Urgent Priority #1:
The Crisis in Maternal and Infant Health

A healthy pregnancy and birth are the foundation for children's future health and development, making the well-being of women and pregnant/birthing people critical. Whether babies are born healthy and with the potential to thrive as they grow depends greatly on their mother's/birthing person's health and wellness—not just before birth, but prior to conception. Thus, birth outcomes and infant health are highly interconnected with women and birthing people's access to quality healthcare before, during and after pregnancy; their experiences while receiving care; and other social and economic factors, all of which can reflect the influences of past and present systemic racism.

Maternal and infant health in the United States remains a crisis, with our country having the highest maternal mortality rate among Organization for Economic Co-operation and Development (OECD) nations. And, tragically, the Centers for Disease Control and Prevention (CDC) estimates that 80 percent of pregnancy-related deaths are preventable.[1] Moreover, stark racial disparities in maternal and infant health outcomes have persisted for decades and worsened during the pandemic. The *Yearbook* data reveal significant racial disparities in prenatal care and other indicators of maternal health such as preterm births and low birthweight. The situation is worsening in the wake of the Supreme Court decision overturning *Roe v. Wade*. States' actions to severely limit access to reproductive healthcare further complicate access to providers and hospitals and pose multiple challenges for maternal health.

Policies must address access to coverage and care, with particular attention paid to culturally responsive services. In addition, if the nation is to make real progress in tackling these challenges, it is critical to address the root causes of health inequities, such as housing, economic security, safety, nutrition and mental health. One example of bold action that has dramatically improved outcomes for babies and their mothers/birthing persons is the pandemic-era policy encouraging states to take up the option of extending comprehensive, continuous health insurance coverage during pregnancy and for no less than 12 months following the end of pregnancy. To date, 46 states have adopted or plan to adopt the permanent Medicaid option for extending coverage 12 months postpartum,[2] and there is growing support to make this a requirement in Medicaid and the Children's Health Insurance Program.

FAMILY STORY

My son Mason is 2½ years old. One thing that I am passionate about in my family is ensuring that we are always filling our space with love and that we are confident to speak up for things we believe in. I want us to know that we deserve to be free from stress and systematic barriers. I have been a Head Start Family Advocate and a community advocate for a long time, and so when I had my baby, I was educated. I knew how to keep myself healthy during pregnancy. I knew I wanted a more natural, organic birth for my baby. I knew I wanted to breastfeed. And I also knew that the maternity mortality rates for Black mothers and the infant mortality rates for Black babies reflect our nation's history of racial inequity.

So I prepared. I looked for a practice that included midwifery that accepted Medicaid. I hired a doula. I thought through a birth plan that reflected what I wanted for the birth. I gave birth during COVID but hoped I could set up a system that could provide me with the attentive, individual care I deserved.

But I was disappointed throughout my pregnancy. I asked to see the same midwife each visit, but I saw a different provider for many visits and had to explain over and over and ask and re-ask the questions that troubled me. I developed a rash early in my pregnancy that got worse and worse and that was continually treated as athlete's foot (though it was much later diagnosed as eczema). I was not referred to a dermatologist until after birth. When I tested as prediabetic, I was told to lose weight. My blood pressure started climbing, and I couldn't afford a blood pressure cuff. No one told me that I could access one for free through Medicaid. When I was diagnosed with pre-eclampsia, late in my pregnancy, an unfamiliar midwife got annoyed when I asked for guidance: "We can just induce, if that's what you want," she kept telling me. And because it was my first baby, and I did not know what to do, I relented.

In violation of my birth plan, I was induced, though my doula was able to be with me during birth. She was an important advocate, pushing back on practices that were not comfortable for me, or helpful. Even so, my birth plan stated that I wanted a midwife to attend my birth. Instead, I was induced by a student, who busted my water without consent! It caused my labor to stall, and the student was performing cervix checks early in dilation, also in violation of my birth plan.

I am grateful every day that Mason was born healthy. But over and over again, my maternal health providers ignored my worries about my health and my wishes for my birth. They insisted I lose weight and limit my stress, but gave me no meaningful strategies. I spent my pregnancy Googling and guessing. I felt disrespected and judged and, ultimately, inadequate. Pregnant people should have more options for care. We should have familiar health providers. And most of all, we should have providers who understand the system, who take time to fully diagnose and treat an issue, and who listen to their patients.

Mahogany L.
Louisville, Kentucky

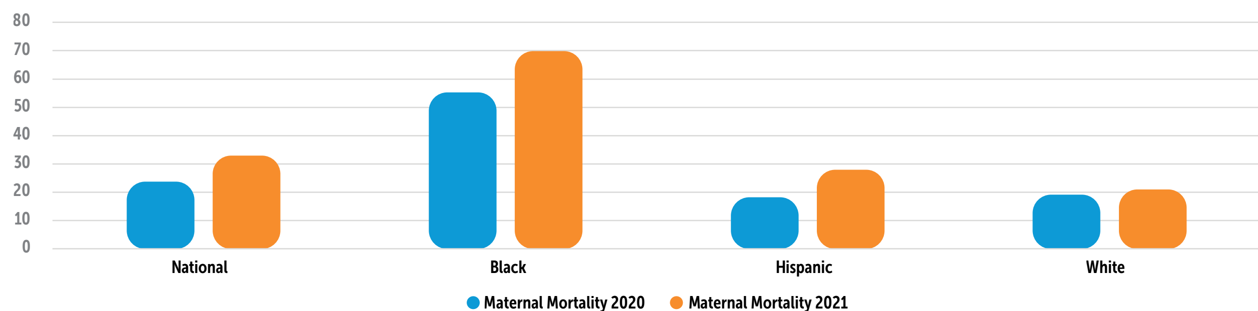
Indicators Underscore Concerns About Racial Disparities in Maternal and Infant Health

The *Yearbook* indicators for both the prenatal period and birth outcomes show that women and birthing people are not receiving the care they need to protect their own health and have healthy outcomes at birth and afterward.

Systemic barriers, along with discrimination in the healthcare system and the cumulative experiences of systemic racism that women and birthing people of color experience throughout their lives, drive the significant racial disparities seen in the data for Black, Latine, American Indian/Alaska Native (AI/AN), and Native Hawaiian women and birthing people and their newborn infants. Difficulties accessing prenatal care, and by extension quality care in giving birth, will only grow as more communities lose obstetrical services.

Maternal Mortality: Maternal mortality refers to a pregnancy-related death that occurs while a woman or birthing person is pregnant or within one year of the end of pregnancy.[3] *State of Babies Yearbook* and CDC data[4] show the maternal mortality rate continued its alarming rise to 23.8 deaths per 100,000 live births in 2020 and 32.9 in 2021. (See Figure 1-1). (The 2021 data shown here was reported after the *Yearbook* data collection ended). The continued steep increase in maternal mortality is largely driven by a rise in the rate for Black women and birthing people, increasing to 55.3 deaths per 100,000 live births in 2020 and 69.9 in 2021. Latine women and birthing people also saw a large increase, from 18.2 per 100,000 live births in 2020 to 28.0 in 2021, putting them well over the national average. While the *Yearbook*'s annual data source does not include data for Indigenous women and birthing people, CDC trend data from 2017 to 2019 reveal high levels among Native Hawaiian (62.8 per 100,000 live births) and American Indian/Alaska Native (32 per 100,000 live births) pregnant women and birthing people.[5]

MATERNAL MORTALITY (BY RACE AND ETHNICITY) 2020 AND 2021 (PER 100,000 LIVE BIRTHS) Figure I-1



The Pandemic's Impact on Maternal Mortality

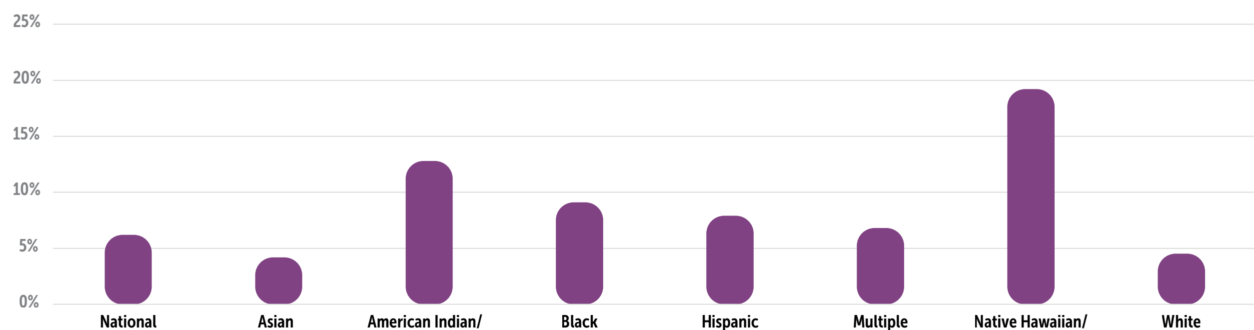
The pandemic worsened pregnancy outcomes, including maternal deaths, and deepened racial disparities with greater impacts of COVID-19 on Black and Latine women and birthing people.[6] The Government Accountability Office (GAO) found COVID-19 contributed to the large increases in maternal deaths reported in 2020 and 2021, serving as a contributing factor in one-fourth of maternal deaths during the period. Pregnant women and birthing people, especially Latine women/birthing people, were more likely to be hospitalized with COVID-19 and need intensive care.[7] As obstetrical care required creative approaches such as telehealth visits and self-monitoring, women and birthing people with low income were less likely to be able to afford equipment for these strategies[8] and more likely to experience such problems as lack of transportation or child care to enable them to attend in-person healthcare visits.[9] They were also more likely to have underlying conditions that made their pregnancies high-risk, increasing the potential consequences of being unable to access care.[10]

GAO noted that pandemic conditions underscored the impacts of racism on maternal health, discussed further below, as systemic racism contributes to the presence or exacerbation of underlying health conditions. The disproportionate impact of the pandemic and resulting economic fallout on the health and economic security of people of color also exacerbated chronic stress. Further, the pandemic increased distrust in the healthcare system via frequent changes to information about pregnancy and COVID-19, as well as policies limiting partners in delivery rooms.[11]

Access to Prenatal Care: Access to regular, reliable, culturally responsive prenatal care is critically important to reducing maternal mortality and morbidity, as well as producing positive maternal health outcomes. *Yearbook* indicators show that a greater percentage of pregnant people of color are more likely to start prenatal care late in pregnancy, particularly Native Hawaiian (19.2 percent), Native American (12.8 percent) and Black (9.1 percent) pregnant people, when compared the average of all pregnant people (6.2 percent). (See Figure 1-2).

