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# **Spending Smarter**

## **A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness**

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November 2005

The National Center for Children in Poverty identifies and promotes strategies that prevent child poverty in the United States and that improve the lives of low-income children and families.

## Spending Smarter: A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness

by Kay Johnson and Jane Knitzer

This document is part of a policy series intended to improve social, emotional, and learning outcomes for young children. Building on NCCP's work over the past several years (see Promoting the Emotional Well-Being of Children and Families series, at [www.nccp.org](http://www.nccp.org)), *Spending Smarter* describes effective programs, highlights policy opportunities, and offers fiscal strategies to promote the emotional health of young children and their families. The analyses in this series will help state officials, community leaders, and advocates take action to ensure the healthy development of children and their families. *Spending Smarter* focuses on strategies to maximize existing funding streams by building on federal programs. The companion document, *Resources to Promote Social and Emotional Health and School Readiness in Young Children and Families—A Community Guide*, describes targeted interventions that can help parents and other early care providers, such as home visitors and teachers, be more effective in promoting healthy relationships and reducing challenging behavior in infants, toddlers, and preschoolers.

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### ACKNOWLEDGMENTS

The authors gratefully acknowledge a group of experts who took the time to review a lengthy manuscript and who provided fresh insights into how to improve this report. This group includes: Brenda Bean, Vermont Department of Child and Family Services, Child Development Division; David Bergman, National Academy of State Health Policy; Charles Bruner, Child and Family Policy Center; Anita Fong, San Francisco Department of Public Health; Barbara Gebhard, Build Initiative; Pat Trohanis, Frank Porter Graham Child Development Institute, University of North Carolina; and Deborah Perry, Georgetown University Center for Child and Human Development. The authors also want to thank Ruth Mayden and Lisa Kane of the Annie E. Casey Foundation for their generous guidance and patience as well as for providing NCCP with the resources to carry out this work.

# Table of Contents

<b>Executive Summary</b> .....	5
<b>Introduction</b> .....	12
<b>Framing the Challenge: What Policymakers Should Know About Social and Emotional Health and School Readiness</b> .....	14
What Does Social and Emotional Health and School Readiness Mean? .....	14
Why Should Policymakers Invest in Social and Emotional School Readiness? .....	15
How Large Is the Problem? .....	16
What Are Major Risk Factors for Poor Social and Emotional Development? .....	17
What Kinds of Interventions Should Policymakers Support? .....	18
What's in a Name? .....	18
<b>Making the Most of Individual Federal Programs to Promote Social and Emotional Health and School Readiness</b> .....	21
<b>Child Health and Mental Health Programs</b> .....	23
The Medicaid Program .....	23
Medicaid and Young Children	
State Children's Health Insurance Program (SCHIP) .....	29
Title V Maternal and Child Health (MCH) Block Grant .....	29
Other Health and Mental Health Programs .....	31
Community and Migrant Health Center Programs	
Community Mental Health Programs for Children and Adults	
<b>Early Childhood Care, Education, and Special Education Funding Streams and Programs</b> .....	33
The Child Care and Development Fund (CCDF) .....	34
Head Start and Early Head Start .....	35
Special Education Programs .....	36
IDEA Part C: Early Intervention Program for Infants and Toddlers with Disabilities	
IDEA Part B (Section 619): Special Education Preschool Grants	
Other Programs Focusing on Early Learning and School Success .....	39
<b>Programs Serving Young Children and Families at Greater Risk</b> .....	40
Child Abuse Prevention and Treatment Act (CAPTA) .....	40
Title IV-B and Promoting Safe and Stable Families .....	41
Title IV-B and Young Children	
Title IV-E Foster Care .....	42
Temporary Assistance for Needy Families (TANF) .....	42
Social Services Block Grant (SSBG) .....	43
Community-Based Family Resource and Support Grants .....	43
Violence Against Women Act (VAWA) .....	43
Substance Abuse Prevention and Treatment Block Grant (SPATBG) .....	44
<b>Moving Forward: Opportunities to Act Now</b> .....	45
<b>Conclusion</b> .....	51
<b>Endnotes</b> .....	52

Appendix 1: The Spending Smarter Checklist .....	56
Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success .....	58

**List of Boxes**

Box 1: Social, Emotional, and Behavioral Skills That Promote School Readiness .....	14
Box 2: What Early Learning Research Tells Us .....	16
Box 3: Early Childhood Mental Health in Action .....	19
Box 4: Correcting Misperceptions About Medicaid Rules .....	24
Box 5: How to Use Medicaid to Promote Social and Emotional Health and School Readiness .....	26
Box 6: ABCD II: Building State Medicaid Capacity to Deliver Care That Supports Healthy Mental Development in Children .....	27
Box 7: Components of Early Childhood Development Services That Can Be Integrated into Title V and Medicaid .....	30
Box 8: Using Title V to Promote Social and Emotional Health and School Readiness .....	32
Box 9: Using Children Care and Development Fund (CCDF) to Promote Social and Emotional Health and School Readiness .....	34
Box 10: Using Part C of IDEA to Promote Social and Emotional Health and School Readiness .....	37
Box 11: Foundations for Learning Grant Program .....	38
Box 12: Maximizing Entitlement Funds .....	46

## Executive Summary

*“The time is long overdue for state and local decision makers to take bold actions to design and implement coordinated, functionally effective infrastructures to reduce the long-standing fragmentation of early childhood policies and programs ... establish explicit and effective linkages among agencies that currently are charged with implementing the work requirements of welfare reform and those that oversee the provision of both early intervention programs and child and adult [health] and mental health services.”*

—*Neurons to Neighborhoods*. Recommendation 10, p. 12

*Spending Smarter* is designed to help state legislators, agency officials, families, and other advocates think strategically and take steps to meet the challenge of utilizing existing funding streams to promote the social and emotional health and school readiness of young children. The framework and content of *Spending Smarter* is designed to help state and local leaders maximize the impact of federal funding and feel confident that they are using existing resources in the most effective way. More detailed information is available in a summary checklist and a technical appendix on the web site of the National Center for Children in Poverty ([www.nccp.org](http://www.nccp.org)).

## The Challenge

Research tells us that social and emotional skills and competencies are the foundation for success in school. Yet reports from all over the country suggest that many young children lack these skills, while a large number struggle with even more distressing behaviors.

Research on early brain development makes a powerful case for investing in strategies to promote healthy early relationships, intervene early when there are signs of problems, and provide intensive treatment for troubled young children and families to improve school-linked outcomes. This is particularly true for young children whose development is compromised by poverty and other risk factors. We also know the costs of not intervening. Children who do not succeed in the first three elementary school grades are often headed for a much longer-term and costly trajectory of failure.

Most importantly, knowledge is growing about effective, evidence-based interventions to help these young children, their families, and others who interact with them promote, prevent and treat signs of early childhood mental health problems so they will not interfere with school learning. But paying for the services remains a major challenge.

## What Policymakers Should Know About Social and Emotional Health and School Readiness

Put most simply, social and emotional health and school readiness means that children have the age-appropriate ability to:

- Manage and regulate emotions (such as how a preschooler responds when another child takes his toy; whether a baby can comfort herself).
- Relate to and trust adults and eventually peers.
- Experience themselves as competent learners (for example, are they eager to engage in learning, or are they too anxious or sad to try new things?).

Because most young children develop age-appropriate social and emotional skills through everyday interactions with parents, caregivers, siblings, and others, it is sometimes difficult for families, policymakers, legislators, and administrators, and even the general public to believe that there are some children who, absent intervention, will not outgrow their problems. But just as there are deliberate ways to promote early literacy, so there are ways to promote healthy early social and emotional development. While they cannot solve every problem, early childhood mental health interventions, especially those that are grounded in strengthening positive relationships, can often make a critical difference in promoting resilience and early school success.

## How Should Policymakers Invest to Promote Social and Emotional Health and School Readiness?

In general, clinical and developmental knowledge indicates that the best way to help young children thrive socially and emotionally is to ensure that those who are closest to them have the needed knowledge and emotional support to be good guides. The primary aim is to change the child's environment and to intervene directly with the child only when the child's problem cannot be addressed by changing the way the caregivers respond or how the environment is structured. Based on scientific evidence, intervention research, and real-world experience, capacity building should focus on three broad types of interventions.

**1) Promotion and prevention strategies targeted to all children, but especially low-income children.** Many of these strategies focus on improving the skills of parents, other caregivers, and front-line providers. Screening, in a variety of settings, with follow-up advice and support for caregivers, is core to promotion and prevention.

Promotion and prevention strategies include:

- Screening all pregnant women for depression in public health clinics and community health centers.
- Routinely screening all young children for developmental risk factors in the context of primary health care.
- Training all community providers working with low-income families in how to help parents “read” the cues of their babies.
- Assuring social-emotional screening and anticipatory guidance in pediatric practices and/or supporting child development specialists in pediatric practices.
- Implementing a social skills curriculum for preschoolers in prekindergarten programs.

2) **Early intervention strategies for groups of young children who face especially high social risks.** Young children at special risk include those with disabilities and special health care needs, those in foster care, those whose parents face serious mental health issues, particularly depression, and those whose parents are incarcerated or abuse drugs.

Early intervention strategies include:

- Routinely screening all young children in foster care for social and emotional problems.
- Training child welfare workers, court personnel, home visitors, family-support team members, and others in the principles of early childhood development and their implications in family service systems.
- Making a mental health consultant available to center-based and family child care to help staff improve how they respond to young children showing early signs of problems.
- Implementing strategies in early childhood settings to help children, staff, and families respond when young children have witnessed domestic violence or have depressed parents.

3) **Child and family-focused treatment strategies sufficiently intensive to help young children with serious social, emotional, and behavioral problems and their parents (or other primary caregivers) and siblings.** These kinds of interventions include services that can help families stay together and ensure the safety and healthy development of young children. For young children, treatments should be relationship-based, involving the parents and other caregivers.

More intensive interventions include:

- Addressing parental trauma and embedding therapy for parents facing special risks, such as depression, in home visiting and early childhood programs.
- Supporting behavioral aides in early childhood programs to promote inclusive child care.
- Ensuring that foster parents have access to training and supports to help them better meet the needs of young children who have been removed from their homes.
- Providing wraparound planning and family-driven case management for young children with serious emotional and behavioral disorders.

## **Making the Most of Individual Federal Programs to Promote Social and Emotional Health and School Readiness**

There is no one funding stream targeted to young children facing social and emotional threats to school readiness. Thus, figuring out how to mix and match the multiple funding streams, eligibility requirements, and administrative requirements to ensure access to developmentally appropriate, family-focused, preventive, early intervention, and treatment services is very challenging. Predictable barriers include:

- **Funding restrictions.** Although major funding streams, such as Medicaid, pay for health and related services to children, it is much more difficult to fund interventions to help parents and other caregivers.
- **Eligibility criteria.** Many of the demographic, familial, and environmental risk factors that predict later problems are not included in the eligibility criteria for mental health and related services unless the child has a diagnosed disorder or delay.
- **Limited financing for parent-child, two-generation interventions.** Reimbursement for services to address the adult conditions that affect parenting, such as depression, and paying for parent-child relationship-based interventions is very difficult.
- **Inadequate systems for tracking children who are deemed at risk.** Screening for social and emotional problems in young children is haphazard, and follow-up monitoring to see if there are any status changes is quite limited.
- **Limited investments in training (and retraining) the workforce.** Mechanisms to disseminate and increase information about evidence-based and effective practices are limited, and workforce development is needed.

Federal funding streams and programs to help these vulnerable children can be divided into three categories:

- **Child health and mental health programs.** Anchor programs that provide potentially major sources of funding for an array of services related to the social, emotional, and behavioral health of young children include Medicaid, the State Children's Health Insurance Program (SCHIP), Title V of the Maternal and Child Health Services (MCH) Block Grant, and to a lesser extent, the Comprehensive Services for Children cooperative agreements or the federal Community Mental Health Services Program for Children and Families.
- **Early care and learning programs** include the Child Care and Development Fund (CCDF), Head Start, Early Head Start, and other early education program, as well as the Infant-Toddler Early Intervention and Preschool Special Education programs.
- **Programs serving young children and families at greater risk** that can be used as entry points and/or funding streams, include: the Child Abuse Prevention and Treatment Act (CAPTA), Title IV-B and Safe and Stable Families, Foster Care—Title IV-E, and Temporary Assistance for Needy Families (TANF) as well as several smaller grant programs. Several smaller programs also offer opportunities to direct resources toward these most vulnerable children and families, including: the Foundations for Learning Act, Social Services Block Grant (SSBG), Community-based Family Resource and Support grants, Violence Against Women Act, and Substance Abuse Prevention and Treatment Block Grant (SPATBG)

*Spending Smarter* highlights how these programs might be used to:

- Provide screening and diagnostic assessment.
- Monitor young children who have identified risk factors but are ineligible for individual services.
- Improve access to preventive, early intervention, and treatment services for young children, their families, and their caregivers.

- Address inconsistencies or confusion related to eligibility, and clarify the extent to which at-risk children can be served.
- Enhance workforce capacity through training and other means.
- Build infrastructure to support an array of services and supports.

## Moving Forward: Opportunities to Act Now

The development of state and community infrastructure for fiscal and service strategies to promote social, emotional, and behavioral health in young children as part of a school readiness agenda requires detailed knowledge of how individual programs and funding streams work. It also requires thoughtful planning to build a common vision, identify priorities, take action to address barriers, and, to the extent possible, promote research-informed practices. Communities and states, however, can begin with the following action steps.

- 1) Convene a broad array of stakeholders, including families, public officials, and advocates to conduct a cross-system programmatic and fiscal analysis of currently funded social and emotional services to identify overlap, gaps, and action priorities.
- 2) Support financing strategies with interagency plans and written agreements to clarify and sustain cross-system efforts and potentially identify new matching funds.
- 3) Adopt a statewide definition of factors that place young children at high risk for social, emotional, and behavioral delays and conditions, and mobilize resources on behalf of these at-risk children across programs.
- 4) Blend dollars to cross-train a variety of professionals regarding early childhood emotional development.
- 5) Use block grants or smaller grant programs to provide flexible funding that can fill gaps left by Medicaid, Part C Early Intervention, and other core funding streams. Certain federal and private philanthropic funds also can be used to launch an initiative, support a pilot project, or convene a planning group.
- 6) Clarify eligibility and payment mechanisms between Medicaid's EPSDT child health component, the IDEA Part C Early Intervention program, child welfare, mental health, and other programs especially for children with dual or multiple eligibility status.
- 7) Adopt policy and billing mechanisms that encourage providers to perform developmental screening with age-appropriate tools and to offer follow-up referrals and treatment, in both medical office-based and nonoffice-based settings.
- 8) Target subpopulations of high-risk children and families for more intensive identification, outreach, and services. Start with one group of vulnerable children, such as young children experiencing abuse and neglect, or with depressed mothers.
- 9) Finance two-generation strategies and parent-child therapeutic interventions that can give two-for-one results.
- 10) Monitor children at risk but not yet eligible for entitlement programs and link them to existing services, for example through the establishment of a high-risk young child tracking program.

## The Spending Smarter Checklist: A Guide for Policymakers, Families, Advocates, and Service Providers

Below are a set of questions for state officials, families, advocates, and practitioners that can help drive a strategic approach to strengthening social and emotional school readiness and building early childhood mental health capacity. No state has implemented all of these recommendations, but together they provide a framework for prioritizing state and local action.

- |   |  |
|---|--|
| <input type="checkbox"/> Yes, done<br><input type="checkbox"/> Under development<br>_____<br><input type="checkbox"/> Needs effort<br>_____ | <p>1. Does your state have a cross-agency strategic planning group to build strategic early childhood mental health capacity? Does the planning group:</p> <ul style="list-style-type: none"><li>• Include families? Providers?</li><li>• Link to a larger early childhood/school readiness planning process?</li><li>• Include a dedicated fiscal planning group?</li></ul>   |
| <input type="checkbox"/> Yes, done<br><input type="checkbox"/> Under development<br>_____<br><input type="checkbox"/> Needs effort<br>_____ | <p>2. Does the state cross-agency strategic agenda include explicit efforts to build overall system capacity? Does your state:</p> <ul style="list-style-type: none"><li>• Map how each system currently supports prevention, early intervention, and treatment services?</li><li>• Map gaps in existing community-based programs or early childhood mental health initiatives across the state?</li><li>• Create incentives for community-based, cross-agency training initiatives?</li><li>• Implement targeted collaborations across IDEA Part C (Individuals with Disabilities Education Act), child welfare, and early childhood programs?</li><li>• Build common definitions across programs for young children at risk of early school failure and/or developing social and emotional disorders?</li><li>• Ensure family/two-generation treatment for the most vulnerable (e.g., promoting collaboration across child and adult mental health, substance abuse, and domestic violence programs)?</li><li>• Pay for treatment for adults in the context of home visiting programs and comprehensive early childhood programs?</li><li>• Use smaller grant programs strategically to promote system-building capacity (e.g., Foundations for Learning; Safe and Drug Free Schools; Early Learning Opportunities; and Good Start, Grow Smart)?</li></ul> |
| <input type="checkbox"/> Yes, done<br><input type="checkbox"/> Under development<br>_____<br><input type="checkbox"/> Needs effort<br>_____ | <p>3. Is your state maximizing the impact of Medicaid/SCHIP? Does your state:</p> <ul style="list-style-type: none"><li>• Require/permit EPSDT age-appropriate screening and diagnostic tools for infants, toddlers, and preschoolers that are sensitive to social, emotional, and behavioral issues?</li><li>• Pay for covered services delivered in a range of community-based settings?</li><li>• Include separate definitions and billing codes for developmental assessment/screening and diagnostic evaluations?</li><li>• Use state matching funds strategically with Medicaid to support behavioral and mental health consultation in child care and home visiting programs?</li><li>• Provide reimbursement for parent-child therapy?</li><li>• Cover necessary services for social and emotional needs under the SCHIP benefits package?</li></ul>   |
| <input type="checkbox"/> Yes, done<br><input type="checkbox"/> Under development<br>_____<br><input type="checkbox"/> Needs effort<br>_____ | <p>4. Is your state maximizing the impact of Title V Maternal and Child Health Services Block Grant? Does your state:</p> <ul style="list-style-type: none"><li>• Use Title V's flexible funding strategically to cover services and supports for families and other caregivers that cannot be provided through Medicaid (e.g., cross-training)?</li><li>• Explicitly include children who are at increased risk for developmental, behavioral, or emotional challenges according to the state definition of Children with Special Health Care Needs (CSHCN)?</li><li>• Maximize the potential of the State Early Childhood Comprehensive Systems (ECCS) planning grants, including a focus on the most vulnerable?</li><li>• Use the flexibility under Title V to develop and/or finance programs for maternal depression or other two-generation treatment strategies?</li></ul>   |

## The Spending Smarter Checklist: A Guide for Policymakers, Families, Advocates, and Service Providers (continued)

- Yes, done
- Under development  
\_\_\_\_\_
- Needs effort  
\_\_\_\_\_

5. Is your state maximizing the impact of the Child Care and Development Fund (CCDF) to promote social and emotional health and school readiness? Does your state:
- Define explicit strategies to promote social and emotional health and school readiness competencies in children and improve the skills of caregivers in the state's CCDF plan?
  - Use CCDF funds to support training for the early childhood community on social, emotional, and school readiness issues?
  - Ensure that the highest-risk young children are in high-quality child care settings?
  - Use CCDF funds to support early childhood mental health consultation through the quality set-aside? Use other funds?

