

THE INFANT, PRESCHOOL, FAMILY, MENTAL HEALTH INITIATIVE
**Strategies for Financing Mental Health
Screening, Assessment, and Services**



By Todd Sosna, Ph.D.
California Institute for Mental Health

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Executive Summary

Mental health is critical for happiness and success throughout the lifespan and across all human endeavors. The development of social-emotional competence in early childhood is an important foundation for mental health throughout childhood and into adulthood. However, social-emotional disorders can develop in infancy and early childhood, and can result in significant and persistent distress and impairment for children and their families. Moreover, impairment resulting from social-emotional developmental delays and disorders can affect many areas of child's functioning, including readiness for and performance in school.

Prevention, early intervention and treatment of early childhood social-emotional delays and disorders are available and effective. However, many infants, toddlers, and preschool-age children with social-emotional developmental delays and disorders go unidentified or when identified do not receive needed services and supports. Early identification of social-emotional delays and disorders, and access to services is important for preventing distress and impairment, and improving outcomes for children and their families.

This is one of three guides designed to support early identification of social-emotional developmental delays and disorders, and access to prevention, early intervention and treatment services, for children birth to five years of age. These guides are intended to support School Readiness sites, other state and county First 5 initiatives, and similar efforts on the part of schools, county behavioral health and social services agencies. The other two guides are:

Mental Health Screening and Referral Capacity for Children 0-5, and Compendium of Screening Tools for Early Childhood Social-Emotional Development.

This guide describes strategies for funding early childhood mental health screening, assessment, and treatment. Early identification and treatment of social-emotional delays and disorders improves outcomes for young children and their families, and can result in substantial cost benefits. However, sufficient funding is not currently available to fully meet the need for mental health screening, assessment and treatment for California's children. Fortunately, communities can begin to fill the gaps in funding, and expand early childhood screening, assessment and treatment services, by implementing strategies that maximize funding resources. Key strategies for optimizing financial resources include intervening early, using treatments with proven effectiveness, and taking full advantage of existing funding opportunities. The foundation for these strategies is interagency collaboration at the community level. Each of these strategies is detailed in this guide, along with a discussion of developing and sustaining collaborative programs.

In addition, lessons learned from the Infant Preschool Family Mental Health Initiative (IPFMHI) are highlighted at the end of this guide. IPFMHI was an effort piloted in eight counties to serve very young children (birth to 5 years of age) and their families, with (or at-risk of) social emotional, or behavioral delays or disorders. Funding to support this initiative was received by the California Department of Mental Health from First 5 California starting in 2001.

This joint effort between the Department of Mental Health and the eight participating counties (Alameda, Fresno, Humboldt, Los Angeles, Riverside, Sacramento, San Francisco, and Stanislaus) resulted in protocols in the areas of screening and assessment, consultative models, and improved provider preparedness. This guide summarizes the strategies used by these counties to fund their IPFMHI projects.

Introduction

Development of social-emotional competence in early childhood provides the foundation for later mental health. However, mental health disorders can develop in early childhood and result in significant impairment, adversely affecting a child's emotional well-being and his/her interactions with parents, other caregivers, peers and the world around him/her. As a result, other areas of development can be impacted resulting in persistent and far-reaching difficulties. Fortunately, mental health treatment is effective in preventing and reducing impairment, and promoting early childhood development.

Screening and assessment to identify children with delays or disorders are important first steps in helping families obtain needed and effective mental health care for their children. Early identification and treatment also results in cost benefits by preventing the occurrence of more severe and far-reaching impairment. Unfortunately no single insurance or funding program that covers the full cost of mental health screening, assessment and treatment is currently available in California.

Funding programs are typically restricted by who is eligible to receive services, and what services may be reimbursed. The combination of restricted eligibility and restricted service benefits results in significant gaps in coverage. Moreover, when funding is available, it may only reimburse a portion of the actual costs of providing services, requiring that the local community or provider be responsible for the remainder of the costs. As a consequence, many communities have established interagency collaborative programs that result in two or more funding opportunities, being used together, to reduce or eliminate gaps in funding.

This guide describes strategies for funding early childhood mental health screening, assessment, and treatment. It will outline three basic strategies for optimizing financial resources, along with the importance of interagency collaboration as a foundation for eliminating gaps in funding. In addition, the guide will review mental health-specific funding streams, and share examples from the Infant Preschool Family Mental Health Initiative.

Strategies for Optimizing Financial Resources

Ideally, comprehensive early childhood screening, assessment and treatment would be available to all children. Unfortunately, gaps in funding exist. As a result, some children do not have access to any screening, assessment or treatment due to lack of health insurance, eligibility for a publicly funded program, or personal financial means. Other children do have access to screening, assessment and treatment; however, the services that are available may not be comprehensive due to restrictions on health insurance benefits or program limitations. The following strategies are helpful in optimizing financial resources for early childhood screening, assessment and services in general. However, this guide will describe strategies and funding opportunities in reference to promoting social-emotional development and mental health services specifically.

Strategies for maximizing financial resources involve taking full advantage of existing resources, in addition to available but underutilized funding opportunities. Inevitably, use of these strategies will require interagency collaboration and specialized expertise about a variety of funding programs. However, program design and administration, often overlooked, is also critical to making full use of existing resources. The following three strategies for maximizing early childhood mental health funding, each of which is discussed in turn, involve program and fiscal decisions made in the context of collaborative service systems:

- Intervene early
- Use treatments with proven effectiveness
- Take full advantage of existing funding opportunities

Intervene Early

Financial resources in the long term are maximized by supporting prevention and early intervention services today. Mental health

prevention and early intervention services preserve and promote social-emotional competence, and prevent or attenuate the occurrence of disorders and impairment, resulting in significant cost benefit. Fewer children develop serious emotional disorders and, as a consequence, the need for intensive, prolonged, and expensive treatment is reduced.

The cost effectiveness of publicly funded prevention and early intervention services can and has been documented in clear and compelling ways. The Washington State Institute for Public Policy provides a good example of how the cost effectiveness of publicly supported services can be quantified in their report *Benefits and Costs of Prevention and Early Intervention Programs for Youth* (Aos, S., et al, July 2004).

Despite the broad acceptance of the value of prevention and early intervention services, relatively little public mental health funding is used to support these activities. California's public mental health system does not receive sufficient funding to meet all of the mental health needs of the state's children. As a consequence, the majority of resources target children who are older and have more serious disorders. An examination of how mental health services are funded makes this clear. The state's public mental health services are primarily administered by counties with the majority of services for children being funded under one of the following three programs:

- **Medi-Cal**—Counties, under contract with the California Department of Mental Health, administer Medi-Cal mental health plans. The mental health plans are responsible for administering the specialty mental health benefit of the Medi-Cal program including those covered under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. All full-scope Medi-Cal beneficiaries are entitled to medically necessary specialty

mental health care through the county operated mental health plans. Medical necessity criteria include, among other things, being diagnosed with a mental health disorder that results in impairment in functioning. The EPSDT program provides services to individuals birth to 21 years of age and includes screening, and diagnostic assessments in addition to medically necessary treatment.

- **State-Supported Public Mental Health—**
The state provides funding, known as “realignment,” to counties to support public mental health services. The mental health realignment funding is used to provide mental health care as specified in state statute, the Bronzan-McCorquodate Act. Funding is prioritized under this act for adults with serious mental illness, and children with serious emotional disorders. Serious emotional disorder criteria include, among other things, being diagnosed with a mental health disorder resulting in substantial impairment. Counties serve individuals with the most severe disorders and greatest needs first, with the available realignment funding, including low-income persons who have no insurance. However, counties may, and routinely do, decline to offer services when sufficient funding is not available.
- **Special Education Pupil’s Program—**
Counties are responsible for providing mental health assessments, as requested by schools, and services for children qualified for special education as a result of an emotional disorder. Program requirements are specified in state statute. Services under this program are restricted to special education-qualified children. Qualifying criteria include, among other things, children with a mental health disorder that impairs the child’s ability to benefit from a free and appropriate education.

