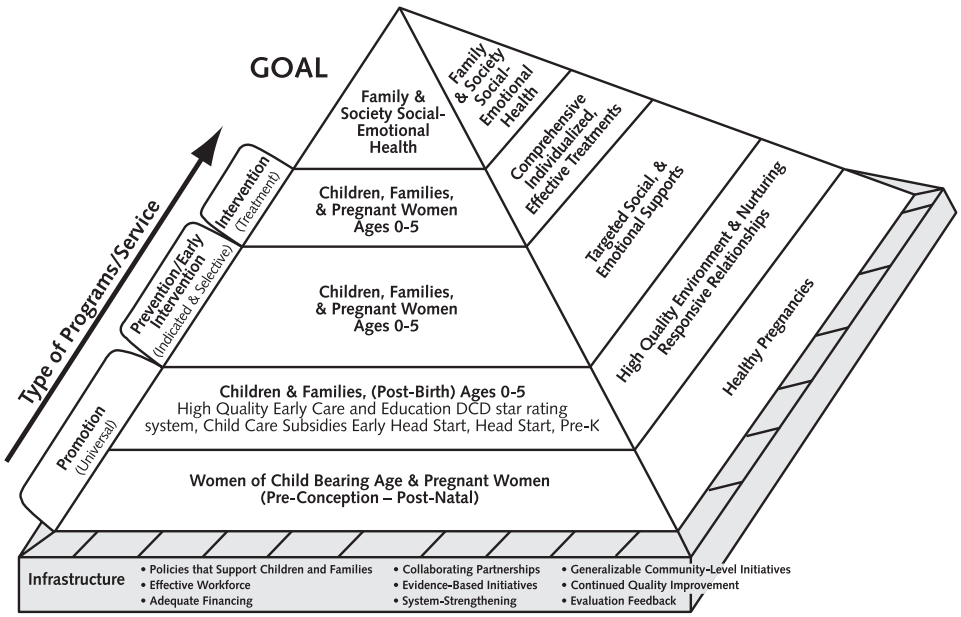
The vision of the Task Force on the Mental Health, Social, and Emotional Needs of Young Children and Their Families is that North Carolina will work to promote young children's social-emotional developmental and mental health by positively shaping and strengthening children's environments and providing a full continuum of services and supports to help all children thrive and become productive members of society. Although elements of this vision are currently in place, challenges remain. In North Carolina, responsibility for promotion, prevention, and intervention services for the mental health of young children are fragmented across a number of different agencies and divisions. This patchwork system for addressing young children's social-emotional development and mental health means that communication is compromised and no single system has leadership responsibility for the social and emotional well-being of North Carolina's children.

The Task Force envisions a coordinated, comprehensive system for fostering the social-emotional development and mental health of young children and their families.

The Task Force envisions a coordinated, comprehensive system for fostering the social-emotional development and mental health of young children and their families that puts children and families first. Currently, North Carolina's network of community services and supports for children and youth with

Figure 2.1
Pyramid for Strengthening Early Childhood Mental Health and Social Emotional Competence in Young Children



Note. This pyramid model conceptualizes the critical building blocks for achieving healthy mothers and healthy children. The front face of the pyramid explains the individuals and families who receive programs and services, which are divided up by the following categories: promotion, prevention, and intervention. The pyramid's side face lists the goals associated with the program/service recipients(s). these are further divided according to the socioecological model of health behavior. The foundation of the pyramid represents the necessary system-building blocks.

serious mental health needs is guided by the System of Care (SOC) framework. The framework's principles are inter-agency collaboration, individualized, strength-based, practices, cultural competence, community-based services, full participation of families at all levels of the system, shared responsibility for successful results.[1] The SOC framework embodies many of the principles that the Task Force envisions guiding a multi-system approach to providing coordinated, comprehensive services and supports to foster young children's social-emotional development and mental health. The Task Force envisions a child-friendly system that actively identifies children with social-emotional development and mental health needs, and works to ensure needs are met within the context of family, culture and community. A family-friendly system works to strengthen families, as the child's primary caregivers and educators, and helps children and families to develop stable, nurturing relationships. A child- and family-friendly system builds upon strengths, and considers families as full participants in designing, implementing and evaluating programs and services for their young children. This system respects the diversity of the population being served by providing culturally, linguistically, and developmentally sensitive services. A child- and family-friendly system provides individualized responses to accommodate different family circumstances and the unique social-emotional and mental health needs of young children and their families. This child- and family-centered system should be grounded in current scientific knowledge of childhood development and should be evidence-based, whenever possible.

In North Carolina, responsibility for promotion, prevention, and intervention services for the mental health of young children are fragmented across a number of different agencies and divisions.

Achieving this vision not only involves improving North Carolina's promotion, prevention, and intervention strategies and systems (as outlined in other chapters) but also ensuring the system for strengthening early childhood social-emotional competence and mental health has a strong infrastructure to support it. Changes at individual levels of the pyramid will not be effective if the infrastructure needed to support those changes is not in place. (See Figure 2.1 and Chapter 3 for more information on the pyramid model.)

