REPORT

Unclaimed Children Revisited

The Status of Children's Mental Health Policy in the United States

Janice L. Cooper | Yumiko Aratani | Jane Knitzer
Ayana Douglas-Hall | Rachel Masi | Patti Banghart | Sarah Dababnah

November 2008

National Center for Children in Poverty
Mailman School of Public Health
Columbia University

The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Using research to inform policy and practice, NCCP seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to ensure positive outcomes for the next generation. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

UNCLAIMED CHILDREN REVISITED: The Status of Children's Mental Health Policy in the United States

Janice L. Cooper, Yumiko Aratani, Jane Knitzer, Ayana Douglas-Hall, Rachel Masi, Patti Banghart, Sarah Dababnah

The needs of children and youth who experience mental health difficulties, as well as the needs of their families, cannot be addressed adequately without solid policy foundations at both state and federal levels. *Unclaimed Children Revisited: The Status of Children's Mental Health Policy in the United States* aims to document and assess how well child mental health policies across the 50 states and three territories respond to the needs of children and youth with mental health problems, those at risk, and their families. Comprising a national study and four sub-studies, this report presents a range of data collected from service users, providers, family members, youth advocates, and state and county system leaders across the child serving spectrum. The report then uses these data to identify state- and federal-level policy implications and recommendations with the goal of promoting improved mental health service delivery through policy reform.

LEAD AUTHORS

Janice L. Cooper, PhD, is Director of Child Health and Mental Health at NCCP and Assistant Clinical Professor, Health Policy and Management at Columbia University Mailman School of Public Health. Dr. Cooper directs Unclaimed Children Revisited, a series of policy and impact analyses of mental health services for children, adolescents, and their families.

Yumiko Aratani, PhD, is a Senior Research Associate for Children's Mental Health at NCCP. Dr. Aratani is the lead data analyst for Unclaimed Children Revisited. Her research has focused on the role of housing in stratification processes, parental assets, and children's well-being.

Jane Knitzer, EdD, is the Director of NCCP and Clinical Professor of Population and Family Health at Columbia University's Mailman School of Public Health. She has contributed many important studies on how public policies can promote the healthy development of low-income children and better support families, particularly those who are most vulnerable. Dr. Knitzer authored Unclaimed Children in 1982.

ACKNOWLEDGMENTS

The following individuals were instrumental in the production of this report: Angela Keyes, Susan Wile Schwarz, Telly Valdellon, Amy Palmisano, Morris Ardoin, and Diana Barnes-Brown. NCCP was ably assisted in data collection by many facilitators and recorders in California. In Michigan, Susan McMahon and Jill Weise provided data collection support. Vivien Savath performed excellently in her data management support role. The project also benefited from consulting support from Mareasa Isaacs, PhD, National Alliance of Multiethnic Behavioral Health Associations and Jane Perkins, JD, National Health Law Program. Our projects each had advisers and those who consulted with us, please see Appendix 1 for a list. We thank all these individuals. We are also grateful to the John D. and Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, the California Endowment, and the Zellerbach Family Foundation for their support of the work described here. All errors and omissions remain the authors'.

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Dedicated to the memory of these life-long
Champions for children, youth, and their families:

Nicholas Hobbs, PhD

Julius B. Richmond, MD

Josie Torralba-Romero, MSW

EXECUTIVE SUMMARY

Over 25 years ago Jane Knitzer, in the report *Unclaimed Children: The Failure of Public Responsibility to Children in Need of Mental Health Services*, documented policy and program disconnects that meant children and youth with mental health needs and their families did not get the services they needed.[1] That report, along with family advocacy, served as a spur to improve service delivery for the most troubled children. In the intervening years, there has also been an explosion of knowledge about the biological and social determinants of children's mental health issues, new understandings of how children and their problems develop, and new ways of providing preventive and treatment services. And so, more than a quarter of a century later, NCCP posed the central question for today's children's mental health system: to what extent is this new knowledge incorporated into the policy and practice frameworks governing children's mental health?

This report is based on a study that documents how current child mental health policies across the United States respond to the needs of children and youth with mental health problems, those at risk, and their families. Our aim was to identify best policy practices that support family- and youth-focused, research-informed, developmentally appropriate, culturally and linguistically competent services and supports.

Our Questions

The study sought to answer the following questions:

1. Overall, how well are states serving children and youth with mental health conditions?
2. How are states moving toward a child mental health system that is guided by a public health approach that integrates prevention, early intervention, and treatment?
3. How are states addressing, in an age-appropriate manner, the mental health needs of children and youth, through a public health lens?
4. How are states improving the systems for service delivery and supports for children and youth with serious emotional disorders and their families?
5. How are mental health practices across the age-span guided by evidence of effectiveness?
6. How well do states respond to the need for culturally- and linguistically-competent services and systems to meet the needs of children, youth, and their families?
7. How well do states meet the need for family- and youth-responsive services and systems to meet the needs of children, youth, and their families?
8. How do states improve service delivery through infrastructure-related supports, fiscal policy and accountability measures?
9. What policy barriers and opportunities exist for states that try to improve their service systems?

Our Approach

To answer these questions, NCCP investigators used multiple methods to collect data. First, we conducted a state policy study (with responses from 53 jurisdictions). In addition to hearing directly from state child mental health directors through a survey, information was gathered from service users, providers, family members, youth advocates, and county system leaders across the child serving spectrum. Four sub-studies informed this report. These include:

- A survey of 19 mental health advocacy organizations in the United States that are under the umbrella of Mental Health America to complement the national survey;
- A case study of over 700 respondents in 11 counties in California;
- A case study of over 100 key informants from child behavioral health systems in six Michigan counties focused on outcomes management; and
- A survey of over 80 child mental health directors and multicultural directors focused on cultural and linguistic competence.

Major Findings

States are struggling to respond to the needs of children with mental health conditions. Children with complex needs such as co-occurring disorders pose the most difficult challenges. But while states have implemented some strategies, they generally lack the scope to address the need.

- Forty-one states (77%) reported that there are groups of children and youth with serious mental health problems that they serve well, but 12 states (22%) reported that there are *no* children and youth with serious mental health problems that they serve well.

States are moving toward a developmentally appropriate public health framework but progress is slow, with different interpretations about what it means to create a balanced service delivery system.

- Thirty-nine states reported that they have taken steps to move to a more public health oriented system, however states varied in their interpretation of what that means.
- In nine of these states, mental health advocates independently reported that such is a shift is not evident.

States vary in their efforts to meet the mental health needs of children and youth in an age-appropriate manner. Only a handful of states reported statewide efforts across the age-span.

- Overall, 42 states reported one or more state-wide initiatives on behalf of young children, school-aged children, and/or youth transitioning to adulthood; but
- Only seven states reported consistent support and funding for children and youth across the age-span, among young children, school-age children, and youth transitioning to adulthood.

For young children (birth to age 5):

- Forty-four states reported that they implement one or more initiatives that are designed to improve services and supports; but
- Half of these states reported that these initiatives are statewide.

For school-age children and youth, (6-18):

Toward a Developmentally Appropriate Public Health Mental Health Framework

A developmentally appropriate system of care should be marked by at least eight core components:

- A balance in the use of resources to encompass all age groups
- A balance in the array of services encompassing prevention, early intervention, and treatment, including for those with the most serious, complex problems
  - Discrete, age-appropriate, research-informed services for young children and their families from pre-natal through age five or even eight
  - Discrete, age-appropriate, research-informed services for school-age children differentiated for elementary school and high-school-aged youth
  - Discrete, age-appropriate, research-informed services for youth transitioning to adulthood
- Age-appropriate family supportive services embedded across all services, including those for mentally ill adults
- Culturally responsive services embedded across all prevention, early intervention and treatment services
- Adheres to system of care principles.

- Forty-seven states reported that they are actively involved in supporting school-based mental health initiatives designed to improve services and supports; and
- Half of these states reported that these initiatives are statewide.

For young adults, (18-26):

- Forty-four states reported that they are involved in supporting one or more initiatives for young adults with mental health problems transitioning to adulthood; and
- Nearly 60% of these states reported that their initiatives are statewide.

States have incorporated system of care values and principles into the service delivery system to support children and youth with serious emotional disorders and their families but only a few states have embedded the principles in regulatory or legislative structures.

- Fifty states (94%) reported that they have incorporated the system of care philosophy and values for children and youth with serious emotional disorders in their delivery systems.
- However, 18 states reported specific steps to make operational and sustain these efforts through legislation and regulation, practice standards, and strategic planning.

System of Care Values and Principles

System of Care Values
- Child driven and family focused
- Community-based
- Culturally and linguistically competent
- Family driven

System of Care Principles
Access to:
- Comprehensive service array
- Individualized services based on individualized needs and service plans
- Clinically-appropriate, least-restrictive service settings
- Families as full partners in service planning, decision-making, and delivery
- Integrated service delivery
- Case coordination and seamless service delivery
- Early identification and intervention
- Seamless transitions to adulthood
- Culturally responsive services and supports
- Youth and family rights and advocacy

Source:

Lourie, I. 1994. *Principles of Local System of Development: For Children, Adolescents and Their Families.* Chicago, IL: Kaleidoscope.

Stroul, B. A.; Friedman, R. M. 1996. The System of Care Concept and Philosophy. In B. A. Stroul (Ed.), *Children's Mental Health Creating Systems of Care in a Changing Society.* Baltimore, MD: Paul H. Brookes Publishing Co.

States have made progress in promoting evidence-based practices across the age-span.

- While 50 states (94%) indicated that they promote, require, or support the use of evidence-based practices, only 19 states reported that they promote, require, or support specific evidence-based practices statewide. Currently:
  - Twelve states mandate the use of evidence-based practices, but only eight states with mandates promote, support, or require specific EBPs statewide;
  - Among community stakeholders, community leaders were most likely to have ever heard about evidence-based practices (69%), compared to family members (11%) and youth (7%);
  - Most state mental health advocates (58%) knew about their state's efforts to advance evidence-based practices, but few knew about the specific strategies; and
  - 33% of county and community stakeholders report that a state-sponsored outcomes-based management system propelled implementation of evidence-based practices.

Children's mental health systems have made significant strides in their efforts to be family- and youth-responsive in service delivery and policy, but these efforts may not be enough.

- Forty-nine state children's mental health directors reported on a range of efforts to strengthen the family and youth voice in policy, but in at least 15 states, mental health advocates reported being dissatisfied with the family and youth voice in policy.

States have implemented policies and strategies to support culturally- and linguistically-competent services and systems, but these appear unsystematic and lack institutionalization.

- Twenty-seven states reported on policies that promote access to culturally- and linguistically-competent services, but only three states reported that they have implemented a range of purposeful steps to promote cultural and linguistic competence including competency-based training, workforce development, assessment and strategic planning, and stakeholder involvement in policy and programming.

States have mixed records in their efforts to improve service delivery through infrastructure-related supports, fiscal policies and accountability measures.

- States lag behind in developing the information technology (IT) infrastructure needed to support children's mental health service delivery.
- Only two states reported advanced information technology infrastructure to support children's mental health service delivery, however 24 states reported intermediate systems, and 19 states described their IT systems as rudimentary.

Accountability and transparency remain major obstacles to furthering strong fiscal structures.

- Many states remain unable or unwilling to document their child mental health budgets:
  - Twenty-seven states reported on their child mental health budgets;
  - Thirteen states reported that they were unable to report their total budget for children's mental health; and
  - Only 11 states reported funding for children with mental health conditions across child-serving sectors.

Many states have tried to exploit federal and state fiscal opportunities, but barriers persist.

- The Medicaid rehabilitation option, which permits significant flexibility in funding services and supports, is the Medicaid strategy most often reported by states (N=29).
- Increasingly states are using Medicaid and state funds to support family members and youth in professional roles in service delivery. Sixteen states reported that they use Medicaid, and 28 states reported that they use state funds to support family members. Twelve states reported that they use Medicaid and 24 states reported that they use state funds to support youth in professional roles.
- In 28 states, leaders recognized that opportunities exists for reform. They reported implementing innovative fiscal reform strategies such as efforts to expand service capacity, require or promote community reinvestment, braid or blend funding, maximize revenue, and establish practice or performance standards.

Overall, states reported two overarching barriers, fiscal constraints in what could be funded, often linked to Medicaid, and lack of service capacity.

- States most frequently considered financing (particularly federal Medicaid policy) (N=27), workforce (N=18), and cross-system collaboration (N=16) as the major obstacles to using their systems.
- Only 19 states reported using Early and Periodic Screening, and Diagnostic Treatment (EPSDT), which allow states to screen, assess, and treat children based on medical necessity, despite its universal availability and applicability.
- Only 16 states reported that they permit reimbursement to young children for certain services irrespective of whether they have a diagnosis.
- States reported that not being able to serve children who are at risk of SED but who do not have a diagnosis is a major problem. This gap impacts both young children and school-age children.
- Even though families tend to trust non-office based settings for services, some states restrict funding for services in non-office based settings, such as child care settings and schools.
  - Ten states reported that they restrict Medicaid reimbursement for mental health services delivered in child care settings and schools, and 14 states restrict reimbursement in parks or recreational settings.
- For youth in juvenile justice, 23 states reported (based on interpretation of federal law) that they restrict Medicaid reimbursement for mental health services.

States have limited capacity for using outcomes-based decision-making, planning and quality improvement and determining programming and policy effectiveness.

- Fifteen states rated their capacity for outcomes-based decision-making as rudimentary despite a federal initiative, National Outcomes Measures, designed to focus on outcomes.
- Forty-five states reported that they had initiatives to improve outcomes management, but it is unclear how deeply rooted these initiatives are or whether they improve service delivery.
- Forty-one states reported that they make state data and data analysis available for community planning, but 10 state mental health advocates reported that this does not happen in their states.

States identified fiscal barriers as the most critical policy challenge they foresaw to addressing the mental health needs of children, youth, and their families.

- Twenty states listed state fiscal barriers as a major challenge, and 31 states identified federal fiscal barriers, including Medicaid, among the top policy challenges. States also pointed to challenges with the workforce and the ability to work across systems.

States offered a range of reforms they would like to see implemented to improve children's mental health service delivery.

- Twenty-five states reported that they would like to see changes at the federal level related to service delivery capacity. In particular, the federal approach to working with states needs re-tooling, and prevention and early intervention as well as workforce capacity issues need to be addressed. At the state level, children's mental health directors identified family- and youth-responsive services and cross-systems work as areas where they would like to see changes.

Moving Forward

The majority of states are taking tangible steps to improve their mental health delivery systems for children and youth. While a quick glance at system improvements over the last 25 years suggests a real shift in the culture of care and numerous commendable advancements, particularly stemming from strong state leadership, more in-depth analysis reveals that these changes, while promising, are often limited in scope and depth. The central questions to ask in moving forward are:

- What should be the vision for a next generation child mental health delivery system?
- What needs to happen to move us toward that vision?

Based on our study, the next generation child and youth mental health system requires services and supports that range from universal strategies designed to promote mental health and prevent mental health problems, to intervention strategies and aftercare for children and youth with mental health conditions, including those with the most intensive needs. Such a system requires financing, service delivery, and infrastructure-related supports for effective, family-, youth-, culturally-, and linguistically-responsive and research-informed practices.

Characteristics of a Next Generation Mental Health System

- Flexible funding that allows rapid response to emerging knowledge about the development of mental health issues in children and research-informed practice
- Attention beyond children and youth with SED to children and youth at risk of SED through the mental health system
- Dedicated funding for prevention and early intervention
- Increased supports for parenting and for family support services in the context of prevention, early intervention, and treatment
- Implementation of core system of care values
- Incentivized systems to improve quality with specific attention to eliminating disparities based on race/ethnicity, culture, language and age
- Increased workforce capacity and competence, with greater attention to cultural responsiveness
- Use of data to drive clinical and administrative decision-making
- Increased attention to functional outcomes for children and youth
- Integrated delivery systems

Major Recommendations

Congress and the Executive branch should codify into law a public health approach to children's mental health services. Specifically:

- Provide a legislative framework for incentives and support for states to implement a public health approach for mental health for all children and youth. These incentives and supports can take the form of special grants, a set-aside in current funding streams, and technical assistance;
- Establish a prevention funding set-aside as part of the mental health block grant mirroring a practice in substance abuse funding and provide training, guidance, and technical assistance to states to implement a public health framework; and
- Create through legislative authority a requirement for state child mental health authorities, child welfare authorities, and state juvenile courts to work collaboratively with the Substance Abuse and Mental Health Services Administration (SAMHSA), Agency for Children and Families, the Department of Justice, and the Department of Education to develop a comprehensive strategy to address the mental health needs of children, youth, and their families in these systems, with the view to providing increased access to mental health promotion, prevention and treatment interventions.

Make an age- and developmentally-appropriate approach to serving children and youth with or at risk for mental health problems, and their families, a priority. Specifically:

- Provide incentives for statewide approaches to improving age-appropriate services; and
- Support states and professional organizations to improve the competencies of all providers (including teachers) who work with children and youth with mental health conditions and those at risk for mental health conditions so they are prepared to meet the needs of children in an age-appropriate manner.

In addition, for young children:

- Direct the Centers for Medicare and Medicaid Services (CMS) to develop a comprehensive strategy to support the provision of prevention,

early intervention, and treatment services for young children.

For school-age children and youth:

- Direct the Department of Education and SAMHSA, in conjunction with CMS where applicable, to develop a comprehensive strategy to support the provision of prevention, early intervention, and treatment services for school-age children.

For youth transitioning to adulthood:

- Remove federal prohibitions that govern federal funding of services to youth in juvenile justice.
- Make available, at the state option, enhanced federal Medicaid participation rates for all youth with mental health system involvement up to age 25.

Implement a comprehensive plan that finances the delivery of empirically-supported practices through payment structures like Medicaid, private insurance, grants, and incentives. Specifically:

- Contribute to the financing of more widespread adoption of evidence-based practices in states.

In conjunction with states:

- Systematically track the use of and outcomes associated with the implementation of evidence-based practice; and
- Create initiatives that educate youth service users and their family members on evidence-based practices.

Take action to reduce disparities in access to mental health services and mental health outcomes based on race/ethnicity and limited English proficiency. Specifically:

- Require states to report on their efforts to address disparities in access and outcomes for children and youth from diverse racial, ethnic, and linguistic backgrounds; and
- Annually report on a state-by-state basis efforts to address disparities through the use of nationally-established benchmarks.

Address the poor information systems capacity of children's mental health delivery systems and stimulate strategic planning and development. Specifically:

- Assess the status of children's mental health information technology infrastructure.
- Include children as a priority for the national health information technology implementation plan and tap into its capital resources to upgrade these systems.

