National Conference of State Legislatures

CHILDREN'S POLICY INITIATIVE

A COLLABORATIVE PROJECT ON CHILDREN AND FAMILY ISSUES

MENTAL HEALTH SERVICES FOR CHILDREN: AN OVERVIEW

by Holly Kenny, Leah Oliver and Julie Poppe *June 2002*

Introduction

"Just as things go wrong with the heart, the lungs, the liver and the kidneys, things go wrong with the brain," says former Surgeon General David Satcher. One in 10 young people suffer from mental illness severe enough to cause some level of impairment,[1] but fewer than 20 percent of these children receive needed treatment each year. At least 7.5 million children and adolescents in the United States (12 percent) suffer from one or more mental disorders, including autism, depression, and alcohol and substance abuse and dependence.[2]

Between 5 percent and 7 percent of children use specialty mental health services every year.[3] However, the majority of children who are likely to benefit from mental health services do not receive care.[4] To ensure that all children have an "optimal chance for a healthy start in life," the former surgeon general recommends that family members, health care providers, educators and policymakers support not only their physical and intellectual growth, but also their mental health.[5]

The Role of Policymakers

Because the state often becomes the payer and caretaker of last resort for people whose mental illness results in dysfunction, state legislators should be concerned about mental health issues. For example, many juvenile offenders have unmet mental health needs that were contributing factors in their offenses. Early detection and treatment of mental illness can prevent later costly problems.

Legislators make decisions about funding and program design and also provide oversight for a number of systems—such as schools, child care centers, primary health care facilities, community mental health centers, the juvenile justice system, and the child welfare system—that provide mental health care to children. Although the federal government provides some funding for children's mental health services, the majority of the funds are controlled at the state and county levels. This report provides an overview for legislators who are interested in learning more about options to address the mental health needs of children.

Assessing the availability and accessibility of mental health services for children has been an issue of concern for many state legislatures, particularly because the majority of mental health services are funded with public

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money. Limited access to and availability of services may mean that young children with mental health needs are unable to achieve positive developmental outcomes such as success in school. An **Arkansas** resolution expresses concern for children with mental health needs: "Judges, child welfare advocates, and juvenile justice workers have expressed concerns that proper mental health services for children are not available or not accessible as an alternative for children." An **Oklahoma** resolution is similar: " . . . the availability of and access to quality mental health treatment are both critical to the long-term well-being of these children and adolescents." According to Tennessee Representative Joe Fowlkes, chair of the Select Committee on Children and Youth, " ... appropriate mental health care for children is generally not available and worse than services offered 12 years ago." He explains, " ... In Tennessee, we just don't have enough mental health services for children. Changes are going to have to be made." According to a report presented to the committee, children with mental health needs suffer from a lack of coordination between TennCare, the state's Medicaid managed care program, and local school systems.

Policymakers have been examining factors that affect the development of young children and society, such as the resources dedicated to the earliest years and the opportunities children have to grow cognitively, emotionally, behaviorally and physically. An emphasis on providing needed services to children with mental health needs and their families increases the likelihood that they will not need costly services through the juvenile justice or child welfare system. By targeting and treating young children and pre-adolescents who have mental health needs, thus preventing more costly and damaging outcomes, states actually may save money.

Policymakers—including many state legislators—have been working to coordinate the efforts of the diverse agencies and organizations that provide mental health services to children. Their work has been supported by researchers and mental health experts who have identified the concept of "systems of care" as an option for pooling funding streams and coordinating and streamlining services. In this way, the individualized needs of children are met, at the same time saving money by eliminating duplication of services. One way to implement a system of care is through "wrap-around services," which are individualized services that address the needs of these children. Several communities have implemented programs based on systems of care to provide services to children with mental health needs. These include **Connecticut** Community KidCare, the Multiagency Integrated System of Care in **California**, Wai'anae Coast in **Hawaii**, and Wraparound Milwaukee in **Wisconsin**. Studies acknowledge that care for children with severe emotional disturbance can be very costly. By developing community-based alternatives to residential care, however, states can coordinate services among multiple agencies, include family members in treatment, and use funding streams more effectively and efficiently.

Background

Mental Health Needs for Young Children

One in five children has a diagnosable mental, emotional or behavioral disorder. However, 70 percent of those children do not receive mental health services.[6] Psychotropic medications, including Ritalin and other anti-depressants, prescribed for preschoolers increased by 50 percent between 1991 and 1995.[7] According to data from the 1995 National Household Education Survey, 59 percent of preschool children regularly were in some type of nonparental care arrangement. Because a considerable number of children younger than age 5 spend their day in child care settings, state policies are beginning to reflect a growing

recognition that child care, preschool and Head Start can be optimal places to identify and provide services for young children and their families who need mental health services and to strengthen providers' capacity to address children's challenging behaviors in ways that foster healthy development and growth. Several state examples are mentioned later in the report. Connecting mental health services with early childhood care helps to:

- Promote healthy early childhood development,
- Improve child and family outcomes, and
- Improve the quality of early childhood care services.

Barriers to Care

Children with mental health needs face many barriers, including stigma, cost, services gaps and poor quality of treatment. Some parents fear their children may suffer social or emotional stigma once the illness is drawn to the attention of medical professionals. Others are afraid they may be blamed. As a result, mental health services may be underutilized. Stigma can be lessened with open dialogue among the family, medical professionals and the child so that parents can secure treatment for their children without fear or shame. In addition, families that cannot find needed services in the private sector sometimes are forced to give up custody of children who have mental health needs so they can receive services through the state. Laws exist in 12 states—**Colorado**, **Connecticut**, **Idaho**, **Indiana**, **Iowa**, **Maine**, **Minnesota**, **North Dakota**, **Oregon**, **Rhode Island**, **Vermont** and **Wisconsin**—that do not allow parents to be forced to relinquish custody of their children. Most of the states use a voluntary placement agreement signed by parents that allows the state to provide treatment without having legal custody of the child.[8] According to a survey conducted by the National Alliance for the Mentally Ill, 23 percent of the respondents reported that they were told that they would have to relinquish custody of their children to get services; 20 percent said they did so to get care.[9]