Leadership

Currently, multiple North Carolina state and local agencies as well as other organizations work independently to meet the mental health, social, and emotional needs of young children and their families. A number of state agencies within the North Carolina Department of Health and Human Services (DHHS) provide programs and services to address mental health, social, and emotional needs of young children. These agencies include the North Carolina Division of Public Health (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), and North Carolina Division of Medical Assistance (DMA). The North Carolina Department of Public Instruction (DPI) also serves some children ages 3 and older with social-emotional and mental health needs. Additionally Smart Start, in partnership

with the state North Carolina Partnership for Children (NCPC), provides programs to assist young children and their families address mental health, social, and emotional needs. Below are descriptions of the major functions of each of these agencies as they relate to young children ages 0-5 with social-emotional and mental health needs and their families.

Division of Child Development and Early Education
The North Carolina Division of Child Development and Early Education (DCDEE) increases access to early care and education for families, implements quality standards, and collaborates to promote enhanced service delivery of early care and education across the state. DCDEE provides licensing and oversight of early care and education providers, administers early care and education subsidies, oversees the NC PreK program (previously More at Four), and funds the North Carolina Child Care Resource and Referral Council. DCDEE also supports efforts to improve teacher quality and education.

Multiple North Carolina state and local agencies as well as other organizations work independently to meet the mental health, social, and emotional needs of young children and their families.

Division of Public Health
The mission of the Division of Public Health (DPH), within the North Carolina Department of Health and Human Services, is to promote and foster the highest possible level of health for the citizens of North Carolina. Within this scope of work, DPH provides services and supports programs that promote the social-emotional development and mental health of young children and their families. DPH, with state and federal funding, supports programs for pregnant women, families, and children, as well as efforts to build community-wide systems of care to effectively meet the needs of families and children.

Department of Public Instruction
The North Carolina Department of Public Instruction (DPI) is responsible for implementing North Carolina's public school laws and the State Board of Education's policies and procedures governing pre-kindergarten through 12th grade public education. DPI oversees North Carolina's federally-funded Head Start and Early Head Start programs as well as North Carolina's Preschool Program.

Federal Individuals with Disabilities Education Act Implemented by DPH and DPI
Young children ages 0-5 with significant social-emotional and mental health needs may qualify for treatment services or special education and related services through the federal Individuals with Disabilities Education Act (IDEA). Children from 0-36 months with certain levels of delay in one or more areas of development, including social-emotional, or those with certain established conditions, including attachment disorder and fetal alcohol syndrome, may be eligible for services through North Carolina's early intervention program, known as the North Carolina Infant and Toddler Program (ITP).[2] The criteria for qualifying for the ITP are determined by the state, within the federal IDEA Part C guidelines. To qualify for ITP in North Carolina, children with a social-emotional, cognitive, physical, communication, or adaptive developmental

delay must meet a specific level of delay[a] or have an established condition that is shown to have a high probability of a corresponding developmental delay.[3] Established conditions related to social-emotional development include fetal alcohol syndrome (FAS) and attachment disorder.[3]

The Division of Public Health oversees the ITP program at the state level while 17 Children's Developmental Services Agencies (CDSAs) across the state administer ITP for their regions. Children who are eligible and enroll in the program receive service coordination or case management services. Families who choose to enroll their eligible child work with CDSA staff to develop an Individualized Family Service Plan (IFSP), which outlines the needs of the child and the family. CDSA staff then work with the family to coordinate services and supports to meet the needs outlined in the IFSP. Services and supports may include community-based rehabilitative services, social work services, language, occupational or physical therapy, psychological services, or other services. Services for the child are provided through a community network of appropriately qualified providers or, if a provider is not available, the CDSA provides the service. Service coordinators provide monitoring and follow-up to ensure that services are received and are adequate for the child's needs. Evaluations and service coordination are available at no cost to families. Therapeutic services are billed to Medicaid, private insurance, or other third-party resources as applicable. For any family (insured or uninsured), the fee for services is determined according to a sliding fee schedule developed by the state under IDEA requirements.

Children ages 3-5 who exhibit atypical social-emotional developmental characteristics that interfere with their ability to learn may qualify for special education and other related services (such as speech therapy, occupational therapy, physical therapy, transportation, etc.) through the North Carolina Preschool Program, administered by the 115 local education agencies across the state. The Department of Public Instruction oversees the Preschool Program at the state level. Children who qualify for services under IDEA receive services in accordance with federal regulations, regardless of income.

Division of Social Services

The Division of Social Services (DSS) provides training, technical assistance and consultation to the 100 local Department of Social Services agencies that provide programs for children and families including Child Welfare, Family Support, Work First, Child Support, and Food and Nutrition Services. DSS oversees the child protective services program which aims to ensure safe, permanent, nurturing families for children by protecting them from abuse and neglect, while attempting to preserve the family unit. Child protective services also helps protect children without a guardian or whose guardian is unable to provide care.

a The delay must be documented at a minimum of two standard deviations from the norm on a standardized test in one area of development or one and a half standard deviations from the norm in two or more areas.[3]

Medicaid

The North Carolina Division of Medical Assistance (DMA) administers North Carolina's public health insurance programs, Medicaid and NC Health Choice for Children. Children ages 0-5 whose family incomes are less than 200% of the federal poverty guideline (FPG) are eligible for Medicaid. Working women with children whose income does not exceed 50% FPG ($11,500 for a family of four in 2012) and non-working women with children whose income does not exceed 37% FPG ($8,500 for a family of four in 2012) may be eligible for Medicaid. Pregnant women with family incomes up to 185% FPG may be eligible for Medicaid for Pregnant Women. Medicaid for Pregnant Women covers women during their pregnancy until 60 days postpartum.

