



## **STATE CASE STUDIES OF INFANT AND EARLY CHILDHOOD MENTAL HEALTH SYSTEMS: STRATEGIES FOR CHANGE**

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**ABSTRACT:** This report examines the efforts made in Colorado, Indiana, Massachusetts, and Rhode Island to develop mental health systems of early identification and intervention for children from birth to age 5. While each state is in a different stage of development, together they provide a picture of progress and opportunities for national change in this evolving area of health care. The study focuses on the process of change and identifies common strategies for achieving innovation. State profiles, examples of major initiatives, and descriptions of exemplary practices illustrate ways that states can improve services and policies. Conclusions underscore the value of articulating a national vision of comprehensive infant and early childhood developmental and mental health systems of care, in which child and family well-being are promoted and needs are identified and treated as early as possible in life.

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## EXECUTIVE SUMMARY

In recent years, states have made progress in identifying and referring children for developmental and mental health problems at a young age, particularly through the Assuring Better Child Health and Development initiatives in primary care. There is more awareness of the potential of intervening in the early years, with an increasing amount of literature that documents policy recommendations to implement and fund systems of early identification and early education and care. Less is known, however, about the strategies state leaders have used to develop comprehensive infant and early childhood mental health systems, and the progress they have made. This report describes mental health identification and intervention systems for children from birth to age 5 in Colorado, Indiana, Massachusetts, and Rhode Island, and focuses on state achievements and the process of change. Interviews with leaders and stakeholders in each state are combined with additional research to profile innovative strategies and initiatives. The findings underscore the importance of collaborative partnerships and point toward a vision of mental health systems for the nation's youngest children and their families.

### **Highlights of State Achievements**

Together, the states in this study demonstrated similar strategies and objectives, with each state showing signature achievements. Colorado was notable for its strategic approach in stakeholder engagement and planning, actively backed by high levels of government. This resulted in a major federal Substance Abuse and Mental Health Services Administration (SAMHSA) systems initiative, as well as the development of a highly effective statewide medical home model, the adoption of a developmentally appropriate diagnostic classification system, and the implementation of expert infant and early childhood mental health (IECMH) consultation in child care and mental health clinic settings. Indiana's signature achievements include innovative interagency screening and service tracking for children in child welfare, development of parent-friendly, Web-based information, and advanced interagency planning. These efforts show potential for federal funding when sufficient political will is generated. Growing interagency collaboration in Massachusetts, accelerated by court order, has supported major Medicaid systems change in children's mental health. The state also has an exceptionally progressive IDEA Part C Early Intervention system (for children from birth to age 3 with developmental disabilities) that has collaborated with child welfare to identify and serve young children at risk. Rhode Island illustrates a long-term vision of community-based early childhood health and development services, driven by a highly collaborative department of health and an integrated children's services agency. Rhode Island has achieved incremental

system building through federal and foundation grant initiatives, supported by innovative Medicaid models and active partnerships with parents.

### **Lessons Learned**

The challenges states faced include administrative and financial hurdles, early identification and access challenges, and workforce issues, but the ways in which they have been addressed provide important lessons. The financial hardships of the current economy are exacerbated by challenges in identifying, tracking, and integrating sources of funding. Unnecessary administrative eligibility and reimbursement barriers impede early identification and access to services. These challenges are magnified by dramatic gaps in the IECMH workforce. The National Scientific Council for the Developing Child points to a larger, national issue, the “gap between what we know and what we do.” That is, the gap between scientific knowledge about the importance of early brain and mental health development and the current abilities and limitations of policy and practice in working with young children and their families. These challenges all present opportunities for change.

There are strategies for achieving change that should begin before system planning and should continue throughout implementation. These are: comprehensive stakeholder involvement in planning, inclusive needs assessment, shared learning, social marketing, evaluation, sustainability planning, and collaborative partnership. Full stakeholder involvement in planning can be expensive and time-consuming, but is critical for buy-in and support. Needs assessment engages communities, providers, and state officials at all levels of government in objective analysis of the system and development of a shared vision of needs. Shared learning helps to refine the vision, gain needed tools, and strengthen the commitments of agency leaders to collaborate and contribute resources. Social marketing engages the general public and lawmakers in understanding and supporting systems change, and in making use of services. Evaluation provides data for quality improvement activities, social marketing, and sustainability planning, a key ingredient. Collaborative partnership is central to successful strategies. The most significant achievements were realized through strong relationships and engaging a broad range of stakeholders and funders in developing a shared vision.

This review resulted in the following recommendations, all aimed at narrowing the gap between what we know and what we do.

**Administration and finance.** It is important to establish expert IECMH advisory groups or councils, which can be highly effective if they cut across agencies and key

programs and have genuine support at the highest levels of government. Initiatives aimed at sharing child-specific data regarding needs identification, service utilization, and outcomes show great promise for tracking children and families across systems and allocating interagency resources effectively. Similar efforts toward “mapping” federal, state, and local sources of funding and documenting where they are spent can reduce duplication and increase the likelihood of cost-sharing, cost effectiveness, and the identification of potential new funding streams. This is especially important while states continue to advocate for more stable sources of federal funding.

**Early identification and access.** Requiring frequent mental health screens with specified screening tools in Medicaid’s Early Periodic Screening, Diagnosis and Treatment (EPSDT) program can help achieve the goal of improving the health of low-income children. Making similar services a requirement of other third-party payers is critical to ensuring that no child, regardless of family income status, falls through the cracks. The most progressive states require frequent screening with clearly identified, developmentally appropriate and validated IECMH tools. Some states, recognizing the profound effects that the mental health of parents can have on infant and early childhood development, are also seeking to establish routine parent depression screening in pre-birth obstetric and postpartum pediatric visits. Those with the most success are providing reimbursement rates that make screening possible.

At the service level, states can expand capacity for identification and service by providing expert IECMH consultation in key settings funded by Medicaid, state dollars, local, grant or foundation funds, or in many cases, a combination of these funding streams. Consultation models include child care consultation and consultation in Early Intervention, mental health clinics, and primary care settings. These models greatly enhance the ability of professionals with little or no formal IECMH training to identify and address the mental health problems of very young children and to make referrals. Embracing diagnostic and eligibility criteria that are developmentally appropriate for infants and young children is also critical. Some states are working on systemwide acceptance by Medicaid and third-party insurers of an infant–toddler diagnostic system so the lack of age-appropriate diagnoses will no longer be a barrier to needed services. States should also continue to work with federal and state agencies to revise definitions of other terms that are often gateways to service, such as “seriously emotionally disturbed” and “medical necessity.”

**Workforce development.** Even if children are found eligible, there is a significant barrier—commonly voiced by pediatricians—that there is little point in mental

health screening if there are no or few IECMH programs or practitioners available for referral. Solutions to this problem include maintaining accessible, updated information on available services and developing a workforce that is properly trained in this specialized area. All of the states reported that there were only a handful of fully qualified IECMH clinicians, many of whom do not or cannot accept Medicaid clients because of inadequate rates, exclusion from managed care panels, or denials of reimbursement for the work of professionals in training. Despite ongoing efforts, all the states need statewide, properly funded interagency plans for cross-disciplinary IECMH higher education and in-service training, as well specialty area credentialing.

**The gap between what we know and what we do.** State feedback suggests that it is critical to use public policy at the federal level to narrow the gap between scientific knowledge about early brain development and what we do in IECMH practice. President Obama’s emphasis on early childhood development now opens opportunities to build on visionary federal programs such as Part C Early Intervention, Head Start, and Early Head Start by continuing to integrate a mental health component in many of the services that reach very young children. This requires a fully articulated national vision statement that supports the universal identification of young children with mental health problems or risks and provides equal access to developmentally and culturally appropriate infant and early childhood mental health services.



