centers Provide a High Quality, Nurturing Environment (PRIORITY RECOMMENDATION)

Research shows that high quality early care and education is associated with better social-emotional development of children and less maltreatment. The Task Force on Essentials for Childhood strongly believes that the right answer is more AND better early care and education. The long-term goal in early care and education should be that all children from families who want early education can afford it and that it be of high quality. North Carolina should seek to maximize its investment in early care and education initiatives, and leverage federal and foundation resources to enhance the child care workforce and allow more children to attend high quality care and education programs.

a) The Division of Child Development and Early Education (DCDEE), in partnership with the Child Care Commission and the Department of Public Instruction (DPI) Office of Early Learning, should continue to re-evaluate its quality star rating system and reimbursement system to identify high quality child care facilities based on updated evidence and best practices. As part of this work, DCDEE should:

1) Include criteria that consider the program's focus on learning to support children's social and emotional development, executive function, language skills, and health.

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2) **Include quality measures focused on teacher/child interactions and teacher education and criteria on continuous quality improvement.**

3) **Work with the North Carolina Rated License Assessment Project to revise its policies and procedures for implementation of rating scale assessments to reflect these criteria changes.**

b) **The North Carolina General Assembly should enhance child care subsidies by:**

1) **Adjusting subsidy funding to increase percentage of eligible children receiving subsidies per year by 1%.**

2) **Increasing subsidies for infant and toddler care, expanding both the number of available child care slots as well as improving access to and affordability of higher quality care.**

3) **Allocating additional recurring funding for child care subsidies and, in conjunction with DCDEE and the Social Services Commission, examining eligibility requirements including household income, employment/education, and redetermination periods in order to ensure children's continuity of care and allow parents to remain in the workforce, weather family transitions, and increase families' economic security without jeopardizing short-term subsidy eligibility.**

4) **Excluding the income of a "non-parent relative caretaker" from the definition of the family income unit so that grandparents and other extended family members can continue to care for their children and support their learning opportunities.**

c) **DCDEE, in partnership with the DPI Office of Early Learning and community stakeholders including child care resource and referral agencies, community colleges, Head Start, Smart Start partnerships, and child care providers, should continue to work towards adequate wages and/or wage support, benefits (especially health insurance), education and training, and career advancement opportunities to continue to grow a high quality and well-trained early care and education work force. DCDEE and partner organizations should:**

1) **Continue ongoing evaluation of professional child care workforce development on a bi-annual basis, using the Child Care Services Association workforce study evaluation model. Evaluation should provide county-specific data.**

2) **Allocate sufficient funding for statewide WAGE$ salary supplementation for eligible child care workers and other workforce development programs. Funding should also support targeted resources and technical assistance for the workforce, in order to improve early education quality, as well as a continuous quality improvement frame.**

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Recommendation 6.2: Enhance Care and Reimbursement Standards to Promote Children and Families' Mental Health (PRIORITY RECOMMENDATION)

a) **Community Care of North Carolina (CCNC), should work with the North Carolina Division of Public Health (DPH), the Division of Medical Assistance (DMA), the North Carolina Pediatric Society, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), the North Carolina Medical Society, and the North Carolina Academy of Family Physicians, to establish guidelines for primary care clinicians for expanded screening of families with children for psychosocial risk factors and family protective factors, using Bright Futures as a model. Guidelines should be applicable to all populations, regardless of payer. Expanded screening guidelines should include/address:**

   1) **Increased referrals, when appropriate, to existing mental health and social services, and improve care coordination and information sharing among health care (primary care and mental health) and social service providers.**

   2) **Ongoing evaluation by DMA, including frequency of and intervals between implementation, quality of existing mental health and social services, and receipt of referred services.**

   3) **Evaluation of payment policies to incentivize universal screening and services provided (prenatal, postnatal, children, new parents). DMA should explore the establishment of incentive structure for primary care providers who reach expected goals for screening (i.e. percentage of parents screened), assessment, referral, and treatment protocol for children and families, as well as development of a data collection process by which to track services and outcomes.**

