Using EPSDT to Promote Early Childhood Mental Health: Idea Kit

Contents

Acknowlegements

This idea kit was developed in 2003 at the request of the National Technical Assistance Center for Children's Mental Health (TA Center), Georgetown University Center for Child and Human Development. Since 1984, the TA Center has been dedicated to working in partnership with families and other leaders to reform services for children and adolescents who have, or are at risk for, mental health problems and their families. Special areas of emphasis and expertise include prevention, early intervention, and financing.

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1. EPSDT – The Child Health Component of Medicaid

Over the past forty years, Medicaid's child health component, known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, children has been shaped to fit the standards of pediatric care and the special physical, emotional, and developmental needs of children. Since 1967, the purpose of the EPSDT program has been "to discover, as early as possible, the ills that handicap our children" and to provide "continuing follow up and treatment so that handicaps do not go neglected." Federal law – including statutes, regulations, and guidelines – requires that Medicaid cover a very comprehensive set of benefits and services for children, different from adult benefits. This toolkit is designed to increase understanding of the program rules and help fulfill the promise of EPSDT for young children and their families, particularly to prevent and ameliorate early childhood mental health risks and conditions.

EPSDT Basics

EPSDT is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. Federal law defines EPSDT and its components. State Medicaid programs must use EPSDT in providing coverage and services to child beneficiaries. Since one in three U.S. children under age six are eligible for Medicaid, EPSDT offers a very important way to ensure that young children receive appropriate health, mental health, and developmental services.

To remember the characteristics of EPSDT, use the name of the program:

Early - identifying problems early, starting at birth,

Periodic - checking children's health at periodic, age-appropriate intervals,

Screening - doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems,

Diagnosis - performing diagnostic tests to follow up when a risk is identified, and

Treatment - treating the problems found.

Specifically, screening services "to detect physical and mental conditions" must be provided at established, periodic intervals (periodic screens) and whenever a problem is suspected (interperiodic screens). Screening is to include a comprehensive health and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests, and health education. In addition, dental, vision, and hearing services are required, including appropriate screening, diagnostic, and treatment.

The treatment component of EPSDT is broadly defined. Federal law states that treatment must include any "necessary health care, diagnostic services, treatment, and other measures" that fall within the federal definition of medical assistance (as described in Section 1905(a) of the Social Security Act) that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services." All medically necessary (see discussion below) diagnostic and treatment services within the federal definition of Medicaid medical assistance must be covered, regardless of whether or not such services are otherwise covered under

the state Medicaid plan for persons ages 21 and older. (See discussion below)

As described in federal program rules: "The EPSDT program consists of two, mutually supportive, operational components: assuring the availability and accessibility or required health care resources; and helping Medicaid recipients and their parents or guardians effectively use them." EPSDT specifically defines benefits to help ensure access to needed services, including assistance in scheduling appointments and transportation assistance to keep appointments.

Medical Necessity Definitions under EPSDT

The term "medical necessity" can be confusing. In conventional, private health insurance, medical necessity is usually defined by the provider (physician), the managed care organization, and/or the insurance company. When used to discuss Medicaid and EPSDT, medical necessity is in part defined by federal law. For example, private insurance rules frequently state that physical therapy is considered medically necessary only following injury or illness. In EPSDT, physical therapy may be necessary following injury or illness, but also may be considered medically necessary to prevent or ameliorate developmental disabilities. This is because the purpose of EPSDT is to prevent, as well as treat conditions of children.

Thus, under Medicaid's medical necessity criteria for children must be consistent with the EPSDT preventive standard of coverage. In a report prepared for the federal Health Care Financing Administration (HCFA, now know as Center for Medicare and Medicaid Services – CMS), Rosenbaum and Sonosky analyzed state-specific information on EPSDT coverage under state Medicaid plans and well described EPSDT medical necessity criteria:

> *"While there is no federal definition of preventive medical necessity, federal amount, duration and scope rules require that coverage limits must be sufficient to ensure that the purpose of a benefit can be reasonably achieved.... Since the purpose of EPSDT is to prevent the onset of worsening of disability and illness and children, the standard of coverage is necessarily broad... the standard of medical necessity used by a state must be one that ensures a sufficient level of coverage to not merely treat an already-existing illness or injury but also, to prevent the development or worsening of conditions, illnesses, and disabilities."*

EPSDT Opportunities

Despite the fact that millions of children are entitled to services, many do not receive mental health services when needed. Confusion about the scope of covered services is widespread, and the definition of medical necessity under EPSDT is widely misinterpreted. This can improve by enrolling more eligible children, promoting greater provider participation, and better defining covered services.