# **STATE CASE STUDIES OF INFANT AND EARLY CHILDHOOD MENTAL HEALTH SYSTEMS: STRATEGIES FOR CHANGE**

## **INTRODUCTION**

### **THE ARGUMENT FOR EARLY MENTAL HEALTH INTERVENTION**

Even though mental and behavioral health issues may be more easily identified when children begin school, it is essential that these issues be detected sooner. The explosion of brain science in the past two decades has shown that, in children's early years, the brain develops rapidly and with a great dependence on the child's interactions with the environment and with other people. Social-emotional development in the early years is highly susceptible to both positive supports and "toxic" stressors in the child's environment and relationships, and is a critical foundation for learning and other developmental domains.<sup>1</sup> There is increasing recognition that healthy social-emotional development in the early years is especially important for positive social relationships and overall health and mental health later in life.<sup>2</sup> Children who are emotionally healthy when they enter school have a significantly greater chance of academic success, as well as attainment of higher education, employment, and social adjustment than those who are not.<sup>3</sup> Developmental trajectories can be improved permanently if healthy development is promoted, risks are identified, and appropriate supports and interventions are put in place for those in need.<sup>4</sup>

To realize savings in the long term, states must make incremental investments in infant and early childhood mental health (IECMH) systems for children from birth to school age. Children can exhibit a broad range of mental health problems in the first months or years of life, and untreated mental health problems in the early years can result in lifelong impairments in learning and behavior.<sup>5,6</sup> Prevalence of social-emotional or behavioral problems among young children has been estimated to approach 13 percent, yet even when issues are identified, most children do not receive intervention.<sup>7</sup> The well-child visit in primary care has proven to be an effective venue for identifying both developmental and IECMH concerns. The Assuring Better Child Health and Development (ABCD) initiatives, administered by the National Academy for State Health Policy (NASHP) and funded by The Commonwealth Fund, have demonstrated the value of screening in primary care for developmental and mental health risks and problems and of making linkages to needed services.<sup>8,9</sup>

## **CHALLENGES**

Identifying mental health issues in children of every age and ensuring access to needed services is a national problem. This is especially pronounced for children from birth to school age. A 2007 “Zero to Three” national policy summit on building early childhood systems concluded: “There does not appear to be a generally accepted operational definition of a comprehensive early childhood system.”<sup>10</sup> Experts also have asserted that no state has yet realized the vision of a comprehensive system of care for infants and very young children, though, as documented in this report, a number are well on their way.<sup>11</sup> Parents seeking services for their young children must navigate an incomplete and fragmented system of care. Those with experience in the system report they have learned to present their children’s disabilities differently depending on which part of the system they are attempting to access. As one Colorado parent said during a focus group held at the Family Voices family advocacy center in Denver, “When are we going to get to— ‘this is a whole child,’ not chunks and pieces?”<sup>12</sup>

Policymakers are challenged by the fact that much of IECMH system development entails spending today’s dollars to achieve tomorrow’s savings. Identifying the mental health needs of very young children and developing new services adds to state expenditures, while sometimes generating only limited short-term returns. However, addressing the mental health needs of young children yields considerable long-term savings, though they may accrue to different entities (e.g., health, education, employment, and criminal justice systems) and may be difficult to calculate. The costs associated with not intervening early may only be incurred when problems become more evident as the children grow older. Yet the investment in preventing and treating these problems will have the greatest payoff when it is made as early as possible.

Because the field of IECMH is relatively young, the nation still lacks a fully articulated vision and firm funding streams that support comprehensive IECMH systems. States often rely on time-limited federal and foundation grants, cobbled together with state and local funds to support region-specific initiatives. All the states in this study face the challenge of finding ways to sustain and expand initiatives so their IECMH systems of care can reach all young children and their families on an ongoing basis. The current economic crisis exacerbates these problems, yet there are also opportunities, one of which is health care reform.

## **THE PROMISE AND CHALLENGES OF HEALTH CARE REFORM**

One key aim of health care reform is to ensure early access to services for all Americans, increasing the provision of preventive, and hence more cost-effective, care. In his focus

on investing in the early education and care of young children, President Obama has opened a door for advocacy around their mental health, as well as educational needs. National growth of knowledge about and attention to IECMH identification and referral in the medical home model and pediatric training are critical to bringing this effort to scale, and thanks to ABCD and other initiatives this work is growing. Developing a fully functional system of IECMH screening in primary care with pathways for referral to sufficient evidence-based interventions can help achieve savings in behavioral and physical health costs, both early in life and in adulthood.<sup>13,14</sup>

Leaders in the public awareness effort include organizations such as the National Scientific Council for the Developing Child, Zero to Three, the National Center for Children in Poverty, the Build Initiative, and the ABCD initiatives.<sup>15</sup> But these efforts have not yet found full traction for influencing policy change.<sup>16</sup> This may be true, in part, because policymakers are burdened by the needs of seriously emotionally disturbed youth and mentally ill adults.<sup>17</sup> There are also competing needs, like expanding access to existing programs such as Early Head Start, which reaches less than 5 percent of the eligible birth-to-age-3 population.

Even with these limitations, Head Start, Early Head Start, Early Intervention, and other early childhood programs provide a strong foundation for IECMH system building. The state strategies identified here provide examples of major initiatives, infrastructure innovations, new mechanisms for early identification and intervention, and creative ways to expand system capacity. Many of these innovations can and should be integrated with health care reform. The information in this report will be helpful to stakeholders at all levels of the system, including parents and families, practitioners, advocates, program administrators, and policymakers, as they work to achieve the promise of system reform.

## **STUDY APPROACH**

Following literature review and consultation with experts at NASHP and The Commonwealth Fund, the states of Colorado, Indiana, Massachusetts, and Rhode Island were chosen in order to illustrate a range different stages and challenges, and also to provide a range of sizes and geographies. They were also chosen because they offer model strategies that can be utilized by other states. States involved in the ABCD initiatives were not included, because their change strategies—many of which are consistent with those in this report—have already been well documented.<sup>18</sup>

Key informants were identified through networking, including contacting state affiliates at the World Association of Infant Mental Health (WAIMH), and by searching

state agency Web sites.<sup>19</sup> More than 70 key informants were selected to provide a range of perspectives on how change can be achieved from the ground up—that is, by parents, practitioners, teachers, and researchers in partnership with high-level state administrators and policymakers. Advocates, parents, parent organizations, and state agency leaders were selected for onsite interviews. A parent focus group at Family Voices in Denver, Colorado, also was held, as was a group interview during a State Early Childhood Comprehensive Systems Advisory group meeting in Providence, Rhode Island. Interviews focused on identifying strategic steps in the process of change, examples of system innovations, and potential changes in public policy ([Appendix B](#)).

## **STATE PROFILES**

While interviews revealed a broad range of strategies (for example, emphasizing IECMH learning curricula, training, early learning standards, and quality rating systems in early education and care), the primary emphasis of this report is on early identification and treatment of mental health problems and risks. Initiatives were selected to illustrate strategies for the change process, as well as to provide concrete examples of what can be done to improve services. These and other examples of state strategies are tabulated in [Appendix A](#).

### **COLORADO**

Colorado has benefitted from visionary leadership at the highest level, from the governor, as well as state agency leaders and experts in the field. A high-level interagency blue-ribbon policy council was established by the governor’s office to focus specifically on early childhood mental health. Leaders of Colorado’s Early Childhood Comprehensive Systems (ECCS) initiative participated in this council, and the governor’s decision to back ECCS by locating it in the lieutenant governor’s office gave IECMH special traction in state strategic planning.<sup>20</sup> Colorado ECCS then was able to take an overarching role in convening many stakeholders to integrate the goals and change strategies of at least 22 programs into one plan for young children, which became part of the governor’s overall state strategic plan.<sup>21</sup>

Colorado demonstrates how a federally funded initiative, when coupled with long-term, consensus-driven, strategic planning, can achieve major systems change. Visionary leaders from the state’s mental health authority and its highest level of government have used its federally funded Project BLOOM (Building and Leveraging Opportunities and Ongoing Mechanisms for Children’s Mental Health) “system of care” grant to link many initiatives together, including its model Medical Home program and

other Medicaid innovations. Project BLOOM was one of few System of Care grants at the time that focused on the mental health needs of infants and young children.