With the exception of the Medi-Cal EPSDT services, these programs all target children with existing mental health disorders and impairment.

Although EPSDT includes funding for screening and assessment activities, funding for treatment services also requires that a mental health disorder be present. Relatively little funding is available for prevention and early intervention services. In addition, gaps in care exist for low-income individuals who do not have Medi-Cal or moderate-income families with private health insurance that only have a limited mental health benefit. Efforts to promote early childhood mental health need to include prevention and early intervention services, as well as services targeting children with serious disorders in order to optimize financial resources.

USE TREATMENTS WITH PROVEN EFFECTIVENESS

Mental health practices that have proven effectiveness are more likely to result in cost benefits, and therefore the use of these practices is a second important strategy for maximizing financial resources. Although all services are intended to be helpful, an increasing body of research on the effectiveness of mental health treatments indicates that some treatment approaches are more effective than others. As a result of this research, a growing emphasis is being placed on offering services with proven effectiveness.

“Evidence-based practice” is a general term referring to practices with some level of research supporting their effectiveness. Research is designed to investigate the degree to which a particular treatment results in, or is responsible for, the achievement of one or more specific outcomes (child and family goals). The relationship between mental health or social service interventions and the achievement of child and family goals is complicated. The goal of research studies is to sort out the degree to which a particular outcome is the result of the intervention itself, as opposed to other factors in the life of a child and his or her family.

A variety of research designs and methods are helpful in determining the success of a particular treatment. Stronger or better controlled research studies support stronger conclusions about the

effect of the treatment. Treatment effectiveness research is developmental, with increasingly rigorous research progressing over time in the course of investigating a specific practice. Confidence in the degree to which the practice is likely to achieve outcomes comparable to those in published studies, when implemented in local communities, increases when the research has been rigorous, conducted in real-world settings, and replicated by independent investigators (researchers other than the developer of the practice).

Administrators who are responsible for program development need to be knowledgeable about a practice's level of effectiveness. Information about a practice's effectiveness can be challenging to locate; however, a growing number of resources have been developed by federal and state agencies, and universities which help organize and make this information available. Although the terms used to describe levels of treatment effectiveness vary, the following general categories are helpful:



- **Effective and Efficacious**—refers to a practice that consistently achieves positive outcomes, based on a course of rigorous controlled research (random clinical trials) that has been independently replicated. When the research is conducted in real-world settings, it is referred to as effective. When the research is conducted only in controlled settings, it is referred to as efficacious. Confidence in the ability to implement a practice in a new community is higher when the course of research includes studies conducted in real-world settings.
- **Not Effective**—refers to a practice that consistently fails to achieve positive outcome based on a course of rigorous controlled research.
- **Promising**—refers to a practice that has shown positive outcomes based on one or more “quasi-experimental” research studies. Quasi-experimental studies consist of a broad range of methods that are less rigorous than random clinical trials. This level of research is commonly a precursor to random clinical trials.
- **Emerging**—refers to a distinct practice based on a clearly articulated theory that is grounded in the literature, or supported by expert-opinion, and is the focus of planned effectiveness research.
- **Not Researched**—refers to the large number of practices routinely used in real-world settings that have not been the focus of research. These practices may or may not be based on a clearly articulated theory but, in either case, they have not been the focus of any outcome evaluation. The effectiveness of these “usual care” practices is not clear.

It is advisable for administrators to consider the effectiveness of a practice when developing or improving programs, giving priority to practices that have demonstrated effectiveness. However, practices with lower levels of research supporting their effectiveness, including promising and emerging practices, may be strong options when

no suitable alternative practice with a higher level of proven effectiveness is available, or when a deliberate decision is made to implement and evaluate a new or innovative, promising or emerging practice.

Early childhood mental health interventions are highly diverse, varying in terms of treatment model, participants, and service delivery location. Numerous treatment models, for example, behavioral, supportive, and educational, are available. Moreover, interventions may promote early childhood mental health by focusing on the child, caregivers or a combination of the two, and may be provided in groups or to individuals, and delivered in clinics, preschools, childcare facilities, or family home settings. For example:

- Multi-component programs like ***Incredible Years*** include skill development curriculums for parents and for children.
- ***Parent-Child Interaction Therapy*** focuses on the parent-child dyad.
- The ***Early Screening Project*** or mental health consultation approaches focus on teachers or other caregivers.
- The ***Nurse-Family Partnership Program*** is a home visitation approach that supports and assists parents and children.

Given the diversity of practices, additional effectiveness research is needed. However, numerous well-researched, effective treatments, many of which have standardized materials and manuals for use across diverse communities, are available for young children (birth to 5 years old) and their families. Effective treatments include parenting, child skills development, parent-child interaction, preschool- or childcare center-based, and home visitation programs.

The following resources provide well-organized and easy-to-use information about a large number of evidence-based practices:

- SAMHSA Model Programs—sponsored by the federal Substance Abuse Mental Health Services Administration at www.modelprograms.samhsa.gov

- Model Programs Guide—sponsored by the federal Office of Juvenile Justice Delinquency Prevention at www.dsgonline.com/mpg2.5/mpg_index.htm

Again, the Washington State Institute for Public Policy report, ***Benefits and Costs of Prevention and Early Intervention Programs for Youth***, is instructive. A comparison of the cost benefits across programs reveals that some practices are more effective in achieving child and family goals and avoiding costly adverse outcomes, resulting in more cost savings. The selection and implementation of practices with proven effectiveness is a second important strategy for maximizing local resources.

Take Full Advantage of Existing Funding Opportunities

Taking full advantage of all allocated funding and claiming opportunities is a critical third step in optimizing financial resources. Counties administer and provide a large variety of services for children and families supported with federal, state and local funding. In some situations, counties receive a fixed allocation of funding for a particular program, in which the maximum amount of funds available is predetermined. In other situations counties submit claims to be reimbursed for all, or a portion of, the costs of the services they provide.

Examples of fixed allocations include the CalWORKs Substance Abuse Mental Health allocation to reduce mental health and substance abuse barriers to employment, and the Promoting Safe and Stable Families Program to prevent children from being removed from their homes, and to support families in their efforts to reunify with or adopt children who are in foster care. Examples of programs in which counties can submit claims for reimbursement of costs include Medi-Cal for the cost of mental health screening assessment and treatment, and Title IV-E for the cost of some training activities.

Although counties have access to a variety of funding opportunities, and obvious incentives to

make full use of these programs, they can fail to maximize available funding in a number of ways as follows:

- Not using all allocated funds—Under some circumstances, allocated funding must be returned to the state or federal governments if it is not spent within the fiscal year. Returning unspent funding, when unmet need exists, is one significant missed opportunity.
- Not claiming for the cost of eligible services—Similarly, the cost of services provided may not be claimed for reimbursement by a county, even though the service is eligible for reimbursement under a state or federal program.
- Using a state or federal allocation instead of a claiming opportunity—When maximizing resources it is often preferable to prioritize the use of “claiming” opportunities provided by state and federal programs rather than using allocated funding. Allocated funding can be

reserved for services for which there are no other “claiming” opportunities.

Taking full advantage of existing funding opportunities involves first claiming for the cost of services from state and federal programs whenever eligible. Next, fully expending funds allocated from state and federal programs, and finally, using county and local funding for remaining areas of need. This general strategy may be applied within a single service system (for example, mental health, education, public health, or child welfare) or across systems.