Individuals with Medicaid receive care through Community Care of North Carolina (CCNC) a non-profit, practitioner-led, patient-centered medical home model that links more than one million Medicaid recipients (80% of all North Carolina Medicaid recipients), and others in the state, to primary care practices. There are 14 autonomous non-profit regional CCNC network entities across North Carolina covering all 100 counties. North Carolina Community Care Network, Inc. (NCCCN) serves as the umbrella coordinating organization for the 14 networks. The CCNC model was developed in accordance with the understanding that many factors affect health, and that networks need to include more than health care providers in order to impact the health of the Medicaid population. Thus, each network incorporates primary care providers, federally qualified health centers and other safety net organizations, hospitals, social services agencies, local health departments, and other community resources that work together to provide high quality care and care coordination for the enrolled population. Primary care providers under contract with CCNC receive a per member per month (pmpm) payment from the state to help manage the care provided to their enrolled patients. In addition, the network receives an additional PMPM payment to help pay for care management, disease management, and quality improvement activities; an informatics system that undergirds the quality improvement initiatives; and other resources needed to improve the care provided to the enrollees.

Programs and services typically exist in silos, and separate children's physical, cognitive, and social-emotional development, rather than treating the components of children's development as integrated and interdependent.

Children ages 0-5 who have certain risk factors may be eligible for care coordination through Care Coordination for Children (CC4C), which is administered jointly by CCNC, DPH, and DMA. The goal of CC4C is to improve young children's health outcomes while reducing their medical costs. Children with special health care needs, children exposed to toxic stress, children in the foster care system, and children transitioning out of the neonatal intensive care unit may receive CC4C services. Families referred to CC4C based on the eligibility criteria receive a comprehensive health assessment, including measures of the parents' life skills that help a family achieve a healthy level of functioning. Then a care manager works with the family to develop a plan of care to meet the desired outcomes. CC4C care managers help families connect with needed services and supports (e.g. health insurance, child care, medical

care, and transportation). CC4C began in 2011 and is still being developed and implemented in CCNC networks across the state.

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) provides the necessary prevention, intervention, and treatment services and supports to people ages three to adult with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families. DMH/DD/SAS funds programs for pregnant and parenting women with a substance related disorder. DMH/DD/SAS administers the federal Community Alternatives Program for Children (CAP-C) and Community Alternatives Program for Individuals with Intellectual/Developmental Disabilities (CAP-I/DD) programs. CAP/C provides cost-effective home care for children who are medically fragile and would otherwise require long-term hospital care while CAP-I/DD helps children, who would otherwise need to be institutionalized, stay in the community or at home.

Because most agencies focus on prevention and treatment, there is little work being done to promote positive social-emotional development for all young children.

Local Management Entities and Managed Care Organization

North Carolina is in the midst of transitioning its publicly funded mental health, developmental disabilities, and substance abuse services system from a loosely organized, fee-for-service system to a more tightly coordinated managed care system. While the transition creates challenges, it also offers new opportunities. Local Management Entities and Managed Care Organizations (LME/MCOs) will be responsible for managing Medicaid and state and federal block grant mental health, substance abuse, and developmental disability dollars. LME/MCOs will receive a pmpm payment to manage all of the mental health, substance abuse, and developmental disabilities services and supports for the Medicaid recipients in their service area. LME/MCOs also receive an allocation of state and federal block grant funds to help provide services to people who are not eligible for Medicaid, and receive varying levels of local funding as well. This provides LME/MCOs with the flexibility to invest more of their money on prevention, early intervention, and effective outpatient treatment—especially if these services can help reduce more costly interventions or hospitalizations. DMA is holding the new LME/MCO entities to higher standards and has built in certain expectations into the MCO contracts. These enhanced performance requirements include community engagement (i.e. engaging community partners), building an adequate network of qualified providers to meet the MH/DD/SA needs of people in their service area, and quality management responsibilities to ensure that high quality services are being delivered.[4]

Individuals with mental health needs ages three to adult who have Medicaid coverage or who are uninsured are referred to the Local Management Entity/Managed Care Organization (LME/MCOs) serving their area.[b] As discussed,

b By 2013, the current system of Local Management Entities will be replaced by a system of Local Management Entity/Managed Care Organizations.

LME/MCOs manage Medicaid funds that are reserved for meeting the mental health needs of the Medicaid population and receive limited state funding to provide mental health services to uninsured target populations. The state determines which consumers can be served, as well as the funding level and eligibility criteria that are required for various funding categories. Individuals receiving state-funded services must pay out-of-pocket expenses according to a state-designed sliding scale based on family income.

Smart Start and the North Carolina Partnership for Children

Smart Start and the North Carolina Partnership for Children, Inc (Smart Start) is a public/private partnership that strives to improve early childhood outcomes by bringing together local stakeholders to improve quality of education, health services, and family supports in their communities. Smart Start was created by the North Carolina General Assembly in 1993 and receives state, private, and local funding to advance a high quality, comprehensive, and accountable system of care and education for every child beginning with a healthy birth. At the state level, Smart Start works to encourage collaboration among the systems that serve children and families, promote high quality early care and education, strengthen families, and ensure that children have access to high quality health care. Thirty percent of Smart Start funding is legislated to go towards subsidizing high quality child care for eligible families.