Children from families of all income levels and ethnic backgrounds have mental health needs. Research has shown that behavioral and emotional problems are more prevalent among poor children than among non-poor children, possibly due to stress on the family, inaccessible services, lack of health insurance or mental health system capacity, misdiagnosis, and parents' mental health issues. Race and ethnicity also affect access to diagnosis and treatment. Children from low-income and minority families are disproportionately represented in the juvenile justice system. In fact, minority children tend to receive mental health services through the juvenile justice and welfare systems more often than through schools or special settings where they are disproportionately represented. Hispanic and African American children are the most likely to lack needed care, according to a recent RAND study.[10] African American and Hispanic children are identified and referred at the same rates as other children, but they are much less likely to receive specialty mental health services or psychotropic medications.

Funding

Some treatment options are funded by public programs such as Medicaid, the State Children's Health Insurance Program (SCHIP), community mental health centers, Head Start, child care, early intervention, special education, early learning programs, home visiting programs, and private sources. States use the Child Care Development Block Grant (CCDBG) and the Temporary Assistance for Needy Families (TANF) Block Grant to fund

mental health early childhood linkages (discussed on page 12). Duplication of services often occurs when parallel services are offered through various funding streams.

Children constitute 28 percent of the general population, but account for only about 7 percent of mental health expenditures. In 1998, total treatment expenditures for children were estimated at $11.68 billion ($172 per treated child). Funding for services for children with mental health needs may be categorized into three major streams:

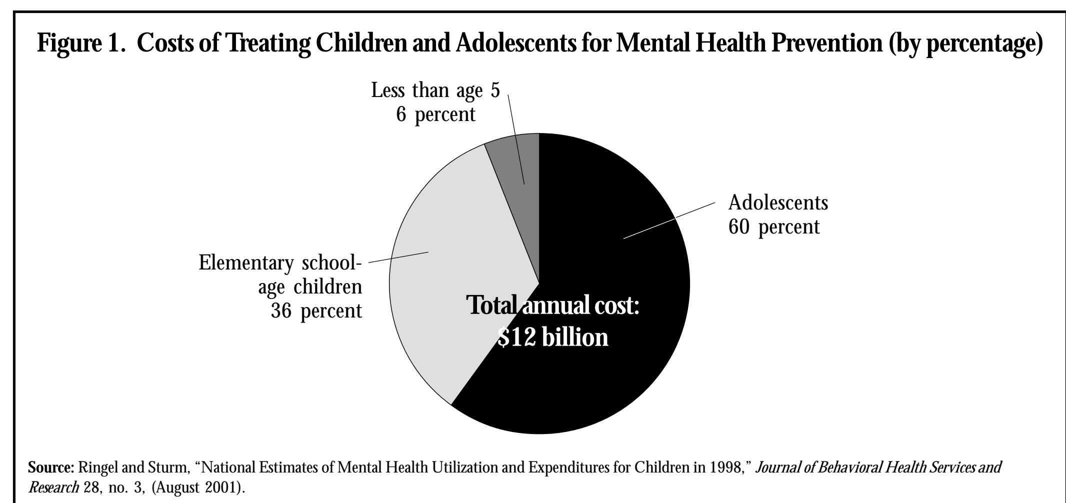
- Private insurance (47 percent),
- Medicaid (24 percent), and
- State and local mental health agencies (21 percent).[11]

Other public insurance programs cover 3 percent of the mental health costs, while children who are uninsured represent 5 percent of the costs.

Approximately 70 percent of the population has private insurance, but these children represent only 50 percent of the costs of mental health care. Children with Medicaid make up 16 percent of the population and account for 24 percent of the total costs of mental health care.[12] A relatively large portion of specialty care is not paid for by insurance; instead, the out-of-plan specialty care is often provided through the education system.

RAND researchers estimate the annual cost of treating children and adolescents for mental health prevention is nearly $12 billion.[13] This estimate reflects the total costs paid by all funding sources, including payments from individuals, private insurance, Medicaid and state mental health agencies. As shown in figure 1, adolescents account for the majority of the costs (60 percent), while elementary school-aged children account for about 34 percent. Children under age 5 account for only about 6 percent of the costs.[14]

Figure 1. Costs of Treating Children and Adolescents for Mental Health Prevention (by percentage)



Source: Ringel and Sturm, "National Estimates of Mental Health Utilization and Expenditures for Children in 1998," *Journal of Behavioral Health Services and Research* 28, no. 3, (August 2001).

Diagnosis, Treatment and Services

Mental health disorders are as prevalent in young children as in older children. Many of the problems evident in older children and adolescents originate in early childhood, according to a study published by the Georgetown University Child Development Center. Although studies have shown that psychological damage early in life may be reversible if addressed during early childhood, child mental disorders usually persist into adulthood.

Either late diagnosis or no diagnosis of mental illness can worsen problems for children, their families and their communities. Brain development in early childhood is critical to healthy development throughout life, making timely screening, diagnosis and treatment important. Few young children are identified as having mental health and behavioral problems, however, and most do not receive needed treatment. Children's emotional and behavioral problems and associated impairments lower their quality of life and reduce their life chances, explains David Offord of McMaster University. He emphasizes that no other set of conditions has such deleterious effects on children and youth. Although parents commonly recognize their children's mental health disorders before age 4, and various school agency records offer certain warning signs, most children received no services until they reached age 10.

Children's mental health services are fragmented and spread across many different systems, including schools, child care centers, primary health care facilities, community mental health centers, the juvenile justice system, and the child welfare system. Historically, these programs have not launched a coordinated effort to serve families and children because they are administered by separate agencies and are not structured to facilitate coordination. Because so many different state and local agencies provide and fund services for children and families, collaboration has been found to facilitate the process for families. The **Montana** Legislature reacted to this issue by enacting a resolution creating a Mental Health Services Oversight Subcommittee because: " ... the issues revolving around mental illness touch many areas of government, and many resources must be brought to bear to understand the issues, to work towards resolution, and to provide strong public policy direction for the further integration and delivery of public mental health care services."