2. Using EPSDT to Promote the Emotional Well Being of Young Children in Low-Income Families

Medicaid can provide financing for a wide array of child development, early intervention, and mental health services. For a simple test to determine whether or not a service can be financed, use the three Es --

Eligible services for

Eligible children delivered by

Eligible providers

In other words:

1. Does the service or item fit within a Medicaid covered service category?
2. Is the child a Medicaid enrolled recipient?
3. Is the provider approved under Medicaid to deliver the service?

Eligible Children

For simplicity, lets start by discussing who is eligible. Nearly one out of every three U.S. children under age six and nearly half of infants are eligible for Medicaid, making it an important source of coverage for young children. States must cover certain children. Federal law (statutes and rules) set minimum coverage levels, and states have various options to extend coverage to higher levels. Children are covered under several categories, some of which are described here. For purposes of this toolkit, the important fact is that all children enrolled in Medicaid are entitled to EPSDT coverage.

- *Low-income Children* - The largest coverage categories are based on family income. All children younger than six with family income at or below 133 percent of the federal poverty level are eligible under federal law. In about half of the states, eligibility for children extends beyond the federal minimum to 150, 200, or even 300 percent of the poverty level. These so called "near-poor" children might be covered under regular Medicaid or through a state Medicaid expansion under the State Children's Health Insurance Program, known as CHIP. (Up-to-date information on state coverage levels by income can be found at <www.cms.gov/>.)

- *Children with Disabilities* - Children with disabilities who qualify for Supplemental Security Income (SSI) become eligible for Medicaid. Some, but not all, young children who qualify for Individuals with Disabilities Education Act Programs (Part C Infant and Toddler or Part B Special Education programs) are also eligible for Medicaid.

- *Children with Private Coverage* - States may not deny Medicaid coverage to children who also have employer coverage. When a child qualifies for both, Medicaid covers services not covered under an employer-based plan.

- *Other Children* - Medicaid also covers: most children in foster care and others in the child welfare system, many homeless children even if they have no fixed address, and legally resident non-citizen children who were legal residents as of August 22, 1996 and/or lived legally in the United States for five years.

Eligible Services

A wide range of services are covered for children. Under federal EPSDT rules virtually all medical and health services for children are covered, including services that may go well beyond what traditional insurance might cover. For example, Medicaid/EPSDT is used to finance certain services that are important to early child development, such as health education, home visiting, preventive health counseling for families, case management, and other "early intervention" services. States define the "amount, scope, and duration" of benefits (how much, how often, etc.), who may provide benefits, and how much will be paid for them.

Eligible Providers

The state determines who is a qualified provider under broad federal guidelines. In general, providers who qualify must meet professional qualifications and are licensed by the state to practice in medical, health, and related fields. Some local agencies which do not independently qualify may deliver services under contract to health departments, hospitals, or other qualified providers.

Providers for children include physicians, psychiatrists, psychologists, federally funded clinics, hospitals, and others designated by a state Medicaid agency. In virtually every state, community mental health centers, local health departments, and similar publicly funded clinics are qualified providers. Most states also approve certified local early intervention program sites. In some states, child development centers and clinical social workers may become qualified providers. The also state determines Medicaid provider payment rates.

Federal Funding for Medicaid and EPSDT

Each state has a set level for Federal Financial Participation (FFP) in Medicaid. This is the percentage of each dollar properly spent in Medicaid that will be paid by the federal government. The FFP for medical services may range from 50 percent to 80 percent. Federal funds are available to match State expenditures for medical care. The FFP is based on a state's medical assistance expenditures and per capita income. For admin-istrative spending, the federal rate is 50% in all states. The federal share is higher for a few select services and activities (e.g., targeted case management at the Medical assistance FMAP; certain administrative activities that require skilled medical personnel at 75%).