Develop and implement a comprehensive financing strategy that supports a public health focus to mental health. Specifically:

- Require child mental health care content expertise in the development of state Medicaid plans and Medicaid policy decision-making;
- Provide incentives for states to use Medicaid innovatively, such as to support mental health consultation or services in a range of non-office-based settings;
- Reward states that are using Medicaid and state funding creatively to improve service delivery and tie these rewards to improved outcomes;
- Identify a set of individual and system-related outcomes for children and youth with mental health conditions and link these to publicly financed public health strategies;
- Reject federal changes to the rehabilitation option that undermine services in child care, schools, and other settings that children, youth, and their families frequent;
- Require CMS to ensure that all states maximize the impact of EPSDT on children's mental health services; and
- Report on benchmarks for behavioral health screenings and services funded by EPSDT, and establish specific targets for meeting the 80% participation threshold.

Require an outcomes-focused approach to service delivery in children's mental health. Specifically:

- Provide incentives and support for states to move toward more outcomes-focused management; and
- Help states link mental health policy and clinical decision-making initiatives.

State governments, territories, and the District of Columbia should:

- Support strategic planning to address unmet need in public mental health systems. Specifically,
  - Document periodically and make publicly available estimates of unmet needs across age groups and states' plans to address these needs.
- Address racial and ethnic disparities in access to mental health services and in mental health outcomes by:
  - Annually reporting on a county-by-county basis efforts to address disparities through the use of nationally-established benchmarks; and
  - Assessing their state children's mental health system's level of cultural and linguistic competence, develop a strategic plan, and publish regular updates of their progress.
- Create mechanisms to sustain family and youth involvement in practice and policy by:
  - Implementing strategies to support family and youth in professional roles using Medicaid; and
  - Providing long-term funding for family and youth advocacy and support.
- Attend to the urgent need for updated information systems by:
  - Ensuring that as states develop information systems for other sectors of their child delivery systems they upgrade the child mental health infrastructure for maximum interoperability across child serving systems.
- Address poor fiscal accountability by:
  - Annually and publicly reporting states' children's mental health budgets; and
  - Documenting how states use EPSDT for children and youth with mental health needs and those at risk.

Conclusion

The vast majority of states are taking tangible steps to improve their mental health delivery systems for children. A quick glance at system improvements over the last 25 years suggests a real shift in the culture of care and numerous commendable advancements, particularly stemming from strong state leadership. More in-depth analysis, however, reveals that these changes, while promising, are often severely limited in scope and shallow in depth due to lack of concerted strategic plans.

While the current structure focuses on children with severe mental health conditions, too few resources have been expended to develop a comprehensive framework for addressing the needs of children and youth with or at risk for mental health conditions, and their families. At the same time, efforts to "get ahead of the curve" and implement an approach to service delivery grounded in the public health framework of mental health promotion and prevention of mental health disorders, early intervention, and treatment remain stymied, subject to few if any resources and the good will of a few leaders.

As with *Unclaimed Children* in 1982, we have an opportunity to radically alter the trajectory of children's mental health policy. Our national and state leaders have the opportunity to take bold policy choices that change how services are delivered. The clear message from this report is that children, youth, and families need their leaders to implement an agenda that places at the forefront the best knowledge about what children and youth need at different stages of their development, effective practices, and the settings and systems most equipped to support them in family- and youth-responsive and culturally and linguistically competent ways.

This framework would put those at risk of mental health conditions on a par with those with mental health conditions. It should drive how services are financed, how training is developed and implemented, how technology is applied, and how the workforce is prepared and compensated, so we can effectively track the outcomes that matter for children, youth, and their families. Now is the time to move forward.

INTRODUCTION

"Americans assign high priority to preventing disease and promoting personal well-being and public health; so too must we assign priority to the task of promoting mental health and preventing mental disorders…."

Surgeon General Report, 1999.

More than 25 years since Knitzer's call for public systems to address the needs of America's most troubled children and youth, the findings appear uncanningly similar. There have been many commissions, hundreds of scholarly papers, and an explosion in the knowledge base on the root causes of child mental health conditions and on effective interventions for them and for those at risk and their families. But our national ability to get ahead of the curve and avert suffering and to reduce the impact of some of these conditions remains wanting despite this new knowledge.

Farther, despite these developments, since 1982 there have been few major studies that have focused comprehensively on access to mental health services and supports thorough a policy lens. Some studies have documented the problem of unmet need, others have assessed the merits of system of care initiatives, and still others have focused on one or two components of the service delivery system or of the age span. This report seeks to update *Unclaimed Children* by examining ways that, through supportive polices, states:

- Provide access to a comprehensive array of prevention strategies, treatment, and supports that are age-appropriate for children and youth with mental health conditions, those at risk, and their families;
- Infuse empirically-supported, effective practice in the service delivery system;
- Promote and support family- and youth-responsive, and culturally- and linguistically-competent services and supports; and
- Maximize effectiveness and efficiencies through fiscal, infrastructure-related, and management supports.

The report draws on data collected through a national survey of state children's mental health directors and from four sub-studies designed to provide on-the-ground context and understanding from a broad range of stakeholders in the United States, California, and Michigan. The focus of the data collection was on nine core questions:

1. Overall, how well are states serving children and youth with mental health conditions?
2. How are states moving toward a child mental health system that is guided by a public health approach that integrates prevention, early intervention and treatment?
3. How are states addressing, in an age-appropriate manner, the mental health needs of children and youth, through a public health lens?
4. How are states improving the systems for service delivery and supports for children and youth with serious emotional disorders and their families?
5. How are mental health practices across the age-span guided by evidence of effectiveness?
6. How well do states respond to the need for culturally- and linguistically-competent services and systems to meet the needs of children, youth, and their families?
7. How well do states meet the need for family- and youth-responsive services and systems to meet the needs of children, youth, and their families?
8. How do states improve service delivery through infrastructure-related supports, fiscal policy and accountability measures?
9. What policy barriers and opportunities exist for states that try to improve their service systems?

Based on the findings of these inquiries, the report lays out a vision for the next generation of federal and state policymaking.

Our Approach to Data Collection

A national survey and four sub-studies including two state case studies encompass Unclaimed Children Revisited.

Below we describe each of the studies.

Unclaimed Children Revisited: A Survey of State Children's Mental Health Directors, 2006

This is a 50-state survey of State Children's Mental Health Directors administered by mail, telephone, and electronically.[a] A national advisory group made up of researchers, policymakers, and family members guided the work. (See Appendix 1 for list of advisors.) The research was conducted in three phases. The process included:

- Three stakeholder meetings to inform the research questions;
- Meetings and review of research questions with representatives of the Children, Youth, and Families Division of the National Association of State Mental Health Program Directors (NASPMD); and
- Solicitation of its members by NASPMD to encourage state participation.

Fifty-five surveys were sent electronically and by mail to state children's mental health directors in all 50 states, the District of Columbia, and the United States territories. Fifty-three directors or their designees responded, yielding a 96% response rate.

About the Respondents

Over 80% of the respondents (N=43) reported having background/training in mental health, and 74% (N=39) also reported having background/training in a related social services/public health field. Five survey respondents did not answer questions about their background. Close to half of the respondents were in their current positions for seven years or more, and just under a quarter were in their current positions for three years or fewer.

Unclaimed Children Revisited: Survey of State Affiliates Mental Health America (MHA), Winter 2007

This is a survey of affiliates of Mental Health America (MHA) administered electronically and by mail. With more than 320 affiliates, MHA is dedicated to helping all people live mentally healthier lives. The survey instrument was modeled after the Survey of State Children's Mental Health Directors 2006. Nineteen state mental health affiliates responded. The design and administration process included:

- Survey amendments in collaboration with MHA staff Luanne Southern and Raymond Crowel; and
- A letter of invitation to participate by MHA President and CEO David Shern. Reminder letters were sent out by MHA Past President and UCR advisor Cynthia Wainscott.

About the Respondents

Almost half of the respondents from 19 advocacy organizations were in their positions for seven years or more and just over one quarter for three years or fewer.

Unclaimed Children Revisited: The California Case Study

This is a study of 11 counties and the State.[b] Investigators used multiple instruments. Data was collected through face-to-face and telephone interviews and secondary data was obtained from the California Department of Mental Health on Community Services Inventory and Medi-Cal. Seven hundred twenty-five individuals responded. The work was guided by a California-based advisory work group that included family members and youth, researchers, policymakers, and advocates. (See Appendix 1.)

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a. Funded by the Annie E. Casey and John and Catherine T. MacArthur Foundation.

b. Funded by the California Endowment and the Zellerbach Family Foundation.

About the Respondents

Roughly one-third of respondents among California system leaders were in their positions for seven years or more, and just over one-third were in their positions for three years or fewer.

Unclaimed Children Revisited: The Michigan Case Study

This is a case study of the mandated use of the Child and Adolescent Functional Assessment Scale (CAFAS) in Michigan's community mental health system.[c] Data were collected through face-to-face and telephone interviews with 111 state and county leaders who participated. Participants came from the service area of six community mental health authorities. A state advisory workgroup made up of policymakers, researchers, providers, and family members guided protocol development and site selection. (See Appendix 1.)

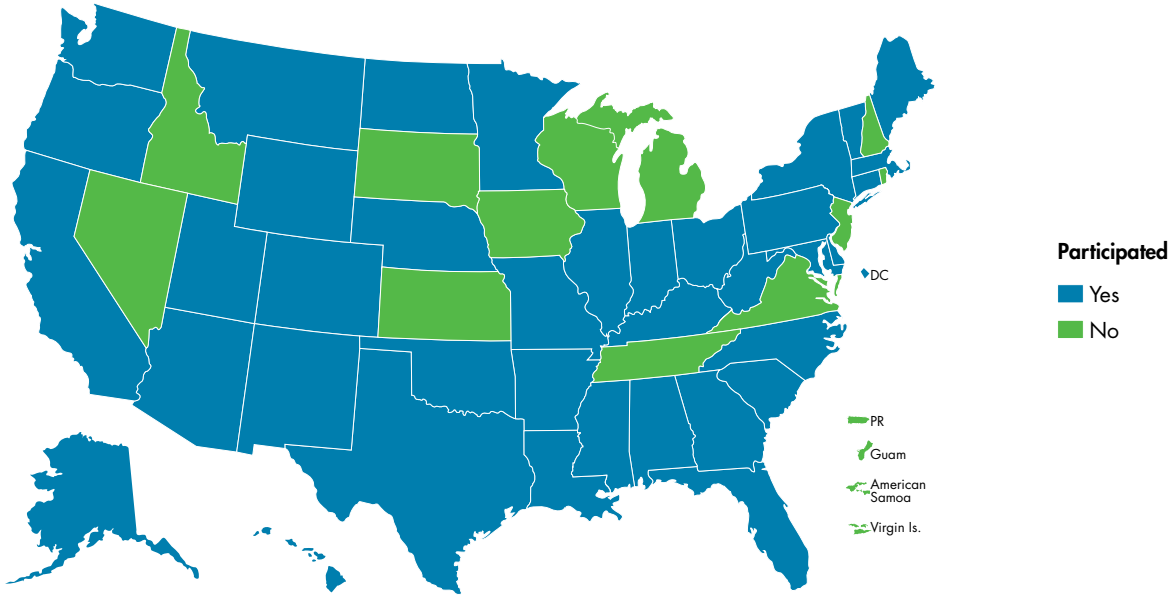
About the Respondents

Just under 40% of the 42 Michigan state and county system leaders respondents were in their current positions for seven years or more and nearly one-fifth were in their current positions for three years or fewer.

Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health

This is a case study of policies to support cultural and linguistic competence in children's mental health.[d] It was administered through an electronic survey to children's mental health directors and state multicultural directors/coordinators on Surveymonkey.com. Thirty-nine individuals responded. The design and recruitment process included: solicitation from NASPMD Board Member Renata Henry to state children's mental health directors encouraging their participation; and pretesting of the survey instrument by three state level policy experts. (See Appendix 1.)

Figure1: **States Participation in UCR: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health**



c. Funded by the Annie E. Casey and John and Catherine T. MacArthur Foundation.

d. Funded by the Mailman School of Public Health, Columbia University, through the Calderone Research Prize for Junior Faculty.

About the Respondents

Eighty respondents from 39 states responded to the survey. Roughly one-third of respondents were in their current positions for at least six years and another one-third positions for at least three years or fewer. The results reported here represent responses from 19 children's mental health directors, those with equivalent authority, or their designees. Ten respondents were multicultural coordinators or directors, and ten held other positions. One respondent did not indicate a position.[e] See Figure 1.

Research Oversight

Unclaimed Children Revisited was conducted under the auspices of the Columbia University Medical Center Institutional Review Board (CUMC IRB). In addition, the State of California, California Health and Human Services Committee for the Protection of Human Subjects, and six local and county IRBs approved this study.

Setting the Context

When Jane Knitzer investigated child mental health policy in the United States in 1982, she portrayed a public mental health policy and service delivery system in shambles.[2] The vast majority of children and youth with mental health conditions were not being served, and the services that did exist were mostly ineffective and often inappropriate inpatient care. Further, the federal government largely ignored its obligation to these children. Among states, only seven were attempting to create a continuum of community-based mental health services, a concept Knitzer coined "system of care." Few policies at the federal or state level embodied a child and family focus.

This report reflects movement since 1982. Today, as our findings will show, there is a focus on family- and youth-centered mental health care (evident in policy and practice), and the debate is on whether it is sufficient. In many states, policy currently includes maintaining and expanding the range of age-appropriate, community-based, research informed services and supports, and reducing racial and ethnic disparities in access to care. Again the debate is whether these efforts are sufficient to meet the need. Finally, an emerging effort to improve outcomes and accountability by focusing on quality and tracking results is apparent.

This chapter reviews the level of unmet needs and two major policy movements of this generation for children's mental health. The system of care movement focuses on the most troubled children and youth, often referred to as children and youth with serious emotional disturbances (SED), or children and youth with emotional and behavioral disturbances (EBD). The second change encompasses more recent efforts to move mental health toward a public health framework articulated in the President's New Freedom Commission report. Both of these policy goals provide important if often potentially contradictory frameworks, and both depend on resources and service capacity-building to succeed.

Tracking Unmet Needs

Estimates of the prevalence of children and youth with mental health conditions range from 5-13%.[3 4] Among young children, between 9.5% and 14% have mental health problems serious enough that they have trouble functioning. For school-age children and youth, rates of severe emotional disturbance can be as high as 20% in some samples.[5] Children and youth in special educational settings experience higher rates of emotional-behavioral disturbances, ranging as high as 70% in special programs.[6] Among children in more vulnerable situations such as those with child welfare, substance-use treatment, or juvenile justice involvement, rates of mental health conditions may be as high or even higher.[7 8 9] Yet research shows significant unmet need in all these groups.[10] Further, this unmet need is exacerbated when one considers factors such as race/ethnicity, age group, socioeconomic status, English language proficiency, and geography.[11 12 13]

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e. Five respondents had children's mental health expertise at the program level, one was a former children's director, three had cultural competence expertise at the program level, and two were planning experts.

Box 1: System of Care Values and Principles

System of Care Values
- Child driven and family focused
- Community-based
- Culturally and linguistically competent
- Family driven

System of Care Principles
Access to:
- Comprehensive service array
- Individualized services based on individualized needs and service plans
- Clinically-appropriate, least restrictive service settings
- Families as full partners in service planning, decision-making and delivery
- Integrated service delivery
- Case coordination and seamless service delivery
- Early identification and intervention
- Seamless transitions to adulthood
- Culturally responsive services and supports
- Youth and family rights and advocacy

Source:

Lourie, I. 1994. *Principles of Local System of Development: For Children, Adolescents and Their Families.* Chicago, IL: Kaleidoscope.

Stroul, B. A.; Friedman, R. M. 1996. The System of Care Concept and Philosophy. In B. A. Stroul (Ed.), *Children's Mental Health Creating Systems of Care in a Changing Society.* Baltimore, MD: Paul H. Brookes Publishing Co.

Box 2: A Public Health Framework

Characteristics of a public health framework
- Anchored in a systems perspective
- Reflects understanding of the causes of mental health conditions
- Uses a population-based perspective [assumes universal and selective interventions]
- Focuses on increasing assets and building on resilience to prevent or ameliorate mental health conditions
- Trained service providers to appropriately screen, assess and treat or refer

Examples include:
- **For young children:** Family support and parent education strategies
- **For school-age children and youth:** Whole school strategies such as Positive Behavioral Interventions and Supports, or Fast Track, a social emotional learning program
- **For youth transitioning to adulthood:** peer-support strategies, independent living and housing supports
- **For families:** Mental health education and access to family centered services and supports
- **For all:**
  - Quality developmentally-appropriate screening, assessments, and interventions
  - Service coordination and linkages with community-based primary care and mental health

This framework enables a response to the most seriously troubled children and families but emphasizes a commitment to developmentally appropriate prevention, early intervention, and treatment for all children at risk for mental health problems.

As Knitzer pointed out in 1982, even where children and youth access services, the quality of the services they receive may be less than optimal.[14] The consequences of this failure by public mental health systems to match children and youth with service needs with appropriate care include prolonged suffering, increased cost, and inappropriate referrals.[15 16 17] Other unintended consequences may be custody relinquishment in exchange for services and even suicide or attempted suicide.[18 19] From a policy perspective, when policymakers are constantly reacting to an onslaught of needy children and youth, they are unable to proactively and strategically re-craft their systems to better respond to needs earlier, and prevent children and youth from reaching crisis points and thereby seeking the most intensive set of services and supports.

Creating a System of Care

The federal government's primary investment in children's mental health in the last two decades has been in children's system of care, formally named the Comprehensive Community Mental Health Services for Children and their Families and funded by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAMHSA). A grant funded program, system-of-care initiatives built on the values of child-centered and family-focused care, cultural competence, and community-based services delivery. They directly reflect the framework that Stroul and Friedman laid out, which promoted principles including individualized care, a comprehensive set of services and supports, care coordination, early intervention, robust transitions and supports, the least restrictive care, and family and youth engaged.[20] Coming closely on the heels of *Unclaimed Children* and in some way a response to it, these initiatives have generated great hope and some concern. The grants provide up to six years of funding for local communities to improve services for the most troubled children and youth. Over $1 billion has been invested in hundreds of communities by the federal government through this mechanism.[21] Every state and many territories in the United States have been grant recipients. However, concern about the states' capacity to address unmet need remains.[22] Fewer than 100,000 children and youth, and their families have been served to date,

although this is arguably more an initiative about systems change than about directly expanding capacity.[23] Evidence suggests that, in some states, these grants have served as an impetus to change the underlying philosophy behind their mental health service systems.

Moving Toward a Public Health Framework

The President's New Freedom Commission followed the opening presented by the *Surgeon General's Report on Mental Health* by situating a vision for an improved mental health system squarely in a public health framework. Like the *Surgeon General's Report,* it called for public education, prevention strategies, early detection through screening, and early access to effective interventions and supports. A public health framework incorporates a population focus to interventions and supports beginning with health promotion and prevention strategies to early intervention, treatment, and care coordination. An expectation of the public health framework is the application of research-informed practices, information on the prevalence of mental health conditions and risk factors, and knowledge of the underlying causes of both mental health conditions and their remedies. The framework presumes a large role for non-hospital-based settings such as community care centers, homes, child care and early learning settings, schools, and other non-office-based settings where children, youth, and their families spend their time. It also emphasizes resilience, strengthening protective factors, and recovery.