National Initiatives to Support States' Integration of Services

Several national efforts are under way to assist states to develop systems of care. Their efforts are reforming mental health systems for children, including requiring private insurance coverage of mental health benefits (parity) and the reorganization of public services.[15]

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has been active in this area through programs sponsored by its Center for Mental Health Services. One such program is the Comprehensive Community Mental Health Services for Children and their Families Program, which provides six-year grants to all states and jurisdictions to develop systems of care that meet the needs of children and adolescents with serious emotional disturbances and their families. Congress appropriated $91 million for the program in 2001. To sustain systems of care beyond the grant period, each grant-funded community must contribute a matching amount of approximately 50 percent of the total funding.

The National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development also assists states to build systems of care for children and adolescents who have—or who are at risk for—mental health problems and their families. The center, funded primarily by federal grants, specializes in assisting states in the areas of strategic planning, leadership development, evaluation, interagency collaboration, cultural competence, family partnerships, policy development, prevention and early intervention, managed care and financing.

Strategies developed by policymakers to enhance children's mental health services are addressed in the next section.

Financing Programs for Young Children with Mental Health Needs

Medicaid

Medicaid funds a significant number of mental health services, representing half of state and local mental health spending, with projections that costs will continue to increase. Estimates of Medicaid funds spent on mental health and substance abuse services range from 9 percent to 12 percent. Jeffrey Buck, associate director for organization and financing at the Center for Mental Health Services within SAMHSA, explains that: "Because Medicaid is the chief funding source for state mental health services, data about Medicaid mental health services and users are essential for understanding the public mental health service system." He says that most people do not realize that, " ... a quarter of Medicaid spending for children (age 6 to 14) is going to mental health services."

Although state Medicaid programs pay for the bulk for mental health services, they often do not collaborate with other agencies and organizations that provide similar or related services. Ann Patla, former Illinois Medicaid and Mental Health director, explains, "There is still a great divide between mental health and Medicaid agencies which is hindering progress in developing better service systems. For mental health agencies, there is a reluctance to collaborate or to share authority over the mental health system. Adding to the problem, Medicaid agencies do not view themselves as stewards of the mental health system or even as sharing stewardship."

Children from low-income families who are enrolled in Medicaid are usually referred for mental health treatment at an earlier age than other children and at an earlier stage in the emergence of their mental disorder as a benefit of Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) program. Under EPSDT, states are required to provide physical and mental health screening and assessment to all Medicaid-eligible children up to age 21. States must cover the cost of treatment for any disease or condition that is diagnosed in young children during the EPSDT screenings.

Medicaid coverage for both physical and mental health services is more comprehensive than coverage under the State Children's Health Insurance Program (SCHIP) (in states using a private insurance model) and most private insurance plans. Mandatory requirements under Medicaid include inpatient, outpatient hospital, and physician services. In addition, states may cover inpatient psychiatric, psychologist, clinic and case management services, and most do. Compared to children who are privately insured or have no insurance, children in Medicaid are most likely to receive mental health services.[16] Mental health costs per child enrolled are higher in Medicaid than under private insurance because of a greater need for services and more generous coverage of mental health services by public insurance programs.

The scope of mental health coverage available to Medicaid-eligible children varies significantly among the states. The most widely covered services are day treatment (42 states), case management for children with serious emotional disturbance (43 states), intensive home-based services (35 states) and independent living skills training (30 states). Although 20 states offer some coverage for therapeutic foster care, only 19 offer coverage for services for families as well as for children. Even fewer states (11) provide Medicaid coverage for child respite care[17] (see appendix A).

Many states are converting their Medicaid programs from traditional fee-for-service models (reimbursing individual providers for each covered service provided) to managed care models (health care systems that use selected providers to furnish a comprehensive set of health care services for a capitated fee). Nearly every state has implemented or is planning to implement managed care for Medicaid beneficiaries. States often approach behavioral health services differently than other managed care services. Some states use a fee-for-service method. Others use "carve-out models"—referring to specific services that are "carved-out" into a managed care benefit package and financed and delivered separately from other health care benefits. States that provide mental health coverage for Medicaid-eligible children usually do so through a "wrap-around approach," meaning that Medicaid will cover services that are not provided through a private plan. Although all states provide behavioral health services through Medicaid to some extent, a few states have created Medicaid programs dedicated specifically to serving children with mental health needs, including:

- **Hawaii's** HI-QUEST Carve-Out for Children and Adolescents,
- **Indiana**'s Dawn Project and Child Mental Health Initiative,
- **Oregon**'s Kids Intensive Treatment Services (ITS) Program, and
- **Wisconsin**'s Children Come First and WrapAround Milwaukee.

Strategies for Providing Mental Health Services to Children

Although benefit packages and service delivery of behavioral health services for children enrolled in Medicaid traditionally have been more complicated than for physical health services, many states are beginning to take a second look at how mental health coverage for children is structured. Each state Medicaid program must clearly define the services that fall within its EPSDT purview. When a child is screened through EPSDT, the state Medicaid program must provide all services that are deemed necessary. Qualified Medicaid providers, as defined in each state's authorizing legislation, also must deliver early intervention services. States are beginning to develop creative approaches that allow them to maximize the full potential of their Medicaid plans, as permitted under federal law.

Although conversion to managed care offers state Medicaid programs opportunities to improve mental health services for children, it also can intensify existing problems. According to separate studies published by the Office of the Inspector General and the Health Care Reform Project, managed care systems may create obstacles, including limited access to care, fragmented services and limited coordination among agencies.

Medicaid managed care can offer states greater flexibility in the design of benefit packages. State plans that offer "wrap-around services" for children with mental health needs tend to use the "systems of care" model more often than a "fee-for-service" model.