Medicaid has strict rules about matching funds. State and local tax dollars are generally a very good source of Medicaid matching funds. Federal dollars from other programs may not be used. Under federal regulations, modest contributions provided by either the public or private sector may qualify as State match. Stricter limits apply to provider donations and provider-specific tax dollars. State Medicaid agencies, working jointly with the federal Centers for Medicare and Medicaid Services (CMS), makes the final decision about what dollars may be used as state/local match.

3. EPSDT Financing for Services to Improve Early Childhood Mental Health and Well Being

Child Development Services in EPSDT

Medicaid primarily finances such services for young children through EPSDT screening, diagnosis, and treatment benefits. No Medicaid benefits categories are specifically labeled "child development" or "early intervention" services, and a particular diagnostic test or intervention may or may not be approved under federal law. Furthermore, state policies may not fully reflect all of the services, tests, and treatments covered.

EPSDT screening and child development

The purpose of the screening component of EPSDT is intended to detect health and developmental problems and risks. When a developmental problem is suspected as a result of an EPSDT screen, a referral for appropriate assessment, diagnosis, treatment or follow-up is required. Notably, the Medicaid/EPSDT legislation and regulation both use the general term "developmental assessment" but two discrete functions – screening and diagnosis – are to be carried out and financed. (See box) States often need and may seek professional guidance in defining these two functions.

Financing for Services to Promote Healthy Emotional Development

Primary Pediatric Care

As described in professional guidelines from the American Academy of Pediatrics and other pediatric care experts, a child's primary pediatric provider (typically a pediatrician, family physician, or nurse practitioner) plays an important role in promoting emotional well being and healthy mental development in early childhood.

"Screening for developmental assessment is a part of every routine initial and periodic examination. Developmental assessment is also carried out by professionals to whom children are referred for structured tests and instruments after potential problems have been identified by the screening process.... In younger children, assess at least the following elements:

- *Gross motor development, focusing on strength, balance, locomotion;*
- *Fine motor development, focusing on eye-hand coordination;*
- *Communication skills or language development, focusing on expression, comprehension, and speech articu-lation;*
- *Self-help and self-care skills;*
- *Social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents, and other adults; and*
- *Cognitive skills, focusing on problem solving or reasoning."*

Source: CMS State Medicaid Manual, Part 5, EPSDT § 5123.2

Bright Future in Practice: Mental Health offers suggestions for primary care pediatric practice and for collaborative practice between primary care pediatricians and a range of professionals (e.g., developmental specialists, child psychiatrists, psychologists, social workers)

Professional guidelines also suggest that when young children need mental health interventions, these are best provided through the coordinated efforts of primary care health professionals, mental health professionals, education professionals, families, and community-based organizations providing support services. Some pediatricians have added social workers and developmental experts to their practices in order to provide more integrated services.

Medicaid-financed home visiting services

Medicaid/EPSDT is used to finance home visiting services for families facing high medical and social risks in more than a dozen states. The CMS has affirmed that Medicaid can be used to finance home visiting services. Key mechanisms include coverage as: a medical assistance service, case management, or targeted case management. These programs often are aimed at reducing risks associated with adverse mental health. Home visiting services might include: assessment of a home environment, assessment of the parent-child relationship, assessment of a child's development, parent education, interventions to reduce child abuse and neglect, maternal counseling for depression, parent-child therapy, or care coordination.

Mental Health Services in Early Childhood

State Medicaid agencies are concerned about the costs associated with mental and behavioral health and have established special rules for Medicaid mental health financing. Some of these rules call for prior authorization, clarify that only treatment certain diagnoses are covered, or allocate Medicaid dollars to community mental health agencies. For children, however, the State's approach should be different because of the EPSDT focus on prevention and early intervention, including healthy mental development. (See Bazelon Center publications.) In terms of early childhood mental health prevention and treatment, Medicaid coverage for benefits and services could include, but is not limited to:

- Screening to detect problems with mental, socio-emotional, and behavioral development;
- Diagnostic assessment for socio-emotional, behavioral, and developmental conditions;
- Family education, training and support;
- Case management and care coordination, particularly for children entering the child welfare system and foster care;
- Child care consultation for individual children;
- Individual behavioral health aides to assist a child in early childhood education or school;
- Relationship-based, parent-child therapy for families at risk, as well as families who have entered the child welfare system; [***continued on next page***]

- Therapeutic day treatment in a variety of early childhood care and education settings;
- Wraparound and community support services;
- Other traditional mental health inpatient and outpatient treatment.