The application of these strategies to maximize interagency (cross system) funding offers the greatest benefits to a community but requires the greatest level of interagency collaboration and program coordination. As described in the following section, collaborative programs offer important benefits but are challenging to establish and sustain.

Interagency Collaboration

Numerous state and federal programs, administered by counties, are available to fund services to promote early childhood social-emotional development. Some programs fund services for children who have a disorder, while others fund services that address risk factors. For example, Medi-Cal is available to reimburse for the cost of providing mental health treatment. Whereas, Child Welfare Services allocations fund foster care and child maltreatment prevention programs, Temporary Assistance for Needy Families (CalWORKs in California) funds services to help parents obtain and maintain employment.

Each program has its own regulations concerning how funds can be used, distribution or claiming procedures, required documentation, and program and fiscal audits. These programs often target a specific population; for example, individuals with a mental health disorder in the case of Medi-Cal, or low-income parents and their children in the case of CalWORKs. Moreover, funding for these programs may be restricted to specific activities; for example, mental health screening, assessment and treatment in the case of Medi-Cal, or promotion of parental employment in the case of CalWORKs. Regulations for many of these programs are complicated and detailed. In addition, regulations and procedures are periodically revised. Appropriate use of these programs requires highly specialized knowledge.

Typically each state and federal program is administered by a single public agency, for example Medi-Cal (specialty mental health benefit) is administered by county mental health departments, and CalWORKs is administered by county social services departments. Corresponding federal and state agencies provide oversight and direction. As a result, the expertise necessary to comply with regulations associated with each program can be found within these agencies. Moreover, in most situations the authority to access funds rests with the designated public agency as well.

It would be an extremely daunting task to become expert in all the funding programs that are available to support services that directly or indirectly promote early childhood social-emotional development. Moreover, knowledge of program regulations is not enough to access funding. Typically, the designated county agency is responsible for authorizing use of program funds. As a consequence, interagency collaboration is essential to optimizing funding.

Interagency collaboration provides the expertise and authority to take full advantage of all available funding, and to prioritize programs and funding in ways that build service capacity and maximize federal, state and local resources. Interagency collaboration is the foundation for program planning decisions, for example, to support early intervention and prevention, or to adopt practices with proven effectiveness. In addition, collaboration is the foundation for developing a plan that makes full use of state and federal funding allocations and claiming opportunities.

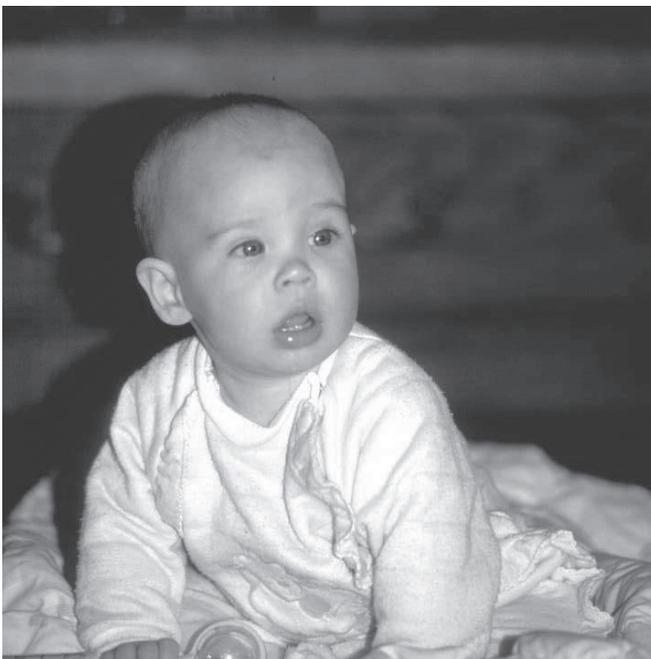
Successful collaborations can be developed between as few as two agencies, and with the goal of maximizing a single funding program. For example, a partnership between a School Readiness site and county mental health agency can be established to provide mental health screening, assessment and treatment for children with emotional disorders. In this example, Medi-Cal and First 5 funding can be used, claiming the former for children who have Medi-Cal and using the latter funding for children who do not have Medi-Cal.

Alternatively, collaborations can be countywide involving multiple agencies (e.g., First 5, county mental health, child welfare, public health, CalWORKs, Head Start) with the goal of maximizing multiple funding programs (e.g., Medi-Cal, child welfare services allocations, CalWORKs Substance Abuse Mental Health

Allocation, Head Start, First 5). Children's Systems of Care are good examples of interagency collaborations that involve multiple agencies. Systems of care, among other things, result in a comprehensive continuum of care supported through interagency collaboration among many agencies. Further information on systems of care is available from:

- California Department of Mental Health at www.dmh.cahwnet.gov/CFPP/csoc_initiative.asp
- Substance Abuse Mental Health Services Administration at <http://www.mentalhealth.samhsa.gov/publications/allpubs/KEN95-0016/default.asp>

Although the benefits of interagency collaboration are substantial, establishing and maintaining interagency collaborative programs is challenging. Each agency has unique authorities, expertise and funding that can be used to make complimentary program decisions and maximize funding opportunities. However, they also have unique responsibilities to administer services that assist children and families with particular areas of need. For example, county mental health departments, through the mental health plans, are responsible for providing screening, assessment



and specialty mental health treatment to children with Medi-Cal. Whereas, child welfare services is responsible for protecting children who have been maltreated, and for preventing subsequent maltreatment. These agencies are stewards of public funds and responsible for its appropriate use. As a result, participation in a collaborative endeavor needs to be consistent with each agency's unique responsibilities.

Successful interagency collaboration is characterized by mutual benefit amongst its partner agencies so that accomplishment of each agency's individual responsibilities are advanced to a greater degree through the collaboration than could be achieved if the agency operated alone. In other words an effective collaboration exists when the "whole is greater than the sum of its parts."

Many counties have already established very successful interagency collaborative policy groups and programs, perhaps as part of a Children's System of Care. These counties have a history of mutual trust, sharing of information, common vision for children and families, and interagency policies and procedures that are all important in sustaining effective collaborative programs. Where there is a strong history of interagency collaboration, a School Readiness site may be in a position to build on the existing collaborative structures to support a focus on early childhood social-emotional development. However, if a county has no history of successful interagency collaboration, the School Readiness site may proactively initiate and lead efforts to establish collaborative agreements, programs and funding.

Initiating and Leading a Collaborative Program

Establishing a successful interagency collaborative is a challenging but rewarding endeavor. School Readiness sites will need to establish a foundation of open communication, understanding, and shared expectation for mutual benefit prior to discussing shared programs or funding. The following steps are offered as a guide to initiating and leading a collaborative.

1. **Be patient.** Establishing a successful collaborative takes time.
2. **Listen and learn.** Take the initiative to contact the agency administrators of potential collaborative partners. Meet with these administrators, one agency at a time; avoid rushing into meetings with multiple agencies. During the early meetings, learn about each agency's areas of responsibilities, authorities, programs and funding sources. Ask about areas of unmet need and current or planned initiatives. Convene these meetings in order to listen and learn about the work of other agencies, not to ask for funding for School Readiness site priorities.
3. **Identify areas of potential mutual benefit.** Based on the information gathered about the priorities and work of other agencies, begin to identify areas of mutual benefit. Specifically, determine how the prevention, early intervention and/or treatment programs that promote early childhood social-emotional development can also promote achievement of goals that are the responsibility of one or more other agencies.
4. **Build shared vision.** Build upon newly established relationships with the administrators of potential collaborative partners by sharing ideas for programs that have mutual benefit. Convene meetings with administrators from one or (at this stage) multiple agencies to share ideas about joint projects. Provide a compelling rationale for how the proposed programs have mutual benefit. Be receptive to feedback about the proposal. Be prepared to amend the proposal so that it better fits the priorities and needs of partner agencies.
5. **Get concrete.** After an agreement is reached on the proposed project(s), establish interagency work groups to develop detailed plans. Work groups typically include managers and supervisors (including those responsible for program, human resources, fiscal, and quality assurance),

direct service staff, and consumers. Program planning includes, at a minimum, policies and procedures, work instructions, and memorandums of agreement. Moreover, target clientele, providers, referral procedures, responsible administrator(s), and program and fiscal documentation need to be included in the plans.

