Centering Babies and the Adults Who Care for Them

States Explore Infant and Early Childhood Mental Health Financing and Policy

ZERO TO THREE
Early connections last a lifetime

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EXECUTIVE SUMMARY

Our earliest relationships and experiences play a critical role in shaping our well-being. There is immense societal benefit in investing in nurturing, responsive relationships between young children and their caregivers.

Since 2016, ZERO TO THREE has been facilitating the Infant and Early Childhood Mental Health (IECMH) Financing Policy Project (FPP). The FPP serves as a learning community for professionals across states committed to centering babies and the adults who care for them in state financing and policy. Through the FPP, state leaders, ranging from infant mental health clinicians to Medicaid administrators to advocates, have been collaboratively developing innovative financing models and advocating for policies that support IECMH promotion, prevention, developmentally appropriate assessment and diagnosis, and treatment.

With support from the Irving Harris Foundation, the Esther A. & Joseph Klingenstein Fund, the W.K. Kellogg Foundation, Perigee Fund, the University of Minnesota, the Robert Wood Johnson Foundation, the Alliance for Early Success, and the state of Minnesota, the FPP has evolved over the last eight years into a dynamic platform fostering collective learning and problem solving. The 30 participating states, organized into three cohorts with Minnesota as a mentor state throughout, have demonstrated practical and visionary approaches. They are innovating in the areas of collective impact, sustainable financing, workforce development, partnerships, and more.

This report provides a high-level summary of the most recent meeting of the FPP states, which was held in September 2023. It offers an overview of the FPP's history and outlines some of the core practices essential for extending the reach of IECMH services. It also acknowledges the complexities of the work, summarizes "sticky issues," and calls out the need to confront systemic racism, all while offering lessons learned as inspiration for continued progress.

The insights and learnings of the states involved in the FPP provide a roadmap for future advancements in IECMH policy and financing. The dedication of the FPP states underscores the transformative impact that can be achieved when communities come together to center babies and their caregivers.

INTRODUCTION

Nurturing, responsive relationships between young children and their caregivers are among society's most precious resources. When we invest in the relationships and experiences of young children, we are investing in their lifelong well-being and our collective future. From a morning giggle to an afternoon yawn to an evening cry, babies traverse a multitude of emotions throughout their day. For many infants, these early days reflect typical joy and sorrow, but for some, intense or prolonged fear and suffering can threaten their development and endanger outcomes.

When we focus on centering babies and the adults who care for them in our financing and policy decisions, we support the child-parent relationship and family unit in ways that can build protective factors to help create strong, long-lasting, nurturing connections between babies and their caregivers — and ultimately strengthen and improve outcomes in our communities.

Now, more than ever, as we reflect on the differential effects of COVID-19, there is deeper understanding of racial inequities and systemic racism and their impact on families. For many, awareness is matched by a commitment to do something — to understand the roots of racism within our systems, identify racial and other inequities, forge an alternative vision that dismantles institutional and systemic racism, and act to implement change. As work unfolds, we must all be held accountable for centering a commitment to equity and creating new anti-racist policies and practices that will benefit all babies and their caregivers, especially those who have been marginalized and denied support.

Since 2016, ZERO TO THREE has been supporting a growing number of professional teams from across states who are passionate about the emotional well-being of babies and are working to create sustainable funding for a cohesive system of services that support mental health promotion, prevention, developmentally appropriate assessment and diagnosis, and treatment.

The Infant and Early Childhood Mental Health (IECMH) Financing Policy Project (FPP) is a learning community for these states to build and test models for IECMH practice, policy, financing, and research. Over the years, the project has enjoyed support from the Irving Harris Foundation, the Esther A. & Joseph Klingenstein Fund, the W.K. Kellogg Foundation, Perigee Fund, the University of Minnesota, the Robert Wood Johnson Foundation, the Alliance for Early Success, and the state of Minnesota.

Early relationships and experiences are foundational. The FPP focuses on policy and systems change in states to ensure a robust continuum of high-quality supports and services that promote nurturing relationships, positive experiences, and the related health and well-being of young children and their caregivers. This work crosses systems, workforces, and terminologies. In different landscapes and with different audiences, these aims and related policy and systems building efforts may be described in various ways, including infant and early childhood mental health (IECMH), early relational health, and social-emotional well-being.

The professionals who participate in the FPP — including representatives from state infant mental health associations; IECMH clinicians; leaders from Medicaid and related state agencies that administer child welfare, child care, and Part C early intervention; and leaders in advocacy — are practical and visionary. Together, they are calling out and challenging structural inequities to break down barriers that stand in the way of progress for families and communities. They are testing new approaches to financing that guarantee opportunities for developmentally appropriate assessment and diagnosis and treatment. And they are exploring strategies to build a diverse, well-equipped, multidisciplinary workforce that can walk alongside families to provide support during challenging times. This collective learning approach — bringing states together for mutual problem-solving — is proving to be efficient and effective in advancing state policy.

From Our Participants

"*I'm new in this space. It's so nice to feel that you have a community of support — people you can turn to for guidance and ideas.*" — A participant from Louisiana

"*It's great to get the group from the state together physically to talk about things. It's very different to do it this way — to be in one place together that is outside our offices. We can stay focused and not be distracted by other day-to-day things. We have been able to discuss things, see opportunities, and decide what we can do together when we go back home.*" — A participant from Hawaii

"*We were inspired by a presentation by Minnesota on how they train adult mental health and substance abuse providers in Attachment and Biobehavioral Catch-up (ABC). We wanted to have ABC as part of the continuum forever. We never thought of non-clinicians being trained to do ABC with families. Our state already has parents as a trained workforce, and maybe we can offer them the ABC training so that they can be the ones delivering that intervention.*"
— A participant from Tennessee

"*I loved the opportunity to be with other infant mental health folks and connect with them, and I also appreciated the opportunity to get more in depth on issues and get into the nitty-gritty, which you often don't have time for in the day-to-day.*" — Anonymous

"*IECMH is a niche field and so having a home — a safe, brave space — for thought-leaders and doers is essential.*" — A national partner

"*The FPP is like having 150 mentors. We now all have research, practice, and policy connections.*" — A participant from Tennessee