Research suggests that a public health approach to mental health may serve as the answer to how to address the gulf between service needs and service provision.[24] It may also help to overcome stigma that interferes with seeking help when it is needed.[25] The public health infrastructure has historically ranged from primary care to schools, including early care and learning settings, to other organized community-based systems like the cooperative extension. It also includes a diverse array of providers from lay workers to highly trained personnel that support service development and provision.

There are other compelling reasons for state mental health directors to advance a public health approach to mental health. First, research continually provides more knowledge about mental health disorders, ways to prevent them and to intervene early together. Second, taking a proactive approach to mental health that encompasses promotion and prevention requires an expansion of the capacity of the service delivery system to meet the needs of children, youth, and their families. Third, there is the natural fit between understanding the role of cognitive, physical, and social and emotional development and the physical and social environments in which children and youth live and grow that comes out of the public health tradition. Indeed, the lessons from large scale public health initiatives include the need to target environmental strategies and the factors that underlie well-being.[26] At the federal level, leadership in advancing a public health agenda has emphasized the benefits of a public health framework, urging "transformation" without much guidance on how children's mental health systems in the United States, with or without federal funding, implement this approach.

The case for a public health strategy includes long-term financing gains, optimal service integration, early detection and increased mental health competencies and capacity in primary care. The latter is particularly presumed for screening and quality services. Most important, the need for a public health strategy for children's mental health stems from repeated failures to anticipate and address mental health needs and prevent mental health conditions on a large scale.

While the call for a public health framework in children's mental health has been positively received, there are many obstacles to implementing a public health approach. Among the major impediments to implementing such an approach in mental health are: current financing structures;[27] level of workforce readiness,[28] systems' readiness and capacity to integrate the mental health specialty and public health infrastructure, particularly in primary care;[29] the poor fit between traditional mental health ways of disseminating information and proven marketing models;[30] and inadequate infrastructure-related, outcomes-based management and supportive fiscal policies.

Nearly one decade since the *Surgeon General's Report* and five years since the *President's New Freedom Commission Report* on children's mental health *Unclaimed Children Revisited* examines state children's mental health policy in light of the vision that these reports espoused.

Released on Nov. 20, 2008, *Unclaimed Children Revisited: The Status of Children's Mental Health Policy in the United States* largely reflects how states have attempted to move their care-delivery systems through policy decisions toward the vision for service delivery for children and youth with mental health conditions articulated through children's system of care development and the implementation of a children's mental health system based on a public health framework.

CHAPTER 1
Overall, How Well Are States Serving Children and Youth with Mental Health Conditions?

"Of the three million seriously emotionally disturbed children in this country, two-thirds are not getting the services that they need. Countless others get inappropriate care. These children are 'unclaimed' by the public agencies with responsibility to serve them.

The most readily available 'help' for these children remains the most restrictive and costly inpatient hospital care."

Knitzer, 1982

One of the major sources of unmet need in children's mental health appear to stem from a lack of adequate capacity to treat all the children and youth who present with mental health problems in various settings. These include insufficient number of providers, too few community-based treatment slots, and poor alignment between the service systems that children and youth are in and the availability of resources.[31 32 33 34 35]

This chapter describes states' responses on how they address the needs of children and youth with otherwise unmet needs. It also reviews data from state mental health advocates. NCCP investigators asked states to report on the children and youth they served well and those they struggled to serve appropriately.

Children States Struggle to Serve and Serve Appropriately

Forty-one states (77%) reported that there are children and youth that their children's mental health systems serve well. The most frequently identified groups of children and youth that child mental health directors reported they serve well include children in need of intensive services, such as those in wraparound or special projects, and children in child welfare, early childhood settings, or juvenile justice. However, 12 states (23%) reported that there were *no* groups of children with mental health conditions that they served well.

Nearly all states also reported that there are groups of children and youth that they struggle to serve appropriately (90%). Of those states that reported on groups that they struggled to serve appropriately, overwhelmingly they identified children with co-occurring disorders, developmental disability, or substance abuse problems, followed by juvenile justice involved youth and transition-age youth. About one-fifth of the states readily admitted that they did not feel that they served any groups of children and youth well. Two states reported that there are *no* children and youth that they have trouble serving.

In all, 23 states indicated that they have implemented effective strategies or policies to appropriately address the needs of youth with substance use conditions. Washington State and Texas specifically reported on these efforts. In Washington State, through 2005's SB 5763, treatment services were expanded for children and adults with substance use conditions, and the state provided a vehicle at the county discretion to increase tax levies to enhance services for both mental health and substance use conditions. To date, eight counties in Washington have adopted the levy, and it is under consideration in an additional five of the remaining counties. SB 5763 has enabled the state to implement the Global Assessment of Needs Scale (GAINS), a standardized and validated assessment tool for substance abuse statewide.[36] The State of Texas also reported conducting evidence-based substance abuse treatment in the schools.

In all, there are populations of children and youth with mental health conditions that states represented both as having served well and struggled to serve. This finding is not inconsistent. Consider that for the groups of children and youth that states do serve, they may do a good job. But for many states the lack of mental health service capacity is such that there are many more that they struggle to serve within any given category.

Box 3: Efforts to Embed Trauma-Informed Practices: Specific Initiatives Trauma and Disaster Related Services that States Report

In recent years, national events and unexpected man-made and natural disasters have brought considerations about trauma and the service and policy response to the fore. Research shows that exposure to disasters and trauma is associated with diagnosable mental health disorders as well as behaviors that put children and youth at risk for poor outcomes in many areas of their lives, such as health and mental health, school achievement, and engagement with juvenile justice.[37] [38]

Children's mental health service delivery and policies are integral to creating research informed policies for children, youth, and those who experience trauma. UCR investigators asked state children's mental health authorities to describe their practice-supported policies in the area of trauma and disaster. States provided information on systematic efforts to screen and treat children, youth, and their families for trauma or suicide risk and on disaster planning for children and youth with mental health problems.

- Forty states reported that they systematically screen or treat children, youth, or their parents for trauma and or suicide risk. However, 13 states did not. Most commonly, states reported that they provided the following services:
  - Twelve states reported that they provide trauma or suicide screening (four states specified the use of the Columbia teen screen, a validated screening tool);
  - Ten states reported they provide training, and standardized and validated tools, such as on Trauma-focused Cognitive Behavioral Therapy (TF-CBT), Applied Suicide Intervention Skills Training (ASIST), Question Persuade & Refer (QPR), and crisis/suicide intervention and prevention;
  - Seven states noted that they provide services for suicide prevention, including projects funded through the Garrett Lee Smith Act;
  - Three states reported 24-hour help lines in connection with trauma services and suicide prevention; and
  - Only one state reported working with the National Child Traumatic Stress Network, trauma-informed juvenile justice and child welfare systems.
- Thirty-four states reported that they have a specific plan for children to deliver mental health services in the event of a disaster or emergency; a large minority of states, 17, reported that no such child specific plan exists; 24 states reported that they have a designated individual in the children's mental health authority charged with coordination of services.

Addressing Trauma

States also reported on efforts to embed a trauma-informed perspective to service delivery. Box 3 outlines states' responses to inquiries about how they address the need for disaster preparation and disaster and trauma prevention, early intervention, and treatment.

Major Findings and Policy Implications

- For the 23% of states (N=12) that were unable to identify any groups of children and youth with mental health conditions that they served well, more federal support and action is needed to improve service delivery.
- No state identified children and youth at risk and those who would most benefit from a public health framework as children that they either served well or struggled to serve. This suggests that for many state children's mental health leaders, these children and youth remain mostly invisible, and the systematic adoption of the public health framework remains elusive.
- States urgently need service delivery and funding strategies that permit them to serve all children and youth with mental health conditions but especially those with co-occurring disorders. The current federal initiative in this area highlighted in Box 4 is inadequate to address the magnitude of the problem.
- States' efforts and federal supports are mostly short-sighted, piecemeal, and disconnected from trauma-informed perspectives.[39]
- Results from this report and our case study work suggest that a myriad of policy and practice barriers prevent states from serving children and youth appropriately. These barriers include funding structures and workforce challenges that impede the simultaneous use of evidence-based treatments for co-occurring substance use and mental health conditions, poor collaboration across systems, disability thresholds that fail to capture some children and youth with low cognitive functioning, and federal prohibitions and state interpretations of the rules that govern federal funding of services to youth in juvenile justice.

Box 4: Federal Support for Children and Youth with Co-Occurring Disorders

SAMHSA's Center for Substance Abuse Treatment and Center for Mental Health Services Joint Grant Program for Co-occurring Disorders

The five-year, $5.3 million grant was awarded to six states and one tribal government:

Arizona	Nevada	Puyallub Tribe in Washington
Georgia	South Carolina	
Nebraska	Utah	

Grants total $750,000 per year and cannot be used for services.

The goals of the grants are to:

- Strengthen states' ability to develop and sustain services for youth with co-occurring mental health and substance use disorders
- Support infrastructure development, collaboration, and a range of efforts that target service expansion

Source:

Sondheimer, Diane, Center for Mental Health Services. Dec. 12, 2007. Personal communication.

Sondheimer, D.; Butler, J. N.D. Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grants. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Recommendations

The federal government should:

- Require that ***all*** children be the focus of the child mental health system without losing the focus on the most troubled children, youth, and their families;
- Provide incentives through grants, entitlement programs and policies for services to all children and youth at risk for mental health conditions irrespective of a mental health diagnosis;
- Expand current initiatives to address children and youth with co-occurring disorders, especially substance use conditions;
  - Establish initiatives to address children and youth with co-occurring cognitive problems and mental health conditions;
  - Convene a task force to provide federal leadership to state child mental health and educational authorities to meet the needs of children and youth with co-occurring disorders that fall through the cracks because they do not reach thresholds for disability;
  - Remove fiscal barriers to the simultaneous treatment of mental health and co-occurring substance use disorders; and
- Target states that lag behind others in their ability to serve children and youth well, beginning with the nearly 25% of states that reported there are no children and youth they serve well.
- Require updated plans for disasters that include designated child mental health specialists with competencies in disaster planning;
- Require state child mental health authorities to engage with National Child Traumatic Stress Network leaders to develop policies that support embedding trauma-informed practices in on-the-ground community mental health practice.
- Create a comprehensive strategy for how to fuse the most updated, effective practices with supportive policies; and
- Develop state leadership and policies that link research, finance, and accountability in trauma practice for children, youth, and their families.

States should:

- Replicate the efforts of Washington to remove barriers to access to Medicaid for youth in juvenile justice to expedite re-enrollment upon re-entry into communities; and
- Address provider competencies ensuring that mental health providers and providers in substance abuse cross train to increase capacity to deal with co-occurring disorders.

CHAPTER 2

How Are States Moving Toward a Child Mental Health System that Is Guided by a Public Health Approach that Integrates Prevention, Early Intervention, and Treatment?

"Collaborative efforts between the Department of Mental Health and Department of Education have focused on providing school-based mental health services via a public health approach by integrating mental health promotion, mental illness prevention, early intervention, and treatment services and supports through a school wide positive behavior support model"

State Child Mental Health Director, 2007

The President's New Freedom Commission Report, *Achieving the Promise*, arguably the guiding policy document in mental health for this generation, heavily emphasizes a public health approach to mental health.[40]

However, since the Surgeon General's report and the more recent New Freedom Commission report, children's mental health related federal initiatives that include a public health focus have been generally limited to targeted interventions related to specific conditions or problems. These projects emphasize suicide and gun or community violence prevention as opposed to a general strategy that seeks to build the foundation for resilience and social skills development that underpins mental health. A few exceptions stand out. Through the Safe Schools Healthy Students Initiative, touted as a drug abuse and violence prevention initiative, policymakers sought to build capacity for mental health promotion and prevention.[41] More recently, Congress authorized Project LAUNCH, a mental health prevention initiative for young and school-age children (birth to age 8).[42] The problem is that where federal funding has been available it has been grant-based and failed to reflect the need for comprehensive strategies that are more easily suited to intervention models supporting promotion, prevention, and early intervention.[43] Even Safe Schools Healthy Students and Project LAUNCH, both grant-funded and time-limited contribute relatively little to the need nationally to embed public health-orientation into children's mental health.

States were asked about their progress toward implementing a public health framework. Twenty-five states responded to queries on whether they funded prevention and early intervention services and supports for children and youth, birth to age 18. In addition, 39 states indicated that they had taken specific steps to balance prevention, early intervention, and treatment services. Thirty-eight states described some of the strategies that made up this shift.

States' responses on strategies used to shift their systems diverged widely, indicating that they had different interpretations of what it meant to balance service delivery within the context of a public health framework. Some states described a movement toward earlier identification and balancing treatment between residential and community-based services exclusively for children and youth with severe emotional disturbance. Others highlighted efforts that expanded capacity for children and youth with mental health conditions and those at risk. Some strategies were targeted more narrowly, for example related to suicide prevention. Table 1 categorizes states' responses and identifies those strategies that focus more squarely on policy and structural reforms. Only one state indicated that there had not been a shift toward balancing

Table 1: **Shifting the Paradigm: States Report Movement Toward a Public Health Framework**

Initiatives	States
Movement toward early identification and balancing the treatment array within mental health services for children with SED	
Funding flexibility and treatment options	Michigan, Kansas
Children's System of Care	Kansas, Maryland, South Dakota, Tennessee, Vermont, West Virginia
Wraparound	Wisconsin
Alternatives to residential	North Dakota, Oregon, Rhode Island
Efforts to expand capacity for children and youth with mental health conditions and those at risk	
Screening and assessment	Montana, North Dakota, New York, Nevada, Wisconsin
Provision of services and supports in non-medical settings	
Child care	Arkansas, Colorado, Maryland, South Dakota, Tennessee
Schools	Florida, Maryland, Missouri, Nevada, South Dakota, Tennessee, Vermont, West Virginia
Community-settings	Massachusetts, Rhode Island, South Dakota, West Virginia (Oklahoma for suicide)
Specific targeted initiatives	Kentucky, North Dakota, Nevada, Oklahoma, West Virginia, Vermont
Policy, funding, and structural changes	California, Connecticut, Florida, Missouri, Massachusetts, Michigan, New York, Ohio, Oregon, West Virginia

prevention, early intervention, and treatment but rather that such a focus had been a system hallmark for a long time.

As an example of a state taking a broader approach, Maine reported the following:

"Children's Behavioral Health Services has always maintained a balance among prevention, treatment, and early intervention. It offers family support services, respite care, and a service system that allows easy access to a rich menu of treatment and other services early on. Early intervention therefore means preventing more serious development of problems through many service options in a system that is easy for families to access."

State Children's Mental Health Leader, Maine

Three states outlined specific policy-related strategies designed to shift resources toward earlier phases of the service continuum. In Connecticut, the Department of Children and Families has earmarked 5% of all new state funding for prevention-related activities. A similar strategy, although targeted to mental health funds, is in use in California where, under the Mental Health Services Act, 20% of funding is allocated toward prevention and 51% of that goes to children. In Ohio, community mental health budgets include line items for early childhood mental health including use of an evidence-based model, the Incredible Years, and funding for maternal depression. Michigan and Oregon have employed strategies to make systemic changes to service delivery for the more vulnerable. Oregon approved use of an age-appropriate diagnostic classification and treatment guideline for children birth through age five. Michigan established access criteria for children birth to age five accompanied by a diagnostic classification crosswalk to guide appropriate billing (DC-03).

Twenty-one states pointed to collaborative efforts to support a more balanced approach to service delivery, ranging from working with traditional collaborative partners such as juvenile justice and child welfare. In the case of Rhode Island, this led to a major respite initiative. In Minnesota, it led to developing new partnerships with entities like the American Academy of Pediatrics, Head Start, children's hospitals, and managed care groups. Many states report collaborating with the schools. Besides the Department of Education, Kentucky's collaboration includes the Department of Public Health and Kentucky Youth First. South Dakota's partnership with public health led to the development of a social-emotional screening tool that is used by all public health nurses for children birth through age two. In Vermont, the mental health authority has a memorandum of understanding with the Department of Health to collaborate on a range of services at the early end of the service delivery continuum.

Table 2. Prevention and Early Intervention Strategies

Prevention and/or Early Intervention		State	Description
Programs	Massachusetts Child Psychiatry Access Project (MCPAP)	MA	Provides primary care providers (PCP) with timely access to child psychiatry consultation and, when necessary, transitional services into ongoing behavioral health care. Data on PCP satisfaction indicated greater ability to meet the psychiatric needs of children and adolescents in their practices.[1]
	Child and Family Clinic Plus	NY	Provides early screening, comprehensive assessments, and increased clinic access in over 300 schools. This strategy helps change the interagency focus from reduction in placement to early detection, treatment, and community support.[2]
	Project BASIC	TN	Establishes school based mental health and early intervention and prevention services for children K-3. Located in 47 schools in 39 counties across the state producing, low cost, broad-based impact on target students, peers, school personnel, and families in rural, resource -scarce areas.[3]
	Regional Intervention Program (RIP)	TN	Encompasses a parent-led program to help parents learn to work directly with their own children. Experienced RIP parents train and support the newly enrolled families. Children are eligible for RIP up to age 6. Children enrolled in RIP with aggressive and antisocial behaviors demonstrated significant reduction in these behaviors and improvements in family relationships.[4]
Initiatives	Pediatric Collaborative Initiative	VT	Through a memorandum of understanding, the Department of Mental Health and the Vermont Department of Health collaborates on the provision of a range of prevention and early intervention services related to early childhood and school-based strategies. These include a comprehensive ADHD project involving 14 primary care providers, co-location of mental health clinicians in primary care offices, and child psychiatry consultation to pediatric and primary care practices in eastern Vermont.[5]
	Birth to 3 Initiative	WI	Focuses on children birth to age three with developmental delays and disabilities and their families. The early intervention team works with the family to enhance the child's development and provide services and supports to increase family members' knowledge, skills, and abilities as they interact with and raise their child. Services and supports are based on the individual needs of the child and family.[6]
Funding	MHSA Funding	CA	Twenty percent of MHSA funding allocated to fund prevention and early intervention activities – estimated at $171 million for FY06-07.
	Funding for Prevention	CT	Department of Children and Families earmarks 5% of new state funding for prevention activities.
	Statewide Infrastructure Grant	NE	Children's Mental Health and Substance Abuse State Infrastructure grants obtained in 2004 address a delivery system for children age birth to five, youth with co-occurring disorders, youth with substance abuse disorders, and transition-age youth. The Early Childhood Mental Health Subcommittee was created with the purpose of focusing on the state infrastructure needed to address mental health needs of children birth to five. System strategies are being developed for birth to five that include screening, referral, and treatment for perinatal depression.[7]
	Funds Allocation	OH	Ohio set aside a community line item in FY 2007 budget to allocate funds for early childhood mental health providers, evidence -based practices, assessment tools, and maternal depression.
	School Based Mental Health	WV	Expands school-based mental health by funding a significant prevention model with $500K in 15 programs.
Other	Florida Association for Infant Mental Health (FAIMH)	FL	State -funded FAIMH assesses needs, identifies effective practices, and takes research findings to programs across the state. A cadre of mental health specialists has been trained and advocacy on ECMH system is supported.[8]
	Zero to Five diagnostic treatment guidelines	OR	Establishes diagnostic classification and treatment guidelines for children birth to five years old.
		WA	HB 1088 requires a state -funded EBP institute that provides training and consultation to specialty and primary care physicians statewide on children's mental health interventions.[9]

1. Massachusetts Child Psychiatry Access Project (MCPAP). 2008. Retrieved on November 10, 2008 from http://mcpap.typepad.com/mcpap_child_psychiatry_in/.