Lack of Health Insurance: The inability to afford health insurance is a key reason for difficulties accessing early prenatal care and extended postpartum care. In general, women and birthing people of color and non-citizens are more likely to be uninsured. Among nonelderly women and birthing people with low income, nearly one in five (19 percent) were uninsured in 2021,[12] with 22 percent of all nonelderly Latine and Native American women/birthing people uninsured during the same period.[13] Despite the importance of good preconception health for a healthy pregnancy, many women and birthing people

LATE OR NO PRENATAL CARE BY RACE AND ETHNICITY Figure I-2



with low income are ineligible for Medicaid, especially in states that have not adopted Medicaid expansion, and are thus less likely to receive preconception and early prenatal care.

Studies show that Medicaid expansion is associated with improved maternal and child health, including reduced disparities in birth outcomes such as infant mortality, preterm birth and low birth weight.[14] However, a study of Medicaid expansion in 2019 found that non-Medicaid expansion states (17 at the time) accounted for more than one-half of uninsured women and birthing people of childbearing age. Currently, only 10 states have yet to adopt Medicaid expansion, but two of these states (Texas and Florida) accounted for approximately one in four uninsured women/birthing people of childbearing age in 2019.[15] In all states, many women and birthing people become eligible for Medicaid when they become pregnant, but the delay experienced if they have not previously been on Medicaid contributes to late access to prenatal care. Even so, the *Yearbook* shows 19 states set their eligibility levels below 200 percent of poverty, which still excludes some women/birthing people who may not be able to afford coverage elsewhere.

An effort to extend Medicaid and Children's Health Insurance (CHIP) coverage during the period after birth has been extremely successful, with 46 states having either adopted a federal option to extend coverage for 12 months postpartum or planning to do so in the future.

Maternity Care Deserts: Geography is another significant predictor of receipt of prenatal care. More than one-third (36 percent) of the nation's counties are considered prenatal care deserts, meaning they are without hospitals providing obstetric care, freestanding birth centers or even individual obstetric providers, including obstetricians or licensed midwives.[16] Many more counties have limited maternity care access. This lack of care is increasing in rural areas and tribal lands, with low-income women and birthing people overrepresented in counties considered maternity care deserts.[17] The need to drive long distances for basic prenatal care, or to obtain care for high-risk pregnancies that require immediate attention if something goes wrong, present further threats to the health of pregnant people.

Disparities in Other Maternal Health Outcomes

The *Yearbook* does not capture measures of maternal morbidity—health problems that could have long-term consequences for a birthing person's health and, often, for the developing fetus. However, the disparities in birth outcomes readily apparent in *Yearbook* data are evidence of the importance of quality maternal care and the consequences of neglecting the needs of many women and pregnant/birthing people.

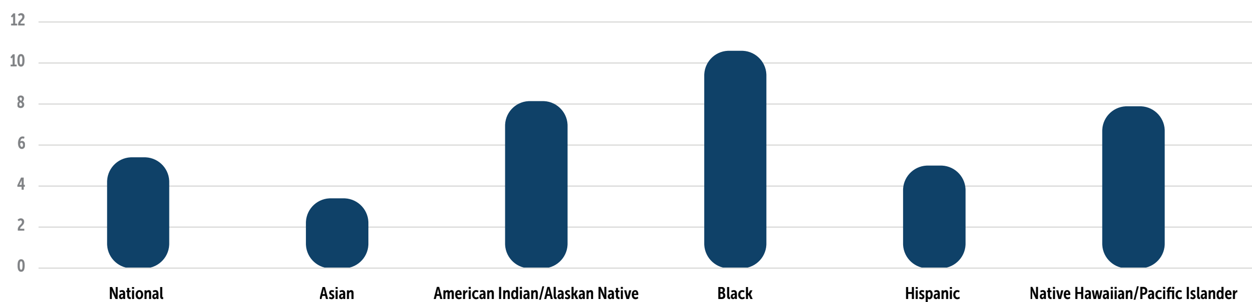
Infant Mortality Rate: The prenatal period has a significant impact on infant mortality (i.e., the number of babies who die before their first birthday). The national infant mortality rate is 5.4 deaths per 1,000 live births. The mortality rate is markedly higher for Black (10.6), Native Hawaiian/ Other Pacific Islander (8.2), and American Indian/ Alaska Native (7.9) infants. The Black infant mortality rate is nearly twice that of the national rate. (See Figure 1-3).

The United States ranks 37th among OECD nations in infant mortality. Even the best performing state (Vermont) would only rank 25th.[18] Several of the leading causes of infant mortality, such as birth defects, preterm birth, low birthweight and pregnancy complications,[19] stem from conditions experienced during the prenatal period, as well as genetic factors. Quality maternal care could prevent or reduce the effects of these Issues.

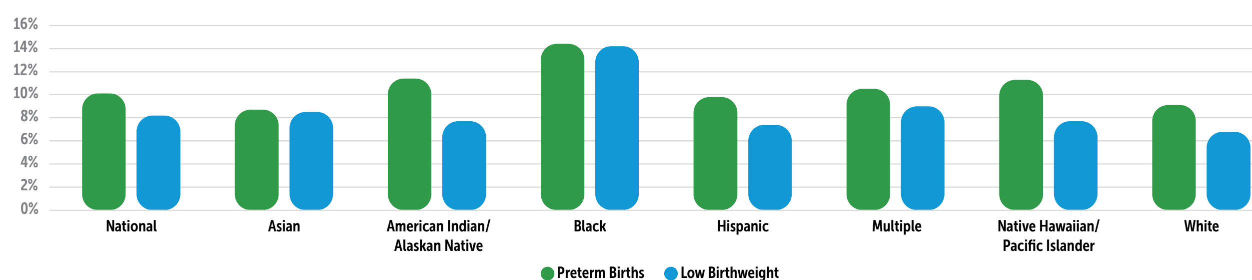
Preterm Births: One in 10 births are preterm (i.e., the baby is born before 37 weeks of completed gestation). Preterm birth rates are significantly higher than the national average (10.1 percent) for Black (14.4 percent), American Indian/Alaska Native (11.4), Native Hawaiian (11.3) and multiple race (10.5) infants. (See Figure 1-4). Factors that can contribute to prematurity range from multiple gestations or physical characteristics of the uterus, little or no prenatal care, chronic medical conditions, poor nutrition and substance use. Improved prenatal care would provide the close monitoring needed to ensure a healthy birth. Premature babies are at higher risk of such developmental issues as cerebral palsy, language and cognitive deficits, and learning disabilities.[20]

Low Birthweight: Of all infants, 8.2 percent are born with a weight of less than 5.5 pounds. The national average for Black infants born at low birthweight is strikingly high at 14.2 percent. (See Figure 1-4). Low birthweight is often associated with premature birth, but other factors can also

INFANT MORTALITY BY RACE AND ETHNICITY (PER 1,000 LIVE BIRTHS) Figure I-3



BIRTH OUTCOMES Figure I-4



lead to slow growth during pregnancy. Risk factors for low birthweight include chronic health conditions, infections during pregnancy, use of such substances as alcohol or tobacco, multiple gestations and exposure to unhealthy environmental conditions such as air pollution.[21]

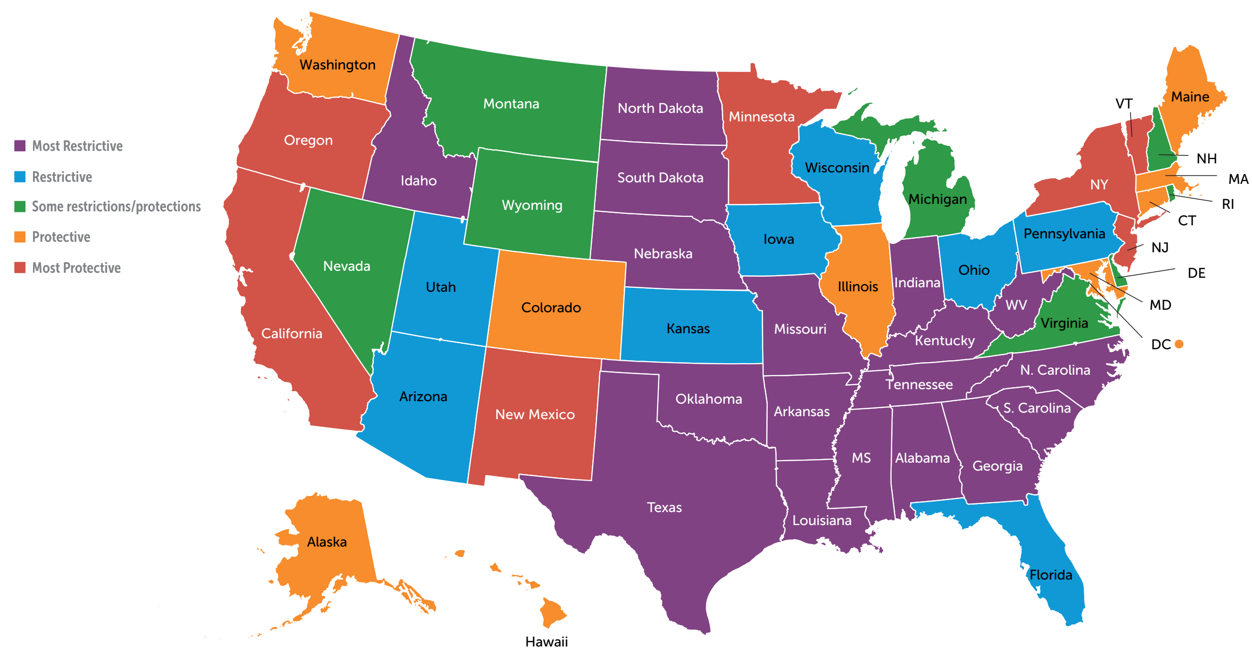
All of these factors point to the need for quality prenatal care to prevent, address or monitor low birthweight, which is strongly associated with poor developmental outcomes that affect school readiness and extend into adult life.