"*I wish we could have brought our entire team!*" — Anonymous

Cohort 1 2016 – 2018	Cohort 2 2018 – 2020	Cohort 3 2022 – 2024
Alaska	Alabama	Connecticut
Colorado	District of Columbia	Georgia
Illinois	Maryland	Hawaii
Indiana	Nevada	Iowa
Louisiana	New Hampshire	Kansas
Massachusetts	New Mexico	Mississippi
North Carolina	New York	Missouri
Oklahoma	South Carolina	New Jersey
Oregon	Tennessee	Utah
Virginia	Washington	

The first two convenings of the FPP occurred in 2016 (with Cohort 1) and 2018 (with Cohorts 1 and 2). Conversation and sharing among teams and across cohorts highlighted the need to align practice, policy, and systems integration with developmental science. Participants made clear that investments were needed to:

- grow, diversify, train, and support the multidisciplinary IECMH workforce;
- secure and sustain financing for IECMH services that can pay for promotion, prevention, developmentally appropriate assessment and diagnosis, and treatment;
- build across systems to support holistic care and service integration;
- cultivate leadership and strategies both inside and outside government for maximum impact on behalf of young children and their caregivers; and
- build awareness for legislators, communities, and families of the vital importance of early relationships and young children's mental health.

Since then, the states have continued to make real progress in these areas, even when the formal technical assistance from ZERO TO THREE ended. Further, their passion, determination, and relationships kept the work going when the world was upended by the COVID-19 pandemic. They have much to share with other states, including the new Cohort 3 of the FPP.

This report features highlights from the FPP including but not limited to the most recent convening of the states. It shares the history of the FPP and provides examples of the core practices that are essential for embedding IECMH into child and family serving systems. It draws attention to progress made by states that have been part of this work — and goals for those that are just beginning. "Sticky issues" remind us that the work is complex. And lessons learned offer inspiration and hope for continued advancement of policy and financing strategies that center the relationships and emotional well-being of babies and their caregivers.

Definitions

IECMH: Infant and early childhood mental health (IECMH), sometimes referred to as social and emotional development, is the developing capacity of infants and young children to form close and secure relationships; to experience, manage, and express a full range of emotions; and to explore the environment and learn — all in the context of family, community, and culture.

DC:0–5: DC:0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood was created to provide developmentally specific diagnostic criteria for and information about mental health disorders in infants and young children. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and the World Health Organization's International Classification of Diseases (ICD) are comparable classification systems for older children, adolescents, and adults. *DC:0–5*, published in December 2016, revised and updated *DC:0–3R* by expanding the age range from 3 years to 5 years old, extending criteria to younger ages, and including all disorders relevant for young children.

2023 CONVENING OF FPP STATES

On September 27 and 28, 2023, the FPP states came together for an in-person meeting in Minneapolis. Though formal technical assistance for Cohorts 1 and 2 has ended, representatives from most of these states still chose to attend, exemplifying the value they place on these opportunities to share with and learn from one another. This was the first time that the Cohort 3 states had an opportunity to assemble, and they came with their full multidisciplinary, multi-sector teams. They demonstrated an eagerness to learn from the earlier cohorts and a hunger for time with their teammates to roll up their sleeves and focus on setting goals and developing work plans.

The two days were marked by a mix of plenary and breakout sessions, team time, and networking time. Conversations ranged from broad theory to nitty-gritty topics about crosswalks between *DC:0–5* and the *ICD*, Medicaid billing codes to use for reimbursable services, strategies for training staff on specific evidence-based interventions, how to pay for staff time when they are in training and reflective supervision/consultation (RS/C), effective approaches to advocacy, and more.

Participants grappled with questions such as how best to invest and coordinate efforts across systems in service of a common goal; the difference between blending and braiding funding and how to maximize resources for the biggest impact; whether it is more beneficial to finance service delivery, workforce development, infrastructure, or something else; and how to embed IECMH in adult mental health and substance use disorder systems. It is fair to say that the convening generated just as many questions as it may have answered, and the strategies being considered and pursued are transformational.

A Commitment to Racial Equity

Equity consultants Sterling Freeman and Kathleen Crabbs of CounterPart Consulting were on hand to provide support throughout the convening. They helped the group grapple with and take on challenging conversations related to the lack of racial diversity in the clinical workforce; how families feel misunderstood, judged, and labeled in the absence of cultural awareness; whether interventions have been normed with diverse populations and the willingness or lack thereof to adapt interventions to better align with culture; and how billing codes might perpetuate inequity.

"We will work together to center equity into your work," said Freeman. "You know your context and challenges. Our work is to meet you in those challenges and understand how to bring a racial equity lens to your work. We will help you look at the root causes of challenges and how you can make structural changes that can bring about real change."

Further, Freeman drew from the work of Race Forward, sharing that, as an outcome, we achieve racial equity when race no longer determines one's socioeconomic outcomes and when everyone has what they need to thrive, no matter where they live. As a process, he explained, we apply racial equity when those most impacted by structural racial inequity are meaningfully involved in the creation and implementation of the institutional policies and practices that impact their lives. They need to be in the center with their wisdom, desire, and needs.

> *"Racial equity is a process of eliminating racial disparities and improving outcomes for everyone. It is the intentional and continual practice of changing policies, practices, systems, and structures by prioritizing measurable change in the lives of people of color."*
>
> — Race Forward

In addition to coaching by Freeman and Crabbs, participants had visual reminders on their tables designed to encourage reflection on how they are grounding policy and systems thinking in racial equity. Table tents included the following key questions drawn from Empowered Parents in Community, the Irving Harris Foundation's Diversity Informed-Tenets, and CounterPart Consulting:

- Who most benefits from and who is most harmed by this issue and the policies being considered?
- How are those people who are most harmed participating in naming the challenges and creating structural solutions?
- How are race, power, and privilege operating to maintain disparate outcomes and patterns of oppression?
- How can policy and systems building challenge or disrupt patterns of oppression?

Freeman and Crabbs have begun more intensive work with the nine states in Cohort 3 to help build their capacity for racial equity analysis and embed goals for advancing racial equity into their work through the FPP and beyond.