2. New York State, Office of Mental Health. 2008. *Child and Family Clinic Plus.* Retrieved on November 10, 2008 from http://www.omh.state.ny.us/omhweb/clinicplus/.

3. Tennessee Department of Mental Health and Developmental Disabilities. 2008. *Intervention Services, Project B.A.S.I.C.* Retrieved on November 10, 2008 from http://www.state.tn.us/mental/mhs/soc8basic.html

4. Regional Intervention Network. 2008. Retrieved on November 10, 2008 from http://www.ripnetwork.org/.

5. Vermont Department of Mental Health. 2008. *Vermont 2008 Restoration of the Department of Mental Health Report to the Legislature on Act 15 2007 (ADJ) Session Section 23 - 18 V.S.A. § 7401 January 15, 2008.* Retrieved on November 10, 2008 from http://healthvermont.gov/admin/legislature/documents/Restoration_DMH_legreport_011508.pdf.

6. Wisconsin Department of Health Services. 2008. *Birth to 3 Program.* Retrieved on November 10, 2008 from http://dhs.wisconsin.gov/bdds/birthto3/index.htm.

7. Nebraska Department of Health and Human Services. 2008. *Nebraska Medicaid Program, Current Initiatives, Children's Mental Health and Substance Abuse Statewide Infrastructure Grant (SIG).* Retrieved on November 10, 2008 from http://www.hhs.state.ne.us/med/sig/.

8. Florida Association for Infant Mental Health. Retrieved on November 10, 2008 from http://www.cpeip.fsu.edu/FAIMH/.

9.Washington State, HOUSE BILL REPORT 2SSB 6479. As reported by House Committee On: Early Learning & Children's Services. Retrieved on November 10, 2008 from http://www.leg.wa.gov/pub/BillInfo/2007-08/Pdf/Bill%20Reports/House/6479-S2.HBR.pdf.

These examples notwithstanding, state mental health advocates were less likely to agree that their states were taking specific steps to shift toward a prevention and early intervention framework based on NCCP's study. Only 37% of states' advocates (N=7) believed that their states had taken specific steps to balance treatment with prevention and early intervention.

Major Findings and Policy Implications

- Thirty-nine states (74%) indicated they had taken specific steps to balance treatment services with prevention and early intervention services, but states varied in their interpretation of balancing the treatment continuum, ranging from a narrow view that balanced treatment between residential and community-based treatment for children and youth with SED to a more expansive view that encompassed all children. In addition, 63% of the state mental health advocates reported that they have seen no such movement toward a public health framework. The discrepancy in implementation or a public health approach may reflect perceived limitations in the mandate of the child mental health authority and/or a lack of capacity to undertake a population-focused approach.
- Only three states (8%) specified policy-related strategies to shift resources to support a public health framework, indicating that many of the strategies that states report lack the potential for more systematic reform.
- Twenty-one states (38%) reported effective strategies in collaboration with other child serving systems ranging from juvenile justice, child welfare, substance abuse agencies, schools and public health. These collaborations ranged from expanding service capacity for a limited number of children and youth with mental health conditions to strategies that changed practice. In addition, states ranked cross-system collaboration as a major challenge that they face. That less than two-fifths of states reported on cross-systems collaboration reinforce the need for policy-related strategies to facilitate better collaboration across systems.
- While states reported collaboration with juvenile justice, child welfare, schools, and other agencies, information from the finance section of the report suggests that the level of collaboration and engagement is uneven. Only 11 states were able to report funding from other sectors to support children's mental health although other agencies make substantial contributions to children's mental health. Given the prevalence of mental health conditions in special education, juvenile justice, and child welfare in particular, lack of knowledge of funding that supports mental health services poses significant barriers to strategic cross-system service planning and implementation.

Recommendations

The federal government should:

- Provide a legislative framework for incentives and support for states to implement a public health approach for mental health for all children and youth. These can take the form of special incentive grants, a set-aside in current funding streams, technical assistance, or new major legislation;
- Establish a prevention funding set-aside as part of the mental health block grant, mirroring a practice in substance abuse funding, and provide training, guidance, and technical assistance to states to implement a public health framework; and
- Create legislative authority that requires state child mental health authorities, child welfare authorities, and state juvenile courts to work collaboratively with the Substance Abuse and Mental Health Services Administration (SAMHSA), Agency for Children and Families, the Department of Justice, and the Department of Education to develop a comprehensive strategy to address the mental health needs of children, youth, and their families in these systems with the view to providing increased access to mental health promotion, prevention, and treatment interventions.

CHAPTER 3

How Are States Addressing, in an Age-appropriate Manner, the Mental Health Needs of Children and Youth Through a Public Health Lens?

"For young children, we really need to approach the caretakers. There's no other partner better at assessing and diagnosing from very early signs, so we want to put money and time into training and staffing so caretakers and parents are familiar with best practices and early signs. We also have a working group which meets for common discussion and case reviews; it increases the breadth of knowledge and can work with parents/caretakers."

System Leader in Butte County, CA

Historically, children and youth at either end of the developmental span – very young children and young adults transitioning into adulthood – with mental health conditions or those at risk have not benefitted from services available in the mental health system as much as school-age children and youth.

After a brief overview of the states that focus on providing services and supports for children and youth across the age span, this chapter highlights states' responses to how they meet needs of and support for young children and children and youth with mental health conditions who are school-age.

Services and Supports Across the Age Span

Despite the historical imbalance between services to school-age youth and young children or older youth and young adults, our survey found no prohibitions based in law or state regulation from serving very young children and few states where the state mental health authority funded services could not legally be provided to young adults over age 18. In fact, only eight state mental health authorities reported that they are legally prohibited from providing mental health authority funded services to young adults over age 18. Even these states had initiatives that addressed transition-age youth. The state/territory child mental health authorities that identified themselves as legally prohibited from serving young adults were Florida, Idaho, Michigan, Montana, North Carolina, Nebraska, Puerto Rico, and Rhode Island. Only two states did not report some initiative to serve youth transitioning to adulthood.

Services and Supports for Young Children

Increasingly, there is a compelling research-based argument to be made for investing in early childhood mental health strategies. Recent research on early brain development has underscored the importance of the earliest relationships in helping to shape how a child responds to others, learns to regulate his own emotions, and feels about himself. For most young children, supportive, nurturing, and stimulating environments provide the active ingredients without special interventions. But for young children whose parents are seriously and chronically stressed by their own life circumstances, including poverty, or by their own mental health related challenges, including parental depression, their parenting behaviors may not provide the necessary consistency and nurturing family-focused interventions.

Only one state, Washington, reported having comprehensive legislation. (See Box 5.)

Box 5: HB 1088 State of Washington, 2007

Washington State enacted comprehensive legislation that:

- Mandates outcomes and performance measures for children's mental health
- Establishes an evidence-based practice institute charged with:
  - Provision of training and consultation on child mental health interventions including psychopharmacology
  - Provision of information to parents and youth on evidence-based practices
  - Serving as state resource for evidence-based practices
- Requires immediate Medicaid reinstatement (within 60 days) for youth who return to the community from juvenile justice facilities
- Creates model wraparound sites as alternatives to out-of-home placements
- Institutes components for the children's mental health system including:
  - Prevention and early intervention including peer support and family mentoring
  - Equity in access to services including for children and youth with co-occurring conditions
  - Developmentally appropriate, high quality and culturally and linguistically competent services
  - Family centered care
  - High caliber diverse workforce
  - Integration and flexibility in services
  - Outcomes-focused
- Relaxes regulation on provider networks to ensure cultural and linguistic competence among providers

Source: An Act Relating to Children's Mental Health Services, State of Washington, 60th Legislature Regular Sess.2007.

Neuroscience calls for special attention to the potential risks to healthy social and emotional development for young children facing toxic levels of stress, for example young children exposed to abuse and neglect or facing separation from their parents. Researchers are also working to untangle more explicitly the complex pre- and peri-natal origins of child and adolescent mental health, again emphasizing both the genetic and environmental interactions.[44] This is supplementing the literature that has long shown that the more risk factors young children experience (of any kind or combination), the more likely they are to experience adverse mental health and educational outcomes as children and to be negatively impacted as adults.[45 46] Infants and toddlers with family risk factors such as maternal substance abuse, parental domestic violence exposure, poverty, and poor educational outcomes faced twice the risk of problems with aggression, anxiety, and hyperactivity compared to young children without these risks.[47] At the same time, these efforts to understand the consequences of the earliest years for the development of pathology are increasingly supplemented by efforts to identify interventions that can help reverse problematic early developmental trajectories, thus providing a growing base for evidence-based interventions.[48 49 50]

Studies show that young children in preschool settings that had supports like mental health consultation were less likely to be expelled.[51] In addition, other types of supports that help young children, such as providers with training in early childhood development, the availability of research-informed practices, and early screening and treatment, were associated with improved outcomes for these children.[52 53]

Research also shows that the majority of young children, birth through age five, do not receive the mental health services and supports that they need, even when their mental health conditions have been identified.[54] Across settings, young children are the least likely to access needed services despite studies showing that between 9.5% to 14.2% of children birth through 5 years old experience social, emotional, and behavioral problems that impact their and their families' ability to function.[55 56] In fact, research demonstrates that more than 85% of children in Head Start and children 3 to 5 with identified behavioral health needs did not receive help.[57]

Contributing factors to this unmet need include practice and policy barriers and poor service capacity. Young children do not access the screening, services, and supports they need because providers often do not have the tools they need to appropriately screen, reimbursement often does not cover the cost of screening, and where parental screening is needed there is no way to pay for it.[58] In addition, Medicaid policy has often not supported treatment and early intervention services for children without a diagnosis.[59] Service capacity and quality suffer from the absence of reimbursement for young children, and from poor provider preparation. Many primary care physicians report that they lack the confidence to manage children identified with developmental delay (29% of pediatricians and 54% of family practitioners).[60] The cumulative effect is that preschool children are disproportionately expelled, compared to other age groups.[61] Research demonstrates that young children with multiple risk factors are more likely to do poorly in school.[62] They also experience

high emergency use rates.[63] And, they participate in EPSDT at low rates.[64]

Legal Restrictions and Funding Approaches

As indicated previously, no state reported that it was legally prohibited from providing services to children birth through age five. However, services and supports for young children have historically been inadequate to meet the need. Although three-fifths of states (N=34) indicated that the child mental health authority funded early childhood mental health services directly, one third reported that they did not provide direct funding to support mental health services for young children birth through five. When states were asked if they funded initiatives or infrastructure related activities that support mental health service delivery in early childhood, even more states, 77%, reported that they did (N=41). The types of strategies that states reported supporting included the data reported in Box 6.

Services Supported

One half of the states reported support for early childhood mental health consultation (N=26). (See Box 7.) States were less likely to support reimbursement for social emotional screening tools and partnerships designed to address parental mental illness. Despite research that demonstrates the importance of early and standardized screening as an integral component of a public health strategy and the endorsement of the President's New Freedom Commission, only 16 states support reimbursement for screening to detect social emotional problems. States also appear to put a low priority on family-centered treatment and support. This is particularly concerning given the data on the importance of healthy parents and strong parent-child relationships. Similarly, only 15 states reported that they engaged state adult mental health systems as partners in addressing the needs of children and youth in families where a family member has mental illness.

All of these initiatives for the most part remain limited. About half of states (23) reported that these initiatives are statewide. Figure 2 shows the states that reported that their early childhood mental health initiatives are statewide.

Box 6: Types of Early Childhood Related Strategies SMHA Authorities Report that They Fund

Type of early childhood initiative	Number of states
Early childhood specialists in community mental health centers	21
Early childhood mental health consultation programs	26
Reimbursement for use of social and emotional screening tools	16
Partnerships with early childhood programs and agencies	34
Partnerships with state adult mental health systems to address the needs of children and youth in families with mental illness	15

Box 7: Mental Health Consultation*

Mental Health Consultation is an intervention strategy associated with reduction in the likelihood of preschool-age children being excluded from child care settings.[1] Mental health consultants, professionals skilled in managing challenging classroom behaviors in preschools, help families and preschools and child care teachers gain the skills they need to manage child behavior provide strategies to foster positive learning, healthy development, and social-emotional well-being.[2] Research has shown that likelihood of expulsion decreases significantly when teachers and families have access to classroom-based mental health consultation.[3]

Mental Health Consultation Encompasses[2]:

- A partnership between a mental health clinician with early childhood development expertise, parents and child care providers.
- Mental health clinician available to consult with child care programs, staff, and parents to provide strategies to foster positive learning, healthy development, and social-emotional well-being.

*Best Practice

1. Gilliam, W. 2005. Preschoolers Sent Home: Expulsion Rates in State Prekindergarten Systems. *Yale University Child Study Center*. New Haven, CT.

2. Johnston, K.; Brinamen, C. 2005. Integrating and Adapting Infant Mental Health Principles in the Training of Consultants to Childcare. *Infants & Young Children*, 18(4): 269-281.

3. See endnote 1.

Twenty states portrayed their strategies and policies focused on early childhood as being particularly effective. Table 3 outlines the list of states and these strategies. Of these, two states highlighted their strategies that expand service capacity for the early childhood population. In addition to these initiatives, states reported on financing, legislation, and efforts to improve and standardize practice. These are described below.

Table 3. States' Initiatives to Expand Early Childhood Mental Health

Funding	
CO	DMH and SAMHSA system of care grant focuses on children birth to 5 and recently provided state funding to all 17 CMHCs for early childhood mental health specialists.
FL	Provides funding to local infant mental health coalitions for local training.
IL	Provides financial support to expand the early childhood mental health consultation demonstration project.[1]
IN	Requires providers contracted with the state to offer a continuum of care for all ages.
MD	MHA with Maryland State Department of Education (MSDE) and other state partners have grown an early childhood system of care with funding for mental health consultation to child care.
NE	Funds two school-based wraparound initiatives.
NH	State's braided funding contract promotes infant mental health regional planning and collaboration. Services do remain in agency silos such as CMHCs, early support and services, preschool special education, and Headstart.
MA	Department of Mental Health and Department of Social Services partnered to address the mental health needs of parents with mental illness. The Options Clubhouse in Marlborough recently received a $1 million private grant to provide services for the children and families of seriously mentally ill adults.
Service Capacity and/or Expansion	
CA	Infant, Preschool & Family Mental Health Initiative (PFMHI) is a State First 5 California Children and Families Commission project extended to Children's Systems of Care services in eight counties to include services to children birth to five and their families. These include new clinical services, training of mental health and other service providers, interagency and interdisciplinary collaboration, the use of screening and assessment tools and billing and funding mechanisms, and expansion of the use of EPSDT to fund direct treatment services for Medi-Cal beneficiaries. From 2001 to 2004, the number of children ages birth to five served by mental health increased by over 50% in the eight counties.[2]
WA	The "Access to Care Standards" is the Medicaid-approved method to determine medical necessity. Children under 6 are not required to have a diagnosis or meet a level of functioning requirement (CGAS score) to qualify for public mental health services under Medicaid and obtain treatment. Encouraged the use of DC 0-3. HB 1088 created a fee-for-service network to serve children who do not meet the SED requirements but need brief intervention (up to 20 visits).[3]
Workforce Development	
GA	The Division of Mental Health, Developmental Disabilities, and Addictive Diseases and the Department of Public Health co-sponsor training to their staff on social emotional development in early and middle childhood. Bright Futures manuals are disseminated and used in the cross training.
MA	The Office of Medicaid and the Department of Early Education and Care (DEEC) co-fund an initiative that places licensed social workers in select daycare centers across the state to consult, train early childhood staff, assess and refer children as necessary, and interface with families.
TN	Provides mental health training and technical assistance for staff in child care, Head Start, and early childhood centers and uses an Early Childhood Network to develop local Systems of Care in two counties to identify and obtain mental health services for children and youth who fall through the cracks of the service system.
Standardization	
MI	Screening and CMH Access/Eligibility criteria for birth to three year olds includes the use of DC 0-3 for billing.
OR	Diagnostic classification and treatment guidelines for birth to five year olds.
SD	Mental Health Division and Department of Health collaborated to develop and implement a social emotional screening tool utilized by all public health nurses for children birth to two.
WA	HB 1088 mandates that a standardized benefit package for children based on principles of developmentally appropriate evidence based and promising practices and family-based interventions and utilizing natural and peer support and community support services implemented by 2012. Children under age of six shall be served irrespective of a diagnosis.[4]
WI	Funds trainings on the use of the early childhood MH diagnosis codes in 2008.
Pending or Planning Phases	
HI	Child and Adolescent Mental Health Division is creating three vignettes on the public health/medical home model of systematically supporting children two to five years and their families to be used to train child clinicians in various disciplines.
ID	Active discussions underway to adapt DC0-3 crosswalk for billing.
MO	Initial phases of building an early childhood system with Mental Health as a partner.
NM	The state funded an infant mental health strategic plan sponsored the Infant Mental Health Summit.