There is a need for a common understanding across state agencies around the importance of young children's social-emotional development and a commitment to foster such development.

Smart Start works in all 100 North Carolina counties through the North Carolina Partnership for Children (NCPC), which supports 77 private, nonprofit, local partnerships. NCPC Local Partnerships (LPs) receive funding from Smart Start and raise money in their local communities to support children and families. The LPs assess community needs, incentivize quality, provide funding for early care and education subsidies, support family strengthening and early literacy efforts, and promote access to high quality heath care. LPs fund many programs and services that impact the mental health and social-emotional development of young children and their families.

These state-level agencies and organizations have implemented a wide variety of programs to help meet specific mental health and social-emotional needs of young children and their families. (See Chapters 3-5 for examples.) While these programs provide much needed services and supports, they typically focus on very narrow and specific needs of young children and their families (i.e. small service array and restricted eligibility). Programs and services typically exist in silos, and separate children's physical, cognitive, and social-emotional development, or carve out even smaller distinctions rather than treating the components of children's development as integrated and interdependent. For example, the North Carolina Preschool Exceptional Children program provides special education and related services, such as occupational, physical and speech therapy, but does not offer family level services such as counseling or

care coordination for mental illnesses.[c] Because of this narrow focus of most programs addressing children's social-emotional development, the current system contains large gaps. For example, no state agency is responsible for ensuring the social-emotional and mental health needs of children ages 0-36 months are met if they are not eligible for the ITP through DPH and there is no significant infrastructure to provide or support parent education. Furthermore, because most agencies focus on prevention and treatment, there is little work being done to promote positive social-emotional development for all young children.

Leadership at the State Level

Positive social-emotional development is facilitated by efforts to directly support children's social-emotional development and efforts to support and strengthen families' abilities to foster positive social-emotional development. Multiple agencies are involved in meeting the social-emotional and mental health needs of young children and their families; however the services and supports they provide correspond to varying goals and target populations. Further, the eligibility criteria for programs vary, as do the pathways for entry into services and supports. This presents a challenge not only for families in need of services, but also for public health and other social service workers, early care and education providers, pediatricians, other health providers, and others who may try to help children and their families access these services and supports. Much more could be done to ensure that the agencies that serve the mental health needs of young children and their families coordinate their efforts and resources. At a basic level, there is a need for a common understanding across state agencies around the importance of young children's social-emotional development and a commitment to foster such development, regardless of the agency's primary mission. There is also a need to identify which state agency has the primary responsibility to address atypical social-emotional development when present and promote positive social-emotional development for all children. These are two steps that should be taken as part of a process towards building comprehensive, coordinated, and integrated systems at the state and local levels for addressing mental health, social, and emotional needs of young children, and their families. At the state level, the Early Childhood Advisory Council has the funding, goals, and leadership to address the structural problems that are preventing North Carolina from employing a well-integrated and coordinated approach to young children's social-emotional development.

There is also a need to identify which state agency has the primary responsibility to address atypical social-emotional development when present and promote positive social-emotional development for all children.

As part of the federal reauthorization of Head Start, Section 642B of the Improving Head Start for School Readiness Act of 2007 called on governors to create State Advisory Councils on Early Childhood Education and Care for children from birth to school entry.[5] Further federal encouragement for creating early childhood councils came through the American Recovery

c James, V., Exceptional Children Section 619 Coordinator, Office of Early Learning. Oral communication. June 13, 2012.

and Reinvestment Act (ARRA) of 2009 which provided $100 million in non-competitive

three-year grants to state early childhood councils (North Carolina received $3.2 million). Governor Perdue created the North Carolina Early Childhood Advisory Council (ECAC) by executive order in 2010.[6] The goals of the ECAC include developing an integrated comprehensive strategic plan; strengthening the quality of programs and expand opportunities for participation; strengthening public awareness and commitment; strengthening coordination and collaboration; and supporting the implementation of an integrated data system. The ECAC includes the leadership of DHHS, DPH, DCDEE, Office of Early Learning within DPI, DSS, NCPC, the North Carolina Community College System, the University of North Carolina System and other state and local organizations serving young children and their families. The ECAC could benefit from the inclusion of the leadership of DMH/DD/SAS who would bring expertise and focus to young children's social-emotional development and mental health.

The Early Childhood Advisory Council has the funding, goals, and leadership to address the structural problems.

The ECAC led the application effort for North Carolina's successful Race to the Top—Early Learning Challenge Grant that was awarded in December 2011. The ECAC is the Lead Agency for the grant and will manage the approximately $70 million dollar grant to assure that all young children come to kindergarten ready for success in school and life. Many initiatives that will be part of the grant have an impact on social-emotional development including: increasing the quality of early care and education programs, expanding diagnostic screening and referral programs, strengthening the early care and education workforce, and piloting a "transformation zone" of high-intensity supports and building community infrastructure in high-need counties. As part of this effort, the ECAC will be engaged in efforts that will positively impact young children with social-emotional and mental health needs.