Accomplishments of Cohorts 1 and 2

The convening provided an opportunity for Cohort 1 and 2 states to reflect on their work and celebrate accomplishments. A representative sample of accomplishments include the following:

COLORADO: Enacted legislation that enables access to limited behavioral health services for individuals under 21 years of age without requiring a diagnosis (beginning July 2024).

ILLINOIS: Passed the Education and Workforce Equity Act that established the Infant/Early Childhood Mental Health Consultations Act, which will increase the availability of IECMH consultation services in the state and require behavioral health providers to use *DC:0–5* diagnostic codes for children under age 5.

MARYLAND: Ensured usage of *DC:0–5* in the 1915(i) waiver and formed the Infant Mental Health Association of Maryland/DC.

MASSACHUSETTS: The state's public-private partnership led to strategic investments and funding from the Massachusetts Department of Mental Health to a collaboration between the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) and the Massachusetts Association for Infant Mental Health (MassAIMH) to develop and implement a reflective consultation opportunity comprised of web-based group reflection experience with a MassAIMH-endorsed/vetted provider. The goal of the reflective consultation offering is to build organizational and systems capacity in the workforce to integrate training into practice and to support requirements towards MassAIMH endorsement for professionals with little to no access to reflective consultation.

SOUTH CAROLINA: Over the past three years, through a combination of state, federal, and private dollars (and as a result of many supportive relationships with committed partners), the South Carolina Infant Mental Health Association (SCIMHA) has grown from a one-person operation to an organization of 38 employees executing a statewide IECMH consultation network, Help Me Grow expansion, Safe Babies Courts in five counties, an IECMH Certificate program, and many other professional development offerings, including Facilitating Attuned Interactions (FAN), Attachment & Biobehavioral Catch-up (ABC), Child-Parent Psychotherapy (CPP), *DC:0–5*, and the Circle of Security® Parenting™ program.

TENNESSEE: Increased funds designated to IECMH programs and services across multiple state agencies, resulting in more than $7 million per year being dedicated to IECMH programs and services across multiple sectors via early childhood-focused organizations.

VIRGINIA: Collaborated with the Virginia Association for Infant Mental Health and secured grant funding for an executive director position to support IECMH workforce development in partnership with the Virginia Department of Behavioral Health and Developmental Services and the IECMH State Coordinator.

WASHINGTON, DC: The district appropriated funds from the DC Council to the DC Department of Health Care Finance to fund a Perinatal Mental Health Task Force. The DC Council also more than doubled investment in IECMH consultation through the DC Department of Behavioral Health, with local dollars from $1.4 million to $3.6 million over the past few years.

Goals for Cohort 3

Even though Cohort 3 states are just at the beginning of their formal engagement with the FPP, many have been working on IECMH policy and financing for some time. Their engagement with the FPP creates an opportunity to level up their work, doing so with other states that can offer encouragement, support, and advice. Examples of goals for each state follow:

CONNECTICUT will streamline IECMH billing codes, propose an enhanced rate for IECMH services, support more clear and comprehensive adoption of early and periodic screening, diagnostic, and treatment (EPSDT), and work to ensure that developmental/mental health assessments and treatment services can be provided in non-mental health settings such as pediatric offices and child care centers, as well as in the home.

GEORGIA will incorporate early home visiting and IECMH consultation into the Medicaid reimbursement structure, create an IECMH financing map, and integrate racial equity into all its financing work.

HAWAII will develop and share strategies for communicating IECMH to Medicaid and other policymakers, identify service gaps and funding opportunities, and build relationships with private insurance in addition to Medicaid.

IOWA will create a blueprint for effective consultation that can be shared statewide.

KANSAS will crosswalk the *DSM* to *DC:0–5*, use the Certified Community Behavioral Health Clinic (CCBHC) delivery model and global payments to enhance capacity and access to care, maximize use of non-licensed providers, expand the list of those who can provide services, and increase capacity by expanding delivery of services in community-based settings, child care facilities, and home-based settings.

MISSISSIPPI will develop a financing map as a step towards making IECMH funding more sustainable.

MISSOURI will improve communication with practitioners about billable IECMH services, including in the community mental health setting.

NEW JERSEY will explore integrating IECMH into adult-serving systems and will undertake a network analysis of players and power holders to facilitate more effective advocacy and policy work.

UTAH will create an IECMH finance map, design a communications plan and training opportunities to support use of *DC:0–5*, and support state leadership to build IECMH into their workforce and systems.

Sticky Issues

Throughout the convening, participants were encouraged to identify the "sticky issues" that confound their progress. Some of the most common issues shared related to the following:

Programs versus practices for long-term sustainability. Sometimes the instinct is to advance a specific program or model that has evidence behind it; however, such an approach may present challenges to long-term sustainability. There can be benefit in defining and supporting the overall IECMH practices that should be funded rather than promoting a particular program or model. In working toward a robust array of supports and services, how should systems builders balance these strengths and challenges?

Limitations of models. Models, with their evidence behind them, are valuable in informing directions for the field. But how do we address issues of gatekeeping by models that block progress and the innovation of others? How does this intersect with our aims to create more culturally specific and community-driven approaches?

Elevating family voice and power. Families are often not robustly represented at the tables where health systems financing and other related policy issues are being decided. How can we meaningfully transfer more power and influence to families, benefit from the wisdom and experience of communities, and follow the lead of families in developing policies that yield the results they want and need?

Billing codes for reimbursement. What works in one state does not necessarily work in another. How can we use the successes of some states to inform others that may be more resistant to reimbursing for services?

Consistency between managed care and Medicaid. Sometimes there is poor operational communication between managed care and Medicaid, such as when services that Medicaid includes in the contract or otherwise approves for funding are still rejected by managed care organizations. How can we make sure there is implementation consistent with Medicaid managed care contracts and Medicaid policy generally?

Disincentive for managed care to provide covered services. Some worry that there is an inherent disincentive for managed care companies to provide covered services because they make determinations based on cost savings. How can we educate managed care about the bottom-line benefits of early and consistent IECMH services for babies and their caregivers?

Additional funding does not always translate to additional services. There is a misperception that additional funding through the American Rescue Plan Act (ARPA) resulted in more children served, which was not always the case. How do we help policymakers understand that more funding is necessary to guarantee and shore up the basic support and reach of services, with further support needed for expansion?