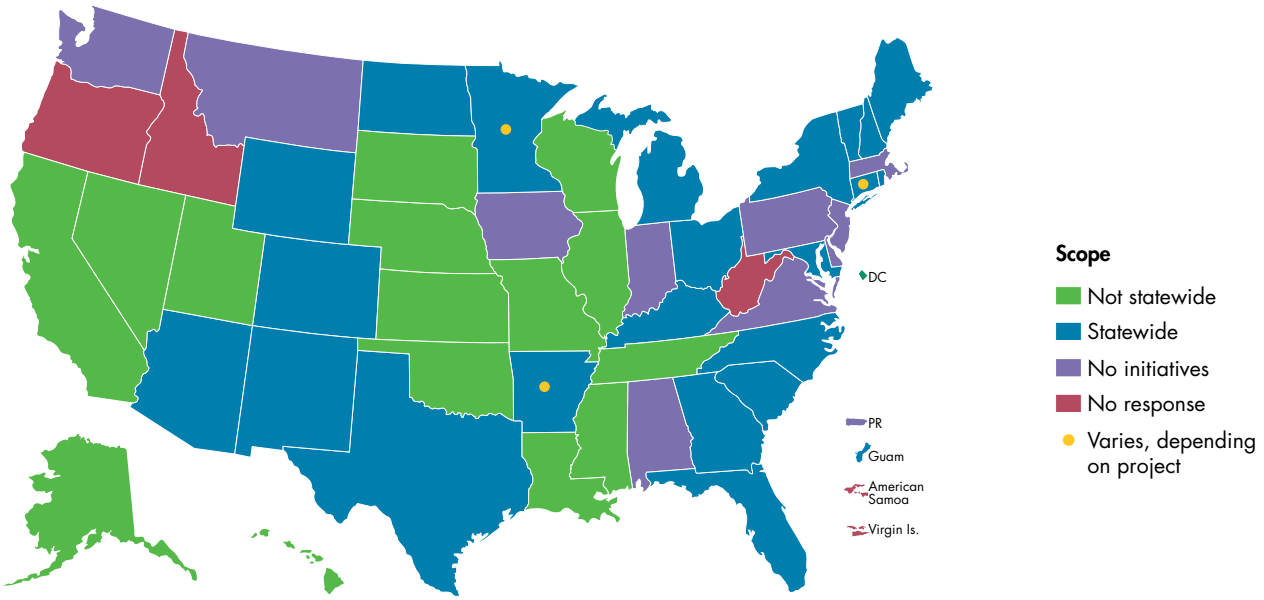
1. Center for Mental Health Services, Division of State and Community Systems Development. 2007. Illinois, Uniform Application FY 2008- State Plan, Community Mental Health Services Block Grant.

2. Arstein-Kerslake, C.; Knapp, P.; Merchant, D. 2005. *Infant Preschool Family Mental Health Initiative: Accomplishments and Lessons Learned.* Retrieved on November 10, 2008 from http://www.wested.org/cpei/ipfmhi_accomplishments.pdf.

3. Personal email correspondence with the Children's Mental Health Director received on July 28, 2008.

4. House Bill 1088, 60th Legislature, Regular Session (2007).

Figure 2: **Scope of Funding for Early Childhood Mental Health Initiatives**



Major Findings and Policy Implications

- Thirty-four states reported that they fund early childhood mental health services and supports directly. But five states reported that they did not fund early childhood mental health. This finding indicates that while funding for early childhood mental health is increasingly recognized, it does not have a 50-state reach nor does it have the depth. There are many states without a statewide strategy.
- Fewer than 40% of states reported directly funding any of prevention, early intervention, and treatment strategies. States were more likely to take a treatment-oriented approach than a public health approach that embraces early identification, treatment for maternal depression designed to prevent its impact on children, and mental health consultation.
- Only 20 states (fewer than half of states) described effective strategies in early childhood, thus suggesting while progress has been made in addressing the needs of young children, there is still a lot more to be done.
- Only 16 states reported support for reimbursement for screening to detect social emotional problems. The small number of states that reimburse screening for social emotional problems reveals much about the lack of depth in many state programs that are trying to implement a public health perspective.
- Fewer than one-third of states reported that they actively supported work with state adult mental health authorities even for mentally-ill parents of young children despite the fact that many state child and adult mental health authorities are under the same governance structure. Among all of the initiatives that states identified they undertake, developing partnerships with state adult mental health systems was the option least often reported. State children and adult mental health authorities failure to partner to address the needs of families who experience mental illness represents squandered opportunities given that these entities are often housed under the same jurisdiction and what we know about the increased developmental, emotional, and behavioral risks for children associated with parental mental illness.
- Collectively, limitations in funding for young children and their families are in conflict with the federal Early Periodic Screening Diagnostic and Treatment (EPSDT) laws and state Medicaid provisions. Specifically, EPSDT provides for developmental mental health history as part of required screening and appropriate treatment services.

School-age Children and Youth

"[The] biggest challenge is earlier identification and what we hear most from parents is that you could have helped us out when our kids were 8 and 9; instead you helped us when our kids were 16 and on the verge of juvenile probation."

Parent Advocate, Santa Clara County, California

Children and youth with mental health problems may miss the bar when it comes to academic achievement. At the elementary, junior high, and high school levels, children with emotional disturbance are less likely to get good grades and more likely to miss school, experience disciplinary action in school including suspension and expulsion, and fail to graduate, compared to other children with disabilities and compared to children in general.[65 66 67 68]

Societal expectations for children and youth include attaining developmental milestones. For school-age children and youth these include achieving at or above grade level, developing healthy peer relationships, and exhibiting behavior that is socially appropriate by settings.[69] In meeting these milestones health, mental health, and academic achievement are closely linked. Youth who are well-developed from a social emotional perspective at an early age are more likely to perform better in school than youth who struggled with social emotional development as young children.[70] Strong social and emotional development in the early years often translates into increased likelihood of high school completion and decreased odds of juvenile justice involvement.[71] School and school success, then, can offer an opportunity for improved functioning and reduced symptoms for children and youth with mental conditions.[72] They can also offer the chance for prevention of more serious mental health conditions.

Research shows the effectiveness of a range of strategies that foster the types of pro-social emotional development that support youth in meeting their developmental goals, such as social competencies, socials skills, self-control, and meeting achievement milestones.[73] These strategies range from mental health promotion to prevention, early intervention, and treatment.[74] Schools provide an appropriate venue for such strategies since educators can clearly link the interaction between academic achievement and social and emotional development.

But schools are not merely conduits for the delivery of mental health interventions. They are integral to conceptualizing plans to address the needs of children and youth with mental health conditions and those at risk. Irrespective of where the educational institutions are, whether in communities, residential facilities, detention, or correctional facilities, the intersection between mental health and education remains critical. Such relationships between schools and those responsible for mental health require joint planning, investments in joint outcomes, and joint evaluation.

In fact, there is a long, albeit imperfect, history of schools working to address behavioral problems that interfere with learning.[75] Contemporary history begins in the mid-1990s with the full-service school movement and the recognition by some schools that they were providing mental health services and supports.[76 77] Despite this history, mental health services and supports remain the exception rather than the rule. While most schools reported that they provide some type of mental health service or support, the majority of public school students in the more than 100,000 school buildings nationwide do not have access to an array of promotion, prevention, or treatment interventions in schools.[78] High quality school-based mental health services are even scarcer.[79] Where services and supports exist, they are often fragmented and not linked to community-based mental health or a wider public health framework.[80] Such a status report on services for school-age children invokes questions about the role of state mental health authorities in the planning, support, and delivery of services to school-age children and youth.

State Support for School-based Initiatives

An overwhelming majority of states (N=47) reported that they are actively involved in supporting school-based mental health services and supports. (See Box 8.)

The nature of states' involvement with school-based mental health services and supports included funding (N=40), shared staffing (N=14), planning and program development (N=39), policy development (N=30), contracting through local schools (N=14).

Box 8. Types of SBMH Initiatives

Type of initiative	Number of states
Positive Behavioral Interventions and Supports (PBIS/PBS)	23
School-based mental health clinics/ school-based clinics	29
Partnerships with state Department of Education and/or Department of Special Education	30
School-wide efforts that promote social emotional learning	18
Targeted supports for school-based services to children and youth with serious emotional disturbance	29

A similar number of states reported that these initiatives were statewide compared to those that reported statewide initiatives in early childhood (N=24 versus N=23). Even more states reported involvement with school-based services overall. Figure 3 shows, by scope, states that reported activities related to school-based services and supports.

Table 4 shows the strategies states report as effective for school-aged children and youth.

Major Findings and Policy Implications

- While nearly all states reported that they are actively supportive of school-based mental health services, only 24 states described these strategies as statewide in scope. Despite a long history and greater attention to school-based mental health services these efforts remain limited, with many gaps.
- Treatment and collaboration-related strategies were more often identified by states, then strategies that embodied promotion and prevention. To advance a public health framework states will need to embed more health promotion with mental health disorder-related prevention strategies for school-aged children and youth.
- A large number of states (N=40) support school-based mental health services through direct funding. However the nature of that funding and its impact is unclear. States need to put in place better tracking and accountability mechanisms.

Figure 3: Scope of Active Participation in School-Based Mental Health Initiatives

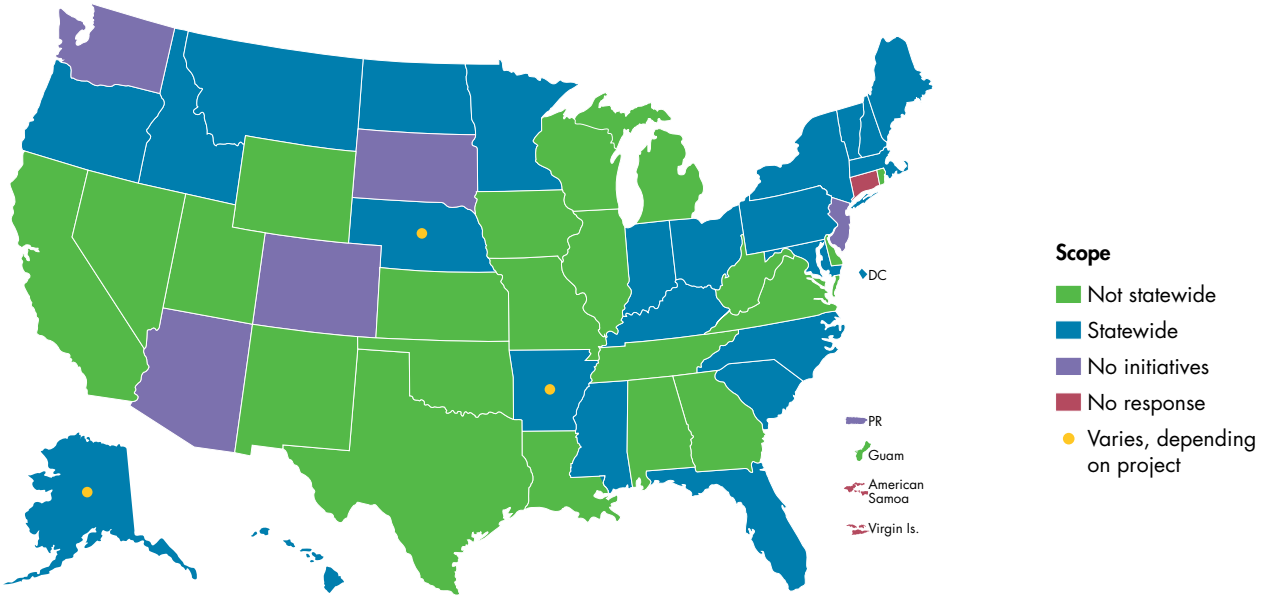


Table 4. State Initiatives to Expand School-Based Mental Health

Funding	
AK	The state implements regulations to allow schools to bill for school- based mental health Medicaid services.
NY	Office of Mental Health funds school support programs providing support and family services beyond normal clinic hours and regulates and funds (state share of Medicaid) school clinics (270+) and day treatment programs.
OH	Department of Mental Health and Ohio Department of Education jointly fund Ohio Mental Health Network for school success managed by the Center for School Based Mental Health Programs at Miami University of Ohio.
Legislation	
IN	Children's Comprehensive Social Emotional Behavioral Health Plan contains recommendations for comprehensive mental health services, early intervention, and treatment services for individuals from birth through 22 years of age.[1]
NY	The Children's Mental Health Act of 2006 requires the state to develop and monitor a children's mental health plan. Section 305 of Education Law was amended to direct the Commissioners of Education and Mental Health to develop guidelines for incorporating social and emotional development into elementary and secondary educational programs "for voluntary implementation by school districts."[2]
Workforce Development	
DE	The state works with the University of Delaware to develop a Positive Behavior Supports course for outpatient therapists.
MA	The state provides consultation and training around mental health for schools and social workers in schools (not necessarily in clinics) through school and community support and partnerships with local districts.
School Based Services for At risk Children	
CA	Early Mental Health Initiative (EMHI) implements school-based early mental health intervention and prevention programs for K-3 students with mild to moderate school adjustment issues. Approximately $3.4 million in FY 2008-09 will be available.[3]
HI	Department of Education directly manages the school-based behavioral health program statewide that incorporates mental health promotion, an array of effective school-based services, and access to community based behavioral and mental health services and programs.
ID	The state contracts with independent school districts statewide to provide mental health services in school to children with SED.
KS	The state supports school based services with children enrolled in its 1915c waiver.
MS	There are 400 school based and statewide day treatment programs.
NE	Funds two school-based wraparound initiatives.
NH	Community Mental Health Centers staff provides in school services for select youth on their case loads.
NY	The state will provide screening in over 300 schools using a validated screening tool (e.g. Pediatric Symptom Check list).
Positive Behavioral Intervention and Supports (PBIS)	
AR	Department of Education received a five-year State Improvement Grant from the U. S. Department of Education to implement Positive Behavioral Support (PBS) systems at the elementary school level.[4]
NY	Office of Mental Health and State Education is collaborating to jointly support PBIS. Created regional school focused family coordinator positions to increase family involvement and support through school-wide PBS implementation.[5]
OH	Center for School-Based Mental Health Program's Mental Health Network for School Success collaborates with affiliate organizations in six regions of the state.[6]

1. Indiana Code 20-19-5, Chapter 5. Children's Social, Emotional, and Behavioral Health Plan. 2006. Retrieved on April 17th, 2008 from http://www.in.gov/legislative/ic/code/title20/ar19/ch5.html.

2. New York State Office of Mental Health. 2008. *Background Information on Social and Emotional Development Guidelines Prepared by the New York State Education Department*. Retrieved on April 17, 2008 from http://www.omh.state.ny.us/omhweb/statewideplan/childrens_mental_health_act/childrens_mental_health_plan_appendix7.html.

3. California Department of Mental Health. 2008. *Early Mental Health Initiative*. Retrieved on November 4, 2008 from http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EMHI.asp.

4. Arkansas State Improvement Grant. 2008. Retrieved on November 5, 2008 from http://www.arstateimprovementgrant.com/dnn/SIGGoals/Goal2Behavior/tabid/55/Default.aspx.

5. OSEP Technical Assistance Center on Positive Behavior Interventions and Supports (2008). *Families and PBIS*. Retrieved on October 20, 2008 from http://www.pbis.org/families.htm.

6. Ohio Mental Health Network for School Success (OMHNSS). 2008. Retrieved on November 5, 2008 from http://www.units.muohio.edu/csbmhp/network/index.html.

Youth Transitioning to Adulthood

"For young adults (transition-age youth) having safe, stable, affordable housing is a mental health service. Without that, how can they have the stability and security? At the most basic level, [they need that] to participate in other aspects of wellness, recovery, and resiliency. Look at how many of our TAY live on the streets, couch surfing, in abandoned buildings and jail; housing first, then age and culturally appropriate 'mental health treatment' is the only reasonable course of action."

Family Advocate, Alameda County

The Government Accountability Office (GAO) estimates approximately 2.4 million young adults between ages 18 and 26 have a serious mental illness.[81] Research suggests that these youth and young adults have little access to public mental health services. In one study, 25% of child mental health system leaders and 50% of adult mental health system leaders reported that their systems provided no mental and supportive services for youth with mental health system transitioning to adulthood.[82] Even for those systems that did offer mental health services and supports, most were generally able to provide no more than one service in an entire state. Best practice demands that transition planning for these young adults begin at age 14.[83] Federal law mandates transition planning for youth in special education.[84] Children with emotional disturbance are less likely to begin transition planning at age 14 compared to children with other disabilities.[85] Policy and practice research shows that for a majority of these youth and their families, transition planning is largely inconsistent, does not include their active participation, is unresponsive to their needs and those of a substantial group of their parents, and leaves them dissatisfied.[86]

In recent years, the importance of access to services for this age group has gained national attention. Several studies point to the adverse outcomes of the lack of health insurance, poor preparation for living independently among youth in foster care, and low or no skills among youth with mental health conditions entering the labor market. Results from this study suggest that some states have begun to heed the lessons of this research, whether as pilots or through more widespread initiatives.

Statewide Initiatives

Forty-four states reported on special initiatives for youth transitioning into adulthood. Twenty-six states reported that these initiatives are statewide in scope and nine reported limited geographic areas are impacted. Among the types of strategies that states reported are health insurance extension and social supports beyond age 18. (See Box 9). Some states (N=8) reported that they are legally prohibited from providing services to youth over age 18.

Negative outcomes are common for young adults who are former foster care youth. These include poor school completion rates and employment rates, homelessness and involvement with the justice system.[87] [88] Some states are beginning to address this gap in need and make connections between access and outcomes for this group.

Almost half of states reported that young adults (18-21) in their states had access to health insurance and other social supports. In large measure due to the Chaffee Act and the work of several prominent national foundations, some states have taken up the federal option to extend Medicaid and many states have made available the option of staying or returning to state guardianship for foster care youth.[89] Table 5 lists a range of strategies that states reported they implemented to expand services for transition-age youth.

Box 9: Types of Transition-Age-Related Initiatives States Report

Type of initiative	Number of states
Health insurance and/or other social supports for young adults 18-21	22
Transition-age young adults can remain and/or return to state guardianship after age 18	21
Partnerships with business/private organizations to create workforce opportunities for youth ages 18-21	13
Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation for transition-age youth 14-21 years old	0

Table 5: State Initiatives to Expand Services for Transition-age Youth

Funding	
AK	Bring The Kids Home (BTKH) is an initiative to return children with SED from behavioral health care in out of state residential facilities to in state residential or community based care. The initiative uses funding that currently provides expensive distant care to in state services and capacity development to serve children close to home. It also uses federal grant funding, state funding, and Alaska Mental Health Trust Authority funding to provide the bridge funding needed to start new programs. The state saw a 7% reduction in out of state placements for children between FY04 and FY05. Department of Health and Human Services, Division of Behavioral Health has requested $3.6 mill in the FY08 Governor's budget to continue the BTKH Initiative.[1]
CO	Mental Health block grant funds will be used for demonstration projects.
HI	Applies system of care cooperative agreement for this population in limited area. Plan to share statewide in the future.
Medicaid Expansion	
CA	Medi-Cal eligible youth can receive specialty mental health services up to age 21.
IN	Expands Medicaid coverage to foster youth up to age 21 during the 2006 legislature.
Independent Living	
ID	The federal Foster Care Independence Act of 1999 funds the Chafee Foster Care Independence Program that assists youth to make the transition from foster care to independent living.[2]
KS	Independent Living Program provides services and supports to youth to facilitate successful transition to self-sufficiency. Eligible youth may receive services for completion of secondary and post-secondary education, training programs, room and board assistance, life skills, leadership opportunities, and free medical services through the Medical Card Extension Program. Independent Living Services are provided by SRS (e.g. DMH local offices or State Independent Living Coordinator).
Housing	
FL	Supports pilot programs to youth 18-25 in supported housing by providing instruction and support classes on local and community college campuses. Some information regarding three programs[3] 1. Road to Independence: Pays a stipend for transition-age youth's living expenses while in school. 2. Transitional Support Services: Requires a written Transitional Plan. 3. Aftercare Services: Aftercare funds for emergencies.
CT	Transitional Living Apartment Program (TLAP) includes:[4] • Community Life Skills Program. • Supportive Work, Education and Transition Program (SWET). Youth in this program focus primarily on the development issues associated with the acquisition of independent living skills, including but not limited to: interpersonal awareness; community awareness and engagement; maximization of educational, vocational, pre-employment, and job placement opportunities. • CHAP for DCF youth ages 16 years and older whose treatment plan goal is not reunification with parents or transfer of guardianship. – Youth in these programs focus primarily on the developmental issues associated with the acquisition of independent living skills, including but not limited to interpersonal awareness; community awareness and engagement; and maximization of educational, vocational pre-employment, and job placement opportunities. Community Housing Assistance Program (CHAP) programs provide apartments for youth age 17-21 years who are transitioning out of foster care. Youth in the CHAP program must be in school and either be working or in extra-curricular activities. Case management services are provided to the youth on a regular basis and other supports are provided as needed.[5]
Transition Services	
AZ	The state pilot projects to ease transition and coordinates joint planning with adult system for youths starting at age 16.
CT	Department of Children and Families has a Bureau of Adolescent and Transitional Services to provide resources and support for youth in DCF care to learn and develop skills in the areas of education, vocation, employment, personal and emotional well-being, personal and cultural identity, and family and community connectedness and to ensure a smooth transition into adulthood.[6]
DE	DCMHS has a flag in automated MIS that generated reminder to planning for adult behavioral healthcare starts and developed a manual for use by children/family that will turn 18 within a year.
GA	Developed protocols in 2002 that need revisions based on changes in MHDDAD regional staff and structure. Regional case expeditors are frequently involved with youth/young adults who are aging out of the C&A MH system and transitioning to adult services.
Guam	Works with the adult MH system to transition services into adult case management.
ID	Written policy on transition to adult. Now drafting new policy servicing youth over 18.
IL	A recent request for proposals was released for agencies to provide transition services. Five agencies across the state were successfully selected to provide transition services for the 16-18 year old population.