Services for Children who Qualify for Early Intervention Programs

Under the federal Individuals with Disabilities Education Act (IDEA) Part C program, states provide early intervention services for infants and toddlers who have or have a high risk for experiencing developmental delays.. Some children qualify for both Medicaid and IDEA financing. Together, the Medicaid and IDEA federal laws clearly say that:

- Medicaid financing for certain services provided to a child and family under an IFSP is permitted by federal law.
- Part C is the "payer of last resort," meaning Medicaid dollars would be used before Part C funds for to finance Medicaid-covered services for dually eligible children.
- States may not reduce or limit medical assistance available or alter the eligibility of a child who qualifies under both Medicaid and Part C.

Services for Children who Qualify for Preschool Special Education Programs

Part B of IDEA authorizes state Preschool Special Education programs for children ages 3-5. All states have participated in the program since fiscal year 1992. Nationwide, more than one-half million children ages 3-5 with disabilities were receiving special education and related services in preschool programs that help prepare them to be successful in school.

Special education financing is a blend of dollars from multiple sources. Federal support is blended with state general revenues, public and private insurance, and family out-of-pocket payments to finance covered services. Under the Part B program, as under part C, some children qualify for both Medicaid and IDEA financing, and Medicaid can (and does) fund health-related special education services and medical services for these dually enrolled children.

In every state, some preschool children living with disabilities are entitled to a free and appropriate public education. However, states set the eligibility guidelines under broad federal parameters. In most states, infants and toddlers with or at risk for socio-emotional delays and behavioral conditions are less likely than children with physical movement or language delays to be identified and to receive services. Some states are working toward greater inclusion of early childhood mental health assessments and services in Part C Programs.

The transition from early intervention services to preschool services presents many challenges to children, families, service providers, and programs. States such as North Carolina and Rhode Island have used interagency agreeements to set the framework for a continuum of services under Parts C and B of IDEA through age five.

4. Tools from the Field

Asking Key Questions

Vermont has been a leader in children's mental health, working to create a system of care, to enhance early childhood mental health prevention services, and to include mental health as part of larger early childhood initiatives. Their questions may help guide providers in other states.

- What services are covered (e.g., case management, diagnostic assessment, child care consultation, intensive home visits, family center-based parent-child counseling)?
- What children are eligible for these services? What diagnostic labels are required?
- Who can be a qualified provider that can be paid for delivering these services? Is special supervision or delegation (e.g., by a physician or psychiatrist) required?
- Who needs to "sign off" – that is, who needs to give referral, approval or authorization?
- What are the fees (payment rates) for such services and where do we find the billing codes?
- What special financing arrangements are used (e.g., providers as subcontractors for community mental health agencies, providers as subcontractors to managed care organizations, or state grants with year-end reconciliation of annual billing)?
- What is the source for the non-federal share, commonly called "matching" funds (e.g., existing state funding categories, newly appropriated state general revenues, local taxes or levies dedicated to children or mental health, local education funding, private dollars)?

Clarifying Medicaid Guidelines

Leadership from inside and outside of government together stimulated changes in Florida. Senior policy makers have advanced early childhood mental health in Florida. Under the Administration of Governor Bush and legislative leadership of Senate President McKay, Florida has taken important steps to improve the mental health and emotional wellness of children birth to five years. An early childhood mental health multi-year strategic planning process brought together representatives from key state agencies, universities, foundations, the judicial system, providers, and private organizations concerned with the health and well being of young children. Their product -- *Florida's Strategic Plan for Infant Mental Health (www.cpeip.fsu.edu)* -- is the blueprint for developing a comprehensive system to prevent, identify and treat emotional and behavioral disorders in families with children birth to age five.