Incentives for using *DC:0–5*. Some states have adopted *DC:0–5* and are having success training providers and getting them to use this developmentally appropriate diagnostic classification system. What are the best ways to incentivize providers so that even more will use *DC:0-5* and join *DC:0–5* groups to inform their practice?

Training a revolving door of clinicians. Training can be expensive, and the worry is always that staff will exit the field after they complete training and take their skills to other higher-paying positions. What can we learn from Minnesota about how the state is offering training and ongoing support to providers?

Short-term philanthropic investments versus long-term sustainability. Philanthropic investments are essential to experimentation, especially in a relatively new field of practice. However, it is also important to consider how efforts can be maintained when the dollars for experimentation sunset. How do you have honest conversations about this with philanthropy and government so that there is a pathway to sustainability for those efforts that show promise?

WE ALL BENEFIT FROM A VILLAGE

Just as babies and their families need strong relationships and a village of support, the policy influencers working on their behalf do too. Fortunately, this village is found in the FPP, where champions for babies come together and continue to learn from one another and innovate. Innovation has focused on strategies for financing IECMH services with public and philanthropic dollars; building and diversifying workforce capacity; expanding access to the unique, developmentally specific services that young children need; and working across systems to respond to the whole child and whole family within the context of culture and community.

The 2023 convening revisited these topics with new data, experiences, and appreciation for all that was uncovered because of COVID. Twists and turns keep the work fresh and remind us of the importance of the community that has been built through the FPP collective learning approach. A few topics that generated significant interest at the convening related to collective impact, mapping and maximizing funding, building core infrastructure to support best practice, and new partnerships. Highlights of each of these topics follow.

Collective Impact

Gretchen Hammer, founder of the Public Leadership Group and former Medicaid Director and Deputy Executive Director at the Colorado Department of Health Care Policy and Financing, reminded participants that to truly advance IECMH policy, we need to move beyond simple coordination and alignment and build collective impact approaches. She reflected on her time in state government and how the systems and programs that serve babies and their families are so diverse and complex that it looks like "a hot mess" when you attempt to map and coordinate all the systems and programs that can fund IECMH.

"That's why we need a state Children's Cabinet or local early childhood councils to play a collective impact role," said Hammer.

She likens the need for collective impact to an orchestra. First, you need trained professionals who are expert in their instruments; second, you need those professionals to want to work together on a common score; and then you need a conductor who knows the music and can draw out all the sections so that they can work together to play a beautiful piece.

The Five Conditions of Collective Impact

The Collective Impact Forum defines the five conditions of collective impact as follows:

Common agenda: Coming together to actively define the problem and create a shared vision to solve it

Measurement: Tracking progress in the same way, allowing for continuous learning and accountability

Mutually reinforcing activities: Integrating participants' many different activities to maximize the end result

Continuous communication: Building trust and strengthening relationships

Strong backbone: Having a team dedicated to aligning and coordinating the work of the group

Tennessee's Approach to Collective Impact

Though they do not call it collective impact per se, the Tennessee IECMH community has effectively built an approach over several decades that incorporates the five conditions of collective impact.

"It started back in 2010," said **Michele Moser of the East Tennessee State University Center of Excellence for Children in State Custody** (ETSU COE). "Many of us were at a conference and we called a 5 p.m. meeting for anyone who was interested in IECMH. About 30 people showed up."

They were from private practice, Medicaid, managed care, early childhood education, advocacy, and other spaces. They did not know one another and did not realize their shared interest. They started convening monthly meetings and used those to identify actions that were needed. People stepped up to work together. They formed subgroups on topics of interest — evidence-based practice in child welfare, safe baby courts, home visiting, and more.

"It was all about our magical belief that if you come together things can happen," said Moser.

For example, the original plan had a vague action step around IECMH consultation. At the time, there was no means for support from any state agency. Today, multiple state agencies have invested millions of dollars in IECMH consultation, and there is a framework for advancing IECMH consultation across sectors.

"IECMH consultation is coming out of the woodwork!" said Moser.

Participating in the FPP provided the extra boost necessary to formalize the collective impact work. Today, the Tennessee IECMH Financing Policy Team is led by a trio of agencies: TennCare, the state's Medicaid agency; the Association of Infant Mental Health in Tennessee (AIMHiTN); and ETSU COE.

Administrative support comes from AIMHiTN, while TennCare provides ultimate oversight. An annual plan is developed with clear goals, actions steps, partners, and timelines. Importantly, each goal has two or three leads, ensuring that the work is shared and not just held by AIMHiTN staff. The plan is reviewed each year, with time to celebrate accomplishments and to refresh goals.

Angela Webster, CEO of AIMHiTN, said that the process was about finding common interests across sectors and "building as you go."

"The plan is almost a wish list that serves many sectors," she said "We have to work together to accomplish these things — all of us. It's not the government plan, not the department plan, not the AIMHiTN plan. It's a collective plan that serves many sectors. For this to be successful, we have to build strong relationships and effective teams to carry the work forward."

For more information, read this article in the *Infant Mental Health Journal*.

Mapping and Maximizing Funding

While Medicaid continues to be the primary funder of IECMH services, convening participants acknowledged that it cannot be the soul funder. Finding ways to maximize other existing funding and advocate for additional resources is essential for the advancement of IECMH.

Kay Johnson of Johnson Policy Consulting put it bluntly: "How do we harness all of the funding streams to do a better job and stop pretending that Medicaid is the bank?"

Johnson has been encouraging the field for decades to "spend smarter." According to Johnson's 2005 paper, Spending Smarter: A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness, this means:

- capturing dollars in existing federal funding streams;
- blending and braiding funds;
- leveraging both smaller grant funds and entitlement dollars;
- maximizing efficiencies through systems approaches and shared resources;
- using flexible funds to fill gaps in systems of care; and
- paying for high-quality, appropriate services.

It helps to first start with clear maps and matrices that illustrate the myriad funding streams that can be accessed to support early childhood development. Consideration needs to be given to federal, state, and local funding streams, as well as funding from across systems (e.g., Medicaid, child welfare, early education, human services, and others). States that have done this exercise, find it to be both challenging, because it is so complex, and extremely helpful, because the visual representation makes the complexities more understandable to policymakers and agency leaders so that they can see the opportunities and the gaps.