Reproductive Health

A growing challenge to maternal and infant health is access to reproductive healthcare. States that have instituted restrictions on women and birthing people's access to comprehensive reproductive healthcare, most commonly by legislating the provision of reproductive healthcare services that result in women/birthing people no longer being empowered to make their own decisions in consultation with their doctors, are likely to see maternal and infant health disparities exacerbated. Studies find associations between unintended pregnancies and lower initiation of breastfeeding,[22,23,24] as well as a greater likelihood of preterm births and low birthweight babies.[25,26] There is also evidence of negative maternal mental health outcomes associated with unintended births, such as depressive symptoms.[27,28,29] Moreover, restrictive reproductive health care policies are likely to deepen disparities along racial, economic and geographic lines. Prior to the Supreme Court decision overturning *Roe v. Wade,* women/birthing people who were young, Black, Latine, experiencing poverty, and/or living in rural settings already had the least access to reproductive healthcare.

States that have adopted restrictive policies on reproductive healthcare access also have fewer supportive policies in place. A comparison of the placement of 18 states with the most restrictive policies on reproductive healthcare access (as of September 2023) with the *Yearbook*'s quartile-based GROW ranking system revealed many of these states falling into the lower tiers (see figure 1-5). In general, these states share a number of areas in need of improvement:

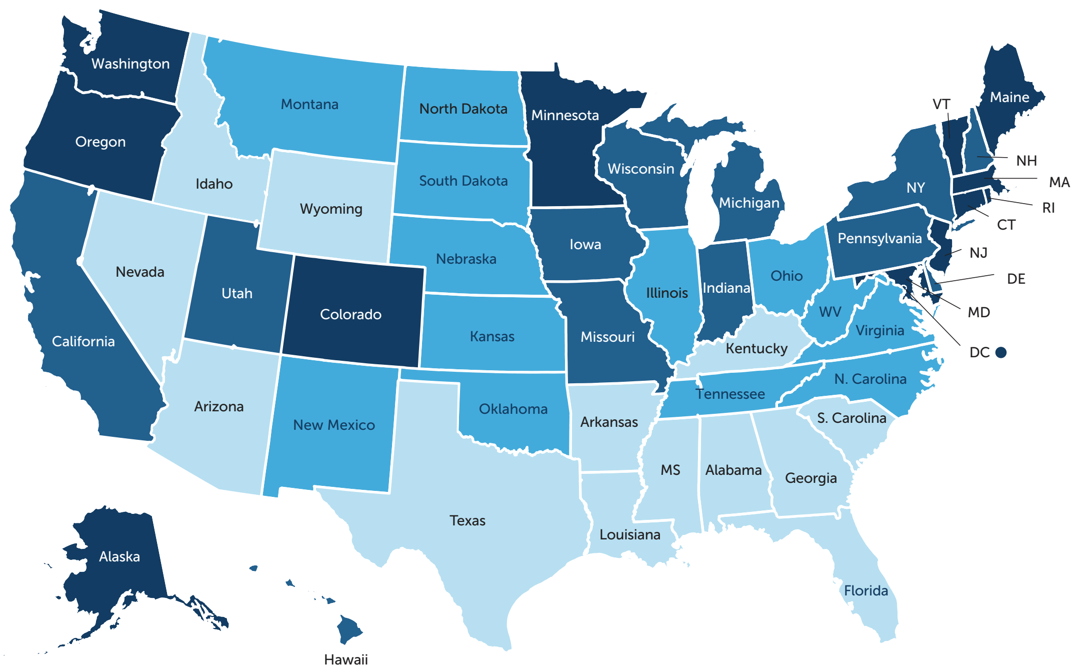
RESTRICTIVE AND PROTECTIVE ABORTION MAP (SEPTEMBER 2023) Figure I-5



Source: Adapted from Guttmacher Institute https://states.guttmacher.org/policies

- higher levels of babies in families with low income (15 of 18) or in poverty (16 out of 18)
- poorer maternal and child health outcomes such as infant mortality (15 of 18) and low birth weight (12 of 18) than seen nationally
- a higher percentage of babies in families with low or very low food security (13 out of 18)
- a higher incidence of babies with one adverse childhood experience (14 of 18) or two or more adverse experiences (11 of 18)
- the lowest levels of families with babies in poverty receiving TANF cash assistance (17 out of 18 in the lowest two quartiles for the percentage of families with infants/toddlers living below 100 percent of the federal poverty line that receive TANF benefits)
- the absence of policies that assist families with the high costs of parenting infants and toddlers:
  - Earned Income Tax Credit (12 of 18 states, no policy)
  - State Child Tax Credit (14 of 18 states, no policy)
  - Paid Family and Medical Leave (0 out of 18 states)
  - Paid Sick Leave that includes caring for a child (0 out of 18 states)
- comprehensive maternal and infant toddler health coverage (Most of the 18 states have adopted the 12-month postpartum Medicaid extension; however, they make up 5 of the 10 states that have yet to expand Medicaid, and 10 of 18 have higher percentages of uninsured infants and toddlers with low income.)

2023 OVERALL RANKING OF STATES Figure I-5



Racism and Discrimination Impact Disparities

Research also makes clear that barriers to realizing good maternal health, such as discrimination in healthcare settings and high levels of stress are in large part rooted in racism and in turn are key drivers of racial disparities in maternal and infant care.

Discrimination in the Healthcare System: Research has found evidence of racism among healthcare providers in the United States, such as racist beliefs, emotions and practices[30] that can particularly affect pregnant people of color at a time when their health is at increased risk and their need for a trusted provider is at its highest. Quality of prenatal care encompasses not only the skills, professional advice and personalized treatment of the provider and facility, but also the ability to build a relationship that fosters trust and ensures patients' participation in decision making.[31,32] People of color are more likely to experience interactions with healthcare providers that are unsupportive and disempowering. Black and Hispanic individuals have highlighted concerns related to racism—such as disparities in health outcomes, discomfort associated with receiving care from physicians of dissimilar races/ ethnicities and fear of being victims of medical experimentation—as negatively impacting their access to medical care.[33] Moreover, people of color often receive care in or only have access to lower-quality hospitals.[34,35]

Stress and "Weathering": The accumulation of chronic stress and individuals' efforts to cope with it can have a serious impact on health, leading to an increased physiological burden across multiple biological systems.[36] Such an accumulation of stress can build in people of color based on repeated experiences with institutionalized and interpersonal racism, detrimentally affecting health outcomes and resulting in the maternal health disparities apparent in our *Yearbook* data. Black individuals of all socioeconomic statuses[37,38,39] can experience *weathering*, defined as the build-up of daily emotional stress related to exposure to racism that leads to differences in health outcomes experienced over one's lifespan, which can affect the incidence of preterm births, low birth weight and infant mortality.[40,41,42]

Risks Associated with Low Income: Women and birthing people of color are overrepresented among those living in poverty or with low income, and they disproportionately experience risks associated with economic insecurity, including unstable or poor-quality housing, environmental toxins, unsafe neighborhoods and a lack of material resources. *Yearbook* data show these experiences are disproportionately affecting babies of color and those in families with low income. Approximately 40 percent of Black and Hispanic/Latine mothers and birthing people, many of whom were economically insecure before giving birth, experienced poverty around the time of birth, even taking into account government support such as nutrition, housing and energy assistance.[43] The circumstances associated with economic insecurity are themselves influenced by systemic racism that affects wage and employment patterns and access to resources. In turn, these circumstances contribute to increased stress levels, threatening maternal and child well-being beginning prenatally.

Policies to Improve Maternal and Infant Health

Improving maternal and infant health requires building a system of policies and services that both expand access to healthcare and seek to improve the cultural responsiveness and quality of care for the women and birthing people of color whose lives and babies are most at risk.

Broad, supportive policies create healthcare and coverage infrastructure, but many solutions must be tailored to local needs and come from within the community itself. Improving access to care without addressing underlying factors associated with past and present systemic racism will not alleviate disparities. For example, compared with White women/birthing people receiving late or no prenatal care, Black women/birthing people accessing prenatal care during the first trimester still experience higher rates of infant mortality.[44] Federal and state policy should create conditions and funding streams that facilitate community and culturally driven responses to the needs of pregnant and birthing people.

Use a Comprehensive Approach to Policies

Enact the Momnibus Act: This collection of measures introduced in both the House and Senate,[45] which recognizes that solutions must be multifaceted, addresses every aspect of maternal health concerns, including investments in the social determinants of health, diversification of the perinatal workforce, improvements to services for veterans and incarcerated mothers/birthing people and the promotion of innovative payment models.

Create Multifaceted, Regional Approaches to Providing Perinatal Healthcare, Especially in Rural Communities: The closure of obstetrical units, especially in rural areas, cannot easily be reversed, but policies must support states and communities in implementing models to both ensure pregnant women and birthing people have better access to services and to prevent further closures. Such solutions often involve regional, cooperative approaches, with locations around the country innovating in this area. Potential solutions include creating networks of providers and using telemedicine to connect rural patients with providers and providers with specialists in large hospital centers. Strategies may also include cultivating a rural health workforce, including nurses, obstetricians, nonclinical partners and emergency medicine partners.[46] For lower-risk pregnancies, freestanding birthing centers, often focused on midwifery, can provide an alternative to hospital delivery in a home-like setting. There also may be a need for higher payments to ensure that units stay open.

Expand Access to Health Insurance

Adopt Medicaid Expansion: Only 10 states have yet to adopt Medicaid expansion, with South Dakota and North Carolina adopting this policy subsequent to the *Yearbook* data cutoff date. Medicaid expansion reduces maternal and infant mortality and improves access to healthcare both prior to conception and at the beginning of pregnancy, increasing the likelihood of better health overall.[47] The *Yearbook 's* GROW ranking shows that most of the states that have not yet adopted expansion rank in the lower tiers for child and family health and wellbeing.