Florida's strategic plan called for improvements in Medicaid. In 2001, Florida made changes to Medicaid regulations and updated its "*Community Mental Health Services Coverage and Limitations Handbook*" to clarify existing policies, implement new policies, and revise definitions related to early childhood mental health. Together these changes improve the ability of community mental health services providers to deliver appropriate, efficient, and effective services. Among other things, Florida's revised Medicaid guidance:

- Clarified that coverage for therapy applies to individuals AND families;

- Extended Medicaid provider qualifications to permit a broader array of mental health service providers (i.e., non-physician providers) to enroll as treating providers and authorize services on a treatment plan (when employing or contracting with a licensed psychiatrist);

- Adopted targeted case management for mental health services to children in foster care; and

- Added a new section addressing services provided to children ages 0 to 5: *"For children 0 through 3 years of age, Medicaid encourages use of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0-3) for assistance in determining the infant or child's ICD-9-CM diagnosis"*

State agency leaders wanted to adopt policies that make it possible for providers to address the mental health needs of young children in an appropriate manner. As described by one state official: "Medicaid has changed its community mental health services program policy to make terms, definitions, and coverage more relevant to young children, to take into account the symptoms and needs of young children…. The new strategy for 0-5 behavioral health assessment will become mandatory and, along with other Medicaid financing modifications, drive our system of care for young children toward prevention and early intervention."

Blending and Braiding Funds

One important key for all of these efforts -- particularly in tight budget times -- is to use a variety of state and local funds to match and draw down federal Medicaid dollars. To expand and/or sustain Medicaid financing, states are looking at state general revenue dollars appropriated for child care, child protective services, early intervention, education, and public health. State officials in only a few states (e.g., Florida, Indiana, North Carolina, and Vermont) have actively reviewed their budget options with an eye toward maximizing use of state general revenue dollars as Medicaid matching funds.

Across the country, much of the creative blending and braiding also goes on at the local level. At the local level, funds are blended to create a balanced budget that will sustain a provider practice or center. The budget below shows an example from an early childhood center-based program, which provides center-based early intervention services, home- and center-based early childhood mental health services, services for children with special health needs, and other supportive services to children and their families.

5. Challenges and Opportunities in Maximizing EPSDT Financing to Promote Early Childhood Mental Health

Challenges

Financing services to promote early childhood mental health particular challenges as a result of at least five factors -- each of which can be overcome through state policy action.

- **The concept of mental health services to infants, toddlers, and preschoolers is new for many decision-makers.** Research shows, however, that appropriate interventions and therapies that can prevent or ameliorate mental health and behavioral health conditions among young children. Many such interventions and therapies can be covered under EPSDT, including parent guidance or parent-child therapy.

- **Prevention and early intervention services for young children are different from those traditionally used/ funded for children with severe emotional disturbances (SED).** Also, the modalities (e.g., treating a baby requires interaction with the parent or other caregivers) and locations for delivering these services (e.g., child care centers) may be different. But, these services can be and are being covered by Medicaid/ EPSDT.

- **Many states separate Medicaid mental health from the physical health side of the program.** When programs are administratively divided, prevention and early intervention services to promote early childhood mental health may fall through the cracks. For example, when the child's condition is not yet serious enough to qualify for intensive mental health services and at the same time EPSDT coverage of early interventions for emotional concerns are not clearly specified, state and local officials may say that the needed services are not covered. Regardless of the states' administrative arrangements, Medicaid-enrolled children are covered for medically necessary physical and mental health services under EPSDT. Clarifying the mechanisms is key.

- **The diagnostic codes used for older children, youth, and adults may not fit the conditions identified for infants and young children**; while a new set of codes has been developed (DC:0-3) they are not widely in use. A related problem is that the Individualized Family Support Plan (IFSP) under Part C and the individual services plan (ISP) under mental health programs may both be required for Medicaid financing but generally are not coordinated or consistent.

- **Among the youngest children, distinguishing between developmental, emotional, and physical conditions may be difficult.** Thus, it may not be clear when a child qualifies for more than one program or source of funding. In most federal/state programs, however, the state has a responsibility to determine eligibility for multiple programs and federal rules govern who pays for which services. States could develop mechanisms that maximize available funding and enhance access to needed services for young children.