According to **Lindsay Usry, Director of Infant and Early Childhood Mental Health Strategy at ZERO TO THREE**: "In order to do the work we need, there is so much information that needs to be held and organized. **Hawaii** is an example of a state that is doing just this."

Hawaii Creates Financing Maps to Guide IECMH Policy

Hawaii has been working to map IECMH financing for many years. Initially, the state was inspired by the early work of Kay Johnson and Jane Knitzer who provided the original model for mapping used by the Early Childhood Comprehensive Systems grant program. In 2016, they took this model and made it relevant for Hawaii, plugging in the various funding streams (public and private) to see how they are interrelated. As part of this, they wanted to understand what funding looked like from the local level.

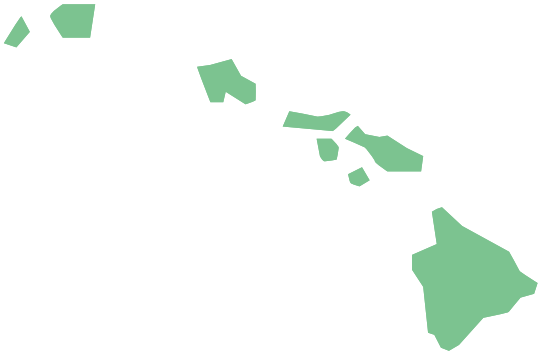
In 2023, as part of the FPP, they set out to undertake an environmental scan with the goal of showing where money comes from and where it goes. They then reorganized the data to look at it from the perspective of the mental health continuum of services — from promotion to prevention, assessment, diagnosis, and treatment. Looking at the data across the continuum helped them see even more possibilities, as well as how the funding streams relate to the various aspects of a comprehensive mental health services system.

Unfortunately, the 2023 wildfires in Lahaina, Maui upended life for thousands of families.

"Now, we are trying to build what we've been talking about for years...building it in days and weeks," said **Keiko Nitta, Early Childhood Coordinator at the Children with Special Health Needs Branch of the Hawaii State Department of Health**. "From mental health consultation to more screening and treatment, all hands are on deck."

Thankfully, Hawaii has these initial maps as an essential tool to help make quick decisions for serving families, such as deploying staff to become navigators to check in with displaced families and assigning a mental health coordinator to each hotel to help with referrals. This early work is paying off, and now, as it is used during a time of crisis, it can be tested and serve as a proof point for further change.

> *"I don't like mess, but it's the reality of what we are living with. The families should not have to figure out the mess and worry about where the services come from and who pays for what. That's our job to figure out how to get the best services to the kids and families. The mess is good."*
>
> — Keiko Nitta, Early Childhood Coordinator, Children With Special Health Care Needs Branch, Hawaii Department of Health



50-State Survey of Medicaid and IECMH

A 2023 report, Medicaid Policies to Help Young Children Access Key Infant-Early Childhood Mental Health Services: Results from a 50-State Survey, presents results of a 50-state policy survey conducted by the National Center for Children in Poverty, Georgetown University McCourt School of Public Policy Center for Children and Families, and Johnson Policy Consulting and examines Medicaid policies related to the identification, prevention, and treatment of IECMH problems. The survey results clearly show that Medicaid can be leveraged to offer families with infants and young children equitable access to supports that are essential to children's healthy development. A few highlights from the survey findings:

Maternal depression screening. Since 2016, Medicaid has been encouraging states to promote maternal depression screening. Currently, 34 states require/recommend a standardized tool for maternal depression screening; 25 offer payments for maternal depression screening under the child's Medicaid; and, of these, 16 report using a billing code specific to caregiver-focused risk.

Social-emotional screening. This type of screening is critical to helping identify children at risk and in need of further evaluation. Currently, 31 states require or recommend a specialized tool for social-emotional screening; 17 provide supplemental payments for such screening; and, of these, 11 have a billing code specific to social-emotional screening.

Social determinants of health screening. In 2017, the American Academy of Pediatrics recognized how the relationship between social determinants of health (SDOH) and family stress can impact healthy development. Currently, 16 states require or recommend the use of a standardized tool for SDOH screening; 21 cover screening for SDOH as part of well-child visits; and four provide supplemental payment for SDOH screening.

Assessment and diagnosis. An increasing number of states now recognize that multiple visits are needed to assess child and family functioning across settings to fully understand well-being and formulate a diagnosis. Currently, 20 states allow as many visits as needed; 11 cover between three and eight visits; and eight report limiting coverage to two or fewer visits. An increasing number of states now understand that, even in the absence of a diagnosis, IECMH support can still be helpful in preventing challenges.

IECMH interprofessional consultation. Infant and early childhood mental health consultation (IECMHC) is a service in which mental health clinicians offer consultation to providers (e.g., pediatricians, child care providers, and home visitors) to increase adults' capacity to recognize and meet the mental health needs of the infants and toddlers in their care. In this survey on Medicaid, the question specifically related to interprofessional consultation between a primary health care provider and an IECMH professional. Such consultations can determine the need for a diagnostic assessment for mental health conditions and/or other supports or modifications to support a child's emotional well-being (e.g., a deeper recognition of how the relationship impacts emotions, behavior, and development; changes to the settings; and suggestions for how to partner with families). Currently, 10 states reimburse for child-specific IECMH interprofessional consultation that is tied to determining whether a further assessment is needed. Half of these states require a mental health diagnosis for reimbursement.

Dyadic treatment. This is a form of therapy in which the parent and child are treated together to help strengthen their attachment. Currently, 38 states pay for dyadic treatment; seven require (and 14 recommend) use of an evidence-based dyadic treatment model (e.g., Child-Parent Psychotherapy, Parent-Child Interaction Therapy, or Attachment and Biobehavioral Catch-up); 35 report the use of a family therapy code; and 14 do not require a mental health diagnosis to cover parent-child dyadic treatment.

Group parenting programs. Groups for parents — led by a clinician or trained facilitator — provide an opportunity to learn about and receive support related to strengthening parent-child relationships, understanding and promoting child social-emotional development, and addressing behavioral challenges. Evidence-based or research-informed programs include the Triple P – Positive Parenting Program, Incredible Years, and the Circle of Security. Currently, 17 states pay for participation in group parenting programs; 10 use a family psychoeducation billing code; seven recommend (and three require) that an evidence-based program is used; and six do not require a child diagnosis for parents to participate.