Require States to Adopt 12-months Postpartum Medicaid Eligibility: States' rapid action to take advantage of the option to extend Medicaid coverage to 12-months postpartum (see text box) shows how the policy is valued as a tool in helping redress the maternal health and mortality crisis. Congress should make this option mandatory and ensure that it is accompanied by policies to screen pregnant people, refer them for ongoing services, and coordinate between OB/GYN and behavioral health providers.

Expand Eligibility for Pregnancy Coverage Through Medicaid and the Children's Health Insurance Program: Medicaid eligibility for pregnant people is determined at the state level, with 13 states having set eligibility at or below 190 percent of the federal poverty limit. Increasing eligibility levels would afford more pregnant people the ability to access prenatal care, especially early in their pregnancy.

National Policy Win: Most States Embrace Extension of Postpartum Coverage

The American Rescue Plan Act of 2021 and subsequent legislation have accelerated state efforts to extend postpartum Medicaid coverage from 60 days to 12 months. A key strategy in reducing maternal morbidity and mortality, postpartum Medicaid extension is expected to reduce the number of new parents who lose their health insurance shortly after birth and lead to improved health and economic outcomes for parents and their babies. The *Yearbook* lists 29 states that acted to extend postpartum coverage beyond Medicaid's required 60 days. By July 2023, 36 states including the District of Columbia were implementing postpartum Medicaid extensions to 12 months, with another 10 states in the planning stages to adopt this policy.[48]

Improve Quality and Cultural Responsiveness of Healthcare

Increase Financial Reimbursement Support for and Access to Culturally Sensitive, Promising Practice Models, Such as Midwifery Care, Group Prenatal Care, Doula Care and Breastfeeding Support: Culturally responsive practice approaches have demonstrated effectiveness in improving maternal care and infant health. For example, integrating midwives into care is associated with improved birth outcomes and lower Caesarian rates. Preliminary evidence suggests that doulas are also impacting these outcomes. Group prenatal care can reduce preterm births and increase breastfeeding. Cultural grounding often shapes the adaptation of such practices for individual populations. These approaches emphasize and build a relationship between pregnant/birthing people and their providers.[49]

Minnesota: Promoting Equity in Prenatal Care

Advocates in Minnesota believe that prioritizing policy opportunities focused on those facing racial, geographic, and economic inequities ensures a state where all infants, toddlers and their families thrive. A growing body of research suggests that doulas providing pregnancy and childbirth support improve birth outcomes, especially when the doulas share racial and ethnic backgrounds with expecting parents. To recruit more doulas of color, Everyday Miracles provides a community-based training program paid for by Blue Cross and Blue Shield of Minnesota, the state's largest nonprofit health insurer. Further bolstering the provision of doula care, Minnesota lawmakers in 2023 raised Medicaid reimbursement rates for doulas from one of the lowest in the country to the highest. These efforts to address maternal health disparities build on the implementation of the Dignity in Pregnancy and Childbirth Act[50] in January 2023, which required hospitals with obstetric care and birth centers to develop or access a continuing education course on anti-racism training and implicit bias, and launched birthing modules to empower perinatal care providers to ensure Black and Indigenous women and birthing people receive quality care.

Promote Diversity and Reduced Bias in the Healthcare Workforce: States should work to expand efforts to recruit people of color into perinatal health and mental health workforces, including investing in the types of perinatal healthcare workers, such as midwives and doulas, that can provide culturally responsive care. Additionally, employers should work to address interpersonal racism among healthcare providers through medical training and research (e.g., by addressing disparities in how race/ethnicity and racism are integrated into teaching and practice, such as in assessing disease risk, and determining diagnoses and treatments).

Adopt and Implement National Family Policies

Establish a National Paid Family and Medical Leave (PFML) Policy: PFML's benefits are far-reaching in terms of maternal health and early childhood development. PFML can reduce infant mortality, reduce low birth weight and preterm births (particularly for Black mothers/birthing people), increase breastfeeding and improve emotional well-being. (See text box.)

Enact Legislation to Guarantee Paid Sick Leave: Paid sick days increase the ability to attend perinatal care visits as well as infant healthcare visits.

Provide Economic Supports Before and After Birth: Pregnancy and birth benefits, as well as the enhanced, expanded Child Tax Credit, relieve financial stress before and immediately after a baby is born.

Expand Participation of Pregnant Women and Birthing People in WIC: The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) has a positive impact on maternal and infant health and is likely to be associated with a lower risk of preterm birth, low birth weight and infant mortality.[51] However, only 46 percent of pregnant people currently participate in the program, compared with 60 percent of postpartum breastfeeding women/birthing people and 82 percent of non-breastfeeding women/birthing people.[52] Multiple strategies are needed to increase participation rates, including promoting greater cultural competence and diversity in WIC staff and outreach efforts, increasing efforts to encourage use of fresh fruits and vegetables and ensuring that more WIC providers make these foods available, and offering implicit bias training to WIC providers. WIC can also support participation in Circles of Support for women and pregnant/birthing people. However, current funding disputes—with severe cuts to WIC in the House of Representatives and funding falling short of increasing need—jeopardize even current participation levels.

Can Cash Be Medicine?

The lead crisis in the Flint, Michigan, water supply illuminated the overlay of this serious hazard for child development with another pernicious threat: high levels of deep and concentrated poverty in many neighborhoods. Children's health leaders from the effort to eliminate lead pipes now have teamed up with researchers and an array of public and private funders to write a prescription to lift pregnant people, infants and children out of poverty and into health. Rx Kids is a cash allowance program aimed at the perinatal period, with a one-time prenatal allowance of $1,500 and a monthly allowance of $500 a month for all infants until the age of one.[53] The Michigan government has committed funds from the Temporary Assistance for Needy Families program as well as the American Rescue Plan Act. Broad community engagement will be part of this unique city-wide approach that aims to change the trajectory of the entire community. A robust evaluation will document the benefits of this approach to inform state and national policy around maternal-infant health, early childhood investments, economic and racial justice, and health equity.

Benefits of Paid Family and Medical Leave for Maternal and Infant Health

Strong association with reduced infant and post-neonatal mortality rates: Researchers conservatively estimate that 12 weeks of job-protected paid leave would result in nearly 600 fewer infant and post-neonatal deaths per year.[54]

Increased breastfeeding: Studies show that paid leave yields higher rates and longer periods of breastfeeding, which reduces the rates of childhood infections.[55] For young children, breastfeeding is associated with numerous benefits, including reduced rates of disease, overweight and obesity.[56] Breastfeeding is also associated with positive outcomes for the breastfeeding parent, including reduced rates of breast and ovarian cancers.[57]

Improved child health:

- Time at home with newborns, infants and toddlers gives parents the flexibility they need to breastfeed, attend well-child medical visits and ensure that their children receive all necessary immunizations. This time may also have long-term benefits for children's health.[58]

- California's statewide paid family leave program is associated with improved health outcomes for children in early elementary school, including reduced issues with maintaining a healthy weight, attention deficit hyperactivity disorder (ADHD) and hearing-related problems, particularly for less-advantaged children, likely due to reduced prenatal stress, increased breastfeeding and increased parental care during infancy.[59]

Health and mental health benefits for new mothers/birthing people: Each week of paid leave up to 12 weeks reduces the odds of a new mother/birthing person experiencing symptoms of postpartum depression.[60] New Jersey's paid leave program was strongly associated with improvements in new mothers'/birthing persons' physical health.[61] Research indicates maternity leave policies during the birth of a first child are linked to reduced depression in older age.[62]

Better care for children: Parents who use California's paid leave program report that leave has a positive effect on their ability to care for their new children and arrange child care.[63] Parents using Rhode Island's program are much more likely to report higher satisfaction with their ability to care for their new children and arrange child care, better health and lower general stress.[64]

Maltreatment prevention: Preliminary research in California suggests that paid leave may also help prevent child maltreatment, perhaps by reducing risk factors such as parental stress and depression.[65]

Endnotes

[1] Trost, S., Beauregard, J., Chandra, G., Njie, F., Berry, J., Harvey, A., & Goodman, D. A.. (2022). *Pregnancy-related deaths: Data from Maternal Mortality Review Committees in 36 US states, 2017–2019.* Centers for Disease Control and Prevention. https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html

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Urgent Priority #2:

Seizing the Opportunity to Promote Positive Infant and Early Childhood Mental Health

Infant and early childhood mental health (IECMH) is fundamental to all early development and learning and encompasses concepts such as social and emotional development and early relational health. IECMH is the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage and express a full range of emotions; and explore the environment and learn—all in the context of family, community and culture. These are the ingredients children need not just for their earliest learning, but also for later success in school and throughout life.

Babies' relationships with parents and other close caregivers play important roles in shaping their mental health, molding the architecture of their brains and setting the stage for other aspects of development, such as language and cognitive development. Positive, supportive relationships can also buffer young children from the impact of adverse experiences and can mean the difference between positive and negative outcomes in school and life. Parents' mental health concerns, particularly maternal depression, can affect not only their own well-being but that of their infants and young children. Taken together, the research is clear that the mental health of young children is inextricably tied to the well-being of their parents and primary caregivers, including early educators.

Yearbook indicators illustrate this policy area's urgency, showing that many infants and toddlers experience circumstances that could undermine IECMH's central influence on early development. The pandemic's isolation and hardships increased parents' overall emotional distress, with a corresponding increase in young children's emotional distress. In addition, *Yearbook* data point to continued exposure to conditions such as poverty, crowded housing, maltreatment and/or structural racism for babies and caregivers. These experiences can create chronic, unrelenting stress that undermines caregiver well-being, essential early relationships and babies' healthy development and learning.

The earliest years present a unique opportunity for ensuring strong mental health from the start for infants, toddlers and their caregivers by building the continuum of services for promotion, prevention, developmentally and culturally appropriate assessment and diagnosis, and treatment. Yet, the country lacks a strong system of supports for parents, caregivers and child-serving professionals, all of whom play a role in shaping and particularly promoting strong early childhood mental health. An expanded, diverse IECMH workforce is critical to building this continuum.