Opportunities that won't bust the budget

- **Remember the basic rule -- most health and health-related services are covered under EPSDT.** Just because it isn't listed in the state manual or listed in the managed care benefits book, doesn't mean it is cannot be covered for children. Several states have started with a simple review of guidelines, in order to identify areas that could be clarified.

- **Don't forget the T in EPSDT**. Many times people focus on the S -- the screening and well-child visits so central to the program -- and forget that most treatment services are covered for detected conditions.

- **Clarify the distinction between developmental screening and diagnostic assessment.** EPSDT uses one term "developmental assessment" for two distinct functions. Screening may be incorporated into the general pediatric well-child visit, while a more comprehensive assessment may require the skills of a developmental or mental health specialist. States might create separate billing codes/rates for these two distinct functions.

- **Recommend effective and appropriate EPSDT screening and diagnostic assessment tools.** Every state could build on professional standards of care and recommend one or more specific screening and diagnostic tools suitable for young children. The state or local chapter of the American Academy of Pediatrics can help identify appropropriate guidelines. Your area also may have an Infant Mental Health Association that could provide advice.

- **Provide training and technical assistance to Medicaid pediatric providers on rules related to young children's conditions**. Providers are more likely to participate in Medicaid if they understand its rules and to provide services for which they can bill. Training and technical support for private practice pediatricians may encourage provider participation and and encourage appropriate services.. Also, if your state is using DC:0-3 or other diagnostic codes for early childhood mental health, pediatric primary care providers should be familiar with the concept and know how to look up a code.

- **Use a general strategy which matches state general funds with federal Medicaid dollars**. Possible categories of state funding include public health, mental health, child care, child welfare, home visiting, preschool education, and special education. Most states have have some Medicaid services that are being financed without federal financial participation because they've been overlooked.

- **Target at-risk populations already eligible for Medicaid benefits; they all are entitled to EPSDT coverage**. This includes low-income children and those children covered due to a disability, as well as those dually enrolled in Medicaid and private insurance. One way to improve services is to create clear definitions and guidelines. Targeted case management focused on social-emotional risk is another strategy.

6. Taking Action

Five Ways to Get the Ball Rolling

Building on the lessons of successful efforts across the country, these five action steps can help other communities and states can take to strengthen their attention to the social, emotional and behavioral needs of young children:

1. **Start small.** Apply for small grants or to local foundations to jump start a community or state-level planning process, building on other collaborations on behalf of young children. Small grants also may be available for pilot demonstration projects. In some case, private funds can be used as Medicaid matching dollars.

2. **Test new service approaches.** Communities have different mental health and pediatric care systems, not to mention early childhood care and education resources. Conducting a pilot project gives an opportunity to see what works for your area. You might test a new billing strategy, a new screening form, different referral approaches, or delivery of mental health consultation services in early care and education settings.

3. **Strengthen collaborative relationships.** Collaboration is key to developing a systematic approach and funding strategy. Most successful collaboration relies on formal mechanisms such as a group, regular meetings, and a written purpose. Establish or use existing formal mechanisms whenever possible. Make sure parents are involved.

4. **Know what you've got to work with.** Conduct an analysis of current funding for early childhood mental health. What is the flow of funds from federal and state to local providers? Are the funds sufficient in aggregate but need to be reorganized? What are the barriers to improved financing (political, structural, etc.)? Are there unmatched state appropriations that pay for Medicaid-covered services and, thus, could be used to draw down additional federal Medicaid dollars.

5. **Train and cross-train to enhance service capacity.** Too few trained professionals are available to deliver services to very young children. Some communities have developed new training programs. In other areas, cross-training initiatives build a shared understanding of what early childhood mental health services are and why they should be funded. Consider cross training with a mix of early childhood educators, mental health professionals, pediatricians, child welfare specialists, early interventionists, and parent advocates. Many programs have funds that could be blended or braided to support multi-disciplinary training..

