Rhode Island Infant and Early Childhood Mental Health Plan

Executive Office of Health and Human Services
Secretary Richard Charest
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Executive Summary

In 2022, the General Assembly directed the Executive Office of Health and Human Services (EOHHS) to form a Taskforce to develop a plan to improve the promotion of social and emotional well-being of young children as well as screening, assessment, diagnosis, and treatment of mental health challenges for children from birth through age five with Medicaid coverage.

EOHHS carried out this work with the help of an interagency team that has collaborated since 2020 to write and implement the Rhode Island Behavioral Health System of Care for Children and Youth. EOHHS determined that this Infant and Early Childhood Mental Health (IECMH) Taskforce would be a public/private entity connected with the System of Care Steering Committee EOHHS was creating, and the Plan would be a component of the broader System of Care plan that was completed in 2022.

The General Assembly gave EOHHS specific direction to develop an Infant and Early Childhood Mental Health plan that:

- Promotes developmentally appropriate screening, assessment, diagnosis, and evidence-based and evidence-informed parent-child dyadic therapies for children from birth through age five.
- Identifies mental health promotion and prevention-related parenting support programs, particularly evidence-based or evidence-informed parent-child programs supporting social and emotional well-being.
- Allows effective screening, evaluation, and treatment over multiple visits with a qualified practitioner in various settings, including children's homes, child care and early learning programs, schools, and clinical and other professional settings.
- Establishes a registry of trained infant and early childhood mental health professionals that can be a resource across health care, education, and human service settings.
- Strengthens infant and early childhood mental health skills, knowledge, and practices of all providers who work with young children (birth through age five) in health care, mental health care, early childhood, and child welfare service sectors.
- Addresses and responds to the intergenerational effects of racism, economic insecurity, and toxic stress that influence the health and mental health of parents/caregivers, babies, and young children.

After a significant number of meetings and collection of community input, described throughout this document, EOHHS presents this Infant and Early Childhood Mental Health Plan.

Because of the critical importance of centering equity - especially racial equity - in discussions about the mental health of children and families, the plan begins with an Equity Statement and then lays out Core Principles that EOHHS followed in the development of the plan. The plan also provides an overview and descriptions of Infant and Early Childhood mental health, including key data on demographics and utilization of services, information about the workforce, and details on the organizational landscape. EOHHS received extensive information from parents, community partners, and providers that summarizes the key themes.

The Plan includes ten priorities, listed below, that came directly from community partners and participants through six Taskforce content meetings and family focus groups. Under each priority, EOHHS presents a set of detailed recommendations that policymakers and others can pursue. The

primary focus of these recommendations is to ensure that Rhode Island children's mental health is supported by promoting and enabling communities and families with young children to thrive.

Figure 1: Infant and Early Childhood Mental Health Priorities

Priority 1. Implement a Coordinated Workforce Development Strategy (IECMH Clinicians)
Priority 2. Implement Coordinated IECMH Workforce Development and Support: Broader Early Childhood Workforce
Priority 3. Advance Policies to Address Underlying Inequities and Root Causes of IECMH Challenges
Priority 4. Promote Universal Awareness of and Access to IECMH Supports
Priority 5. Screen, Evaluate, and Connect Parents and Caregivers to Treatment
Priority 6. Screen and Refer Children to Evaluation and Treatment for IECMH Challenges
Priority 7. Ensure a Robust and Coordinated System of Preventive Interventions and Support
Priority 8. Provide Infant Early Childhood Mental Health Consultation (IECMH Consultation) in Early Childhood Settings
Priority 9. Expand Access to Evidence-Based, Family-Based Dyadic IECMH Treatment
Priority 10. Promote Developmentally Appropriate Assessment and Diagnosis

The Plan ends with suggestions on Next Steps for implementation – and shares a set of related plans and other background information in a set of Appendices to ensure that this implementation is aligned with existing activities to support our children and families.

**Planning Process Methodology**

EOHHS is grateful for the large number of participants in the planning process. A total of 97 community partners across multiple sectors participated in the Taskforce. Participating partners included the RI Association for Infant Mental Health, pediatric and perinatal health care, mental health care, child psychiatry, Child Welfare, Early Intervention, family visiting, early care and education, advocacy organizations, Medicaid Managed Care Organizations (MCOs), Medicaid Accountable Entities, and families with young children. For a full list of participants, see Appendix A.

These participants took time out of their days to share their expertise, experiences, and wisdom about the needs of our most vulnerable children - the babies, toddlers, and young children who are the future of our State. EOHHS is tremendously grateful for every person who participated and provided important feedback in this time consuming process.

The planning process took place over seven months, starting with an introductory meeting in November 2022 to provide an overview of infant and early childhood mental health, review the current landscape of services and supports, and review the planned process. Over four meetings, the Taskforce discussed each component of the infant and early childhood services and supports (promotion, prevention, assessment, diagnosis, and treatment) and considered workforce needs. For each meeting, the Taskforce discussed:

- What is happening right now? What is the current state analysis?
- Nationally, what is the best practice?
- What must the state do to address and respond to the intergenerational effects of racism, economic insecurity, and toxic stress within these topics?

- How should we plan for the future? What would the group consider for the final report recommendation?
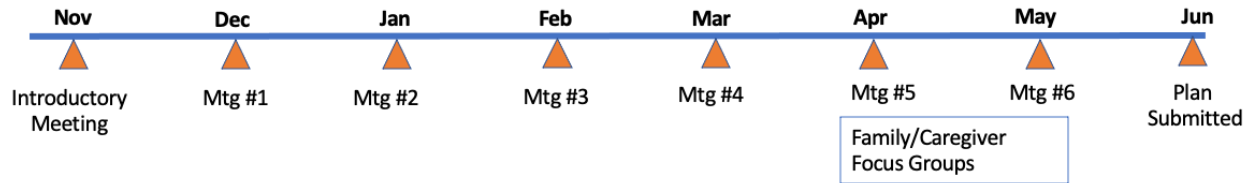
Taskforce participants provided input between meetings using a cloud-based whiteboard called Padlet, to add feedback and ideas and comment on others' posts.

The Taskforce also hosted six one-hour focus groups during April with parents and caregivers of young children. The focus groups were hosted over Zoom with live, simultaneous translation. Participants were given a $50 gift card to compensate them for their time. The focus group sought families' perspectives on the following questions:

- Have you had concerns about your child's behavior or development?
- Were you able to get the help you wanted? If not, what made it hard?
- What would have helped?
- Who would you feel comfortable talking with about your concerns? E.g., someone in your child's preschool or child care? Your child's doctor's office? Anyone else?
- Is there anything else you would like to share?

A total of 36 parents/caregivers participated in these focus groups. A complete summary of the key themes can be found in Appendix D.

EOHHS finalized the plan during the last two Taskforce meetings by refining the focus areas and strategies based on the focus group input and Taskforce feedback, along with hours of discussion to ensure clarity, consistency, and viability across the plan.

Acknowledgments & Appreciation

EOHHS gratefully acknowledges the leadership and particular dedication of several community partners who played critical roles in the work of the Taskforce, along with the ongoing support and collaboration of our interagency colleagues in state government and the commitment and talent of our staff and consultant team.

Thank you to Rhode Island KIDS COUNT, the Rhode Island Association for Infant Mental Health, and the Washington County Coalition for Children. KIDS COUNT staff contributed tremendously to the value of this report, and EOHHS very much appreciates the time they took throughout the process to share their insights and knowledge. They also introduced us to an extremely helpful team of national experts, who played a key role in the thinking and planning behind this report. Thank you to:

- Therese Ahlers, MS, MPA, IMH-E®, Senior Technical Assistance Specialist for Infant and Early Childhood Mental Health, ZERO TO THREE
- Elisabeth Wright Burak, Senior Fellow, Georgetown University's McCourt School of Public Policy's Center for Children and Families (CCF)
- Sheila Smith, Early Childhood Researcher, National Center for Children in Poverty
- Daniel Ferguson, Research Associate & Project Manager, National Center for Children in Poverty

EOHHS' interagency partners work with us daily to improve the lives of children and families in Rhode Island. Our colleagues are smart and dedicated public servants from the Rhode Island Department of Health, the Department of Children, Youth, and Families, the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, the Rhode Island Department of Education, the Department of Human Services, and Office of Governor Daniel J. McKee. EOHHS is tremendously grateful for their committed partnership.

We appreciate the work of the System of Care staff team, who is driven by their commitment to improving the lives of children and families every day:

- Marti Rosenberg, Director of Policy, Planning, and Research
- Ellie Rosen, Director of the Rhode Island Children's Behavioral Health System of Care
- Susannah Slocum, Lead Evaluator of the Rhode Island Children's Behavioral Health System of Care
- Susan Lindberg, Senior Project Manager of the Rhode Island Children's Behavioral Health System of Care
- And our primary consultant team, Elevated Results: Kristin Lehoullier and Jen Oppenheim

Finally, EOHHS Assistant Secretary Ana Novais (and Acting Secretary from 2022 through Spring 2023) has been a driving force behind EOHHS' focus on making transformational changes in our behavioral health system across the lifespan. We thank her for her leadership and commitment to the health of Rhode Island families. The team looks forward to working with her and with EOHHS Secretary Richard Charest on the next steps to improve the mental health of all of Rhode Island's children.

Infant and Early Childhood Mental Health Equity Statement

The recommendations of this Taskforce intentionally consider the foundational components of well-being. According to the World Health Organization, well-being is a positive state experienced by individuals and societies. Like health, it is a daily life resource determined by social, economic, and environmental conditions. Well-being encompasses quality of life and the ability of people and societies to contribute to the world with a sense of meaning and purpose. Focusing on well-being includes attending to the equitable distribution of resources, overall thriving, and sustainability. A society's well-being can be determined by the extent to which individuals in society are resilient, build capacity for action, and are prepared to transcend challenges.

The recommendations seek to improve the overall health of children in Rhode Island, particularly those most disenfranchised. A social justice approach to improving disparities upholds resource allocation to those most susceptible to poor outcomes. The Taskforce acknowledges the history of institutional and structural racism and its impact on health. We are committed to improving the quality of life for all Rhode Island residents while eliminating the inequities that threaten the lives of low-income communities and communities of color disproportionately affected by substance use, chronic diseases, and their risk factors.

The first 1,000 days of life are a sensitive and critical period for an infant's brain and biological development, significantly impacting long-term cognitive, physical, and socio-emotional growth. This timeframe is even more critical for Black babies living in the U.S. The legacy of enslavement and racism embedded in policies in housing, education, healthcare, the justice system, policing, politics, and other facets of American society, has caused considerable damage to Black people, including their young children. Despite this structural racism, Black families have shown remarkable fortitude. These recommendations seek to uncover data through the discovery of strengths and amplify factors that promote resilience in communities lending to well-being. This Taskforce acknowledges that unless the structural, social, and environmental determinants of health are acknowledged and addressed, it is impossible for the highest level of health to be realized for infant and early childhood populations in totality.

Infants and young children as a population do not exist in a vacuum. In these recommendations, the Task Force considers the links between community, family, and parental health to that of their children. Mental health must therefore be considered a dynamic state whereby multiple layers of intersecting social and environmental factors influence individual cognitive, psychosocial, and physical development. This starts in the womb, with a parent's mental and physical health status during pregnancy impacting the developing fetus. Infants and young children are greatly affected by their relationships with their caregivers, home environment, and community. Factors such as neglect or abuse in childhood, unemployment, poverty, and physical health problems in adulthood, and levels of social and community connectedness in later life all have a part to play in influencing an individual's ability and opportunity to access mental health protection, such as can be found in positive relationships, quality employment, and healthy living conditions. This picture is often complicated by the role of issues such as intergenerational trauma and the far-reaching and sustained impact of adversity in childhood, which again suggests that upstream interventions are critical when taking a public mental health approach. As new data - quantitative and qualitative - emerge, as well as best and promising practices on addressing IECMH disparities, this Taskforce encourages the evolution of these recommendations acknowledging that the science of effectively addressing disparities is behind the data on disparities.

Infant and Early Childhood Mental Health Core Principles

During the planning process, discussions with Taskforce participants revealed the following guiding principles for Rhode Island's Infant and Early Childhood system development. The State is committed to building a system where:

- Children's mental health is first and foremost about supporting, promoting, and enabling communities and families with young children to thrive.
- When a child needs support for mental health or behavioral challenges, all families can equitably access a family centered IECMH care system (as a component of the Rhode Island Behavioral Health System of Care for Children and Youth).
- The IECMH system of care empowers families by making them full partners in the planning and delivery of services.
- The IECMH system of care actively works to eliminate racial and ethnic disparities and class inequities in all actions and responses. This includes:
  - Fostering inclusion and countering the effects of discrimination and marginalization jeopardizing healthy development.
  - Providing culturally competent, linguistically responsive, strengths-based, trauma-informed services that respect how different cultures and ethnic groups may have different views and interpretations, both of the concepts of children's social and emotional development and wellness and the type of system needed to address the needs of young children and their families.
  - The IECMH system of care strives to strengthen and preserve the child's primary attachment and caregiver relationships.
- The IECMH system of care prioritizes the universal promotion of healthy social and emotional development of young children and family well-being beginning prenatally.
- The IECMH system of care emphasizes prevention and early intervention through timely screening, identification, and delivery of services to maximize opportunities for babies and young children to thrive.
- The IECMH system of care supports the stability of the child's family, whether biological, adoptive, or foster, including attention to social determinants of health and mental health.
- Services and supports in the IECMH system of care are evidence-based/informed and embedded in a wide range of settings.
- Services and supports in the IECMH system of care are delivered by a high-quality, well-trained, racially and ethnically diverse workforce reflective of the communities they serve.
- Services and supports are coordinated, aligned, and integrated at the state and local/community levels.
- The workforce is supported with appropriate compensation and workloads, training, consultation/coaching, and attention to wellness to increase continuity and stability of care and avoid burnout and turnover.

Note on the Use of the Terms 'Parents' and 'Families' in the IECMH Plan

In this Plan, parents and families are central figures given tremendous importance based on what we know about the critical role of caregivers in nurturing the social-emotional development and mental health of young children, particularly in the first few years of life. The Taskforce recognizes that families can take many forms and are conceptualized very differently by different racial and ethnic groups and

within different subcultures. Families are defined very broadly to include individuals who are – due to a biological tie, legal connection, or chosen role – in a parenting or caregiving relationship with a young child and part of the child's environment and experiences in a significant or ongoing way. It is also important to note that our use of parenting people makes it clear that the gender identity of birthing parents is not assumed. It is the understanding of this body that a primary caregiver is not defined by biology or a legal relationship so much as the role of the adult in caring for, responding to the needs of, and providing stimulating and varied learning and play opportunities for young children, as well as meeting basic needs for food, shelter, safety, and so on. This Taskforce also recognizes the important role of male caregivers/parents, who are sometimes left out of important conversations with IECMH providers and programs, as well as parents who may be struggling with their own mental health or addiction challenges but who nevertheless bring many strengths and desire for their children to thrive. Parents and other family members should be valued for their individual strengths, wisdom, and understanding. They should be recognized for the ways in which they contribute to the well-being of the child. EOHHS also recognize the role many other individuals can play in supporting primary caregivers of young children who need support and nurturing in carrying the heavy burden they may experience in raising young children, often in challenging situations.

