



Early Relational Health
An initiative
of CSSP



POLICY CHANGE TO PROMOTE EARLY RELATIONAL HEALTH

The early and [foundational early relationships](#) that babies and toddlers experience with their parents shape the health and well-being of two generations.

This brief highlights opportunities to promote early relational health with policy change and investments, including with existing programs, pandemic funding, and pending legislation in Congress.

At its core, Early Relational Health (ERH) focuses on a paradigm shift in [early childhood community systems](#) to improve child and family health, development, and well-being through a focus on [early relationships](#). ERH rests on the following tenets: 1) the importance of [positive and nurturing](#) caregiver-child relationships that promote two-generational well-being, 2) the recognition of [family strengths](#) and goals and not simply risks, and 3) the promotion of equitable and just policies for families and communities that disrupt systemic inequities and support families and communities. ERH is explicitly [anti-racist](#) and guided by both science and family wisdom.

Relational health uses a strengths-based, solutions-focused approach that is aimed at building individual, family, and community capacities. These capacities promote safe, stable, and nurturing relationships (SSNR), buffer adversity, and foster resilience. The recent statement from the American Academy of Pediatrics, [Preventing Childhood Toxic Stress: Partnering with Families and Communities to Promote Relational Health](#) (Garner et al.), calls for translating the relational health framework into clinical practice, research, and public policy, and for adopting a public health approach that builds relational health by partnering with families and communities.

For far too long, our nation has perpetuated maternal-infant health, family, economic, and early childhood policies that do not attend to the critical need for developing foundational early relationships between baby and family. One in five children under age five lives in poverty. The lack of stable housing, food insecurity, and other basic needs associated with poverty can increase caregiver stress and impede early relationships and optimal child development.

COVID-19 has further exacerbated these conditions, causing significant additional stress to millions of families with young children, especially those in under-resourced neighborhoods and communities. Virtually all families with young children are negatively affected by the pressures of the the COVID-19 public health emergency. However, many families with higher income are able to defray some of these pressures by taking advantage of resources like unpaid family leave policies, quality child care, and creating a safe, stable, and nurturing home environment. Among families with



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lower incomes, lack of comprehensive national parental leave policies may force parents back to work within a week or two following birth, child care arrangements may be unstable, and providing adequate housing, food, and other basic necessities can become significant challenges that compromise early relational health.

We also know that quality health care, support for mental health, housing, transportation, and other community resources for families are not equitably distributed. Across the 100 largest metropolitan areas, 46% of Black children and 32% of Hispanic children live in [neighborhoods that are considered very low opportunity](#), without the educational, health, environmental, and socioeconomic conditions they need to thrive.

Despite these challenges, current policy changes offer unprecedented opportunities to reimagine our health, early childhood, economic, housing, and family-serving systems to reflect what children and families want and need. In addition, COVID-era funding represents new investments in programs, services, and supports that can strengthen families and communities.

Now is the time to partner with families, early childhood leaders, and communities to advance equity and [strengthen early relational health](#) through effective policy advocacy and implementation.



THE AMERICAN RESCUE PLAN ACT

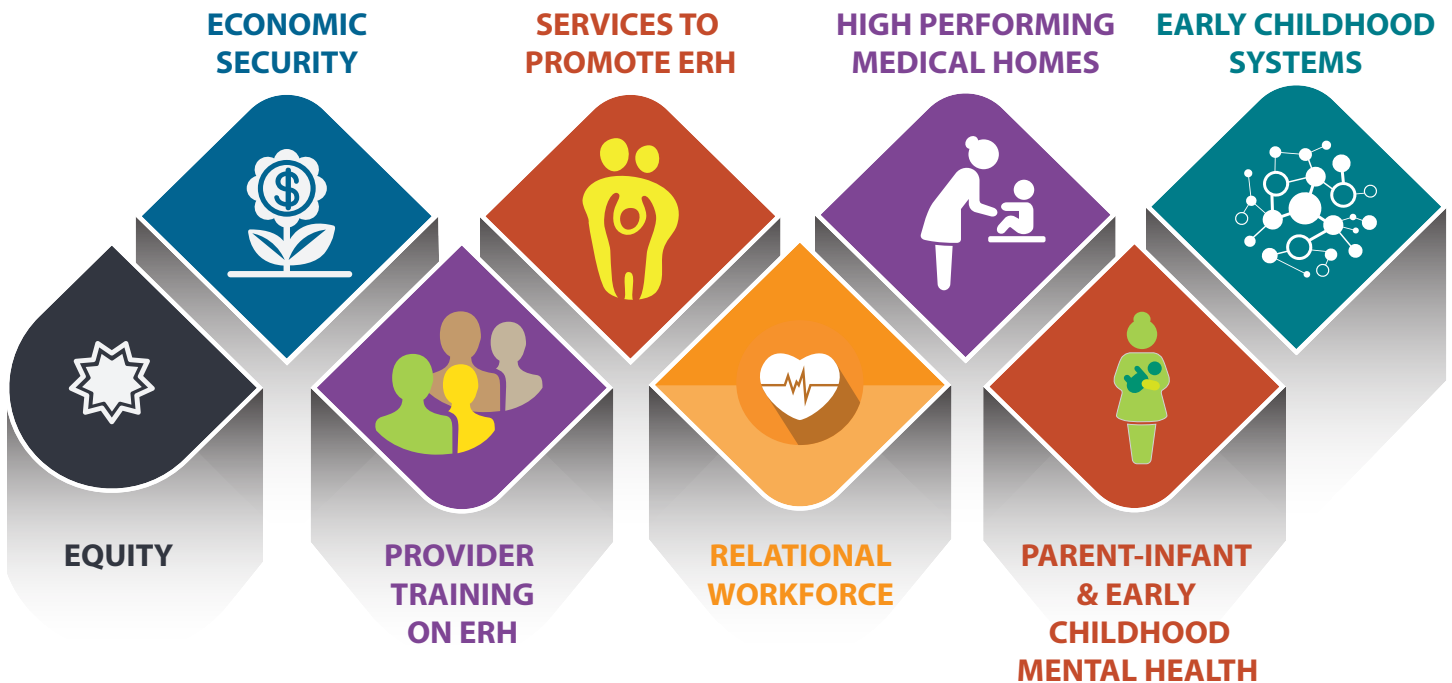
The American Rescue Plan Act (ARPA) offers substantial investments and changes to current child and family policy. With both direct supports to families and increased resources to state and communities, ARPA helps to create conditions that foster early relational health, including provisions to:

- Increase family economic security [by restructuring and boosting the Child Tax Credit](#) and other tax credits (along with community economic development) that can reduce poverty among families with children. If this and related tax credits are made permanent and reach all eligible families, they will [cut child poverty almost in half](#), and significantly advance racial equity.
- Provide for basic needs that support greater family well-being through enhanced assistance for child care, food, income, utilities, transportation, and housing.
- Invest in community supports to partner with and strengthen families, including increased funds for [home visiting](#), [pediatric mental health care access](#), [community health workers](#), [community-based doulas](#), [community navigators](#), and other programs.
- Give states the option to [extend Medicaid postpartum coverage for one year](#), so that birthing people and their babies will have guaranteed coverage for 12 months, including Medicaid coverage for two-gen, relational services. [Half of states have taken action to use this new option](#) and provide extended postpartum coverage.

The [Build Back Better Act](#), as passed by the U.S. House of Representatives in November 2021, included policies that would further support ERH, including: paid family leave, continuation of expanded Child Tax Credit, Medicaid postpartum coverage for one year in all states, mental health investments, health equity investments and more.



PRIMARY POLICY GOALS TO ADVANCE EARLY RELATIONAL HEALTH



- ◆ Aim to **advance equity** in the design of all policies.
- ◆ Support family **economic security** and mobility for two-generational success, including paid family leave, child tax credit, and assistance to address insufficient food, housing, income, and other concrete needs.
- ◆ Train **providers serving families** in ERH principles and best practices, including anti-racist and anti-bias training approaches.
- ◆ Scale up and sustain **evidence-based interventions and community system innovations** that promote ERH.
- ◆ Develop a diverse and well-trained **relational workforce**, including community health workers, doulas, home visitors, and others.
- ◆ Advance **high performing medical homes** using team-based, family-driven approaches, with relational care coordination.
- ◆ Increase access to **maternal, infant, and early childhood mental health**, beginning prenatally and including promotion, prevention, and treatment for parents and children together.
- ◆ Strengthen **early childhood systems** in communities, with linkages and coordination among health, family support, early care and education, home visiting, early intervention, mental health, housing, child welfare, and other services and informal supports.



POLICY OPPORTUNITIES TO ADVANCE EARLY RELATIONAL HEALTH

Policies should respect and bolster family strengths and support adults' efforts to create safe, stable, and nurturing relationships and environments for young children in the context of their cultural traditions and communities. Policies and programs should be designed to reduce the stressors and remove the structural barriers (e.g., limited time, income, racism, safety) that affect parents' capacities to develop strong foundational relationships with their infants and toddlers.

Many different types of policies can support and promote the foundational relationships that shape the health, development, social, and mental well-being of both the parent and the baby, perhaps for a lifetime. The ERH policy goals found on page three reflect the breadth of the policy agenda. The examples in this brief highlight some of the opportunities that exist today with ARPA and other current funding and the potential that exists in pending policy proposals. In addition, as discussed above, states, tribes, and communities have expanded funding under ARPA to build stronger home visiting, child care, and children's mental health programs, which could be used to focus more attention on ERH and support training for providers.

The [National League of Cities](#), [National Association of Counties](#), and others have identified examples of local investment using ARPA funds to support [families with young children](#) and community resilience include: investments to support: improvements in availability of food, enhanced pay and bonuses for child care workers, abatement of lead and other environmental hazards in homes and child care centers, home visiting services to home-based child care providers, creation of family support centers, mental health services, affordable housing, and investment in historically underserved communities using equity focused design thinking. At the same time, most ARPA investments in children and families were for school-aged children and youth, not the youngest children.