7. Assess Your Community Resources and Strategies

The eight examples below (taken from real situations) each has a set of specific questions. Also, ask yourself the following general questions for each situation:

A. How would these children and their families be served in your area?

B. What supports and resources are available when no clear mental health diagnosis or disability is present?

C. How might the services for child and family be financed?

D. What agencies or programs would take lead responsibility?

1. Home visitor serving infant with depressed, teenage mother. Dante, a 6-month-old infant of a teenage, single mother, is enrolled in a special home visiting program that targets high-risk mother's living in public housing. The home visitor, a para-professional trained to teach the mother parenting skills, is very worried about both the baby and the mother, and perceives a lack of bonding between them. The baby is very fussy, difficult to feed and sooth, and the mother seems very unhappy or depressed. The home visitor is supposed to adhere to a curriculum, but feels that it does not address the real problems that exist for this family.

- In your community, what resources and supports would be available to the home visitor as she continues to work with this family?
- Where might the home visitor refer the mother and infant for a screen or assessment of their bonding? How would such a service be financed?
- Is there a parent support group or play group with mental health professionals involved where the mother and infant could gain skills to improve their relationship?
- What steps would be necessary to refer the mother for mental health counseling?

2. Family resource center serving socially isolated family with toddler. Lian is a quiet toddler, age 18 months. She and her mother are considered "at-risk" and "socially isolated." The father has returned to China for a period of six months. Lian and her mother attend classes at a neighborhood family resource center. The mother told center staff that she feels sad and doesn't enjoy playing with the baby. Observations suggest that Lian is behind on language development, but, when tested, she was not found eligible for the early intervention program. The family resource center staff are concerned and are looking for ways to do more to help.

- In your community, what resources and supports would be available to through the family resource center?
- Are mental health professionals available to enhance the services of family resource centers?
- Is there a parent support group or play group with mental health professionals involved where the mother and infant could gain skills and improve their relationship?
- Where could Lian receive services to improve her language development? How would these services be paid for if she is only "at-risk" and not diagnosed with a developmental/language delay?

3. Family day care home with two-year-old who has been a victim of abuse. Kirsten, age two, and her parents were living together when she started at the family day care home. But during the following few months, the child care provider became aware that her father was physically abusing her mother and sexually abusing her. With assistance, the mother found a temporary shelter with counseling and legal aid for women. Now that the mother and daughter are safe and living in their own apartment, her caregivers are concerned about Kirsten's mental health. She cries easily, never sleeps at nap time, eats little, and seems withdrawn.

- How might the family day care home provider arrange for mental health consultation at the center?
- Would mental health consultation be more readily available for a child care center than a family day care home?
- What about ongoing mental health counseling and treatment for mother and daughter?

4. Child care center with a teacher competency problem. Mrs. Jones, the teacher in Red Rock Child Care Center's group for 3-year-olds has asked the director to remove two boys from her classroom because she finds their behavior too difficult to control. The director is concerned because a similar request, made by Mrs. Jones last year, resulted in the removal of one child from the center and two others to another classroom. These children are all African American, and Mrs. Jones is white. The assistant teacher in the classroom has charged that Mrs. Jones is a racist. The director does not know how to sort out these problems and has called the Community Mental Health Center for help.

- What kind of support could the director expect to receive from the Community Mental Health Center?
- Does this community have resources to help the teacher improve her cultural competency?
- Is a mental health program consultant available for child care centers? How would these services be financed?

5. Child care center serving three-year-old with emotional-behavioral problems. Gregory is three years old and has been attending a quality child care center for five months. He loses his temper easily and has very little impulse control. Sometimes he engages in behaviors that seem almost compulsive, such as wringing his hands constantly or repeated shaking his head. His mother is a single parent, who recently started work after four years at home when she had Gregory and received cash assistance (welfare). His mom is extremely anxious about leaving him with others and about going to work. The caregivers in the center are concerned about Gregory and are uncertain how to handle his behavior.

- Where in your community can the child care staff turn for mental health program consultation? What about family services?
- Is the TANF program linked to mental health services for families in the transition from welfare to work?
- Where could Gregory go for an assessment financed through Medicaid?
- If he needs treatment, is there a mental health provide who is appropriate for a three-year-old and who accepts Medicaid?