### **Project BLOOM**

Colorado used a five-year 2002 Substance Abuse and Mental Health Services Administration (SAMHSA) Comprehensive Community Mental Health Services for Children and Their Families Program grant to develop Project BLOOM.<sup>22</sup> In doing so, Colorado became the second state in the nation to target a system of care initiative on the birth-to-5 age group. In addition to developing an array of community-based early childhood services, the initiative has provided training to child care providers on supporting social-emotional development in the classroom. Experts have also provided advanced training of professionals so that they can train others in the use of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0–3R), a diagnostic classification system for children from birth to age 3 that crosswalks to the International Classification of Diseases, 9th Revision (ICD–9) system currently used by third-party payers for youth and adults.

A state innovation grant from the U.S. Department of Health and Human Services supported Colorado in laying the groundwork for Project BLOOM. Key family and state agency leaders also attended a Georgetown University Center for Child and Human Development Policy Academy. This national learning experience helped leaders to develop a shared vision and commitment. The project, implemented in four of the state’s 64 counties, provided a major impetus for statewide strategic planning. The lieutenant governor’s office also created an annual early childhood summit, outlined early learning outcomes to inform legislative policy priorities, and established an early childhood advisory team.

Colorado engaged diverse communities in assessing needs and developing demographic reports, prevalence estimates, and surveys that have provided key information to build the case for early intervention.<sup>23,24</sup> Active social marketing and communication tools, like fact sheets, tool kits, speakers’ points, and information briefs, disseminated the message and promoted a unifying message about the importance of early childhood social-emotional development. Positive evaluation results have since been strategically disseminated to provide evidence for new sources of state, federal, and foundation funding after the grant’s 2007 termination.<sup>25</sup> Members of the state’s WAIMH affiliate have been instrumental in these and other efforts.

Colorado also used its SAMHSA funding to support a collaborative process of “mapping” all available funding sources. Leaders of key state and local human service and government agencies reviewed all sources of funding for infant and early childhood programs and developed comprehensive online matrices of braided funding for specific programs.<sup>26</sup> In Part C Early Intervention, for example, Colorado has found ways to draw upon funding from the Department of Education, the Division of Developmental Disabilities, private and public (i.e., Medicaid and Children’s Health Insurance Program) health insurance, Title V, child welfare, Temporary Assistance for Needy Families, and child care development block grant dollars. This leaves Part C as “payer of last resort.”<sup>27</sup> Foundation funding is used to provide seed money for new projects, fill gaps in training and services, and provide leverage for state and federal sustainability funding.

### **Other Colorado Advancements**

The synergies created by Project BLOOM have been beneficial for other Colorado advancements, including the use of medical homes, which are supported by active Medicaid participation; IECMH consultation pilots; and adoption of the DC: 0–3R as a diagnostic classification system. Together these advancements are helping to integrate medical and mental health services, gaining better access for children and parents, and developing system capacity.

**Medical homes.** Colorado stands out as a state that is bringing medical homes to scale. Medical homes use a team approach to coordinate mental, physical, and oral health care in compassionate, culturally competent, family-centered primary care practices.<sup>28</sup> The medical home facilitates communication among team members, which include the family, health care providers, payers, and community programs, supported by a centralized and comprehensive record of all health-related services.<sup>29</sup> According to the project’s director as well as the director of the state’s Medicaid authority, Colorado’s program has improved medical and mental health services and saved money.

The project began as part of a learning collaborative implemented in 2002 by the National Initiative for Children’s Healthcare Quality. A survey of pediatric providers found that a lack of social service support for families and poor access to and coordination of mental health services were frequently reported barriers to care. To address these challenges, the Colorado project emphasized care coordination for parents, which is provided by two ABCD coordinators. It was championed by the Colorado chapter of the American Academy of Pediatrics. with the support of 145 Colorado organizations, including other pediatric associations, managed care entities, a number of foundations, and academic institutions. The Colorado medical home project has the

backing of a state law mandating access to medical homes for children covered by public programs and is coordinated by a not-for-profit agency partnership with the state's Medicaid and public health authorities.

**Medicaid participation.** Colorado Medicaid is an enthusiastic supporter of the medical home project. Positive outcomes and cost savings in a 7,000-child pilot helped convince the Medicaid authority to provide an enhanced fee-for-service rate for medical home practices, which is helping to yield both savings and quality improvement. Medicaid administrative dollars also support planning, training and quality improvement processes, and other performance incentives.<sup>30</sup> Colorado Medicaid also has provided a high reimbursement rate for developmental screening, with recommended tools for social-emotional screening of infants and young children.

**IECMH consultation pilots.** In Colorado's child care consultation project, IECMH consultants conduct classroom observations and teacher consultations, work with teachers and parents to facilitate linkages with needed mental health services, and conduct trainings in the community. IECMH consultation is a cost-effective way to leverage resources by expanding the capacity of staff in various settings to promote social-emotional wellness, identify needs, and make linkages to family support services.<sup>31</sup> Evaluation of Colorado's program demonstrated reduction in emotional disturbances and improved child interactions and classroom quality.<sup>32</sup> The program has been named by the Georgetown National Technical Assistance Center for Children's Mental Health as one of six exemplary programs for replication. Colorado also funds expert IECMH training and consultation for professionals serving non-Medicaid children in all of its state community mental health centers, thus expanding the capacity of outpatient clinicians to provide age-appropriate assessment and treatment for young children, regardless of coverage.

**Developmentally appropriate diagnostic classification.** A challenge articulated by one state Medicaid official is that third-party payers and IECMH experts often "do not speak the same language" regarding diagnosis.<sup>33</sup> There is no universally accepted diagnostic classification system for infants and young children as there is for youth and adults. This constitutes a barrier to age-appropriate diagnosis and reimbursement. The Colorado Division of Behavioral Health, with the support of the state's Medicaid authority, has officially adopted DC: 0-3R diagnoses as justification for service reimbursement. This important

In diagnostic classification, third-party payers and IECMH practitioners "do not speak the same language."

*State Medicaid Official*

step helps providers, payers, and parents to “speak the same language,” opening a gateway to the mental health services children need.

## **INDIANA**

Indiana illustrates how state agencies (mental health, child welfare, and Medicaid) can collaborate to screen and track services for at-risk children. Indiana’s Family and Social Services Administration, which oversees Medicaid, as well as the state’s mental health and child welfare agencies, has been a leader in implementing an innovative mental health screening initiative for children receiving child welfare services. A strong evaluation component links data systems across agencies to enable administrators to assess the needs, utilization, and specific outcomes of their child welfare population. Indiana’s ECCS program has been also highly active in strategic planning, training, and social marketing. The state has committed state staff time to IECMH efforts; however it would benefit from additional federal funding for services and strong support at the highest levels of state government.

### **Child Welfare Mental Health Screening Initiative**

This initiative, conceived by the state’s mental health authority, implemented behavioral screening for children of all ages entering the custody of the child welfare system, using Medicaid and state funds for indicated mental health services. Nearly half of children screened were under age 5. In preparation for this initiative, Indiana commissioned a 2004 statewide children’s behavioral health needs assessment that involved 1,500 respondents.<sup>34</sup> It found deficiencies in early identification of mental health problems and in access to interventions for young children. The assessment process helped to develop consensus on priorities among a broad range of constituents. A task force was created and included representatives from state departments of health, education, mental health and addictions, child care services, child welfare, corrections, and Medicaid/Children’s Health Insurance Program (CHIP), as well as parent advocates. This led to legislation in 2005 that required the state to develop a strategic plan for children’s mental health and called for a greater focus on IECMH.<sup>35</sup>

Responding to the deficiencies identified in federal review of mental health screening and intervention for children in child welfare services, Indiana secured a technical assistance grant for a learning collaborative at the Georgetown Policy Academy. Juvenile justice, state budget, and Medicaid officers were invited along with parent advocates and other child-serving agencies. In addition to gaining needed technical assistance and tools for systems change, leaders developed a shared vision and action plan for screening and treating children entering the child welfare system.