With representation from all of the North Carolina agencies and major organizations that play a role in providing services and supports to meet the social-emotional and mental health needs of young children, the ECAC is uniquely positioned to operationalize the vision of the Task Force to build the system and to address the problems that prevent North Carolina from having a coordinated, comprehensive system to support the social-emotional health of young children and their families. Therefore, the Task Force recommends:

Recommendation 2.1: Operationalize a Coordinated System for Young Children's Mental Health

The North Carolina Early Childhood Advisory Council (ECAC) should collaborate with state partners to develop and operationalize a cross-systems plan for all North Carolina agencies that fund and serve the physical, social, emotional, and mental health needs of infants, young children and their

families. As part of this plan, the ECAC should consider ways to promote the social-emotional development of children including:

a) Strategies to fund and facilitate the coordination of programs/services across systems.

b) How to develop shared data systems to facilitate better planning and treatment.

c) Ways to increase access to and reduce barriers to health promotion, prevention and treatment faced by families.

d) Ways to incentivize quality early care and education and the use of evidence-based practices.

e) How to support the development and implementation of cross-system plans in local communities that align with and inform the state goals and plan.

Evidence-Based Initiatives

To make the best use of limited resources, efforts should focus on implementing evidence-based strategies exercising fidelity to proven models, and monitoring and accountability.

North Carolina's approach to meeting the social-emotional and mental health needs of young children and their families should be grounded in developmental knowledge and should be evidence-based whenever possible. Over the past 20 years, our understanding of young children's development has increased dramatically. Research into young children's brain development has shown that experiences in early childhood literally shape the brain's development.[7] Furthermore, research in this area has shown that children's social-emotional development in the earliest years provides the foundation for all other development from the early years into adulthood.[8] Research over this time has also focused on which programs, practices, and services actually lead to achieving intended outcomes. Evidence-based strategies are subject to rigorous evaluation and have been shown to produce positive outcomes. Although definitions vary, typically an intervention is considered evidence-based when it has been subject to multiple evaluations across different populations (including large enough sample sizes to measure meaningful effects), and when the evaluations consistently yield positive results (representing achievement of target outcomes). Interventions that are theory-based are developed based on existing research and theory, but have not been rigorously evaluated to see if they consistently improve outcomes. As discussed, there are many organizations and governmental agencies in North Carolina working to improve the social-emotional development and mental health of young children and their families. However, not all efforts underway are evidence- or theory-based.

Selecting an evidence-based or theory-based program or service is just the first step to successful implementation. State and local agencies and organizations that want to use evidence-based strategies to achieve positive outcomes must

carefully assess their needs, examine existing strategies and their outcomes, review the requirements for successful implementation, and then assess the overall fit of the strategy to both community needs and organizational

structure and ability. After selecting an evidence-based strategy, organizations typically need to make structural and instrumental changes in order to be prepared to initiate new ways of doing their work.[9] The practitioners delivering services need to be trained and a system for further coaching and support must be developed. Once an organization begins implementing a new evidence-based strategy, they must find ways to rapidly address any barriers and deploy solutions. Implementation requires processes, procedures, and systems to be in place to support the new work and practitioners have the skills to deliver the services. For example, Prevent Child Abuse NC currently provides implementation supports to community-based agencies for the Incredible Years programs across the state. These supports include: readiness assessment, training, coaching, evaluation and technical assistance.

Successful implementation of an evidence-based program from selection to full integration and beginning to see outcomes should be expected to take 2-4 years.[9] Research on successfully implementing evidence-based strategies has shown that without strong leadership and policies and systems in place to ensure organizational and practitioner competency, organizations will struggle to achieve the promised results. Organizations that have the infrastructure to support practice, organization, and systems change are more likely to implement with fidelity and achieve positive outcomes.[9]

To make the best use of limited resources, efforts should focus on implementing evidence-based strategies (or theory-based strategies when evidence-based strategies are unavailable or inappropriate), exercising fidelity to proven models, and monitoring and accountability. Through increasing the use of evidence-based strategies, we can maximize our return on investment in this area. Therefore, the Task Force recommends:

Recommendation 2.2: Strengthen and Expand Evidence-Based Programs

The North Carolina Early Childhood Advisory Council (ECAC), in collaboration with state and local agencies, non-profits, and philanthropic organizations, should expand evidence-based strategies to improve young children's mental health for more families in North Carolina. As part of this effort:

a) The ECAC, in collaboration with North Carolina philanthropic organizations, Prevent Child Abuse North Carolina, and state and local agencies, should focus new funding on evidence-based strategies or, if unavailable, theory-based strategies that support and strengthen the social and emotional well-being of infants, young children and their families.

b) The ECAC should work with other partners, including but not limited to representatives from the North Carolina Division of Public Health, the North Carolina Division of Medical Assistance, North Carolina Child Treatment Program, the North Carolina Infant/Young Child Mental Health Association, Prevent Child Abuse North Carolina. The North Carolina Partnership for Children, Inc., and North Carolina Practice Improvement Collaborative to review the needs of the population ages 0-5 for each county in North Carolina, the existing evidence-based programs that are being implemented in North Carolina, evidence about costs and outcomes (e.g. impact on early childhood social and emotional well-being, readiness for school, and other measures of early child well-being), numbers of children and families impacted, sustainability over time, and resources needed to implement these programs with fidelity. Based on this analysis, the group should identify priority programs for expansion to other parts of the state, as well as existing or new resources needed to support this expansion. The ECAC should present this plan to the North Carolina General Assembly no later than May 15, 2015.

c) All funders of strategies to improve the mental health of infants and young children should provide funding to evaluate program implementation in North Carolina to determine the impact on the social-emotional health and well-being of infants and young children and their families.