   4) **CCNC should ensure transfer of patient information from psychosocial risk screening done as part of pregnancy medical home to infants' pediatric medical provider and other medical services.**

b) **DMH/DD/SAS, DMA, the North Carolina Foundation for Advanced Health Programs, CCNC, North Carolina Pediatric Society, and the North Carolina Academy of Family Physicians should support current work to increase integrated behavioral health care under Medicaid reform. DMA and DMH/DD/SAS should build in methods to facilitate and establish integrated behavioral health within their practices (i.e. onsite mental health providers, social workers, etc.).**

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Recommendation 6.3: Ensure Economic Security for Children and Families (PRIORITY RECOMMENDATION)

The North Carolina General Assembly (NCGA) should commission a non-partisan economic analysis of the impact of current North Carolina state tax policy on children and families, including impact on economic security, take home pay, and employment rates. This analysis could be conducted by the North Carolina Center for Public Policy Research, the Fiscal Research Division of the NCGA, or a similar non-partisan policy analysis firm. The NCGA should use findings from this analysis to inform future policies to address economic opportunity and security for families and children.

Recommendation 6.4: Enhance Career Training and Education Opportunities to Promote Economic Security for Families

The North Carolina Community College System and local education agencies should work with local industry to enhance career training opportunities consistent with the needs of local industry. These programs should apply best practices from apprenticeship models, job certification programs, and early college integrated programs.

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RECOMMENDATION	NCGA	DHHS					DPI	PCANC	NCPC	LAT	Designated Working Group	Other
		DPH	DMH/DD/SAS	DCDEE	DSS	DMA						
REPORT BACK January 2016 (or before)												
Recommendation 3.1: Establish Coordinated State Leadership Efforts to Address Essentials for Childhood through a Collective Impact Framework (PRIORITY RECOMMENDATION) DPH and PCANC should establish membership and convene a Leadership Action Team, which will plan for and oversee investment in childhood and family programs to promote safe, stable, and nurturing relationships and environments and prevent child maltreatment.		✓						✓				
Recommendation 3.2: Support the Establishment and Continuation of Trauma-Informed Practices and Communities (PRIORITY RECOMMENDATION) The LAT should establish a working group to examine research on brain development, the impact of trauma on development and behavior over the lifespan, and ways in which other states and communities have established trauma-informed practices in communities, schools, and among health care providers. The working group should explore additional strategies to disseminate knowledge of brain development, trauma, and adverse childhood experiences.										✓	✓ Trauma-informed practices working group	
Recommendation 4.1: Establish a Child Data Working Group of the Leadership Action Team to Identify and Support Data Collection and Collaboration a) The LAT should establish a child data working group composed of experts from DPH (e.g. Office of the Chief Medical Examiner, State Center for Health Statistics, Women and Children's Health Section, and Injury and Violence										✓	✓	

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RECOMMENDATION	NCGA	DHHS					DPI	PCANC	NCPC	LAT	Designated Working Group	Other
		DPH	DMH/DD/SAS	DCDEE	DSS	DMA						
Prevention Branch); DMH/DD/SAS; DSS; DPI; SBI; local police departments; NCPC; NC Child; PCANC; academia; and others. b) The LAT should designate staff from the Chronic Disease and Injury Section of DPH to lead the child data working group and report back to the LAT at regular intervals. c) The child data working group should identify indicators from the CDC's indicators of impact report as well as additional data to be included in the LAT's annual report on Essentials for Childhood. d) The child data working group should monitor the progress of the Wake County Child Maltreatment Surveillance System and, if successful, make recommendations to the LAT on steps to expand the system to include all 100 counties. e) The child data working group should monitor the progress of the ECIDS and explore the possibility of expanding the ECIDS to include data on older children and other data sets relevant to child maltreatment surveillance. f) The child data working group should examine existing case management operations and child maltreatment surveillance data and explore how data can be used at the population health level to improve services and child welfare.												
Recommendation 4.2: Gather Data on Social Norms around Children and Parenting The child data working group should explore and identify the most appropriate mechanism and funding source by which to measure public opinion and social norms around parenting, children, and families, and report back to the LAT.											✓ Child data working group	