The state's juvenile justice authority, who understood how screening could prevent later involvement in the juvenile justice system, lent its support for the project. The state's budget office, recognizing potential cost-savings through early intervention, offered line-item funding. The state's Medicaid authority predicted savings accrued from reduced intensive services, and was ready to accept the needed increases in ambulatory mental health services for children of all ages. Participating agencies agreed to supply data sets (with identifiers removed) of all children who were in child welfare placement.

The state is funding an evaluation of the initiative by Indiana University–Purdue University Indianapolis. Nearly three-quarters of more than 21,000 children removed from home were screened from 2005 to 2009. A mental health risk was identified in one-third of screenings. Children with risks identified through formal screening were more likely to receive treatment than those without identified risks, suggesting that screening is helping to channel resources toward children with the highest level of need. Screening and the Medicaid services that followed were found to be significantly correlated with placement stability and decreased recidivism.<sup>36</sup>

### **Other Indiana Advancements**

Indiana's IECMH work has Medicaid support and active ECCS participation, with a focus on using screening to improve system performance and laying the groundwork for further improvements that can be undertaken when needed political support is developed.

**Medicaid support.** Indiana's Medicaid authority has collaborated closely with the state's health and mental health departments to standardize health and behavioral health screening for prenatal and postpartum women. Indiana is now awaiting approval from the Centers for Medicare and Medicaid Services to roll out presumptive eligibility with notification of pregnancy, which will increase the reach of these screens. The state also plans to reimburse care management organizations for comprehensive health and behavioral health risk screens in mothers, as well as their infants.

**Screening as an administrative tool.** Indiana Medicaid is supporting the state's mental health authority to introduce a screening tool, the Child and Adolescent Needs and Strengths (CANS), which has a special version for infants and young children, the CANS 0–5.<sup>37</sup> The CANS tool can be used to plan care according to the strengths and needs of each child and family, and has been developed so each state can tailor its own version by selecting from a broad menu of individually validated questions. The state is now working on CANS algorithms for children of all ages that will help agencies make care decisions and justify Medicaid payments for rehabilitative services. CANS and utilization

data also will be used as performance indicators for providers and behavioral health organizations. Eventually these indicators are envisioned to be used in pay-for-performance incentives.

**Early Childhood Comprehensive Systems.** Indiana’s ECCS program has played a leadership role in convening constituents to develop plans that facilitate access, information-sharing, and cross-system training content and competencies.<sup>38,39</sup> Indiana ECCS helped expand a Web site for parent use that provides information about community, early care and education, health, safety, parenting, and family resources.<sup>40</sup> This work also has been supported by WAIMH affiliates, who have been especially active in training.

## **MASSACHUSETTS**

Massachusetts is in the midst of wholesale systems change supported by growing interagency collaboration but also mandated by court order (as the result of a class action lawsuit) to reconstruct its system of Medicaid behavioral health care for children from birth to age 21. The state must implement and monitor comprehensive systems for early identification of mental health problems and develop a coordinated system of community-based services. The very broad court order requires statewide system change within extremely tight timelines. The court process also has made it a challenge to build consensus and recruit and train the staff needed for new services. As the result of active health and human services leadership, an active ECCS group, and collaborative partnerships, Massachusetts has won two SAMHSA grants for infants and young children in 2009. These dovetail with a highly progressive Part C system that works in partnership with child welfare. Significant progress also has been made in bringing all child-serving state agencies together. Commissioners meet on a monthly basis to determine how they can collaborate for more coordinated service delivery for children, highlighting the growth in recent years, as one official puts it, of “a spirit of collaboration that hasn’t existed in this way before.”<sup>41</sup>

### **The Massachusetts Medicaid Children’s Behavioral Health Initiative**

The Children’s Behavioral Health Initiative resulted from a 2006 court decision in favor of plaintiffs who had argued that their children with serious emotional disturbances (SED) had not received appropriate services through the state’s Medicaid authority, MassHealth.<sup>42</sup> The court found that the state had not complied with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions for behavioral health screening for children from birth to age 21 and had not provided the necessary range of properly coordinated community-based services to maintain SED children at home rather than in

residential settings. In its response, the state is working to meet and exceed court mandates, by dramatically improving EPSDT behavioral health screening and obtaining CMS approval to provide a range of home-based wraparound services for any child on Medicaid for whom services are shown to be medically necessary. It is implementing CANS and Birth to 4 CANS (similar to Indiana's 0–5 CANS), and has procured a system of 32 community service agencies to provide wraparound services and intensive care coordination for children with SED.<sup>43</sup> In the current economy, this is a major challenge for the state Medicaid budget.

Another challenge the state has faced has been to find ways to condense time-consuming stakeholder processes into the fast-track planning that was required, by court order, to implement a system of children's Medicaid behavioral health services by July 1, 2009. Despite time pressures, MassHealth has actively reached out to many in the IECMH provider community for expertise. Developmental pediatricians who have been leaders in implementing screening have been engaged to train other pediatric providers. IECMH expertise was sought in developing the state's Birth to 4 CANS and in providing training. Few clinicians, however, have participated in this training, underscoring the workforce gaps in this area.

As part of the Children's Behavioral Health Initiative, MassHealth now requires EPSDT behavioral health screens using specified, validated IECMH screening tools (generally briefer than the CANS tools) in all well-child visits from birth to age 5. Trainings for pediatric primary care providers have been offered statewide, a toolkit is posted online, and parents have received repeated notification of screenings and available services. As a result of these efforts there has been a major increase in EPSDT developmental screening in the birth-through-age-5 group. In 2008, the percent of MassHealth well-child behavioral health screens for children under age 6 nearly tripled compared with the previous year. As of September 2009, behavioral health needs were being identified in roughly 2 percent of Massachusetts screens for children under 6 months, in 6 percent of screens for children 6 months to 2 years, and in 12 percent of screens for children ages 3 to 6 years, which is consistent with trends in 2008.<sup>44</sup> The percent of well-child visits in which screens were conducted, however, remain significantly lower for infants under 6 months (under 21%) than for children 6 months to 2 years (48%) and for children ages 3 to 6 years (nearly 54%).<sup>45</sup> MassHealth is now analyzing claims data to assess service utilization by families with positive screens. A study at Tufts Medical Center is also validating a new screening tool for developmental problems, social-emotional concerns, and family risk factors that is brief enough to be used in 15-minute well-child visits.

Massachusetts is also refining a comprehensive online information gateway to support the MassHealth children’s initiative. CANS screening scores are entered by clinicians and can be accessed on a need-to-know basis (e.g., by other clinicians involved with the child) with appropriate confidentiality safeguards. While the system is facing implementation challenges, this is a major step forward in tracking children in Medicaid behavioral health services. The gateway is also being designed to provide resource information links targeted for consumers, providers, researchers, and government officials.<sup>46</sup>

### **Other Massachusetts Advancements**

Massachusetts has made a number of other advancements, notably its exceptionally progressive Part C system and innovative collaborations between Part C and child welfare.

**Part C.** The state’s Part C Early Intervention system is one of only six in the nation that serve the at-risk population (as opposed to only children with established delays), making Massachusetts the second-highest in the nation in

For Infant and Early Childhood Mental Health, Part C EI is often the only game in town.  
*Part C Coordinators*

its static count of the birth-to-age-3 cohort served.<sup>47,48</sup> Fewer than 4 percent of children in the state’s Early Intervention system are served under the at-risk eligibility category. However, more than one-quarter of those ultimately show developmental delays.<sup>49</sup> The state also accepts and tracks social-emotional delays as primary and secondary Part C eligibility criteria (as does Colorado), which is helping increase Part C attention to mental health concerns.<sup>50</sup> Massachusetts clinicians report that assessing mental health delays is difficult because many assessment tools are weak in that area, a problem the state is currently working on.

A partnership between the United Way and IECMH experts has resulted in the development of a statewide infant mental health training institute, with the support of private foundations.<sup>51</sup> Part C has collaborated with the institute to develop a vision statement that emphasizes the responsibility of Part C to identify social-emotional disabilities and risks and support the mental health of the child and family. This group is now working together on a statewide IECMH training plan. These efforts constitute a philosophical shift that recognizes the key role that Part C should have in fostering social-emotional development as a cornerstone of learning in all developmental domains.