Table 5: **State Initiatives to Expand Services for Transition-age Youth (cont.)**

Other	
CT	The Department of Children and Families collaborates with individual providers to provide culturally competent, affirming services for lesbian, gay, bisexual, transgender, questioning, and intersex youth.
CA	DCMHS works closely with the California Workforce Investment Board to promote work opportunities for transition-age youth.

1. Department of Health and Social Services for Severely Emotionally Disturbed Youth Component Budget Summary. 2006. *State of Alaska FY2008 Governor's Operating Budget.* Retrieved on April 18, 2008 from http://gov.state.ak.us/omb/08_OMB/budget/HSS/comp1436.pdf.

2. Chafee Foster Care Independence Program State Plan, state of Idaho FFYs 2005-2009. Retrieved on September 16, 2008 from http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/children/2005%20IL%20Plan1%206-16-04.pdf.

3. Florida Guardian ad Litem. Programs for Youth 18 and Older. Retrieved on November 6, 2008 from http://www.guardianadlitem.org/teen_faq.asp#overeighteen.

4. Bureau of Adolescent and Transitional Services Program. 2007. Menu of adolescent and transitional services. Retrieved on April 20, 2008 from http://www.ct.gov/dcf/lib/dcf/adolescent_services/pdf/menu_of_adolescent_and_transitional_services_program_june_12__3_.pdf.

5. Ibid

6. Connecticut Department of Children and Families. 2008. *Bureau of Adolescent and Transitional Services.* Retrieved on April 17, 2008 from http://www.ct.gov/dcf/cwp/view.asp?a=2562&Q=314306#Mission.

Work Opportunities

Few states have recognized the importance of providing work opportunities for youth and young adults. This notwithstanding, research that demonstrates that among all youth with disabilities youth with EBD were least likely to have a combination of paid employment, post-high school education, and job training.[90] Youth with EBD also lagged behind other youth with paid employment.[91] Only 13 states reported that they were engaged with the private sector to expand work opportunities for youth and young adults. No state reported on activities to address shortcomings in the administration of social security income (SSI), despite current regulations that compel youth to make choices between basic needs such as health insurance and employment.

The GAO estimates that 186,000 young adults with SSI have mental illness. Yet, despite longstanding concerns with disincentives within SSI that impact young people, no state reported any initiatives or involvement with any federal or state demonstration or program to relax SSI-related rules that discourage participation in work for transition-age youth.[92] There are 10 current and former federal demonstration projects in SSI.[93] Current programs are in California, Colorado, Florida, Maryland, Mississippi, New York, and West Virginia. Recently ended demonstration programs are in Iowa, Vermont, and Washington. But child mental health authorities do not seem to know about them and are not connected to them.

Effective Service Delivery-related Strategies in Child Welfare and Juvenile Justice

Thirty-four states reported that they have implemented especially effective strategies and programs to ensure access to appropriate mental health services for children and youth involved in child welfare. Five states described these activities. These include Minnesota, where the state reported on its mandate that requires every child to be screened, assessed, and provided brief treatment when warranted; Missouri, that noted it has implemented custody diversion/transfer of custody protocols in response to the number of families relinquishing custody in exchange for mental health services for their children. In partnership with child welfare, Title IV-E funding is accessed for residential treatment when needed. South Carolina described its efforts to place mental health clinicians in child welfare agencies to increase screening and early assessment capacity and provide clinical support in child welfare where worker turnover is high. Washington reported ongoing linkages with child welfare to ensure all children and youth in that system are served. The state's settlement of a major lawsuit propelled significant investments in child welfare that included enhanced mental health and substance abuse services. North Dakota indicated that through their Children's Screening Coordination Committee, those involved with child welfare family preservation services access wrap-around training.

While not exclusive to transition-age youth, access to a range of mental health services is critical for

youth involved with juvenile justice. Transition-age youth are disproportionately represented in the juvenile justice system. Over 80% of youth in juvenile justice are over age 14, and 65% are over age 15.[94] Access to mental health services prior, during, and after juvenile justice involvement is important, given data that indicates a large majority of these youth have mental health and substance use conditions.[95] But significant policy barriers stand in the way of ensuring that mental health conditions do not precipitate juvenile justice involvement and allowing services systems to address these needs so that impaired functioning does not exacerbate or prolong juvenile justice involvement.[96 97]

Thirty-five states identified themselves as implementing effective strategies to address the population of youth with mental health conditions who are also involved with juvenile justice. Five states, Colorado, Massachusetts, Minnesota, Texas, and Washington, reported on these activities. In addition, California, Nebraska, and North Dakota raised the lack of Medicaid support for youth who are incarcerated as a top barrier to service delivery and a federal policy that should be reformed. In Massachusetts, state officials report that the Juvenile Court clinics have reduced the number of juvenile justice-involved youth in detention by more than two thirds from 2004 to 2006 through pre-adjudication screening.

Children and youth incarcerated or in detention with mental health conditions require access to a comprehensive array of services irrespective of their criminal history or juvenile justice involvement. For some youth, juvenile justice is the gateway to mental health services.[98] Indeed, 14 states identified children and youth in juvenile justice as those they struggled to serve appropriately. NCCP asked state children's mental health authorities about partnerships with juvenile justice and state fiscal policies to ensure continuity of care and support for mental health services to juvenile justice involved youth. Only two states, Minnesota and Washington, described these strategies. In Minnesota, mental health screening for children is mandated, and a state appropriation is available to cover the cost of screening and brief treatment. In Washington, an extensive service delivery system exists for youth in juvenile justice. (See Box 10 for a description of the major legislative underpinnings of these services.)

Box 10: State Legislation to Improve Services for Youth in Juvenile Justice

Policy advancing knowledge: Washington State HB 1483

As early as 2005, Washington's legislature passed a law that:

- Recognized the need to invest in cost-effective evidence-based interventions for youth involved with juvenile justice
- Called for a youth and family focused framework for service delivery
- Returned cost savings to local government
- Created grants for communities to establish empirically based early intervention strategies
- Grounded itself in improving mental health to address juvenile crime
- Built-in cost-benefit assessments of these efforts

Source:

An Act Relating to Investments in Cost-Effective Intervention Programs for Juvenile Justice-Involved Youth, State of Washington, 59th Legislature Regular Sess.2005.

Major Findings and Policy Implications

- Even more so than for other age groups, state mental health authorities have been either unwilling or unable to build collaboration across systems to facilitate access, as evidenced by the lack of state knowledge or activities to reduce disincentives and the low number of states engaged in work strategies. Only California reported that they worked specifically with their Workforce Investment Board to ensure work opportunities for transition-age youth.
- Fewer than half of all states reported that they provide health insurance and social supports for youth with mental health conditions over age 18, despite the research showing that these youth experience poor outcomes that ultimately cost taxpayers more to address and the knowledge that these youth need access to services. Without health insurance and other social supports, few transition-age youth will automatically qualify for adult mental health services. States can prevent young adults becoming involved in other deep-end systems like criminal justice or welfare by providing these supports.
- State child mental health authorities do not report widespread efforts to prepare young adults with mental health conditions to address their housing and independent living needs. Only two reported that they provided housing support when describing other initiatives for transition-age youth, and three other states stressed their

work in supporting youth to develop independent living skills.

- Only 13 states reported that they were engaged with the private sector to expand work opportunities for youth and young adults. The private sector remains a largely untapped resource for children's mental health authorities despite the decades of experience in private industry for other disabilities.

Recommendations

For Young Children

The Congress or the secretary of DHHS should direct the Centers for Medicare and Medicaid Services (CMS) to develop a comprehensive strategy to support the provision of prevention, early intervention, and treatment services for young children, including children at risk for mental health conditions. Specifically:

- Require that CMS provide guidance to states on how to appropriately bill through Medicaid for screening to detect social emotional problems;
- Provide CMS assistance in collaboration with SAMHSA to state mental health authorities on which tools to use and how to bill Medicaid to support implementation of prevention, early intervention, and treatment strategies; and
- Through CMS, provide guidance to states to support Medicaid reimbursement for specific EBPs such as those they commonly use and for effective strategies with a proven record of preventing more serious behavioral problems such as mental health consultation.

States should:

- Inventory current efforts to expand statewide early childhood strategies and develop strategic plans to expand these; and
- Build partnerships across mental health, public health, child care, the Department of Education, and substance abuse services.

For School-age Children and Youth

The federal government should direct the Department of Education and SAMHSA, in conjunction with CMS where applicable, to develop a comprehensive strategy to support the provision of prevention, early intervention and treatment services for school-age children. Specifically:

- Facilitate Medicaid funding for school-based prevention-related interventions and for treatment;
- Make funding available for promotion of mental health and prevention of mental health conditions contingent upon an assessment of resources and gaps across the child serving systems and a comprehensive plan to maximize the impact of resources and address gaps;
- Require that any federal funding to support residential treatment should be based on improved quality and reduction in ineffective care; and
- Provide guidance to state child mental health authorities and educational authorities about how to develop and implement statewide mental health plans.

States should:

- Inventory across sectors efforts to address the needs of school-aged children and youth with mental health conditions and those at risk, and create coordination points to maximize the impact of these efforts; and
- Ensure that state and local educational authorities working with mental health agencies develop comprehensive plans to address the mental health needs of school-age children designed to maximize current efforts and reduce duplication and the provision of ineffective care.

For Youth Transitioning to Adulthood

The federal government should:

- Remove federal prohibitions that govern federal funding of services to youth in juvenile justice;
- Make available at the state option enhanced federal Medicaid participation rates for all youth with mental health involvement up to age 25;
- Require child mental health authorities' involvement in all SSI demonstration projects that involve youth and young adults;
- Provide funding and technical assistance to states to replicate Washington's policy supports for older youth with mental health conditions;

- Require as a condition of both juvenile justice and mental health funding that states provide mental health screening and interventions for youth with mental health conditions in juvenile justice; and
- Promote the adoption of Chafee option for Medicaid and other social supports for youth in the care of states and localities.

State and federal government should:

- Develop incentives for partnerships with the private sector to provide work opportunities and career paths for youth with mental health conditions moving into adulthood;
- Require that housing-support programs for individuals with mental health conditions also include youth transitioning to adulthood;
- Provide incentives for adult and child mental health authorities to work together in order to better serve the children and youth under their jurisdiction; and
- Support the replication of the Washington State model that implemented a series of policy steps to most efficiently provide services to juvenile justice-engaged youth, ensuring access to effective practices, attending to the needs of youth with co-occurring disorders, and mandating reinstatement of Medicaid enrollment for youth released from juvenile justice custody.

For all age groups, the federal government should direct the Centers for Medicare and Medicaid Services to re-craft its payment system to support practices that are empirically supported, including using knowledge from child development. This will require a mix of short- and long-term strategies that move fiscal support for service delivery toward an evidence-based and outcomes-focused approach. Specifically, federal regulation should:

- Provide incentives for statewide approaches to improving age-appropriate services;
- Reject changes to the rehabilitation option that undermine services in child care, schools and other settings that children, youth, and their families frequent; and
- Support states and professional organizations to improve the competencies of all providers (including teachers) who work with children and youth with mental health conditions and at risk for mental health conditions so they are prepared to meet the needs of children in an age-appropriate manner.

States should:

- Document periodically and make publicly available estimates of unmet need across the age groups and states' plans to address these needs.

CHAPTER 4

How Are States Improving the Systems for Service Delivery and Supports for Children and Youth with Serious Emotional Disorders and Their Families?

"Only seven states have departments of mental health that have taken even limited, explicit steps to create systems of care for children and adolescents. In these states there have been sustained efforts to increase the range of mental health services available, reduce the fragmentation of services, and counter the rigidity often built into mental health funds."

Knitzer, 1982

The development of children's system of care was called for by Knitzer in 1982, further developed and expanded by Stroul and Friedman, gained momentum in the 1990s with the passage of the Comprehensive Mental Health Services for Children and their Families Program in 1992.[99] [100] Large-scale efforts to develop service delivery elements, including wraparound and family and youth decision making followed.[101] The federal government seized the opportunity and marketed children's system of care development as its signature initiative. The system of care movement embodied a multi-million dollar long-term investment (over six years) in communities.

The results of nearly two decades following the federal government's leadership on the development of system of care at the community level are mixed. Competing evidence about its success prevails. There is evidence showing that children and youth do better in school and experience fewer encounters with law enforcement.[102] Other data suggest that clinical competency in service delivery may be wanting, that implementation of effective practices lacks consistency and fidelity, and that communities struggle to sustain the level of services after the federal grant ends.[103] [104] [105] In addition, reduction of out-of-home placements remain challenging for these sites.[106] In some quarters, enthusiasm has waned for the concept of the system of care movement as the primary vehicle for fixing the ills of community mental health for children. For example, some states have significantly reduced system of care funding.[107] Specifically, there is a growing recognition that even if system of care development occurred as crafted, it would still only account for the most troubled children, youth, and their families. Its mandate remains to cover children with the most severe mental health conditions.[108]

This chapter describes how states reported they have created the policy and practice framework for children and youth with severe emotional disturbance by incorporating the values and principles of the system of care philosophy into their service delivery systems.

Table 6: States Report How They Incorporate System of Care Principles

Methods of incorporating SOC principles	Number of states
Legislation or regulation	18
Funding and fiscal incentives (RFPs)	23
Practice standards	6
Local system of care development	8
Training	3
Wraparound initiatives	7
Legal agreements (e.g. MOUs)	4
Infusing specific system of care principles in strategic planning	7
Partnerships	20

Overwhelmingly, states told NCCP that they have incorporated the values and principles of system of care. Fifty states indicated that the system of care philosophy impacted their state's approach to children's mental health. Three of these states did not provide details of how they had incorporated these principles. The remaining states described examples ranging from legislation and regulations, funding and other fiscal incentives to changes in practice, standards of care, legal agreements, training and service capacity enhancements. The list below catalogs the manner in which states incorporated system of care principles into their way of doing business. Establishing partnerships with other agencies and creating fiscal incentives to develop components of the system of care were the most common mechanisms that states reported.

Seven states – Arizona, California, Florida, Nebraska, New Hampshire, New Jersey, and Wisconsin – cited legislation that incorporated system of care principles. An additional 11 states reported regulations that reflected system of care principles. Almost half of the states that reported funding or fiscal incentives such as contract language or requests for proposals that require making operational system of care values or principles. Many states also focused on the enhancing capacity using system of care principles, specifically wraparound as a service delivery approach.

States listed other types of service enhancement that included changes to practice standards, such as requiring assessments using validated tools, establishing protocols for diverting custody relinquishments, and using common care plans. Partnerships and changes in the states' relationships with stakeholders represented one of the most frequently cited ways that state leaders believed that system of care principles had infiltrated their service delivery system. Examples that states cited included presenting caregivers with choices in service delivery and providing a range of family- and youth-engagement opportunities. Five states reported that they implemented four or more of these methods, including Florida, Indiana, Oregon, Texas, and Virginia.

Major Findings and Policy Implications

- States have used a range of methods to incorporate the system of care principles in their mental health services delivery systems. Some of these have the potential to be enduring such as:
  - Eighteen states with legislation or regulation to implement system of care principles;
  - Twenty-three states with targeted funding and fiscal incentives; and
  - Twenty states with partnerships following the system of care principles

  However, the scope of these components is unclear and may be narrowly targeted.
- The difficulty in gauging the impact of the system of care efforts on the overall service-delivery system, especially on increasing capacity even for the population of focus, children and youth with SED, calls for more data. In a later section of this report, we detail states' responses to the top challenges they face. Cross-systems work ranked among the top challenges that states most frequently cited, suggesting that while the system of care movement has had a substantial impact on service delivery processes, it has not done all the heavy lifting that is required for cross systems engagement.

Recommendations

The federal government should:

- Expand the focus of the system of care initiatives to include a public health framework
- Make available the system and child and family outcomes that the grant program has demonstrated to all states
- Work with states to identify system and service capacity enhancements to improve outcomes for children and youth with mental health conditions and those at risk
- Nationally share the learning of recent system of care grants that have included lead partners other than mental health or children other than school-age youth

CHAPTER 5

How Are Mental Health Practices Across the Age-span Guided by Evidence of Effectiveness?

"The optimal use of evidence to inform practice is likely to go beyond any use of evidence-based practices. It is likely to require the use of tested interventions along with additional information gathered at all levels of the service system in which care is delivered."