Rationale for Mutually Beneficial Early Childhood Mental Health Programs

Developing programs that achieve mutual benefit is a core element of a successful interagency collaboration. Moreover, the expectation of mutual benefit is a primary motivator during the planning and early implementation phases of a collaborative program. Whereas, demonstrating improved outcomes becomes important in maintaining and sustaining the program over time.

Partnerships among county agencies (e.g., mental health, social services, public health, or probation) and schools, private foundations, community-based organizations and School Readiness sites are beneficial to all. The following outlines a rationale to illustrate how expectation for mutual benefit can be developed.

- **Young children do experience social-emotional delays and disorders.** Mental health is critical for happiness and success throughout the lifespan and across all human endeavors. The development of social-emotional competence in early childhood is a critical foundation for mental health throughout childhood and into adulthood. However, social, emotional and behavioral disorders can, and do, develop in infancy and early childhood.
- **Social-emotional delays and disorders can result in significant impairment.** Mental health disorders can, and do, result in significant and persistent distress and impairment for children and families. Social emotional development delays and disorders can adversely affect other areas of child development, including a child's readiness

for, and performance, in school (U.S. Department of Health and Human Services, 1999). Moreover, social-emotional disorders are associated with higher incidences of child maltreatment, school failure, drug abuse, and criminal behavior in later childhood and adolescence.

- **Prevention and early intervention work.**

Prevention and early intervention programs are successful in reducing the incidence of more severe impairment, and result in significant cost-benefits. Again, the Washington State Institute for Public Policy report, *Benefits and Costs of Prevention and Early Intervention Programs for Youth*, is a good example of a real-world application of research on cost-effectiveness.

- **Children in need of services can be identified.** Factors that promote social-emotional development, and factors that put young children at risk of developing an emotional or behavioral disorder have been well studied. Moreover, good screening tools and assessments for identifying children with (or at-risk of) a social-emotional delay or disorder are available.

- **Effective interventions are available.** Numerous prevention and early intervention practices that have proven effectiveness in

promoting early childhood social-emotional development, and in preventing adverse long-term outcomes, including child maltreatment, substance abuse, school failure, and juvenile crime are available.

- **Prevention and early intervention services are under-funded.** Funding for public mental health is not sufficient to meet the needs of children with (and at-risk of) emotional and behavioral disorders. As a consequence, funding is prioritized for children who experience the most serious needs and impairment. These children tend to be older, and often are involved in the special education, child welfare, substance abuse treatment, and/or juvenile justice systems.

- **Through interagency collaboration, mutual outcomes for children and families can be achieved.** Through interagency collaboration, funding resources can be optimized to support prevention and early intervention services for children with (or at-risk of) social-emotional delays and disorders. Many of these interventions involve parenting skills and improving parent-child interactions. The long-term effects of these services includes improved school performance, and decreased child maltreatment, drug abuse and juvenile crime.

Funding Opportunities

This section presents brief descriptions of funding programs that support activities promoting early childhood social-emotional development. Particularly relevant opportunities are featured; however, the list is not exhaustive. Moreover, the applicability of the featured programs may change over time. Therefore, readers are strongly encouraged to partner with local public agencies and private organizations to explore the available opportunities that are most appropriate for their communities. Each summary includes:

- Descriptions of the opportunity
- Overview of the funding program
- Citations for further information
- Challenges and solutions

The descriptions are brief and intended to prepare the reader to start a dialogue with local public agencies and private organizations about potential collaborative programs. However, the programs listed have complex regulations and procedures that exceed those presented in the summaries. Again, School Readiness sites need to work collaboratively with local agencies that have the responsibility and expertise to administer these programs.

Medi-Cal (Medicaid) Early Periodic Screening Diagnosis and Treatment (EPSDT)

Opportunity

Medi-Cal can fund the cost of mental health screening, assessment and treatment, when provided by a county mental health plan, on behalf of Medi-Cal beneficiaries. Requires partnership with county mental health department. Federal and state reimbursement can be as high as 95% of the cost of services.

Overview

Medicaid is a federal health insurance program for low-income individuals administered by the states. California's Medicaid program is called Medi-Cal. Medi-Cal includes a mental health benefit. Medi-Cal also includes early and periodic screening, diagnosis and treatment (EPSDT) services for individuals under the age of 21.

The California Department of Health Services administers the Medi-Cal program. The California Department of Mental Health has an agreement with the Department of Health Services to oversee the specialty mental health benefit. The Department of Mental Health has, in turn, established contracts with county-operated mental health plans to administer the specialty mental health services on behalf of Medi-Cal beneficiaries residing in their county.

Specialty mental health services are provided when certain conditions are met, among others, the beneficiary must be experiencing an included disorder with impairment, and need specialty care (as opposed to mental health treatment that can be obtained through the general health care system). In addition, mental health screening and assessment activities are covered under the EPSDT program.

To be eligible for reimbursement, the service must be covered under the state's Medi-Cal program, and be provided by an organization or individual clinician who has been selected by, and has a contract with, the mental health plan.

Medi-Cal specialty mental health services are reimbursed through a combination of federal, state and county funding. Reimbursement is based on the actual cost of providing services. The full cost of services is reimbursable as long as they do not exceed maximum rates established by the state. Reimbursement is about 51% federal (based on the federal medical assistance percentage) and 49% matching (county or state) funding. State general funds are available to match the cost of EPSDT outpatient services beyond a baseline level. The state reimbursement of EPSDT services is about 44%, with the county being responsible for the remaining 5% of the cost of services.

Citations

California Medi-Cal Mental Health Plans

- Administered by the California Department of Health Services—<http://www.dhs.ca.gov/>
- Specialty mental health benefit administered by the California Department of Mental Health—<http://www.dmh.cahwnet.gov/>
- Mental health plan regulations California Code of Regulation Title 9, Division 1, Chapter 11 starting with Section 1810.100—<http://www.calregs.com/default.htm>

Federal Medicaid Program (Title XIX of the Social Security Act)

- Administered by the United States Department of Health and Human Services—<http://www.hhs.gov/>
- Centers for Medicaid & Medicare Services—<http://www.cms.hhs.gov/medicaid/mover.asp>

**Medi-Cal (Medicaid)
Early Periodic Screening Diagnosis and Treatment (EPSDT)**

Challenges	Solutions
Reimbursement is only available for individuals with Medi-Cal who meet criteria for specialty mental health service, which includes evidence of a disorder, impairment, and need for specialty care.	<p>Allowable disorders include those commonly experienced by children birth to 5 years of age. In addition, screening and assessment activities prior to confirmation of a disorder are covered services under EPSDT.</p> <p>Some agencies that work with young children express concern about diagnosing or “labeling” children. Sensitivity in working with parents is critical when discussing any diagnosis. Moreover, confidentiality of the mental health records needs to be strictly maintained. Finally, concerns about the use of diagnostic labels may be related to stigma about mental illness. Efforts to reduce stigma associated with mental health disorders and treatment will be important.</p>
Reimbursement is only available for services provided by an organization or individual clinician who is a contract provider for the county Mental Health Plan.	County mental health plans have existing contracts with organizational providers and individual clinicians. Moreover, mental health plans may establish additional contracts with new organizations and/or clinicians as needed.
Requires county or state (non-federal) matching funds.	Funding allocated to county mental health departments that can be used to match federal programs is limited; however, through interagency collaboration and application of strategies described in this guide match funding may be identified.
Requires documentation including an assessment, service plan and progress notes.	<p>Documentation of mental health screening, assessment and treatment requires dedicated time. However, documentation is an important part of care planning, continuity of treatment and accountability, independent of any claiming considerations.</p> <p>Existing county mental health providers are familiar with Medi-Cal documentation requirements. New providers can learn these standards with assistance from the county, a local organizational provider who demonstrates exemplary documentation, or a mental health Medi-Cal consultant.</p>
Requires documentation of program costs.	Existing mental health providers are familiar with documentation of program costs. New providers can learn these procedures with assistance from the county, or consultation with a Medi-Cal cost report consultant.
Claims are subject to program and fiscal audits and corresponding denial of payment when requirements are not met.	Good planning, careful attention to program and fiscal requirements, and diligent self-monitoring will limit disallowances. Agencies interested in Medi-Cal will need to dedicate staff to develop expertise in program and fiscal regulations and requirements.