Bold pandemic policies recognized the importance of mental health funding and seamless health coverage to access services. The American Rescue Plan Act invested $4 billion to address the mental health issues the pandemic thrusted to the surface. Yet, these funds' uses did not spotlight young children's needs. Moreover, unwinding the pandemic's continuous Medicaid coverage is severing many adults as well as children from coverage that allows them to access mental health supports. The country still needs to bring young children's mental health squarely into overall mental health policy. Such policies must strengthen the continuum by leveraging the health system to provide multigenerational support, expanding community supports and family-oriented policies, and strengthening the capacity of the IECMH system, including building a diverse workforce.

FAMILY STORY

I have two children, a high schooler and a toddler. I know the importance of social and emotional development to our children's future. I know it as a professional—I work as a Family Coordinator at a high school. I love the work, which helps me advocate for and support the community that I love. Many of the kids I work with had a strong social and emotional foundation, and I see what that has meant to their development. I see their confidence, their ability to interact with others and to find success. But too often, I know that some of the kids who I work with could have benefited from infant and early childhood mental health services early on.

I also know it as a parent—my high schooler had a rough beginning. I experienced domestic violence, and while I tried to protect my young son, I could not protect him from all things. He expressed his anger in ways that got him in trouble, and I did not know how to help him deal with his trauma, or what services were available to support his social and emotional development. The "helpers" in my community made damaging assumptions about how I contributed to his trauma, and who I was as a young parent. In so doing, they made his trauma worse. Today, he is on the path to graduate from high school, and I am so proud of him. But we are still working to help him heal wounds from almost two decades ago. Now, I want to make things better for his younger sister. She is very sensitive, and I worry about her sadness. When I have asked for services for her, my worries are often minimized. But I know that just down the street, there are communities where these kinds of services are available and well used. I am frustrated and deeply concerned for my children and my community.

Mental health is a taboo topic in minority communities, and 10 times that when involving infants and toddlers! The social-emotional needs of so many children from birth to three years old go unmet because many families, especially families in low-income areas, aren't given information so they can be better informed and prevent, to the best of their abilities, long-term impacts of not rendering proper healthcare—physical and mental. We need to make sure that all children have access to the services they need, when they are most helpful.

Emily C.
Bronx, New York

State of Babies Data Raise Concerns About Early Mental Health

The *Yearbook*, including data from the RAPID Survey, raises concerns about the key factors that shape babies' early mental health: their parents' emotional well-being and the level of adverse experiences they encounter.

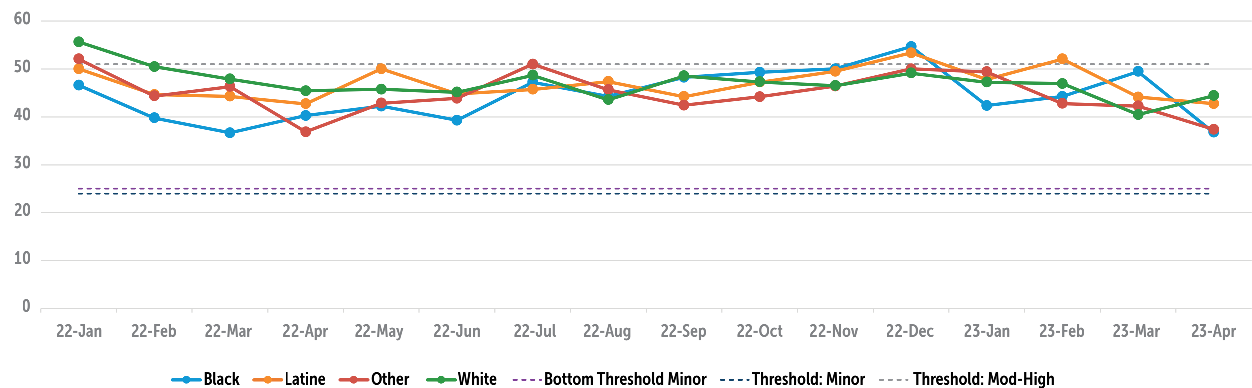
Yearbook indicators show persistent disparities by race/ethnicity and income for babies with adverse experiences. RAPID data show that emotional distress has stabilized, but is still elevated in key areas such as stress, loneliness and child behaviors. Disparities in material hardship that are sources of family stress continue, as do other adverse experiences including higher rates of maltreatment for babies which carries significant implications for early mental health.

Parent and Child Mental Health

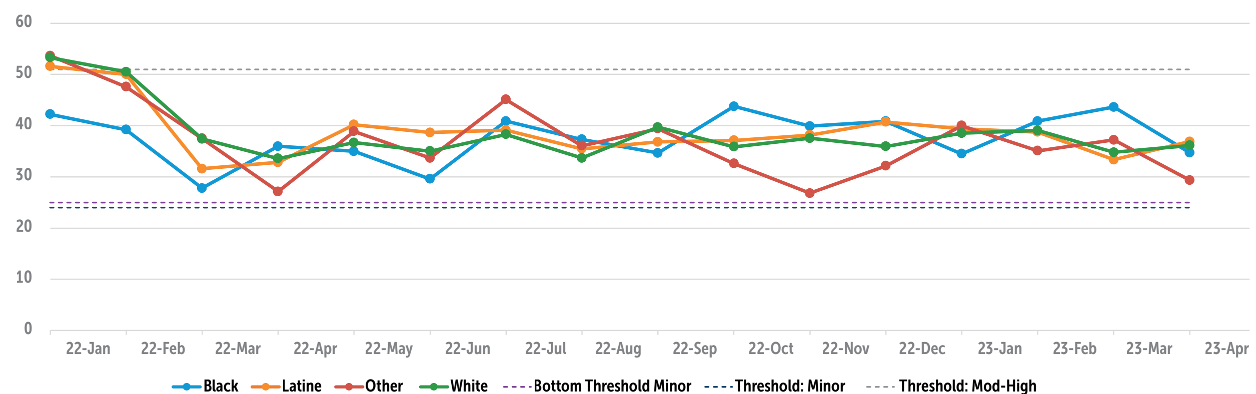
Parents' mental health concerns, particularly maternal depression, can affect not only their own well-being but also that of their infants and young children. Untreated depression, substance use disorder, experiences of interpersonal and community violence, and trauma disrupt parenting and the responsive care young children need to thrive.[1] RAPID Survey data collected during the pandemic clearly showed that increased levels of financial hardship led to higher ratings of emotional distress among parents and were accompanied by increases in infant-toddler emotional distress, although at lower rates.[2]

Parents' Emotional Distress: From January 2022 through April 2023, parents' overall emotional distress ratings moderated but were consistently at a somewhat elevated level. Stress and loneliness measurements remained high,

PARENT MENTAL HEALTH STRESS SCORE BY RACE AND ETHNICITY Figure 2-1



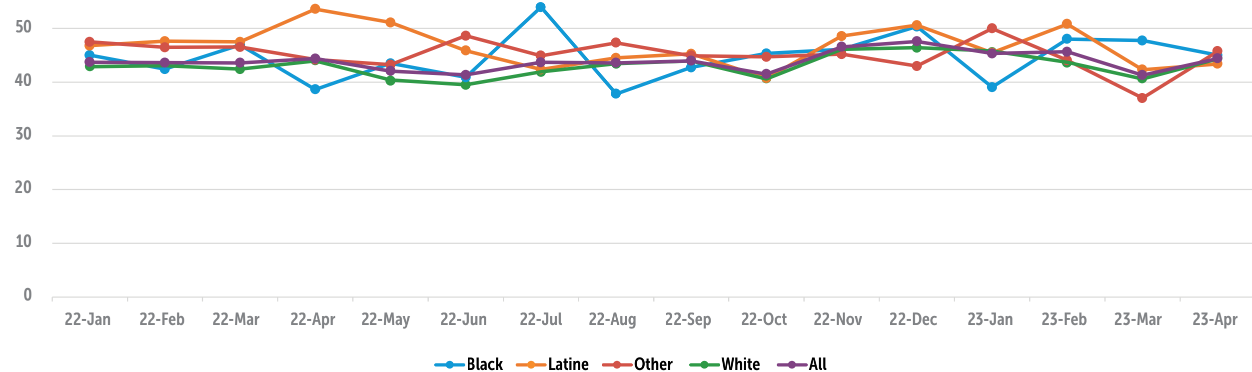
PARENT MENTAL HEALTH LONELINESS SCORE Figure 2-2



squarely within a range that raises concerns at a minor level, occasionally moving up to a level of moderate concern. (See Figures 2-1 and 2-2). Experiences across race and ethnicity were more closely aligned than earlier in the pandemic, although the concerns of Black parents and those of other races were more volatile.

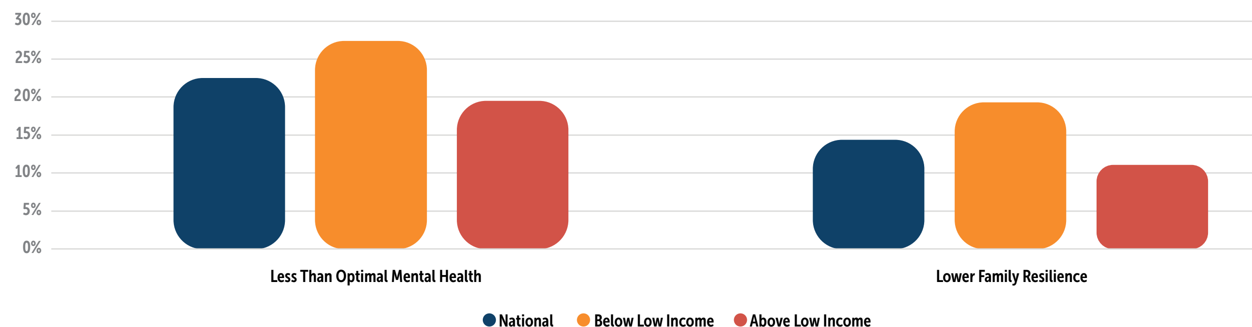
Children's Emotional Distress: RAPID data also show that as the pandemic waned, children's emotional distress, similar to that of their parents, leveled off, yet remained at an elevated level. However, externalizing behaviors were higher, at a level where symptoms would be at least of minor concern. (See Figure 2-3). This pattern seems consistent with reports of increased challenging behaviors as young children interact more with the outside world after the relative isolation of the pandemic. Black and Latine children, as well as those of other races, appear to have had more volatility in measures of externalizing symptoms, possibly reflecting the greater hardships they experienced during the pandemic.