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RECOMMENDATION	NCGA	DHHS					DPI	PCANC	NCPC	LAT	Designated Working Group	Other
		DPH	DMH/DD/SAS	DCDEE	DSS	DMA						
REPORT BACK January 2016 (or before)												
Recommendation 4.3: Create an Online Data System for an Expanded Kindergarten Health Assessment a) DHHS, DPI, NCPS, NCACP, NCAFP, and partners should develop an online data system for the KHA that could be shared between health providers, schools, and parents or guardians and integrated into the Child Profile generated by the KEA. Development of the system and ongoing maintenance will require DPI and DHHS investment or legislative appropriations. b) DPI and DHHS should expand the KHA's comments section to include prompts for addressing specific concerns, including developmental, behavioral, social-emotional, and health-related concerns, as well as provide space for physicians to detail specific recommendations for teachers and school staff on addressing individual children's needs appropriate to their scope of practice. To be effectively utilized, DPI and DHHS will need to invest in educating health care providers and school personnel in the use of the KHA as an essential communication tool between health homes, schools, and families.		✓	✓	✓	✓	✓	✓					✓ NCPS, NCACP, NCAFP and partners
Recommendation 5.1: Promote Positive Community Norms around Child Development and Parenting (PRIORITY RECOMMENDATION) NCECF should continue and expand their work on changing social norms through the First 2,000 Days campaign. NCECF should partner with stakeholders including DCDEE, DPH, DPI, PCANC, CCSA, NCPS, NCPC, and NCAFP to identify professional and community organizations and opinion		✓		✓			✓	✓	✓			✓ NCECF, CCSA, NCPS, NCAFP

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RECOMMENDATION	NCGA	DHHS					DPI	PCANC	NCPC	LAT	Designated Working Group	Other
		DPH	DMH/DD/SAS	DCDEE	DSS	DMA						
leaders and conduct trainings on how to promote the First 2,000 Days. NCECF should seek funding support from North Carolina and national funders (public and private) to develop and implement future phases of the First 2,000 Days campaign.												
Recommendation 5.2: Foster Community Support for Healthy Children and Families DHHS, DPI, PCANC, and NCPC should partner with the CSSP to identify steps for implementing the Strengthening Families Framework in North Carolina and work towards incorporating the Strengthening Families Framework in state and local child maltreatment prevention efforts. DCDEE, in partnership with stakeholders listed above, should convene a working group to examine current family engagement and parent leadership strategies in early care and education, and social services settings.		✓	✓	✓	✓	✓	✓	✓	✓			✓ CSSP
Recommendation 5.3: Support Implementation of Evidence-Based Programs to Prevent Child Maltreatment and Promote Safe, Stable, and Nurturing Relationships and Environments (PRIORITY RECOMMENDATION) The LAT should convene and staff a state Essentials for Childhood Evidence-Based Programs working group, comprised of public and private funders, committed to funding and scaling evidence-based programs. The working group should be charged with coordinating and aligning the implementation infrastructure across those programs, advising the backbone organization, and reporting to the LAT on an annual basis.										✓	✓ Evidence-based programs working group	

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RECOMMENDATION	NCGA	DHHS					DPI	PCANC	NCPC	LAT	Designated Working Group	Other
		DPH	DMH/DD/SAS	DCDEE	DSS	DMA						
REPORT BACK January 2016 (or before)												
Recommendation 5.4: Assess Potential Funding Strategies to Ensure Adequate Investment in Evidence-Based Programs to Prevent Child Maltreatment The LAT should study existing alternative funding strategies for evidence-based program investment, examining the experience of South Carolina and other states. The LAT should explore the application of cost-benefit models to inform policymaking and public investments in evidence-based programs, as well as North Carolina's current data capacity to apply such a model.										✓		
Recommendation 5.5: Explore Incentivizing Outcomes Resulting from Evidence-Based Treatment Programs (PRIORITY RECOMMENDATION) DMA, in collaboration with CCNC, DMH/DD/SAS, and DPH, should identify opportunities to incentivize payment for outcomes resulting from evidence-based treatment programs, especially as quality of care is incentivized under reform of Medicaid in North Carolina.		✓	✓			✓						✓ CCNC