Healthy Families Program (State Children's Health Insurance Program)

Opportunity

Healthy Families Program can fund the cost of mental health treatment, when provided by county mental health agencies, for a Healthy Families Program recipient. Requires partnership with county mental health. Federal reimbursement is about 66% of the cost of services.

Overview

State Children's Health Insurance Program is a national health insurance program for uninsured low-income children administered by the states. California's State Children's Health Insurance Program is called Healthy Families Program.

The California Managed Risk Insurance Board (MRMIB) oversees the Healthy Families Program. The Healthy Families Program includes a mental health benefit. The mental health benefit is divided into a basic benefit (administered by the recipient's health plan), and a seriously emotionally disturbed (SED) benefit (administered by the county mental health agencies).

The basic benefit is provided by the recipient's health plan and includes:

- Outpatient services, 20 visits annually with a small co-payment
- Mental health inpatient hospital services, up to 30 days annually
- Alcohol and drug abuse inpatient as medically necessary
- Alcohol and drug outpatient services, 20 visits annually with a small co-payment
- Prescription medication

The SED benefit is provided by county mental health agencies for children who show a serious emotional disorder. SED criteria are specified in California's Welfare and Institutions Code (Bronzan-McCorquodale Act), and among others, the child must be experiencing an included disorder with substantial impairment. Children who are determined by county mental health agencies to have a serious emotional disorder have access to a full range of medically necessary services to the extent resources are available.

The services provided by county mental health agencies under the Healthy Families Program are the same as those provided under the Medi-Cal program. To be eligible for reimbursement, the service must be covered under the state's Medi-Cal program, and be provided by an organization or individual clinician who has been selected by and has a contract with the county mental health agency.

Healthy Families Program services provided by county mental health agencies are reimbursed through a combination of federal and matching (county or state) funding. Reimbursement is based on the actual cost of providing services. The full cost of services is reimbursable as long as they do not exceed maximum rates established by the state. Reimbursement is about 66% federal, and 33% matching (county or state) funding.

Citations

California Healthy Families Program

- Administered by the California Managed Risk Medical Insurance Board—<http://www.mrmib.ca.gov/>
- Seriously emotionally disturbed criteria as specified in California Welfare and Institution code Sections 5600-5623.5(Bronzan-McCorquodale Act)— <http://www.leginfo.ca.gov/calaw.html>

Federal State Children's Insurance Program (Title XXI of the Social Security Act)

- Administered by the United States Department of Health and Human Services—<http://www.hhs.gov/>
- Centers for Medicaid & Medicare Services—<http://www.cms.hhs.gov/medicaid/mover.asp>

Healthy Families Program (State Children's Health Insurance Program)

Challenges	Solutions
<p style="color: red;">Mental health services for children with serious emotional disorders provided by county mental health agencies or their contract providers involve the same challenges as those associated with using Medi-Cal, including:</p> <ul style="list-style-type: none"> • Evidence of a disorder and impairment • Services provided by the county or a provider who has a contract with the county • Need for local (county or state) matching funds • Treatment and fiscal documentation requirements • Program and fiscal audits with the potential for payment disallowance. <p>See the summary of Medi-Cal for specifics.</p>	<p>The solutions described for using Medi-Cal will also apply for the use of the Healthy Families Program when provided by county mental health agencies or their contract providers.</p> <p>See the summary of Medi-Cal for specifics.</p> <p>In addition, families may receive mental health assessments and treatment under the basic benefit through their Healthy Families Program health plan.</p>

Targeted Case Management

Opportunity

Targeted Case Management can fund the cost of case management services, when provided under the authority of a local governmental agency, for a Medi-Cal beneficiary meeting the targeted case management target population. Requires an agreement with the local governmental agency. Federal reimbursement is about 51% of the cost of allowable services provided to eligible individuals.

Overview

Medicaid is a national health insurance program for low-income individuals administered by the states. Medicaid includes case management that may be provided by social service agencies other than health or mental health providers (for example, child welfare, probation, public health, and so forth). Medicaid case management is defined as a service that will assist an individual, eligible under the state plan, in gaining access to needed medical, social, educational, and other services.

California offers targeted case management under the Medi-Cal program administered by the California Department of Health Services. The program consists of case management services that assist Medi-Cal-eligible individuals, within specified targeted populations, to gain access to needed medical, social, educational, and other services.

California has identified six target populations of which one, called "Community," is particularly relevant for School Readiness sites. The Community target population consists of Medi-Cal-eligible adults and children at risk of abuse and unfavorable developmental, behavioral, psychological, or social outcomes including the following individuals:

1. Persons abusing alcohol or drugs, or both
2. Persons at risk of physical, sexual, or emotional abuse
3. Persons at risk of neglect

Allowable services include:

1. Documented assessment
2. Individualized service plan development
3. Linkage and consultation
4. Assistance in accessing services
5. Periodic review
6. Crisis assistance planning

Providers of targeted case management are limited to local governmental agencies (counties or chartered cities) under contract with the Department of Health Services, as identified in the California State Plan. Local agencies need to have an agreement with their local governmental agency to be a targeted case management provider. Services are reimbursed, based on actual costs of providing services to eligible individuals. Time studies and cost reports are used to account for services and costs. Reimbursement is about 51% federal (based on the federal medical assistance percentage) and 49% matching (county or state) funding.

Citations

State Medi-Cal Targeted Case Management

- Administered by the California Department of Health Services—<http://www.dhs.ca.gov/>
- Targeted case management authorizing legislation California Welfare and Institution Code Sections 14132.44, 14132.47, 14132.48 and 14132.49—<http://www.leginfo.ca.gov/calaw.html>
- Targeted case management governing regulations California Code of Regulations Title 22, Division 3, Chapter 3—<http://www.calregs.com/default.htm>

Federal Medicaid Targeted Case Management (Title XIX of the Social Security Act)

- Administered by the United States Department of Health and Human Services —<http://www.hhs.gov/>
- Centers for Medicaid and Medicare Services—<http://www.cms.hhs.gov/medicaid/mover.asp>

Targeted Case Management

Challenges	Solutions
Reimbursement is only available for case management services provided to individuals with Medi-Cal who meet the target populations.	The number of children and families qualified under the “Community” target population may overlap substantially with those served by the School Readiness sites.
Reimbursement is limited to allowable (case management) activities.	Case management is a commonly needed service, and may be important for helping children and families served by School Readiness sites.
Reimbursement is only available for services provided by an organization that has an agreement with their local governmental agency.	If targeted case management is available in your county, then a local governmental agency has been established and has developed the expertise to support targeted case management claiming. The School Readiness site will need to identify this agency and seek a collaborative agreement.
Requires county or state (non-federal) matching funds.	Funding allocated to counties that can be used to match federal programs is limited; however, through interagency collaboration and application of strategies described in this guide match funding may be identified.
Requires documentation including time study of activities, assessments, service plans, and so forth.	Existing targeted case management providers are familiar with documentation requirements. New providers can learn these requirements with assistance from the local governmental agency.
Claims are subject to program and fiscal audits and corresponding denial of payment when requirements are not met.	Good planning, careful attention to program and fiscal requirements, and diligent self-monitoring will limit disallowances. Agencies interested in targeted case management will need to dedicate staff to develop expertise in program and fiscal regulations and requirements.