Overview of Infant and Early Childhood Mental Health

IECMH refers to the social and emotional skills children develop in their first years of life. These skills are the foundation for mental health across the lifespan and include the capacity to form close and secure interpersonal relationships; experience, regulate and express a range of emotions; and explore the environment and learn. These skills are critical "building blocks" for other skills that children need when they enter school, such as listening and paying attention, following directions, and managing their emotions well enough to engage in learning and master increasingly complex cognitive and linguistic tasks. Children are at risk for a range of negative outcomes when they do not have early nurturing experiences that help them develop these skills or when genetic or environmental adversities compromise development. Young children who do not achieve early social and emotional milestones are more likely to perform poorly in the early school years and are at higher risk for school problems and juvenile delinquency later in life.

The earliest years are considered a critical window for development because the brain is growing most rapidly, and other core biological systems are developing. Early experiences become embedded in these brain and biological systems, impacting health and mental health throughout life. Critically important ingredients to helping children develop a strong social and emotional foundation include primary caregivers who provide nurturing, consistent, and responsive care; living in safe and economically secure environments; and high-quality environments for learning. Nurturing and responsive caregiving relationships are critical in promoting healthy development and mitigating the impacts of adversities on children's brains and bodies when they occur. These relationships - whether with parents/caretakers, grandparents, or child care providers - help children develop the ability to adapt and cope when faced with adversity. However, when these protective relationships are absent or disrupted, there is little to counterbalance the negative effects of adversity, creating poor outcomes.

Under challenging circumstances, young children can and do develop mental health problems. Young children who live in families dealing with parental loss, substance use, mental illness, or exposure to trauma are at heightened risk of developing mental health disorders during infancy, early childhood or later, and the stressors of poverty can multiply these risks. Between seven and ten percent of children under five experience clinically significant emotional, relational, or behavioral problems. Additionally, some children will show signs of developmental disabilities, such as autism spectrum disorders, or the consequences of in-utero or environmental exposure to drugs or alcohol in early childhood. Whether these issues result from social, environmental, genetic, or biological predispositions, the earlier they are recognized and addressed, the better the chances the child can achieve their potential to be healthy and successful in life.

The good news is that the science and tools exist to create early childhood systems of care that promote the healthy development of all young children, identify children who are at risk for developing behavioral challenges, and support them and their families in building resilience and addressing some of the social and environmental stressors that negatively impact their wellbeing. Tools also exist for screening and carefully assessing children who are experiencing social or emotional issues, formulating a holistic understanding of the child and their functioning in the context of developmental stage, family, caregiving environments, community, and culture. This process of assessment can lead to recommendations for evidence-based, strengths-based, and culturally respectful interventions that support families, and when appropriate, may result in a diagnosis. Evidence-based treatments for children and their families have proven successful in improving relationships, improving young children's social skills and functioning, and decreasing behavioral issues associated with negative academic, social,

and mental health outcomes in later childhood, adolescence, and adulthood. Effective early childhood interventions address symptoms as well as underlying social and economic root causes of behavioral challenges.

This plan for the mental health of Rhode Island's infants and young children that has resulted from the work of the Infant and Early Childhood Mental Health Taskforce aims to recommend strategies that will strengthen the early childhood mental health care system throughout Rhode Island equitably for all children and families so that the long-term costs to individuals, communities, and society can be greatly reduced.

Continuum of Services and Supports

A robust and comprehensive early childhood care system supports all caregivers in their efforts to nurture young children and help them reach their developmental potential, learn, grow, and thrive. EOHHS has defined this system of care in our overarching Rhode Island Behavioral Health System of Care for Children and Youth, released in 2022.

EOHHS adds to our shared understanding of this system of care with this plan. A comprehensive system of care includes the following elements:

Mental Health Promotion
Mental health promotion involves activities that support all young children's healthy social and emotional development. Mental health promotion efforts are universal and include the education and support of all caregivers interacting with young children to equip them with the knowledge and skills to promote mental health. Mental health promotion activities should:

- Support families in creating nurturing and responsive relationships and safe and stable home environments
- Ensure that the other environments in which children live, learn, and play are healthy and safe (e.g., child care settings, neighborhoods, parks, libraries)
- Address social and environmental factors that can interfere with healthy development (e.g., community violence, racism and other forms of discrimination, lack of access to safe housing, jobs, food, and clean water).

Mental health promotion activities include universal social and emotional screening to identify and address behavioral or developmental concerns and the implementation of social-emotional learning curricula in early care and education settings. Many communities also promote IECMH through public education campaigns that raise awareness about the importance of early childhood mental health, early relational health, and the impacts of toxic stress and adversity on young children's development. Educational campaigns can be tailored to early childhood providers, parents, and key decision-makers, helping to demystify IECMH and destigmatize mental health and mental health services.

Screening
Social-emotional screening at regular intervals throughout early childhood is critical to promoting mental health for every child. It can be instrumental in the early identification of social-emotional or behavioral concerns. Evidence-based screening tools are inexpensive to use and require minimal training to implement. Sometimes screenings can alert a parent and provider that a child needs additional support and that extra time and resources can help them acquire skills where they may have been struggling. At other times, screening results suggest that an emerging problem is concerning enough that further investigation is needed to help better understand the nature and scope of the issue. In such cases, a trained infant and early childhood mental health clinician can conduct a more in-depth assessment that includes the use of high-quality, valid, and reliable assessment tools. Screening is an important conduit to accessing needed services so that when children enter kindergarten, they are equipped and prepared to succeed.

Prevention
Prevention efforts are more targeted services and supports for children and families in which the child is showing early signs of social, emotional, or behavioral issues and/or is at increased risk of developing

issues as a result of things like a family history or presence of mental health issues or substance use; a history of trauma or exposure to violence; involvement in the child welfare system; challenges with social determinants of health (e.g., poverty, parental unemployment); and experiences of racial and other discrimination.

Examples of prevention activities include mental health consultation to help providers, such as early care and education teachers, family visiting, Early Interventionist specialists, and child welfare case workers, to develop strategies and skills to address children's behavioral issues, reduce conflict, and strengthen provider-child relationships; and parenting support and education groups that strengthen parenting skills and positive parent-child interactions and attachments.

Developmentally Appropriate Assessment and Diagnosis
When young children experience more serious behavioral concerns, it is crucial that there are practitioners trained to assess the nature and extent of these issues and, in partnership with the child's family and caregivers, develop a plan to help the child experience improved health and wellbeing. Developmentally appropriate assessment of young children requires the use of evidence-based assessment tools and the skills and knowledge to understand children's behaviors within developmental, familial, and cultural contexts to produce a clinical formulation and follow-up recommendations. Practitioners must be trained to make developmentally and culturally informed diagnoses when relevant and necessary.

Treatment
Young children experiencing significant social or emotional distress can be treated effectively. The best practice for treating young children is to work with the child along with at least one primary caregiver since the relationship between young children and their caregivers is a major determinant of their well-being, and the most powerful interventions are those that heal not just the child but also the relationship, and sometimes the adult caregiver. Adults who have histories of trauma, depression, and/or substance use may need support in understanding how these struggles can manifest in their parenting and relationships as caregivers, and children who experience trauma themselves may also require specialized attention and care from their caregivers to help them recover, regulate, and manage trauma responses over time. A comprehensive system of care requires that all children have equitable access to trained providers who can offer evidence-based and effective infant and early childhood treatment interventions, many of which are family-focused, dyadic, or multi-generational approaches, are time-limited, and have demonstrated effectiveness.

# Rhode Island Public Mental Health Data for Children Six and Under

EOHHS gathers data on young children eligible for Medicaid who receive mental health services. The Taskforce looked at Medicaid claims data from Calendar Year (CY) 2018 to 2021. The analysis used this data to address the following questions:

- How many children between zero and six years of age are Medicaid eligible, and what are their characteristics?
- What presenting mental health diagnoses are identified for Medicaid eligible young children?
- What services are provided to young children and their families?
- How many young children have difficulty accessing needed mental health services?

Due to privacy concerns, data is redacted when they pertain to less than ten persons. In many cases in this analysis, the small numbers policy was applied given the multiple variables being analyzed.

Characteristics of Young Children Eligible for Medicaid: The total number of children enrolled in Medicaid has remained stable year over year, with the enrollee age being evenly distributed. As of the last year of available data (2021), 47,000 children six years old and under were enrolled in Medicaid. On average, children under six represent 1/3 of Medicaid enrolled children and youth and approximately 63% of all children aged 0-6 in Rhode Island.

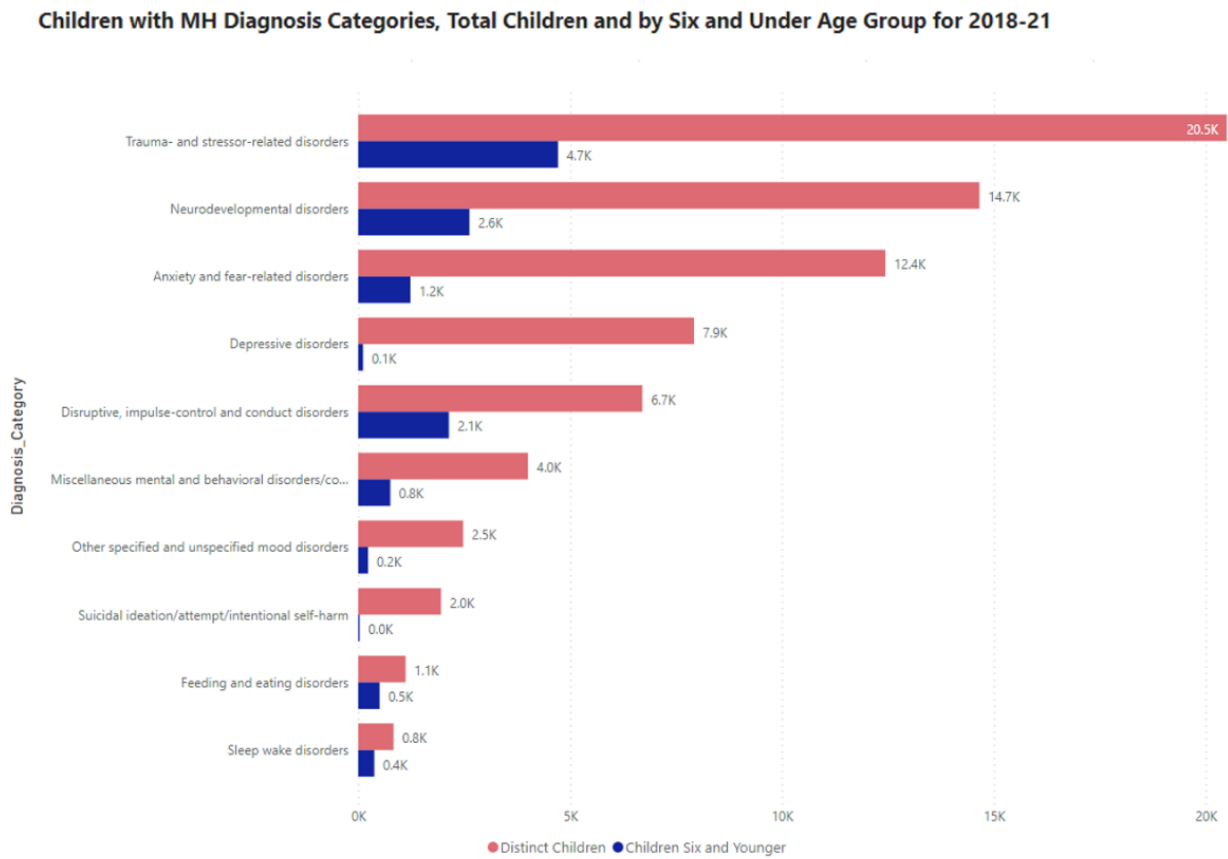**Figure 2: Young Children Eligible for Medicaid**
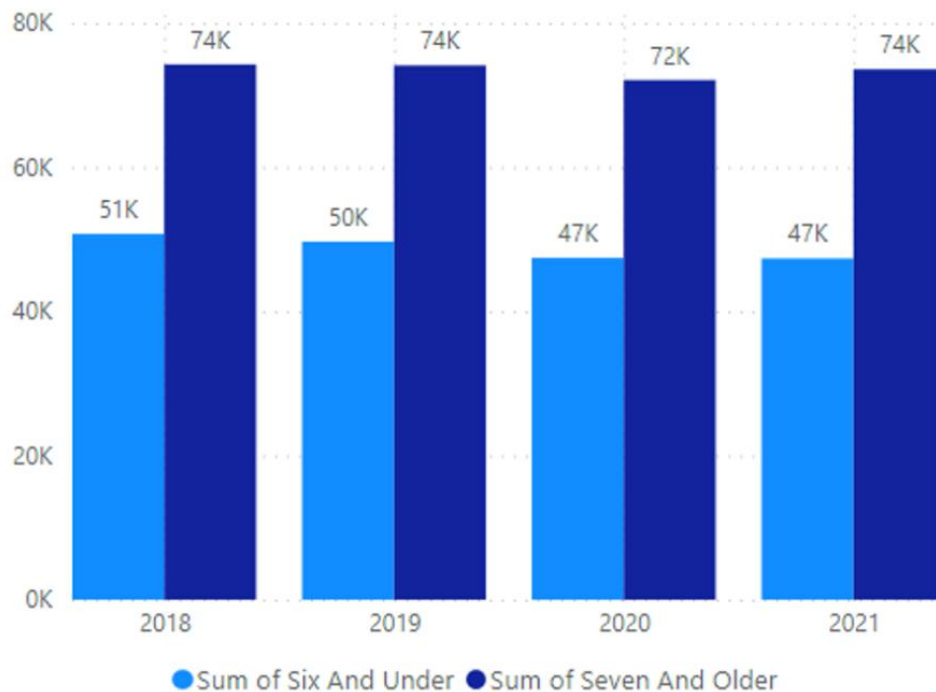
On average, of Medicaid enrolled children who are six years old and under, 45% identify as Hispanic, 9% identify as Black, and 32% as White, 49% are female and 51% are males.