Most key informants and all Part C coordinators asserted that Early Intervention is often a “default referral,” especially in primary care, for children under age 3 showing

social-emotional concerns. Part C coordinators agreed that while their clinicians have been trained in and practice relationship-based interventions for developmental disabilities, their systems do not yet have the tools, training, or reimbursement structures necessary to carry out expert mental health interventions, including therapeutic work in child–parent relationships. This work often must address the mental health of the parents. Part of the dilemma faced by many states is how Part C and adult-serving agencies will collaborate to jointly serve the mental health needs of all partners in parent–child relationships. This requires ongoing discussion between state mental health, Medicaid and Part C authorities, and third-party payers.

**Part C collaboration with child welfare.** The Massachusetts child welfare agency—the Department of Children and Families (DCF)—has been a national leader in partnering with Part C, Brandeis University, and selected provider agencies to win federal and foundation funding to implement and evaluate its Child Abuse Prevention and Treatment Act (CAPTA) pilot.<sup>52</sup> CAPTA requires that states assess and address the developmental needs of children under age 3 who have been abused or neglected. The state has gone a step farther than CAPTA requirements by including not only children for whom abuse has been substantiated, but also any child from birth to age 3 who is living in a household where a report on behalf of another family member has been supported. This approach recognizes the traumatic effects on infant and early childhood development of living in homes where neglect, abuse, or violence are occurring.

Massachusetts is also the only state in this study that has created a high-level child welfare management position specifically devoted to the developmental and social-emotional needs of infants and young children. This person serves as a liaison with experts, advocates, and providers, and helps to develop policies and procedures for identification and service, plan trainings, and maintain DCF staff and administrator awareness of IECMH issues. Collaboration with the public health agency through this liaison has helped to win a number of federal grants on behalf of infants and their families.

**Maternal depression screening.** A Maternal and Child Health Bureau–funded project through the Department of Public Health has used postpartum pediatric visits in Boston-area practices to conduct a brief, two-question maternal depression screen, with supportive services for identified parents. A bill mandating maternal depression screens during prepartum obstetrics visits, immediately postpartum, and during the first year of the baby’s life is still under debate in the Massachusetts House of Representatives.

**Child care consultation.** The state's Department of Early Education and Care supports mental health consultation in child-care settings, targeting classrooms that serve children from birth through age 13 and children who are involved with child welfare services, and therefore likely to be at risk. The department funded two-thirds of the salary of a mental health consultant placed in each of 14 programs in 2008. By agreement with MassHealth Medicaid, the clinicians cover the rest of their costs by billing Medicaid for services to diagnosed children. Such consultations benefit many of the children in a classroom by increasing the skills and strategies of teachers. Some of the clinicians are now able to cover most of their costs with Medicaid or third-party billing. However, expansion funding for the consultation services suffered cuts of more than 55 percent in 2009, underscoring the fragility of these new initiatives.<sup>53</sup>

## **RHODE ISLAND**

Rhode Island's Department of Children, Youth, and Families (DCYF) has been a key leader in developing coordinated, community-based mental health systems for children of all ages. DCYF is an integrated agency that oversees mental health, child welfare, and juvenile justice services. Rhode Island is notable for building its IECMH initiatives through a series of SAMHSA grants. These include Linking Actions and Unmet Needs in Children's Health (LAUNCH) and Rhode Island Positive Educational Partnerships. Rhode Island shows innovation in its partnerships with parents, both in planning and service delivery. State officials hope to use its 2008 global Medicaid waiver to work toward expansion and sustainability of federally funded IECMH systems initiatives.

### **Positive Educational Partnerships and Linking Actions and Unmet Needs in Children's Health**

Rhode Island's Positive Educational Partnerships, a 2005 SAMHSA Comprehensive Services for Children and Their Families Cooperative Agreements initiative, had its origins in the state Child and Adolescent Service System Program federal grant work begun in 1992.<sup>54</sup> This six-year project identifies SED children from birth to age 11 in schools, child care, and infant-toddler programs; provides interventions; and makes linkages to a wraparound system of family services and supports. The project began with school-aged youth and over time included children from birth to age 3 in Part C and other early childhood programs. Project leaders have invested in needs assessment and stakeholder involvement; engaging the community of parents, schools, providers and other stakeholders; hosting or joining community meetings; and giving stakeholders a chance to shape the project.

The fact that SAMHSA funding was focused on SED in this initiative posed a challenge for Rhode Island and other early childhood grantees, because there has been no nationally established definition of SED that is developmentally appropriate for infants and very young children. Professionals and parents have been reluctant to accept or use the SED label for young children. This has been a barrier in establishing eligibility for service, though SAMHSA does accept DC: 0–3R diagnoses as eligibility for some of its initiatives. Grantee dialogue with the Center for Mental Health Services regarding this barrier has resulted in the development of new terminology to establish eligibility of children from birth to age 5 for SAMHSA initiatives. Hence “diagnostic impression of imminent risk” is now acceptable as an eligibility criterion and is part of official guidance to SAMHSA grantees.<sup>55</sup> A National Academy for State Health Policy survey of states indicates that the need for a developmentally appropriate definition of SED in IECMH has been an issue for many states.<sup>56</sup> Similar recommendations have been made by national policy experts regarding the Medicaid definition of “medical necessity,” the threshold for Medicaid reimbursement.<sup>57</sup>

Linking Actions and Unmet Needs in Children’s Health (LAUNCH), Rhode Island’s new SAMHSA-funded initiative for children from birth to age 8, promotes the integration of developmental and behavioral screening in primary care. This project places mental health consultants in participating practices to conduct family assessments, follow up on referrals, and provide evidence-based positive parenting practices. Consultants in child care also provide teacher behavior management training and parent training for targeted families. Long-range plans include improving systems integration, developing the workforce, and identifying third-party payment mechanisms for sustainability.

### **Other Rhode Island Advancements**

Rhode Island’s health and Medicaid authorities have a long history of partnering to identify IECMH and other developmental needs at birth, share IECMH and other health information across programs, and increase eligibility for low-income populations. These partnerships extend to primary care practitioners, child care providers who provide them with screening results, and parents who are providing peer-to-peer support services.

**Medicaid partnerships.** Despite recent budget setbacks, Rhode Island Medicaid has been historically aggressive in expanding eligibility to exceed CHIP expansion targets. The state’s new global Medicaid waiver shows promise in opening up billing codes and increasing emphasis on parent choice and family support in community-based services.<sup>58</sup> The waiver allows the state to make broad changes to services, potentially

improving access as well as cost-efficiency in exchange for caps on annual Medicaid spending. The waiver has been controversial, but was essential to address problems in Medicaid and will allow for a much greater flexibility in services.

Rhode Island's Medicaid EPSDT initiative is notable for its partnerships between primary care and early care and education settings, in which behavioral health screenings are conducted with children in their care and results sent to the children's pediatricians. A Department of Health visiting nurse helps to assess the readiness of primary care providers to follow up on referrals of positive screens, as well as conduct EPSDT screens with other children, and then provides them with necessary information and support.<sup>59</sup> The additional time that child care providers can spend with children observing their behavior and conducting more thorough screenings is likely to provide primary care professionals with more information than they would have been able to gather in brief well-child visits.

**Child care consultation.** Rhode Island's child care consultation project provides classroom observations, consultation, and teacher training in settings serving children from birth to age 5.<sup>60</sup> Launched by IECMH practitioners and researchers from Brown University/Bradley Hospital Hasbro Children's Center, the initiative has the support of the Rhode Island American Academy of Pediatrics chapter and is supported by state, Title V, ECCS, and block grant funds. Rigorous evaluation by Brown University has demonstrated significant improvements in classroom environments and a decrease in expulsions. Leaders of this project from Brown University used this empirical evidence to support an application for the state's SAMHSA LAUNCH initiative, which they cowrote in partnership with ECCS leadership.