Chambers, 2008

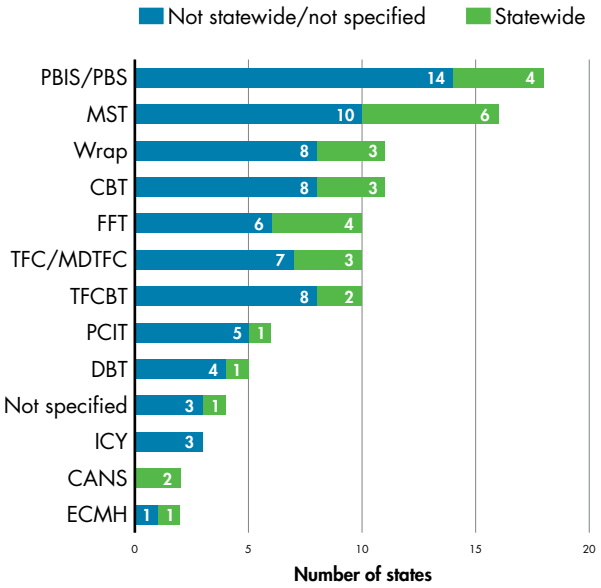
Widespread use of ineffective practice, combined with an external movement in health care to raise the bar on the quality of service delivery, has propelled the evidence-based practice (EBP) movement.[109] [110] In children's mental health services research, the term EBPs refers to scientific-based knowledge about service practices. It provides "a shorthand term that denotes the quality, robustness, or validity of scientific evidence as it is brought to bear on these issues."[111]

Implementation issues such as provider attitudes, competency, and the organizational culture in which providers operate represent potential impediments.[112] [113] [114] Family engagement has been associated with improved outcomes in children's mental health.[115] [116] [117] This chapter reviews responses from state children's mental health providers, mental health advocates, and families and youth on their perspectives on implementation of evidence-based practices. It draws on state children's mental health directors and state advocates responses to inquiries about specific strategies that states use to promote EBPs and the specific types of EBPs they promote, support, or require. It also uses data from our California case study work to ascertain community stakeholders' knowledge about EBPs.

Overall Approaches

The movement toward implementation of EBPs is a state priority.[118] Nearly all states are promoting, supporting, or requiring implementation of some practices that are empirically supported (N=50). Figure 4 shows the most frequently cited EBPs that states reported they promote, support, or require and whether they are statewide.

Figure 4: **Type of EBPs States Require, Support, or Promote**



PBIS/PBS	Positive Behavioral Intervention and Support/ Positive Behavioral Intervention
MST	Multisystemic Therapy
Wrap	Wraparound
CBT	Cognitive-Behavioral Therapy
FFT	Functional Family Therapy
TFC/MDTFC	Therapeutic Foster Care/Multidimensional Treatment Foster Care
TFCBT	Trauma-focused Cognitive-Behavioral Therapy
PCIT	Parent Child Interaction Therapy
DBT	Dialectical Behavior Therapy
ICY	Incredible Years
CANS	Child and Adolescent Needs and Strengths
ECMH	Early Childhood Mental Health Consultation

Overall, the scale of EBP implementation as supported by states lacks breadth and depth. Only 19 states reported that they promote, support, or require evidence-based practices statewide. Of the most frequently cited EBPs, such as multi-systemic therapy, functional family therapy, and positive behavioral interventions and supports, only four to six states reported statewide implementation for any of these interventions. States also identify a number of practices that they promote support or require that currently do not have the level of empirical support to be evidence-based but that have proven effective in community-based settings. Wraparound and early childhood mental health consultation initiatives were identified by states as practices they promote, support, or require.

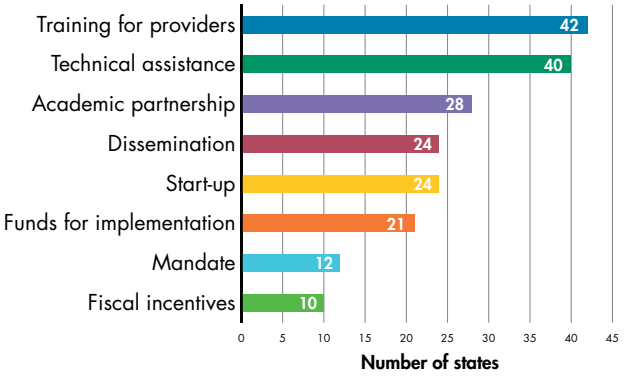
Research suggests a continuum between diffusion and dissemination is necessary for adoption of EBPs. Factors that favor diffusion include social interaction, robust social networks, influential thought leaders and champions, and links across structures and sectors.[119] Intentional dissemination, on the other hand, requires attention to the range of potential adopters, customization to different demographic groups and cultural factors, tailored messaging, appropriate communication channels, financing – especially targeted financing – and evaluation.[120]

Common Approaches and Legal Mandates

States have employed a range of different strategies to promote evidence-based practices. Some align better than others with the research of the components of a purposeful approach to dissemination. These include:

- developing academic partnerships for training and infrastructure-related development;
- dissemination;
- technical assistance;
- training;
- providing funds for implementation or start up;
- offering fiscal incentives; and
- mandating implementation.

Figure 5: **Types of Initiatives to Expand EBPs**



The most common strategies that states reported were workforce-related, such as training for providers (N=42) and technical assistance (N=40). Over half of states reported having academic partnership (N=28); state dissemination infrastructure (N=24); or providing start-up funding (N=24). No state reported having an umbrella mechanism for bulk purchasing. (See Figure 5.)

While training and technical assistance were the most frequently mentioned methods of promoting EBPs that states reported, the nature, quality, and impact of these strategies were not described.

Some states that reported academic partnerships as a vehicle for promoting EBPs are actively involved in developing and sustaining centers of excellence charged with the dissemination and implementation of evidence-based practices. Centers fully or partially funded by state child mental health authorities included centers in New York, California, and Ohio. (See Box 11.)

Legal mandates to provide evidence-based practices have been adopted in Guam and 11 states: Hawaii, Indiana, Iowa, Minnesota, New Mexico, North Carolina, Oregon, Tennessee, Texas, Washington, and Wisconsin.

Of the states that mandate the use of evidence-based practices, only eight support, promote or require specific EBPs on a statewide basis.

Box 11: California Institute of Mental Health (CIMH) Values-Driven Evidence-Based Practices Initiative

The Initiative's goals include:

- Disseminate information about Evidence-based Practices (EBPs) and Promising Practices (PPs) to youth (consumers), family members, service providers, managers, and administrators so that each of these groups can participate in fully informed decision making
- (2) Prioritize youth (consumers) and family voices, cultural competency, and proven effectiveness in the selection and accommodations of EBP/PPs
- (3) Adequately support practitioners, managers, and administrators through a "comprehensive implementation process"
- (4) Assuring the model to adherent and sustainable implementation of EBPs and PPs.

The Initiative's Approach uses "the Community Development Team" (CDT) model, a multi-level training and technical assistance strategy. EBPs supported include:

1. Multi-Dimensional Treatment Foster Care (MTFC)
2. Functional Family Therapy (FFT)
3. Teaching Pro-social Skills (including Aggression Replacement Training ™ curriculum)
4. Multidimensional Family Therapy (MDFT)
5. Depression Treatment Quality Improvement (DTQI)
6. High Fidelity Wraparound
7. Incredible Years (IY)
8. Trauma Focused Cognitive Behavioral Therapy (TFCBT)
9. Multi-Systematic Therapy (MST)

Sources:

California Institute of Mental Health. *About the California Institute for Mental Health.* Retrieved Oct. 31, 2008 from http://www.cimh.org/About.aspx.

Carter, Bill, CiMH Deputy Director. October 29, 2008. Personal Communication.

Box 12: Parent Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy is an evidence-based treatment for young children ages 2 to 7 with conduct disorder. It is designed to improve parent child interactions and teach parents how to change interaction patterns. Parents are taught specific skills to enhance pro-social interaction and reduce negative behaviors.

The treatment lasts an average of 14 sessions but ranges from 10 to 20. PCIT encompasses two components:

- Child Directed Interactions (CDI) – parents engage their child in play situations
- Parent Directed Interactions (PDI) – parents learn to use specific behavior management techniques as they play with their child.

Sources:

Parent Child Interaction Therapy Training Center, UC Davis. 2008. *About us.* Retrieved Oct. 30, 2008 from http://www.pcittraining.tv/about.asp. Oct. 30, 2008 from http://www.cachildwelfareclearinghouse.org/program/5/detailed.

The California Evidence Based Clearinghouse for Child Welfare. 2008. Parent Child Interaction Therapy (PCIT) Detailed Report. Retrieved Oct. 20, 2008 from http://www.cachildwelfareclearinghouse.org/program/5/detailed.

Box 13: Multisystemic Therapy (MST)

Multisystemic Therapy is an evidence-based community- and family-based treatment model for youth with serious behavioral problems to reduce antisocial behavior in youth. MST is a goal -oriented treatment that specifically focuses on the factors in each youth's social network that contribute to his or her antisocial behavior. Therefore, MST interventions aim to reduce risk factors by improving caregiver discipline practices, decreasing youth association with negative peers and increasing association with prosocial peers, improving school and vocational performance, and building on youth and family strengths to develop and enhance family relationships and support networks. MST is highly individualized and comprehensive. The treatment is delivered in natural settings and is designed in collaboration with family members. MST strives to empower families to build an environment to enhance protective factors. The main goals of MST are to decrease rates of antisocial behavior and other clinical problems, improve functioning, and achieve these outcomes at a cost savings by reducing the use of out-of-home placements.[1] Therapists have caseloads of four to six families and work as a team. The average treatment involves 60 hours of contact during a four-month period.[2]

Findings from 15 published outcome studies have shown MST to be effective in treating youth with criminal behavior, substance abuse disorders, and emotional disturbances.[3]

Sources:

1. MST Services.2008. *Multisystemic Therapy – MST.* Retrieved Oct. 30, 2008 from www.mstservices.com.

2. OJJDP Model Guide. 2008. *Multisystemic Therapy.* Retrieved Oct. 30, 2008 from http://www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?id=363.

3. MST Services. 2008. *Research on Effectiveness.* Retrieved Oct. 30, 2008 from http://mstservices.com/text/research.html.

Box 14: Functional Family Therapy (FFT)

Functional Family Therapy is an empirically based family intervention for at-risk and juvenile justice-involved youth. FFT is for youth ages 10 and older and their families. It can be provided in a variety of environments, such as schools, juvenile justice system, or in the home.

The FFT clinical model organizes the intervention around specific phases. Phase 1 engagement and motivation; Phase 2 behavioral changes; and Phase 3 generalizations, the ability to maintain and generalize change to other settings. Each phase includes goals, assessment, specific techniques of the intervention, and the necessary skills of therapist. Intervention sessions can range from, on average, eight to 12 one-hour sessions and up to 30 sessions of direct service for more difficult situations. FFT has been proven to be very effective for a wide range of youth, and their families in various multi-ethnic, multicultural contexts with conduct disorders, violent acting out, and substance abuse.

Sources:

Functional Family Therapy. 2008. Retrieved Oct. 30, 2008 from http://www.fftinc.com/

New York State Office of Mental Health. *Functional Family Therapy.* Retrieved Oct. 30, 2008 from http://www.omh.state.ny.us/omhweb/EBP/children_fft.htm.

Box 15: Incredible Years (ICY)

Incredible Years is a research based program to reduce children's aggression and behavior problems and to increase social competence at home and at school. ICY is for children age three to eight, their caregivers, and teachers. It is a comprehensive curriculum-based training series for parents, teachers, and children. It is designed to promote self competence and reduce, prevent, and treat aggression and conduct-related behaviors. ICY uses a level of intervention model for parent- and teacher-training and child-training programs. The interventions that make up the parent-training, teacher-training, and child-training programs are guided by developmental theory on the role of multiple interacting risk and protective factors (child, family, and school) in the development of conduct problems.[1]

ICY has shown to be effective in multiple research studies with parents, teachers, and children.
Research has shown the parenting series to:[2]

- Increase positive affect and effective limit setting discipline with non-violent discipline techniques
- Foster positive family communication
- Reduce parental depression and conduct problems in children's interactions with parents.

Research has shown the teacher series to:

- Increase use of praise and encouragement and reduce use of criticism and harsh discipline
- Increase children's positive affect and cooperation with teachers
- Increase children's positive interactions with peers, school readiness, and engagement with school activities
- Reduce peer aggression in the classroom.

Research has shown the children series to:

- Increase appropriate cognitive problem solving strategies and pro-social conflict management with peers
- Reduce conduct problems at home and school.

Sources:

1. Incredible Years. 2008. *Incredible Years Series Training Programs.* Retrieved on October 31, 2008 from http://www.incredibleyears.com/program/index.asp.

2. Incredible Years. 2008. *Evidence of Effectiveness.* Retrieved on October 31, 2008 from http://www.incredibleyears.com/ResearchEval/effective.asp.

Box 16: Positive Behavioral Intervention System (PBIS)

Positive Behavioral Intervention System is an empirically supported framework designed to promote positive school climates and facilitate conditions for effective learning. Its major aim is to reduce disciplinary action caused by disruptive behavior, particularly in the classroom. It is designed for all children and youth and it has been used in settings other than schools, such as juvenile detention centers. PBIS focuses on creating and sustaining an environment to improve educational results for all students. The key elements of PBIS include addressing inappropriate behaviors, facilitating positive behavior change, and encouraging academic achievement.

PBIS is based on a three-tier intervention model that provides universal primary intervention strategies (a whole-school approach), targeted individual and group interventions for secondary prevention, and individually focused behavioral interventions and supports for children and youth with behavioral problems and more severe disorders. It relies on a continuous coaching, training, and support infrastructure.

Research has shown that schools that have implemented PBIS have experienced positive outcomes on school climate, reduction in problem behaviors, increase in instruction time, and increase in efficiency in school-wide discipline. PBIS has also been shown to be effective in juvenile detention and correction facilities. Research has shown reductions in major and minor behavior incidents and use of restraints. In a follow up observation of one juvenile justice facility, it was revealed that there were no fights reported for two years after the implementation of PBIS.

Source:

Brook, L.; Quinn, M. 2006. The Positive Behavioral Interventions and Supports (PBIS) Model. *National Evaluation and Technical Assistance Center.* Retrieved October 31, 2008 from http://www.neglected-delinquent.org/nd/resources/spotlight/spotlight200601a.asp.

Advocates Weigh In

"[We are] moving toward [where] state-of-the-art services are perceived as a risk. [They are] doing things in a way that isn't supportive."

County Mental Health Leader, California

NCCP's study of state mental health advocates sheds light on states' success in their efforts to spread the word about evidence-based practices. Respondents reported overall awareness of their states' efforts to implement evidence-based practices. Nearly 60% (N=11) of state advocates knew that their state had made efforts to implement specific strategies to promote the appropriate use of evidence-based practices. However, few advocates knew about the specific strategies used.

The implementation of evidence-based practices is often hampered by concerns about cultural and linguistic competence and concerns about their impact on the ever-expanding disparities in access and outcomes for children and youth from diverse racial/ethnic backgrounds.[121] Yet recent research has demonstrated both a strong association between culturally and linguistically competent mental

health care and improvements in mental health outcomes for children and youth.[122] [123] This research also suggests that for some populations, we know less about what is effective, especially in the long term.[124] Only one state, Arizona, discussed the role of diverse cultural groups in the planning for selection of evidence-based practices. In NCCP's study in California, some leaders and providers expressed the need for evidence-based practices to be culturally and linguistically competent. Leaders and providers frequently discussed concern about cultural and linguistic competency in the context of evidence-based practices in light of the racial and ethnic diversity of their population.

Community Stakeholders

Whether states compel, incentivize, or use persuasion to ensure implementation of evidence-based practices, research suggests that responsiveness varies among providers and service users.[125] There is evidence in the literature on quality about the importance of consumer knowledge to promote adoption and implementation of evidence-based practices.[126] However, such research is more limited in mental health and children's mental health in particular. Recent data suggests that family organizations can be both supportive and skeptical about state initiated implementation of evidence-based practices.[127] [128] But research also suggests very little knowledge on the part of service users and family members about EBPs.[129] NCCP's case study of family members and youth in California reinforces this fact. Among community stakeholders, community leaders, family members, and youth service users were the least likely to have ever heard about EBPs. While 67% (N=24) of community leaders knew about EBPs, only 7% (N=15) of youth interviewed and 18% (N=22) of family members knew about them.

In this study, knowledge varied by race/ethnicity and English language proficiency. White and African-American family members and youth were more likely to have heard about evidence-based practices than Asian-Pacific Island, Latino/Hispanic, or American-Indian/Alaska Native family members and youth. (See Figure 7.) Family members and youth who were primary Spanish language users were less likely than those of English

Figure 6: **EBP Knowledge Among Stakeholders by Language**

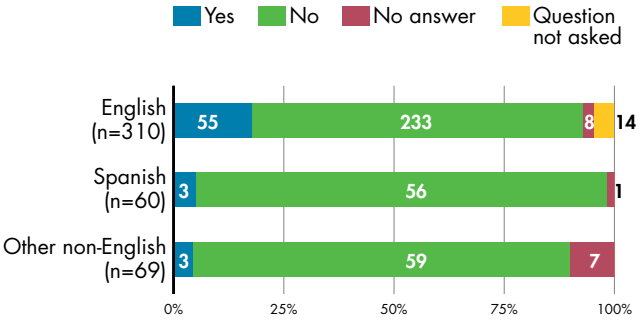
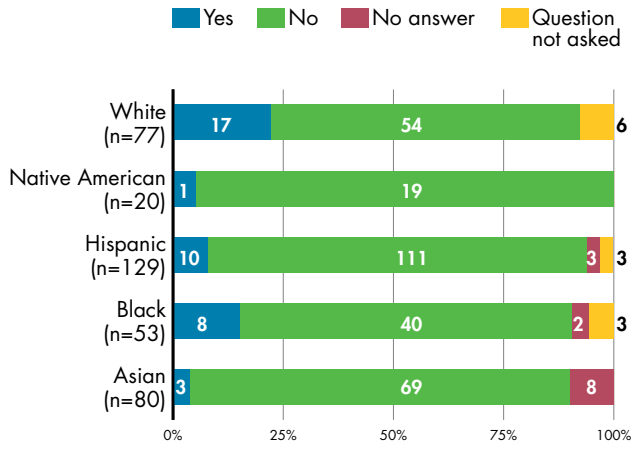


Figure 7: **EBP Knowledge Among Youth and Family Members by Race/Ethnicity**



or other languages to have heard about evidence-based practices.