- Yes, done
- Under development  
\_\_\_\_\_
- Needs effort  
\_\_\_\_\_

6. Is your state maximizing the potential of special education programs on behalf of infants and toddlers at risk of developmental delays and on behalf of preschoolers with identified disabilities? Does your state:
- Ensure appropriate social and emotional assessments in IDEA Part C Child Find screening activities, as well as in comprehensive, developmental, multidisciplinary evaluations?
  - Use the option to extend IDEA Part C eligibility to at-risk infants and toddlers, with emphasis on social, emotional, and environmental risk factors?
  - Identify infants and toddlers exposed to substance abuse, domestic violence, and maternal depression as a high-risk group? Extend eligibility for Part C services?

- Yes, done
- Under development  
\_\_\_\_\_
- Needs effort  
\_\_\_\_\_

7. Is your state maximizing the impact of the new CAPTA amendments? Does your state:
- Require collaboration across public health agencies, child protection systems, and community-based programs to provide child abuse and neglect prevention as well as treatment services?
  - Have a mechanism to ensure that screenings of young children at risk who have experienced abuse or neglect and/or witnessed domestic violence lead to interperiodic reviews, assessments, and/or referrals for early intervention?
  - Require that all children from birth to age 3 entering the foster care system be assessed through the IDEA Part C Early Intervention program?

- Yes, done
- Under development  
\_\_\_\_\_
- Needs effort  
\_\_\_\_\_

8. Does your state maximize the impact of programs serving the most vulnerable families with young children? Does your state:
- Use Title IV-B funding to create two-generation child mental health and behavioral interventions for families with young children in or at risk for foster care placement?
  - Use TANF grant dollars for family counseling, service coordination, substance abuse treatment, family support, and training activities?
  - Transfer TANF funds to the CCDF or the SSBG to jump-start behavioral and mental health early childhood consultation strategies?
  - Strategically use funds from family violence/domestic violence, substance abuse, prevention, treatment, and community-based family resource and support to promote treatment and two-generation strategies targeted to families with young children?

## Introduction

In 1994, the Educate America Act set forth an ambitious national goal: “Every child shall enter school ready to learn.”<sup>1</sup> Since then, a remarkable body of research has emerged, painting a rich portrait of the factors that promote or inhibit early learning success. This research makes it clear that caring parental relationships and other early life experiences equip most young children, including low-income children, with the appropriate tools to support their learning and enable them to succeed in school. It also makes clear that not only are babies born “wired to feel and to learn,”<sup>2</sup> but most children are “eager to learn.”<sup>3</sup> All young children respond to high expectations and to environments that promote their curiosity and provide appropriate learning challenges.

At the same time, the research sounds a cautionary note. The early childhood years are a time of great opportunity, but they are also a time of vulnerability.<sup>4</sup> When a child’s earliest experiences do not provide the kinds of warm and stimulating relationships that are the foundation of early success in school, the odds of early school failure become greater.<sup>5</sup> Poor social and emotional skills predict early school failure. This, in turn, predicts ongoing school problems, and, for some, later school failure leading ultimately to involvement in high-cost child welfare, mental health, and juvenile justice systems.<sup>6</sup>

The group of young children who are at risk of early school failure is sizable—somewhere between one-fourth and one-third of all young children.<sup>7</sup> Disproportionately, these are low-income children. Particularly vulnerable are those whose early experiences do not provide them with warm, nurturing environments, whose language development lags, and whose social and emotional development is problematic.

Some young children at risk are resilient and are able to thrive despite challenges. (Resilience in children is the capacity to cope with adversity in a positive way.) But many do not fare so well. Child care workers describe too many young children as “mad, bad, and sad,” and even the most skilled and seasoned workers tell of encounters with young children they do not know how to help. The number one request from teachers of young children is for help in dealing with children with challenging behaviors, some of which are far more serious than many teachers have ever encountered.<sup>8</sup> Young children are being expelled from state preschool settings at three times the rate of older students.<sup>9</sup> Parents are being asked to remove even babies from child care settings.<sup>10</sup>

The knowledge base about how to design and implement strategies that can help infants, toddlers, and preschoolers develop age-appropriate social, emotional, and behavioral competencies is growing.<sup>11</sup> But building the fiscal and service delivery infrastructure to support the development of needed preventive, early intervention, and remediation strategies has proven to be very challenging. There is no one policy approach and no single, or even clearly targeted, funding stream. Instead, piecing together a coherent funding and service delivery infrastructure requires creative, strategic, and proactive leadership at both the state and community levels.

*Spending Smarter* is designed to help legislators, agency officials (e.g., health, child care, mental health, early education, and child welfare professionals), families, and other advocates take steps to maximize the impact of existing funding streams and feel confident that they are using available resources in the most effective way. The first section, “Framing the Challenge,” is a primer for policymakers about the social and emotional challenges facing young children, how these challenges prevent early school success, and what services and supports can make a difference. The second section, “Making the Most of Individual Federal Programs,” provides an analysis of how individual funding streams and programs can be used to build components of a coherent system of supports and services. The third section, “Moving Forward,” highlights strategies for advocates and policymakers to consider for immediate adoption in their own states or communities as well as questions to help guide strategic fiscal planning processes.

The strategies described in *Spending Smarter* cannot do the job alone. To build the kind of health, mental health, and quality early care and learning systems so crucial to America’s future, additional investments will also be necessary. However, without a deliberate focus on the social and emotional well-being of young children, even schools and communities that are ready will not be enough for many children and their families.

# Framing the Challenge: What Policymakers Should Know About Social and Emotional Health and School Readiness

## What Does Social and Emotional Health and School Readiness Mean?

Put most simply, social and emotional health and school readiness is about the age-appropriate ability of children to:

- Manage and regulate emotions (e.g., how a preschooler responds when another child takes his toy; whether a baby can comfort herself)
- Relate to and trust adults and eventually peers
- Experience themselves as competent learners (e.g., are they eager to engage in learning, or are they too anxious or sad to try new things?)

Research tells us that these abilities are the foundation of effective learning and life skills (see Box 1). When the earliest nurturing and stimulation provided by parents (including foster parents and grandparents) and by others (e.g., child care providers and teachers) does not help young children develop these expected competencies, the stage is set for cascading problems in mental health and other areas of development and achievement. Social, emotional, and behavioral problems in young children can take many forms, from a child who will not listen to a teacher, to one who disrupts the class, to one who is always sad and will not engage with peers, to one with a diagnosable mental health disorder.

### Box 1: Social, Emotional, and Behavioral Skills That Promote School Readiness

Young children are more likely to succeed in the transition to school if they can:

- Accurately identify emotions in themselves and others (Children who cannot do this persistently misinterpret social situations and routinely perceive the motivations of others as hostile.)
- Relate to teachers and peers in positive ways (Children who lack what are often called “prosocial skills” are likely to have few friends and negative relationships with teachers.)
- Manage feelings of anger, frustration, and distress when faced with emotionally charged situations (e.g., when another child takes a favorite toy)
- Enjoy academic learning and approach it enthusiastically
- Work attentively, independently, and cooperatively in a structured classroom environment

Young children are less likely to succeed in the transition to school if they:

- Engage in frequent fighting, hitting, shouting, or other aggressive behaviors
- Are unable to control impulsive behavior
- Are unable to pay attention to tasks or follow directions
- Engage in oppositional, noncompliant, or even defiant behavior
- Are unable to cooperate with others
- Constantly seek attention from peers or teachers
- Ignore peers or teachers

Source: Raver, C. C. & Knitzer, J. (2002). *Ready to enter: What research tells policymakers about strategies to promote social and emotional school readiness among three- and four-year-old children* (Promoting the Emotional Well-being of Children and Families Policy Paper 3). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

Just as there are deliberate strategies to promote early literacy, so there are strategies to promote healthy early social and emotional development.

Because most young children develop age-appropriate social and emotional skills through everyday interactions with parents, caregivers, siblings, and others, it is sometimes difficult for families, policymakers, legislators, administrators, and even the general public to believe that there are some children who, absent intervention, will not outgrow their problems. It is also difficult for them to comprehend that there are ways to promote social and emotional competencies in young children that, in turn, can help them succeed in school. Just as there are deliberate strategies to promote early literacy, so there are strategies to promote healthy early social and emotional development. While they cannot solve every problem, early childhood mental health interventions, especially those that are grounded in strengthening positive relationships, can often make a critical difference in promoting resilience and school success.

### Why Should Policymakers Invest in Social and Emotional School Readiness?

There are five major reasons that policymakers should invest in young children's social and emotional school readiness and mental health:

- 1) The earliest years are a time of opportunity, with public investments showing a large payoff.<sup>12</sup>
- 2) There is a powerful body of scientific knowledge showing the consequences of failure to address early signs of risk factors. Children who do not succeed in the first three elementary school grades are often headed for a much longer-term and costly trajectory of failure.<sup>13</sup>
- 3) The knowledge of how to design, implement, and evaluate effective interventions is growing.
- 4) Research tells us that social, emotional, and cognitive learning are intertwined for young children. Improving the capacity of young children to regulate their emotions seems to be a critical pathway to improve cognitive and early academic learning. Research also tells us that teachers may not accurately see the academic capacity of children with problem behaviors.<sup>14</sup>
- 5) Mental health disorders are being identified in younger and younger children. Even babies can show signs of depression. The impact of trauma, particularly related to exposure to violence and abuse, is as devastating for babies and young children as it is for older children and adults. Moreover, for some disorders, such as early onset conduct disorder, the earliest years represent a window of opportunity for intervention that may shut down.

## Box 2: What Early Learning Research Tells Us

Most young children are “eager to learn”<sup>1</sup> and have the cognitive and social and emotional skills to succeed.

- How the brain develops in the earliest years actually lays the foundation for later learning and the capacity to manage emotions.<sup>2</sup>
- The earliest relationships set the stage for healthy brain development and early learning.
- Almost all children are born “wired to learn.”
- Social, emotional, and cognitive learning are all interconnected in young children (perhaps even more than in older children).<sup>3</sup>

Although there are many children in low-income families who excel in school, there is a persistent achievement gap related to family income.<sup>4</sup>

- The lower the income, the lower the children’s academic achievement.
- The lower the income, the lower the children’s social skills, and the greater the reports of children’s emotional and behavioral problems.

Intentional strategies can make a difference.

- Improved parenting of infants and toddlers has been linked to improved cognitive, behavioral, and language skills in 3-year-olds.<sup>5</sup>
- Parents who have learned how to better manage young children’s behavior report positive changes at home and at school.<sup>6</sup>
- Classroom-based strategies to help young children master social and emotional skills have been linked to improved reading ability.<sup>7</sup>

<sup>1</sup> National Research Council, Committee on Early Childhood Pedagogy, Commission on Behavioral and Social Sciences; Bowman, B. T.; Donovan, M. S.; & Burns, M. S. (Eds.). (2001). *Eager to learn: Educating our preschoolers*. Washington, DC: National Academy Press.

<sup>2</sup> Institute of Medicine; Shonkoff, J. P. & Phillips, D. A. (Eds.). (2000). *From Neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

<sup>3</sup> Knitzer, J. & Raver, C. C. (2002). *Ready to enter: What research tells policymakers about strategies to promote social and emotional school readiness among three- and four-year-old children* (Promoting the Emotional Well-being of Children and Families Policy Paper 3). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

<sup>4</sup> Gershoff, E. T. (2003). *Low income and the development of America’s kindergartners* (Living at the Edge Research Brief 4). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

<sup>5</sup> See findings from the Early Head Start Research and Evaluation Project at <[www.acf.hhs.gov/programs/ohse/ehs\\_research/index.html](http://www.acf.hhs.gov/programs/ohse/ehs_research/index.html)>.

<sup>6</sup> Reid, M. J.; Webster-Stratton, C.; & Baydar, N. (2004). Halting the development of conduct problems in Head Start children: The effects of parenting training. *Journal of Clinical Child and Adolescent Psychology*, 33(2), pp. 279-291.

<sup>7</sup> Bodrova, E. & Leong, D. J. (2001). *Tools of the mind: A case study of implementing the Vygotskian approach in American early childhood and primary classrooms* (UNESCO Innodata Monographs: Educational Innovations in Action No. 7). Geneva, Switzerland: UNESCO, International Bureau of Education <[www.ibe.unesco.org/International/Publications/INNODATAMonograph/inno07.pdf](http://www.ibe.unesco.org/International/Publications/INNODATAMonograph/inno07.pdf)>.

## How Large Is the Problem?

Although there are no national epidemiologic data, findings from small community-based samples and some larger national datasets tell a similar story. Overall, about 10 percent of young children entering kindergarten are rated by teachers as showing some degree of behavioral problems.<sup>15</sup> In samples of low-income young children, reported rates of behavioral problems are often two or three times higher. A recent national study found that young children are expelled from preschool settings at three times the rate of children in grades K through 12.<sup>16</sup> New data on young children with diagnosable disorders reveal that about 17 percent show some kind of significant mental health disorder, with rates varying by problem. About 10 percent of them have acting out, aggressive disorders.<sup>17</sup>

## What Are Major Risk Factors for Poor Social and Emotional Development?

Four clusters of risk factors have been repeatedly identified in research:

- 1) **Poverty and low-income status.** Over 40 percent of all young children are in families with incomes at or below 200 percent of the poverty level; about 17 percent of them live at or below poverty, and half of those live in extreme poverty.<sup>18</sup> Poverty is the greatest risk factor for poor developmental outcomes, whether social, emotional, health related, or academic. Although many low-income parents are nurturing and effective, sometimes the hardship and stress of unrelenting poverty take their toll.
- 2) **Poor quality early care and learning.** The quality of early care and learning experiences affects the potential for early success in school. Young children spend large amounts of time in informal or formal child care and early learning settings.<sup>19</sup> Unfortunately, the quality of much of that care is poor, especially for low-income children.<sup>20</sup> The mental health of child care providers also plays a role. Providers who experience more job stress or higher levels of depression are also more likely to expel young children from their programs.<sup>21</sup> But regardless of caregiver mental health, those who work with young children in early care and learning settings are calling for help. A national survey carried out by the National Association for the Education of Young Children reported that help with behavioral problems was the number one request.<sup>22</sup>
- 3) **Parental risk factors.** Decades of research point to the power of nurturing relationships to foster resilience and counterbalance negative experiences. The converse is also true. The greatest threat to healthy emotional development is inadequate parenting—parenting marked by inappropriate expectations, indifference, inconsistency, or harshness.<sup>23</sup> Low educational levels, poor parental health, untreated parental trauma, and negative parenting role models all contribute to problematic parenting. Risk factors that receive far less attention than they should include substance abuse, domestic violence, and, especially, parental depression.<sup>24</sup>
- 4) **Child-specific risk factors.** There is also a group of young children who have serious, diagnosable emotional and behavioral problems. Sometimes these are young children in families facing multiple stresses and parental risk factors, but sometimes they are not. An analysis of a sample of young children served by mental health agencies found that, as with older children, about half of young children currently receiving mental health services are in families facing multiple demographic and psychosocial risk factors, while half are not.<sup>25</sup> Children with chronic health problems or with other disabilities are also at higher risk for emotional and behavioral problems. Supporting interventions for these most vulnerable young children and their families in an effort to improve school readiness is a crucial challenge. Such interventions need to be viewed through a family lens, addressing the parents, the parent-child relationship, and, if necessary, any developmental delays experienced by the child. Paying for such a combination of services, however, is particularly difficult.

## What Kinds of Interventions Should Policymakers Support?

Based on scientific evidence, intervention research, and real-world experience, capacity building should focus on three broad types of interventions. (For specific examples, see Box 3.)

- 1) **Promotion and prevention strategies targeted to all children, but especially low-income children.** Such strategies can help families and caregivers foster social skills, emotional health, and positive behaviors as part of a school readiness agenda. These strategies include anticipatory guidance by pediatricians or others, social and emotional skill-building curricula in preschool programs, and mobilizing local community leaders, mentors, and coaches.
- 2) **Early intervention strategies for groups of young children who face special risks.** Young children at special risk include those whose parents are incarcerated or abuse drugs, those in foster care, those with disabilities, and those whose parents face serious mental health issues, particularly depression. Screening and assessment tools that focus on age-appropriate social and emotional functioning, as well as provide full-scale diagnostic evaluations, can also be important in identifying young children in need of early intervention or treatment.
- 3) **Treatment strategies sufficiently intensive to help young children with serious social, emotional, and behavioral problems and their parents (or other primary caregivers) and siblings.** These kinds of interventions include access to case management, mental health, and other treatment services that can help families stay together and ensure the safety and healthy development of young children.

In general, clinical and developmental knowledge indicates that regardless of the type of intervention, the best way to help young children thrive socially and emotionally is to ensure that those who are closest to them have the needed knowledge and emotional support to be good guides. The primary aim is to change the environment that supports the child, and to intervene directly only when the child is the problem, not the symptom of the problem.

## What's in a Name?

Many different terms are used to describe early childhood mental health, social and emotional health, and school readiness interventions. For example:

- In the health and pediatric world, such interventions are often called *developmental services*, especially if efforts are made to have them paid for by “bundling” discrete Medicaid-eligible services.
- The early childhood and school worlds use nonmental health language, and speak primarily of *social and emotional competencies* to prevent early school failure.
- In the mental health world, the terms *infant* or *early childhood mental health* are used, although these terms can initially be stigmatizing and off-putting to families and others, evoking images of young children on a psychiatrist's couch.

### BOX 3: Early Childhood Mental Health in Action\*

#### Examples of Prevention Strategies

- Screen all pregnant women for depression in public health clinics and community health centers.
- Routinely screen all young children for developmental risk factors in the context of primary health care.
- Talk to parents about their depression and safety in pediatric practices.
- Train all community providers working with low-income families in how to help parents “read” the cues of their babies.
- Support a child development specialist in pediatric practices.
- Implement a social skills curricula for preschoolers in prekindergarten programs.

#### Examples of Early Intervention Strategies

- Make mental health consultants available to all center-based and family child care programs to help staff improve how they respond to young children perceived as having challenging behaviors.
- Provide training to early childhood staff (home visitors, child care providers) in social and emotional development
- Provide family support groups to improve parenting practices and reduce the isolation of parents with known risk factors for poor parenting in early childhood settings.
- Routinely screen all young children in foster care for social and emotional problems.
- Train child welfare workers and court personnel in the principles of early childhood development and the implications for child welfare processes.
- Establish protocols for effective cross-agency referrals to early intervention, special education, and other community services.
- Offer parental support and training to incarcerated parents.

#### More Intensive Interventions

- Embed cognitive behavioral therapy for depressed parents in home visiting programs.
- Support intensive relationship-based therapies for infants, toddlers, and parents exposed to trauma.
- Support behavioral aides in early childhood programs to promote inclusive child care.
- Ensure that foster parents have access to training and supports to help them better meet the needs of young children who have been removed from their homes and placed with multiple caregivers.
- Provide wraparound planning and family-driven case management for young children with serious emotional and behavioral disorders.

\* For other resources see: The National Center for Children in Poverty <[www.nccp.org](http://www.nccp.org)>; The Center on the Social and Emotional Foundations for Early Learning <[csefel.uiuc.edu](http://csefel.uiuc.edu)>; The Center for Evidence-Based Practices <[www.evidencebasedpractices.org](http://www.evidencebasedpractices.org)>; Georgetown University Center for Child and Human Development’s National Technical Assistance Center for Children’s Mental Health <[gucchd.georgetown.edu/cassp.html](http://gucchd.georgetown.edu/cassp.html)>; Child and Family Policy Center’s State Early Childhood Policy Technical Assistance Network <[www.cfpciowa.org](http://www.cfpciowa.org)>; and the Portland Research and Training Center on Family Support and Children’s Mental Health <[www.rtc.pdx.edu](http://www.rtc.pdx.edu)>.