**Information systems.** Rhode Island's health department points to its online information system as one of the nation's most fully functioning models of a primary care interagency data system.<sup>61</sup> This system links pediatric health data with 10 public health programs, including newborn screening, home visits, and other child and family support programs, as well as Part C and Part B Special Education programs. The efficiencies of this system, combined with the state's focus on early identification at birth, have helped make Rhode Island Part C fourth in the nation in numbers of children served at any one time.<sup>62</sup>

**Parents as service providers.** Rhode Island's commitment to partnering with parents as service providers is especially notable. Parents were instrumental in shaping Title V services, later becoming parent consultants.<sup>63</sup> The state's medical home initiative



involves parents as trained consultants in early childhood primary care services. Parents, many of them raising children with autism spectrum disorders, provide resource information for physicians and resource coordination and referral support for other parents. An evaluation showed an 11 percent reduction in overall health care costs; improved sense of support and empowerment for parents; and stronger physician understanding of resources and patient needs, with increased overall productivity.<sup>64</sup> The project has been funded by the Rhode Island Department of Health (Title V and Part C), and state and federal Medicaid dollars.<sup>65</sup> Parent consultants also serve a special role in Early Intervention services by supporting parents and representing them with Early Intervention clinicians, as members of care planning teams. There is great potential in these and other services for parent consultants, with greater cost-effectiveness than often occurs when professionals perform these functions.

## **LESSONS LEARNED**

The states in this study learned important lessons. First, state champions identified a number of challenges, many of which they shared in common. In most cases these challenges or barriers presented opportunities for change, which leaders seized through a common set of strategies that emerged as key ingredients for success. By demonstrating what works at the local level, these and other states are pointing the way to state and federal policy changes that can bring IECMH systems to scale.

Challenges shared by states include administrative and financial hurdles, early identification and access challenges, and workforce issues. Unnecessary administrative eligibility and reimbursement barriers impede early identification and access to services. Early mental health identification and service has generally had less priority than intensive services for older SED children, many of whom might have benefitted from earlier identification. In addition, there is the combined challenge of the financial hardships of the current economy and problems in identifying, tracking, and integrating sources of funding. These challenges are compounded by a severely limited IECMH workforce. This makes it difficult for frontline providers to know where to refer patients, and leaves parents struggling to find services and gain eligibility and payment for them.

The National Scientific Council for the Developing Child identifies the wide “gap between what we know and what we do” as a national issue.<sup>66</sup> In the states studied, planning efforts and stakeholder groups included researchers and early childhood experts, as well as providers and practitioners. The goals of closing the gap between science and practice were advanced through communication and planning efforts that sought to build a common vision among families, professionals, and government officials.

The most successful initiatives employed a set of change strategies that resulted in consensus-driven plans with funding support. They focused on making a commitment to stakeholder involvement in planning and using needs assessments to engage stakeholders. In doing so, these initiatives involved communities, providers, and state officials in an analysis of the system and in developing a shared vision of needs. Engaging stakeholders right from the beginning gives them a chance to get to know each other and shape planning decisions, which enhances their sense of ownership and shared responsibility for implementation and outcomes. Funders, including private and foundation funders, are especially important in this mix.

Other successful change strategies included shared learning, which helps to refine vision, gain needed tools, and strengthen the commitments of agency leaders to collaborate and contribute resources; social marketing, which engages the general public and lawmakers in understanding and supporting systems change; and evaluation, which provides data for quality improvement activities, and is best conducted by an independent, highly regarded institution. When results are positive, evaluation lends strength both to social marketing and to sustainability planning. Many states have used sources such as federal grants to implement successful pilots, but those that failed to consider sustainability from the start have usually been unable to maintain or expand services when grant funds come to an end.

When asked about their most effective change strategies, state champions consistently emphasized the importance of nurturing ongoing collaborative relationships. The most successful state agency leaders in this study formed active partnerships with parents, IECMH practitioners, and members of teaching, research, and clinical institutions. Together, they used the power of knowledge and experience to engage the support of high-level government. They noted that this works best when all partners benefit. This is often best reflected in memoranda of understanding that commit partners to sharing resources and information. Maintaining these relationships and using strong planning processes requires significant investment of time and resources, yet this is a necessary investment. Champions in Illinois—a state nationally recognized for its IECMH system—describe the process as “relationship-based change.”<sup>67</sup>

Based on these achievements, we make the following recommendations, which all seek to reduce the gap between what we know and what we do.

#### **ADMINISTRATION AND FINANCE**

It is important to establish expert IECMH advisory groups or councils, which can be highly effective if they cut across agencies and key programs and have support from the

highest levels of government. At least one state illustrated how such a council can fail if it is not championed at the gubernatorial or legislative level.

Initiatives aimed at sharing child-specific data regarding needs identification, service utilization, and outcomes show great promise for tracking children and families across systems and allocating interagency resources effectively. This is an ambitious task that usually involves finding a way to share information across incompatible data systems. To be effective, it must involve considerable management information systems work. Similar efforts toward “mapping” federal, state, and local sources of funding and documenting where they are spent can reduce duplication and increase the likelihood of cost-sharing, cost-effectiveness, and identifying potential new funding streams. Bringing state agency officials together also increases the likelihood that they will coordinate and share resources and develop powerful collaborations that can result in additional federal funding.

#### **EARLY IDENTIFICATION AND ACCESS**

Identifying children early and ensuring that every child has equal access to a full array of services is absolutely critical to preventing more devastating and costly problems later in life. Integration of mental health and primary care services is essential in this effort and is beginning to happen. Requiring frequent mental health screening in Medicaid EPSDT with specified, validated tools is an important step. Making similar services a requirement of other third-party payers is needed to ensure that no child, regardless of family income status, falls through the cracks. There is considerable variation in the interpretation by state Medicaid authorities of EPSDT requirements, with the most progressive states requiring frequent screenings with clearly identified, developmentally appropriate, and validated tools. Some states, recognizing the profound effects that the mental health of parents can have on infant and early childhood development, are also seeking to establish routine parent depression screening in prebirth obstetric and postpartum pediatric visits. Those with the most success have set reimbursement rates that make screening possible.

At the service level, all the states are seeking to expand capacity for identification and service by providing expert IECMH consultation in key settings funded by Medicaid, third-party payer, state dollars, and local, grant or foundation funds, or in many cases, a combination of these funding streams. Consultation models include child care consultation and consultation in Early Intervention, mental health clinics, and primary care settings. These models greatly enhance the ability of professionals with little or no formal IECMH training to identify and address the mental health problems of very young

children and to make referrals. Employing parents as consultants is a highly effective strategy, both for parent consumers and for professionals.

Embracing diagnostic and eligibility criteria that are developmentally appropriate for infants and young children is also critical for improving access. Examples include systemwide acceptance by Medicaid and third-party insurers of an infant–toddler diagnostic system such as the DC: 0–3R and continuing with federal and state agencies to revise definitions of terms that are often gateways to service, such as “seriously emotionally disturbed” and “medical necessity.”

### **WORKFORCE DEVELOPMENT**

Even if children are found eligible, there is a significant barrier—often voiced by pediatricians—that there is little point in mental health screening if there are no or few IECMH programs or practitioners for referral. Solutions include maintaining accessible, updated information on available services and developing a workforce that is properly trained in this specialized area. All of the states reported that there are only a handful of fully qualified IECMH clinicians, many of whom do not or cannot accept Medicaid clients because of inadequate rates, exclusion from managed care panels, or denials of reimbursement for the work of professionals still in training. Despite ongoing efforts, all the states in this study show a need for statewide, properly funded interagency plans for cross-disciplinary IECMH higher education and in-service training, as well specialty area credentialing. Again, employing parents as consultants is a cost-effective way to expand capacity.

### **THE GAP BETWEEN WHAT WE KNOW AND WHAT WE DO**

State feedback suggests that using public policy at the federal level to close the gap between what we know and what we do is critical. While federal programs such as Head Start, Early Head Start, and Part C Early Intervention have been visionary, more work is needed to apply scientific knowledge about the importance of social-emotional wellness in infant and early childhood and development to public policy and practice. This can be accomplished only by actively involving researchers in the change process, allowing their knowledge to inform change strategies and allowing them to better understand the issues that practitioners and families need addressed through new research. With President Obama’s emphasis on early education and care and health care reform, we have a chance to achieve universal identification of young children with mental health problems or risks and provide equal access to developmentally and culturally appropriate infant and early childhood mental health services.