- **Michigan**'s Infant Mental Health Program is an early intervention program that focuses on at-risk infants and young children and their families. In addition to intensive mental health therapies and interventions provided in the child's home, practitioners provide behavioral and coping skills to parents and caregivers. The program, which operates in more than 40 sites across the state, is funded through a combination of Medicaid funds, state prevention grants, state mental health money and a 10 percent local match.

- **Michigan** and **Nebraska** cover a wide range of services that encourage family involvement, provide parental support, and emphasize treatment plans that are targeted for the individual needs of each child.

- **North Carolina** uses Medicaid funds that are earmarked for children's mental health treatment (known as "high risk" funding) to help cover services for young children enrolled in Medicaid. High risk funding is used to pay for intervention and treatment services for infants and toddlers who are believed to be at risk for developmental or mental disabilities.

- **Kentucky**, **Pennsylvania** and **Maine** offer substantive support services for families, including coping skills and therapy groups for parents and transportation assistance.

- Medicaid programs in **New York**, **Texas** and **Vermont** offer coverage for respite care services, which provide temporary interventions for children and provide a short break for parents and caregivers who serve as full-time attendants to their children. These states also support transportation assistance to help children get to school, day care and treatment appointments.

Using Medicaid Billing Codes

Vermont has worked within the Medicaid model to create greater opportunities for children with developmental disabilities or mental health needs. A Medicaid billing code was developed for the statewide parent-child centers to bill for early intervention services for infants and toddlers who are eligible for the Part C Special Education Program. Vermont also developed a series of early childhood mental health services, including direct work with children and families, interagency training, and consultation with early care and education providers. The direct services consist of case management, specialized rehabilitation, and individual and family therapy at home and in child care settings, all of which are reimbursable on a fee-for-service basis by Medicaid. The direct services also include state-funded respite care that has been proven through research to be particularly successful for children, resulting in fewer "out-of-home placements."

Florida lawmakers also have recently strengthened emotional supports for young, at-risk children—those who have exhibited signs of developmental delays and disabilities. The state has also reclassified its Medicaid billing codes to include reimbursement for "appropriate diagnostic tools" used to identify social, emotional and behavioral issues. In addition, legislators amended the language in the Florida Medicaid statute " ... to include individualized and family therapy (infant/parent therapy) to allow a greater scope of service coverage." Florida used the original federal Medicaid language in attaining its goal of expanded coverage.

Legislators in **Rhode Island** also have worked to develop new procedure codes to ensure that early intervention services that are within the purview of the state's managed care plan are accurately covered. As a result, the early intervention sites can bill Medicaid directly. In Rhode Island, Medicaid managed care plans must cover up to $3,000 per year of medically necessary physical, speech and occupational therapy. When this limit has been reached, the state pays for any additional treatment outside the required managed care capitated fee. This ensures that Medicaid funds are available to finance required services and permits follow through from assessment to treatment.

Expanding Provider Definitions

Some states have expanded their Medicaid definitions of qualified case managers and service providers in order to efficiently use resources and ensure access to care.

- Through a Medicaid section 1115 waiver, the **Florida** Medicaid program is participating in a national demonstration project, Cash and Counseling, which allows families with Medicaid to hire their own caregivers, thus helping to foster consumer choice and independence. Relatives and friends can be paid as caregivers.

- Under a new law in **Colorado**, family members may provide care to children with special health care needs and be reimbursed through Medicaid. Family members must obtain a statement from their physicians indicating that they have sound judgment and the ability to direct the child's care.

- In **Kansas** and **Maine,** for example, parents can become certified case managers and behavioral aides after completing a brief training program.

- In **Maryland**, mental health providers in the managed care system may diagnose adjustment disorders in young children. Head Start and child care centers across the state also can gain access to mental health services through the managed care system.

The State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program (SCHIP) is available to uninsured children whose families earn too much to qualify for Medicaid but not enough to afford private insurance. Infants and children through age 18 living in families above Medicaid income thresholds (which typically range from 133 percent to 200 percent of the federal poverty guidelines) may be eligible for mental health benefits through SCHIP.

States have the option to expand Medicaid, establish a private SCHIP plan or create a combination. Non-Medicaid expansion SCHIP plans are more restrictive than those that follow the Medicaid model because they are not required to cover the full range of services that may be needed when a physical or mental condition is identified during a health examination.

Inpatient mental health services that are available to children enrolled in SCHIP include inpatient psychiatric hospitalization, residential treatment centers and inpatient rehabilitation. Outpatient services include outpatient psychiatric hospitals, counseling (individual, group and family therapy) and clinician office visits. Most states with separate non-Medicaid SCHIP plans limit inpatient mental health services to 30 days per year. In some states, inpatient substance abuse services are included in this annual limit. For outpatient mental health services, treatment limitations typically range from 20 to 30 days per year. A few states—**Connecticut**, **Iowa**, **North Dakota** and **Pennsylvania**—have more extensive inpatient coverage (60 days per year). Other states—including **Florida**, **Connecticut** and **Montana**—provide coverage for children with severe emotional disturbances through separate programs that often are referred to as "carve-outs." In **Delaware**, the Department of Services to Children, Youth and Families covers inpatient and outpatient mental health services after SCHIP benefit limits are reached. (See appendix B: "Mental Health Benefits in Non-Medicaid SCHIP Plans.")

Parity for Mental Health Care

Some lawmakers are focusing on ensuring access to children's mental health services through increasing insurance coverage for mental health conditions. This issue, parity between mental and physical health services, has been hotly debated in state legislatures. The concept of parity means providing the same level of benefits for mental illness, serious mental illness or substance abuse as for physical disorders and diseases. Opponents of providing mental health parity usually argue that mandates increase premium costs. Numerous studies support this point, but cost estimates vary.[18] In 2001, the Congressional Budget Office estimated that the federal mental health parity legislation would increase premiums for group health insurance on average by about 1 percent per year.