CHILD MENTAL HEALTH EXTERNALIZING SYMPTOMS SCORE (FUSSY AND DEFIANT) BY RACE AND ETHNICITY Figure 2-3



Parental Mental Health and Income: Concerns about parental mental health are often tied to economic challenges. *Yearbook* indicators show that mothers' mental health was more likely to be less than optimal among those with low income, and fewer families with low income were likely to say they are resilient. (See Figure 2-4).

FAMILIES' EMOTIONAL SECURITY BY INCOME Figure 2-4

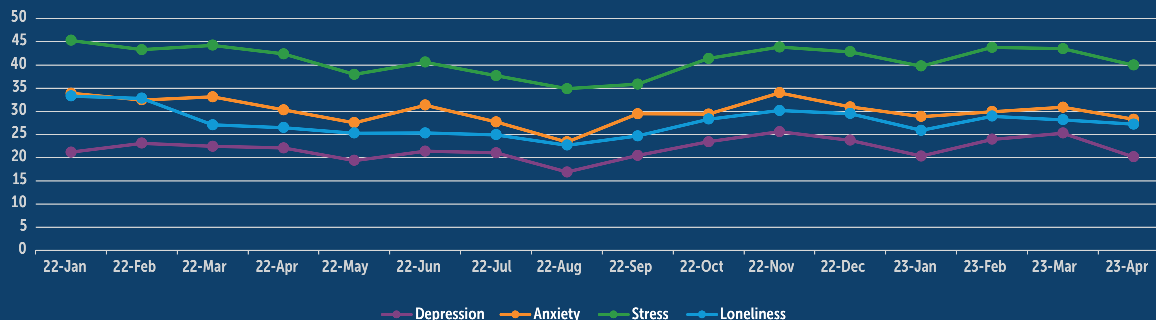


Early Childhood Educators Also Face Mental Health Challenges

The chaos of the pandemic for child care programs, coupled with low wages and continuing staff shortages, has had a significant impact on the well-being of early childhood educators.[3] Just as these adults help shape young children's early development, so too does their emotional well-being affect their ability to connect with the young children who spend many hours in their care. The RAPID Survey data on early educators who work with infants and toddlers included in the *Yearbook* show they are under considerable strain as staffing challenges and financial worries mount. Half of these early educators reported experiencing burnout. Similar to the elevated emotional distress of parents, measures of early childhood educators' well-being since early 2022 show continued elevated levels, especially for stress. (See Figure 2-5.)

RAPID Survey data reported for early educators of all ages of children show that providers have experienced material hardships such as hunger and housing worries throughout the pandemic and economically challenging times.[4] These hardships have also contributed to stress and mental health concerns. Urgent Priority #3: Commitment to Early Care and Education as a Public Good discusses the challenges for early educators in greater detail. The levels of stress, burnout and mental health concerns are highlighted here to underscore the necessity for policies promoting early childhood mental health to address the needs of all the significant adults in children's lives, including early childhood educators.

CHILD CARE PROVIDER WELLBEING SYMPTOMS OVER TIME 2022-23 Figure 2-5



Many Young Children Experience Adversity That Impacts IECMH

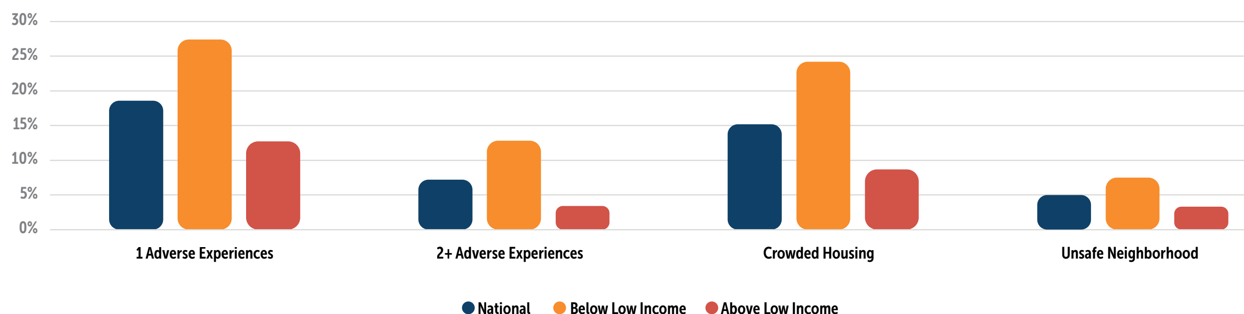
While positive early childhood experiences promote strong mental health, negative experiences can adversely impact brain development, with serious lifelong consequences. These experiences can cause stress that, if chronic and unrelenting, can alter how the brain wires and undermine the strength of early brain architecture. Adverse experiences such as living in poverty, parental depression, maltreatment and violence in the home or neighborhood can contribute to social and emotional issues such as behavioral problems, as well as delays in cognitive and language skills. These issues stem from the disruption of parents' abilities to provide responsive, stimulating caregiving in an environment of adversity.[5]

When an infant or young child's emotional health deteriorates significantly, they can, and do, experience mental health disorders. Approximately 9.5% to 14.2% of children from birth to 5 years old experience emotional, relational or behavioral disturbances.[6] Young children who live in families dealing with adverse experiences and exposure to trauma are at heightened risk of developing IECMH disorders.[7] And the stressors of poverty can multiply these risks. It is important to note, however, that even in a nurturing environment, mental health problems can still manifest. If untreated, IECMH disorders can have detrimental effects on every aspect of a child's development, as noted above, and young children do not "grow out" of them. Over time, these issues often become more frequent, intense and more expensive to address with interventions or treatment. When mental health concerns are identified early on, there are services that can redirect a child's course and place those who are at risk on a pathway for healthy development.

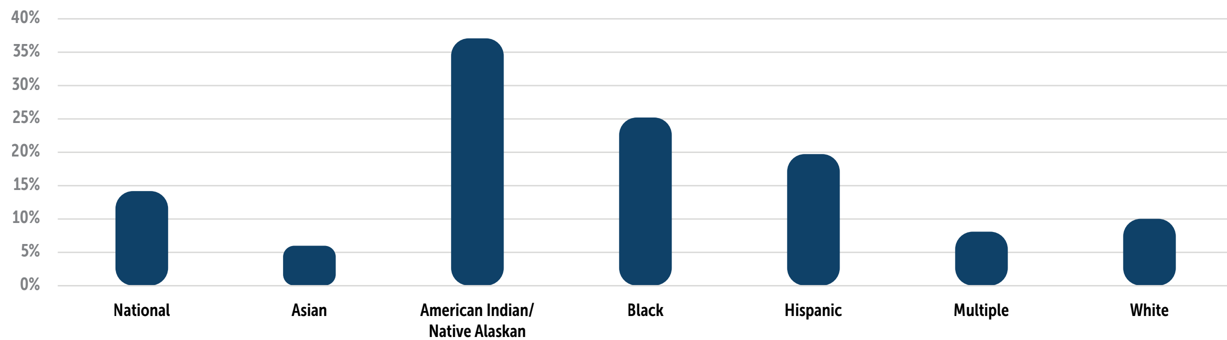
Adversity Intensified by Low Income: Adverse childhood experiences (ACEs) are stressful events in a child's life that can affect development and future health, with risk increasing as the number of ACEs accumulates. Studies of ACEs have focused on a set of indicators of household instability, abuse and neglect, but the range of experiences that can have an adverse impact extends beyond these factors.[8] (See Figure 2-6).

The *Yearbook* includes indicators that raise concerns about the exposure of infants and toddlers, especially those in families with low income, to adverse conditions that can elevate family stress, placing them at risk for mental health and developmental problems. The *Yearbook* presents indicators that ask families about whether their babies have had any of a group of adverse early experiences, including income insecurity, death or separation of parents or guardians, incarceration of a family member, family violence and/or exposure to racism. Babies in families with low income were more likely than babies in families with higher incomes to have one early adverse experience or two or more early adverse experiences. They were also more likely to have experiences shown in two other indicators of specific adverse experiences—

STRESS-INDUCING EXPERIENCES BY INCOME BY RACE AND ETHNICITY Figure 2-6



HOUSEHOLDS WITH BABIES WITH HIGH OR VERY HIGH FOOD INSECURITY BY RACE AND ETHNICITY Figure 2-7



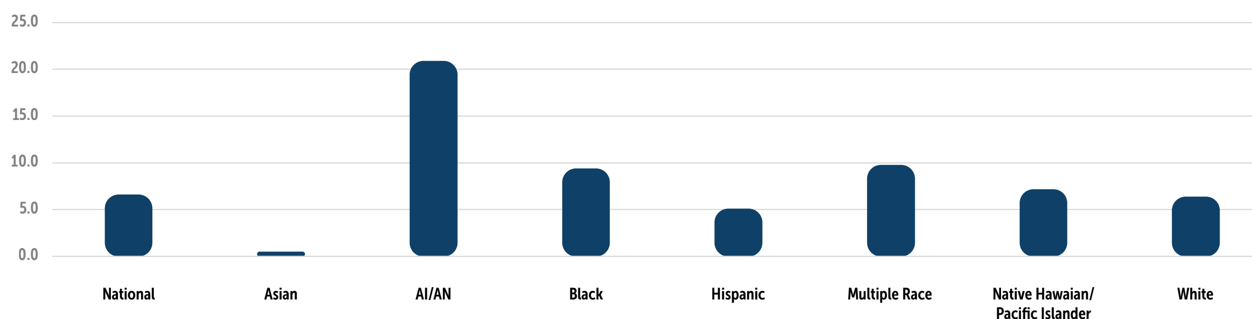
crowded housing and/or unsafe neighborhoods. (See Figure 2-6). Finally, living in poverty is itself an adverse experience, as will be discussed in Urgent Priority #5: The Economic Insecurity That Engulfs Many Babies. A large proportion (38%) of infants and toddlers live in families with low income, including more than 18% in poverty.