Figure 2: Medicaid Enrolled Children Six and Under by Race and Ethnicity
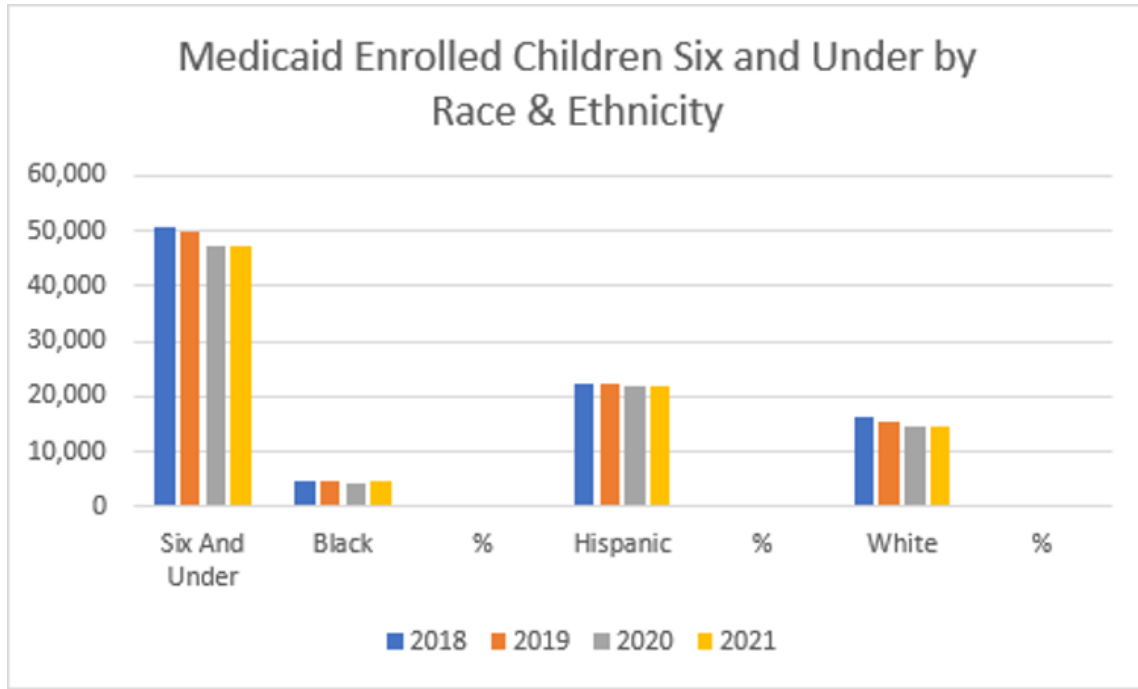
Mental Health Diagnosis: Of those children six and under enrolled in Medicaid who received a mental health-related Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, the most prominent diagnosis category was trauma and stressor-related disorders. In fact, trauma and stressor-related disorders is the most prominent diagnosis category for children of all ages. Neurodevelopmental disorders are the second most frequent diagnosis given to children under six who have received a DSM diagnosis. Two diagnosis categories are utilized at a higher rate for children six and under, sleep/wake disorders and feeding disorders.

Figure 4: Children with Mental Health Diagnosis Categories

Children with MH Diagnosis Categories, Total Children and by Six and Under Age Group for 2018-21

Diagnosis Category	Distinct Children	Children Six and Younger
Trauma- and stressor-related disorders	20.5K	4.7K
Neurodevelopmental disorders	14.7K	2.6K
Anxiety and fear-related disorders	12.4K	1.2K
Depressive disorders	7.9K	0.1K
Disruptive, impulse-control and conduct disorders	6.7K	2.1K
Miscellaneous mental and behavioral disorders/co...	4.0K	0.8K
Other specified and unspecified mood disorders	2.5K	0.2K
Suicidal ideation/attempt/intentional self-harm	2.0K	0.0K
Feeding and eating disorders	1.1K	0.5K
Sleep wake disorders	0.8K	0.4K

● Distinct Children ● Children Six and Younger

Young Children (Ages 1-5) Enrolled in Medical Assistance Presenting with Serious Emotional Disturbance (SED) According to RI KIDS COUNT, the number of young children enrolled in Medicaid presenting with SED has grown from 12% in 2017 to 20% in 2022.
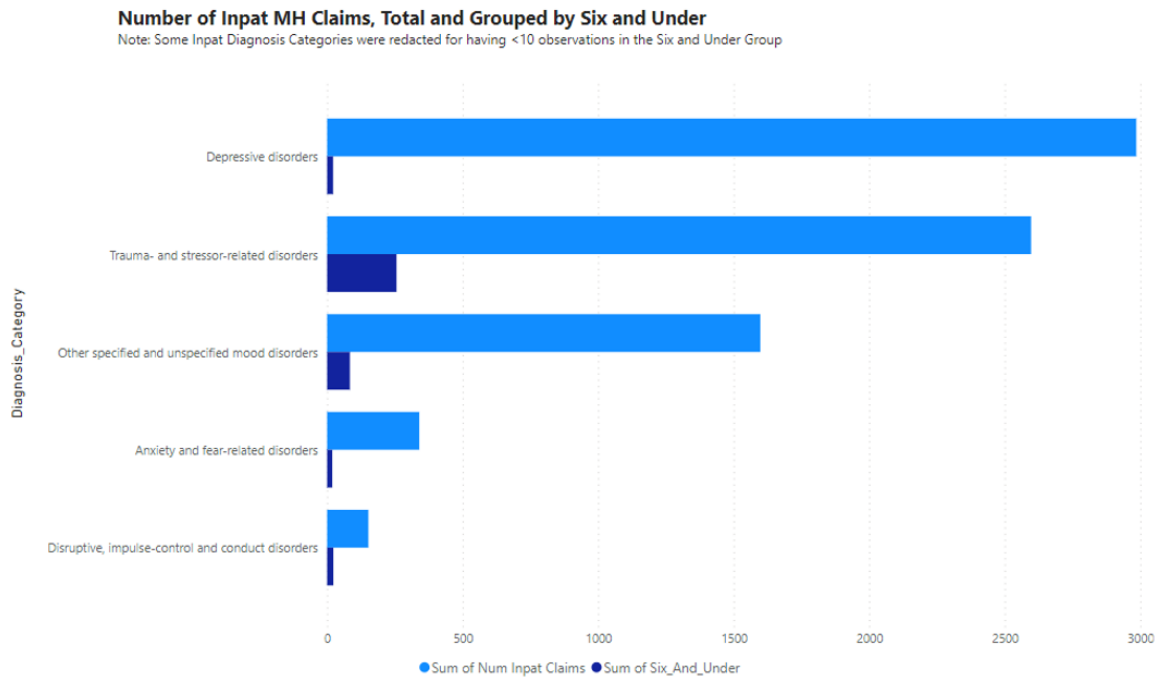
Figure 5: Young Children in Medicaid Assistance with Serious Emotional Disturbance

Year	% of Children (Ages 1-5) Enrolled in Medical Assistance Presenting with SED
2017	12%
2018	15%
2019	16%
2020	16%
2021	17%
2022	20%

RI KIDS COUNT also reported that an estimated 33% of children ages three to 17 who needed mental health treatment or counseling had a problem obtaining needed care in Rhode Island in 2020.

Types of Services Received: In reviewing procedure codes billed from 2018-2021, children six and under most frequently received services related to screening, Early Intervention, and family home visiting programs.

Figure 6: Number of Inpatient Mental Health Claims for Children Six and Under

Number of Inpat MH Claims, Total and Grouped by Six and Under
Note: Some Inpat Diagnosis Categories were redacted for having <10 observations in the Six and Under Group

Outpatient mental health services are sometimes billed under a parent or family member and not always directly billed for children six and under, accounting for ten to 15 percent of claims billed. No children six and under enrolled in Medicaid had claims related to residential placement, however, children six and under did receive inpatient psychiatric hospital level of care. From 2018-2021, approximately 400 Medicaid-enrolled children six and under received treatment at an inpatient psychiatric facility. The graph above shows the primary diagnoses related to admission.

The Infant and Early Childhood Mental Health Workforce

Supporting families in their efforts to create nurturing, safe, and responsive relationships and environments for their infants and young children is one of the most important ways the IECMH workforce can promote early relational health and mental health. Many providers interact with families during this exciting, challenging, and vulnerable period of a child's development, and each can play a role in offering this support and serve as a resource for information about IECMH and linkages to care. It is strategic to educate and train a wide variety of providers who interact with young families in the foundations of IECMH as there is no single care delivery system that interacts with all children between the ages of birth and five years old (unlike the school system once a child reaches kindergarten). Furthermore, some providers form ongoing and intimate relationships with families that endure over time (e.g., pediatric and family medicine providers, family visitors, or early educators). These individuals can serve as trusted sources of IECMH information, and they provide critical services and play a significant role in fostering early relational health through their relationships with families.

The IECMH Taskforce has identified a 'short list' of providers (below) that are the initial focus for IECMH training due to their work with young children and families in an ongoing way. That said, the Taskforce identified the importance of broadening IECMH training, messaging, and support to a wider array of providers interacting with young families as the work continues. This can include, for example, Women, Infant, and Children Services (WIC) and housing staff, police, other emergency responders, and providers in residential treatment programs for adults who are parents of young children.

Providers in Perinatal and Pediatric Health Care Settings
Prenatal care providers are crucial in promoting IECMH in their visits with pregnant people and their partners during pregnancy. They can raise awareness about risks associated with perinatal depression and substance use, screen for behavioral health issues that can significantly impact child development, and educate about attachment, early relational health, and infant and early childhood mental health. They can also help families access needed support or services to address social determinants of health that impact child health and well-being, such as housing, food, or economic instability. Similarly, pediatric care providers are frequently in contact with families in the first years of a child's life. Parents often turn to them with concerns about their children's behavior. Pediatric primary care staff can conduct developmental and behavioral screening, assess relational health and attachment, provide information and resources on IECMH, and ideally provide warm handoffs and easy access to parenting IECMH supports and services (e.g., consultation, in-depth assessment, and treatment services) as needed.

Early Childhood Educators
Early care and education providers (including home-based and center-based child care providers and Head Start staff) are often primary caregivers for young children and consequently significantly influence their development and mental health. They are instrumental in promoting social and emotional skills acquisition and screening for, identifying, and addressing emerging behavioral or developmental issues. They also work with families to ensure children are referred for further assessment and treatment interventions when needed. They can also provide key resources or connections to help families access supports that address social determinants of health.

Early Intervention Providers
Early Intervention providers offer in-depth assessment and treatment services for children experiencing developmental or behavioral concerns from birth to age three. They are a critical universal resource for

families, and they must have the training and knowledge needed to assess for and treat IECMH issues - either when this is the primary presenting concern for a child or when it is secondary to and co-occurring with another developmental issue such as autism or a speech or cognitive delay.

Family Visitors
Family Visitors are often the first formal support that a pregnant person or new parent works with, and they play a crucial role not only in educating and supporting families concerning health and safety but also in promoting IECMH and early relational health through sharing information about social and emotional development, attachment, and behavioral health. Because family visitors are in family home environments, they can form intimate and trusting relationships with parents and caregivers. Therefore, when trained and equipped with IECMH knowledge, they can play a crucial role in helping families identify a parent's behavioral health issue that needs assessment or treatment. (For example, they can screen for, educate about, and help families to address perinatal depression; they also provide resources to address social determinants of health that significantly impact children's mental health).

Child Welfare Workers
The child welfare system staff play an outsized role in promoting mental health because their clients are among the most vulnerable families in communities, and these workers interact with families at particularly challenging moments. Child welfare staff with foundational IECMH training can be instrumental in motivating parents to seek behavioral health treatment, engage in services that help them strengthen parenting practices, support their children's mental health, and build on family, cultural, and faith practices to address situational challenges. Ideally, child welfare systems can offer evidence-based IECMH services (ranging from parenting education and support groups to family-based dyadic therapies), especially those interventions that have been developed specifically for individuals who have experienced trauma, family disruption, loss, and/or violence, and can help break intergenerational cycles of trauma.

Infant and Early Childhood Mental Health Consultants
Infant and early childhood mental health consultants are mental health clinicians who have specialized training both in infant and early childhood mental health and in offering consultative services to early childhood providers (including early care and education, early intervention, child welfare, and family visiting staff, as well as perinatal and pediatric providers). Mental health consultants partner with early childhood providers to strengthen their knowledge and capacities to promote children's healthy social and emotional development and to address behavioral concerns. Mental health consultants work with programs to create healthy environments for children and staff; they also offer preventive approaches when a particular child or family presents with an emerging issue. Consultants partner with early childhood providers to gather information, make observations, formulate an understanding of the issue and implement a plan to address it. They assess and revise the strategy as needed until the issue is resolved; and, when necessary, can conduct assessments and facilitate referrals for specialty care, linking families with community-based supports to address parental behavioral health concerns or infant and early childhood mental health treatment. Finally, consultants can work at the program level to offer training and reflective consultation and help programs make policy and practice changes that lead to better mental health outcomes for staff, children, and families.

Licensed Mental Health Clinicians with Specialization in Infant and Early Childhood
Infant and early childhood mental health clinicians are typically licensed master-level clinicians with specialized training in infant and early childhood mental health. They may work in various settings (e.g., community-based, home-based, or medical practice settings). They should be trained in the specific

approaches to (and tools for) conducting developmental and behavioral assessments, diagnosis, and treatment of children ages birth to five. Evidence-based mental health treatment of young children almost universally involves dyadic or whole-family multigenerational approaches that focus on the interactions and relationships between the young child and primary caregivers as a central means to address concerns and build mental health and resilience. Infant and early childhood mental health clinicians may work directly with parents on parenting or related issues or with parents and young children together. They may also help families access other needed services and supports or coordinate with other treatment providers, such as individual mental health or substance use treatment providers working with parents, other family members, or family therapists.

IECMH Professional Development in Rhode Island
Developing a trained infant early childhood workforce is a critical first step toward improving infant and early childhood mental health. Currently, Rhode Island has several community-based organizations that support the development of the infant early childhood workforce, including but not limited to:

The Rhode Island Association for Infant Mental Health (RIAIMH): RIAMH supports reflective, relationship-based, cultural humility and evidence-based practices that help professionals promote infant and early childhood mental health. They also promote a nationally recognized set of infant mental health competency guidelines and an Infant Mental Health Endorsement® system to recognize the specialized knowledge and expertise of the diverse array of professionals in Rhode Island's infant, early childhood, and family workforce. And they offer workshops and training for professionals in various disciplines, such as nursing, social work, psychology, early care and education, pediatrics, medicine, child welfare, and early intervention. Currently, 41 cross-sector and multidisciplinary professionals from child and/or human development, education, nursing, pediatrics, psychiatry, psychology, social work, and others have obtained Endorsement®. Endorsement® indicates an individual's efforts to specialize in the promotion/practice of infant mental health within his/her chosen discipline.

The Center for Evidence-Based Practice (CEBP) at the Bradley Learning Exchange: The Learning Exchange provides Teacher Classroom Behavior Management Program for professionals working with children ages preschool through grade three in child care and educational settings and Incredible Beginnings™ Program for professionals working with children one to five years old in child care and educational settings to provide an environment that supports children's optimal early development.

In addition, the ***Early Childhood Collaborative at Bradley*** provides foundational training to the RI Family Visiting programs on Reflective Practice and Supervision (RP/S). They also provide mental health consultation to RIDOH-supported Family Visiting programs utilizing a Coordination of Care Team model (informed by RP/S principles; reflective conversations about social, emotional, and behavioral needs of children/caregivers).

Journ3i LLC.: Journ3i, LLC is an urban perinatal community-based founded and led wellness organization primarily focused on eliminating health disparities and identifying social health determinants within infant and maternal health by providing empowering education and services. Its focus is on culturally diverse maternal and perinatal workforce development, training, mentorship, and professional development.

For more detail on these organizations' current programs and professional development, please refer to the Current IECMH Landscape in the Appendix B.

RI Infant and Early Childhood Mental Health Landscape

Infant and early childhood mental health services for children and their families/caregivers can and should be delivered in various child and family serving settings. Because this is such a critical window for development (especially brain development), it is crucial that developmental or behavioral issues are identified and addressed quickly. Problems left unaddressed until a child reaches school age are more likely to interfere with academic success and become harder to remediate. Several providers play a significant role as trusted advisors to parents and primary caregivers to children in early childhood, and these providers can have a significant impact on promoting infant and early childhood mental health and preventing longer-term mental illness. Supporting these front-line providers to be equipped to promote mental health eliminates a host of barriers that families experience in accessing traditional mental health services, including transportation and child care challenges, cultural and linguistic barriers, as well as stigma and trust.