In 2001, **Arkansas** enacted a law mandating parity for mental health care under the State Children's Health Insurance Program (SCHIP). The Arkansas law defined it as " ... coverage for the diagnosis and mental health treatment of mental illnesses and the mental health treatment of those with developmental disorders under the same terms and conditions as provided for covered benefits offered under the program for the treatment of other medical illnesses or conditions and with no differences in the program."

Twenty-three states have laws that require parity benefits for the treatment of mental illnesses, and 23 others offer or provide some lesser level of coverage.[19] A survey conducted by the National Alliance for the Mentally Ill found that 66 percent of families reported the lack of health insurance parity for the treatment of a mental illness; 49 percent said it impeded their receiving care.[20]

Delivery Mechanisms for Young Children with Mental Health Needs

Head Start

Head Start and Early Head Start are early childhood development programs for children from families in poverty from infancy through age 5. Head Start programs served more than 900,000 children in 2000, through a combination of center-based classrooms, home-based family child care programs or home-visiting programs. Federal law requires local Head Start and Early Head Start programs to allocate a portion of their federal funding to cover health care for uninsured children who are participating in either of these programs through Medicaid's EPSDT program.

Head Start is mandated to meet the mental health needs of preschool children from low-income families and includes these services in early childhood programs. The number of Head Start children who received needed mental health services doubled between 1992 and 1996, probably due to the increased national attention and ongoing concern about the importance of the social and emotional development of young children. In 1997, approximately 77 percent of the Head Start children who were identified as being in need of mental health services received these services. Possible reasons include that there are limited mental health services available, especially in rural areas, and that parents may have chosen not to follow up on the recommendation for services.[21] Head Start administrators must facilitate the assessment of each child's health status within 90 days of enrolling in the program and must identify an "ongoing source of continuous, accessible health care" for each child. To accomplish this goal, Head Start sites establish health services advisory committees comprised of Head Start parents, staff, community volunteers and health care

professionals. States can work with local agencies and programs to encourage collaborative financial resources and planning.

Community Mental Health

A variety of federal, state and county funding streams support community mental health centers. One federal source of funding is SAMHSA's Community Mental Health Services Block Grant, which supports comprehensive, community-based care for children with serious emotional disorders. A major goal of the program is to support and enhance state capacity to provide community-based mental health care to such children through outreach, mental and other health care services, individualized supports, rehabilitation, employment, housing and education. The program is the single largest federal contribution dedicated to improving mental health service systems across the country.

Many states have acknowledged a need for coordination of services across various programs and systems. In 2001, the **Connecticut** General Assembly enacted a law creating the Connecticut Community KidCare plan, which has evolved into a collaborative program involving three state agencies: the Department of Mental Health and Addiction Services, the Department of Children and Families, and the Department of Social Services. In order to support this comprehensive, integrated community-based service system, the state is blending inter-agency funds with available federal funds. The mental health initiative now provides 24-hour emergency, mobile psychiatric services, which parents can access through a hotline to obtain an immediate assessment of children with mental health problems. In the future, the program also will provide home-based counseling and therapy, therapeutic mentoring and respite services.

During the past 15 years, mental health care for children has shifted from inpatient to community services, especially for children with severe emotional disturbances. In fact, 60 percent of resources are used on outpatient services. The economy, managed care, therapeutic advances and new psychotherapeutic drugs have driven the shift from inpatient care toward outpatient care. A substantial amount of mental health care is provided in primary care settings. Community-based services may either be delivered in the child's home or in a public child care setting, such as a therapeutic nursery or preschool. Therapeutic nurseries (for children from birth to age 3) and therapeutic preschools (for children ages 3 to 6) are designed for children with mental and developmental needs that cannot be met with traditional interventions. These settings also offer an alternative for children who have been repeatedly expelled from traditional day care programs as a result of their behaviors.

Therapeutic nurseries and preschools may be located within a school, Head Start program or community mental health agency; others may be independent entities. A handful of states—**Maryland**, **Oklahoma**, **Oregon**, **South Carolina** and **Tennessee**—and the **District of Columbia**, have developed explicit criteria that therapeutic nurseries and preschools must meet in order to be considered eligible to receive Medicaid funding.

The Federal Early Intervention Program

The Federal Early Intervention Program was created in 1994 to improve access to mental health screening, assessment and treatment for children from birth to age 3 who are either at risk of developing or have exhibited early signs of mental health problems. Early intervention programs are implemented at the state and local levels, as part of the Individuals

with Disabilities Education Act (IDEA). Individual programs are funded through state and federal Medicaid appropriations, with supplemental funds from local education funds and private insurance.

Early Childhood and Mental Health: Connecting Services and Systems that Support the Healthy Emotional Development of Young Children

As mentioned earlier in this report, early childhood care settings can be appropriate places to identify and provide mental health services for young children and their families and also can help providers address children's mental health needs to stimulate healthy childhood development and growth. The National Center for Children in Poverty (NCCP) recently published a report that provides policy considerations for investing in the social and emotional health of young children. Research shows that the earliest years set the stage for lifetime emotional skills, competencies and problems. Many young children are not developing the emotional skills they will need to succeed in school and be productive members of society. Getting children ready for school requires that more strategic attention be paid to early social, emotional and behavioral challenges and to cognitive and physical development in young children. Early childhood presents an opportunity to promote healthy early childhood development and support emotional and mental readiness for school, with such innovative practices as incorporating mental health consultants and home visitation programs in early childhood settings. This section outlines several state examples.

Using Funding to Promote Early Childhood Services and Mental Health Linkages

States use a variety of federal funds to link mental health services with services for young children, including Medicaid, Temporary Assistance to Needy Families (TANF), the Individuals with Disabilities Education Act (IDEA), the Child Care Development Block Grant (CCDBG) and Head Start. Using federal and state funding mechanisms, legislatures and other policymakers in some states—including Colorado, Michigan and Vermont—are creatively funding initiatives that connect mental health to young children in early childhood settings. Colorado's program connects mental health consultants to children in child care settings. Michigan's mental health program makes parenting education, family support, counseling and other services available to families with infants who are at risk of developing mental health problems. Vermont's statewide program provides early childhood mental health services to very young children and their families.