Medi-Cal Administrative Activities

Opportunity

Medi-Cal Administrative Activities claiming can fund the cost of administering the Medi-Cal program, including assisting individuals who are potentially eligible for Medi-Cal to complete an application, and the provision of non-emergency, non-medical transportation to Medi-Cal services. Requires an agreement with the local governmental agency or local educational consortia. Federal reimbursement varies from 50-75% of the cost of allowable services provided to eligible individuals.

Overview

Medicaid is a national health insurance program for low-income individuals administered by the states. The costs associated with the administration of the Medicaid program may be reimbursed. In California, Medicaid is called Medi-Cal and administered by the California Department of Health Services. Claimable Medi-Cal administrative activities include:

- *Medi-Cal Outreach*—Brings potential eligible individuals into the Medi-Cal system for the purposes of determining eligibility, and assist Medi-Cal eligible individuals to obtain Medi-Cal covered services.
- *Facilitating Medi-Cal Application*—Explains the Medi-Cal eligibility rules and processes to applicants, assists an applicant in filling out a Medi-Cal eligibility application, gathers information related to the application, and provides necessary forms, and packages all forms.
- *Medi-Cal Non-Emergency, Non-Medical Transportation*—Arranges and/or provides non-emergency, non-medical transportation of Medi-Cal-eligible individuals to Medi-Cal services, and when medically necessary, accompaniment by an attendant.
- *Program Planning and Policy Development for Medi-Cal*—Develops strategies to increase Medi-Cal system capacity and close Medi-Cal service gaps, coordinates with other agencies and entities to improve delivery of Medi-Cal services, and develops resource directories of Medi-Cal services and providers.
- *Medi-Cal Administrative Activities Coordination, Claims Administration, and Contracting for Medi-Cal Services*—Drafts, revises and submits Medi-Cal administrative activities claiming plans; serves as the liaison with claiming program with the local governmental agency or educational consortia; administers local governmental agency or educational consortium claiming, attends trainings or meetings involving Medi-Cal administrative activities; trains local governmental agency or educational consortia staff or subcontractors on state, federal and local requirements of Medi-Cal administrative activities; insures that Medi-Cal administrative activities claims do not duplicate Medi-Cal claims for the same activities from other providers; or administers contracts.

Providers of Medi-Cal administrative activities are limited to local governmental agencies (counties or chartered cities) or local educational consortia under contract with the California Department of Health Services, as identified in the California State Plan. Local agencies need to have an agreement with their local governmental agency or local educational consortia to claim for Medi-Cal administrative activities. Activities reimbursed are based on actual costs of providing services to eligible individuals. Time studies and cost reports are used to account for services and costs. Reimbursement varies from 50% federal and 50% matching (county or state) funding, to 75% federal and 25% matching (county or state) funding.

Citations

State Medi-Cal Administrative Activities

- Administered by the California Department of Health Services—<http://www.dhs.ca.gov/>
- Medi-Cal Administrative Activities Program authorizing legislation California Welfare and Institution Code Section 14132.47—<http://www.leginfo.ca.gov/calaw.html>

Federal Medicaid Administrative Activities (Title XIX of the Social Security Act)

- Administered by the United States Department of Health and Human Services —<http://www.hhs.gov/>
- Centers for Medicaid & Medicare Services—<http://www.cms.hhs.gov/medicaid/mover.asp>

Medi-Cal Administrative Activities

Challenges	Solutions
<p>Reimbursement is limited to allowable Medi-Cal administrative activities.</p>	<p>Assisting individuals obtain Medi-Cal is a commonly needed service, and may be important for helping children and families served by School Readiness sites.</p> <p>In addition, increased access to Medi-Cal benefits will increase the number of children who will be eligible for Medi-Cal EPSDT services.</p>
<p>Reimbursement is only available for services provided by an organization that has an agreement with their local governmental agency or local educational consortia.</p>	<p>If Medi-Cal administrative activities are available in your county, then a local governmental agency and/or local educational consortia has been established and has developed the expertise to support Medi-Cal administrative activities claiming. The School Readiness site will need to identify this agency or consortia and seek a collaborative agreement.</p>
<p>Requires county or state (non-federal) matching funds.</p>	<p>Funding allocated to counties that can be used to match federal programs is limited; however, through interagency collaboration and application of strategies described in this guide, match funding may be identified.</p>
<p>Requires documentation including time study of activities.</p>	<p>Existing Medi-Cal administrative activities providers are familiar with documentation requirements. New providers can learn these requirements with assistance from the local governmental agency or local educational consortia.</p>
<p>Claims are subject to program and fiscal audits and corresponding denial of payment when requirements are not met.</p>	<p>Good planning, careful attention to program and fiscal requirements, and diligent self-monitoring will limit disallowances. Agencies interested in Medi-Cal administrative activities will need to dedicate staff to develop expertise in program and fiscal regulations and requirements.</p>

California Work Opportunity and Responsibility to Kids—CalWORKs (Temporary Assistance For Needy Families) Substance Abuse Mental Health Allocation

Opportunity

The CalWORKs Substance Abuse Mental Health Allocation can fund the cost of mental health treatment (and/or substance abuse treatment) for parents and/or their children, when it is in support of the CalWORKs recipient's welfare-to-work plan. Requires partnership with county social services agencies. Each county receives an annual substance abuse mental health allocation.

Overview

Temporary Assistance for Needy Families is a national block grant to support welfare programs for needy families implemented by the states. California's Temporary Assistance for Needy Families is called California Work Opportunity and Responsibility for Kids (CalWORKs).

CalWORKs is administered by the California Department of Social Services, and implemented through county welfare departments. CalWORKs recipients and their children may be eligible for an array of health, food, childcare, and employment services. Moreover, counties receive a substance abuse mental health allocation to assist recipients overcome substance abuse and/or mental health barriers to work.

Specific CalWORKs eligibility requirements take into account an applicant's citizenship, age, income, resources, assets and other factors. Generally, services are available to:

- Families that have a child(ren) in the home who has been deprived of parental support or care because of the absence, disability or death of either parent.
- Families with a child(ren) and both parents in the home, but the principal earner is unemployed.
- Needy caretaker relatives of a foster child(ren).

Many programs and benefits are available for which a CalWORKs family may qualify, including:

- Food stamps
- Child support from an absent parent
- Family planning
- Child Health and Disability Prevention (CHDP) preventive medical check-ups
- Medical coverage
- Welfare-to-work program
- Social services
- Childcare

A key provision of the CalWORKs program is the inclusion of substance abuse and mental health services as components which meet work participation requirements. CalWORKs substance abuse- and mental health-funded services may include, but are not limited, to:

- Evaluation, assessment and case management
- Treatment, including rehabilitative services, employment counseling and provision of community service jobs
- Treatment for family members, if the mental health or substance abuse problem interferes with ability to participate in the welfare-to-work program
- Outreach and marketing of services
- Capacity building

Each county receives an annual substance abuse mental health allocation. Funding is made available through the county welfare department, and may be used for a wide variety of services and supports, including mental health treatment for parents and/or their children. It is noteworthy, that most CalWORKs recipients and their children will be eligible for Medi-Cal. Medi-Cal may be available to fund mental health screening, assessment and treatment (as described in the Medi-Cal summary). In order to optimize local funding, the substance abuse mental health allocation can be prioritized for the cost of services and supports that are not eligible for Medi-Cal reimbursement.