Data

Data sets play a critical role in both strengthening the current system and expanding the use of evidence-based practices. Although data about young children's physical health are available, there are very few data about children's social-emotional development and mental health available at the state or local level. At the most basic level, there are no state-level data on the prevalence of young children with social-emotional and mental health needs or about the specific nature of these needs. These data would help the various agencies involved in the planning and provision of services. Such data would also be valuable in measuring the effectiveness of investments at the population level. Data on individuals' needs, treatment, and outcomes are also needed to facilitate the move to performance-based incentives and value-based payments, as recommended in Recommendation 5.2.

There is very little data about children's social-emotional development and mental health available at the state or local level.

Additionally, as discussed, there are significant gaps in the data that are collected. The move to electronic health records (EHRs) could improve services for young children and their families, and has the potential to increase the data for program planning and oversight. The American Recovery and Reinvestment Act of 2009 provided funding to encourage primary care physicians and hospitals to adopt and use EHR systems. In addition, funding was provided to states to help create state health information exchanges (HIEs), so that practitioners and other health care providers can share health information electronically. Most primary care practices in the state, and many other types of health professionals, are in the

process of adopting EHR systems. EHRs offer the potential for improved clinical care by making more clinical information readily available and by providing clinical prompts to practitioners treating certain populations. (For example, a pediatric electronic health record could prompt a pediatrician to conduct a social-emotional developmental screen at appropriate visits or identify the need for a missed immunization.) The North Carolina Health Information Exchange (HIE) is not currently set up to aggregate all clinical data on a statewide level. It serves primarily as an information highway to allow practitioners or health care providers treating specific patients to share patient-level data between practices or organizations. In the future, however, the HIE—or other state designated data systems—may be created in a way that could aggregate patient level data to gain a better understanding of social and emotional well-being of children at the population level, as well as the effectiveness of different treatment programs.

While North Carolina has many different data systems that collect specific health data, these data systems are not well-integrated. They often operate in silos, making it difficult to capture a complete picture of the health and well-being of young children and their families. To connect existing data systems, legal and physical infrastructure as well as a linking methodology is required. Currently there are efforts underway to improve cross-system data compatibility. As part of North Carolina's Race to the Top—Early Learning Challenge Grant, the ECAC will be working to create an integrated early learning data system that will link with the existing K-12 data system, develop and implement a Kindergarten Entry Assessment, and conduct annual early childhood workforce studies. [10]Over time, this system has the potential to provide data about the long-term educational impact of various investments in early care and education, including efforts to improve quality and investments in workforce training.

Data is needed to monitor young children's health and well-being, state investments in this population, and children's progress towards positive outcomes. While some data currently exists, lack of compatibility among the various data systems in operation makes it difficult to identify the social-emotional and mental health needs of young children, understand the comprehensive needs of this population, and measure the impact of investments made. Therefore, the Task Force recommends:

Recommendation 2.3: Develop a Data System to Monitor and Evaluate Changes in Young Children's Health

a) The Early Childhood Advisory Council (ECAC), in collaboration with the North Carolina Department of Health and Human Services, North Carolina Department of Public Instruction, Community Care of North Carolina, Center for Child and Family Health and The North Carolina Partnership for Children, Inc., should ensure that data are available and utilized for ongoing assessment of the status of young children's health,

including the social-emotional health of young children and their families by:

1) **Defining the data required for measuring social-emotional health and treatment.**

2) **Identifying sources of data elements that are currently collected.**

3) **Developing a plan to collect data for elements not in existing data systems, and link those data to existing data, with appropriate safeguards to ensure data security and protection of privacy.**

4) **If additional funding is needed, the ECAC should report to the Joint Legislative Oversight Committee on Health and Human Services of the North Carolina General Assembly about resources needed to collect this data no later than June 30, 2014.**

5) **Establishing an ongoing monitoring system to measure population-based changes in health, with the ability to look at physical, social-emotional, and mental health independently.**

b) **Data should be used to identify outstanding needs and treatment gaps. As this information becomes available, it should be used to modify priorities for funding for new evidence-based practices to address the largest unmet needs. Data should also be used to monitor the effectiveness of interventions.**

Workforce

Early Care and Education Workforce

North Carolina's early care and education workforce includes approximately 50,000 individuals, 35,000 of whom work directly with the more than 260,000 children enrolled in more than 8,000 regulated child care facilities around the state.[11] Women make up the vast majority of the workforce. This workforce typically earns low wages and few benefits. The early care and education workforce represents a wide range of education levels, and most staff are parents themselves. There are many educational pathways for the early care and education workforce. The professional competencies, standards, and education requirements vary by the type of early care and education setting. Regulated facilities and programs, including early care and education programs, Early Head Start and Head Start programs, and NC Pre-K, have specific staff qualifications and education requirements. These requirements are developed and monitored by DCDEE, the Office of Head Start, and the Department of Public Instruction, respectively.