The visual below shows the range of programs and settings serving children and families in the early years.

Figure 7: Programs Serving Children and Young Families
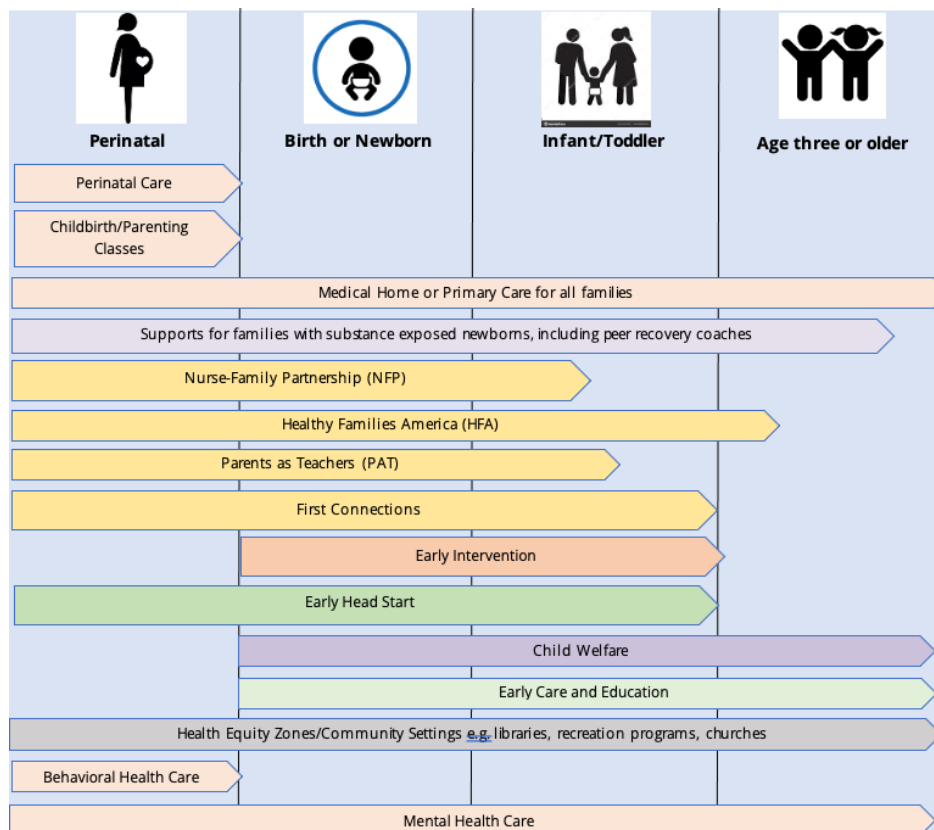
Note that mental health services are an important component of the system of care for children and families across the age range, while behavioral health care - inclusive of treatment for substance use - is needed for many pregnant and parenting caregivers in the early years.

For more in-depth information on the current array of services and supports provided in each setting, please see Appendix C.

State Organizations Serving Young Children in Rhode Island

Publicly funded services and support**s** to promote the mental health of infants and young children in Rhode Island are currently dispersed across six state agencies and programs. The following organizations do not include all agencies and organizations but rather represent some of the primary agencies involved in the system. The role of each agency, the scope of services, and the population of focus are discussed below.

Pediatric Health Care: Most opportunities for supporting infants, young children, and their caregivers occur through pediatric health care visits. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children from birth to age 20 enrolled in Medicaid is overseen by the Rhode Island Department of Health (RIDOH). Rhode Island's current EPSDT schedule recommends developmental screening at nine, 18, and 30 months of age, plus a psychosocial/behavioral assessment at every well-child visit. Psychosocial assessments are required to be family centered. The scope of the assessment and tool used is at the provider's discretion. RIDOH is responsible for policies related to primary care. The Executive Office of Health and Human Services (EOHHS) provides oversight of Medicaid and managed care contracts.

Maternal and Child Health: Maternal and Child Health is overseen by RIDOH. RIDOH works to support and promote the health of all birthing parents, children, and families to reduce racial, environmental, and socioeconomic inequities and improve outcomes by:

- Aligning and facilitating the coordination of efforts among RIDOH health topics and programs related to maternal and child health
- Integrating a health equity focus within its priorities and strategies
- Focusing on key areas including women/maternal health, perinatal/infant health, child health, adolescent health, children with special healthcare needs, and social determinants of health
- Administering the Title V Maternal and Child Health Block Grant in Rhode Island "to support the health and well-being of all parents, children, and families."

Early Intervention: EOHHS oversees Rhode Island's Early Intervention program to provide services to families with children from birth to age three with developmental delays, disabilities, or certain medical diagnoses that may impact child development. Eligibility for Early Intervention includes social and emotional delays.

Child Welfare: The Department of Children, Youth, and Families (DCYF) is responsible for child welfare and juvenile justice. Additionally, DCYF is charged with children's services and behavioral health, along with other focuses on strengthening the capabilities and expanding the capacity of parents and caregivers to effectively care for their children and safely reduce the need for foster care by partnering with families and communities to raise safe and healthy children and youth in a caring environment.

Family Visiting: Rhode Island's Family Visiting programs aim to enhance maternal and child outcomes and to increase school readiness for children from birth to age five through evidence-based home visiting models, including Nurse-Family Partnership, Parents as Teachers, and Healthy Families America.

Early Childhood Education: The Department of Human Services (DHS) oversees child care licensing, child care subsidy, and the Rhode Island Head Start State Collaboration. The Rhode Island Department of Education is responsible for pre-kindergarten education, targeting three and four-year-olds and

kindergarten-age children and overseeing Early Childhood Special Education (IDEA Part B 619). Both Departments invest in direct services for young children and mental health consultation for early learning providers.

Children's Mental Health: The Executive Office of Health and Human Services (EOHHS), the Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH), the Department of Education (RIDE), the Department of Children Youth and Families (DCYF), the Department of Health (RIDOH), and the Office of the Health Insurance Commissioner (OHIC) all have a role to play in the management and oversight of the continuum of health services for children and youth, including mental health services for children and mental health and substance use (behavioral health) services for adolescents and young adults up to age 21. The agencies all work in different ways to improve access and oversight of behavioral health services. In addition, BHDDH contracts with six community mental health centers to ensure the provision of an array of mental health services and supports to children ages three to seventeen and their families.

Summary of Key Themes from Taskforce Community Partners

Throughout the planning process, Taskforce participants, families, and caregivers were asked to share the changes they most wanted to see. Below is a summary of the most prevalent themes:

Services and Supports Themes

Prioritize Promotion and Prevention	Rhode Island needs to build awareness and understanding of the importance of IECMH among the general public and people providing care to young children across a variety of settings, including pediatric, family medicine, and perinatal providers, Early Intervention, family visiting, child welfare, early care and education, and families and caregivers. In addition, promotion efforts should reach parents/caregivers in natural settings like religious organizations, libraries, and recreation programs and equip parents to build nurturing relationships with their children. The State also needs to do more to increase access to parenting and economic resources and support families before they get to the point of crisis. This should include the implementation of family resource hubs, expanding family visiting, and increasing the availability of evidence-based parent support and education groups. Parents participating in IECMH Taskforce focus groups identified training for parents that destigmatizes mental health, enhances parenting skills, and gives them a forum to connect with and learn from other parents as a priority. For children ages zero to three, providers would like more on-site clinical or billing supports to implement the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedule as designed. This includes eliminating billing hurdles, providing toolkits and resources, and using monetary incentives for providers or practices to achieve them. For children ages three to five, Rhode Island needs to do more to improve young children's developmental/behavioral health screening rates. In 2022, only 30% of children ages three to five were screened by Child Outreach. Taskforce members would like more social-emotional screening of children and families using strengths-based assessments and evidenced-based and culturally valid tools.
Increase Accessibility to High-Quality, Evidence-based, Family-based Dyadic Treatment	Rhode Island's children and families need more access to high-quality, evidence-based dyadic, family-based treatment (such as Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT), and Attachment and Biobehavioral Catch-up (ABC). **Currently, there are only 8 licensed clinicians in Rhode Island trained in these models.** The state needs to increase the number of clinicians trained in evidence-based models, especially Black,

	Indigenous, and People of Color (BIPOC) clinicians, and make accessing appropriate reimbursement for these services easier. The system should minimize obstacles to accessing care by removing transportation and child care barriers.
Ensure Services and Supports are Culturally Competent, Linguistically Responsive, Strengths-Based, and Trauma-Informed	It is paramount that all providers of services and supports build relationships with families, have foundational knowledge in infant, early childhood mental health, and be able to provide trauma-informed, strengths-based, linguistically appropriate, and culturally sensitive services.
Advance Policies to Address Underlying Inequities and Root Causes of IECMH Challenges	Parent Focus Group participants articulated that more help to meet their family's basic needs would increase their capacity to attend to their own and their children's mental health issues. To do this, Rhode Island needs to address social determinants of health, systemic racism and inequity, child poverty, and chronic stress on families with babies and young children by improving state policies and expanding state investments to reduce stress on families with children under age six and to promote stable, healthy, nurturing relationships between young children and parents/caregivers. Rhode Island needs to make it easier for young parents to work by strengthening family-friendly workplace policies such as paid family medical leave and ensuring families have access to basic needs, including affordable housing, health care coverage, healthy food, home and community safety, cash assistance when needed, and living wages.
Address Environmental Factors that Interfere with Healthy Development and Mental Health	Social determinants of health (including access to safe and affordable housing, quality education, healthy food, etc.) account for 80% of health outcomes. Rhode Island must increase public investment to address systemic and structural problems that can interfere with healthy development and enact public policies that reduce inequities in social determinants of health (e.g., improve access to high-quality education, affordable, safe, and healthy housing, healthy food, living wages, paid family leave, and high-quality child care/early learning) and reform the criminal justice system to reduce mass incarceration.
Prioritize Services and Support to Populations and Regions with the Greatest Need	The system should prioritize delivering services and supports to populations and regions with the greatest need. There should be a focus on preventing family separation by supporting parents with substance use and other mental health issues and prioritizing treatment services for parents with serious and persistent mental illness and substance use disorder.

Ensure Developmentally Appropriate Diagnosis (when needed)	Mental health clinicians involved in the Infant Early Childhood Mental Health Taskforce planning process largely supported recommending the DC:0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) diagnosis system, because the DC:0-5 is: • More developmentally appropriate for assessing, diagnosing, and treating young children than the Diagnostic and Statistical Manual of Mental Disorders (DSM), as it includes age-related guidance for making diagnoses • Relationship-based, including the context of family, culture, and other environments in the assessment and diagnostic process and formulation of recommendations • Better at identifying strengths in the child, family, and parent/child relationship, as well as in cultural assets, in clinical formulation, and in guiding clinicians to develop treatment recommendations in collaboration with the family However, some community members raised concerns that mental health diagnoses (regardless of the diagnostic system used) could potentially harm children of color by mislabeling and stigmatizing children and families who have experienced discrimination and prejudice. The concern is NOT specific to the type of diagnostic system used (e.g., the DC:0-5 or DSM) but rather about diagnosing young children in general.

Workforce Themes

Increase the Capacity of the IECMH Workforce to Address the Social, Emotional, and Mental Health Needs of Young Children and their Families	Rhode Island needs to increase the capacity of the early childhood and mental health workforce to build relationships with parents and caregivers and address the social, emotional, and mental health needs of young children and their families in ways that are culturally competent, linguistically responsive, strengths-based, and trauma-informed. Community members involved in the Taskforce's IECMH planning process clearly indicated that providers skilled in relationship-building are more trusted and helpful to them, and these skills can be developed and refined through IECMH training. In addition, the workforce must have foundational training in IECMH competencies and anti-racist practices. In addition, as mentioned above Rhode Island has very few clinicians trained in evidence-based dyadic therapy. Finally, the State should invest in IECMH professional development and training and expand Infant and Early Childhood Mental Health

	Consultation in family visiting, early care and education, and Early Intervention.
Address the Mental Health of the Early Care and Education Workforce	There are concerning rates of depression and general stress among the early care and education workforce. Since young children's development is largely shaped by their interactions and relationships with adult primary caregivers, such as the early care and education workforce, the mental health of these professionals impacts both their own lives and the health and development of the young children in their care. Rhode Island needs to ensure the early care and education workforce has access to mental health treatment and should support the workforce by expanding Early Childhood Mental Health Consultation in family visiting, early care and education, and Early Intervention.

Systems Coordination and Alignment Themes

Invest in Systems Coordination/Alignment	The State needs to invest in all aspects of systems coordination. Specific themes include: making sure all stakeholders are informed and aware of the programs, understanding the role of each state agency, strengthening universal screening, and increasing linkages across the system.
More Effectively Coordinate Care Across Programs	The system should effectively coordinate care for individual participants or families by working as a team or as part of a team across programs to share information and coordinate on behalf of a family.
Foster Integration of Mental and Behavioral Health Services within the Medical System	IECMH services and supports should be integrated with primary and perinatal care. Better integration of behavioral health in perinatal practice would help to meet the mental health needs of pregnant people and new parents. Integrating mental health into primary care would result in more training for pediatrics and family medicine providers to strengthen their relationships and improve communication with families, screening for mental health concerns, easier access to specialty mental health treatment when needed, and interdisciplinary team-based care. Strengthening coordination between doulas and medical providers is also needed to improve care for pregnant women and new parents.

Infant and Early Childhood Mental Health System Recommendations

by the Participants of the Infant and Early Childhood Mental Health Taskforce for the RI Executive Office of Health and Human Services

The following section outlines the priorities and recommendations of the Taskforce participants for specific actions or changes that Rhode Island should undertake to improve the system of care for infant and early childhood mental health.

Some of the Taskforce participant recommendations would require little funding but will necessitate fundamental changes in how people think, work together, interact with families and partners, and make decisions. Other changes would require new investments. Even if efficiencies can be found in how current resources are being used, it is understood that there simply would not be enough funding, for example, to expand access to social-emotional interventions or mental health treatment to all young children who need this help unless new resources are devoted to meeting this need.

Participants in the Taskforce process were clear: Rhode Island policymakers must support a system responsive to the diverse needs of children and families of different races, languages, and cultures that intentionally address racial and economic disparities. Moreover, to ensure that the decisions made, the policies developed, and the services funded eliminate racial disparities and do not overtly or covertly create further inequities, there must be investments in new thinking and systems change efforts. The Taskforce participants were clear that more resources are needed, and more can be done with existing resources to develop a more effective approach to meeting young children's needs - an approach that better integrates early childhood mental health services and supports into child- and family-serving systems.