Building Core Infrastructure to Support Best Practice

Another set of conversations in plenaries, breakouts, and hallway discussions focused on the infrastructure needed to support IECMH best practice. At a minimum, this includes (a) adoption of *DC:0–5* in state policy and support for its implementation; (b) building a diverse workforce and offering comprehensive training; (c) supporting the workforce with ongoing professional development opportunities, including reflective supervision; and (d) ensuring mechanisms for billing.

DC:0–5

DC:0–5 is increasingly recognized as the premier diagnostic classification system for providers to use in conducting the most complete assessment of infants and young children and in designing effective treatment approaches. As a comprehensive diagnostic nosology with discrete billing codes, *DC:0–5* is helpful for states as they work to address IECMH within policy and practice.

According to a 2023 technical assistance tool created by ZERO TO THREE, states must do the following to ensure effective integration of *DC:0–5* into their systems and infrastructure:

- Determine if Medicaid requires or allows use of the classification system.
- Develop professional competence on *DC:0–5* use.
- Identify the credentials of those allowed to bill for assessment and diagnosis.
- Specify the number of assessment sessions allowed.
- Identify allowable places of service.
- Ensure that staff across the service delivery continuum understand that *DC:0–5* is an accepted classification system.

Illinois Embeds DC:0-5 in Medicaid Policy

Illinois is an example of a state that has *DC:0–5* embedded in Medicaid policy. According to **Alli Lowe-Fotos, Senior Policy Manager at Start Early**, steps to get to this point were first taken more than a decade ago when there was an adjustment to Medicaid administrative rules allowing providers to bill for children from birth to age 3 even before a diagnosis is needed.

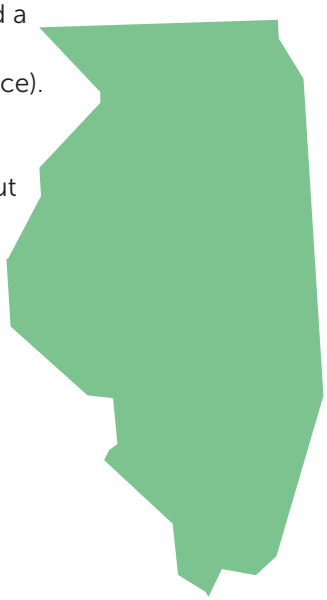
"Since then, and as a result of state participation in the FPP, a lot of advocates have been pushing the state for additional language," said Lowe-Fotos.

The Illinois Healthy Minds Healthy Lives Coalition (composed of mental health advocates who serve the lifespan) added to the forward movement by embedding in legislation preventive services for children under age 21, including a provision allowing for six sessions without a diagnosis. Medicaid then amended their administrative rules so that *DC:0–5* could be used, along with the crosswalk. All of this helped lay the groundwork for an even bigger step toward use of *DC:0–5*.

"In 2020, the Illinois Black Caucus was working on a huge omnibus bill that had many pillars," said Lowe-Fotos. "They reached out to Start Early to provide suggestions for early childhood, and we threw lots of ideas their way, including requiring *DC:0–5* for diagnosis and using the ZERO TO THREE crosswalk for billing. Though we didn't hear back from them for what seemed like a long time, we were thrilled to learn that our recommendations stuck! The Caucus included this in legislation."

This illustrates how continued, relentless pressure from multiple directions can help eventually move policy forward.

IECMH leaders in the state know that it is one thing to have the policy in place and another to ensure that there is a workforce trained in *DC:0–5* to effectively implement the policy. Fortunately, the omnibus bill included funding for the Governor's Emergency Education Relief Fund implemented through the Governor's Office of Early Childhood Development for the development of a train-the-trainer program. They were able to build a network of 15 *DC:0–5* trainers reaching across the state and across systems (e.g., early intervention, higher education, and private practice). Now, more than 500 clinicians in community-based mental health centers, hospitals, and independent practice have been trained in *DC:0–5*, building eagerness among many others to learn more about and incorporate *DC:0–5* into their practices.



"We now see a need for communities of practice and support — ideally like what Minnesota has done — and need to encourage the state agencies to take up the mantel and build such a system for our providers," said Lowe-Fotos.

Comprehensive Training

As Illinois notes and Minnesota has so well established previously, building a qualified, diverse workforce requires ongoing, comprehensive training and support, including reflective supervision and consultation. States are exploring many options to and layers of training — from building train-the-trainer programs that focus on clinical providers to offering training to those in allied professions. To date, Minnesota is unique in paying for staff time to achieve certification in evidence-based practices, which comes with an expectation of continued commitment to the field of IECMH.

Minnesota Invests in Training Licensed Mental Health Professionals

> *"Bringing in outside trainers is expensive, so consider growing your own; it's a tenth of the cost. Also, pay for lost productivity time for people to attend trainings, because it does take away from people actually seeing clients, and community mental health agencies just don't have the funding for someone to NOT have a billable hour."*
>
> — Catherine Wright, Early Childhood Mental Health System Coordinator, Minnesota Department of Human Services

Building upon a decades-long commitment to advancing IECMH, for the past 10 years, **Minnesota** has had a training program in child-parent psychotherapy (CPP) for licensed mental health professionals and their clinical supervisors who serve children insured through state health care programs and have a history of billing Medicaid. The training is offered to cohorts over an 18-month period and includes a mix of face-to-face training and semi-monthly meetings via Zoom.

Recognizing the value of application during training, there is an expectation that each clinician will use CPP with at least four cases and that supervisors will use CPP with at least two cases. Clinicians must also receive regular clinical and reflective supervision throughout the 18 months. The Behavioral Health Division of the Minnesota Department of Human Services covers the cost of tuition for the trainer, with local agencies responsible for the cost of certified clinical supervision, as well as any costs related to required readings and equipment needed to participate in the training and video-record CPP sessions with families.

Reflective Supervision

Reflective supervision/consultation (RS/C) is an essential component of workforce development and support for IECMH clinicians. It is through regular reflective supervision that staff can step back and process their work with families, gain insight and knowledge from their supervisors, consider next steps, and develop a sense of comfort and confidence with moving forward in support of the children and families they serve. It is widely recognized that RS/C enhances program quality by expanding the capacity of providers and organizations to pay more attention to how power, privilege, bias, and diversity show up in their work.