Enhancing the Mental Health Skills in Child Care Providers

A major report by the National Research Council and the Institute of Medicine, *From Neurons to Neighborhoods,* concluded that, " ... given the substantial short- and long-term risks that accompany early mental health impairments, the incapacity of many early childhood programs to address these concerns and the severe shortage of early childhood professionals with mental health expertise are urgent problems." The report, which was compiled by some of the nation's most distinguished early childhood development scientists, recommended that investments be made to expand professional child care training opportunities and to provide incentives for expert individuals to work in settings with young children for more effective screening, treatment and prevention of serious childhood mental health problems.[22]

Generally, child care providers can care for many children at one time. Child care providers face many demands when caring for a child who is behaviorally or emotionally challenged or when one child acts out or becomes withdrawn in the group. Policymakers in some states are enhancing the skills of child care providers by supporting mental health training or providing mental health consultants to work with children and providers onsite. Mental health consultants carry out a range of tasks to enhance the emotional and behavioral well-being of children, families and early childhood providers. These include:

- Helping early childhood staff observe and understand behavior.
- Teaming with early childhood staff to design classroom interventions to promote emotional strengths and strong relationships, including social skill building.
- Providing information about what to expect in infants, toddlers and preschoolers and the importance of early relationships for them.
- Increasing staff competencies in caring for children with challenging behaviors or problematic emotional development.
- Helping staff identify when children or families need more specialized assistance and engaging staff to work more effectively with families individually or through parent support groups.
- Helping staff address cultural or other work-place tensions.
- Helping children, staff, programs and communities respond to community or family violence or other crises.

Two States' Approaches: Colorado and Vermont

Colorado: Supporting Children's Mental Health Needs

A recent children's mental health survey found that, of more than 1,000 Colorado early childhood care and education providers, 84 percent of respondents ranked mental health at the very top of their list of concerns for young children.[23] The survey also indicated that at least 15 percent of Colorado's young children had emotional or behavioral problems serious enough to disrupt child care or early childhood classroom settings. The providers surveyed serve more than 26,000 Colorado children from birth to age 8 in an average month. The Colorado General Assembly recently funded an early intervention pilot program that authorizes onsite early childhood mental health specialists to consult and work directly with children in child care and Head Start settings. In FY 2002, the state funded the program at $350,000. Results from the two pilot sites showed reduced child expulsion from classrooms and increased capabilities of teachers and assistants to handle problematic behaviors, making for more manageable classroom settings.

Vermont: Promoting the Emotional Wellness of Young Children and Their Families through a Statewide Approach

Vermont provides statewide early childhood mental health services to very young children and their families. The state has used the federal Children's Mental Health Services Program to fund the initiative at a total of $5.7 million between 1998 and 2002. Through this program, the state has built on existing state and community early childhood collaboratives to plan and deliver early childhood mental health services. The initiative's goal is to develop an early childhood care system that includes prevention, early intervention and treatment and to build local and state planning mechanisms that team early childhood community and mental health, domestic violence and substance abuse agencies. Services include home visiting, mental health consultation, family support and child behavior and development information, therapeutic outreach services, teen parent services

and community development. In the first two years of the program, more than 1,000 children and their families received these services and more than 1,000 consultations were provided in early care and education settings to reach more than 4,000 people. Vermont allows certified early interventionists to bill Medicaid for mental health diagnosis and certain therapies for the birth to age 3 population. In some cases, the parent and the young children are eligible for services because of the parent's disability.

Conclusion

Although most will agree that being healthy—both mentally and physically—is important, it remains a struggle to provide care for children with mental health needs. One challenge is the lack of coordination between many different programs and systems. The systems—child care, child welfare, juvenile justice, Medicaid, primary health care facilities and schools—have access to funds that, if coordinated, could provide a seamless delivery of services. Policymakers have an important role in determining which services not only are most effective and cost-efficient but also serve the greatest number of people. Reviewing current state and federal funding streams, assessing various program examples, and comparing numerous approaches to meeting the mental health needs of children is important to develop plans that best serve each community.

Research shows that in the early childhood years numerous developmental achievements occur. Research also points out that most mental illnesses occur at the same rate in young children as they do in older children, although they usually are not diagnosed and treated until later. Finding, diagnosing and treating mental illness at an early age may increase the chance that children will reach developmental milestones and do well. Coordinating resources to detect mental health needs may save money in both the public and private sectors. Policymakers may choose to facilitate this process by allocating funds so that services are coordinated across various systems.

State governments spend millions of dollars on services for children with mental health needs. Such children usually are involved in numerous, costly systems. Providing quality services is expensive, but lack of adequate care also is costly. In the long run, lack of care for children with mental health needs may result in increased welfare costs, greater need for foster care, increased rates of crime, inappropriate health care, reduced educational achievement and lost productivity. Legislators can help to create policies that coordinate multiple systems to provide needed but cost-efficient care and services to children, at the same time conserving resources during a time of strained state budgets.