For each priority, the participants in this planning process have identified a set of recommendations. The recommendations for each priority are differentiated by the type of recommendation and investment required as follows:

Recommendations that could be accomplished within twelve months and/or supported through reallocation of resources or policy change

Recommendations requiring additional resources: One-time investment

Recommendations requiring additional resources: Ongoing investments

Recommendations particularly important to parents and caregivers, as noted in parental/caregiver focus groups carried out by Taskforce consultants

Priority 1. Implement a Coordinated Workforce Development Strategy: IECMH Clinicians

It was widely recognized by Taskforce participants that Rhode Island needs to increase the size and capacity of its clinical workforce with specialized training to offer infant and early childhood mental health services. **As noted above, there are currently only eight licensed clinicians in Rhode Island trained in these models.** Best practice in meeting young children's and their caregivers' mental health needs requires training mental health clinicians in evidence-based family-based dyadic treatment models distinct from those appropriate for older children and adults. It is also necessary to engage in activities that build a pipeline for a diverse and well-trained workforce into the future by embedding foundational IECMH and anti-racist practices into pre-licensure courses and training opportunities and investing in infrastructure for training and supporting mental health professionals' post-graduation so that they continue to build new skills and stay current in their practice as advancements in interventions/therapies are developed. Training of trainers is an important strategy for ensuring that, as the workforce turns over, there are cost-effective mechanisms for new IECMH clinicians to receive training in evidence-based models. And a registry of clinicians with IECMH training is a means to ensure that families can more easily access mental health providers with the skills and expertise to work with this age group. To diversify the workforce, educational programs must increase incentives and reduce barriers to entry for BIPOC individuals so that families can access more racially, culturally, and linguistically diverse providers.

The full recommendations for this priority are below:

Recommendation	Recommendation Type
Create train-the-trainer capacity in Rhode Island to offer training on evidence-based, family-based dyadic treatment (such as Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT), and Attachment and Biobehavioral Catch-up (ABC).	❶⏱
Offer state-supported training in evidence-based, family-based dyadic treatment for clinicians and other relevant early childhood providers (such as Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT), and Attachment and Biobehavioral Catch-up (ABC))	💲
Increase the number of mental health clinicians identifying as BIPOC through focused recruitment strategies and targeted investments. For example, tuition and wraparound supports, loan repayment, and holding training program slots.	👪💲
Establish infrastructure, such as a hub, to: • Train and support infant and early childhood mental health professionals in RI • Maintain a registry of professionals. • Monitor the availability of services, new national recommendations, and advancements in interventions/therapies. • Make recommendations to Medicaid and behavioral health systems to address gaps.	💲

Recommendation	Recommendation Type
Embed education on Diversity Informed Tenets/Anti-Racist Practices and foundational IECMH competencies in higher education programs leading to licensure to practice as a mental health clinician.	

Priority 2. Implement Coordinated IECMH Workforce Development and Support: Broader Early Childhood Workforce

The second priority of Taskforce participants is building foundational infant early childhood mental knowledge and skills among the broader early childhood workforce. Children and young families interact with and receive critical services and guidance from a wide range of providers in early childhood. Each of these individuals plays a very important role in promoting mental health (see page 18 for more information). However, most of these professionals did not receive foundational infant and early childhood mental health knowledge and skills as part of their training to become pediatric and family medicine providers, child care providers, child welfare caseworkers, family visitors, etc. While all early childhood providers need to be trained, training should be prioritized first for those who serve populations experiencing the greatest number of risk factors (and also experiencing inequities in access to care). Further, the Taskforce's priority is to diversify the workforce to represent the racial and linguistic diversity of families served more closely as this increases the engagement of families who have traditionally not participated in services because they do not feel represented or understood.

Finally, early care and education is one sector of the broader early childhood workforce that deserves special attention. Young children frequently spend most of their day with ECE providers, who consequently promote healthy development and IECMH. The pandemic has not only raised attention to the poor compensation of the ECE workforce (historical and current), but there is also evidence that the ECE workforce is experiencing increased economic instability and symptoms of burnout, stress, and depression. When ECE providers are stressed and depressed, this negatively impacts their ability to be responsive and sensitive to young children in their care. As a result, the Taskforce participants recommend strategies to improve the mental health of the early care and education workforce, which will also benefit the children and families they work with.

The full recommendations for this priority are below:

Recommendation	Recommendation Type
Universally train staff and providers in all settings in Diversity Informed Tenets/Anti-Racist Practices, parent engagement and relationship building, and foundational IECMH competencies. Prioritize providers who serve populations experiencing adversity.	👪💲
Expand training in evidence-based parenting support and education group facilitation. Prioritize providers who serve populations experiencing adversity, including families involved with child welfare.	👪💲
Increase the number of family visitors, early care and education providers, and child welfare caseworkers who identify as BIPOC through focused recruitment strategies and targeted investments. For example, tuition and wraparound supports, loan repayment, and holding training program slots.	👪💲
Ensure sustainable, fair compensation for the early care and education workforce.	💲

Recommendation	Recommendation Type
Develop and implement strategies to support the mental health of the early childhood workforce, who are often key attachment figures for infants and young children (e.g., support voluntary screening and connection to mental health services when needed)	

Priority 3. Advance Policies to Address Underlying Inequities and Root Causes of IECMH Challenges

Many mental health issues that children and families experience have root causes in social factors (e.g., systemic racism, poverty, disparities in access to quality education, employment and housing, and historical and intergenerational trauma). Chronic stress resulting from such social inequities can interfere with the ability of parents to provide safe, stable, and nurturing relationships and environments at the foundation of infant and early childhood mental health. Therefore, the Taskforce participants concluded that an effort to effectively prevent mental health disorders and improve mental health outcomes of young children should include remedies that address these root causes of IECMH challenges. A second, equally important aspect of increasing equity and improving IECMH outcomes involves increasing equity in delivering mental health services to families with young children. This begins with ensuring data and analytic capacity to identify where disparities in care and racial bias are present in Rhode Island's service delivery system and using this data to develop strategies to improve equitable outcomes and eliminate disparities.

The full recommendations for this priority are below:

Recommendation	Recommendation Type
Address social determinants of health, systemic racism and inequity, child poverty, and chronic stress on families with babies and young children by improving state policies and expanding state investments to reduce stress on families with children under age six and to promote stable, healthy, nurturing relationships between young children and parents/caregivers by: • As noted in Governor McKee's 2030 Plan, ensuring families with babies and young children have consistent support to meet their basic needs including affordable housing, health care coverage, healthy food, safety at home and in the community, cash assistance when needed, and living wages. • Strengthening family-friendly workplace policies such as paid family medical leave and economic support for families and increasing access to high-quality early care and learning programs as noted in the Governor's 2030 plan.	
Update certification requirements and state contract language to direct state agencies (including Medicaid) to enter contracts with vendors that include anti-racist policies and best practices that improve the cultural responsiveness of the agency and service delivery.	
Review existing disparity data in birth outcomes, child welfare involvement, and early care and education suspensions and expulsions to identify populations and regions throughout the state (urban, suburban, and rural) with the greatest need for IECMH services and prioritize services and supports to these communities.	

Recommendation	Recommendation Type
Prioritize receipt of IECMH professional development and mental health consultation services as well as equity-focused reflective consultation and supervision for family visiting programs, Early Intervention, early care and education, and healthcare providers serving populations experiencing adversity throughout the state.	
Prioritize training (outlined in priorities 1 and 2) for IECMH and healthcare providers who reflect the cultural diversity of their community.	
Build data and analytical capacity to more comprehensively identify equity, disparity, and racial bias in Rhode Island's IECMH systems and identify strategies to increase equity and access to services throughout the state.	

Priority 4. Promote Universal Awareness of and Access to IECMH Supports

All caregivers of young children, including parents, pediatric and family medicine providers, early care and education providers, and other caregivers must understand the importance of infant and early childhood mental health and their role in promoting it. In addition, parents need access to support and resources that help them create nurturing and responsive relationships and safe and stable home environments – all critical ingredients in building children's social and emotional skills and mental health.

Parent Focus Group participants and community members of the IECMH Taskforce were clear about the importance of having easily accessible and culturally relevant spaces within communities for obtaining parenting and economic resources and support, peer supports, and educational information about IECMH. Parent Focus Group members also shared that places to build social networks (both online and in the community) were very helpful in their efforts to address their own and their children's mental health challenges.

The full recommendations for this priority are below:

Recommendation	Recommendation Type
Implement a communications campaign intended for parents, grandparents, and caregivers of children and perinatal and pediatric providers to promote the importance of infant and early childhood mental health and decrease stigma around IECMH. Ensure that parents/caregivers are involved in the development of the campaign.	💲
Identify new or leverage existing community-based, culturally sensitive family resource hubs (such as Health Equity Zones, Community Action Programs, etc.) to provide a range of parenting and economic resources and supports, including peer supports, to de-stigmatize mental health concerns and address Social Determinants of Health, based on the needs and interests of families.	👪 💲
Distribute and promote educational resources on the importance of IECMH through community centers, early care and education programs, Health Equity Zones, libraries, health care settings, and other neighborhood spaces that families regularly access. Resources could include Welcome Baby packets, books that promote social and emotional well-being, website resources, newsletters, screening passports, evidence-based programs promoting bonding through reading such as Reach Out and Read, and/or a texting service with weekly tips to parents for building mental wellness in their young children.	👪 💲
Work with Medicaid to modify Managed Care Organization (MCO) contracts to require the promotion of IECMH, linkages to community resources, and engagement in the Reach Out and Read Initiative.	🕐 📝
Develop and distribute data, information, and personal testimony to policymakers to improve understanding of the importance of early infant childhood mental health among decision-makers.	📝

Priority 5. Screen, Evaluate, and Connect Parents and Caregivers to Treatment

One of the most widely held tenets of IECMH is the understanding that young children's mental health and well-being are highly related to and, to some degree, dependent on the mental health and well-being of parents/primary caregivers. Data have demonstrated, for example, that depression in parents of infants and young children is associated with poorer developmental outcomes, including cognitive and social-emotional outcomes in young children. Therefore, screening for and addressing behavioral health issues among pregnant people and new parents can be instrumental in promoting children's mental health. The IECMH Taskforce recommends several strategies to improve screening, evaluation, referral, and treatment practices for parents and caregivers.

The full recommendations for this priority are below:

Recommendation	Recommendation Type
Provide clear guidance and training to perinatal, family medicine, and pediatric providers on parent/caregiver mental health and substance use screening, including valid and reliable screening tools, screening frequency, billing for screenings (including billing the child's insurance). Implement a quality incentive to promote parent/caregiver mental health and substance use screening and referrals to evaluation and treatment (including IECMH dyadic therapies).	👪 📋
In partnership with Medicaid and managed care organizations (MCOs), explore strategies for compensating perinatal providers for more complex postpartum visits focused on behavioral health.	💲
Prioritize rate increases for behavioral and mental health screening of parents/caregivers (based on OHIC's legislatively mandated rate review).	💲
Identify and expand pilots focused on integrated behavioral health care in perinatal settings.	⏱ 📋
Expand the continuum of behavioral health services (such as hospital/partial, residential, and community/outpatient services) for pregnant people and parents of young children struggling with mental health and substance use challenges.	👪 💲
Sustain the MomsPRN program so that more perinatal practices have access to information, education, and consultation that enables early identification of behavioral health-related concerns, helps develop treatment plans, and assists in helping patients connect to appropriate care.	💲

Priority 6. Screen and Refer Children to Evaluation and Treatment for IECMH Challenges

Social-emotional screening at regular intervals throughout early childhood is critical to promoting mental health for every child. It can be instrumental in the early identification of social-emotional or behavioral concerns. Screening is an important conduit to accessing needed services so that when children enter kindergarten, they are equipped and prepared to succeed. One concern in Rhode Island is the very low screening rate for children ages three to five, and a strong recommendation of the IECMH Taskforce participants is to update the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedule to include evidence-based developmental and behavioral screening for children in this age range.

Understanding that children's mental health is inextricably intertwined with parent and family wellbeing, the IECMH Taskforce came to the recommendation that early childhood screenings should not only capture children's functioning but must also be inclusive of both social determinants of health (e.g., social factors that greatly influence IECMH) and family strengths. SDOH screening tools and assessments of family strengths provide critically important information about risk factors and supports that could be offered to prevent the onset or worsening of social-emotional problems. Identifying family strengths is also a way to move from a deficit-based model to recognizing and supporting individual, familial, and cultural practices that build mental health and resilience in children. In building relationships between pediatricians and parents (something highly valued by parents in Focus Groups), focusing more on strengths/assets and areas of concern is helpful.

The full recommendations for this priority are below:

Recommendation	Recommendation Type
Consider updating the EPSDT schedule and guidance to align with the American Academy of Pediatrics (AAP) 2022 updated Bright Futures recommendations for evidence-based developmental/behavior/social/emotional screening and family strengths assessment in children zero to six.	🫂🔄📝
Explore updating the EPSDT schedule to expand evidence-based developmental/behavior/social/emotional screening and family strengths assessment to children at ages three, four, and five by pediatric and family medicine practices in partnership with local education authorities and RIDE.	🫂🔄📝
In partnership with Medicaid and MCOs, develop billing guidance documents and training to ensure pediatric and family medicine providers understand how to bill for developmental/behavior and SDOH screening and how to respond appropriately.	🔄📝
In partnership with Medicaid and MCOs, explore strategies for compensating providers for more complex well-child visits focused on mental health.	🔄$
Prioritize rate increases for psychosocial/behavior screening of children (based on OHIC's legislatively mandated rate review)	🔄$

Recommendation	Recommendation Type
Expand the delivery of IECMH treatment, behavioral health services, and SDOH interventions in primary care settings by exploring sub-capitated Medicaid payment models on an at-risk basis for integrated behavioral and IECMH services.	

Priority 7. Ensure a Robust and Coordinated System of Preventive Interventions and Support

Preventive interventions are mental health services designed specifically for children and families at increased risk for mental health issues or showing early signs of problems. This includes children and families experiencing adversity due to historical or intergenerational trauma, exposure to violence, racial discrimination, poverty, parental behavioral health challenges, or other factors. Preventive interventions can help to improve the trajectory for young children who would otherwise be likely to develop social, emotional, or behavioral challenges through promoting positive parenting practices and skills; creating forums for peer-to-peer support among parents and caregivers; reducing social isolation; providing education and information about IECMH; and helping families to access a wide range of social services and concrete supports to meet basic needs. Preventive interventions can be delivered in a wide range of venues and a variety of formats, which makes them more accessible and less stigmatizing than traditional mental health services. The IECMH Taskforce recommends expanding several evidence-based or promising preventive programs, most of which have been successfully implemented in Rhode Island but not at a sufficient scale to meet the need.

The full recommendations for this priority are below:

Recommendation	Recommendation Type
Offer First Connections universally to all Rhode Island families. Continue to triage families with greater need into longer-term evidence-based programs. Sustain Medicaid rate increase for First Connections.	
Expand evidence-based parenting support and education groups, such as Incredible Years, Strong Roots, or Circle of Security, to young children and their families referred to child welfare or at risk for child welfare involvement.	
Expand Kids Connect program eligibility criteria to serve all children, with less severe social, emotional, and behavioral needs, and prioritize services for children involved in the child welfare system.	
Sustain the MomsPRN program and PediPRN (leverage Medicaid reimbursement for inter-professional consultation as a component of funding)	
Build capacity within pediatric and family medicine to implement IECMH preventive practices such as those included in models like Healthy Steps or Developmental Understanding and Legal Collaboration for Everyone (DULCE) to support parents and young children's mental health.	
In partnership with Medicaid and MCOs, develop billing guidance documents and training to ensure that pediatric and perinatal practices understand how to bill for community health worker and peer support specialist services to improve care coordination and increase access to basic needs to help families navigate early childhood and family service systems.	