## CONCLUSIONS

Infant and early childhood mental health champions in this study acknowledged progress at the local level, yet also voiced concern that they have a long way to go in developing comprehensive statewide services. Systems of mental health care for infants and young children are in early stages of development and lag behind youth and adult systems. This could be an advantage—IECMH leaders can learn from these older systems and potentially skip some stages of development (e.g., moving directly to integration of mental health and primary care services). However, this requires that IECMH needs be prioritized on a par with the needs of mentally challenged youth and adults. In the words of one state mental health agency official, “We have been way behind in looking at mental health services for little ones.”<sup>68</sup>

Although the initiatives we studied are innovative and exciting, in most cases, state funding has been cobbled together with time-limited federal and private grant support. When these sources end, states face significant challenges in sustaining initiatives and expanding them into statewide systems. Until federal policy changes yield more consistent, long-term funding streams, states must make better use of existing resources through integration of funding sources, new methods of early identification, and innovative, cost-effective models of early intervention and family support.

Nationally, leaders can learn from each other by sharing system strategies and innovations. Successful strategies are embedded in a holistic public health approach, in which child- and adult-serving agencies share joint responsibility for early identification, services, and outcomes later in life as well as in infancy and early childhood. Resulting savings, which can begin at birth and extend across the lifespan, are not just felt financially but also reduce the time, effort, and suffering of caregivers and their young children.

Yet, despite scientific evidence and cost-benefit rationales, the economic returns are difficult to quantify, because IECMH systems are as much an investment in future development as they are in current well-being. This underscores a major dilemma facing policymakers and funders. In developing systems of care for very young children, states and the nation must invest today’s dollars for tomorrow’s savings in a time of remarkable worldwide economic turmoil. Progressive states are currently attempting to do this in the absence of fully articulated national policy that supports comprehensive and accessible systems for universal mental health screening and skilled interventions for those in need, regardless of race, language, culture, or socioeconomic status. As state leaders address the challenges in their states, they can also advocate for national health care reforms and other federal policy and funding changes that reflect the values and vision of a society that seeks to effectively care for its youngest children by addressing mental health problems as early as possible in life.

## NOTES

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<sup>34</sup> Pakov, T. (2004). Indiana local systems of care assessment project. Indiana University – Purdue University. Calumet.

<sup>35</sup> Indiana Interagency Task Force. (2006). Social, emotional and behavioral health plan. Required by Senate enrolled Act 529 / Indiana Code 20-19-5.

<sup>36</sup> Lawson, A, Quantz, S. and Wright, E., (2007). Child welfare mental health screening initiative evaluation progress report. Center for Health Policy, School of Environmental Affairs, Indiana University-Purdue University. Indianapolis, IN.

<sup>37</sup> [www.buddinpraed.org](http://www.buddinpraed.org). Accessed June 29, 2009.

<sup>38</sup> <http://www.sunnystart.in.gov>. Accessed May 3, 2009.

<sup>39</sup> Sunny Start (2007). Social-emotional development of young children training content: Consensus statement.

<sup>40</sup> <http://earlychildhoodmeetingplace.indiana.edu>. Accessed May 20, 2009.

<sup>41</sup> Massachusetts Interview, February 25, 2005.

<sup>42</sup> <http://mass.gov/masshealth/childbehavioralhealth>. Accessed July 17, 2009.

<sup>43</sup> Ibid.

<sup>44</sup> United States District Court, District of Massachusetts. (2009). Civil Action No. **01-CV-30199-MAP** - Children's behavioral health initiative, interim report on implementation. Massachusetts Executive Office of Health and Human Services. From [http://www.mass.gov/Eeohhs2/docs/masshealth/research/chbi\\_interim-court-report.pdf](http://www.mass.gov/Eeohhs2/docs/masshealth/research/chbi_interim-court-report.pdf) Retrieved June 19, 2009; <http://www.rosied.org/content/documents/document.ashx?docid=99621> Accessed January 14, 2010.

<sup>45</sup> Ibid.

<sup>46</sup> <https://service.hhs.state.ma.us/ier/jsp/screening/LoginServlet?Application=Screening> Accessed November 20, 2009.

<sup>47</sup> "At risk" is defined as a combination of any four of a comprehensive list of risk factors that include those affecting infant mental health, such as domestic violence, child abuse or neglect, parental mental illness or poverty.

<sup>48</sup> Over 6.7 percent in FY08 (compared to a 2006 national average of 2.5 percent). Office of Special Education Programs (2008). *Op. cit.*

<sup>49</sup> Reported by Jean Shimer, Massachusetts Department of Public Health, July 2, 2009.



<sup>50</sup> In FY08 only 1 percent of Massachusetts children were eligible for EI under this category, but 13 percent had social-emotional delay in combination with other developmental delays (this percentage was 1.2% in Colorado, where stigma was cited as a factor in avoidance by EI clinicians of the social-emotional label).

<sup>51</sup> Connected Beginnings. *Op. cit.*

<sup>52</sup> Lippit, J. (2005). Building linkages for early childhood mental health: The Massachusetts early childhood linkage initiative. The 18<sup>th</sup> Annual Research Conference Proceedings: A System of care for Children's Mental Health: Expanding the Research Base. Tampa: University of South Florida, Louis de la Parte Mental Health Institute, Research and Training Center for Children's Mental Health. In 2005, *MECLI* found that of 188 children referred to and evaluated by EI programs, two thirds had developmental delays, making them eligible for service. Nearly half of the referrals were under one year of age, and more than a quarter of those evaluated exhibited social-emotional delays. This underscores the importance of identifying and treating this vulnerable population.

<sup>53</sup> <http://www.eec.state.ma.us/>. Accessed July 20, 2009. Education department initiatives were preceded by a Health Foundation of Central MA funded project, *Together for Kids*, where clinically significant behavior problems were found in 35 percent of preschool children. Positive results of evaluation by the University of Massachusetts Medical School help convince the state to expand its support for consultation. With over 27,000 infant, toddler and preschool children in state subsidized slots, funding issues are exacerbated by inadequate workforce capacity. A DEEC needs assessment survey of behavioral health specialists found that although nearly three-quarters had expertise in early childhood mental health, only about a fifth reported infant-toddler expertise. *Together for Kids* found that, at a ratio of 200:1, there would not be enough properly trained social workers to cover all the preschool settings (much less infant-toddler settings) in the Central Massachusetts area.

<sup>54</sup> Rhode Island Department of Children, Youth and Families. Positive Educational Partnerships, <http://www.ripep.org/>. Accessed June 11, 2009.

<sup>55</sup> <http://www.samhsa.gov/Grants/2010/SM-10-005faq.pdf>. Accessed December 8, 2009.

<sup>56</sup> Rosenthal, J. and Kaye, N. (2005). State approaches to promoting young children's healthy mental development: A survey of Medicaid, maternal and child health and mental health agencies. Portland, ME: National Academy for State Health Policy, supported by the Commonwealth Fund.

<sup>57</sup> Cohen, E and Kaufman, R. (2005). *Early Childhood Mental Health Consultation*, (DHHS Pub. No. CMHS-SVP0151. Rockville, MD, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

<sup>58</sup> <http://www.dhs.ri.gov/dhs/famchild/shcare.htm>,  
[http://www.dhs.ri.gov/dhs/reports/rc\\_rs\\_fact\\_sheet\\_eng\\_09.pdf](http://www.dhs.ri.gov/dhs/reports/rc_rs_fact_sheet_eng_09.pdf). Accessed July 2, 2009.

<sup>59</sup> <http://www.health.ri.gov/family/successfulstart/watchmegrowri.php>. *Watch Me Grow* was first funded in Connecticut by the Commonwealth Fund, which is now supporting a similar new initiative in Colorado. Accessed June 17, 2009.

<sup>60</sup> Berger, B. and Dickstein, S. (2009). Successful start: Rhode Island's comprehensive early childhood systems plan. Presented at the RIAIMH Annual Conference, Providence, RI.