Within regulated child care facilities, the lead teacher for each classroom must have, at a minimum, a high school diploma or GED and a North Carolina Early

Childhood Credential. Assistant teachers must have, at a minimum, a high school diploma or GED. Program administrators must have at least a Level 1 North Carolina Early Childhood Administration Credential which can be obtained by taking two required classes and seven additional hours of coursework in early childhood education. Head Start program teachers must have an associate degree or higher in early childhood education or related field. As of September 2013, at least 50% of Head Start teachers will be required to have a bachelor degree or advanced degree. NC Pre-K teachers must have a bachelor degree and have or be working towards Birth-to-Kindergarten (BK) Licensure. All NC Pre-K assistant teachers must have a high school diploma or GED and have or be working towards an associate degree. All administrators and staff working in regulated early childhood settings must also meet professional development requirements for continuing education.

More than 260,000 children are enrolled in more than 8,000 regulated childcare facilities around the state.

The Early Childhood Credential can be obtained by taking one course, "Intro to Early Childhood Education," that is offered by all 58 campuses of the North Carolina Community College System (NCCCS). The NCCCS also has an elective (EDU 154) focused on social-emotional behavior and development, but it is not a requirement and may not be offered by all the NCCCS schools with two-year early childhood degrees. North Carolina's colleges and universities with four-year degree programs in early education are geared toward graduates obtaining licensure. The BK License credentials teachers to work with children ages 0-5 and has pre-service and in-service requirements including coursework on child development, assessment, intervention, and children considered exceptional.

North Carolina has a number of programs and incentives to support and promote higher levels of teacher education. While the basic education requirements for regulated early care and education programs are low, higher levels of staff and administrator education are encouraged and rewarded through the Quality Rating and Improvement System.[d] For example, to obtain the highest staff education score, 75% of lead teachers must have an associate degree in early childhood or a related field and 50% of assistant teachers must have the credential and six hours of early childhood coursework.[12] The Child Care Services Association (CCSA) provides educational scholarships and salary supplements to child care professionals through the T.E.A.C.H. Early Childhood® Project and Child Care WAGE$® Project to increase education and reward higher levels of education respectively.[13]

The CCSA is one of three organizations that make up the North Carolina Child Care Resources and Referral (CCR&R) Council. The CCR&R Council, with funding from DCDEE and others, funds ongoing professional development and training in 14 regions across the state. Professional development and training classes are offered on a wide variety of topics including managing challenging

d The five star rating system weighs a number of factors that impact the mental health and social-emotional development of young children including staff/child ratios, staff education, program quality, curriculum, and staff/child interaction.

behaviors, playground safety, early intervention services, and choosing a curriculum. In addition to providing professional development opportunities, the CCR&R Council also provides resources to help early care and education providers promote young children's social-emotional development. The Infant Toddler Enhancement Project provides regional infant-toddler specialists who work with child care providers, families, and community agencies to improve the quality of infant-toddler care by providing training, technical assistance and an increase in access to resources. The Promoting Healthy Social Behaviors in Child Care Settings program supports statewide social-emotional development specialists who provide resources, technical assistance, and training to assist teachers in promoting positive social-emotional development and in dealing with challenging behaviors.

We need to increase understanding of the role of social-emotional development among early care and education professionals.

DCDEE and Smart Start also provide resources to help early care and education providers promote young children's social-emotional development through funding for training and technical assistance on how to implement the pyramid model developed by the Center on the Social and Emotional Foundations for Early Learning (CSEFEL). The CSEFEL training and technical assistance provide evidence-based practices for promoting young children's social emotional competence. It also provides training on how to prevent and address challenging behavior. Additionally, some local NCPC partnerships fund child care health consultants who assist early care and education programs in creating environments that support healthy development.

The ECAC will work to strengthen the early childhood workforce as part of North Carolina's Race to the Top—Early Learning Grant. Efforts will be made to increase early childhood teacher education requirements, improve professional development, increase access to high quality NCCCS coursework, and strengthen coordination of professional development opportunities. As part of this work, the professional development delivery capacity of CCR&R Council will be expanded with a particular focus on providing trainings on the revised Early Learning and Development (ELD) standards and the Classroom Assessment Scoring System (CLASS) instrument to improve instructional practice. The ELD standards outline a common set of age-appropriate learning and developmental skills and abilities that are important for the successful development of young children ages 0-5, and provide ideas for fostering those skills and abilities. One of the domains covered in the ELD standards is social-emotional development, which will be an update to prior standards.[e] The CLASS instrument is a tool to evaluate the quality of teacher-child interactions. Used correctly, the CLASS instrument can help strengthen the relationships between young children and their teachers. In addition, as part of the Early Learning Challenge Grant, the ECAC will work with partners to develop the statewide infrastructure support for local child care health consultants.

e The ELD standards will replace the earlier "Foundations: Early Learning Standards for North Carolina Preschoolers and Strategies for Guiding Their Success." The new ELD standards include children ages 0-2 and include both learning and developmental milestones where "Foundations" did not.