Recommendation	Recommendation Type
Explore the feasibility of Medicaid authority and authorization to reimburse for group visits in medical settings such as Centering Pregnancy.	

Priority 8. Provide Infant and Early Childhood Mental Health Consultation in Early Childhood Settings

Community members and child and family serving providers from multiple sectors prioritized expanding access to infant and early childhood mental health consultation (IECMHC) in the IECMH Taskforce planning process. IECMHC is a prevention-based approach that builds the skills, knowledge, and capacities of adults who care for young children in early care and education, home visiting, early intervention, and other programs. Mental health consultation is an indirect service that helps primary caregivers to examine and understand the root causes of children's distress or challenging behaviors and develop and deliver strategies that prevent them from escalating. IECMHC helps the caregiver to understand young children's social and emotional development and the impacts of toxic stress and trauma; understand children's behaviors in the context of their environments and cultures; build trusting relationships with families; and make appropriate referrals for children, families, and caregivers needing additional mental health services or supports. The research on IECMHC has demonstrated significant positive outcomes, including increased social-emotional competencies in young children, increased provider knowledge of social-emotional development, lower levels of educator stress, reductions in staff turnover, and improvements in program quality. IECMHC supports staff wellness by helping early childhood providers use new approaches in their work. It creates opportunities for providers to reflect on their own experiences and build self-care practices that reduce stress and secondary trauma. Consultants can also work with program directors to create healthier and more supportive work environments.

The full recommendations for this priority are below:

Recommendation	Recommendation Type
Expand mental health consultation to staff within Early Intervention, Child Welfare, and healthcare programs.	⟳$
Expand the SUCCESS model in early care and education settings. SUCCESS provides mental health consultation to early learning programs (center-based and family child care).	⟳$
Explore the feasibility of funding infant and early childhood mental health consultation as a Medicaid preventive direct service (learn from Michigan's approach).	⟳$

Priority 9. Expand Access to Evidence-Based, Family-Based Dyadic IECMH Treatment

Strong infant and early childhood mental health systems include equitable access to evidence-based, trauma-informed, multi-generational treatment interventions. Because the mental health and development of young children are so dependent on and shaped by relationships with primary caregivers, the best practice in treating social-emotional and behavioral issues in young children are family-based dyadic treatment approaches - defined as the treatment offered to the young child and parent(s) or other primary caregivers together. The focus is frequently on improving parenting and parent-child interactions, often to support changes in the child's behavior. These therapies may involve modeling or coaching from the therapist, observation and feedback from the parents, and opportunities to practice new skills. While dyadic and family-based therapies primarily focus on the relationship between the child and caregivers and the child's mental health, parental behavioral health issues or historical trauma that influence parenting behaviors may emerge, and helping parents to access individual treatment to address these issues can be adjunctive to and supportive of the treatment. Evidence-based and promising early childhood mental health treatment interventions include Parent-Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP), and Attachment Biobehavioral Catch-up (ABC).

One of the biggest challenges emerging from the IECMH Taskforce planning process was recognizing the shortage of trained clinicians to offer evidence-based IECMH treatment in Rhode Island. With only eight licensed clinicians in Rhode Island trained in these models, parents noted in focus groups their concern over the lack of access to treatment services and long waiting times for care. Consequently, the Taskforce recommends expanding the number of behavioral health providers trained to provide evidence-based, family-based dyadic treatment to this population and prioritizing rate increases for behavioral health treatment services to incentivize clinicians to offer such treatments. Another facet of this strategy to increase access to IECMH treatment involves expanding the settings in which it is offered and developing strategies for successfully funding and sustaining these services.

The full recommendations for this priority are below:

Recommendation	Recommendation Type
Offer training to expand the number of clinicians trained to provide evidence-based, family-based dyadic treatment (such as Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT), and Attachment and Biobehavioral Catch-up (ABC)) (see Priority 1)	
Prioritize rate increases for behavioral health treatment services (based on OHIC's legislatively mandated rate review).	
Support partnerships between pediatric/family medicine practices and outpatient behavioral health providers to integrate behavioral health and IECMH clinicians in pediatric/family medicine practices OR co-locate behavioral health and IECMH clinicians to offer consultation.	
In partnership with Medicaid and MCOs, develop billing guidance documents and training to ensure that (1) clinicians understand when a diagnosis is not necessary	

Recommendation	Recommendation Type
for referral to IECMH treatment or interventions, (2) clinicians understand how to bill integrated behavioral health and/or IECMH treatment (such as dyadic therapies), (3) billing staff are educated about the appropriate and allowable billing codes, and (4) barriers to successful reimbursement for IECMH services identified by clinicians are addressed.	
Expand school-based Medicaid coverage and reimburse delivery of mental health treatment delivered in Local Education Agencies (LEAs), child-care, and non-public school-based preschools for Medicaid-eligible children with no IEP/diagnosis.	⟳$

Priority 10. Promote Developmentally Appropriate Assessment and Diagnosis

A high-quality and comprehensive early childhood system of care includes routine developmental and behavioral screening to identify any emerging concerns. Screening results sometimes suggest a need for further investigation to understand the nature and scope of an issue, and this next step is a more in-depth assessment by a trained infant and early childhood mental health clinician with access to high-quality, valid, and reliable assessment tools. A comprehensive assessment in early childhood is based on developmental understanding. It considers the family's cultural context and beliefs, other social and environmental determinants of health, and assets and strengths. Often this assessment requires multiple sessions with the family. The assessment process should result in recommendations such as parenting support, help accessing social services and supports, and/or IECMH treatment and other specialized care.

In some cases, a mental health diagnosis will be the result of the assessment process. When a diagnosis is appropriate, the clinician will likely either use the DSM-V or the DC:0-5, which is a diagnostic system developed specifically for use in infancy and early childhood. The DC:0-5 includes extensive cultural considerations, focuses exclusively on mental health disorders typically diagnosed in the birth to five years age range, and uses a relational lens. Using the DC:0-5 system requires specialized training, resulting in a diagnosis, relationship-based clinical formulation, and treatment recommendations. Clinicians may also use Z codes to maximize access to IECMH services without a diagnosis. Z codes are insurance codes (called ICD-10-CM) used to report social, economic, and environmental determinants affecting health. A clinician can use Z codes to help children access treatment when they are experiencing symptoms of distress due to stressful life situations (e.g., a sudden change in living situation or a parent losing a job) even if they do not meet the criteria for a diagnosis. Z codes can also be used to highlight the social or environmental factors in a child's life that may be at the root of symptoms – which can be useful in helping adult caregivers to both understand the important role of these social determinants and develop remedies that address them.

The IECMH Taskforce and community participants (both providers and parents) engaged in lengthy discussions about optimal policies and practices related to developmentally appropriate assessment and diagnosis for young children in Rhode Island. Within these discussions, multiple participants - particularly parents - raised concerns about the potential harm that might result from a young child being diagnosed with mental health, especially early in life. **The concern is NOT specific to the type of diagnostic system used (e.g., the DC:0-5 or DSM) but rather about diagnosing young children in general.** While the DC:0-5 is more developmentally appropriate, recommending the DC:0-5 will require significant system investments. Therefore, the Taskforce feels that it is important to engage in more discovery time to understand and explore the community concerns before making recommendations that will change current practices, professional development, and systems around diagnosis.

The full recommendations for this priority are below:

Recommendation	Recommendation Type
Align managed care organization (MCO) and fee for service (FFS) practices around utilizing Z codes to maximize access to IECMH services without a clinical diagnosis.	⟳
Allow IECMH clinicians to bill for evaluation/diagnosis over multiple visits.	$

Recommendation	Recommendation Type
Hold for Further Study: The state needs more time to better understand community concerns about diagnosis before recommending and supporting the use of DC:0-5 to support relationship-based assessment and treatment selection. (Please see the next steps for more detail.)	

Next Steps

To ensure the effective implementation of this Infant and Early Childhood Mental Health plan and further explore concerns around diagnosis to inform a recommendation on using the DC:0-5, the Taskforce will continue to convene as a workgroup of the Behavioral Health System of Care Steering Committee. Over the next six months, the Taskforce will:

- Prioritize the plan recommendations
- Gather additional clinical and community perspectives on the diagnosis of young children to inform decisions regarding state investment in the DC:0-5 diagnostic classification system.

Diagnosis: Gathering Additional Community and Clinical Perspectives
The Taskforce will oversee a process to gather additional clinical and community perspectives on concerns raised by some community members that mental health diagnoses (regardless of the diagnostic system used) could potentially harm children of color by mislabeling and stigmatizing of children and families who have experienced discrimination and prejudice. As noted previously, the concern is NOT specific to the type of diagnostic system used (e.g., the DC:0-5 or DSM) but rather about diagnosing young children in general. While the DC:0-5 is more developmentally appropriate, recommending the DC:0-5 will require significant system investments. Therefore, the Taskforce felt it was important to engage in more discovery time to understand and explore the community concerns before making recommendations that will change current practices, professional development, and systems around diagnosis.

The Taskforce will explore the following questions:

- In what settings or scenarios are families, especially families of color, experiencing discrimination and prejudice due to a mental health diagnosis? How is this impacting the child and the family? What policies and practices are contributing? What are potential remedies?
- What recourse does a family have if they disagree with a diagnosis? Where do families go for advocacy if they are unable to access services without a diagnosis?
- In which situations is a mental health diagnosis required to access treatment? In which situations is a mental health diagnosis unnecessary?

The first step will be to host a public forum for families and caregivers to gather examples and input specific to diagnosis (note: prior caregiver/family focus groups focused more broadly on infant and early childhood mental health). The Taskforce will research the examples shared to better understand the underlying policies and practices that might have contributed to the situation. Once the Taskforce has a more complete understanding of family/caregiver concerns about diagnosis, it will seek input from behavioral health clinicians via surveys and 1:1 interviews on the following:

- What is the best way to remedy family/caregiver concerns about diagnosis?
- What are the most significant professional barriers impacting behavioral health providers' ability to properly/effectively screen, diagnose, and treat infants/young children, if any?
- What are the benefits and challenges of using the DC:0-5 diagnostic classification system?
- How important is it for clinicians to use the DC:0-5 in conducting mental health assessments with infants and young children?
- Should Rhode Island recommend or require the use of the DC:0-5 diagnostic classification system for clinicians working with young children from birth to age five?

Once the clinical perspective has been gathered, the Taskforce will host a joint meeting of behavioral health clinicians and families/caregivers to share both sets of feedback/input and discuss potential recommendations.

Aligned and Connected Plans

As EOHHS wrote this IECMH Taskforce Plan and Report, it consulted the following existing state plans addressing the healthcare needs of infants, children, and young families in general. It is our intention to align our planning with these existing documents to ensure collection and avoid either duplicative or conflicting proposals.

- RI Breastfeeding Strategic Plan
- Early Care and Education Strategic Plan
- Report and Recommendations on Expanding RI Pre-K
- Rhode Island SNAP-Ed Plan FY 2022
- Rhode Island Behavioral Health System of Care for Children and Youth
- Meeting the Social-Emotional Needs of RI's Youngest Learners

Appendices:

Appendix A: List of Taskforce Participants

EOHHS thanks the many parents, advocates, providers, and state staff who participated in the Infant and Early Childhood Mental Health Task Force. This list includes anyone who shared their name during any of our virtual meetings.

- Aditi Subramaniam, Massachusetts Society for the Prevention of Cruelty to Children
- Alice Carter, University of Massachusetts Boston
- Alicia Morgan-Nelson, Meaningful Outcomes Behavioral Health Services
- Amy Hulberg, RI Medicaid/RI Executive Office of Health and Human Services
- Andrea Oliveira, Massachusetts Department of Mental Health
- Andrea Martin, Early Care and Education Consultant
- Angel Schultz, Rhode Island Regional Coalitions
- Ann Caretti, Ph.D., RI Coalition for Children and Families
- Ashley O'Shea, RI Executive Office of Health and Human Services
- Beth Bixby, Tides Family Services
- Betsy Sheridan, RI Department of Human Services/RI Works
- Blythe Berger, RI Department of Health
- Catherine Green, RI Head Start Collaboration Office/RI Department of Human Services
- Christina Schulz, RI Executive Office of Health and Human Services
- Christine Low, Bradley Hospital
- Dan Ferguson, National Center for Children in Poverty
- Dana Mullen, Children's Friend
- Denise Achin, RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals
- Donna Razza, East Bay Community Action Program
- Elisabeth Burak, Georgetown University Center for Children and Families
- Ellie Rosen, RI Executive Office of Health and Human Services
- Emerald Ortiz, RI Department of Health
- Dr. Gina La Prova, Family Medicine Provider
- Harriet Holder, RI Department of Children, Youth, and Families
- Heather Pelletier, East Greenwich Pediatrics
- Jackie Ferreira, Trudeau Early Intervention
- James DiNunzio, Neighborhood Health Plan of RI
- Jamie Higgins, Parent Support Network of RI
- Jen Oppenheim, Oppenheim Consulting
- Jenn Fucci, Family Service of Rhode Island
- Jenn Kaufman, Early Intervention/RI Executive Office of Health and Human Services
- Jenna Nelson, Family Service of RI
- Dr. Jennifer Levy, RI Department of Health
- Jesse Rosene de Brito, Parent Support Network
- Jessica Rice, Northeast Family Services
- Jillian McLeish, East Bay Community Action Program
- Jim Beasley, RI Department of Health
- Jordan Maddox, RI Department of Behavioral Health, Developmental Disabilities, and Hospitals
- Joseph Carr, RI Department of Children, Youth, and Families
- Kaitlyn Rabb, Rhode Island KIDS COUNT
- Katy Thomas, RI Executive Office of Health and Human Services

- Kayla Rosen, RI Office of the Governor
- Kelci Conti, Comprehensive Community Action Program
- Khadija Lewis Khan, Beautiful Beginnings Child Care Center
- Kim Joly, RI Department of Children, Youth, and Families
- Kristin Lehoullier, Elevated Results
- Laura Scussel, Thrive Behavioral Health
- Leanne Barrett, Rhode Island KIDS COUNT
- Lex Regan, Child and Family of RI
- Lisa Kennedy, Tri-County HEZ
- Lisandra Dju, Family Service of RI
- Liz Rutkowski, Neighborhood Health Plan of RI
- Madeleine Tremblay, RI Association for Infant Mental Health
- Margaret Holland McDuff, Family Service of RI
- Margaret Howard, Women & Infants Hospital and RI MomsPRN
- Margo Katz, RI Department of Health
- Marie Palumbo, Family Service of RI
- Marti Rosenberg, RI Executive Office of Health and Human Services
- Maryann Lynch, RI Association for Infant Mental Health
- Maryellen Hagerty, Sherlock Center on Disabilities
- Meg Hassan, RI Office of the Governor
- Melissa Worcester, Optum
- Michelle Rivera, Progreso Latino
- Naiommy Baret, Parents Leading for Educational Equity
- Nicole Faison, Meeting Street
- Nicole Vadnais, RI Department of Children, Youth, and Families
- Dr. Olutosin Ojugbele, RI Department of Health
- Paige Clausius-Parks, Rhode Island KIDS COUNT
- Dr. Patricia Flanagan, Care Transformation Collaborative RI
- Rebecca Silver, SUCCESS, Bradley Early Childhood
- Rena Sheehan, Blue Cross Blue Shield of RI
- Rhonda Farrell, Tri-County Community Action Agency
- Russ Cooney, Neighborhood Health Plan of RI
- Ruth Gallucci, RI Department of Education
- Samuel Gaston, RI Executive Office of Health and Human Services
- Sarah Coutu, United Healthcare
- Sarah Hagin, PediPRN, Bradley Hospital, Hasbro Children's Hospital
- Sarah Nardolillo, RI Department of Human Services
- Sarah Sparhawk, RI Department of Children, Youth, and Families
- Seena Franklin, Comprehensive Community Action Program
- Sharon Zanti, University of Pennsylvania
- Sheila Grant Orphanides, RI Association for Infant Mental Health
- Sheila Smith, National Center for Children in Poverty
- Susan Aiken, Washington County Coalition For Children
- Susan Dickstein, RI Association for Infant Mental Health
- Susan Lindberg, RI Department of Children, Youth, and Families
- Susannah Slocum, RI Executive Office of Health and Human Services
- Tanja Kubas-Meyer, RI Coalition for Children and Families
- Therese Ahlers, ZERO TO THREE
- Valentina Laprade, Children's Friend
- Dr. Victor Pinkes, Blue Cross Blue Shield of RI