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RECOMMENDATION	General Assembly	DHHS					DPI	PCANC	NCPC	LAT	Designated Working Group	Other
		DPH	DMH/DD/SAS	DCDEE	DSS	DMA						
REPORT BACK January 2016 (or before)												
Recommendation 5.6: Increase Funding for Evidence-Based and Evidence-Informed Programs Implemented by the Smart Start Network (PRIORITY RECOMMENDATION) The NCGA should increase appropriations by 5% per year to the Smart Start network to support their work in promoting and implementing a range of evidence-based and evidence-informed programs to support and strengthen families and contributing to improved school readiness, long-term educational success, and lifelong well-being.	✓											
Recommendation 6.1: Ensure that Child Care Centers Provide a High Quality, Nurturing Environment (PRIORITY RECOMMENDATION) a) DCDEE, in partnership with the Child Care Commission and the DPI Office of Early Learning, should continue to re-evaluate its quality star rating system and reimbursement system to identify high quality child care facilities based on updated evidence and best practices. b) NCGA should enhance child care subsidies by adjusting subsidy funding to increase percentage of eligible children receiving subsidies per year by 1%; increasing subsidies for infant and toddler care; allocating additional recurring funding for child care subsidies and, in conjunction with DCDEE and SSC, examining eligibility requirements; excluding the income of a "non-parent relative caretaker" from the definition of the family income unit c) DCDEE, in partnership with the DPI Office of Early Learning and community stakeholders including child care resource	✓			✓			✓					✓ Child Care Commission, SSC, Head Start, Smart Start, additional community partners

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RECOMMENDATION	General Assembly	DHHS					DPI	PCANC	NCPC	LAT	Designated Working Group	Other
		DPH	DMH/DD/SAS	DCDEE	DSS	DMA						
REPORT BACK January 2016 (or before)												
and referral agencies, community colleges, Head Start, Smart Start partnerships, and child care providers, should continue to work towards adequate wages and/or wage support, benefits (especially health insurance), education and training, and career advancement opportunities to continue to grow a high quality and well-trained early care and education work force.												
Recommendation 6.2: Enhance Care and Reimbursement Standards to Promote Children and Families' Mental Health (PRIORITY RECOMMENDATION) a) CCNC should work with DPH, DMA, DMH/DD/SAS, the NCPS, NCMS, NCAFP, to establish guidelines for primary care clinicians for expanded screening of families with children for psychosocial risk factors and family protective factors, using Bright Futures as a model. b) DMH/DD/SAS, DMA, the North Carolina Foundation for Advanced Health Programs, CCNC, NCPS, and the NCAFP should support current work to increase integrated behavioral health care under Medicaid reform. DMA and DMH/DD/SAS should build in methods to facilitate and establish integrated behavioral health within their practices (i.e. onsite mental health providers, social workers, etc.).		✓	✓			✓						✓ CCNC, NCPS, NCMS, NCAFP, NC Foundation for Advanced Health Programs
Recommendation 6.3: Ensure Economic Security for Children and Families (PRIORITY RECOMMENDATION) The NCGA should commission a non-partisan economic analysis of the impact of current North Carolina state tax policy	✓											

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RECOMMENDATION	General Assembly	DHHS					DPI	PCANC	NCPC	LAT	Designated Working Group	Other
		DPH	DMH/DD/SAS	DCDEE	DSS	DMA						
on children and families, including impact on economic security, take home pay, and employment rates. The NCGA should use findings from this analysis to inform future policies to address economic opportunity and security for families and children.												
Recommendation 6.4: Enhance Career Training and Education Opportunities to Promote Economic Security for Families NCCCS and local education agencies should work with local industry to enhance career training opportunities consistent with the needs of local industry. These programs should apply best practices from apprenticeship models, job certification programs, and early college integrated programs.												✓ NCCCS and local education agencies