Each of these terms may be useful in particular contexts. For example, if the Maternal and Child Health Bureau undertakes an initiative to reach out to pediatricians to encourage them to use age-appropriate screening tools, the terms *social and emotional health* and *child development services* may work best. If the public mental health agency embarks on a partnership with the early childhood community, it may be appropriate to speak of *promoting early childhood mental health*, particularly in relation to accessing funds. If Medicaid pays for wrap-around services for a young child to support the parent and prevent placement in a residential treatment setting, they are funded as *mental health services*. The bottom line is that whichever

term is used—*social and emotional competencies, infant mental health*—is far less important than the goal: to promote healthy relationships among and age-appropriate social and emotional behaviors in all young children, even those whose early experiences place them at the greatest risk.

\*\*\*\*\*

With this as a framework, we turn now to the core challenge that this document addresses: how to fund a system of integrated strategies to promote the social and emotional health and school readiness of young children.

## Making the Most of Individual Federal Programs to Promote Social and Emotional Health and School Readiness

*Sarita is 4½ years old. She is very bright and very active, and is constantly asking interesting questions. The staff in her new child care program find her very challenging and at least once a day give her a time-out. She is becoming increasingly depressed and silent. She used to participate in discussions about books; now she does not. Her grandmother, who is raising her, does not know what is wrong. When she talks with the teachers, they say she needs to be disciplined; otherwise, they will have to expel her.*

*Jeremy is 18 months old but seems much younger. Often he is angry. He cries a lot and clings to almost anyone. Although the Early Head Start staff have tried to get him to be more responsive, their efforts have not worked, and they do not know what else to do. His mother, who has two other young children, seems listless and not interested in Jeremy.*

*Aliza is a 3½-year-old child whose single mother is trying to work full-time. Aliza has been asked to leave two child care settings because of her behavior. She constantly runs out of the room, hits other children, grabs toys and doesn't seem to enjoy the activities. Her mother has just received a call from the third child care program informing her that other parents are alarmed and the staff feels they cannot be helpful any longer. Aliza's mother is distraught; she has already lost one job because of child care problems.*

—Adapted from Knitzer, J. (2001). *Building Services and Systems to Support the Healthy Emotional Development of Young Children: An Action Guide for Policymakers.*<sup>26</sup>

These children illustrate the kinds of social and emotional challenges likely to get in the way of successful early learning. They also illustrate why funding interventions to help these children is so complex. Absent intervention, each child may be at risk of early school failure. But each is likely to need a different type of intervention. For Sarita, help needs to be targeted to her caregivers and perhaps to support her exhausted grandmother. For Jeremy to thrive, it appears his mother will need help with her depression, preferably in the context of the Early Head Start program. For Aliza, who is showing signs of a more significant disorder, and her family, careful assessment and treatment are needed.

Because there is no one funding stream targeted to young children facing social and emotional threats to school readiness, figuring out how to mix and match the multiple funding streams, eligibility requirements, and administrative requirements to ensure access to developmentally appropriate, family-focused, preventive, early intervention, and treatment services is very challenging. Predictable barriers include:

- **Funding restrictions.** Although major funding streams, such as Medicaid, pay for direct services to children, and some involvement with parents, it is much more difficult to fund interventions directed to others who work with children (e.g., for consultations with child care providers or teachers). Therefore, one major policy challenge for promoting social

and emotional health in the context of school readiness is developing state-level planning and financing approaches to pay for services that improve nonfamily caregiver skills and interactions.

- **Eligibility that excludes at-risk children.** There is a mismatch between knowledge about the kinds of risk factors that increase the odds for poor social and emotional development in young children and existing eligibility rules for early intervention and treatment of young children, their families, and their other caregivers. The demographic, familial, and environmental risk factors that put young children in harm's way for poor social and emotional development are not typically included in the eligibility criteria for mental health and related services; only having a diagnosis is. There are no major “categorical” federal programs providing resources for young children and their families who are at risk of early school failure because of familial or environmental risk factors.
- **Limited financing for parent-child, two-generation interventions.** For higher-risk young children, addressing the mental health and related needs of their primary caregivers is often essential for change to happen. Yet, in some states, it is still difficult to pay for parent-child or family therapy. In other states, it is almost impossible to get adults the help they need to address the barriers, such as depression, that they face and that reduce their parenting capacity. Yet the adult treatment systems and the early childhood systems have limited experience in collaborating together.
- **Inadequate systems for tracking children who are deemed at risk.** Screening for social and emotional problems, even through Medicaid, is haphazard, and follow-up monitoring to see if there are any status changes is quite limited. Screening and/or evaluation in Part C (Infants and Toddlers with Disabilities) Early Intervention programs of the Individuals with Disabilities Education Improvement Act (IDEA) of 2004 may identify an infant or toddler at risk but may not allow that child to receive services under state eligibility criteria. Models exist for how states may use high-risk tracking, referrals, and alternative service strategies to intervene before children's risks turn into more serious and costly problems, but these models are not widespread.
- **Limited investments in training (and retraining) the workforce.** Mechanisms to disseminate and increase information about evidence-based and effective practices are limited, and workforce development is needed. Virtually every initiative focused on early childhood mental health or social and emotional school readiness reports that too few professionals have the combination of required skills: deep knowledge of early child development and the science of prevention and promotion, clinical knowledge about family dynamics and psychopathology, and the ability to consult with adults. Moreover, too much money is spent on fragmented and disconnected workshops rather than on coherent training strategies consistent with the principles of adult learning. There is also a need to invest in preservice, academic training to build the workforce.

Based on this analysis, the remainder of this section highlights the federal programs that might be used to:

- Provide screening and diagnostic assessment.
- Monitor young children who have identified risk factors but are ineligible for individual services.

- Improve access to preventive, early intervention, and treatment services for young children, their families, and their caregivers.
- Address inconsistencies or confusion related to eligibility, and clarify the extent to which at-risk children can be served.
- Enhance workforce capacity through training and other means.
- Improve infrastructure to support an array of services and supports.

Although *Spending Smarter* focuses on federal programs, state, and even local funding streams can be directed to address these same goals, and public-private funding partnerships can be organized to fill the gaps.

Note: Shaded boxes in this report provide strategies for specific federal programs.

## Child Health and Mental Health Programs

Child health and mental health programs are “anchor” programs, providing potentially major sources of funding for an array of services related to the social, emotional, and behavioral health of young children. Child health programs fund screening, diagnostic assessment, early intervention, and treatment for individual children. Medicaid, as the largest source of public financing for child health and mental health, is the most important program in this cluster. The State Children’s Health Insurance Program (SCHIP) offers parallel services to Medicaid in some states but has more limited coverage in others. Title V Maternal and Child Health (MCH) Block Grant funds are flexible, permitting states to finance an array of services (including direct services), enabling such services as case management, population-based screening, and infrastructure improvements (e.g., professional training). Funding streams that support children’s mental health, either through the Comprehensive Services for Children cooperative agreements or the federal Community Mental Health Services Program for Children and Families, are also being used to support early childhood mental health in a growing number of places.

### The Medicaid Program

Medicaid is a federal-state entitlement program for medical assistance to low-income children and pregnant women, as well as to persons over age 65 and to those with disabilities who meet income and resource requirements. (At the state’s discretion, certain persons regardless of their income who are considered medically needy based on their high medical costs may also be eligible for Medicaid assistance.)<sup>27</sup> Most states now purchase services through contracts with managed care plans, and many states separate behavioral/mental health financing from physical health services.

### *Medicaid and Young Children*

Medicaid is particularly important for young children. Congress and the states have made special efforts to ensure the coverage of young children through Medicaid, requiring eligi-

#### BOX 4: Correcting Misperceptions About Medicaid Rules

Under Medicaid rules:

- States can be flexible about the location of screening or treatment, as long as the child, the provider, and the services qualify under Medicaid rules. *There is no federal requirement for office- or clinic-based services.*
- States are allowed to distinguish between (and pay separately for) a routine developmental screening conducted as part of an EPSDT screen and a more detailed developmental exam or diagnostic assessment (evaluation). Either of these might focus on social and emotional development and mental health; evaluation would be more in-depth and specific.
- Current federal Medicaid rules do not define child development services or provide incentives for bundling them (see Box 7). However, states can issue and have issued guidelines for providers and set payments to promote child development, including healthy social and emotional development.
- Parents, pediatricians, and/or teachers can recommend an interperiodic screen to track emerging problems.
- Although every state has an obligation under EPSDT to cover medically necessary and appropriate services for children with social, emotional, and behavioral risk factors, medical necessity is defined differently in different states.\*

\* For more information, go to the Centers for Medicare and Medicaid: <[www.cms.gov](http://www.cms.gov)>. Also see Rosenbaum, S. & Sonosky, C. (2000). *Federal EPSDT coverage policy*. Washington, DC: Prepared by the George Washington University Center for Health Services Research and Policy under contract to the U.S. Health Care Finance Administration, U.S. Department of Health and Human Services <[www.gwumc.edu/sphhs/healthpolicy/chsrp/medicaid\\_publications.html](http://www.gwumc.edu/sphhs/healthpolicy/chsrp/medicaid_publications.html)>; Rosenbaum, S.; Proser, M.; Schneider, A.; & Sonosky, C. (2002). *Room to grow: Promoting child development through Medicaid and CHIP*. New York, NY: Commonwealth Fund; Perkins, J. (2002). *Medicaid Early and Periodic Screening, Diagnosis, and Treatment as a source of funding early intervention services*. Los Angeles, CA: National Health Law Program; and Perkins, J. & Olson, K. (1999). *Medicaid Early and Periodic Screening, Diagnosis, and Treatment as a source of funding early development services*. New York, NY: Prepared by the National Health Law Program for the Commonwealth Fund <[www.cmf.org/publications/](http://www.cmf.org/publications/)>.

lity for children younger than age 6 in families with income up to 133 percent of the federal poverty level (FPL). Many states use the option to cover infants and pregnant women up to 185 percent FPL.<sup>28</sup> All states have the option to extend Medicaid coverage for children and pregnant women to a higher percentage of the poverty level (e.g., 200 percent or 300 percent FPL). Some states also extend Medicaid coverage to low-income parents, but typically the eligibility levels are very low.<sup>29</sup> (Lack of parental coverage is a significant barrier when children are covered but parents facing health, mental health, or substance abuse challenges are not.)

Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides a comprehensive child health benefit that requires states to fund well-child health care, diagnostic services, and medically necessary treatment services to all Medicaid-eligible children from birth through age 21. Under federal EPSDT law (Section 1905 of the Social Security Act), states must cover any Medicaid-covered (i.e., allowed under the federal Medicaid statute) service that would reasonably be considered medically necessary to prevent, correct, or ameliorate children's physical and mental conditions. This requirement is at the heart of EPSDT's preventive purpose and potential. (In contrast, most employer-based health plans address only "diagnosis or treatment of disease, illness, or injury.") Services to prevent, correct, or ameliorate physical and mental conditions are covered for children, whether or not they are part of the state Medicaid plan for adults.<sup>30</sup> Thus, services such as children's intensive mental health therapy, home visits, rehabilitation, or dental care are covered by Medicaid because they are part of the EPSDT benefit.

In theory, Medicaid/EPSDT is the most important potential source of funding for prevention of, early intervention for, and treatment of the social and emotional challenges facing young children. Many services targeted to individual children can be covered through Medicaid,<sup>31</sup> but sometimes explicit state policy guidance is necessary.

**Making Screening Work for Young Children.** EPSDT requires periodic (based on a state-established schedule) and, as necessary, interperiodic (as needed outside the established schedule) screening. But for screening to be effective, screening tools must be age-appropriate and include developmental, emotional, and behavioral measures.<sup>32</sup> (Federal EPSDT regulations call for screening, diagnosis, and treatment of mental health and development but do not specify the mechanisms or tools to be used.) Additionally, reimbursement mechanisms must be in place. Most states have not yet identified such age-appropriate screening tools or established simple reimbursement mechanisms for providers who conduct these screenings and assessments.

**Financing Services to Prevent Problems.** Another problematic area is the difficulty of using Medicaid to finance services to promote healthy development before problems start. There is widespread agreement about the importance of what health professionals and many others are calling early childhood development services to promote healthy child development (physical, emotional, and cognitive) in infants, toddlers, and preschoolers.<sup>33</sup> (See Box 5.) However, financing such services through Medicaid is not simple. One problem is that current federal guidance does not specifically define child development services.<sup>34</sup> Thus, despite potential overlaps between Medicaid's EPSDT benefits and commonly defined early childhood development services, the final determination as to whether federal Medicaid matching funds are allowable for a particular service is made by the federal Centers for Medicare and Medicaid Services (CMS). A second problem is that Medicaid was designed to finance health care, while child development services often are provided by education or social service agencies, which generally do not qualify as Medicaid providers on their own. A third problem is that a number of other public programs (e.g., for early intervention, mental health, or children with special health needs) are involved in the delivery of child development services, making it difficult to sort out which program rules apply and who should pay. However, states are taking steps to deal with the confusion. For example, Illinois and Iowa are looking at levels of early childhood developmental screening and assessment to streamline the process for Medicaid providers and families. Other states (e.g., Connecticut and Florida) are considering new billing codes for a defined set of services related to social and emotional development. (See Box 6.)

**Delivering Services Where Young Children and Families Are.** Another misperception about Medicaid that can have a chilling effect on its role in preventing physical and mental conditions is the widespread belief that services must be delivered in office settings. In fact, while the provider must be qualified to deliver the medical assistance covered, *nothing in federal law* requires that the service be delivered in a clinic or physician's office.<sup>35</sup> Reimbursing for early childhood health and mental health services in settings where the children, families, and caregivers are (e.g., in Early Head Start, child care, and home visiting programs; domestic violence shelters; and community health clinics) is an important way to "spend smarter." Some states (e.g., Illinois and North Carolina) have guidelines that define the role of nurse home visitors or clinical social workers who deliver services to families with young children outside medical care settings.

## **BOX 5: How to Use Medicaid to Promote Social and Emotional Health and School Readiness**

### **Provide effective screening and diagnostic assessment.**

- Promote use of EPSDT screening tools that are appropriate for identifying social and emotional concerns among young children.
- Differentiate developmental screening done as a component of an EPSDT screen from a developmental diagnostic assessment (evaluation).
- Ensure that the EPSDT screens that every child should have within 60 days of enrollment are age-appropriate and can detect social, emotional, and behavioral problems.
- Strengthen links between EPSDT screens and follow-up referrals for services.
- Improve the mechanisms to ensure that every young child entering foster care has an appropriate screening, followed, as needed, by an appropriate assessment that pays special attention to attachment and other issues and includes a family assessment.

### **Offer more outreach and monitoring for high-risk children.**

- Use the required EPSDT family-informing process to provide information to families about the benefits of early screening and intervention to promote social and emotional health and school readiness.
- Use interperiodic screening for ongoing assessment of children who are at risk of social and emotional delays and disabilities but who do not yet have a mental health diagnosis.

### **Improve access to appropriate services.**

- Use EPSDT to provide financing for a broad array of child development and mental health services for young children, including early childhood mental health consultation for individual children and parent-child therapy.
- Develop a definition of child development services that can be used by Medicaid providers and includes managed care contracts.
- Use billing codes that are appropriate for children from birth to age 5 to clarify state coverage of:
  - Parent-child, relationship-based therapies
  - Early childhood mental health consultation by a Medicaid-qualified provider in child care settings, home visiting programs, and pediatric offices
  - Various components of child development services, such as parent-child assessment or comprehensive social and emotional evaluation
  - Treatment services to ameliorate social, emotional, and behavioral problems (delivered in offices, clinics, or nonoffice-based settings by qualified providers)
- Provide Medicaid financing for early childhood mental health consultation provided in child care settings by a Medicaid-qualified provider to individual children enrolled in Medicaid. (Note: While a potentially covered service, this would require states to develop benefit definitions, provider qualifications, and billing codes, such as who is a qualified provider, what agency gives prior authorization, and what are the billing codes for consultations.)

### **Develop clear eligibility definitions.**

- Clarify financing (i.e., who pays for what) when children have dual eligibility in Medicaid and Part C.
- Clarify which young children are eligible for services under Medicaid behavioral health managed care “carve-outs” and which young children should continue to receive social and emotional services and supports from their primary care provider (medical home).

### **Enhance professional training and capacity.**

- While Medicaid funds are not generally available to train professionals, state Medicaid agencies are responsible for determining which providers may participate and bill for specified services. To maximize the provider pool available to provide services such as comprehensive assessments and interventions, states should include licensed psychologists, social workers, and other health providers who serve young children as qualified Medicaid providers.

### **Improve infrastructure.**

- Use state interagency planning, rulemaking, and managed care contracts to clarify and coordinate Medicaid financing. These are the tools for carrying out the recommendations above.
- Coordinate mental and physical health financing mechanisms. Medicaid pays for mental health services for children and adolescents, but often these services are administered through a separate agency.

### Box 6: ABCD II: Building State Medicaid Capacity to Deliver Care That Supports Healthy Mental Development in Children

The Assuring Better Child Health and Development (ABCD) Program is funded by the Commonwealth Fund, administered by the National Academy for State Health Policy (NASHP), and designed to assist states in improving the delivery of early childhood development services for low-income children and their families.<sup>1</sup>

The ABCD Program is now in its second phase.<sup>2</sup> The first ABCD Consortium (2000–2003) provided grants to four states (North Carolina, Utah, Vermont, Washington) to develop or expand service delivery and financing strategies aimed at enhancing healthy child development for low-income children and their families. The experiences of the ABCD I Consortium made clear that it is entirely feasible for states to put programs in place to enhance child development and that Medicaid is a viable home for such programs.