Appendix B: Key Terms

Adversity (populations experiencing adversity)	Adversity is a broad term that refers to a wide range of circumstances and events that pose a threat to a child and/or family's physical or psychological well-being. In the context of this plan, the intention is to prioritize the delivery of IECMH services to populations facing the greatest adversity, such as (but not limited to) children and families experiencing extreme poverty, homelessness, domestic violence, community violence, and discrimination on the basis of race, sexual orientation or disability.
Behavioral Health	The term infant and early childhood **mental health** is used when talking about the social and emotional well-being of young children from birth to age 5. The term **behavioral health** is an umbrella term that encompasses both mental health and substance use, and it is generally used only in referring to the well-being of older children (adolescents) and adults. In this plan, behavioral health is generally used when discussing the well-being of parents/adult family members and the early childhood workforce.
DC:0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (Version 2)	Developmentally based system for diagnosing mental health and developmental disorders in infants, toddlers, and young children from birth to age 5.
DSM: Diagnostic and Statistical Manual of Mental Disorders	Used to diagnose mental health disorders in older children and adults.
Dyadic Treatment (aka family-based dyadic therapy)	A form of therapy in which the infant or young child and parent are treated together. A clinician is present with the parent-child dyad or in a nearby room and coaches the parent to encourage positive interactions that can help improve parenting, the parent-child relationship, and the child's behavior—also referred to in this plan as family-based dyadic treatment to emphasize the importance of the whole family approach and the centrality of the family in the treatment of infants and young children.
EPSDT: Early and Periodic Screening, Diagnostic, and Treatment	A core tenant of Medicaid that requires comprehensive coverage of medically necessary services, including preventive services, for children under 21.
Evidence-based Interventions	Evidence-based interventions are practices or programs that have evidence to show that they are effective at producing results and improving outcomes when implemented with fidelity.

ICD-10	ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD). It contains codes for diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. It is the diagnostic classification standard used for billing purposes.
IECMH (Infant and Early Childhood Mental Health)	Infant early childhood mental health is synonymous with healthy social and emotional development. It is the developing capacity of the child from birth to age 5 to form close and secure interpersonal relationships; experience, regulate and express emotions, and explore the environment and learn.
IECMHC (Infant and Early Childhood Mental Health Consultation)	IECMHC is a prevention-based approach that pairs a mental health consultant with adults who work with infants and young children in the different settings where they learn and grow, such as child care, preschool, home visiting, and early intervention programs. Mental health consultation equips caregivers to promote children's healthy social and emotional development and recognize and respond to social, emotional, and behavioral concerns.
Integrated Care	Integrated care is a general term for any attempt to fully or partially blend behavioral health services with general and/or specialty medical services. Integrated care occurs when providers work together to address both the physical and mental health needs of their patients.
PediPRN and MomsPRN	Rhode Island has two statewide Psychiatry Resource Network (PRN) teleconsultation programs: RI MomsPRN and PediPRN. These programs support Rhode Island healthcare providers by offering same day specialized clinical consultations and resource/referral services related to mental health. This service enables providers to comprehensively care for their patients more promptly with the goal of avoiding long wait times for specialized care. • **RI MomsPRN**: serves providers treating pregnant and postpartum people. Services are implemented by the Center for Women's Behavioral Health at Women & Infants Hospital. Perinatal providers and family visitors can call the RI MomsPRN teleconsultation line for clinical guidance in treating their perinatal patients, connection to community resources, and/or referral to mental/behavioral health services. (Funding is ending Sept 2023) • **PediPRN:** serves primary care providers (PCPs)treating children and adolescents. Services are implemented by Bradley Hospital. Pediatric and family medicine providers can call PediPRN for

	teleconsultation and resource and referral (PediPRN is currently expanding its capacity to support providers in addressing needs in early childhood).
Reach Out and Read	A national initiative supported by the American Academy of Pediatrics that helps integrate reading into pediatric and family medicine practices. Participating providers advise families about the importance of reading with their children and share books that serve as a catalyst for healthy childhood development.
Reflective Supervision	Reflective supervision is a distinct form of supervision in which attention to all of the relationships is important, including the ones between practitioner and supervisor, practitioner and parent, and between parent and child - contemplating how each of these relationships affects the others. It includes consistent time for the service provider and supervisor to reflect on thoughts and feelings evoked during encounters with families for the supervisee's professional and personal growth.
Social Determinants of Health	Social determinants of health (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These include economic policies and systems, social norms, social policies, racism, climate change, and political systems.
Trauma-Informed Care	A trauma-informed approach to care acknowledges that healthcare organizations and care teams need to have a complete picture of a patient's life situation — past and present — in order to provide effective healthcare services with a healing orientation. Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, health outcomes, and provider and staff wellness.
Z Codes	Z codes are a set of ICD-10-CM codes used to report social, economic, and environmental determinants that affect health. Z codes can help children access treatment when they are experiencing symptoms of distress due to stressful life situations (e.g., a sudden change in living situation or a parent losing a job) even if they do not meet the criteria for a diagnosis. Z codes can also be used to highlight the social or environmental factors in a child's life that may be at the root of symptoms – which can be useful in helping adult caregivers to both understand the important role of these social determinants and develop remedies that address them.

Appendix C: Current IECMH Landscape

Please see this PowerPoint Deck for a review of the current landscape of Infant and Early Childhood Mental Health in Rhode Island. This was developed through Key Informant Interviews conducted by Elevated Results consultant Kristin Lehoullier, between October 2022 and November 2022.

IECMH in Rhode Island - Current Landscape

Appendix D: Infant Early Childhood Mental Health in Rhode Island – Perceptions of Parent and Caregiver Focus Group Qualitative Report

Introduction

In 2022, the General Assembly directed the Executive Office of Health and Human Services (EOHHS) to form a Taskforce to develop a plan to improve the promotion of social and emotional well-being of young children as well as screening, assessment, diagnosis, and treatment of mental health challenges for children from birth through age five with Medicaid coverage. To help inform this plan, the Taskforce hosted a series of focus groups with parents and caregivers in Rhode Island. They were executed by a skilled facilitator, hired through EOHHS, who was also a parent with lived experience navigating mental health problems with her own children. These focus groups aimed to gain knowledge on infant and early childhood mental health through the experiences and perspectives of parents and caregivers.

Methodology

To fulfill the directive that EOHHS was given by the General Assembly, EOHHS and RIDOH conducted a total of six one-hour focus groups during April 2023 with parents/caregivers of young children. A focus group discussion guide (a uniform set of open-ended questions and discussion prompts) was developed to explore participants' experiences accessing mental health support for their children and family in Rhode Island. The focus groups were conducted virtually using Zoom with an option for live, simultaneous translation. Participants were recruited by early childhood programs and partners in various settings throughout the state. The focus groups were scheduled at times suitable to the participant's needs. Participants received a $50 gift card to compensate them for their time.
The focus group sought families' perspectives on the following questions:

- Have you had concerns about your child's behavior or development?
- Were you able to get the help you wanted? If not, what made it hard?
- What would have helped?
- Who would you feel comfortable talking with about your concerns? E.g., someone in your child's preschool or child care? Your child's doctor's office? Anyone else?
- Is there anything else you would like to share?

Focus groups were transcribed, and thematic analysis was performed on the data to identify major themes.

Participant Characteristics

A total of 36 parents/caregivers participated in these focus groups, including families/caregivers with children enrolled in Head Start, early care and education programs, and family visiting. The focus groups also included parents/caregivers involved with the Department of Children, Youth and Families (DCYF) and parents/caregivers identifying as Black, Indigenous, and people of color (BIPOC). The table shows the focus group host and the number of participating parents/caregivers in each group.

Setting/Participants	Host	n
Parents/Caregivers with Children Enrolled in Head Start	RI Head Start Collaboration Office and RI Head Start Association	3

Parents/Caregivers with Children Enrolled in Early Care and Education (2 groups)	Beautiful Beginnings	11
Parents/Caregivers Involved with DCYF	Parent Support Network/RIPIN	7
Parents/Caregivers Enrolled in Family Visiting (including EI)	Rhode Island Parent/Caregiver Advisory Council	11
BIPOC Parents/Caregivers	Rhode Island KIDS COUNT	4

Notes:
- *While Early Intervention (EI) could not host a dedicated focus group of EI participants, several participants had children enrolled in Early Intervention.*
- *Race and ethnicity information was not collected from participants. One focus group was explicitly focused on parents and caregivers identifying as BIPOC.*

Participants in focus groups had or cared for children between the ages of 11 months and 22 years old. Many parents/caregivers, who had teen and young adult children, had up to 20 years of experience navigating mental and health services for their children and adolescents, while some with children under five were just learning that their children were not too young for mental health care. Participants came from urban, suburban, and rural parts of the state. The map below shows the geographic distribution of the participants.

Figure 8: Geographic Distribution of Parents/Caregivers in IECMH Focus Groups

Geographic Distribution of Parent/Caregiver Participants in Focus Groups
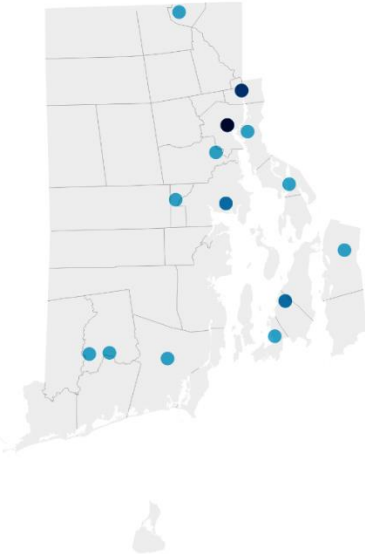
Created with Datawrapper

The focus group participants shared their children's specific diagnoses, which included autism spectrum disorders, obsessive-compulsive disorder (OCD), attention deficit and hyperactivity disorder (ADHD), anxiety, depression, and behavioral/physical health comorbidities. In addition to formal diagnoses, parents and caregivers reported behaviors that included tantrums, biting, hitting, and screaming.

Parents also spoke of their own mental health struggles and trauma and worried about how that would impact their children. Parents/caregivers also spoke of the persistent impact of the COVID-19 pandemic on social-emotional learning and routines and discussed the social isolation children with food allergies experience.

Key Themes
The following eight main themes were identified from focus group discussions: family challenges obtaining care for mental health concerns; structural racism and mental health; economic instability and mental health; mental health promotion and de-stigmatization; family relationships with providers/schools and culturally responsive care; proactive screening to identify and address concerns; peer support and community-based parenting and mental health supports; and access to high-quality early care and educational supports.

Family Challenges Obtaining Care for Mental Health Concerns
The implications of workforce shortages frequently interfered with access to mental health care. Participants shared how difficult it is to access appropriate treatment for themselves and their children. They expressed frustration and despair around long wait times – often between six to twelve months – to receive community-based therapy and/or intensive services without access to interim care. And when they could find a provider, they were concerned about their experience and lack of training in children's mental health:

> *"I have been calling to try and find some support, and I ran into like several year-long or six-month long waitlists that were really defeating and frustrating and upsetting probably called like eight places, and finally found an appointment with someone, and they, you know, it's a new…staff……and I'm not really sure……..what their background or skill set is in terms of child's support or family support."*

In addition, families also reported challenges in accessing mental health therapies for non-verbal children, home-based services, and providers who offer family-friendly, flexible scheduling. Participants were also concerned with the lack of connection to care after intensive therapies, with one parent reporting that after receiving intensive in-patient treatment for postpartum depression, she and her peers in the program received no connection to ongoing stabilization, leaving them feeling abandoned and without resources to navigate PTSD.

Parents and caregivers also spoke about the importance of having access to therapists that are trauma-informed, culturally competent, and trained in domestic violence. They shared how getting help from culturally competent, trauma-informed therapists helped them heal their own trauma and understand childhood trauma better. And they spoke of how important it is for therapists and social workers to be trained to address domestic violence issues, as parents are very concerned about family separation when accessing treatment for domestic violence-associated trauma.

> *"Personally, I have a therapist who's trauma-informed, and she specializes in domestic violence. And like, I'm really open and honest with her, and I found her to be incredibly helpful for the kids, too, and she's gone through a lot of like about childhood trauma. She's helped me educate me on that, as part of my treatment, to understand how me, being in a situation like that with their father, has affected them, and I found that to be really helpful."*

They also felt that it was critical that healthcare providers be trained on how racial bias and intergenerational racialized trauma impact mental health. They wished there were more therapists of color, particularly male therapists of color, and they reported a shortage of providers with a specialty and lived experience in cross-cultural issues.

Structural Racism and Family Mental Health and Well-being
Behind the expressed need for providers with lived experience and training in racial and bi-cultural concerns were participants' experiences of structural racism. Parents and caregiving expressed that they suffered from intergenerational racialized trauma and worried about how it would impact their children, and parents who were born outside of the United States worried that their children would experience xenophobia. One parent described her child's experience of racialized bullying in school and her difficulty finding a therapist to help him navigate the school stress. Parents and caregivers generally felt a lack of compassion for Black and brown children experiencing mental health problems in schools. As described by one parent:

> "*It's very easy for Black boys to be considered problems if they don't fall in line with what the educational setting is expecting.*"

In addition, BIPOC parents and caregivers also experienced frustration and powerlessness when advocating for their children of color. One mother described how her son, who suffered from anxiety and comorbidities, was frequently taken to the emergency department from school. When she tried to advocate for him, she came up against racial bias and was dismissed by providers.

> "*When I get to the hospital and try to explain to them that you know he has issues with food and he has anxiety and they need to give him some room, they don't listen to the parent because I become like one of those crazy Black women, talking and talking.*"

Economic Instability and Family Mental Health and Well-being
Constrained financial resources were cited as a major barrier to families taking care of mental health needs. In some cases, essential therapies for children were not covered by insurance, requiring families to pay out of pocket, creating further financial strain on the family. They also spoke of the chronic stress resulting from living with economic instability and how that stress negatively impacted the mental health of their family. They were also concerned about the well-being of the healthcare workforce and how their mental health impacts their ability to care for their patients. In the words of one parent:

> "*If you don't have economic stability, it's very hard to be mentally stable….and our families are going through it…along with the workforce. We are expecting them to do so much to care for others, you know, when they can't really care for themselves, you know.*"

It was noted that when families have the financial resources to meet their basic needs, they have a greater capacity to address their children's and their own mental health needs.