Massachusetts Supports Diversity-Informed Reflective Consultation Groups

According to **Aditi Subramaniam of the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC)**, who leads workforce development efforts in partnership with the **Massachusetts Association for Infant Mental Health (MassAIMH)**, "The responsibility of having access to and receiving reflective supervision should not be on the individual but on the system."

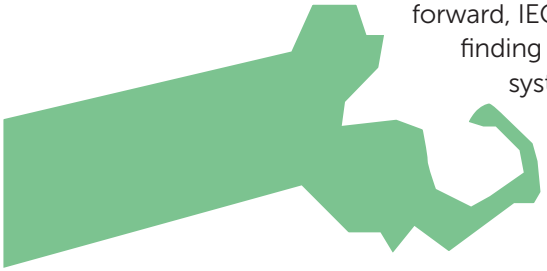
As such, **Massachusetts** developed diversity-informed reflective consultation (RC) groups statewide that have been funded by the Department of Mental Health and through other contracts and grants. The RC groups are coordinated by MSPCC in partnership with MassAIMH.

In 2019, MSPCC and MassAIMH adopted the Michigan Infant and Early Childhood Mental Health Endorsement® system. MassAIMH Endorsement® promotes culturally sensitive, relationship-focused practice and is supported nationally by the Alliance for Advancement of Infant Mental Health. With MassAIMH's endorsement credential rollout, it became vital to build equitable access to reflective consultation.

Leveraging Massachusetts' long history of public-private partnership in IECMH and recognizing the value of RS/C for providers across the infant and early childhood field, the state made an intentional effort to offer RS/C groups to providers from diverse settings (e.g., physical and mental health, early care and education, family support, and home visiting). The work, which is grounded in the Diversity-Informed Tenets for Work with Infants, Children, and Families established in 2018 by the Irving Harris Foundation, includes a mix of didactic training and biweekly group meetings (all virtual), facilitated by MassAIMH-endorsed professionals.

An evaluation of the first year of Massachusetts' RS/C effort found an average 14% increase in providers' self-efficacy in the ability to practice reflectively. To date, the state has offered 28 groups over three years to 208 providers across the state representing diverse scopes of service, race, ethnicity, linguistic capacity, and geography.

Currently, with ARPA funding from the Executive Office of Health and Human Services, MSPCC continues to offer 18 statewide reflective consultation groups. Through public-private partnership in the state, there will be two additional RS/C trainings offered in 2024 centered on the Diversity-Informed Tenets to specifically reach racially and ethnically diverse supervisors in the field. These offerings continue to build pathways and access to MassAIMH endorsement for not only individuals but also systems that are investing in their IECMH workforce. Going forward, IECMH strategy in Massachusetts is focused on finding sustainable resources to build reflective relational systems through offering ongoing reflective consultation groups centered on the Diversity-Informed Tenets to "hold" the workforce serving families and their young children.



Billing

The 50-state survey of Medicaid and IECMH shows that many, but not all, states are now covering IECMH services.

"We are seeing increasing interest in promoting the use of evidence-based treatment models in the states," said **Sheila Smith, Director of the National Center for Children in Poverty** and lead author of the report. "[There is] a growing understanding that *DC:0–5* is best practice because it supports developmentally-based and relationship-focused assessments of infants and young children…and [there is] a commitment to leveraging [early and periodic screening, diagnostic, and treatment], including for medically necessary services like IECMH, even when there is not a diagnosis."

This represents transformational change for the field and is the linchpin for ensuring equity and promoting best practice. Still, rules for billing vary by state, and even when rules are in place, they are not always uniformly implemented. Just because billing may be allowable, that does not mean it is honored or used effectively.

"So much of what I do is train people how to bill for the services they provide," said Wright.

This is a persistent challenge that hopefully abates in time as members of the FPP learning community continue to share their strategies and build "good noise" that will bring about financing policy change.

Washington State Builds System for Supporting Provider Billing

IECMH leaders in **Washington** realized they had a gift — time to think about building a system for IECMH billing that included a robust communication component.

"Even with the best of intentions, state agency staff often are tasked with quickly making and implementing decisions, and this context makes it difficult for communications to be the top priority upfront," said **Christine Cole, IECMH Program Manager, Washington State Health Care Authority**.

Lack of comprehensive communication can create misunderstanding and mistrust and may prevent learning and retooling of policies along the way. So, Cole and her Health Care Authority colleague **Kiki Fabian, IECMH Systems Analyst**, set out to demonstrate that they could implement a policy and communicate it in ways that would help providers in their day-to-day work with children and families. They knew that to be successful, they would need to build relationships with the communications side of the agency, engage the provider community, and commit to an iterative process that was informed by the questions that came from providers as information was shared with them.

Cole and Fabian took time to understand their resources and process — and how to embed IECMH communications work into the agency communication platform. They started with mass emails, then hosted a webinar to explain the new billing policy, and then added "office hours" to answer additional questions and extend the conversation. They updated the Medicaid billing guide and developed a web page for essential resources and archived documents. They are also active on social media, make presentations at partner meetings, and offer tailored technical assistance.

A host of other resources to support IECMH policy and practice have since been developed, including a service model toolkit, crosswalk with *DC:0–5*, a multidisciplinary referral guide for young children, and more. Cole and Fabian's provider communication efforts are really a partnership between agency program staff and communications staff, both working together to ensure that timely information is shared with the provider community and that any feedback is used to retool products and inform the development of new resources.

Like Minnesota, **Colorado** is a state that has made solid progress in billing for IECMH services. **Shannon Bekman, Director of Right Start Colorado**, shared that they are employing billing codes for CPP, using either the child or parent as the client of record. Bekman walked through each phase of CPP and the codes that are allowable for the services provided.

IECMH leaders in **Washington, DC** have also made strides in billing. As a result of growing awareness of the need for IECMH services, recognition that a billing crosswalk was available, and backbone support from Children's National Hospital and the Early Childhood Innovation Network, IECMH leaders in the district worked with the DC Department of Health Care Finance to include the ZERO TO THREE *DC:0–5* billing crosswalk on the DC HealthCheck website. DC HealthCheck is a training and resource hub for primary care providers and other health care professionals who are serving children in the Medicaid program. Those providers who have been trained in *DC:0–5* may use the crosswalk to identify the relevant *DSM-V* and *ICD-10* billing codes.