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CCFH	Center for Child and Family Health
CCNC	Community Care of North Carolina
CDC	Centers for Disease Control and Prevention
DCDEE	Division of Child Development and Early Education, North Carolina Department of Health and Human Services
DHHS	North Carolina Department of Health and Human Services
DMA	Division of Medical Assistance, North Carolina Department of Health and Human Services
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services
DPH	Division of Public Health, North Carolina Department of Health and Human Services
DPI	North Carolina Department of Public Instruction
DSS	Division of Social Services, North Carolina Department of Health and Human Services
ECIDS	Early Childhood Integrated Data System
KHA	Kindergarten Health Assessment
KEA	Kindergarten Entry Assessment
NCACP	North Carolina Academy of Child Psychiatrists
NCAFP	North Carolina Academy of Family Physicians
NCCCS	North Carolina Community College System
NCGA	North Carolina General Assembly
NCOGS	North Carolina Obstetrical and Gynecological Society
NCPC	The North Carolina Partnership for Children, Inc.
NCPS	North Carolina Pediatric Society
SSC	North Carolina Social Services Commission, North Carolina Department of Health and Human Services
PCANC	Prevent Child Abuse North Carolina

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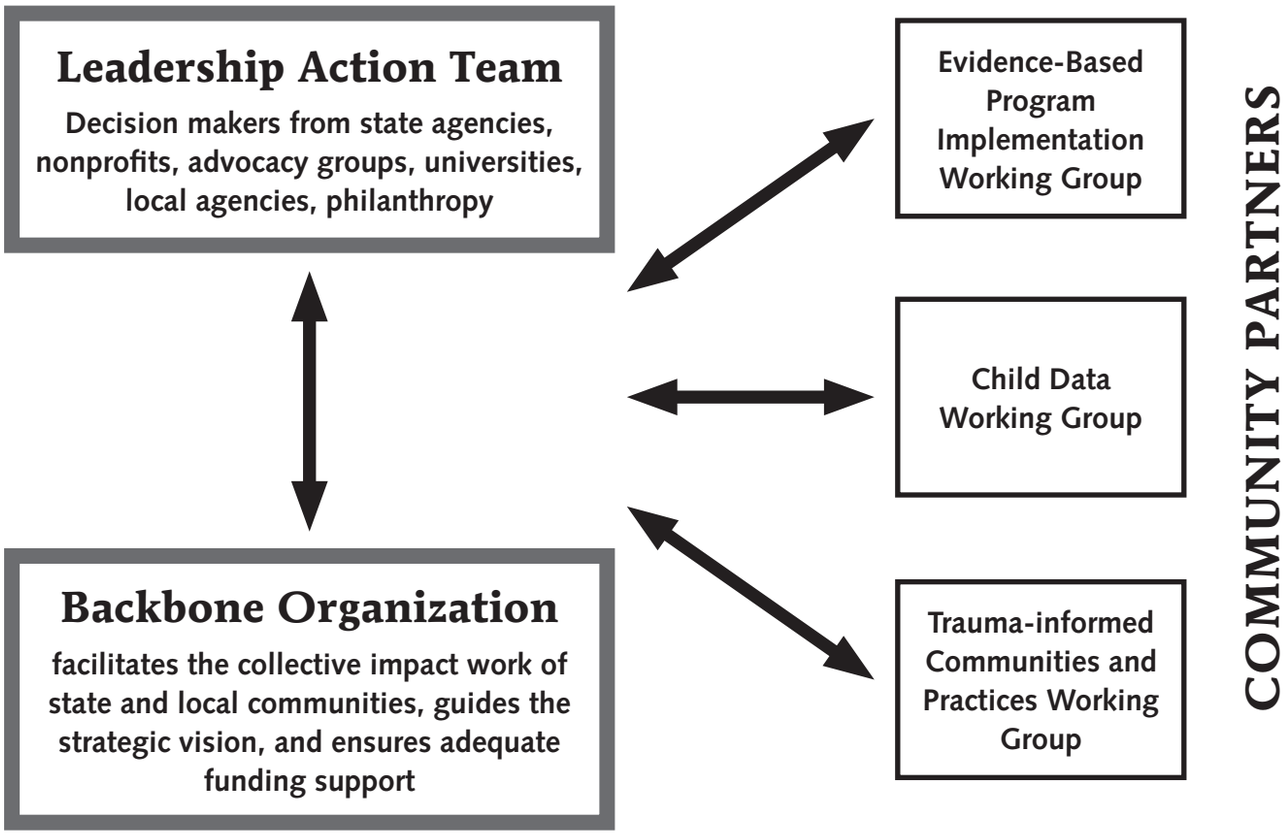
Proposed Collective Impact Leadership Structure for North Carolina Essentials for Childhood



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