The ABCD II Initiative, launched in 2003, is designed to strengthen primary health care services and systems that support the healthy mental development of young children from birth to age 3. The program focuses on the preventive care of children, and the approach is to assist states in building the capacity of Medicaid programs to deliver care that supports children's healthy mental development. California, Iowa, Minnesota, and Utah have projects funded by the Commonwealth Fund, and Illinois has a locally funded project. These five states form the ABCD II Consortium, a laboratory for program development and innovation that shares its findings with all 50 states. A brief description of the projects underway in these five states follows:

- **California's BEST-PCP.** Behavioral, Developmental, Emotional Screening and Treatment by Primary Care Providers (BEST-PCP), administered by the California Department of Health Services, is a two-tiered project that seeks to clarify various agency responsibilities for mental health and developmental services for young children, identify policy and finance changes needed, and implement quality improvement projects in primary care practices in two counties. During the first year, California's ABCD II project convened stakeholder groups, developed a matrix framework for identifying roles and responsibilities of agencies, identified pilot sites, recommended screening tools for use in the pilot sites, and reviewed privacy laws that may inhibit collaboration. In 2005, the ABCD II project in California aims to begin pilot site implementation, identify areas for policy and process change, and develop the quality improvement model.
- Significant collaborative efforts have emerged to promote children's healthy physical, social, and emotional development in Illinois, including the ABCD II project known as **Illinois Healthy Beginnings**. The goals of the project are to pilot a range of strategies that will improve children's primary care, reach more mothers with needed mental health services, and make changes in Medicaid policy. The pilot is administered by the Illinois Department of Public Aid (the parent organization of the Medicaid agency). During the first year, the Illinois project formed an advisory committee, conducted a needs assessment, identified four pilot sites, launched a training effort, modified Medicaid reimbursement policy for perinatal depression screening and consultation services, and clarified billing policy related to children's developmental screening. During 2005, Illinois Healthy Beginnings ABCD II project has aimed to implement the service strategy in pilot sites, review the impact of Medicaid policy changes, expand resources for maternal depression, engage managed care plans, and increase parental awareness.
- **Iowa's Care for Kids Healthy Mental Development project** was designed to build on existing efforts. Over the last 10 years, Iowa has engaged in a number of initiatives to improve the health and well-being of children. The state's Care for Kids ABCD II project is intended to build the capacity of primary care providers to deliver developmental assessment for all Medicaid-eligible children from birth to age 3. The project is administered through the Iowa Department of Human Services (parent to the Medicaid agency). During its first year, the state's ABCD II project: established an advisory structure, endorsed a screening tool for well-child visits, defined levels of care and established minimum standards for services associated with those levels, and defined a process to ensure that all children are referred to appropriate services. In 2005, state leaders aim to assess capacity, select and implement two pilot sites, improve interagency linkages, assess gaps in care coordination, identify Medicaid barriers, and educate providers.
- The **Great Start Minnesota** project, administered by the Minnesota Department of Human Services (parent organization to the Medicaid agency), is building on several previous and ongoing initiatives. The goal is to address the emotional and behavioral needs of young children under age 3 by giving primary care practitioners the ability to detect children's mental health problems early. Through Great Start Minnesota, the state Medicaid program aims to introduce mental health screening of parents, expand early childhood mental health screenings through the co-location of behavioral health specialists in primary pediatric practices, establish a separate billing

**Box 6: ABCD II: Building State Medicaid Capacity to Deliver Care That Supports Healthy Mental Development in Children** *(continued)*

mechanism, establish a new Medicaid benefit for at-risk children who do not meet current diagnostic criteria, link existing diagnostic criteria to Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–3), and train primary pediatric practitioners. During the first year, Minnesota leaders convened an Interagency Planning Group and a stakeholder advisory group, identified the Ages & Stages Questionnaire: Social-Emotional (ASQ-SE) as the screening tool of preference, received approval from the Centers for Medicare and Medicaid Services (CMS) to use the DC:0–3 for the state’s new Medicaid Rehabilitation Option benefit, prepared and distributed a review of maternal depression screening tools, and began significant collaboration with Head Start.

- The Utah Department of Health, Division of Health Care Financing, initiated a multipronged project—**Enhancing Utah’s Capacity to Support Children’s Healthy Mental Development**—to increase the number of children enrolled in Medicaid who receive developmental screenings, including a focus on mental health concerns, as part of regular well-child visits, as well as appropriate treatment when indicated. This work builds on efforts already underway. In its first year, the Utah ABCD II project formed an advisory council, recommended developmental and social emotional screening tools, sponsored a learning collaborative on social and emotional development for infants, conducted a system capacity study, and supported development of a Utah Medical Home web portal. During 2005, Utah has aimed to enhance the system capacity report to track trends, place practicum students in community provider settings, identify a menu of social and emotional screening tools for toddlers (ages 1 through 3) and host a learning collaborative on this issue, and update the CHEC (EPSDT) provider manual regarding a recommended screening schedule and screening tools.

<sup>1</sup> Johnson, K. & Kaye, N. (2003). *Using Medicaid to support children’s healthy mental development*. Portland, ME: National Academy for State Health Policy.

<sup>2</sup> For more information, see The Commonwealth Fund child development initiatives <[www.cmfwf.org](http://www.cmfwf.org)>.

**Covering Parent-Child Therapy.** States have opportunities to clarify Medicaid rules to cover parent-child therapy for the youngest children. No federal law prohibits state Medicaid programs from financing so-called “family therapy” for a child at risk for or diagnosed with a mental or behavioral health condition. Coverage of parent-child treatment in the case of children younger than age 6 makes sense in clinical terms. Experience in Florida, particularly in the Infant Mental Health Pilot Project, suggests that Medicaid financing for parent-child therapy in the case of very young children is both clinically appropriate and fiscally feasible.<sup>36</sup>

**Promoting Early Childhood Development Through Medicaid Managed Care.** Medicaid managed care offers clear opportunities to promote early childhood development. Medicaid managed care contracts typically include prevention and early intervention through EPSDT, as well as treatment. States can clarify which services are covered under managed care and/or behavioral health contracts and give particular attention to services such as developmental screening, diagnostic assessment, and monitoring health and developmental risk factors. In 2004, Connecticut, Ohio, and Wisconsin convened interagency workshops to focus on opportunities to better use Medicaid managed care for young children with social and emotional risk factors and conditions. Researchers at George Washington University have prepared purchasing specifications to assist states in efforts to finance child development and mental health services through Medicaid managed care. (See Title V discussion below.)<sup>37</sup>

## State Children’s Health Insurance Program (SCHIP)

SCHIP is a federal-state program to enable states to expand health coverage to uninsured, low-income children (and their parents). Unlike Medicaid, it is not an entitlement, but it does help states provide health insurance coverage to uninsured children whose family income is up to 200 percent of the federal poverty line (FPL) (and with federal approval well above that level). State SCHIP plans either expand eligibility for children under Medicaid or create a separate children’s health insurance program managed by the state and typically operated by private insurance companies. Currently 39 states<sup>38</sup> have created separate, non-Medicaid SCHIP plans, sometimes in combination with Medicaid SCHIP plans. In either case, only uninsured children (and their families, with a federal waiver) may qualify for SCHIP.

If SCHIP is part of Medicaid, the benefits must be comparable, including EPSDT. Thus, for children with social and emotional challenges, the Medicaid strategies highlighted above would also help children covered by Medicaid-SCHIP expansions. For example, Medicaid-SCHIP plans should offer appropriate screening and diagnostic tools and interperiodic screens to check on mental health risk factors among young children.

If the state uses a separate SCHIP plan, benefits may be more limited, and family cost sharing may be required. In the case of separate SCHIP programs, states could promote social, emotional, and behavioral readiness by offering coverage for a small set of key services. In particular, states should use a broad definition of medical necessity and cover child development services. Covering children and their parents also is a valuable strategy to finance services essential for family health and mental health. Because SCHIP is not an entitlement to children, states may reduce eligibility and/or create waiting lists when the budget is low, or the state benefit plan may or may not cover necessary services.

States could also ensure mental health parity in SCHIP coverage, even if they do not require mental health parity for all privately insured adults. Such policies are important when SCHIP plans are private insurance, rather than Medicaid, and do not have Medicaid’s EPSDT benefit package. For example, Arkansas adopted such a provision for children in 2001, requiring “coverage for the diagnosis and mental health treatment of mental illnesses and mental health treatment of those [children] with developmental disorders under the same terms and conditions as provided for covered benefits offered under the [SCHIP] program.”<sup>39</sup>

## Title V Maternal and Child Health (MCH) Block Grant

Title V is a program of grants to help state public health agencies maintain and strengthen their leadership in planning, promoting, coordinating, and evaluating service systems for pregnant women, mothers, infants, and children who do not have access to adequate health care and to coordinate or provide health services to children with special health care needs (CSHCN) and their families.

As defined in the legislation, state Title V MCH Block Grant programs aim to:

- Reduce infant mortality.

- Reduce the incidence of handicapping conditions among children.
- Increase the number of children appropriately immunized against disease.
- Increase the number of children in low-income households who receive assessments and follow-up diagnostic and treatment services.
- Provide and ensure access to perinatal care for pregnant women, preventive child health services, and comprehensive care for CSHCN and disabled children eligible for Supplemental Security Income (SSI).
- Facilitate the development of comprehensive, family-centered, community-based, culturally competent, coordinated systems of care for CSHCN.

In the context of Title V, young children with social and emotional risk factors may be considered among those with special health needs. CSHCN are defined as: “children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.”<sup>40</sup> Because Title V funds are limited, however, each state defines which categories of special-needs children will be eligible for the programs and services for CSHCN. (See Box 7.) Typically, these categories include children with chronic illnesses, genetic conditions, and physical disabilities, but not children with social and emotional disabilities. Therefore, it is important that each state’s definition of children with special health care needs explicitly include children who have or are at risk for chronic developmental, behavioral, or emotional conditions.

Every state Title V agency has both a Maternal and Child Health (MCH) unit and a CSHCN unit that receive core funding and special grant initiatives funding. The Title V MCH Block Grant funds are allocated to the states based on a matching formula that requires a \$3 state match for every \$4 in federal funds. At least 30 percent of each state’s allocation must be spent on activities for CSHCN, and an additional 30 percent must be dedicated to primary health care for children. A portion of overall funding is set aside at the federal level for Special Projects of Regional and National Significance (SPRANS). Other funds are set aside for special initiatives.

Title V funding can be used for direct services, enabling case management, population-based screening, and infrastructure improvements, such as professional training. It can be used stra-

#### **BOX 7: Components of Early Childhood Development Services That Can Be Integrated into Title V and Medicaid**

- Developmental surveillance, screening, and assessment
- Developmentally based health promotion and education
- Developmentally based interventions
- Care coordination

Source: Grason, H.; Hess, C.; Van Landeghem, K.; Silver, G.; Brown, B.; & Schor, E. (2004). *Integrating measures of early childhood health and development into state Title V Maternal and Child Health Services Block Grant plans*. Baltimore, MD: The Women’s and Children’s Health Policy Center, Johns Hopkins Bloomberg School of Public Health; Washington, DC: Child Trends; New York, NY: The Commonwealth Fund. This brief is based on the skills-building session, “Enhancing State Measurement for Early Childhood Preventive Health and Developmental Services, supported by The Commonwealth Fund and presented at the Association of Maternal and Child Health Programs 2004 Annual Meeting. The session web cast and visuals are available at: <128.248.232.90/archives/mchb/amchp2004/>.

tegitally to balance the Medicaid medical model with a public health model that can address risk factors through both population-based services (e.g., screening for maternal depression, and early childhood mental health consultants) and direct services (e.g., parent-child relationship-building services). It is also possible to use enabling services to support outreach to families and family engagement strategies (e.g., care coordination using peer-parent advisers).

### *Title V and Young Children*

In fiscal year 2002–2004, Title V funded 3-year State Early Childhood Comprehensive Systems (ECCS) planning grants to help develop more comprehensive approaches to early childhood service delivery.<sup>41</sup> States were charged to build partnerships with other stakeholders, to improve early childhood outcomes, and to develop an early childhood strategic plan. Five priority areas are: 1) access to “medical homes” (i.e., pediatric care providers who coordinate comprehensive health services); 2) services and supports to promote the positive social and emotional development and mental health of young children; 3) early care and education services; 4) parenting education services; and 5) family support services.<sup>42</sup> The ECCS planning grants offer one opportunity to move the agenda for integrated early childhood systems, providing resources for interagency planning, leadership development, fiscal analysis, and other infrastructure supports. (See Box 8.) The implementation grants in future years will create additional opportunities for state-level action. Some states (e.g., Indiana) have used SPRANS and other special project funding to integrate and coordinate services for children with social and emotional risk factors. Most state Title V agencies also have an initiative to establish CSHCN medical homes. This is an opportunity to identify providers with the capacity to screen and coordinate services for young children with social and emotional risk factors.

Title V agencies can also influence the quality and availability of services. Flexible Title V funds can be used to provide cross-training for a range of professionals serving young children. Title V agencies might promote use of *Bright Futures in Practice: Mental Health*,<sup>43</sup> which includes guidelines for screening and referrals for early childhood mental health in pediatric practices and well-baby clinics, as well as encourage collaborative practice between primary care pediatricians and a range of professionals (e.g., developmental specialists, child psychiatrists, psychologists, and social workers). States have the flexibility to carry out these activities with their usual block grant allocation; no special initiative grants are required. The organization of Title V services into direct services, population-based services, concrete enabling services (e.g., transportation), and infrastructure services represents another possible lens through which to analyze not just Title V but other streams as well.

### **Other Health and Mental Health Programs**

#### *Community and Migrant Health Center Programs*

Health centers are a major health care provider for low-income children and families,<sup>44</sup> caring for 1.3 million children under age 6 per year nationwide.<sup>45</sup> They care for families before and after the birth of a child, providing opportunities to screen, assess, and monitor social and emotional risk factors and conditions both in the young child and in the parent. Some-

## BOX 8: Using Title V to Promote Social and Emotional Health and School Readiness

### Provide effective screening and diagnostic assessment.

- Provide screening for adult risk factors that impair parenting in pediatric settings as well as community health and mental health centers.

### Offer more outreach and monitoring for high-risk children.

- Integrate services (or expand integrated services) for infants and toddlers through the Part C Early Intervention program and the Program for Children with Special Need to pay for combined training, pooled funding streams, and consolidated service contracts).

### Improve access to appropriate services.

- Develop a definition of child development services that can be used by Medicaid providers and is included in managed care contracts.
- Finance services not covered under Medicaid and/or SCHIP such as:
  - Early childhood mental health program/staff consultation.
  - Various components of child development services, such as parent-child assessment.
  - Screening and treatment programs for maternal depression.
- Support evidenced-based treatment for parents to improve child development outcomes in early childhood settings (e.g., initiatives to reduce depression in Early Head Start parents, Cognitive Behavioral Therapy in Home-Visiting).

### Develop clear eligibility definitions.

- Include children who are at risk of or who have chronic developmental, behavioral or emotional conditions in the state definition of Children with Special Health Care Needs.

### Enhance professional training and capacity.

- Support the cross-training of community providers to build capacity to promote social and emotional health and competencies, to respond to challenging behavior and to facilitate referrals for high-risk families.
- When advancing the concept of a “medical home” for children—a pediatric care provider who coordinates comprehensive health service—identify providers with the capacity to screen and coordinate services for young children with social-emotional risks.
- Promote use of the early childhood mental health guidelines in setting where young children access health care (e.g. well-baby clinics, pediatric offices). *Bright Futures in Practice: Mental Health*\* includes guidelines for screening and referrals for early childhood mental health in pediatric practices, and offers suggestions for primary care pediatric practice and for collaborative practice between primary care pediatricians and a range of professionals (e.g., developmental specialists, child psychiatrists, psychologists, social workers).

### Improve infrastructure.

- Use Title V resources to support cross-agency team planning, fiscal analysis and the development of state plan to promote social and emotional school readiness in the context of broader school readiness strategies.
- Apply for Special Projects of Regional and National Significance (SPRANS) and other special project funding. For example, use the current ECCS project as a basis for planning and development of an early childhood system that includes services for more vulnerable families and children at-risk.

\* Jellinek, M. (2002). *Bright Futures in practice: Mental health—Vol. 1. Practice guide*. Washington, DC: National Center for Education in Maternal and Child Health and Georgetown University <[www.brightfutures.org/mentalhealth/](http://www.brightfutures.org/mentalhealth/)>.

times, they can serve parents and children in the same visit, although some payer rules (e.g., Medicaid) may not allow this. Also, they offer families enabling services, such as translation, transportation, and case management, which may make it easier for families to use the health services. Thus, while health centers do not represent a funding stream, they do represent an important entry point within the service delivery system to identify and offer health and related services to low-income young children and families. They should be included in cross-training efforts and be part of any strategic effort to integrate and coordinate services to promote social and emotional health and school readiness.

### *Community Mental Health Programs for Children and Adults*

Although the recently released President's New Freedom Commission on Mental Health Report explicitly calls for the development of early childhood mental health services,<sup>46</sup> federal funding streams do not provide any targeted support for early childhood mental health. Other than Medicaid, the major mental health funding stream explicitly targeted to children is the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, which provides multi-year grants to communities to develop systems of care for children with, and sometimes at risk for, serious emotional and behavioral disorders. There is no explicit incentive to address the mental health needs of young children, families, and caregivers. However, states have successfully sought approval to use the funds for early childhood mental health initiatives. For example, in Vermont, a 6-year, \$5.7-million federal Child Mental Health Services grant stimulated state and local activities aimed at prevention and funded the Children's UPstream Services (CUPS) project. Colorado is engaged in a similar effort. As new money is available for systems development, other states might target system-building efforts for young children, families, providers, teachers, and other caregivers. This program provides important opportunities to focus on the small group of young children who are seriously emotionally disturbed and on their families, building on the lessons from working with older children and their families.

The Community Mental Health Services Block Grant Program assists states in providing comprehensive community mental health services to children and adults and in implementing a comprehensive, community-based mental health system. Overall, the program provides only about \$400 million, so it is a limited part of mental health funding streams. Funding goes to the states on a formula basis. The program is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). States could choose to set aside some funding to provide incentives to local communities to address early childhood mental health issues more strategically, especially in concert with other school readiness initiatives.

## **Early Childhood Care, Education, and Special Education Funding Streams and Programs**

Funding streams and programs that focus on early childhood care and learning include the Child Care and Development Fund, Head Start, Early Head Start, and other early education programs, as well as the Infant-Toddler Early Intervention and Preschool Special Education programs. Resources from some of these programs can be used for activities to promote social and emotional competencies in young children, particularly prevention and early interven-

### **BOX 9: Using the Child Care and Development Fund (CCDF) to Promote Social and Emotional Health and School Readiness**

#### **Provide effective screening and diagnostic assessment.**

- Ensure that all providers know about Medicaid EPSDT screens and can inform parents.

#### **Offer more outreach and monitoring for high-risk children.**

- Build links to providers to facilitate on-site screening.

#### **Improve access to appropriate services.**

- Use quality initiative funds to help providers promote social and emotional health and school readiness.
- Support early childhood mental health consultant programs for the early childhood community to reduce child care staff turnover and work with young children at risk of child care expulsion.
- Support the capacity of resource and referral (R&R) agencies to help parents with young children at higher risk to find appropriate child care.
- Support efforts to reach out to family child care providers as well as other providers (e.g., friends and neighbors) to help promote social and emotional health and school readiness in the context of broader school readiness outreach efforts.

#### **Enhance professional training and capacity.**

- Support the cross-training of community providers to build capacity, promote social and emotional health and competencies, respond to challenging behavior, and facilitate referrals for high-risk families.
- Provide child care providers special training in working with higher-risk young children and families (e.g., those affected by substance abuse or domestic violence).
- Provide training in the inclusion of young children with serious emotional and behavioral disorders.

#### **Improve infrastructure.**

- Build linkages between child care and Title V efforts to enhance the early childhood system of care.
- Create a work group, plan, or other mechanism to study the availability of early childhood mental health consultation to child care centers and family child care homes.

tion strategies, such as classroom-based social and behavioral interventions for individual children and teacher-training strategies. These programs are also important entry points for the delivery of services financed through Medicaid or mental health funding streams. In addition, states are increasingly investing in programs for preschoolers, with schools or child care settings serving as delivery sites.

### **The Child Care and Development Fund (CCDF)**

Child Care and Development Fund (CCDF) dollars go to states on a formula basis to be used for child care subsidies to low-income working families, as well as for activities to improve the quality and availability of child care. States, territories and tribal governments must spend 70 percent of their CCDF monies to provide child care services for families on or transitioning off the Temporary Assistance to Needy Families (TANF) program or at risk of welfare dependency. Consistent with a block grant approach, states have the flexibility to create child care programs and policies that best suit the needs of their populations, that help working parents make informed choices about child care, and that implement each state's health, safety, licensing, and registration standards. Four percent of program funds are set aside for implementing strategies to improve the quality of child care.