Food Insecurity: Household food insecurity, another source of family stress and adversity, has remained at a high level of 15.3%. Examining this indicator by race and ethnicity reveals disturbing findings: more than one-third (37.1%) of American Indian and Alaska Native (AI/AN) infants and toddlers live in households with low or very low food insecurity, as do one-quarter (25.2%) of Black and one-fifth (19.7%) of Hispanic infants and toddlers. (See Figure 2-7). The *Yearbook* section on economic security provides a more in-depth discussion of food insecurity.

Child Maltreatment: Mental health concerns are particularly heightened for infants and toddlers who have experienced maltreatment, especially when they have been removed from their homes and placed in foster care. The maltreatment rate for infants and toddlers is 15.5 per 1,000, with the rate for infants alone being 25.3 per 1,000—the highest rate by far of any age group, including toddlers (10.7 per 1,000 for 1-year-olds and 9.8 per 1,000 for 2-year-olds).[9]

The *Yearbook* finds that 6.6 per 1,000 babies are placed in foster care, with Native American babies having an alarmingly high rate of 20.9 per 1,000. Black, Native Hawaiian, and multiple race infants and toddlers also have disparately high rates of removal (9.4, 7.2 and 9.8 per 1,000, respectively). (See Figure 2-8.) Babies in the child welfare system, who cannot process what is happening to them, are found to have high levels of social and emotional disturbance, particularly attachment disruption.[10,11] A study of infant-toddler court programs using the Safe Babies™ approach found one-half of the children in need of IECMH services, specifically Child Parent Psychotherapy, which the program ensured they received.[12]

INFANTS AND TODDLERS PLACED IN FOSTER CARE BY RACE AND ETHNICITY Figure 2-8



Barriers to IECMH Services

While efforts to increase the capacity to support IECMH along the entire continuum of promotion, prevention, developmentally and culturally appropriate assessment and diagnosis, and treatment have grown over the past few years, families and professionals in other systems still face barriers to finding services and support. A lack of specially trained IECMH providers, especially those representing the diversity of babies and families, is a critical need.

Financing for basic screening services is improving, but states are only slowly grappling with the conundrum of how to reimburse for the diagnosis of very young children, many preverbal, as well as services that must be provided in the context of the adults who care for these very young children. The lack of supports for parents and caregivers across systems that could fill an essential role in promoting positive IECMH is also a barrier. Finally, even with the indicators that a large proportion of infants and toddlers live in circumstances that increase the stress that can undermine their mental health, monitoring of early development and mental health remains inconsistent, particularly within child health and early learning and care settings.

Workforce Challenges: Efforts to promote positive IECMH often encounter difficulty finding qualified, culturally responsive and diverse IECMH professionals, making the IECMH workforce a critical focus for policy efforts. Specially trained IECMH professionals are essential to providing consultation that infuses IECMH knowledge into child-serving settings and to diagnosing and treating young children when problems do emerge. A short supply of IECMH professionals hampers successful implementation of all parts of the IECMH continuum.

For example, Washington state has noted shortages in qualified IECMH professionals, with infant-toddler services less likely to be provided even among mental health professionals who serve children ages 5 and under.[13] In a survey of state efforts to integrate IECMH into Early Intervention programs under Part C of the Individuals with Disabilities Education Act (IDEA), multiple states reported workforce issues such as a lack of qualified IECMH providers or geographic

mismatches as barriers to accessing services.[14] Parents in ZERO TO THREE's Family Advocacy Network have cited difficulty finding mental health services that are culturally responsive, as well as the need for more diversity among mental health professionals.

Financing: The potential for IECMH coverage through Medicaid is not fully maximized. Even in states that are beginning to cover behavioral health as part of managed care and accountable care organizations, there is still work to do to ensure efforts are targeted enough to support IECMH services. General policies common for adult mental health cannot be extended downward to infants and toddlers, who require specific IECMH services to be reimbursable.

For example, diagnosis of an infant or toddler can take several sessions. And treatment involves the dyad of parent or close caregiver and baby. Neither of these factors is contemplated in the mental health reimbursement system oriented around adults. Further, both diagnosis and treatment require a provider specially trained in the mental health of very young children, using age-appropriate screening and diagnostic tools. Only 15 states require or recommend use of the *DC:0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (or its predecessor, the DC: 0–3R), developmentally based systems for diagnosing mental health and developmental disorders in infants and young children through 5 years old.[15] Coverage of screenings for mothers and children is improving, however, with now up to 46 states offering such benefits.[16]

Gaps in Supportive Services: Access to high-quality, culturally responsive supportive services for parents and caregivers, including services to address their own mental health needs, is a key part of promoting all children's mental health, as well as preventing IECMH problems when families are under stress. Supports that can help parents cope with their own stresses and nurture their babies' positive development are not widely available or not infused with an understanding of how they can better support IECMH.

For example, the *Yearbook* finds that only about one-half of infants and toddlers have a medical home, where family issues potentially can be identified and addressed through a dyadic or multigenerational approach. Those least likely to have a medical home include Black (39.6%) and Latine/Hispanic (40.7%) infants and toddlers, as well as young children living in families at or below low-income levels (40%). (See Figure 2-9.) The *Yearbook* also shows that only 2.1% of infants and toddlers receive home visiting services, with a range of 1.25% to 6.2% in the state with the greatest number of such services (Kansas). (This indicator is based on total infants and toddlers because home visiting programs do not have specific eligibility criteria that families must meet to receive services).

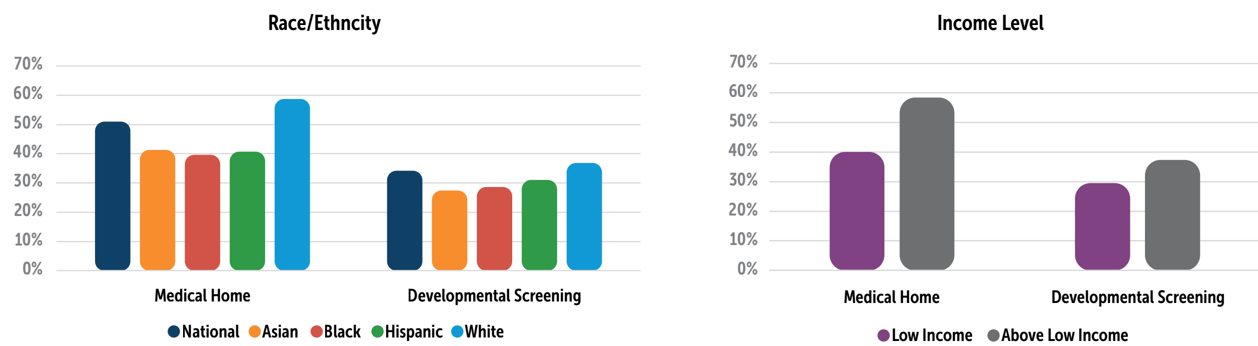
Monitoring Development and Mental Health Needs Improvement

Despite multiple indicators that signal young children could be at risk developmentally, and particularly for social and emotional concerns, the nation has not developed a strong system of monitoring and screening young children. As noted above, only about one-half (51%) of babies have medical homes, where children can receive consistent developmental monitoring and

multigenerational services. Parents reported low rates of basic developmental screening for infants and toddlers (34.2% overall), with particularly low rates for those with low income (29.5% compared, with 37.3% for babies in families above low income). (See Figure 2-9).

Early Intervention (EI) services under Part C of the Individuals with Disabilities Education Act cover social and emotional development, and states are working to incorporate stronger supports for babies with social-emotional delays and mental health concerns. Few states require use of a tool specifically for social and emotional screening, although the majority recommend one.[17] Moreover, the *Yearbook* finds only six states extend EI eligibility to children with characteristics that place them at risk for developmental concerns. While expanding eligibility more broadly can help states reach more infants and toddlers, cost and workforce constraints may prevent other states from adopting this course.

INFANTS AND TODDLERS WITH A MEDICAL HOME AND RECEIVING DEVELOPMENTAL SCREENING BY RACE AND ETHNICITY Figure 2-9



Policies to Build Strong Early Mental Health

Infancy and early childhood offer the opportunity to promote a strong foundation from the start, setting children on a positive course for later mental health and learning. Policymakers must ensure that broad discussions of mental health policy reform include young children and specifically address infants and toddlers.

Policymakers should take an active role in promoting and endorsing a full continuum of services—promotion, prevention, developmentally and culturally appropriate assessment and diagnosis, and treatment—to best support babies and young children, and the significant adults in their lives. Federal policy should facilitate, and states should adopt, comprehensive approaches to monitoring development, supporting families in nurturing their children's development and connecting to needed services. Moreover, given the significant time young children spend in non-parental care, these efforts should be inclusive of early care and education settings.

Given the role that economic and material hardship plays in elevating family stress, policies to address other urgent needs as outlined in the sections of this report on economic security, child care and housing are also part of an overall approach to ensuring the early emotional health of babies.