Citations

California Work Opportunity and Responsibility to Kids (CalWORKs)

- Administered by the California Department of Social Service—<http://www.dss.ca.gov>
- Substance Abuse Mental Health Allocation, California Department of Social Services, All County Information Notices (ACIN) Number 1-16-00

Federal Temporary Assistance for Needy Families (Social Security Act Title IV, Part A, Personal Responsibility and Work Opportunity Reconciliation Act of 1996)

- Administered by the United States Department of Health and Human Services—<http://www.hhs.gov/>
- Administration for Children & Families—<http://www.acf.dhhs.gov/programs/ofa/>

**California Work Opportunity and Responsibility to Kids–CalWORKs
(Temporary Assistance For Needy Families)
Substance Abuse Mental Health Allocation**

Challenges	Solutions
<p>Reimbursement is restricted to CalWORKs recipients and their children, most of whom are eligible for Medi-Cal and therefore have access to mental health screening, assessment and treatment.</p>	<p>Children living in or near poverty are at greater risk of social-emotional delays or disorders; therefore, the children of CalWORKs recipients are likely to show increased need for services and supports.</p> <p>Medi-Cal is available for most children of CalWORKs recipients to fund screening, assessment and medically necessary treatment; however, other preventive services and supports not reimbursed by Medi-Cal can potentially be funded with the substance abuse mental health allocation.</p>
<p>The substance abuse mental health allocation is intended to assist CalWORKs recipients achieve and maintain employment. How are services targeting the young children of CalWORKs recipients related to achievement of work goals?</p>	<p>The demands of parenting are substantial. When children experience social-emotional delays or disorders, their needs can interrupt a parent's efforts to obtain and maintain employment. Moreover, success with parenting activities is very reinforcing to parents and may support their efforts to achieve their employment goals.</p>
<p>The substance abuse mental health allocation is a limited amount of money; therefore, use of these funds for early childhood mental health services competes with other potential uses of these funds in supporting the CalWORKs recipients' efforts to achieve and maintain employment.</p>	<p>In some counties the substance abuse mental health allocation may not be fully expended each year reducing competition for these funds.</p> <p>However, even in counties where the allocation is fully expended, there may be agreement that use of these funds to support activities that both address early childhood mental health and parent work goals (for example an evidence-based parenting program) is a mutual priority.</p>

Child Welfare Services (Federal Foster Care and Adoption Assistance, and Promoting Safe and Stable Families)

Opportunity

Child Welfare Services in California is funded by an array of federal and state programs which support a broad range of prevention and intervention services for children and families. These services target children who have experienced maltreatment or are at-risk of maltreatment, and children involved in the foster care system or at-risk of involvement. Requires partnership with county social services agencies. Each county receives a combination of federal and state funding including allocations and opportunities to claim for service costs.

Overview

The California Department of Social Services, Children and Family Services Division¹, is responsible for developing and overseeing a vast array of programs and services for California's at-risk children and families. California's program for child protection is comprised of a number of services and interventions called Child Welfare Services. These services are organized into programs which together form a continuum of efforts aimed at safeguarding the well-being of children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence. Generally, the continuum can be broken down into four broad categories:

- Programs and services intended to prevent abuse or strengthen families
- Programs and services intended to remedy the effects of abuse or neglect (e.g., emergency response, family maintenance and family reunification)
- Programs and services that provide for the out-of-home care of children (e.g., foster care and relative home placements)
- Programs and services that provide for the permanent removal of children from abusive homes (e.g., adoptions, legal guardianship, kinship care).

Counties are responsible for administering child welfare services programs including activities that strengthen families, prevent child maltreatment, and promote early childhood safety and well-being. Services are provided by county staff and through contracts with community-based organizations. Counties receive federal and state funding consisting of allocations and claiming opportunities including the following federal programs:

- Title IV-B Sub-Part 1 (Child Welfare Services)
- Title IV-B, Subpart 2 (Promoting Safe and Stable Families)
- Title IV-E Foster Care and Adoption Assistance Program

It is noteworthy, that many children involved in the child welfare system will be eligible for Medi-Cal. Medi-Cal may be available to fund mental health screening, assessment and treatment (as described in the Medi-Cal summary). In order to optimize local funding, the child welfare services funding can be prioritized for the cost of services and supports that are not eligible for Medi-Cal reimbursement.

Citations

California Child Welfare Services

- Administered by the California Department of Social Service—<http://www.dss.cahwnet.gov>
- Children and Family Services Division, Child Welfare—http://www.childsworld.ca.gov/ChildWelfa_312.htm

Child Welfare Services (Social Security Act Title IV-B, Subpart 1)

Promoting Safe and Stable Families (Social Security Act Title IV-B, Subpart 2)

Federal Foster Care and Adoption Assistance (Social Security Act Title IV-E)

- Administered by the United States Department of Health and Human Service—<http://www.hhs.gov/>
- Administration for Children and Families—<http://www.acf.dhhs.gov/programs/ofa/>
- Children's Bureau—<http://www.acf.hhs.gov/programs/cb/>
- Child Welfare League of America²—<http://www.cwla.org/>

¹ The summary of California's Child Welfare Services is based on the Child Welfare Services/Case Management System Program Overview published on the California Department of Social Services website (http://www.childsworld.ca.gov/ChildWelfa_355.htm)

² A thorough summary of federal child welfare services funding has been published by the Child Welfare League of America in their advocacy brief titled Funding Resources for Child Welfare (<http://www.cwla.org/advocacy/financingfunding.htm>).

Child Welfare Services
(Federal Foster Care and Adoption Assistance,
and Promoting Safe and Stable Families)

Challenges	Solutions
<p>Reimbursement is restricted to activities that support Child Welfare Services' goals and target children, many of whom are eligible for Medi-Cal, and therefore have access to mental health screening, assessment and treatment.</p>	<p>Children with social-emotional delays or disorders are at increased risk of child maltreatment. Services and supports that improve parenting skills and promote early childhood social-emotional development can strengthen families and reduce the risk of child maltreatment.</p> <p>Medi-Cal is available for many children involved in the child welfare system to fund screening, assessment and medically necessary treatment; however, other preventative services and supports not reimbursed by Medi-Cal can potentially be funded with Child Welfare Services programs, in addition to supporting services for children who do not have Medi-Cal.</p>
<p>Child Welfare Services' allocations are a limited amount of money; therefore, use of these funds for early childhood mental health services competes with other potential uses of these funds in supporting child abuse prevention and foster care activities.</p>	<p>In some counties portions of their Child Welfare Services' allocations may not be fully expended each year reducing competition for these funds.</p> <p>However, even in counties in which all allocations are fully expended, there may be agreement to use some of these funds to support activities that target high-risk children birth to 5 years of age and their families, for example, by providing an evidence-based parenting or foster care program. This focus may be particularly relevant, given that about 44% of the children who contact the child welfare system are under the age of 5.</p>
<p>Federal claiming opportunities require county or state (non-federal) matching funds.</p>	<p>Funding allocated to county social services agencies that can be used to match federal programs is limited; however, through interagency collaboration and application of strategies described in this guide match funding may be identified.</p>

Special Education Pupil's Program, Early Start (Individuals With Disabilities Education Act–Part C), Individuals With Disabilities Education Act–Part B, and Even Start

Opportunity

Children birth to 5 years of age with identifiable disabilities may qualify for an array of special education services. In California, special education services for children birth to 3 years of age are provided through the Early Start Program, administered by the California Department of Developmental Services through Regional Centers and local education agencies. Special education services for children 3 to 5 years of age are administered by local educational agencies and Special Education Local Planning Areas. In addition, county mental health agencies are responsible for providing mental health services to children who qualify for special education as a result of an emotional disorder (applicable to children 3 years of age and older). Special education services are funded by federal and state allocations.