Appendix A. Community-Based Services for Children with Mental Health Needs

State/Jurisdictions	Type of Service	Targeted Case Management	Intensive Home-Based Services	School-Based Day Treatment	Day Treatment (Excluding School-Based)	Summer Camps/Summer Programs	After School Activities	Family Support/Wraparound	Child Respite Care	Therapeutic Foster Care	Therapeutic Nurseries	Therapeutic Preschool	Independent Living Skills Training	Other Independent Living Programs	Other Psychosocial Rehabilitation
Alabama	FFS	+	+	+	+			+					+		
Alaska	FFS	+	+	+	+			+							
Arizona	MC	+	+	+	+			+		+			+	+	
Arkansas	Both	+	+	+	+		+		+	+	+	+	+		
California	MC	+	+		+										
Colorado	MC	+			+			+					+		
Connecticut	Both	+			+										
District of	FFS				+						+				
Delaware	MC		+		+					+			+		
Florida	Both	+	+	+	+	+				+			+		+
Georgia	FFS	+		+	+		+			+					
Hawaii	FFS	+													+
Idaho	FFS			+	+								+		
Illinois	FFS	+	+		+										
Indiana	FFS	+			+								+		
Iowa	MC		+	+	+				+						
Kansas	FFS	+	+	+		+	+	+	+	+			+		+
Kentucky	Both	+	+	+	+	+	+	+		+					+
Louisiana	FFS		+										+		
Maine	FFS		+	+	+			+							+
Maryland	MC	+	+	+	+						+		+		
Massachusetts	MC		+		+										
Michigan	MC	+	+		+			+	+	+					
Minnesota	Both	+	+	+	+			+		+			+		
Mississippi	FFS	+		+	+										
Missouri	Both	+	+											+	
Montana	FFS	+	+	+	+				+	+			+		
Nebraska	Both		+	+				+		+					+
Nevada	FFS	+	+	+	+		+	+		+			+		
New Hampshire	FFS	+	+		+			+					+		
New Jersey	FFS	+													
New Mexico	FFS	+		+	+					+			+		+
New York	FFS	+	+	+	+				+	+		+	+		+

Appendix A. Community-Based Services for Children with Mental Health Needs (continued)

North Carolina	FFS	+		+	+		+			+			+		+
North Dakota	FFS	+	+		+			+	+	+			+		
Ohio	FFS	+		+	+			+					+		
Oklahoma	Both	+	+		+					+	+		+		+
Oregon	MC	+	+	+	+		+	+	+	+	+				
Pennsylvania	Both	+	+	+	+	+	+	+					+		+
Rhode Island	Both	+		+	+										
South Carolina	FFS	+	+	+	+			+	+	+	+	+	+	+	
South Dakota	FFS	+						+							
Tennessee	MC	+	+	+	+						+		+	+	
Texas	Both	+	+	+	+				+				+		+
Utah	MC	+													+
Vermont	Both	+	+			+		+	+				+		
Virginia	FFS	+	+	+	+										
Washington	MC	+	+		+								+		
West Virginia	FFS	+	+	+	+								+		+
Wisconsin	Both	+	+	+	+								+		
Wyoming	FFS	+			+					+			+		
TOTAL		**43**	**35**	**30**	**42**	**5**	**8**	**19**	**11**	**20**	**7**	**3**	**30**	**4**	**14**

FFS= Community-based services are provided on a fee-for-service basis.
MC= Community-based services are provided through managed care plans.
BOTH= Community-based services are provided on a fee-for-service basis or through managed care plans.
Source: Judge David L. Bazelon Center for Mental Health Law, *Making Sense of Medicaid for Children with Serious Emotional Disturbance* (Washington, D.C.: Bazelon Center for Mental Health Law, 1999).

Appendix B. Mental Health Benefits in Non-Medicaid SCHIP Plans, Sept. 30, 2001

State	Inpatient	Outpatient	Other Benefits
Alabama	30 days/calendar year	20 visits/calendar year; 100%	Case management/care coordination
Arizona	Covered when medically necessary	Covered when medically necessary	Case management/care coordination
Arkansas	Unlimited visits	$500 limit without prior authorization; the next $2,000 requires prior authorization; maximum benefit of $2,500/year	Case management/care coordination covered only in an acute care hospital
California [2]	30 days/benefit year	20 visits/benefit year	Case management/care coordination
Colorado [3]	45 days/year; may be converted to outpatient visits at 2:1 rate	20 visits/year	Case management/care covered when medically necessary
Connecticut	60 days/year; 100% coverage for all conditions except mental retardation, learning and motor skills, communication and relational problems, caffeine-related disorders and other conditions; for these, up to 35 days of inpatient hospital benefits can be converted to outpatient services (1 inpatient hospital day is equivalent to 1 sub-acute day, 2 partial hospitalization days, 2 intensive outpatient visits or 3 outpatient visits)	Limited to evaluation, crisis intervention, and treatment for conditions which, in the judgement of a physician, are subject to significant improvement $5 copayment except for conditions not covered under inpatient care; on these stated conditions: 30 visits/year 1-10 visits: 100% 11-20 visits: $25 copayment 21-30 visits: lesser of $50 copayment or 50%	Supplemental coverage available through HUSKY Plus for children who meet the criteria for the HUSKY Plus Behavioral Health Plans (see table 7)

Appendix B. Mental Health Benefits in Non-Medicaid SCHIP Plans, Sept. 30, 2001 (continued)

State	Inpatient	Outpatient	Other Benefits
Delaware [4]	31 days/calendar year as a "wrap-around" service of combined mental health and substance abuse services	30 days/calendar year covered by MCO; 31 additional days/calendar year available as a "wrap around" benefit that may include outpatient mental health services	
Florida	30 days/year	40 days/year	
Georgia	Limited to short-term acute care in general acute care hospitals up to 30 days/admission; residential or other 24-hour therapeutically planned structural services are covered through the Multi-Agency Team for Children Program	Services covered through community mental health centers, subject to limitations specified in the Department of Human Resources standards; licensed applied psychologists, limited to 24 hours/year; psychiatrists, limited to 12 hours/year	
Iowa	60 days/year for Iowa Health Solutions; 30 days/year for John Deere and Wellmark	20 visits/year for Iowa Health Solutions; 30 days/year for John Deere and Wellmark	
Illinois	Limits not specified	Limits not specified	
Indiana	Limits not specified	Limits not specified	
Kansas	Covered when medically necessary	Covered when medically necessary	
Kentucky [5]	No limits if medically necessary; prior authorization and concurrent review required; pre-set criteria established by Department for Medicaid Services	No limits provided, must be medically necessary; prior authorization required under Impact Plus	Case manager available under Impact Plus
Maine	Same as Medicaid	2 hours/week up to 30 weeks/year	
Maryland	60 days/year	Limits not specified	