States can use CCDF allocations to increase access to services that promote the social, emotional, and behavioral health and school readiness of young children. For example, states have used the 4 percent quality set-aside, state-appropriated, and/or TANF funds to finance early childhood mental health consultation in child care settings. By blending federal, state, and local child care quality funds, states might finance training for child care professionals in the area of social and emotional development, as well as support early childhood mental health consultation.

### Head Start and Early Head Start

Head Start and Early Head Start serve young children in comprehensive, developmentally appropriate programs. Head Start programs enroll preschool-age children (i.e., children 3 or 4 years old), while Early Head Start programs serve children from birth through age 2. Approximately 700,000 children participate in Head Start, while 62,500 participate in Early Head Start. Both Head Start and Early Head Start programs are designed to:

- Promote school readiness by enhancing the social and cognitive development of low-income children.
- Provide comprehensive health (including mental health), educational, nutritional, social, and other services.
- Involve parents in their children's learning.
- Help parents make progress toward achieving their educational, literacy, and employment goals.

Head Start and Early Head Start emphasize the importance of parental involvement in the operation and administration of their local programs.

Project grant funds for local Head Start/Early Head Start programs, including a portion of training and technical assistance funds, are awarded by regional offices directly to the grantees. Head Start grantees are required to provide (match) 20 percent of the total cost of the program, although this requirement may be waived. Many states use their own dollars to provide state-funded Head Start programs, and a few support Early Head Start. Both Head Start and Early Head Start must meet performance standards that include requirements for on-site mental health services and collaboration with parents. However, because of limits in Head Start budgets, programs often struggle to meet even the minimal performance requirements.

Helping Head Start programs access other funding streams to support activities that strengthen staff capacity to promote positive social and emotional outcomes and to respond more effectively to families could be part of a state strategy to serve higher-risk young children and families. Although Early Head Start improves outcomes for most of the enrolled babies, toddlers, and parents, research shows that it is not as effective for mothers with high levels of depression<sup>47</sup> or for parents and young children with four or more demographic risk factors. As a result, Early Head Start programs are trying to embed more intensive mental health supports into the program. Similarly, national initiatives such as Free To Grow<sup>48</sup> are helping Head Start redesign programs to better serve families with different levels of needs. State attention to supporting, evaluating, and expanding these efforts could have a long-term payoff.

## Special Education Programs

Under the Individuals with Disabilities Education Improvement Act (IDEA), Congress authorized two major special education programs for young children with disabilities, one focused on children from birth to age 3 and the other on children ages 3 through 5. Every state participates in both programs. Because of differences in the structure of the two programs, the program for infants and toddlers is especially important.

### *IDEA Part C: Early Intervention Program for Infants and Toddlers with Disabilities*

Part C of IDEA gives limited funds to assist states in developing and implementing state-wide, comprehensive, coordinated, multidisciplinary, interagency systems to provide early intervention services for infants and toddlers with disabilities and their families. The law also requires that there be an individualized family services plan (IFSP), while many other federal programs require only child-focused plans. States choosing to participate in the program must serve infants and toddlers with developmental delays or disabilities, or with a high probability of developmental delays or disabilities, who meet the state's criteria. States also may serve children at risk for developing delays or disabilities (e.g., children with combinations of demographic, familial, or environmental risk factors).<sup>49</sup>

**Problems and Opportunities.** While Part C could be a major tool in helping infants and toddlers at risk for poor social and emotional outcomes, at present there are at least three core barriers that states might address: 1) Too few states actually include at-risk infants and toddlers; 2) too few states have developed tracking programs for those at risk; and 3) there has been no focus on infants and toddlers with serious emotional delays and disabilities, even though the law requires it.

In 2004, only eight states included definitions of at-risk infants and toddlers in their Part C eligibility criteria,<sup>50</sup> and only a few states (e.g., California, New Hampshire, New Mexico, and North Carolina) explicitly mentioned family or environmental risk factors in those definitions.<sup>51</sup> Although some states (e.g., Arkansas, Michigan, Montana, Ohio, and Washington) use various other programs to offer services and supports to families with children at risk, such approaches do not ensure access to assessment and potential treatment. For states that do not extend eligibility to at-risk infants and toddlers, federal law permits the use of IDEA funds to identify, evaluate, refer, and conduct periodic follow-up to determine changes in eligibility status. Thus, even if states do not serve at-risk children or expand eligibility, they could establish a monitoring system (similar to high-risk infant tracking, which is often used for babies leaving neonatal intensive care) for those children showing elevated risk factors in screening or evaluation. Several states report that they might strengthen the emphasis on social and emotional risk factors in these tracking systems (e.g., Connecticut, Idaho, Maryland, Minnesota, Puerto Rico, Utah, and Virginia). Augmented monitoring systems also might be linked with programs such as EPSDT, foster care, or Early Head Start.

Most state Part C eligibility definitions do not mention social-emotional, psychosocial, or behavioral conditions in their list of qualifying developmental delays. If they do, the system to identify such children is weak, and few early interventionists are trained in relationship-based servi-

## BOX 10: Using Part C of IDEA to Promote Social and Emotional Health and School Readiness

### Provide effective screening and diagnostic assessment.

- Ensure that all providers know about Medicaid EPSDT screens and can inform parents.
- Require that local agencies conduct an assessment of all children from birth to age 3 entering the foster care system to determine whether or not they are eligible for early intervention services. This is similar to linkages with child abuse and neglect programs. (See description below.)
- Monitor program performance to ensure that appropriate social and emotional assessments are included as part of Child Find screening activities as well as a comprehensive developmental, multi-disciplinary evaluation for each potentially eligible infant and toddler identified through screening.

### Offer more outreach and monitoring for high-risk children.

- For at-risk children not yet eligible for Part C, monitor their developmental status through identification, evaluation, referral, and ongoing, periodic follow-up.

### Improve access to appropriate services.

- Require that the Individualized Family Service Plan (IFSP) contain a statement and services plan regarding appropriate child care for young children with delays and disabilities, including those who do have identified social and emotional challenges.
- Include psychologists in the set of qualified providers (federal law mentions “psychological services” as a required category of services).

### Develop clear eligibility definitions.

- Use the option to extend eligibility to infants and toddlers who are at risk if they do not receive early intervention, with emphasis on social and emotional conditions and multiple social/environmental risk factors. For example, states might include all children who have parents with substance abuse problems, have experienced or witnessed family violence, and/or have a mother with diagnosed depression.
- Include “atypical development based on clinical judgment” as one of the eligibility categories.

### Enhance professional training and capacity.

- Use training dollars as part of a strategy to cross-train professionals in early childhood development and risks.

### Improve infrastructure.

- Build linkages between Part C and Title V efforts to enhance the early childhood system of care.
- Create an interagency work group, plan, or other mechanisms (e.g., through the required state Part C Interagency Coordinating Committee) to study the availability of screening, early intervention, and treatment for social, emotional, and behavioral problems under Part C.
- Track social and emotional indicators (now required).\*

\* New IDEA requirements for infants and toddlers with disabilities and their families mandate that indicators for these risk factors, one of which deals with children and their social-emotional skills, are to be incorporated in new state 6-year plans and reported on annually to the U.S. Department of Education. Similar requirements apply to preschool-aged children. For more information, see Part C Annual Performance Reports at <[www.ed.gov/policy/speced/guid/idea/capr/index.html](http://www.ed.gov/policy/speced/guid/idea/capr/index.html)>.

ces. The Part C legislation mentions social and emotional development as one of five domains to be assessed, but neither the required Child Find screening nor comprehensive evaluations to determine eligibility generally do enough to identify and measure social and emotional delays.

However, there have been recent important developments. First, states are now required to refer children with substantiated abuse for Part C screening as a result of recent amendments to the Child Abuse Prevention and Treatment Act. (See description below.) Each Part C program has or will need to set up mechanisms for evaluating the children referred and for financing appropriate services for those determined eligible.<sup>52</sup> It is important for states to use this opportunity to evaluate and treat infants and toddlers with serious attachment and other relationship disorders.

### **BOX 11: Foundations for Learning Grant Program**

The Foundations for Learning Grant Program, enacted in 2002, is the only federally legislated program that is directly focused on improving school readiness and preventing school failure among children at social and emotional risk. It is explicitly structured to help children whose social and emotional development is compromised by demographic, familial, or community risk factors. The funds can be used on behalf of children under age 7, who are at social and emotional risk for school failure, as indicated by the presence of two or more of the following factors: 1) abuse, maltreatment, or neglect; 2) exposure to violence; 3) homelessness; 4) removal from child care, Head Start, or preschool for behavioral reasons or at risk of being removed; 5) exposure to parental depression or other mental illness; 6) family income below 200 percent of the federal poverty level (FPL); 7) exposure to parental substance abuse; 8) early behavioral and peer relationship problems; 9) low birth weight; or 10) cognitive deficit or developmental disability.

Second, new federal guidelines have been released that include a new indicator that will require states to focus more attention on social and emotional issues. States must now indicate the number of infants and toddlers enrolled in Part C who demonstrate:

- Improved positive social-emotional skills, including social relationships.
- Acquisition and use of knowledge and skills, including early language and communications skills.
- Use of appropriate behaviors to meet their needs.<sup>53</sup>

There are a number of other ways states could strengthen the Part C program to be more responsive to infants and toddlers with social and emotional disabilities and developmental delays, as well as to those at risk for delays and disabilities. States could monitor program performance to ensure that appropriate social and emotional assessments are included as part of Child Find screening activities, as well as in the comprehensive developmental, multidisciplinary evaluation of each infant and toddler identified through screening as potentially eligible. States might also deem young children exposed to domestic violence, substance abuse, or maternal depression as eligible for services, rather than categorize them merely as at risk.<sup>54</sup> (A recent effort to do so was proposed at the national level.)

### ***IDEA Part B (Section 619): Special Education Preschool Grants***

The IDEA Preschool Grants program provides states with formula grants for special education and related services for children with disabilities aged 3 through 5. Unlike the Part C program, the Part B preschool program uses definitions comparable with those for older children, including children with behavioral disorders or serious emotional disturbance. It can be used to promote inclusion of these children in early care and learning settings<sup>55</sup> and may provide some training funds. However, as this program is currently structured, there is no possibility of reaching out to and serving at-risk children. This means that there is no continuity for at-risk children served under Part C when they become preschool aged, although, as noted below, states do have the option.

States can decide to merge Part C and Part B preschool programs to provide a continuum of services and early interventions for all children from birth to age 5. The 2004 reauthorization of IDEA gives states the option (i.e., gives parents the choice) to allow a child to stay in the

Part C program until kindergarten instead of moving to the Part B, Section 619, Preschool Special Education Program at age 3.<sup>56</sup> Such continuation programs would apply only to children and their families who had previously participated in Part C and there must be services in place to promote school readiness until the children enter (or are eligible under state law to enter) kindergarten. Under this approach, state dollars, which already comprise more than one-third of most Part C programs, can be used to facilitate continued coverage of at-risk children.

### Other Programs Focusing on Early Learning and School Success

A number of small grant programs also have the potential to promote social and emotional health and school readiness. Three are highlighted below, but others also exist and could be used as part of a planning process. While these smaller grant programs do not provide funds for sustained services, they could be used as catalysts to build partnerships between the schools and early childhood and mental health agencies in high-need communities, as well as to design preventive interventions in the context of prekindergarten, kindergarten, the primary grades, and preschool special education. Of particular potential importance are the Foundations for Learning Grant Programs. Although woefully underfunded, this is the only federal grant project specifically designed to support social and emotional interventions for children experiencing multiple risk factors before their problems escalate.

States could adopt the Foundations for Learning framework (see Box 11) to develop state definitions and fund programs serving similar populations of young children at risk for early school failure by virtue of exposure to multiple risk factors. It is likely there will also be efforts to increase the federal dollars for this program since it is the only one of its kind.

Another potential platform is Even Start, which combines adult literacy (adult basic education or instruction for English language learners), parenting education, early childhood education, and interactive parent and child literacy activities into a unified family literacy program. The focus is on families with children from birth through age 7. The goals are to help parents improve their literacy or basic educational skills, become full partners in educating their children, and assist their children in reaching their full potential as learners. States receive formula grants from the federal Department of Education and, in turn, make competitive subgrants to partnerships comprised of local education agencies (LEAs) and other organizations, giving priority to areas with large numbers of families most in need. Even Start offers a special opportunity to address social and emotional issues through family literacy strategies.

The Early Learning Opportunities Act (ELOA) was passed by Congress to award grants to local councils (directly or through the states) for increasing, supporting, expanding, and better coordinating early learning opportunities. ELOA grants could be used to increase the availability of services that support early childhood development, remove barriers that limit access to early learning programs, increase professional development activities and compensation, and “facilitate the development of community-based systems of collaborative service delivery models characterized by resource sharing, linkages between appropriate supports, and local planning for services.” The federal Child Care Bureau of the Administration on Children, Youth and Families, which administers the Child Care and Development Fund (CCDF) and ELOA, has accepted initial applications in 2005 and anticipates awards for 30 to 55 projects.

Other grant programs include the Safe and Drug-Free Schools program, which provides approximately 20 federal grants to LEAs each year to assist in implementation of “an integrated, comprehensive, communitywide plan designed to create safe and drug-free schools and promote prosocial skills and healthy childhood development.” LEAs establish interagency agreements and work in partnership with local law enforcement, juvenile justice, and mental health agencies, and include an explicit focus on prevention and early intervention for young children.<sup>57</sup> States and communities can also ensure that efforts to promote early reading and literacy through Early Reading First and Good Start, Grow Smart, the President’s initiative to promote early school success, include attention to social and emotional skill development.<sup>58</sup>

## Programs Serving Young Children and Families at Greater Risk

Young children who witness domestic violence, are parented by a severely depressed parent, are abused or neglected, or are in foster care are young children whose social and emotional health is severely threatened. Some of these children are resilient and will make it, but many are on a trajectory of failure that is likely to cost the public systems dearly. To promote social and emotional health and school readiness in every child, it is critical that states include special attention to groups of young children in especially compromised circumstances. Several key programs can be used as entry points and/or funding streams.

### Child Abuse Prevention and Treatment Act (CAPTA)

The Child Abuse Prevention and Treatment Act (CAPTA) is a formula-funded, state grant program that provides flexible funding to improve child protective service systems. States may use CAPTA funds to improve the investigative process, management of cases, information and tracking systems, staff and provider training, prevention and treatment, and research. The program also funds the National Center for Child Abuse and Neglect. Acting on advocacy by a variety of organizations concerned with the development and emotional well-being of children, Congress amended CAPTA to require that children under age 3 in substantiated cases of abuse or neglect be referred to early intervention services funded under IDEA Part C. The Community-Based Child Abuse Prevention Program (CBCAP), authorized in 2003 by Title II of the CAPTA, also provides funding to States to develop, operate, expand, and enhance community-based, prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect. Clearly, this language fits with the principles and purposes of ECCS projects. While the amounts of funding through CAPTA is not large, these provisions create a window of opportunity and leverage for ECCS planners.

The amendments of the Keeping Children and Families Safe Act of 2003 call for states to support and enhance “collaboration among public health agencies, the child protection system, and private community-based programs to provide child abuse and neglect prevention and treatment services (including linkages with education systems) and to address the health needs, including mental health needs, of children identified as abused or neglected, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports.” Other new provisions call for

improving training, retention and supervision of caseworkers, protection of infants affected by prenatal substance abuse, and an array of administrative improvements.

In most states, responding to the intent of new CAPTA rules will require a substantial change in practice for staff in local child welfare, TANF, Medicaid, and Part C programs. CAPTA now requires each state to submit a plan for early intervention referrals among children from birth to age 3 with confirmed cases of child abuse and neglect. Some states are using this requirement as an opportunity to restructure the linkages between child welfare, the Part C Early Intervention program, and Medicaid (e.g., Rhode Island and Connecticut). Strategies include contracts with child mental health professionals to complete the social and emotional assessment of children referred to IDEA Part C early intervention programs under CAPTA rules, similar to the approach states have often used for children with physical disabilities. States also might use CAPTA research and demonstration funds to pilot test innovative approaches, particularly in combination with Medicaid, to help address the trauma these young children have already experienced and to try to ensure that they get back on a positive trajectory for social and emotional development. Research on adults who have been abused as children shows that for many of them, the trauma has long-lasting, negative consequences.

#### **Title IV-B and Promoting Safe and Stable Families**

Title IV-B of the Social Security Act has two parts: 1) the standard Title IV-B program, which can be used to finance services for both families in care and families at risk, and 2) the Promoting Safe and Stable Families program (formerly Family Preservation and Support), which is designed to prevent separation of children and their families. Part 1 of Title IV-B provides grants to states for child welfare services, including preventive intervention, placements and permanent homes through foster care or adoption, and reunification services to encourage a return home for children who have been removed from their families for reasons of safety. The primary goals of the Promoting Safe and Stable Families program are to prevent the unnecessary separation of children from their families, improve the quality of care and services to children and their families, and ensure permanency for children by reuniting them with their parents or by facilitating adoption or another permanent living arrangement. The funds may be used by states to provide family support, family preservation, time-limited family reunification services, and services to promote and support adoptions.

Most Title IV-B funding is designated for services that prevent child welfare placement. To be eligible for funds, states (and Native American tribes) are required to ensure certain protections for all children in foster care. In addition, state courts receive grants to improve foster care and adoption proceedings. Administrative expenditures are limited to 10 percent of state grants.

#### ***Title IV-B and Young Children***

Title IV-B funds can be used to improve the social, emotional, and behavioral health and school readiness of young children, particularly in combination with Medicaid or early intervention programs. States could provide EPSDT screening for children served under the Title IV-B program according to a schedule for periodic screening, along with additional necessary interperiodic screening, diagnosis, and follow-up treatment. Such an intensive screening ini-

tiative might be linked to a statewide, early childhood, high-risk tracking effort. (See discussion above of IDEA, Part C.) Title IV-B funds also permit states to establish two-generation intervention models designed to provide parent-child mental health and behavioral interventions for families with young children.

### **Title IV-E Foster Care**

Title IV-E Foster Care is an open-ended entitlement program that provides funds to states to assist with the costs of foster care and adoption assistance for eligible children; administrative costs to manage the program; and training for staff, foster parents, and private agency staff. Funds may not be used for costs of services provided to a child, the child's family, or the child's foster family if those services include counseling or treatment to ameliorate or remedy personal problems, behaviors, or home conditions.

As a group, young children in foster care are among the most vulnerable. They have already experienced at least one separation from their family, and many experience multiple moves. Although Title IV-E does not provide service funds, the children in foster care should be the focus of careful planning to ensure that they receive appropriate screening and intervention services to reverse early emotional damage and/or promote healthy relationships with their current caregivers through both EPSDT and Part C Early Intervention programs. For example, states might require that all children from birth to age 3 entering the foster care system be evaluated through the Part C program to determine whether they have delays or risk factors that meet state eligibility rules for early intervention services.<sup>59</sup> This requirement would parallel efforts for children exposed to abuse and neglect. (See description above of CAPTA.) Repeated EPSDT screening could then be provided, along with treatment, as necessary. (The Appendix lists additional opportunities.) States also could implement evidence-based approaches to support foster parents caring for young children who have already experienced trauma and loss.<sup>60</sup>

### **Temporary Assistance for Needy Families (TANF)**

Adopted under the welfare reform legislation—Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996—Temporary Assistance for Needy Families (TANF) replaced the Aid to Families with Dependent Children (AFDC) entitlement program. The new program provides formula-based grants to states, giving them broad flexibility to use the grant funds in any manner that promotes self-sufficiency. Many states have used TANF dollars to support child care activities, either through TANF or by transferring funds (up to 30 percent per year) to either the Child Care and Development Fund (CCDF) or the Social Services Block Grant (SSBG).