<sup>61</sup> *Kidsnet*. <http://www.health.ri.gov/family/kidsnet/index.php>. Accessed November 20, 2009.

<sup>62</sup> In 2007 4.6%. U.S. Department of Education, Office of Special Education Programs (2008). "Report of Infants and Toddlers Receiving Services in Accordance with Part C." (2007). Accessed July 23, 2009.

<sup>63</sup> Title V of the Social Security Act is administered by the Maternal Child Health Bureau of the Health Resources and Services Administration to fund training, demonstration and research aimed at supporting women, children and families in addressing social, behavioral, financial and structural barriers. <http://www.amchp.org/AboutTitleV/Documents/UnderstandingTitleV.pdf>. Accessed November 13, 2009.

<sup>64</sup> Office of Special Health Care Needs RI Department of Health, Rhode Island Parent Information Network, Neighborhood Health Plan of RI, (2007) Pediatric Practice Enhancement Project: Strengthening Rhode Island's Medical Home Infrastructure <http://www.medicalhomeinfo.org/downloads/pdfs/PPEPposter6-20-07.pdf>. Accessed July 2, 2009.

<sup>65</sup> Office of Special Health Care Needs, Rhode Island Department of Health. (2007). "Pediatric practice enhancement project: Strengthening Rhode Island's health care system. From <http://www.medicalhomeinfo.org/States/Downloads/RI/ppep%20poster%206-20-07.ppt>. Accessed June 16, 2009.

<sup>66</sup> National Scientific Council on the Developing Child. (2007). The science of early childhood development. From <http://www.developingchild.net>. Accessed July 23, 2007.

<sup>67</sup> Gilkerson, L. and Kopel, C. (2005). Relationship-based systems change: Illinois' model for promoting social-emotional development in Part C Early Intervention. *Infants and Young Children*, Vol. 18, No. 4, pp. 340-365.

<sup>68</sup> State children's mental health administrator. Interviewed February 25, 2009.

**APPENDIX A. STATE EXAMPLES OF STRATEGIES FOR CHANGE**

	Stakeholder Involvement in Planning	Collaborative Partnerships	Needs Assessment	Shared Learning / Technical Assistance	Social Marketing	Evaluation	Funding Alignment
<b>COLORADO</b> <i>Project BLOOM</i>	<b>Blue Ribbon Policy Council</b> <i>Strategic Plan for Early Childhood Mental Health</i> In state strategic plan <b>ECCS</b> <i>Early Childhood CO Framework</i> Vision for all key areas of child development	<b>Division of Behavioral Health and Addictions</b> Working with Child Welfare, Juvenile Justice, Medicaid, and foundations	<b>JFK Partners</b> <i>Behavioral Health Prevalence Estimates</i> <b>Dept. of Human Services</b> <i>The Cost of Failure</i> Mental health system analysis	<b>Georgetown Policy Academy for Developing Systems of Care</b> Preparation for SAMHSA grant application by project partners	<b>Blue Ribbon Policy Council</b> IECMH toolkits for practitioners, parents, and advocates	<b>JFK Partners</b> Pre and post analysis of child and family functioning	Funding matrix that integrates state revenues, federal block and systems initiative grants, leveraged with foundation funding (Project Braid)
<b>INDIANA</b> <i>Child Welfare Mental Health Screening Initiative</i>	<b>Senate Enrolled Act 529 (2006)</b> <i>Children's Social, Emotional &amp; Behavioral Health Plan</i> Developed by ECCS and many stakeholders, this helped lay ground work	<b>Division of Mental Health &amp; Addiction</b> Medicaid authority working with the Division's Mental Health and Child Welfare departments, with Juvenile Justice support	<b>Indiana University-Purdue University Indianapolis</b> <i>Indiana Local Systems of Care Assessment Project</i> 2004 behavioral health study	<b>Georgetown Policy Academy</b> Learning collaborative for Indiana Family and Social Services Administration	<b>Meeting Place</b> Online resources for parents <b>ECCS</b> Resource and financial fact sheets	<b>Indiana University-Purdue University Indianapolis</b> Annual evaluation of incidence, cost, and recidivism	Medicaid and state Mental Health and Child Welfare dollars
<b>MASSACHUSETTS</b> <i>Children's Behavioral Health Initiative</i>	<b>MassHealth (Medicaid)</b> Request for Information for Medicaid Community Service Agency procurement	<b>Children's Behavioral Health Advisory Council</b> Heads of EOHHS child-serving agencies working together with ECCS director	<b>MassHealth</b> Assessment of numbers of Medicaid SED children in the state	<b>MassHealth</b> Training and consultation by pediatricians in EPSDT mental health screening; Wraparound training	<b>MA Executive Office of Health and Human Services</b> Online information and news alerts	<b>Behavioral Health Research and Training Center</b> Department of Mental Health with private contractor	Medicaid funds by court order, to be supplemented by state child serving agency dollars
<b>Rhode Island LAUNCH</b>	<b>ECCS</b> <i>Early Childhood Strategic Plan</i> Broad stakeholder involvement facilitated by ECCS	<b>Department of Health</b> with Department of Children, Youth, and Families, Brown University, Bradley Hospital and others	<b>Department of Health</b> <i>2005 Medical Home Survey</i> Survey of pediatric & child care providers	<b>SAMHSA</b> Grantee meetings for multiple grants	Each initiative has a Web site	<b>Brown University</b> Evaluation of LAUNCH and Child Care Support Network	Competitive federal grants supplemented by state and some foundation funding

Source: Author's analysis of information from interviews and Web searches.

## APPENDIX B. KEY INFORMANTS

Key informant interviews targeted infant and early childhood mental health (IECMH) leaders in state agencies and programs, including mental health, child welfare, public health, Early Intervention, Healthy Families, and Early Childhood Comprehensive Systems (ECCS) initiatives. Parent organization leaders, staff, and members were also interviewed, as were IECMH practitioners, pediatric providers, and graduate-level teachers and researchers. Members of state affiliates of the World Association of Infant Mental Health in were interviewed in each state.

Key informants were interviewed primarily in person, although some were interviewed via telephone. Group interviews included focus group with parents, an ECCS steering committee, and groups of state agency officials. Key informants were:

### **Colorado**

Jordana Ash  
Eileen Bennett  
Christy Blakely  
Joy Brown  
Nathaniel Ellison  
Bob Emde  
Ardith Ferguson  
Karen Frankel  
Jodi Hardin  
Sarah Hoover  
Phyllis Kickendal  
Lorraine Kubicek  
Megan Marx  
Cheryl Miller  
Maureen Paris  
Steve Poole  
Gina Robinson  
Brian Stafford  
Ayelet Talmi  
Carol Villa  
Carol Wahlgren  
Abby Waldbaum  
Janet Wood  
Sarony Young  
Claudia Zundel

### **Indiana**

Daniel Clendening  
Caroline Doebbeling  
Dawn Downer  
Judy Ganzer  
Audie Gilmer  
Maureen Greer  
Janice Katz  
Susan Lightle  
Kevin Moore  
Melissa Norman  
Angela Tomlin  
Betty Walton  
Andrea Wilkes

### **Massachusetts**

Ron Benham  
Patty Fougere  
Lisa Lambert  
John Lippitt  
Neal Michaels  
Joan Mikula  
Anita Moeller  
Kate Roper  
Emily Sherwood  
Jean Shimer  
Dayana Simon  
Sarah Stephany

### **Rhode Island**

Janet Anderson  
Lee Baker  
Leanne Barrett  
Blythe Berger  
Carrie Bridges  
Christine Campagne  
Ginny Carter  
Missy Deitrich  
Susan Dickstein  
Brenda DuHamel  
Seena Franklin  
Deborah Garneau  
Pam High  
Bill Hollinshead  
Sue Libutti  
Christine Low  
Deb Mickeljohn  
Deborah Milton  
Michelle Palermo  
Larry Puchiarelli  
Ron Seifer  
Peter Simon  
Virginia Stack  
Maureen Whelan  
Charles White