Appendix B. Mental Health Benefits in Non-Medicaid SCHIP Plans, Sept. 30, 2001 (continued)

State	Inpatient	Outpatient	Other Benefits
Massachusetts	60 days in psychiatric hospital for non-managed care; covered as medically necessary for managed care; unlimited days in general hospital for managed care	30 days/year	
Michigan	Covered when medically necessary	Covered when medically necessary	
Mississippi	30 days/benefit period; psychiatric treatment as medically necessary; prior authorization required	52 visits/benefit period; prior authorization required	
Montana [6]	21 days/benefit year (Oct. 1-Sept. 30); partial hospitalization may be exchanged at a rate of 2:1	20 visits/benefit year (Oct. 1-Sept. 30)	Children with severe emotional disturbances may be eligible for Montana's mental health services plan, which imposes no coverage limits beyond medical necessity
Nevada	Prior authorization required for residential treatment centers, placements and extended stays	24 sessions/calendar year	
New Hampshire	15 days/year of combined mental health and substance abuse services	20 visits/year of combined mental health and substance abuse services	Case management/ care coordination
New Jersey	Plans B and C, limits not specified; Plan D, limited to 35 days/year	Plans B and C, limits not specified; Plan D, limited to 20 visits/year	
New York	30 days/year of combined mental health, inpatient detoxification and substance abuse	60 days/year of combined mental health, alcoholism and substance abuse services	

Appendix B. Mental Health Benefits in Non-Medicaid SCHIP Plans, Sept. 30, 2001 (continued)

State	Inpatient	Outpatient	Other Benefits
	services		
North Carolina	Requires prior authorization from mental health case manager	26 visits/year; additional visits require authorization from mental health case manager	
North Dakota [7]	60 days of mental health and substance abuse inpatient hospital treatment combined; up to 120 days of residential treatment; prior authorization is required	Partial hospitalization up to 120 days for mental health and substance abuse combined; prior authorization required; up to 46 days of inpatient care can be traded for outpatient care at the rate of 2 outpatient days for 1 inpatient day	Case management/care coordination
Oregon	Medically necessary services listed on the Oregon Health Plan Prioritized List and funded by the state legislature are covered	Medically necessary services listed on the Oregon Health Plan Prioritized List and funded by the state legislature are covered	Developmental assessments; psychological services and evaluations through the Oregon School-Based Health Services Program
Pennsylvania	90 days/year	50 visits/year	Case management; interventions in the home, school or other community setting
South Dakota	Prior authorization required	Unlimited services from physicians and community health centers; 40 hours of individual therapy/year	
Texas	With prior authorization for initial and continued stay; limits not specified	30 days/calendar year; authorization required for longer stays	Case management/care coordination
Utah	30 days/plan year of	30 visits/plan year of	Case

Appendix B. Mental Health Benefits in Non-Medicaid SCHIP Plans, Sept. 30, 2001 (continued)

State	Inpatient	Outpatient	Other Benefits
	combined substance abuse and mental health benefits	combined substance abuse and mental health benefits	management/care coordination
Vermont[8]	Prior authorization required; limits not specified	Limits not specified	
Virginia	Covered if received in a general acute care hospital; limits not specified	Initially, 26 sessions with possible extension of 26 sessions in first year; each succeeding year, 26 sessions when approved by the Department of Medical Assistance Services	
Washington[8, 9]	Limits not specified	Limits not specified	
West Virginia	30 days/year for inpatient care; 60 visits for partial hospitalization and day programs	26 visits/12 months of coverage	
Wyoming[10]	Covered up to $7,500/year, combined with outpatient services	Covered up to $7,500/year, combined with inpatient services	

Key
Inpatient = Includes inpatient psychiatric hospital, residential treatment centers, and inpatient rehabilitation.
Outpatient = Includes outpatient psychiatric hospitals, counseling, individual/group/family therapy, and office visits.
Other benefits = Other benefits relevant to mental health.

Notes
1. This table describes the benefits offered through the state-designed programs in each state. Entries for combination states contain information only on the state-designed component of the plan. Medicaid expansion states and components are not included in this table because these states offer the same mental health benefits as the state's Medicaid program.
2. In California, children with serious emotional disturbances are referred by the health care plan to the county mental health department for treatment.
3. In Colorado, treatment for neurobiologically based mental illnesses are treated as any other illnesses and are not subject to inpatient and outpatient limitations.
4. Delaware's inpatient and outpatient services are provided by the Department of Services to Children, Youth and their Families once the SCHIP benefit ends.
5. "Impact Plus" is Kentucky's program of community-based behavioral health services provided through an agreement between the state's Medicaid Department and its Department for Public Health. To be eligible for inpatient or outpatient Impact Plus-covered substance abuse services, recipients must have a current mental health diagnosis that is the primary reason for the treatment. Substance abuse is treated as a dual diagnosis only.
6. Montana places no limits on benefits for children with severe emotional disturbances (SED).
7. North Dakota's case management/care coordination benefits are for SED, developmentally disabled and pregnant women only.
8. Vermont and Washington provide the same services as their Medicaid programs.
9. Washington's mental health services are limited through the state's regional support networks.
10. Benefits listed pertain to Wyoming's Kid Care Plan C; Wyoming's Kid Care Plan B offers the same mental health coverage as its Medicaid program.

Source: The National Conference of State Legislatures. *2001 State Children's Health Insurance Chartbook*. (Washington, D.C.: National Conference of State Legislatures, March 2002).

NOTES

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4. Ibid., 323.

5. U.S. Public Health Service, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* (Washington, D.C.: U.S. Public Health Service, 2000), 1.

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13. Ibid., 319.

14. Ibid., 327.

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16. Ibid., 323.

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19. Health Policy Tracking Service, *Behavioral Health: Mental Health Parity* (Washington, D.C.: NCSL, 2002), 1.

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