Jurisdictions have used TANF dollars to address the social and emotional needs of young children and to improve the quality of child care as a work support for parents transitioning off TANF. For example, in San Francisco, county-level flexibility has permitted the use of child care quality funds from the TANF program as the base funding for an early childhood mental health consultation program that has reached hundreds of child care providers and thousands of families. States also might use TANF grant dollars for two-generation strategies, such as: 1) family counseling, service coordination, and family support activities (e.g., creation of family resource centers

and funding of home visiting programs); 2) intensive home visiting for families with young children at risk (e.g., Ohio), or 3) substance abuse treatment for parents, as part of their efforts to reduce dependency and prepare for work. (The Appendix lists additional opportunities.)

### **Social Services Block Grant (SSBG)**

The Social Services Block Grant (SSBG) gives states flexibility in furnishing social services. SSBG funds may be used to provide services directed toward one of five goals. The program goal of “preventing neglect, abuse or exploitation of children” links directly to promoting school readiness for vulnerable children. The annual SSBG allotments to states are determined by a formula based on population. A state may transfer up to 10 percent of its allotment for any fiscal year to preventive health and health services, alcohol and drug abuse, mental health services, maternal and child health services, and low-income home energy assistance block grants. Transfer to other agencies can ensure that the impact of these monies is maximized.

SSBG funds are flexible and can be used in combination with other programs to improve the social, emotional, and behavioral health and school readiness of young children, particularly for professional training, family services and supports, tracking at-risk children, or other related activities. (The Appendix lists additional opportunities.)

### **Community-Based Family Resource and Support Grants**

This program is designed to assist states in implementing and enhancing a statewide system of community-based, family-centered, family resource programs through innovative funding mechanisms and broad collaboration with educational, vocational, rehabilitation, health, mental health, employment and training, and child welfare and other social services. The primary goals of these family resource programs are to strengthen family supports and prevent child abuse and neglect. Whether family resource programs or centers are funded through these federal grants or other combinations of state and federal dollars, they can be a potent source of support for families. Attention to social and emotional issues could be embedded into the strategies.

### **Violence Against Women Act (VAWA)**

The Violence Against Women Act (VAWA) was reauthorized in 2000 to provide grants to states for training police, prosecutors, and courts and for enhancing law enforcement activities (e.g., STOP Grants—Services and Training for Officers and Prosecutors); for shelter services for battered women and their children; for civil legal services to give women help with protection orders, family court matters, housing, immigration, and administrative matters; for battered immigrant women to receive protections and receive lawful permanent residence without leaving the country; for grants for research and data collection on violence; and for training law enforcement personnel and developing policies to address the needs of older or disabled victims of domestic and sexual violence.<sup>61</sup>

VAWA has been authorized for \$3.3 billion; however, congressional appropriations have yet to reach this “allowed” amount. Additionally, VAWA is set to expire in 2005. Advocates are fighting to reauthorize the bill.

## Substance Abuse Prevention and Treatment Block Grant (SPATBG)

The Substance Abuse Prevention and Treatment Block Grant (SAPTBG), which provides formula-based funds to the states, includes an emphasis on the provision of treatment for special groups, specifically injecting drug users, pregnant substance-using women, and women with dependent children. Priority goes to populations that are at risk for developing a pattern of substance abuse. SAPTBG was also designed to educate and counsel persons with substance abuse issues, provide activities to reduce the risk of substance abuse, and increase the availability of treatment services designed for pregnant women and women with dependent children, either by establishing new programs or by expanding the capacity of existing programs.

## Moving Forward: Opportunities to Act Now

*“The time is long overdue for state and local decision makers to take bold actions to design and implement coordinated, functionally effective infrastructures to reduce the long-standing fragmentation of early childhood policies and programs ... establish explicit and effective linkages among agencies that currently are charged with implementing the work requirements of welfare reform and those that oversee the provision of both early intervention programs and child and adult [health] and mental health services.”*

—*Neurons to Neighborhoods*. Recommendation 10, p. 12

The development of state and community infrastructure for fiscal and service strategies to promote social, emotional, and behavioral health in young children as part of a school readiness agenda requires detailed knowledge of how individual programs and funding streams work. It also requires thoughtful planning to build a common vision, identify priorities, take action to address barriers, and, to the extent possible, promote research-informed practices. (See **Appendix 1 for questions policymakers and advocates should ask.**) Drawing on all the many suggestions provided in the previous section, 10 foci are highlighted below for immediate action.

- 1) **Convene a work group to review currently funded social and emotional services and systems to support young children, their families, and their caregivers, and to identify priority funding strategies for early childhood mental health prevention, early intervention, and treatment.**

In the context of larger efforts to strengthen early childhood systems to better achieve school readiness goals, some states are trying to increase the capacity to provide intentional prevention, early intervention, and treatment to families, other caregivers, and, when needed, young children. For example, a number of states have used strategic planning efforts to create a vision and build a common purpose across multiple agencies, stakeholders, and funding streams (e.g., Colorado, Connecticut, Florida, Iowa, Maryland, and Vermont) around social and emotional health and school readiness.

One key to success, as reported by state officials and advocates, is to engage a broad array of stakeholders, including families, public officials, and advocates. It is important to include in this group the early childhood community (child care, Head Start, education); health, mental health, early intervention, and special education professionals; and agencies serving higher-risk young children and families (e.g., child welfare, domestic violence). It is also helpful to have representatives from Medicaid and the state budget office involved from the beginning. Most states already have partnerships to build on. For example, almost all states have State Early Childhood Comprehensive Systems (ECCS) grants, and over half the states have joint planning efforts between the CCDF and IDEA agencies. Other states use the recently enacted requirements to refer children with substantiated child abuse or neglect to Part C of IDEA as an opportunity to build

## **BOX 12: Maximizing Entitlement Funds**

### **Better serve children.**

- Focus on enrolling more currently eligible children.
- Specify clear definitions of benefits.
- Adopt optional eligibility categories for at-risk children (e.g., IDEA Part C).
- Create special initiatives to better serve entitled children (e.g., Medicaid and IDEA Part C services for children in the child welfare system).
- Adopt targeted case management approaches (e.g., Medicaid).

### **Use leverage to augment existing funds.**

- Use state and local funds to leverage federal matching funds.
- Apply for and use federal waiver authority.
- Blend and braid funds to offer parallel services to children not eligible under federal criteria.

### **Operate more efficiently.**

- Reduce administrative costs through central billing, shared staff, joint training, and other mechanisms.
- Better use entitlement funds available for administrative costs.
- Streamline enrollment and services for children eligible for two or more programs.

stronger linkages between child welfare and early intervention programs. The Child and Family Policy Center has proposed model legislation to structure an office and advisory board to promote child development and health.<sup>62</sup>

In these cross-system planning efforts, some states have used a “system-mapping” approach to identify gaps within and between systems. Using the programs identified in this document, states can begin to identify gaps and opportunities to “spend smarter,” and then use this analysis to develop state-specific priorities and action strategies. It is important to conduct analyses both within individual programs as well as across programs to identify current opportunities and barriers. (Some states, such as Connecticut, have actually been able to map existing financing and services.) The next step is to begin to restructure programs and financing in ways that promote social and emotional health and school readiness for more children. In some ways, given the many cuts in core federal programs, this is a difficult time to engage in such planning. However, looked at in another way, it is an important time to ensure that the resources that are available are used most wisely. Moreover, even though federal funding is being cut, some states continue to realize the wisdom of continuing to invest in young children and prevention. State circumstances vary considerably.

## **2) Support priority financing strategies with interagency plans and written agreements.**

State and local governments have many, often untapped opportunities to maximize flexibility and streamline administration. The Finance Project<sup>63</sup> has compiled strategies for success in creating more flexibility in financing. It suggests pooling (or blending) funds across agency or program lines, decategorizing funds by removing eligibility requirements and allocation rules, and coordinating (or braiding) categorical funds to

better support an array of services within a single program. The State Early Childhood Policy Technical Assistance Network has compiled a useful bibliography of resources on financing school readiness.<sup>64</sup> States and communities have also relied on the strategic use of state funds to match federal dollars. (For case studies of how this plays out in actual communities and states, see *Making Dollars Follow Sense*.<sup>65</sup>)

Once opportunities for flexible financing or administrative changes have been identified, interagency agreements are valuable implementation tools. Interagency memoranda of understanding (MOU) and similar agreements clarify the terms for sharing fiscal or personnel resources, specify roles and responsibilities, and institutionalize changes. Practically, such agreements also serve as documentation of how the state intends to carry out integration of federal programs.

- 3) **Adopt a statewide definition of factors that place young children at high risk for social, emotional, and behavioral delays and conditions, and mobilize resources to engage in prevention and early intervention on behalf of these at-risk children.**

Once states have reviewed definitions for young children at risk for social and emotional problems across programs, the next step is to explore a common definition that can streamline administrative burdens and promote simplified access. The Foundations for Learning Grant Program sets out one possible framework that can be used on behalf of children under age 7 who are at social and emotional risk for school failure. Young children are eligible if two or more of the following factors are present: 1) abuse, maltreatment, or neglect; 2) exposure to violence; 3) homelessness; 4) removal from child care, Head Start, or preschool for behavioral reasons or at risk for being so removed; 5) exposure to parental depression or other mental illness; 6) family income below 200 percent of the federal poverty level; 7) exposure to parental substance abuse; 8) early behavioral and peer relationship problems; 9) low birth weight; or 10) cognitive deficit or developmental disability.

The Title V–funded 3-year State Early Childhood Comprehensive Systems planning grants have been used by some states as the umbrella for work groups that are turning their attention to state definitions (e.g., Colorado, Connecticut, and Illinois). The reevaluation of state definitions is necessary for drawing up a state early childhood strategic plan and for supporting the development of integrated community-based platforms for promoting optimal child development. States that secure implementation grants will be well positioned to adopt statewide definitions and frameworks for an early childhood system.

- 4) **Blend dollars to cross-train a variety of professionals regarding early childhood emotional development.**

Flexible funding for training is available in many programs and often can be used on an interagency basis. For example, at least 34 states conducted joint training between CCDF and IDEA Part C programs in 2003.<sup>66</sup> Some states have made specific efforts to provide training related to early childhood social and emotional development. Indiana created a common, core training curriculum for early childhood mental health and financed training with flexible funding from a Title V MCH Block Grant. In Vermont

and Michigan, core principles and a training approach aimed at system development infused these principles into a variety of settings. Other states, such as Connecticut, Illinois, Iowa, Ohio, and Colorado, are in the planning stages of training projects.

- 5) **Use block grants or smaller grant programs to provide flexible funding that can fill gaps left by Medicaid and other core funding streams.**

The Title V MCH Block Grant, Social Services Block Grant, TANF, and Substance Abuse Prevention and Treatment Block Grant are examples of programs that provide flexible funding. Such funds can support colocation of social work or child development staff in pediatric offices and clinics, early childhood mental health program consultation, and/or programs for maternal depression or substance abuse. State funds can also be used for similar purposes.

One core task is to engage in fiscal strategizing to support early childhood mental health consultation, building on the models and approaches emerging around the country. Innovative state and local programs reach children and their caregivers at child care centers, family day care homes, Head Start centers, family resource centers, shelters, and other settings. Different federal funding streams are being used, including mental health, child care, TANF, Medicaid, Title V MCH Block Grant, and Social Services Block Grant, as well as state general funds, county tax dollars, and private foundation support.

- 6) **Clarify eligibility and payment mechanisms between Medicaid's EPSDT child health component, the IDEA Part C Early Intervention program, child welfare, mental health, and other programs (i.e., clarify financing for children with dual or multiple eligibility status).**

While no state can afford to extend eligibility to all at-risk children, use of targeted and clear definitions can help include more children in need of interventions to achieve school readiness. States should also clarify eligibility rules and financing (e.g., who pays for what) when children have dual or multiple eligibility in Medicaid and Part C, or Medicaid and foster care. For example, some Medicaid agencies now require the signature of a primary care provider on each child's Individualized Family Service Plan under the IDEA Part C Early Intervention program, which then activates prior approval for Medicaid-covered services (e.g., Louisiana).

The most important step in maximizing available funding is to ensure that each child eligible for a federal entitlement program is enrolled for needed services. National estimates indicate that more than 2 million children are eligible for but not enrolled in Medicaid. As states plan for ways to refer young children with confirmed abuse and neglect to Part C Early Intervention, most are finding that infants and toddlers are eligible for but not previously enrolled in programs for children from birth to age 3 with developmental delays and disabilities. Most states also have identified young children from poor families who need child care subsidies and may need augmented or specialized child care services. Targeting existing funds to meet the needs of children eligible for federal entitlements maximizes the total amount of funds available to serve those children.<sup>67</sup>

- 7) **Adopt policy and billing mechanisms that encourage providers to perform developmental screening with age-appropriate tools and follow-up referrals and treatment in nonoffice-based settings.**

Surveys indicate that care for the social, emotional, and behavioral development of young children lags behind that of other preventive and developmental services recommended by the American Academy of Pediatrics.<sup>68</sup> Studies have reported screening-related problems not just in Medicaid, but through the Part C program for infants and toddlers, as well as through the Title V Children with Special Health Care Needs programs. (CSHCN is comprised of young children and families especially in need of social and emotional supports.) Screening for social and emotional issues represents what the President’s New Freedom Commission report calls “social and emotional check-ups.” For states to spend smarter, screening must use appropriate tools, be appropriately reimbursed, and, where indicated, lead to follow-up steps.

One starting point is for states to promote uniform and appropriate screening for children entering foster care based on protocols developed by professionals, as well as approved for financing by Medicaid, Part C, and other resources. Mandatory referrals for Part C screening or EPSDT exams could be better implemented. States also might give “prior authorization” for Medicaid financing of developmental assessments for young children entering foster care. States could also promote the use of the same tools across programs as well as ensure that there are follow-up evaluations, referrals, and, above all, access to timely and appropriate early services.

A most important strategy is to adopt clear billing codes. Without clear billing codes and payment rates, providers are less likely to deliver early development services essential to screening, diagnosis, and treatment of social and emotional needs. Some states have found that billing codes tailored to young children’s conditions—using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0–3)<sup>69</sup>—helps to reduce unnecessary spending, minimize fraud, and maximize early intervention.

- 8) **Target subpopulations of high-risk children and families for more intensive identification, outreach, and services. Start with one group of vulnerable children.**

Research is clear that some groups of young children are, in the aggregate, at higher risk for poor social and emotional health and poor early school outcomes. Entry points through Part C and CAPTA have already been described. However, working across multiple systems, states could provide incentives for community planning for all high-risk young children, as, for example, has been done in Pima County, Arizona.<sup>70</sup>

- 9) **Finance two-generation strategies and parent-child interventions that can give two-for-one results.**

The financing for two-generation strategies is reportedly one of the biggest challenges in developing services and supports to improve social and emotional health and

school readiness. Flexible funding sources, such as Title V, SSBG, and SAPTBG, offer opportunities to finance services otherwise uncovered. In addition, some smaller programs are targeted at specific risk factors—domestic violence, child abuse, or substance abuse. Similarly, developing partnerships among agencies that do not usually partner (e.g., mental health, early childhood, and domestic violence, substance abuse, and mental health agencies serving adults) to fund cross-generational service initiatives could provide an important jump start to increasing state capacity to serve the more vulnerable.

States also might:

- Require a parent-child, relationship-based, family support approach in all programs for young children.
- Identify existing financing that can be used for parent-related services (e.g., treatment for maternal depression, substance abuse).
- Create special programs (with blended or new funding) for parent-child dyads who have experienced extreme social/family distress (e.g., party or witness to violence, incarceration, abuse).

**10) Monitor children at risk but not yet eligible for entitlement programs and link them to existing services. This might lead to establishment of a high-risk young child tracking program to monitor all at-risk children from birth to age 5, following an adverse report or screen.**

A high-risk young child tracking program might imitate the design of a state's high-risk newborn tracking program. Such a project might include a follow-up database linked to case management, reminders, and ongoing assessments. It might be funded through a combination of administrative dollars from IDEA, Title IV-B, Title IV-E, and Medicaid. Models for structuring a follow-up database might be found in the state's Part C, birth defects, lead screening, and/or newborn screening programs.

Several existing mechanisms could be used by states to finance efforts for monitoring the status of young children at risk. For example:

- Part C regulations permit those states not serving at-risk children (all except nine states) to use IDEA money to identify, evaluate, refer, and conduct periodic follow-up to determine changes in children's status.
- For the youngest children identified through the child welfare system, monitoring could become a routine activity financed jointly by IDEA, Title IV-B, and Title IV-E.
- For children whose EPSDT periodic screening exams indicate a high risk for social, emotional, or developmental delays, state Medicaid agencies should finance more frequent interperiodic screening to assess their progress and indicate if a need for treatment arises.
- Families of young children referred to IDEA Part C programs who do not yet have a delay sufficient to qualify for eligibility could be offered reassessment at appropriate intervals.

## Conclusion

Most states are facing fiscal challenges across a broad range of programs, and federal support for core programs that are the lifeline for low-income children and families is shrinking. At the same time, in every state, considerable resources targeted to young children in need do exist. Strategic fiscal planning to maximize the impact of these resources as well as to target funds for intentional interventions before serious problems escalate is key, especially for young children. Preventing early school failure in young children at risk for poor social and emotional development is too important for their future and the future of this country to leave to chance.