"Once we focused on it, it didn't take too much time to go through the process together and was very collaborative," said **Sarah Barclay Hoffman, Program Manager, Community Mental Health CORE at Children's National Hospital**.

The expectation is that this resource will support health care providers in the use of developmentally appropriate diagnostic criteria for young children insured by Medicaid, and in attendant reimbursement.

New Partnerships

IECMH leaders are looking to new partnerships and opportunities to extend the reach of supports and services to more children and families. For example, IECMH consultation is increasingly being incorporated into early care and education settings and home visiting models. States are also exploring opportunities to promote IECMH in the child welfare system, including but not limited to implementation of The Family First Prevention Services Act of 2018 (Family First Act) and ZERO TO THREE's Safe Babies™ approach.

While partnerships have typically focused on child-serving systems, there are a few examples emerging of effective partnerships with adult mental health and substance abuse systems. In **Hawaii**, programs are supporting mothers with substance use disorders and their babies, while in **Minnesota**, adult mental health practitioners and substance use disorder providers are being effectively trained and coached to implement Circle of Security principles and ABC.

Efforts in Minnesota to train adult mental health practitioners and substance use disorder providers in Circle of Security and ABC were influenced by data showing that (a) more than 13,000 parents with serious mental illness are currently parenting children, (b) 60% of families in the child protective services system have mental health challenges and/or chemical dependency, and (c) nearly 50% of parents receiving Temporary Assistance for Needy Families (TANF) have accessed mental health services for themselves in the past 12-months (see this link). Further investigation found that many of the parents experienced trauma in childhood.

The efforts in Minnesota were influenced by data showing that infusing IECMH into adult-serving systems would be an effective strategy for supporting families with challenging histories. Following a research study to test effectiveness, the state set out to train Adult Rehabilitative Mental Health Services supervisors and workers in Circle of Security and ABC. The state also began training licensed alcohol and drug counselors in ABC, as well as embedding IECMH in substance use disorder residential facilities. Data continues to be collected to measure the effectiveness of this approach, but based on early evaluations, one can only expect that it is a good thing for the adults involved in these systems, as well as their children.

LESSONS TO GUIDE NEXT STEPS

During the September 2023 policy convening, Cohort 1 and 2 team leads shared their tips for advancing IECMH policy:

Embrace and seek out diversity within your IECMH team to ensure each person or entity represented can leverage their perspective, knowledge, skills, and resources to influence your policy work.

Language matters, so it is essential to consistently use words that resonate with policymakers in your state and to steer clear of IECMH jargon that might not be commonly understood.

Visuals help too, so consider illustrations and infographics to help bring clarity to your team and those you are trying to influence.

Inspire decision-makers about what is possible for IECMH by sharing examples from other states.

Have a roadmap and be nimble and ready so that when an opportunity arises, you have a plan to act upon that can move you toward your ultimate vision of a comprehensive IECMH system.

Be clear about what needs policy change and what does not, because administrative actions can often be an easier lift and achieved more quickly than legislative changes.

Focus on the good kind of messy and have faith that sometimes the best solutions can emerge from periods of chaos.

Sustainability needs to be built into the work from the beginning through conversations with philanthropy as well as local, state, and federal policy leaders.

Decide who holds the work and how it continues as political and agency leadership, financing, and other critical issues are always in flux. This is where a collective impact approach can prove beneficial.

Practice "relentless incrementalism" because, as former Massachusetts Department of Public Health (MDPH) Assistant Director of Early Childhood Services Kate Roper always said, sometimes the big changes we are striving for will come about more quickly via small, intentional steps.

> *"One of the biggest challenges is stressing the importance of IECMH, which is as important to mental health access and services for older children and adolescents. While policymakers understand the urgency of the youth mental health crisis, not very much of the current focus is on infancy and early childhood. We hope in the coming years we can ensure priority is given to early intervention and prevention methods for this population."*
>
> — Sarah Barclay Hoffman, Program Manager, Community Mental Health CORE, Children's National Hospital, Washington DC

These lessons very much align with a recent report by Kay Johnson of Johnson Policy Consulting and Elisabeth Wright Burak of the Georgetown University McCourt School of Public Policy's Center for Children and Families. Johnson and Burak looked at the journey of five states — California, Colorado, Michigan, North Carolina, and Washington — to support IECMH through Medicaid policy and found that:

- leadership matters;
- strategic partnerships make a difference, especially through transitions;
- advocacy is critical and needs to be both inside and outside the agency;
- incremental progress can signal progress and help build momentum;
- Medicaid policy levers need to be understood and used; and
- work is needed across the continuum of care from promotion and prevention to intervention and treatment.

CONCLUSION

Just as babies pass through periods of equilibrium and disequilibrium as they develop, broader society does too. It might be helpful to think about the COVID-19 pandemic as a period of disequilibrium from which we are emerging smarter and ready to grow in new ways that get us closer to our ultimate goals for infants, toddlers, and young children — and their families. COVID surely called attention to racial inequities and structural racism like never before. Health disparities can no longer be ignored. And now more than ever, there is a real appreciation for and commitment to building processes that are equitable.

In the IECMH space, we know that when we build strong, trusting relationships and center babies and their caregivers in all that we do, it is possible to gain clarity on (and make progress with) the work that needs to be done. And like with babies, small steps add up to big change. As Kate Roper reminded us in 2018, relentless incrementalism is the key to long-term transformation. The 30 states that have been a part of the FPP community have whole-heartedly embraced this mindset and are proceeding accordingly — taking one step at a time with babies and their caregivers at the center.

> *"The health of a system is not based on the strengths of the nodes of the system but the interrelationships between them. We can spend lots of time focused on one thing, but to do it in relation to others, that is a systematic relationship that needs to be attended to."*
>
> — Gretchen Hammer, Founder, Public Leadership Group, and former Medicaid Director and Deputy Executive Director, Colorado Department of Health Care Policy and Financing

About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based center working at all levels of government and across multiple issue areas that affect babies and their families. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/our-work/policy-center/.

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