The Importance of Mental Health Promotion and Destigmatizing Mental Health
Many participants talked about shame, stigma, and judgment around mental health in their communities and families. The pressure to keep these problems hidden or within the family was a barrier to accessing mental healthcare. For instance, one parent reported that it was easier for her to get mental health services for her child as a single parent because she didn't have pushback from the other parent who didn't believe in seeking help outside the family.

"The men in my family are the type that, like whatever they say, whatever goes on in our house, stays in our house type thing. And so, I was not able to seek outside help for my children unless I was without a partner. So, when I was without my partner was when I was able to seek the help of like, you know, Parent Support Network and CCAP and all those things that would come into the house and visit with my kids, and my son got a case worker and all those things that all benefited him. But if you don't have the right support at home, that also plays a part of it, and also the teachers at school."

In addition, they spoke of the importance of peers speaking openly and publicly to promote healthy, open discussions about mental health:

"There is fear among people, and there is definitely a stigma attached to the issue, so if others are willing to be open about getting help, it can cause a few others to try to do the same as well."

It was noted that there was a particular need for mental health promotion in environments where stigma was deep-rooted and pervasive, such as in certain cultural contexts and industries (e.g., construction). Participants said that using media to share stories around family mental health problems would promote awareness, normalize conversations about mental health concerns, and help families feel connected and hopeful:

"Another point I wanted to express is that of educating parents by running a campaign in which parents willing to come forward and speak about their experiences can do so publicly to show that there is no shame in seeking help for your child/children. Sometimes hearing someone's testimony and having it be similar to or exactly like yours, you will be open to listening and mimicking how they overcame. Experience teaches wisdom!"

The Importance of Parent/Caregiver Relationships and Culturally Responsive Care with Health Care Providers and Schools

Parents and caregivers spoke about how important it is for providers of services and support to build relationships with families and provide linguistically appropriate and culturally sensitive services. In particular, participants stressed that their relationship with providers in healthcare and school settings made a big difference in the quality of care.

Participants felt that the strength of the family's relationship with the provider in healthcare settings impacted the ease of access to mental healthcare and support. They shared stories about responsive pediatricians who made referrals to more intensive care as needed and caring medical specialists who helped them access care from multiple specialists (particularly for autism spectrum disorders). The care and concern these providers demonstrated resulted in their access to critical support for their children. On the other end of the spectrum, participants talked about pediatricians who were unresponsive to communication, visits that were too short, and providers who did not take the time to listen to youth and families or screen their children for mental health issues. Participants wanted providers to have a more family-centered approach and longed for interactions with providers that were more kind:

"Yes, we need more training, but we also need, you know, more compassion, more sympathy"

Parents and caregivers felt that strong relationships with teachers, guidance counselors, and school

social workers were also important supports for their children's health and well-being in school settings. These relationships were reported, on occasion, to facilitate curriculum modifications that supported and developed a child's natural interests and strengths. On a more universal programmatic level, parents and caregivers spoke of how sign language in child care and preschool settings supported learning and communication skills for children with speech delays, and many expressed support for milestone development, Conscious Curriculum, and play-based learning. Some parents and caregivers also reported that they would like more educational materials that engaged neuro-typical peers around neuro-atypical behaviors and communication styles.

The Importance of Screening to Proactively Identify and Address Concerns
Participants discussed the importance of universal mental health screenings during pediatric visits to prompt meaningful discussions with families. One father made a key point about the importance of pediatricians encouraging youth engagement by using open-ended questions:

> "When you go to …. annual physicals, they're basically just doing a questionnaire, you know, which is, pretty much, yes, no, yes, no…. My recommendation would be more open-ended questions. So at least …. youth can …..actually express how they feel."

This father's statement speaks to the need and desire for proactive pediatric consultation on mental health. It highlights the lack of opportunity for children and families to express feelings and discuss issues during a well-child visit.

They also mentioned EXCEED and KidsRI as two organizations that were helpful in connecting their children to appropriate educational settings and community-level outreach screenings and assessments. They spoke about how the results of those screenings were communicated to schools, giving families a head start on securing appropriate school-based support.

The Importance of Peer Support and Community-based Parenting and Mental Health Supports
Many parents and caregivers spoke of the social isolation they experienced and how connecting with other parents navigating similar concerns with their children helped them relieve stress accumulated during COVID isolation. Community involvement with other parents and caregivers increased their confidence to parent and provide care. They shared examples of social connections happening online (e.g., Facebook groups) and in person, formally and informally (e.g., parenting classes and meeting others in community settings such as libraries).

> "If you can find like a Facebook support group with black mamas, and …. neurodivergent kids, that is awesome. You feel like you're going through it alone, and you're struggling, and even the best parent on the best day feels like the worst parent because there's never enough time, and if you have more than one kiddo, you're like already stretching yourself then, and it's just a lot to go through."

Parents and caregivers discussed how community spaces helped them navigate mental health resources for children. They found great benefits in peer learning opportunities that taught parenting skills and helped parents and caregivers connect and form relationships with each other. They felt these forums served to destigmatize mental health. Some parents reported when these opportunities became available in a virtual format, they were significantly more accessible. One parent spoke of a transformative experience participating in "Incredible Years", a 14-week training program based on building community, where parents determine the topics of concern and clinical and educational

professionals helped them learn ways to build positive relationships with their child and form secure attachments.

The Importance of Access to High-Quality Early Care and Education and Educational Supports
In addressing equity concerns in school and early learning environments, participants reported the need for more multilingual child care settings, financial assistance for child care, more resources to educate children about their peers with mental and behavioral health problems, and shorter wait times to develop IEPs. Participants additionally noted variations in Early Intervention program quality across agencies and municipalities. There were concerns over social-emotional learning being increasingly pushed out of curriculums to make more time for academics. One parent spoke about the importance of recess, art, and music and how lacking these social-emotional learning spaces created environments that were not necessarily supportive of children's mental health.

> *"Both of my boys, when they were little, were very, very active and they did not like to do things that required a lot of sitting, and you know, just listening to a teacher, or a lot of work. So, we did find child care, but I knew the transition to school was gonna be something that I had to pay attention to, and at the time the State was talking about taking recess away because the children, the test scores were not high enough for reading and math. So, they wanted more academic time, and there were fights in the legislature to keep recess in the schedule, and other things like art and music were also being cut at the time. So, I made the decision to send my kids to a school, ended up being a private school, where they had two recesses a day, because I think kids need to move … because the child has you know different behaviors that are outlying, but also a lot of things have to do with the environment that their in."*

One parent expressed the need for more therapeutic learning environments, including nature and agricultural-based learning. Participants additionally noted early childhood workforce concerns, such as wanting to see more workforce retention so children can build strong relationships over time with educators. They also wanted to see more training on mental health for educators, including ways to address root causes of mental health problems, more training around comorbidities, and family-centered practices. Finally, focus groups revealed a lack of access to information about pre-K enrollment.

Appendix E: DC:0-5 Survey Results

EOHHS and RIDOH surveyed behavioral health clinicians and other early childhood providers on whether RI should promote training in and adoption of the DC:0-5 as a diagnostic assessment system. Below is a summary of the survey results.

Clinician Survey Summary
11 total responses

Should Rhode Island recommend or require adoption of DC0-5?

Seven clinicians believe it should be recommended for clinicians working with children 0-5; four believe it should be required.

All clinicians report they would use DC:0-5 if the state recommended it. All would use it if the state published a billing crosswalk to DSM-5.

Clinicians expressed hesitation around DC:0-5 being a state requirement because of:
- Concerns around the challenge of insurance companies integrating new codes while clinicians are simultaneously required to start using DC:0-5
- Belief that if it is a recommendation rather than a requirement, clinicians will feel curious about the tool rather than forced into something.

Those who believed it should be required rather than recommended expressed:
- Things that are required are more likely to be implemented.
- Standardization of diagnostic criteria would improve communication between multiple providers
- Recommending rather than requiring would result in inconsistent adoption of DC0-5
- It is easy to maintain the status quo, a requirement would push the old, ineffective ways into obsolescence.

What are the most significant barriers to screening and diagnosing infants and young children?
- Not enough workforce with early childhood specialty.
- Medicaid reimbursement for family sessions is insufficient.
- Screening and diagnosing infants and young children requires the proper training, support, consultation and supervision. Many settings do not have these things in place.
- Long wait times for services and time restraints when meeting with patients

Reported benefits for clinicians using DC:0-5 in their practice:
- Provides proper diagnosis that allows clinicians to target appropriate developmental, social-emotional and relational supports to parent-child dyad
- Useful as a framework for observation and clinical case conceptualization
- Encourages clearer communication and collaboration across sectors
- Results in more appropriate and timely referrals

Community Partner Survey Summary
27 total responses
21 community partners respondents have heard of the DC:0-5 classification system; six have not heard of it.

Do the benefits outweigh the costs and what are the pros and cons?
Sixteen community partners believe the benefits of promoting DC:0-5 in RI outweigh the costs; two do not believe benefits outweigh the costs; and 9 do not know if the benefits outweigh costs.

Pros from community partners' perspective of promoting the use of DC:0-5:
- More accurate diagnoses, referral to services, improved care for infants and families, enables early detection and intervention
- More culturally and age appropriate than DSM-5
- The tool can give providers a better understanding of the nuances of infant and early childhood behaviors
- Workforce development: reorients providers to think of mental health in a relational framework, allowing providers to focus on the parent/child relationship.
- Encourages valuing cultural context and norms
- Standardization would improve coordination of care between partner agencies that are supporting children and families.
- Would improve healthcare utilization and outcome data.
- Potential for increased reimbursement for professional time
- Minimizing stigma/pathologizing of mental health, allowing behaviors to be viewed as part of development

Cons (and challenges) from community partners' perspective of promoting the use of DC:0-5:
- Insurance barriers:
  - Lack of faith that insurance companies will reimburse for clinical services within the existing billing structure.
  - Lack of insurance parity in RI
  - Reimbursement rates for behavioral health are too low in RI (both Medicaid and private).
  - Statewide implementation would be expensive especially if not supported by insurance/reimbursement
- Lack of faith in the capacity/desire of state to implement DC:0-5 due to perceived lack of Children's Behavioral Health leadership in RI, too many agency staff in interim positions, with competing priorities
- Not sustainable when funding for children's behavioral health comes in the form of time-limited grants and state legislators have not demonstrated that they are willing to invest long-term in behavioral health services
- Would not be supported by current EMR systems
- If training insufficient, there is a risk of people applying the diagnostic codes inappropriately

Would you participate in DC:0-5 training, why or why not?
24 responded yes, three responded no. All three who reported no are in positions where they report the training is not applicable.

While clinicians see the value, some expressed concerns that they do not have the time and financial resources to participate in training and feel training would not be sufficient unless it incorporated ongoing support and professional development.

Questions:
- Are there enough trainers in RI to be embedded in the various contexts in which the tool may apply to support fidelity outcomes?
- What has implementation of DC:0-5 looked like in other states and what are the lessons learned in engaging insurers, both public and private?
- How is training being incentivized for providers to be trained in, and utilize DC:0-5?
- How is this sustainable in the long-term?
- Are there dangers of pathologizing behaviors that are normal responses to environmental factors?
- How family focused is DC:0-5?
- What is the cost of investing in training for DC:0-5?
- What free and simplified information is available or can be made available?
- Will there be sufficient response resources and services to address increased identification of needs?
- How many people in RI are trained in DC:0-5 and how many are using it in their practice with 0-5?
- Would there be a high quality crosswalk with DSM/ICD that could be maintained?
- Is it more or less culturally sensitive than DSM?
- Is the time required to use the tool feasible in existing practices?
- Is autism included in DC:0-5?
- After diagnosis, what are any next steps laid out by DC:0-5?

Appendix F: Infant Mental Health Endorsement in Rhode Island

The Rhode Island Association for Infant Mental Health (RIAIMH) Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® (RI-IMH-Endorsement®) is intended to recognize activities that lead to competency in the infant-family field. It does not replace licensure or certification, but instead is meant as evidence of specialization in this field.

The Endorsement is available to cross-sector and multidisciplinary professionals, including child and/or human development, education, nursing, pediatrics, psychiatry, psychology, social work, and others. Endorsement® indicates an individual's efforts to specialize in the promotion/practice of infant mental health within his/her chosen discipline.

The Endorsement® is a credential that:
- Recognizes and honors specialized knowledge and expertise.
- Acknowledges professionals who apply infant & early childhood mental health principles to their practice.

There are several types of endorsement as follows:

Type	Description	Number of Endorsements in RI
I/EC Family Associate	- Promotion (e.g., early childhood education, pediatricians, child welfare, etc.) - Shares with families an understanding of infant/young child and family relationship development.	12
I/EC Family Specialist	- Prevention/Early Intervention (e.g., home visiting, early head start, IECMH consultation, etc.) - Supports and reinforces each caregivers' strengths, emerging capacities, and positive infant/young child interactions and relationships.	13
I/EC Family Reflective Supervisor	- Prevention/Early Intervention & Macro (e.g., home visiting AND reflective supervision) - Supports and reinforces each caregivers' strengths, emerging capacities, and positive infant/young child interactions and relationships.	1
I/EC Mental Health Specialist	- Clinical Intervention/Treatment (e.g., infant/child parent psychotherapy, Child First, etc.) - Develops service plans that consider each infant's/very young child's and family's unique needs, desires, history, lifestyle, concerns, strengths, resources, cultural community, and priority.	4

Type	Description	Number of Endorsements in RI
I/EC Mental Health Mentor	Macro (e.g., researcher, higher education professor, provider of reflective supervision, policy maker, etc.) Promotes an I/ECMH service delivery that includes screening, referral assessment, use of diagnostic tools, development of trusting relationships, service planning, interagency collaboration, etc.	11

The tables below show the employment discipline and field of Endorsed professionals in RI:

Field Employed	# of Endorsed Employed in this Field
Consultant-other	3
Early Care & Education	1
Early Head Start	5
Education-other	1
Family Visiting	11
Mental Health - Non-Community Mental Health	8
Part C (Early Intervention)	1
Policymaker	1
Program Administrator	2
Supervisor Direct Service	4
Teaching Faculty	4

The individuals above were trained in the following disciplines:

Discipline	# of Endorsed in this discipline
Licensed Clinical Disciplines	19
Marriage & Family-therapy	2
Psychology	7
Social-work	10
Other	
Child-development	6
Early Care & Education	10
Human Development	2
Special-education	1
Other	3

Appendix G: Taskforce Meeting Materials

PowerPoint decks from each of the Infant and Early Childhood Mental Health Taskforce meetings held between November 2022 and May 2023 are linked below:

- RI IECMH Planning - 11.17.22 - Intro Session
- RI IECMH Planning - 12.16.22 - Promotion - Community Input
- RI IECMH Planning - 1.18.23 - Prevention - Community Input
- RI IECMH Planning – 2.15.23 – Assessment, Diagnosis, and Treatment
- RI IECMH Planning - 3.15.23 - Workforce Development
- RI IECMH Planning - 4.20.23 - Round 1 Draft Recommendations
- RI IECMH Planning - 5.22.23 - Round 2 Draft Recommendations