North Carolina has a strong foundation for educating its early childhood workforce through the higher education system, the CCR&R Council, and the networks of consultants who can work with providers in the field. While this system includes some information involving young children's social-emotional development and mental health, there is a need for greater focus on this domain of young children's development. Therefore, the Task Force recommends:

Recommendation 2.4: Increase Understanding of the Role of Social-Emotional Development Among Early Care and Education Professionals

The Early Childhood Advisory Council should ensure that funding for early educator development and quality improvement through the Race to the Top—Early Learning Challenge Grant is maintained. Additional efforts should be made to align early educator professional development standards at the pre-service, in-service, and continuing education levels with the Early Learning Development Standards. In particular, there should be an increased focus on the social-emotional domain of development. To make these changes:

a) North Carolina Community College System (NCCCS) and North Carolina universities should embed Early Learning and Development Standards into their early childhood education programs.

b) NCCCS should expand the Early Childhood Associate Certificate and Degree core requirements to include EDU 154 Social/Emotional/ Behavioral Development.

c) The Division of Child Development and Early Education should require all early care and education licensed facilities to have at least one administrator or staff trained on the Early Learning and Development Standards and Curricula by June 30, 2016.

d) At least 20% of the trainings provided by the Child Care Resource and Referral Council should have social-emotional development as the main focus. Training should be made available to families and staff in all early care and education settings.

The Workforce Providing Social-Emotional Development and Mental Health Services and Supports to Young Children and Their Families

The workforce providing social-emotional development and mental health services and supports to young children and their families is quite diverse, made up of physical and mental health professionals and paraprofessionals. This workforce includes individuals outside the field of mental health who help identify children in need of evaluation or intervention and individuals

providing intervention and treatment services for young children with social-emotional and mental health needs. The workforce providing social-emotional development

and mental health services, and supports includes public health and other social service workers, counselors, nurses, psychologists, psychiatrists, pediatricians, and family practitioners as well as developmental specialists, parent educators, and family partners. While many workforce members have some level of professional training, very few clinical training programs offer specialization in early childhood.[14] Instead, most of the workforce gains knowledge through on-the-job training and professional development. Given the diverse backgrounds of these professionals and the lack of standardized training and education, it is difficult to know how qualified this workforce is to work effectively with young children with social-emotional and mental health needs and their parents.[14]

There is a need to define the core competencies needed by the workforce providing mental health services and supports to young children and their families

Because the workforce comes from diverse backgrounds with varying education and training requirements, it would be difficult to try to standardize their education and training experiences. However, there is a need to ensure that the workforce is qualified and prepared to meet the social-emotional and mental health needs of young children and their families within the family friendly system that the Task Force envisions. Additionally, with the move towards measuring treatment outcomes (See Recommendation 5.2, Chapter 5.), comes a need to ensure the workforce possesses competencies that lead to better outcomes. Other states facing similar challenges in building mental health services capacity for young children have begun defining professional competencies and infusing them into training programs.

There is a need to define the core competencies (e.g. knowledge, attitudes, and skills) needed by the workforce providing mental health services and supports to young children and their families in order to provide effective and developmentally appropriate care. For example, individuals providing early intervention and treatment services to this population should demonstrate knowledge of family dynamics; understand strategies for facilitating change and growth in families with significant relationship problems; be able to identify capacities and strengths, developmental delays, and emotional disturbances in infants and young children; and understand the impact of chronic stress on development. Once core competencies are defined, efforts could be made to align training and education programs with these competencies. Subsequently, there would need to be a way to verify individual proficiency across these competencies areas—whether through accreditation, certification, licensure, or some other means.

The newly formed North Carolina Infant and Young Child Mental Health Association (NCIMHA) is dedicated to promoting and supporting the social-emotional development of all young children. Members include psychologists, pediatric nurse practitioners, licensed clinical social workers, licensed professional counselors, occupational therapists, and other professionals

serving the mental health needs of young children and their families. One of the goals of the NCIMHA is to serve as "an interdisciplinary organization to facilitate, support, and encourage cooperation, coordination and collaboration among

those concerned with promoting the optimal development of infants, toddlers, young children, and families."[15] As such and with funding support, the NCIMHA is uniquely poised to bring together the diverse group of professionals serving the mental health needs of young children and their families to examine ways to develop and strengthen the mental health workforce serving young children. Therefore, the Task Force recommends:

Recommendation 2.5: Develop the Workforce that Provides Social-Emotional and Mental Health Supports and Services

The North Carolina Infant and Young Child Mental Health Association should work with the Division of Medical Assistance, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Division of Public Health, Division of Social Services, University of North Carolina System, Area Health Education Centers, North Carolina Psychiatric Association, North Carolina Psychological Association, North Carolina Pediatric Society, North Carolina Families United, North Carolina Social Services Association, and others to identify the training needs and address barriers to developing an effective workforce to meet the clinical needs of young children ages 0-5 and their families. As part of their work, this group should consider:

a) The competencies that support the range of physical and behavioral health professionals and paraprofessionals who address the social-emotional and mental health needs of young children ages 0-5 and their families.

b) How to incorporate these competencies into pre-service and in-service education through credentialing or certification courses.

c) How these competencies can be demonstrated.

d) The need for clinical training sites and clinical training supervision for this workforce.

e) Whether a young child certification system is needed to document provider competence to effectively address the socio-emotional and mental health needs of young children and their families.

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