Some communities are learning about the positive effects of [unconditional cash transfers to pregnant women](#) living in poverty and [the positive impact of cash transfers during the first year of life on infant brain development](#).

PAID FAMILY LEAVE

What does paid family leave have to do with ERH? A growing body of science related to brain development, child health, mental health, and trauma-informed care along with historical, indigenous, and traditional parenting practices, all point to what is uniquely special about the foundational relationship between parents and infant in those first weeks following birth. [Paid family leave has health benefits. Yet current federal law provides only for unpaid leave.](#)

A paid family leave policy should be part of our social insurance system and: provide for all families and workers, be of meaningful amount and duration, and protect workers from discrimination and retaliation in the workplace. Such a policy should reflect and respect the value of early relationships for every family, of every race/ethnicity, and of every socio-economic level.

Beyond debates about whether it should be for six months, 12 weeks, or even four weeks, the United States *needs* paid family leave policy now to support the well-being of the next generation.



A CHILD ALLOWANCE

Adequate income is critical for healthy child development and [research consistently shows that additional income leads to better health, educational, and employment outcomes over the long term](#). Families need a child allowance, or a guaranteed minimum income, that provides regular support so they can meet their needs and thrive. Under ARPA, the expanded Child Tax Credit temporarily functioned like a child allowance during 2021, providing families with monthly payments of up to \$300 per child to help with the costs of raising children.

This additional support was critical for families who received it, [allowing them to meet basic needs](#) and invest in their children, with half using funds to buy food and one third applying to school expenses. It also [reduced parental stress](#), giving them the time and space to parent in the way they hoped. The expanded Child Tax Credit should be made permanent, and improved so that all families who need it are eligible, regardless of immigration status, and that it is easy and straightforward for families to access.



POSTPARTUM MEDICAID COVERAGE

Current federal policy limits pregnancy-related Medicaid coverage to only 60 days for many birthing people. [Among new mothers with an infant who lacked coverage](#), nearly half become uninsured due to loss of Medicaid after 60 days. Without coverage, they may not be able to afford care for diabetes or hypertension, depression, family planning, or preventive visits.

As a result of ARPA, beginning in April 2022, states have the option to use a state plan amendment to extend postpartum coverage to one full year. Some states are already using Medicaid waivers to do this. As of January 2022, 25 states have taken some related policy action.

For babies with a Medicaid-financed birth, [federal law has long guaranteed coverage through the first year of life](#). With extended postpartum Medicaid coverage added to babies' coverage, many dyadic and ERH interventions can be routinely financed in the year following a birth. All states have the opportunity to provide enriched payments for high performing medical homes with team-based care and more support for mothers and babies.



COMMUNITY HEALTH WORKERS

Community health workers (CHWs) are frontline public health workers who are trusted members of the community, which enables them to serve as a liaison between people and providers to facilitate access and improve service quality and cultural responsiveness. They are known by many names, including *promotores* and peer navigators.

In response to the COVID-19 public health emergency, the CDC received funds under five Congressional acts to support the training and deployment of CHWs. [The CDC's Community Health Workers for COVID Response and Resilient Communities \(CCR\) initiative](#) was launched in August 2021. In addition, some states (e.g., California,



Indiana, Oregon, Washington, South Dakota), are currently or are planning to authorize CHWs as providers who can be reimbursed under Medicaid. [Rules vary by state.](#)

This expanded community-based workforce can be used, in part, to provide services to families prenatal to 3. Placement in care teams with health providers/ medical homes, as part of home visiting programs, and in roles as outreach or family support workers are best and promising practices.

PRIMARY CARE CHILD DEVELOPMENT

In the first three years of life, more than 90 percent of infants and toddlers are served by pediatric primary care providers. In the first year alone, there are six recommended well-baby visits, all of which are opportunities to promote ERH and optimal development. Using a team-based approach in a high performing medical home, more health promotion and support can be offered to families.

In his campaign priorities and discretionary budget request for FY2022, President Biden called for funds to ensure that there is an early childhood development expert in every community health center and grants to help cities place early childhood development experts in other pediatrician offices with a high percentage of patients covered by Medicaid and Children’s Health Insurance Program (CHIP).

Now, the federal Health Resources and Services Administration (HRSA) has an opportunity to support [Transforming Pediatrics for Early Childhood](#) in primary care clinics and practices that serve a high percentage of prenatal-to-five year old (P-5) populations who are eligible for Medicaid or the Children’s Health Insurance Program (CHIP) or are uninsured.



Early Relational Health (ERH) refers to the foundational relationships between a young child and their caregivers that advances physical health and development, social well-being, and resilience. In partnership with stakeholders and leaders in child health, public health, and communities CSSP’s ERH Initiative works leverage the urgent need and immediate opportunity to further galvanize interest in an early relational health frame. Learn more about our work here: [CSSP.org/our-work/project/advancing-early-relational-health/](https://cssp.org/our-work/project/advancing-early-relational-health/).