Leveraging the Health System to Support Development

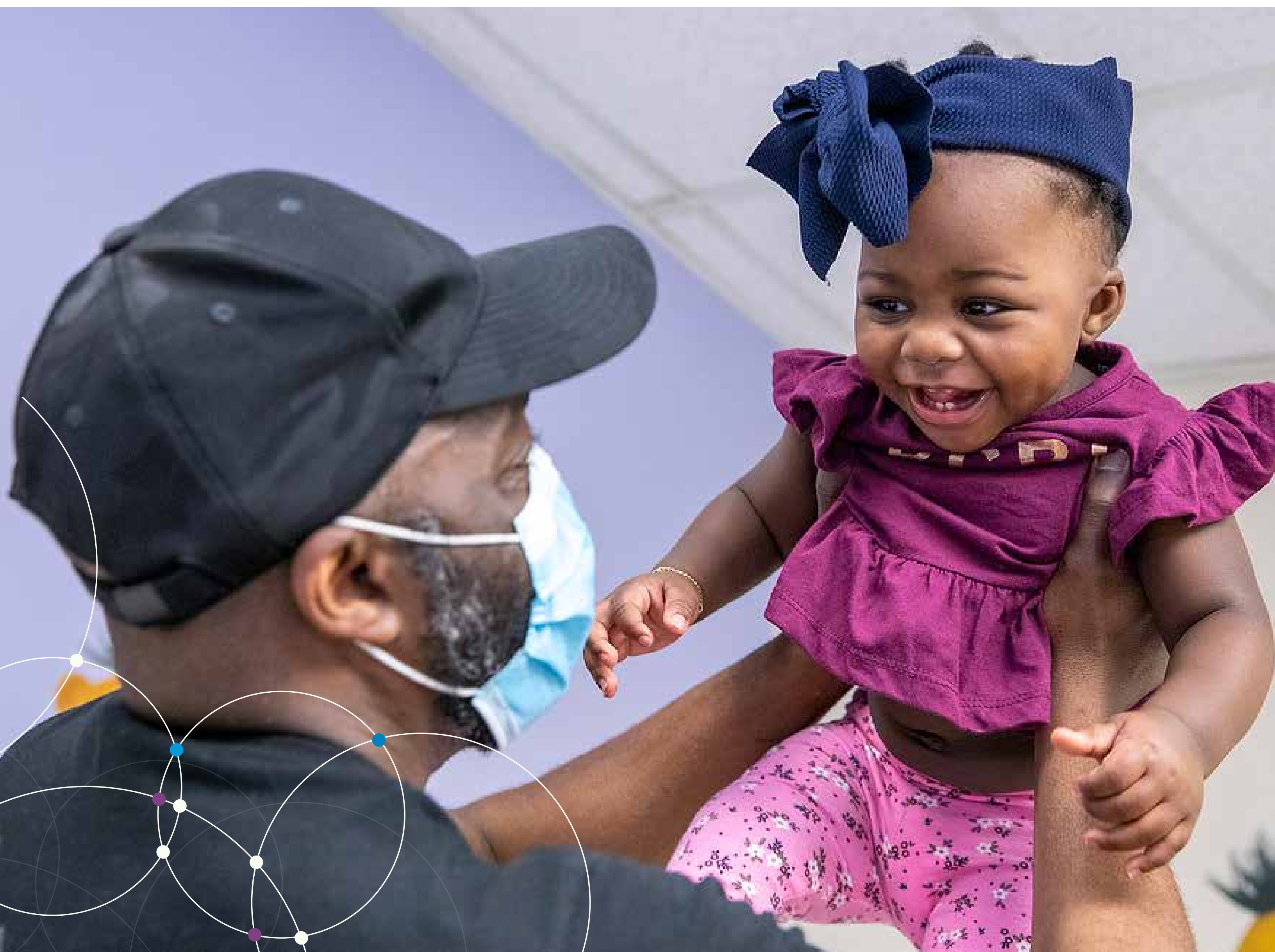
Establish early childhood specialists in primary care. Embedding early childhood development experts in primary care leverages the most common touch point for babies' primary care and can transform this setting to drive better developmental trajectories and outcomes for young children and caregivers. ZERO TO THREE's HealthySteps program pioneered this approach to whole-family, team-based care in support of healthy development and caregiver well-being. Existing federal funding streams such as those in the Bureau of Primary Health Care's Health Center Program and the Maternal and Child Health Bureau should be expanded to build early

California Creates a Dyadic Services Benefit

In a groundbreaking move for funding early development and family services, California's Medi-Cal program now incorporates coverage for dyadic services, which includes preventive services provided to the child and caregiver at the same location. Medi-Cal also expanded its family therapy benefit, which now covers family therapy without requiring the child to have a diagnosis, allowing for greater access to this existing dyadic service.[18] This policy change recognizes the fundamental importance of the parent's well-being to young children's development, opening the door to identifying and addressing concerns for both parent or caregiver and child in one site. HealthySteps, a program of ZERO TO THREE that incorporates an early childhood development specialist into primary care practices, was a model for this innovative approach.

childhood systems that include the healthcare setting and facilitate this transformation of primary care. States can also support early childhood experts in primary care by including such dyadic approaches in their Medicaid plans, as California has done to allow reimbursement for preventive services, as well as other funding mechanisms.

Increase Medicaid's focus on IECMH and development to reach the infants and toddlers most at risk for developmental concerns. Requiring continuous coverage for all children until the age of 6 would enable the monitoring and treatment of children throughout early childhood. Currently, states have the option to provide continuous coverage for 12 months, which will be required as of January 1, 2024. Oregon and Washington have received, and New Mexico has applied for waivers to extend continuous coverage until age 6. Other steps include promoting more rigorous application of Medicaid's Early, Periodic Screening, Diagnosis and Treatment to adhere to screening schedules and ensure early mental health and family need screens are included; requiring state Medicaid plans to cover and collect data on maternal depression screening during well-child visits and social-emotional screening for young children; and ensuring access to age-appropriate diagnosis and treatment, including through the *DC:0-5*™.



Develop Community Approaches to Supporting Families and Early Social and Emotional Development

Promote family strengthening through funding to encourage community-wide approaches to ensure that every family can access comprehensive support for parenting, positive child development and family services. Such readily accessible support through early childhood specialists in primary care, home visiting, family resource centers, parenting-support programs and other approaches can help address the social determinants of health and form protective factors that buffer young children from intolerable stresses that can derail their development.

Expand early childhood mental health consultation to infuse understanding of supporting early social and emotional development into child-serving settings. Such support is particularly important for early childhood educators, who face increasing burnout and mental health challenges while also caring for young children emerging from the pandemic with increased emotional distress often communicated through challenging behaviors or withdrawal. Early childhood mental health consultation is also a key support for home visitors and others who work with young children and families. These adults, but especially early childhood educators, play an important role in helping children develop regulatory skills. Mental health consultants can help them interpret and address child behaviors that adults see as challenging and support the relationship between parents or close caregivers and children, as well as attend to their own self-care.

Collective Movement Toward a Diverse IECMH Workforce

Since 2021, a national IECMH Clinical Workforce Diversity Collective initiated by ZERO TO THREE has brought together more than 25 representatives from across the United States from diverse backgrounds, cultures and disciplines to explore the need for radical, systematic change in the IECMH field and workforce. The Diversity Collective is not only pursuing increases in diversity, equity and inclusion in the IECMH field, but is seeking to radically change the field to de-center the focus of Eurocentric, colonial theory, practice and power, and to actualize the centering of the knowledge, practices and ways of being of non-dominant people, including Black, Indigenous, People of Color and other marginalized peoples. Through participation in an intense collective process of joining together diverse perspectives, experiences and knowledge, the Diversity Collective has developed a long-range vision and several policy and systems benchmarks for the evolution of the IECMH field and workforce.

Enact the bipartisan Strengthening America's Families Act to establish community teams to use a comprehensive, two-generational approach to holistically address the needs of infants, toddlers and families at risk for involvement or already in the child welfare system, including concerns about mental health and the impacts of trauma. The bill is based on the Safe Babies approach, which ensures babies and families receive a comprehensive array of needed services and has demonstrated that careful coordination ensures infants and toddlers have medical homes, receive appropriate social and emotional as well as developmental screens, and are successfully referred to IECMH services.

Increase the Capacity to Address Infant and Early Childhood Mental Health and Perinatal Mental Health

- Develop a well-trained and diverse **IECMH workforce,** with a particular focus on addressing trauma and adverse experiences and providing healing-centered care. Federal funding should establish IECMH Centers of Excellence and clinical leadership programs. States should assess workforce needs and devise strategies to train providers to meet them.
- Promote applying the science of **IECMH** through developmentally appropriate **classification systems** such as the DC:0-5™ to assess and diagnose mental health disorders in infants and young children.
- Leverage current funding streams to **better integrate IECMH** into states' overall mental health policy, including dedicating at least 10% of Community Mental Health Services Block Grant funds for services for children from birth to age 5 experiencing or at risk for mental health disorders.
- **Increase funding for the National Maternal Mental Health Hotline.** The Maternal Mental Health Hotline is staffed by qualified counselors and provides specialized culturally and linguistically appropriate voice and text support for mothers and families. Additional funding will enable states to increase public awareness about maternal mental health conditions and the hotline.

Regional Approach to IECMH Workforce Needs

Having too few mental health clinicians with the specialized training needed to serve babies and their families creates a barrier for states looking to build out a robust IECMH prevention, promotion and treatment continuum. To boost the pool of mental health professionals prepared to serve children from birth to age 4, Alabama hosted a cross-state Child-Parent Psychotherapy training collaboration, including practitioners from Georgia and South Carolina.[19] This pilot collaboration expanded with funding from Georgia's Departments of Early Care and Learning and Public Health to provide training to an additional 60 clinicians in 2022.

- **Increase funding for the Screening and Treatment for Maternal Depression and Related Behavioral Disorders (MDRBD) Program.** Maternal mental health conditions are the most common pregnancy and postpartum complications and can have a detrimental impact on new parents' abilities to provide the supportive relationships their infants need; however, 75% of affected women remain untreated. MDRBD programs train health providers to screen, assess and treat for maternal mental health conditions and provide specialized psychiatric consultation to assist the providers in meeting the needs of their patients. Additional funding will support the establishment of new state programs and improvements in existing programs.

Adopt Broad-Based Family Policies

Paid family and medical leave Gives parents or other caregivers time to begin developing all-important, close relationships with their newborn or newly adopted children and supports improved maternal mental health. For children with ongoing health and developmental needs, paid leave allows parents and caregivers to attend regular therapeutic sessions.

Paid sick days gives parents and caregivers time to care for themselves and children with short-term illnesses and to attend visits to address health and mental health needs.

Expanded Child Tax Credits help relieve stress created by economic hardship and allow parents to give up second jobs or gig work to make ends meet and spend more time with their children, which is especially important for families with infants and toddlers.

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