In addition, low-income families with young children may qualify for an array of “family literacy” services through the Even Start Program. In California, Even Start is administered by the California Department of Developmental Services which provides grants to local educational agencies and community-based organizations.

It is important for School Readiness sites to coordinate services they provide with those provided through Early Start, schools, and Even Start to maximize access to needed services and reduce redundancy. Although special education services are funded through federal and state allocations, the cost of special education services typically exceeds these allocations. Collaboration between School Readiness sites, schools, Regional Centers, and county mental health agencies to promote early childhood social-emotional development can support efforts to maximize funding from Medi-Cal, Healthy Families Program, and special education programs.

Overview

The Individuals with Disabilities Education Act (IDEA) is federal legislation to ensure access to a free and appropriate education and early intervention programs for children with disabilities, administered by the states. The Individuals with Disabilities Education Act has provisions for children from birth to 3 years of age, and 3-5 years of age.

In California, special education services for children birth to 3 years of age (IDEA Part C) is called Early Start, and administered by the California Department of Developmental Services (which contracts with local Regional Centers) in partnership with the California Department of Education. Eligible children have a qualified disability, and have access to a broad array of services as specified in their Individualized Family Service Plans (IFSP) and provided or arranged for by Regional Centers and/or local educational agencies. Early Start services are funded by federal and state allocations.

In California, special education services for children 3-5 years of age (IDEA Part B) is administered by the Department of Education through local educational agencies (school districts), and Special Education Local Planning Areas (SELPA). Eligible children have a qualified disability, and have access to a broad array of services as specified in their Individualized Education Plans (IEP). Special education services are funded by federal and state allocations.

However, when a child (3 years of age and older) in California qualifies for special education services as a result of an emotional disorder, the county mental health agencies, under the direction of the state Department of Mental Health, are responsible for completing mental health assessments and providing treatment services as agreed to in each child's Individualized Education Plan.

Eligibility for these services, among other things, requires an emotional disorder that impairs the child's ability to benefit from a free and appropriate education. Mental health services are specified in the child's Individualized Education Plan. These services are funded by federal and state allocations, and through claims submitted to the state as specified by the Unfunded Mandates Commission.

Even Start is a federal program targeting low-income families to promote academic achievement through “family literacy.” Even Start in California is also administered by the Department of Developmental Services which, in turn, contracts with local educational agencies and community-based organizations. Services include early childhood education, parenting, and literacy education. Even Start is funded by a federal allocation.

Citations

California Early Start

California Special Education for Preschool Children

California Even Start

California Special Education Pupil's Program (for children who qualify for special education as a result of an emotional disorder)

- Even Start and Early Start (IDEA Part C) is administered by the California Department of Developmental Services—<http://www.dds.ca.gov/>
- Special Education Programs (IDEA Part B) is administered by the California Department of Education—<http://www.cde.ca.gov/>
- Special Education Pupil's Program is administered by the California Department of Mental Health—<http://www.dmh.cahwnet.gov/>
- Authorizing legislation California Government Code Title 1, Division 7, Chapter 26.5, starting with Section 7570—<http://www.leginfo.ca.gov/calaw.html>

Federal Individuals with Disabilities Education Act (IDEA) Part C: Special Education

Federal Individuals with Disabilities Education Act (IDEA) Part B: Special Education

Federal Even Start

- Administered by the United States Department of Education—<http://www.ed.gov/index.jhtml>
- Office of Special Education and Rehabilitative Services—<http://www.ed.gov/about/offices/list/osers/index.html?src=oc>
- Office of Elementary and Secondary Education—<http://www.ed.gov/about/offices/list/oese/index.html?src=oc>
- National Early Childhood Technical Assistance Center—<http://www.nectac.org/>

Special Education Pupil's Program, Early Start (Individuals With Disabilities Education Act–Part C), Individuals With Disabilities Education Act–Part B, and Even Start

Challenges

Reimbursement is primarily available for children who meet criteria for special education services, which includes evidence of a disorder and impairment.

Solutions

Some agencies that work with young children express concern about diagnosing or “labeling” children. Sensitivity in working with parents is critical when discussing any diagnosis. Moreover, confidentiality of the mental health records needs to be strictly maintained. Finally, concerns about the use of diagnostic labels may be related to stigma about mental illness. Efforts to reduce stigma associated with mental health disorders and treatment will be important.

Lessons From the Field

The Infant-Preschool Family Mental Health Initiative (IPFMHI) was an effort piloted in eight California counties to serve very young children (ages birth to 5 years), and their families, with (or at-risk of) social, emotional or behavioral delays or disorders. Funding to support this initiative was received from the California Department of Mental Health and First 5 California beginning in 2001.

Protocols have been developed in areas of screening and assessment, consultative modes, and improved provider preparedness as a joint effort between the California Department of Mental Health and the eight participating counties (Alameda, Fresno, Humboldt, Los Angeles, Riverside, Sacramento, San Francisco, and Stanislaus) to best serve very young children and their families. Experiences with interagency funding for these efforts are shared below.

Funding for IPFMHI Sites

Services and supports for children and families served by the IPFMHI sites were primarily funded through a combination of Medi-Cal EPSDT and local First 5 funding. Local First 5 funding was critical for services to children and families who do not have Medi-Cal. All eight counties have local First 5 grants to support new services to children and families. However, a number of other funding sources were important. The following table summarizes funding used by the IPFMHI sites.

FUNDING OF IPFMHI PROGRAMS 2003-2004	Alameda	Fresno	Humboldt	Los Angeles	Riverside	Sacramento	San Francisco	Stanislaus
FUNDING SOURCE	FREQUENCY OF USE <i>Never=0, Seldom=1, Often=2, Very often=3</i>							
Medi-Cal EPSDT	3	3	3	3	3	3	3	3
Healthy Families Program	1	3	1	2	1	0	1	1
Targeted Case Management	2	0	0	2	0	0	1	0
Medi-Cal Administrative Activity	2	3	0	1	0	3	0	2
CalWORKs	1	1	2	0	0	0	1	0
HMO's serving Medi-Cal	0	3	0	0	2	0	0	3
Private Insurance	2	0	2	1	1	0	1	1
Victim Witness Program	3	1	2	1	1	0	1	1
Regional Center Funds	2	0	1	1	0	0	0	0
Patient Fees	0	2	1	2	0	0	1	1
California Endowment Grant	0	3	0	0	0	0	0	0
Local First 5 Commissions	3	3	3	2	3	3	3	3

Challenges with Collaborative Funding

County IPFMHI coordinators describe a number of challenges around funding mental health services. The concerns raised by these coordinators involved the following themes.

- Funding services for children of the “working poor,” those families that make too much money to qualify for Medi-Cal.
- Funding services for children of families who are not U.S. citizens and do not have legal status in the country or are “undocumented.”
- Private insurance with limited mental health benefits, and providers with limited expertise in addressing early childhood mental health needs.
- Funding for primary prevention activities, and consultation and training for agencies to promote social and emotional development.

Although these funding issues remain challenges to public mental health agencies, interagency partnerships with local First 5 Commissions and others public and private agencies have made it possible for these counties to serve more children and families than would have received support otherwise.

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Based in Sacramento, CIMH has launched numerous public policy projects to inform and provide policy research and options to both policy makers and providers. CIMH also provides technical assistance, training services, and the Cathie Wright Technical Assistance Center under contract to the California Department of Mental Health.

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