6. Head Start program serving four-year-old who recently came from a refugee camp. Dahoud is a tall, bright four-year-old boy who survived the past two years in a refugee camp. There he witnessed violence and was separated from his parents for about six months. His parents also survived and were able to find him. Now the family is pleased to be living together in the United States. With the help of a refugee resettlement agency, both of his parents just found much needed employment. Dahoud attends Head Start, but staff are concerned because he doesn't play well with other children and seems afraid of being separated from adults. The Head Start program is looking for a mental health consultant to help.

- Is mental health program consultation available for the Head Start staff? How might it be financed?
- Is an appropriate family mental health consultation available? How might it be financed?
- What other services and supports might be available in your community for this family?

7. Family physician caring for a four-year-old with mother in substance abuse treatment program. Angelo is nearly four years old. He is very small for his age and seems to have stopped growing. His mother is now in treatment and recovering from substance abuse. However, for the prior two years she was heavily using drugs. During that time the family lived in a motel room, where Angelo was witness to many events related to drugs, violence, and prostitution. Although Angelo has a cheerful disposition and is interested in learning, his family practice physician at the community health center is concerned about his growth and emotional well-being.

- Are mental health services available for children with mothers in substance abuse treatment? How are they financed?
- Where could the doctor refer this child for further assessment to determine the cause of growth retardation? Is a pediatric endocrinologist available?
- Would funds from the Title V Program for Children with Special Health Care Needs be available to help finance treatment for growth retardation caused by biological and/or psychological factors?

8. Child care center serving five-year-old with severe emotional-behavioral problems. At age five, Nathan has already failed at school. After attending developmental day care for three years, he was found to be "not socially ready" after the first few weeks of public kindergarten. Enrolled in another child care center that has a kindergarten curriculum for five-year-olds, he frequently exhibits troubling behavior. Teacher/caregivers report that when he loses his temper he might throw chairs, hit others, or scream loudly. His single mother reports that she is exhausted from working two jobs and doesn't know how to handle him.

- Where could he be referred for an assessment?
- If he is diagnosed with an emotional-behavioral problem, what special education services might be available?
- Would school and child care staff be linked or work in a coordinated fashion?
- Is mental health program consultation available for the child care center? How might such consultation be financed?

8. References and Resources

On-Line Resources about EPSDT (updated 2012)

Federal Agency Resources

Centers for Medicare & Medicaid Services wwww.cms.gov or medicaid.gov
EPSDT web site http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html

Medicaid and CHIP Program, Mental Health Services http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Mental-Health-Services-.html

Maternal and Child Health Bureau www.mchb.hrsa.gov
EPSDT & Title V Collaboration to Improve Child Health web module http://mchb.hrsa.gov/epsdt/
Mental Health & EPSDT web module http://mchb.hrsa.gov/epsdt/mentalhealth/index.html
Collaboration and Action to Improve Child Health Systems: A Toolkit for State Leaders http://mchb.hrsa.gov/programs/collaboration/child_health_took_kit.pdf

Substance Abuse and Mental Health Services Administration, Children's Mental Health http://www.samhsa.gov/children/index.asp

Links to National Policy and Advocacy Organizations

Family Voices www.familyvoices.org/.

George Washington University www.gwhealthpolicy.org/

Georgetown University Center for Chil and Human Development, National Technical Assistance Center for Children's Mental Health (NTAC) http://gucchd.georgetown.edu/67211.html

Georgetown University Health Policy Institute, Center for Children and Families http://ccf.georgetown.edu

Kaiser Family Foundation http://www.kff.org/

Maternal and Child Health Library at Georgetown University http://www.mchlibrary.info
Knowledge Path on EPSDT http://www.mchlibrary.info/KnowledgePaths/kp_EPSDT.html
Knowledge Path on Emotional, Behavioral, and Mental Health Challenges in Children and Adolescents http://www.mchlibrary.info/KnowledgePaths/kp_Mental_Conditions.html

National Health Law Program www.healthlaw.org/

National Center for Children in Poverty www.nccp.org

National Center for Mental Health Promotion and Youth Violence Prevention http://www.promoteprevent.org/about/tacenter

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