## Endnotes

1. Educate America Act. (1994).
2. Institute of Medicine; Shonkoff, J. P. & Phillips, D. A. (Eds.). (2000). From *Neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.
3. National Research Council, Committee on Early Childhood Pedagogy, Commission on Behavioral and Social Sciences; Bowman, B. T.; Donovan, M. S.; & Burns, M. S. (Eds.). (2001). *Eager to learn: Educating our preschoolers*. Washington, DC: National Academy Press.
4. Thompson, R. A. (2001). Development in the first years of life. *The Future of Children*, 11(1). Thompson, R. (2002). The roots of school readiness in social and emotional development. In: *Set for success: Building a strong foundation for school readiness based on the social-emotional development of young children*. Kansas City, MO: The Ewing Marion Kauffman Foundation.
5. See Shonkoff and Phillips in endnote 2.
6. Knitzer, J. & Raver, C. C. (2002). *Ready to enter: What research tells policymakers about strategies to promote social and emotional school readiness among three- and four-year-old children* (Promoting the Emotional Well-being of Children and Families Policy Paper 3). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.
7. Ibid.
8. National Association for the Education of Young Children. (2003). Strengthening teachers, Strengthening families. *Beyond the Journal: Young Children on the Web*, May, pp. 1-2
9. Gilliam, W. S. (2005). *Prekindergartens left behind: Expulsion rates in state prekindergarten programs* (FCD Policy Brief 3). New York, NY: Foundation for Child Development <[www.fcd-us.org/PDFs/NationalPreKExpulsionPaper03.02\\_new.pdf](http://www.fcd-us.org/PDFs/NationalPreKExpulsionPaper03.02_new.pdf)>.
10. Cutler, A. & Gilkerson, L. (2002). *Unmet Needs Project: A research, coalition building, and policy initiative on the unmet needs of infants, toddlers and families*. Chicago, IL: University of Illinois at Chicago and Erikson Institute.
11. Knitzer, J. & Lefkowitz, J. (2005). *Resources to promote social and emotional health and school readiness in young children and families—A community guide*. New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health <[www.nccp.org/pub\\_rps05.html](http://www.nccp.org/pub_rps05.html)>.
12. See Shonkoff & Phillips in endnote 2.
13. See Knitzer & Raver in endnote 6.
14. Ibid.
15. Vandivere, S.; Pitzer, L.; Halle, T. G.; & Hair, E. C. (2004). *Indicators of early school success and child well-being* (Cross Currents Report 3). Washington, DC: Child Trends.
16. See Gilliam in endnote 9.
17. Angold, A.; Egger, H. L.; Erkanli, A.; & Keller, G. (submitted). Prevalence and comorbidity of psychiatric disorders in preschoolers attending a large pediatric service.
18. Based on NCCP data.
19. Capizzano, J. & Main, R. (2005). *Many young children spend long hours in child care* (Snapshots III of America's Families No. 22). Washington, DC: Urban Institute, Assessing the New Federalism.
20. Helburn, S. W.; Culkin, M. L.; & Morris, J. R., et al. (1995). *Cost, quality, and child outcomes in child care centers study: Public report*. Denver, CO: University of Colorado, Department of Economics.
21. Gilliam, W. & Shahar, G. (In press). Prekindergarten expulsion and suspension: Rates and predictors in one state. *Infants and Young Children*.
22. See National Association for the Education of Young Children in endnote 8.
23. Luthar, S. (In press). Resilience in development: A synthesis of research across five decades. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental Psychopathology: Risk, Disorder and Adaptation*, Vol. 3, 2nd ed. New York, NY: Wiley.
24. Knitzer, J. & Lefkowitz, J. (2005). *Pathways to early school success: Helping the most stressed infants, toddlers, and families*. New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.
25. Knitzer, J. (2001). *Building services and systems to support healthy emotional development of young children—An action guide for policymakers* (Promoting the Emotional Well-being of Children and Families Policy Paper 1). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

26. These three examples (adapted from Knitzer in endnote 25) illustrate some of the issues.
27. Medicaid is currently an open-ended entitlement program (i.e., if states participate in the program, federal-state funds must be made available for necessary services. The required percentage of state funds necessary to match federal dollars varies (and can be comprised of general revenues, local funds, as well as some types of private contributions), but is at least 50 percent.
28. See Centers for Medicare and Medicaid Services for specific state eligibility levels <[www.cms.gov](http://www.cms.gov)>.
29. Under federal law, states have flexibility to cover pregnant women and women with children at income levels up to or beyond poverty. Using Medicaid waiver programs and options under the SCHIP program, states also may extend coverage to low-income parents with children. These options are applied in various ways across the country. Notable examples are Illinois, Minnesota, Washington State, and Wisconsin. See National Center for Children in Poverty state databases at <[www.nccp.org](http://www.nccp.org)>.
30. Rosenbaum, S. & Sonosky, C. (2000). *Federal EPSDT coverage policy*. Washington, DC: Prepared by the George Washington University Center for Health Services Research and Policy under contract to the U.S. Health Care Finance Administration, U.S. Department of Health and Human Services.
31. This is because states must cover any Medicaid-covered (i.e., allowed under the federal Medicaid statute) service that would reasonably be considered medically necessary for covered children. Koyangai, C. & Brodie, J. R. (1994). *Making Medicaid work: An advocacy guide to financing key components of a comprehensive state system of care*. Washington, DC: Bazelon Center for Mental Health Law.
32. The three general categories of tools are: 1) broad tools to assess overall health, developmental, and mental health risks, 2) tools that provide a general screen for social-emotional problems, and 3) tools that screen for specific problems (e.g., depression, ADHD). See Bergman, D. (2004). *Screening for behavioral developmental problems: Issues, obstacles, and opportunities for change*. Portland, ME: National Academy for State Health Policy.
33. See VanLandeghem, K.; Curtis, D.; & Abrams, M. (2002). *Reasons and strategies for strengthening childhood development services in the healthcare system*. Portland, ME: National Academy for State Health Policy. Also see: Brown, B. & Weitzman, M.; et al. (2004). *Early child development in social context: A chartbook*. New York, NY: Commonwealth Fund.
34. Perkins, J. & Olson, K. (1999). *Medicaid Early and Periodic Screening, Diagnosis, and Treatment as a source of funding early developmental services*. New York, NY: Prepared by the National Health Law Program for the Commonwealth Fund. See also: Rosenbaum, S.; Proser, M.; Schneider, A.; & Sonosky, C. (2002). *Room to grow: Promoting child development through Medicaid and CHIP*. New York, NY: Commonwealth Fund; Perkins, J. (2002). *Medicaid Early and Periodic Screening, Diagnosis, and Treatment as a source of funding early intervention services*. Los Angeles, CA: National Health Law Program.
35. See Section 1905 of the Social Security Act.
36. See The Center for Prevention & Early Intervention Policy at the University of Southern Florida: [www.cpeip.fsu.edu/](http://www.cpeip.fsu.edu/) and also Lynch, T. & Harrington, J. (2003). *Cost benefit analysis of the Florida Infant & Young Child Mental Health Pilot Project*. Tallahassee, FL: Center for Economic Forecasting and Analysis (CEFA).
37. See George Washington University, Department of Health Policy. (2000). *Purchasing specifications for child development services in Medicaid Managed Care, July, 2000* <[www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/child](http://www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/child)>.
38. As of October 2004, more than 20 states were using both Medicaid and non-Medicaid SCHIP plans, sometimes referred to as combination programs. Only 18 states have only separate SCHIP plans, that is, these states do not enroll the near-poor, uninsured children who qualify for SCHIP into Medicaid. For the latest SCHIP plans, see the official federal government map at <[www.coms.hhs.gov/schip/chip-map.pdf](http://www.coms.hhs.gov/schip/chip-map.pdf)>.
39. See National Conference of State Legislatures (NCSL). *State Health Tracking Reports* <[www.ncsl.org/programs/pubs/shnmain.htm](http://www.ncsl.org/programs/pubs/shnmain.htm)>.
40. McPhearson, M. (1998). A new definition of children with special health care needs. *Pediatrics*, 102, pp. 137-140.
41. Halfon, N.; Uyeda, K.; Inkelas, M.; & Rice, T. (2004). *Building bridges: A comprehensive system for healthy development and school readiness* (Building State Early Childhood Comprehensive Systems Series 1). Los Angeles, CA: National Center for Infant and Early Childhood Health Policy, University of California at Los Angeles, Center for Healthier Children, Families and Communities <[www.healthychild.ucla.edu/NationalCenter](http://www.healthychild.ucla.edu/NationalCenter)>.
42. Ibid.
43. Jellinek, M. (2002). *Bright Futures in practice: Mental health—Vol. I. Practice guide*. Washington, DC: National Center for Education in Maternal and Child Health and Georgetown University <[www.brightfutures.org/mentalhealth](http://www.brightfutures.org/mentalhealth)>.
44. National Association of Community Health Centers. (1998). *Access to community health care: A national and state data book, 1998*. Washington, DC: National Association of Community Health Centers.
45. See: Center for Health Services Research and Policy, The George Washington University. Analysis of 1998 Uniform Data System of the Bureau of Private Care, US-DHHS. They provide more than 3 million pediatric

visits, nearly 2 million well-child visits to children under age 12, and tens of thousands of visits for developmental problems—an average per center of more than 2,000 encounters for well-child care and 95 encounters for developmental problems (e.g., missed developmental milestones, failure to thrive).

46. See <[www.mentalhealthcommission.gov/](http://www.mentalhealthcommission.gov/)>.

47. U. S. Department of Health and Human Services, Head Start Bureau. (2000). *Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start. Vol. 1: Final technical report*. Washington, DC: Administration on Children, Youth and Families, Head Start Bureau, U. S. Department of Health and Human Services.

48. See <[www.freetogrow.org](http://www.freetogrow.org)> and Knitzer & Lefkowitz in endnote 11.

49. The 1997 IDEA amendments (restated in the 2004 reauthorization of IDEA) encouraged states “to expand opportunities for children under 3 years who would be at risk of having substantial developmental delay if they did not receive early interventions services,” 20 USC Section 1431(b)(4).

50. Danaher, J.; Armijo, C.; & Shackelford, J. (Eds.). (2002). *Part C updates*. Chapel Hill, NC: National Early Childhood Technical Assistance Center. Also see <[www.nectac.org](http://www.nectac.org)>.

51. Shackelford, J. (2002). *State and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA*. (NECTAC Notes No. 11). Chapel Hill, NC: National Early Childhood Technical Assistance Center. Also see <[www.nectac.org](http://www.nectac.org) and [www.osep.gov](http://www.osep.gov)>.

52. Experts estimate that between 50 percent and 70 percent of infants and toddlers who have experienced abuse and neglect will have development delays. Dicker, S. (1999). The promise of early intervention for foster children and their families. In *Interdisciplinary Report on At Risk Children and Families*. Kingston, NJ: Civic Research Institute. See also: Halfon, N. et al. (1995). Health status of children in foster care. *Archives of Pediatric and Adolescent Medicine*, 149, pp. 386-392.

53. New IDEA requirements for infants and toddlers with disabilities and their families mandate that indicators for these risk factors, one of which deals with children and their social-emotional skills, are to be incorporated in new state 6-year plans and reported on annually to the U.S. Department of Education. Similar requirements apply to preschool-aged children. For more information, see Part C Annual Performance Reports at <[www.ed.gov/policy/speced/guid/idea/capr/index.html](http://www.ed.gov/policy/speced/guid/idea/capr/index.html)>. See also: federal code: 20 USC 1416(a)(3)(A) and 1442.

54. Cohen, E. & Walthall, B. (2003). *Silent realities: Supporting young children and their families who experience violence*. Washington, DC: The National Child Welfare Resource Center for Family-Centered Practice.

55. Brennan, E. M.; Bradley, J. R.; Ama, S. M.; & Cawood, N. (2003). *Setting the pace: Model inclusive child care centers serving families of children with emotional and behavioral challenges*. Portland, OR: Portland State University, Research Training Center on Families Support and Children's Mental Health <[www.rtc.pdx.edu/pgPubsScript.php?documentID=472&choice=download](http://www.rtc.pdx.edu/pgPubsScript.php?documentID=472&choice=download)>.

56. IDEA 2004 reauthorization.

57. Lederman, C. S. & Osofsky, J. D. (2004). Infant mental health interventions in juvenile court: Ameliorating the effects of maltreatment and deprivation. *Psychology, Public Policy, and Law*, 10(1). Lederman, C. S.; Osofsky, J. D.; & Katz, L. (2001). When the bough breaks the cradle will fall: Promoting the health and well-being of infants and toddlers in juvenile court. *Juvenile and Family Court Journal*, 33.

58. See Knitzer & Raver in endnote 5.

59. See Cohen & Walthall in endnote 54.

60. See Knitzer & Raver in endnote 5.

61. See the Family Violence Prevention Fund at <[endabuse.org/vawa/](http://endabuse.org/vawa/)>.

62. Bruner, C. & Schor, E. (2003). *Health care and school readiness: The health community's role in supporting child development—new approaches and model legislation*. Des Moines, IA: Child and Family Policy Center.

63. Fisher, H.; Cohen, C.; & Flynn, M. (2000). *Federal Funding for early childhood supports and services: A guide to sources and strategies*. Washington, DC: The Finance Project.

64. Bruner, C.; Floyd, S.; & Copeman, A. (2003). *State Early Childhood Policy Technical Assistance Network — Financing school readiness strategies: An annotated bibliography*. Des Moines, IA: Child and Family Policy Center.

65. Johnson, K. & Knitzer, J. (2001). *Making dollars follow sense: Financing Early Childhood Mental Health Services to Promote Healthy Social and Emotional Development in Young Children* (Promoting the Emotional Well-being of Children and Families Policy Paper 4). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

66. Mezey, J.; Beh Neas, K.; & Irish, K. (2003). *Coming together for children with disabilities: State collaboration to support quality, inclusive child care*. Washington, DC: Center for Law and Social Policy.

67. Flynn, M. & Hayes, C. D. (2003). *Blending and braiding funds to support early care and education initiatives*. Washington, DC: The Finance Project

68. Bethell, C.; Peck, C.; Adams, M.; Halfon, N.; et al. (2002). *Partnering with parents to promote the healthy development of young children enrolled in Medicaid: Results from a survey assessing the quality of preventive and developmental services for young children enrolled in Medicaid in three states*. New York, NY: The Commonwealth Fund.
69. Zero to Three: National Center for Infants, Toddlers, and Families. (1997). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood (DC:0-3) (1994) and DC: 0-3 Casebook*. Washington, DC: Zero to Three Publications.
70. See Knitzer & Lefkowitz in endnote 11.

## Appendix 1: The Spending Smarter Checklist: A Guide for Policymakers, Families, Advocates, and Service Providers

Below are a set of questions for state officials, families, advocates, and practitioners that can help drive a strategic approach to strengthening social and emotional school readiness and building early childhood mental health capacity. No state has implemented all of these recommendations, but together they provide a framework for prioritizing state and local action.

- |   |  |
|---|--|
| <input type="checkbox"/> Yes, done<br><input type="checkbox"/> Under development<br>_____<br><input type="checkbox"/> Needs effort<br>_____ | <p>1. Does your state have a cross-agency strategic planning group to build strategic early childhood mental health capacity? Does the planning group:</p> <ul style="list-style-type: none"><li>• Include families? Providers?</li><li>• Link to a larger early childhood/school readiness planning process?</li><li>• Include a dedicated fiscal planning group?</li></ul>   |
| <input type="checkbox"/> Yes, done<br><input type="checkbox"/> Under development<br>_____<br><input type="checkbox"/> Needs effort<br>_____ | <p>2. Does the state cross-agency strategic agenda include explicit efforts to build overall system capacity? Does your state:</p> <ul style="list-style-type: none"><li>• Map how each system currently supports prevention, early intervention, and treatment services?</li><li>• Map gaps in existing community-based programs or early childhood mental health initiatives across the state?</li><li>• Create incentives for community-based, cross-agency training initiatives?</li><li>• Implement targeted collaborations across IDEA Part C (Individuals with Disabilities Education Act), child welfare, and early childhood programs?</li><li>• Build common definitions across programs for young children at risk of early school failure and/or developing social and emotional disorders?</li><li>• Ensure family/two-generation treatment for the most vulnerable (e.g., promoting collaboration across child and adult mental health, substance abuse, and domestic violence programs)?</li><li>• Pay for treatment for adults in the context of home visiting programs and comprehensive early childhood programs?</li><li>• Use smaller grant programs strategically to promote system-building capacity (e.g., Foundations for Learning; Safe and Drug Free Schools; Early Learning Opportunities; and Good Start, Grow Smart)?</li></ul> |
| <input type="checkbox"/> Yes, done<br><input type="checkbox"/> Under development<br>_____<br><input type="checkbox"/> Needs effort<br>_____ | <p>3. Is your state maximizing the impact of Medicaid/SCHIP? Does your state:</p> <ul style="list-style-type: none"><li>• Require/permit EPSDT age-appropriate screening and diagnostic tools for infants, toddlers, and preschoolers that are sensitive to social, emotional, and behavioral issues?</li><li>• Pay for covered services delivered in a range of community-based settings?</li><li>• Include separate definitions and billing codes for developmental assessment/screening and diagnostic evaluations?</li><li>• Use state matching funds strategically with Medicaid to support behavioral and mental health consultation in child care and home visiting programs?</li><li>• Provide reimbursement for parent-child therapy?</li><li>• Cover necessary services for social and emotional needs under the SCHIP benefits package?</li></ul>   |
| <input type="checkbox"/> Yes, done<br><input type="checkbox"/> Under development<br>_____<br><input type="checkbox"/> Needs effort<br>_____ | <p>4. Is your state maximizing the impact of Title V Maternal and Child Health Services Block Grant? Does your state:</p> <ul style="list-style-type: none"><li>• Use Title V's flexible funding strategically to cover services and supports for families and other caregivers that cannot be provided through Medicaid (e.g., cross-training)?</li><li>• Explicitly include children who are at increased risk for developmental, behavioral, or emotional challenges according to the state definition of Children with Special Health Care Needs (CSHCN)?</li><li>• Maximize the potential of the State Early Childhood Comprehensive Systems (ECCS) planning grants, including a focus on the most vulnerable?</li><li>• Use the flexibility under Title V to develop and/or finance programs for maternal depression or other two-generation treatment strategies?</li></ul>   |

**Appendix 1: The Spending Smarter Checklist: A Guide for Policymakers, Families, Advocates, and Service Providers** *(continued)*

- Yes, done
- Under development
- Needs effort

5. Is your state maximizing the impact of the Child Care and Development Fund (CCDF) to promote social and emotional health and school readiness? Does your state:

- Define explicit strategies to promote social and emotional health and school readiness competencies in children and improve the skills of caregivers in the state's CCDF plan?
- Use CCDF funds to support training for the early childhood community on social, emotional, and school readiness issues?
- Ensure that the highest-risk young children are in high-quality child care settings?
- Use CCDF funds to support early childhood mental health consultation through the quality set-aside? Use other funds?

- Yes, done
- Under development
- Needs effort

6. Is your state maximizing the potential of special education programs on behalf of infants and toddlers at risk of developmental delays and on behalf of preschoolers with identified disabilities? Does your state:

- Ensure appropriate social and emotional assessments in IDEA Part C Child Find screening activities, as well as in comprehensive, developmental, multidisciplinary evaluations?
- Use the option to extend IDEA Part C eligibility to at-risk infants and toddlers, with emphasis on social, emotional, and environmental risk factors?
- Identify infants and toddlers exposed to substance abuse, domestic violence, and maternal depression as a high-risk group? Extend eligibility for Part C services?

- Yes, done
- Under development
- Needs effort

7. Is your state maximizing the impact of the new CAPTA amendments? Does your state:

- Require collaboration across public health agencies, child protection systems, and community-based programs to provide child abuse and neglect prevention as well as treatment services?
- Have a mechanism to ensure that screenings of young children at risk who have experienced abuse or neglect and/or witnessed domestic violence lead to interperiodic reviews, assessments, and/or referrals for early intervention?
- Require that all children from birth to age 3 entering the foster care system be assessed through the IDEA Part C Early Intervention program?

- Yes, done
- Under development
- Needs effort

8. Does your state maximize the impact of programs serving the most vulnerable families with young children? Does your state:

- Use Title IV-B funding to create two-generation child mental health and behavioral interventions for families with young children in or at risk for foster care placement?
- Use TANF grant dollars for family counseling, service coordination, substance abuse treatment, family support, and training activities?
- Transfer TANF funds to the CCDF or the SSBG to jump-start behavioral and mental health early childhood consultation strategies?
- Strategically use funds from family violence/domestic violence, substance abuse, prevention, treatment, and community-based family resource and support to promote treatment and two-generation strategies targeted to families with young children?

## Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success

HEALTH AND MENTAL HEALTH PROGRAMS					
Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
<p><b>Medicaid/EPSDT</b></p> <ul style="list-style-type: none"> <li>Promote use of screening tools that are appropriate for identifying social and emotional concerns among young children.</li> <li>Provide EPSDT screens (that include social, emotional, and behavioral components) for every child within 60 days of enrollment. Then, provide ongoing periodic screening, along with necessary interperiodic screening, diagnosis, and medically necessary treatment.</li> <li>Differentiate developmental screening conducted as part of an EPSDT screen from a developmental diagnostic assessment (evaluation) conducted by a medical social worker, public health nurse, or developmental pediatrician.</li> </ul>	<ul style="list-style-type: none"> <li>Finance more frequent interperiodic screening to monitor the status of children whose EPSDT periodic screening exams indicate high risk for social, emotional, or developmental problems.</li> </ul>	<ul style="list-style-type: none"> <li>Use EPSDT to provide financing for a broad array of child development and mental health services for young children.</li> <li>Finance early childhood mental health consultation for individual children.</li> <li>Adopt clear language in Medicaid to denote parent-child treatment coverage in the case of children younger than age 6.</li> <li>Clarify which services are covered under managed care and/or behavioral health contracts.</li> <li>Define and finance medically necessary and appropriate services for young children with social, emotional, and behavioral risk factors.</li> <li>Clarify the financing for at-risk children who may not yet qualify for mental health benefits. For example, define categories of at-risk children who may qualify for intensive home visits, child care consultation, or parent-child assessment.</li> <li>Use billing codes tailored to young children's conditions (using DC: 0-3) to reduce unnecessary spending, minimize fraud, and maximize early intervention.</li> </ul>	<ul style="list-style-type: none"> <li>Clarify which young children are eligible for services under Medicaid "carve-outs."</li> <li>Clarify financing (i.e., who pays for what) when children have dual eligibility in Medicaid and Part C.</li> </ul>	<ul style="list-style-type: none"> <li>Medicaid funds are generally <i>not</i> available to finance training of professionals.</li> <li>Include licensed psychologists and social workers who provide services to young children as "qualified providers."</li> <li>Offer adequate compensation for developmental and mental health services for young children.</li> </ul>	<ul style="list-style-type: none"> <li>Use state-level, inter-agency planning and rulemaking to clarify and coordinate Medicaid financing.</li> </ul>

## Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
<b>HEALTH AND MENTAL HEALTH PROGRAMS</b>						
<b>SCHIP—separate non-Medicaid</b>			<ul style="list-style-type: none"> <li>• Cover necessary services for social and emotional needs under the SCHIP benefit package.</li> <li>• Use a broad definition of medical necessity, as in Medicaid/EPST.</li> <li>• Adopt legislation or rules to ensure mental health parity in SCHIP coverage.</li> </ul>	<ul style="list-style-type: none"> <li>• Do not reduce eligibility when funds are low. If eligibility limits are necessary, maintain waiting lists and inform families when eligibility is reopened.</li> </ul>	<ul style="list-style-type: none"> <li>• SCHIP funds are not available to finance training of professionals.</li> </ul>	
<b>Title V Maternal and Child Health (MCH) Block Grant</b>			<ul style="list-style-type: none"> <li>• Use funds to support colocation of social work or child development staff in pediatric offices and clinics.</li> <li>• Use funds to support early childhood mental health program consultation.</li> <li>• Use the flexibility under Title V to develop or finance screening and/or treatment programs for maternal depression.</li> </ul>	<ul style="list-style-type: none"> <li>• Expand the definition of “special needs” to include young children with identified social and emotional risk factors.</li> </ul>	<ul style="list-style-type: none"> <li>• Use flexible funds for professional, cross-system training.</li> <li>• Promote use of the Bright Futures mental health guidelines for pediatric care.</li> <li>• When advancing the medical home concept, identify providers with the capacity to screen and coordinate services for young children with social and emotional risk factors.</li> </ul>	<ul style="list-style-type: none"> <li>• Apply for special project funding.</li> <li>• Use Title V role to integrate services better (e.g., combined training, pooled funding streams, and consolidated service contracts).</li> <li>• Where the same agency administers both the Part C Early Intervention program and the Program for Children with Special Need, use this opportunity to better integrate services (e.g., combined training, pooled funding streams, and consolidated service contracts).</li> <li>• If the Title V agency does not administer the Part C program, develop interagency linkages.</li> </ul>

**Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success** *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
<b>HEALTH AND MENTAL HEALTH PROGRAMS</b>						
<b>Community Health Centers</b>	<ul style="list-style-type: none"> <li>• Provide screening and assessment as part of or in addition to well-child exams.</li> <li>• Use nonphysician staff to offer more in-depth assessment of child development and social and emotional risk factors.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop and use high-risk tracking projects.</li> <li>• Develop referral linkages to and from Part C, CAPTA, Head Start, and other programs.</li> </ul>	<ul style="list-style-type: none"> <li>• Identify families with parental risk factors (e.g., maternal substance abuse or depression) and parent-child interventions, for a two-generation strategy.</li> <li>• Colocate social work or child development staff in pediatric offices and clinics.</li> </ul>	<ul style="list-style-type: none"> <li>• Join efforts to develop and implement shared definitions of at-risk children.</li> </ul>	<ul style="list-style-type: none"> <li>• Participate in joint training efforts to augment capacity.</li> </ul>	
<b>Community Mental Health Services Block Grant (CMHS)</b>	<ul style="list-style-type: none"> <li>• Provide professional support and technical assistance for screening and diagnostic activities.</li> </ul>		<ul style="list-style-type: none"> <li>• Give priority to financing mental health services for young children and their parents.</li> <li>• Use a portion of state block grant funds to increase early childhood mental health capacity in community mental health centers. For example, block grant funds could be allocated for center-level awards to start early childhood mental health projects with parent-child assessment, intervention, and/or consultation services.</li> <li>• Designate a portion of state block grant funds to be used for early intervention and treatment of young children with mental health conditions.</li> <li>• Seek approval to use Child Mental Health Services Initiative funding for activities focused on prevention of severe emotional disturbance (SED) among young children.</li> </ul>	<ul style="list-style-type: none"> <li>• Clarify eligibility rules to include children starting at birth.</li> </ul>	<ul style="list-style-type: none"> <li>• Use flexible funds for professional, cross-system training.</li> <li>• Use funds to increase early childhood mental health capacity in community mental health centers.</li> </ul>	

**Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success** *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
<b>Head Start and Early Head Start</b>	<ul style="list-style-type: none"> <li>• Offer developmental and social and emotional screening on site.</li> <li>• Identify families at high risk through family-focused screening and assessment.</li> </ul>	<ul style="list-style-type: none"> <li>• Use and enhance the skills of parent-involvement coordinators, family resource staff, and parent educators.</li> <li>• Develop more intensive, augmentative strategies to assist children whose families have multiple risk factors beyond poverty (e.g., low parental education, contact with child welfare, older siblings with poor school performance).</li> </ul>	<ul style="list-style-type: none"> <li>• Increase the number of Head Start and Early Head Start programs with state supplemental funds, if necessary.</li> <li>• Use early childhood mental health consultation to improve competencies of the children and the skills of the teacher/caregivers in Head Start.</li> </ul>	<ul style="list-style-type: none"> <li>• If Head Start and Early Head Start enrollment is limited by lack of funding, include children and families at high social risk as high priority groups.</li> </ul>	<ul style="list-style-type: none"> <li>• Use flexible funds for professional, cross-system training.</li> <li>• Use Head Start training dollars to improve teacher skills in promoting social and emotional health.</li> </ul>	
<b>Child Care and Development Fund</b>			<ul style="list-style-type: none"> <li>• Use child care quality funds for early childhood mental health consultation.</li> </ul>	<ul style="list-style-type: none"> <li>• Give priority to children and families being simultaneously served by the child welfare system.</li> </ul>	<ul style="list-style-type: none"> <li>• Use flexible funds for professional, cross-system training.</li> </ul>	<ul style="list-style-type: none"> <li>• Blend federal, state, and local child care quality funds to promote services for social-emotional development and school readiness to low-income, high-risk children.</li> <li>• Where available, use state general revenue funds appropriated for child care as a match for federal Medicaid dollars to finance mental health consultation to individual children in child care settings.</li> </ul>

## Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
<b>Special Education Programs</b>						
<b>IDEA Part C</b>	<ul style="list-style-type: none"> <li>• Ensure age-appropriate social and emotional screening as part of Child Find.</li> <li>• Ensure quality of the social and emotional component of each multidisciplinary evaluation for every infant and toddler identified through screening as potentially eligible.</li> <li>• Require a Part C assessment for all children from birth to age 3 with substantiated cases of abuse and neglect, whether or not the family enters the child welfare system.</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen mechanisms for referrals to Child Find for infants and toddlers with substantiated cases of abuse and neglect, whether or not the family enters the child welfare system.</li> <li>• Offer reassessment at appropriate intervals for young children referred to Part C who have risk factors but not yet a delay sufficient to make them eligible.</li> <li>• For at-risk children not yet eligible for Part C, monitor their developmental status through identification, evaluation, referral, and ongoing periodic follow-up.</li> </ul>	<ul style="list-style-type: none"> <li>• Specify interventions for social and emotional needs in the Individualized Family Service Plan (IFSP), as appropriate.</li> <li>• Measure the percentage of infants and toddlers with Part C IFSPs who demonstrate improved positive social-emotional skills (including social relationships) and use of appropriate behaviors to meet their needs. Such measurement is part of a new indicator under Part C and will be required starting with FFY 2005.</li> </ul>	<ul style="list-style-type: none"> <li>• Use the option to extend eligibility to infants and toddlers at risk without early intervention, with emphasis on social and environmental risk factors.</li> <li>• Include "atypical development based on clinical judgment" as one eligibility category.</li> <li>• Part C regulations permit those states not serving at-risk children (all except nine states) to use IDEA money to identify, evaluate, refer, and conduct periodic follow-up to determine changes in children's status.</li> <li>• Clarify financing for children with dual eligibility in Medicaid and Part C.</li> </ul>	<ul style="list-style-type: none"> <li>• Use training funds from Part B as part of a blended funding strategy for cross-training professionals.</li> </ul>	<ul style="list-style-type: none"> <li>• Merge Part C and Part B preschool programs to provide a continuum of services and early interventions to all children ages birth to 5.</li> </ul>
<b>IDEA Part B Preschool Special Education</b>	<ul style="list-style-type: none"> <li>• Jointly, with Part C, monitor to ensure that appropriate social and emotional assessments are included as part of Child Find.</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen mechanisms for referrals to Child Find for children aged 3 to 5 with substantiated cases of abuse and neglect, whether or not the family enters the child welfare system.</li> </ul>			<ul style="list-style-type: none"> <li>• Use flexible funds for professional, cross-system training.</li> <li>• Make funds available for training in early childhood mental health and social and emotional well-being.</li> </ul>	<ul style="list-style-type: none"> <li>• Merge Part C and Part B preschool programs to provide a continuum of services and early interventions to all children ages birth to 5.</li> </ul>

**Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success** *(continued)*

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
<b>OTHER PROGRAMS FOCUSED ON EARLY LEARNING AND SCHOOL SUCCESS</b>						
<b>Safe and Drug-Free Schools</b>		<ul style="list-style-type: none"> <li>Build linkages to facilitate referrals among mental health, substance abuse, and early intervention programs.</li> </ul>	<ul style="list-style-type: none"> <li>Working in partnership with local law enforcement, justice, and mental health agencies, local education authorities (LEAs) may request referrals and treatment of young children whose parents have identified substance abuse problems.</li> <li>In community plans, include specific actions directed to serving children ages 3 to 5 with mental health needs attending preschool and preschool special education programs.</li> </ul>		<ul style="list-style-type: none"> <li>Use flexible funds for professional, cross-system training.</li> </ul>	<ul style="list-style-type: none"> <li>During the process of developing community-level plans and agreements for mental health services, review the availability of mental health services for young children at risk.</li> </ul>
<b>Even Start</b>		<ul style="list-style-type: none"> <li>Use contacts with families as an opportunity to enhance caregiver skills and parent knowledge of child development.</li> </ul>				<ul style="list-style-type: none"> <li>Use the required performance objectives process to set goals promoting social development along with literacy.</li> </ul>
<b>Foundations for Learning Grants</b>				<ul style="list-style-type: none"> <li>Use to guide development of statewide definition for at-risk children.</li> </ul>	<ul style="list-style-type: none"> <li>Use flexible funds for professional, cross-system training.</li> </ul>	<ul style="list-style-type: none"> <li>Use community-level grants to deliver services, coordinate resources, and build toward a system of care.</li> </ul>

Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success (continued)

	Provide effective screening and diagnostic assessment	Offer more outreach and monitoring for at-risk children	Improve access to appropriate services	Develop clear and coordinated eligibility definitions	Enhance professional training and capacity	Overcome fiscal and policy barriers
<b>PROGRAMS SERVING CHILDREN IN OR AT RISK OF INVOLVEMENT WITH CHILD WELFARE</b>						
<b>Child Abuse Prevention and Treatment Act (CAPTA)</b>	<ul style="list-style-type: none"> <li>Require a Part C assessment for all children from birth to age 3 with substantiated cases of abuse and neglect, whether or not the family enters the child welfare system</li> </ul>	<ul style="list-style-type: none"> <li>Strengthen mechanisms for referrals to Child Find for infants and toddlers with substantiated cases of abuse and neglect, whether or not the family enters the child welfare system.</li> </ul>			<ul style="list-style-type: none"> <li>Use flexible funds for professional, cross-system training.</li> <li>Contract with child mental health professionals to complete the social and emotional assessment of children referred to IDEA Part C Early Intervention programs under CAPTA rules. This is an approach states have used often for children with physical disabilities.</li> </ul>	<ul style="list-style-type: none"> <li>Act on opportunity created by new CAPTA rules to develop a systematic approach to referral and assessment of young children at-risk who have experienced abuse or neglect and/or witnessed domestic violence.</li> <li>Given overlapping eligibility, establish general rules regarding which services will be financed by child welfare, Medicaid, and Part C.</li> </ul>
<b>Title IV-B Child Welfare Services and Promoting Safe and Stable Families</b>	<ul style="list-style-type: none"> <li>Provide EPSDT screening for children served under the Title IV-B program according to the state's schedule for periodic screening, along with additional necessary interperiodic screening, diagnosis, and medically necessary treatment.</li> </ul>	<ul style="list-style-type: none"> <li>Establish new programs using a two-generation intervention model designed to provide parent-child mental health and behavioral interventions for families with young children.</li> </ul>			<ul style="list-style-type: none"> <li>Use administrative funds as part of financing for professional, cross-system training.</li> </ul>	<ul style="list-style-type: none"> <li>Include participating children birth to age 6 in a statewide early childhood high-risk tracking effort.</li> </ul>
<b>Title IV-E Foster Care and Adoption Assistance</b>	<ul style="list-style-type: none"> <li>Require that all children from birth to age 3 entering the foster care system be assessed through the IDEA Part C Early Intervention program to determine whether or not they meet eligibility rules.</li> <li>Structure and finance EPSDT screens within 60 days after children enter foster care. Ongoing screening could then be provided according to a state's schedule for periodic screening, along with additional necessary interperiodic screening and medically necessary treatment.</li> </ul>				<ul style="list-style-type: none"> <li>Use Title IV-E training funds as part of cross-system training efforts.</li> </ul>	

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<b>OTHER PROGRAMS TO SERVE CHILDREN AND FAMILIES FACING SOCIAL AND ECONOMIC RISKS</b>						
<b>TANF</b>		<ul style="list-style-type: none"> <li>Use TANF grant dollars for family outreach, service coordination, and family support activities (e.g., creation of family resource centers, funding home visiting programs).</li> </ul>	<ul style="list-style-type: none"> <li>Use funds for early childhood mental health consultation.</li> <li>Use TANF funds to assist parents in securing substance abuse treatment, as part of their efforts to reduce dependency and prepare for work.</li> </ul>		<ul style="list-style-type: none"> <li>Use flexible funds for professional, cross-system training.</li> </ul>	<ul style="list-style-type: none"> <li>Transfer TANF funds to the CCDF or the SSBG to fund additional activities in child care and family support.</li> </ul>
<b>Social Services Block Grant (SSBG)</b>		<ul style="list-style-type: none"> <li>Use funds as part of financing for family resource centers, community action agencies, and other centers that can provide outreach and referrals for families and young children at risk.</li> </ul>	<ul style="list-style-type: none"> <li>Use flexible funds for early childhood mental health consultation.</li> </ul>		<ul style="list-style-type: none"> <li>Use flexible funds for professional, cross-system training.</li> </ul>	<ul style="list-style-type: none"> <li>Transfer funds to the Title V MCH program, when it has been selected as a hub for planning, training, or coordination of the early childhood system of care.</li> <li>Transfer funds to the state mental health agency, when it serves as the base for an early childhood mental health initiative.</li> </ul>
<b>Community-based Family Resource and Support Grants</b>			<ul style="list-style-type: none"> <li>Create or augment community-based, family-centered, family resource programs, and child abuse and neglect prevention through innovative funding mechanisms and broad collaboration with educational, vocational, rehabilitation, health, mental health, employment and training, child welfare, and other social services in the state.</li> </ul>			

**Appendix 2: Strategic Financing to Promote Social-Emotional Readiness and School Success (continued)**

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<b>OTHER PROGRAMS TO SERVE CHILDREN AND FAMILIES FACING SOCIAL AND ECONOMIC RISKS</b>					
<p><b>Violence Against Women Act of 2001</b></p>	<ul style="list-style-type: none"> <li>• Provide assistance for transitional housing, including short-term housing assistance and support services to locate and secure permanent housing, and to integrate the individual or dependent into a community through transportation, counseling, child care services, case management, employment counseling, and other assistance.</li> </ul>	<ul style="list-style-type: none"> <li>• Create children's groups for children with parents who are substance dependent or abusers.</li> <li>• Treat women who are pregnant and/or who have dependent children or are attempting to regain custody of their children. Services should include medical care for women (e.g., prenatal), child care, therapeutic interventions (for both women and children), and case management and transportation to ensure women and their children have access to services.</li> <li>• Develop a clearinghouse, information resource center, resource director, and/or information line to provide information on available family treatment and child abuse and neglect prevention services.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide child abuse training to judicial personnel and practitioners.</li> </ul>	<ul style="list-style-type: none"> <li>• Use funds to provide continuing education and training to staff who work with substance abuse treatment and prevention programs.</li> </ul>	<ul style="list-style-type: none"> <li>• Enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco, and drug abuse disorders. Activities include organizing, planning, enhancing and efficiency collaboration, coalition building and networking.</li> </ul>
<p><b>Substance Abuse Prevention and Treatment Block Grant</b></p>	<ul style="list-style-type: none"> <li>• Provide screenings to children whose parents have substance abuse problems to assess their developmental needs.</li> <li>• Use funds for substance abuse treatment programs to provide therapy, activities, pediatric care, immunizations, and other services to children with parents in treatment programs.</li> <li>• Use funds for prevention programs for children at risk of substance dependence.</li> <li>• Use funds to disseminate outreach information (e.g., availability of prevention programs, effects of substance abuse on families and children).</li> </ul>	<ul style="list-style-type: none"> <li>• Create children's groups for children with parents who are substance dependent or abusers.</li> <li>• Treat women who are pregnant and/or who have dependent children or are attempting to regain custody of their children. Services should include medical care for women (e.g., prenatal), child care, therapeutic interventions (for both women and children), and case management and transportation to ensure women and their children have access to services.</li> <li>• Develop a clearinghouse, information resource center, resource director, and/or information line to provide information on available family treatment and child abuse and neglect prevention services.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide child abuse training to judicial personnel and practitioners.</li> </ul>	<ul style="list-style-type: none"> <li>• Use funds to provide continuing education and training to staff who work with substance abuse treatment and prevention programs.</li> </ul>	<ul style="list-style-type: none"> <li>• Enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco, and drug abuse disorders. Activities include organizing, planning, enhancing and efficiency collaboration, coalition building and networking.</li> </ul>