Lack of knowledge of EBPs suggests room for states to develop strategies for families and youth to join them in promoting effective practice. In nine states, mental health advocates reported that their state children's mental health authority provides ongoing training to families and youth in best practices and/or how to navigate the children's mental health system. These states include:

California	New Jersey	Pennsylvania
Georgia	New York	Tennessee
Kansas	North Carolina	Wisconsin

Major Findings and Policy Implications

- States have made great strides in their efforts to implement evidence-based practices (EBPs). They have promoted, supported, or required specific age-appropriate EBPs although these have been limited in scope. Most of these gains have occurred despite obstacles created by the payment systems, which either do not reimburse at all or reimburse poorly for many of the components of these practices. (See Chapter 8.).
- Only 19 states have at least one EBP that they support, promote, or require statewide. States are challenged to bring these efforts to scale if they hope to impact service delivery in a meaningful way.
- Despite states' declared commitment to implementation and quality of EBPs, the high cost of many of the "model" programs that they promote or require, and the concerns these costs raise about uptake and maintenance, no state reported using a basic cost saving mechanism such as bulk purchasing to increase the availability of EBPs in their systems of care. Advancing adoption of EBPs requires a long-term fiscal commitment, yet all the signals from states and the federal government through Medicaid indicate only short-term planning and solutions.
- States' ability to appropriately bill for, and provide fiscal and other incentives (such as reduction of administrative tasks and paper work) to implement EBPs will contribute significantly to the more widespread adoption of these practices. However, the fact that payment systems often will not reimburse for EBPs puts them at a disadvantage and hampers their widespread implementation.
- Of the eight states that mandate the use of EBPs and require this statewide, half (Indiana, New Mexico, Oregon, and Texas) describe their IT systems and their outcome-based decision making as intermediate or advanced. This and prior analysis suggests that mandates represent blunt policy instruments that may distract from local efforts to own and attain the stated outcomes.[131] [132] Even states with mandated EBP initiatives that are statewide need improved levels of IT infrastructure and outcome-based decision making capacity to improve quality.

Recommendations

The federal government should implement a comprehensive plan that finances the delivery of empirically-supported effective practices through payment structures like Medicaid, private insurance, grants, and incentives. Such a plan would include:

- Supporting statewide implementation of EBPs by:
  - Permitting billing for EBPs that support the bundled nature of the interventions and support the integrity of these practices;
  - Providing guidance and technical assistance to states on how to bill and receive reimbursement for developmentally appropriate EBPs;
  - Supporting reimbursement for effective practices such as mental health consultation and proven community-based interventions; and
  - Convening a summit to produce a set of recommendations for implementation by state Medicaid, mental health authorities, and experts on dissemination of EBPs to help make EBPs more common among the reimbursable services.
- Demonstrate the impact of efforts to reduce the cost of proprietary-based practices through bulk-purchasing and other types of initiatives.
- Increase research on best practices models, especially those designed for diverse populations, for example, by funding entities like the National Network for the Elimination of Disparities that focuses on developing culturally and linguistically competent evidence-based practices; and
- Promote national recognition to institutions of higher education that provide competency-based training in evidence-based practices for degree and certificate programs.

The federal government and states should:

- Systematically track the use of and outcomes associated with the implementation of evidence-based practice;
- Create initiatives that educate youth service users and their family members on EBPs; and
- Fund the use of advocates as allies in states efforts to disseminte EBPs.

CHAPTER 6

How Well Do States Respond to the Need for Culturally- and Linguistically-competent Services and Systems to Meet the Needs of Children, Youth, and Their families?

"Race, ethnicity, and culture of children play a major role in shaping the care provided to them by health institutions. Racial, ethnic, and cultural differences influence the expressions and identification of the need for services"

Margarita Alegria, PhD, 2000, Conference on Children's Mental Health: A National Action Agenda

In 1982 Knitzer pointed to the disadvantage in access to care experienced by minority children and youth. For the subsequent 20 years, cultural competency became a mainstay of the rhetoric surrounding children's mental health reform. Cultural competence is one of the principles of the system of care philosophy.[132]

For more than a decade, advocates and leaders in children's mental health have also stressed the importance of linguistic competence.[133] Linguistic competence, recognized and codified in Title VI of the Civil Rights Act in 1984, received renewed attention with the development and publication of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS).[134]

Despite this extensive history, children, youth, and their families with mental health needs are less likely to get their needs addressed if they come from a diverse background, are part of an underrepresented minority group, or are from a family with limited English proficiency.[135] Disparities in access and outcomes persist.[136 137 138]

Of the many state and federal efforts over the last two decades to address racial and ethnic disparities, few in children's mental health take the form of strategic approaches that involve specific expert-informed techniques that are linked to improved outcomes.[139] For policymaking in particular, researchers point to the prominence of policy in a three-pronged approach that requires changes in attitudes and practice.[140] Even for changes at the service-delivery level, researchers note that policy impacts systematic change.[141] Specific agency-level techniques tied to system performance for cultural and linguistic competence identified in the research include cultural advisory bodies, implementation of a cultural competence plan, and linguistic competence training and education.[142] Other research promotes the significance of workforce development strategies.[143] Among policymakers, measurement and leadership emerge as factors instrumental to progress toward system cultural and linguistic competence.[144]

NCCP used these policy indicators to develop a set of questions for states to gauge their progress they have made toward cultural and linguistic competence. This chapter describes the level of institutionalization of the policy-related cultural and linguistical competence strategies states designed and implemented to reduce racial/ethnic disparities. The data described here come from a survey described in the first section of this report. (See page 14.)

Comprehensive and Intentional Policy Steps that States Reported

Overall, three states reported purposeful steps toward cultural and linguistic competence through policies, including the following:

- Competency-based training for cultural and linguistic relevance;
- Infrastructural support for developing and sustaining a culturally and linguistically competent workforce;
- Regularly updated assessments of cultural and linguistic competence;
- Up-to-date strategic plan for cultural and linguistic competence; and
- Stakeholder involvement in policy and programming

These states include Arizona, California, and Delaware. North Carolina, Georgia, Oregon, Ohio, and Massachusetts also reported most of the strategies above. Nine states did not report on these policy indicators.

Access to Services for Children and Youth from Diverse Communities

Of all groups of from diverse backgrounds, state leaders were most likely to indicate that they served African-Americans well, compared to 12 states who reported they serve Hispanic/Latinos well, and 10 who reported they serve Asian-Pacific Island children and youth well. Nine state leaders reported they serve American Indian/Alaska Natives children, youth, and their families well. Across all racial/ethnic groups, five states reported consistently that they served children and youth well. These states included Arkansas, California, District of Columbia, Maine, and Minnesota.

Two states, Maine and Kentucky, identified children and youth who were deaf or who had other cultural needs (from Appalachia) as being among those they served well.

State leaders were more likely to identify Hispanic/Latinos, American Indian/Alaska Natives and Asian-Pacific Islanders, as groups they struggled to serve appropriately, compared to African-Americans (See Appendix 2, Table A).

States Identified Gaps that Underlie Disparities

Stigma, immigration status and language barriers were top among the gaps in access that states identified for children and youth from diverse backgrounds. States also reported top gaps in access to services by racial/ethnic groups. For African-American children, youth, and their families, stigma, poor cultural competence, and low mental health literacy ranked high among the top gaps. For children, youth of Asian-Pacific Island descent and their families, language barriers, stigma, and poor cultural competence among providers were among the top gaps that states reported. Hispanic/Latino children, youth, and their families, according to state leaders, face gaps in access that included language barriers, immigration status and poor provider cultural competency. Lack of health insurance also ranked high. For American-Indian/Alaska Natives poor provider cultural competence, lack of trust in providers and the existence of structural barriers such as poor transportation, cost and location were cited. (See Table 7.)

Table 7: **Top 3 Factors Creating Gaps in Mental Health Service Access for Each Racial/Ethnic Group**

Racial/ethnic group	Number of states
African Americans	
1. Stigma	20
2. Poor provider cultural competence	14
3. Lack of mental health literacy	13
Asian Americans	
1. Language barriers	19
2. Stigma	16
3. Poor provider cultural competence	13
Hispanics	
1. Language barriers	22
2. Immigration	20
3. Poor provider cultural competence	13
Native Americans	
1. Poor provider cultural competence	14
2. Lack of trust of providers	13
3. Structural barriers	13

These access gaps are reinforced by other sections of this study. For example, states identified workforce challenges as a major issue with which they grapple, in particular training and maintaining a workforce that is responsive to the cultural and language needs of the children, youth, and families served. NCCP's case study in California also serves to underscore this gap. Fifty-eight county system leaders in 11 counties

identified cultural and linguistic competence among the workforce as major infrastructural challenge that they face. These concerns notwithstanding, system leaders in California were proud of their efforts to diversify their workforce and to provide more skills in cultural and linguistic responsiveness to their current providers. Over half of county system leaders touted the diversity of their workforce and strategies such as explicit language in provider contracts that addressed cultural and linguistic competence (N=107). Some county system leaders (N=21) attributed the strength of their systems' cultural and linguistic responsiveness to the Mental Health Services Act. (See Box 17 for a list of policy steps derived from MHSA.) States also reported that lack of health insurance coupled with immigration factors significantly impacts access to services for children and youth, particularly for children of Hispanic/Latino descent. These responses are also supported by data from California where county leaders and providers grapple with access to services for the undocumented child and family.

Box 17: Mental Health Services Act (MHSA) Innovative Strategies to Promote Cultural Competence and Build Workforce

MHSA: 5-Year Workforce Education and Training Development Plan, 2008-2013

The Workforce Education and Training Development Plan's goal is to build and maintain a competent workforce capable of providing client- and family driven, culturally competent services that promote wellness, recovery, and resilience and lead to measurable, values-driven outcomes. Efforts to develop qualified individuals for the public mental health workforce include:

- Expanded loan repayment and scholarship programs offered in return for a commitment to employment in California public mental health and expanded loan repayment programs available to current employs who want to obtain higher degree
- Stipend program modeled after Federal Title IV-E stipend program for persons enrolled in academic institutions who want to be employed in mental health system
- Regional partnerships between the mental health system and education system to expand outreach to multicultural communities and promote the use of web-based technologies
- Recruitment of high school students for mental health occupations
- Employment of mental health clients and family members in mental health system
- Increased eligibility for federal workforce funding by increasing the number of CA communities recognized by federal government as having shortage of mental health professionals
- Expanded postsecondary education capacity to meet needs of identified mental health occupational shortages
- Development of curricula to train and retrain staff to provide mental health and other supportive services in accordance with provisions and principles of MHSA
- Promotion of inclusions of cultural competence in all workforce education and training programs

Source:

California Department of Mental Health. 2008. *Mental Service Act Five-Year Workforce Education and Training Development Plan, For the Period April 2008 to April 2013*. California Department of Mental Health.

Language Access

Poor English language proficiency was also identified as a determining factor in the access gap, especially for children and youth raised in multi-lingual families. Twenty states reported that children, youth, and their families from Spanish speaking families with limited English proficiency were well served in their states. A much smaller number of states identified Vietnamese (N=6) speaking families as one group that they served well. For a list of states that reported they serve well, and struggle to serve, children and youth with mental health conditions, by language groups, see Appendix 2 Table B. Spanish, Vietnamese, Chinese and Arabic were language groups of children and youth that states reported that they struggle to serve appropriately.

Policies That Promote Cultural and Linguistic Competence

Many states (N=30) reported that they had policies in place that promoted access to culturally and linguistically competent services. Fewer states identified these policies (N=25). Thirteen states identified state regulation or legislation as the underpinnings of their policies that promote cultural and linguistic competence and efforts to eliminate disparities based on racial/ethnic/cultural and linguistic attributes. In the case of linguistic competence, 10 states pointed to state legislation and regulation. Other policy mechanisms states reported they have used include: federal legislation, executive orders or directives, agency rules, and guidelines and standards.

Box 18: MHSA Increases Workforce Diversity and Capacity

MHSA funds were used by California Social Work Education Center from 2005 -2007 to train:

- Nearly 400 MSWS
  - 50% from diverse communities
  - 60% spoke a second language
  - 95+% graduated

Source:

Midgley, J.; Lloud, M. 2008. Berkely Leads in Creating State Mental Health Stipend Program. Social Work at Berkeley (Spring).

State Infrastructure Support for Cultural and Linguistic Competence

States implemented a range of strategies to foster infrastructure-related supports for cultural and linguistic competence. These ranged from a designated individual responsible for cultural and linguistic competence (as in the case of 21 and nine states respectively), to specific task forces or advisory bodies, to efforts to infuse cultural and linguistic competence within the workforce. As Box 19 shows, of the 19 states reporting that they have designated multicultural task forces, only 14 of these have policy or programmatic responsibilities for cultural competency and only five have policy for linguistic competence. Table 8 lists the states by type of infrastructural supports.

Box 19: Number of States with Designated Task Forces by Charge and Responsibilities

State Multi-cultural Task Force has:

- Policy and program responsibility for cultural competence 14
- Stakeholder input but no responsibility for cultural competence 10
- Policy and program responsibility for linguistic competence 7
- Stakeholder input but no responsibility for linguistic competence 6

Table 8: Types of Infrastructure Support States Report

	State designated cultural/ linguistic competence director	State designated taskforce/body	Training	Infrastructure supports for workforce development	Statewide assessment system	Statewide cultural and linguistic competence plan
ARIZONA	✓	✓	✓	✓	✓	✓
CALIFORNIA	✓	✓	✓	✓	✓	
COLORADO	✓		✓	✓		
CONNECTICUT	✓	✓		✓	✓	
DELAWARE		✓	✓	✓	✓	
DISTRICT OF COLUMBIA	✓	✓	✓	✓		✓
FLORIDA				✓		
GEORGIA	✓	✓	✓	✓		
HAWAII	✓			✓		
INDIANA	✓		✓			
ILLINOIS	✓	✓		✓		
INDIANA	✓					
KENTUCKY	✓		✓			
LOUISIANA	✓	✓	✓	✓		
MARYLAND	✓			✓		
MAINE	✓	✓	✓			✓
MASSACHUSETTS	✓	✓	✓	✓	✓	✓
MINNESOTA	✓	✓	✓	✓		
MISSISSIPPI		✓	✓	✓		
MONTANA			✓		✓	✓
NEBRASKA			✓	✓		
NEW MEXICO	✓	✓		✓		
NORTH CAROLINA	✓	✓	✓	✓		✓
OHIO	✓	✓	✓	✓		
OREGON		✓	✓	✓		✓
PENNSYLVANIA	✓	✓	✓	✓		✓
SOUTH CAROLINA	✓	✓	✓		✓	✓
TEXAS				✓		
UTAH	✓	✓	✓		✓	✓
VERMONT	✓	✓		✓		
WASHINGTON	✓	✓		✓		
WEST VIRGINIA				✓		
WYOMING			✓		✓	

States' Efforts to Improve Cultural and Linguistic Competence Based on Assessment of Need and Strategic Planning

The states' abilities to implement cultural and linguistic competence and to measure their progress are highly dependent on their baseline understanding of where they stand, and goals for where they want to improve. Only nine states (slightly over one-fifth of respondents) indicated that they regularly conduct a statewide assessment of the level of cultural and linguistic competence in their service delivery system. Of these states, seven focus on disparities in access and/or treatment, two focus on outcomes, one examines workforce and one focuses on disproportional minority representation in non-community settings. (See Table 8.)

Slightly more states reported that they had a statewide cultural competence plan. Eight states reported that they had such a plan and five indicated that they did not. Other respondents did not answer the question. Half of the states with cultural competence plans indicated that they maintain an up-to-date plan that addresses disparities. Two states indicated that their plans around cultural and linguistic competence were not stand-alone plans but embedded in their state mental health plan. Three states reported that they had benchmarks for cultural and linguistic competence in the state mental health planning process and strategic plan. North Carolina and Minnesota indicated that they engage in multiple efforts focused on strategic planning, including planning for the service delivery system and for the state mental health agency.

Developing Cultural and Linguistic Competence through Training

Twenty-two states reported that they implement training for providers on cultural and linguistic competence. Fifteen states reported that these are yearly or ad-hoc events that promote awareness or diversity. Only nine states reported that they implement in-depth, competency-based training and only Colorado reports that this leads to certification. States that reported in-depth training in cultural and linguistic competence included:

Arizona	District of Columbia	Oregon
California	Indiana	South Carolina
Colorado	Massachusetts	Utah

Among states that focused on workforce development, this included a range of strategies varying from policies to support recruitment and retention, to efforts to address barriers in credentialing and licensing that keep professionals and paraprofessionals from entering the field. States most often reported policies to support recruitment and retention and contracted language or request for proposal specifications that required enhanced cultural and linguistic competency as strategies they used. Funding as a strategy was least often employed by states. Only six states reported funding to support recruitment and retention efforts (California, Colorado, Connecticut, Maryland, Massachusetts and North Carolina). Only four states (California, Maryland, Massachusetts and Oregon) reported that they provide funding to support collaboration with higher education to increase the supply of providers from diverse communities. Eight states reported that they have undertaken efforts to address credentialing and licensing-related barriers with state licensing boards. These included:

California	Minnesota	Oregon
Delaware	North Carolina	Texas
Maryland	Ohio	

Five states indicated some of their workforce development strategies had their impetus or regulatory support in laws. These states were Arizona, Maine, Mississippi, Ohio and Texas. In addition, 10 states reported that they are engaged in multiple strategies designed to address cultural and linguistically competent-related workforce challenge. The following states were in this category:

California	Massachusetts	Texas
Delaware	North Carolina	Vermont
District of Columbia	Ohio	
Maryland	Oregon	

The Role of Cultural Competence Coordinator in State Mental Health Authority

Fewer than half of the states that responded indicated that they employed an individual to promote cultural and linguistic competence in mental health. Of the 17 states that had such a position on staff, 14 states indicated the level of the position. Three of these positions were in senior management with direct reports to a commissioner, assistant or deputy commissioner (California, North Carolina and

Minnesota). Nine of these positions had a mid-level professional rank. Only one of the individuals in this position had budget decision making authority (in Utah). In eight states, the multicultural coordinator held supervisory authority. Despite the variation in level of authority, in most of the states with multi-cultural coordinators, the individual (14 states) was in engaged in policy decision making.

Major Findings and Policy Implications

- Despite data showing that African-American and Latino children and youth with mental health conditions are disproportionately represented in restrictive care settings, face obstacles to accessing mental health services and experience poor outcomes nearly half of the states reported that they serve African American children and youth well. Additionally, 12 states reported that they served Latino children and youth well. States may be referring to their successes with groups of children and youth in targeted programs since most of the literature suggests that many African-American and Latino youth are ill-served by the children's mental health system and are disproportionately among those with poor mental health outcomes.
- Only three states reported on systematic efforts to advance cultural and linguistic competence.[145] This suggests that states have a long way to go in their attempts to reduce disparities based on race/ethnicity or language access. Since policy research indicating that state leadership represents a driving factor necessary to improve cultural and linguistic competence in children's mental health from a quality and access perspective, this is troubling.
- Twenty-six states reported on policies that promote access to culturally and linguistically competent services. However, only three states reported that they have implemented a range of purposeful steps to promote cultural and linguistic competence including competency-based training, workforce development, assessment and strategic planning, and stakeholder involvement in policy and programming. This suggests that states may be employing diluted versions of what is needed and that a more comprehensive approach that engages a range of policy strategies may have greater impact on improving the cultural and linguistic competence.
- Twenty states reported the use of statewide multi-cultural stakeholder groups but in only 13 states do these bodies hold policymaking or program responsibilities. However, if such groups are to become a force for change it appears that they will need more authority and responsibility.
- Only 10 states reported that they regularly assess their system's level of cultural and linguistic competence and only eight have statewide strategic plans to improve their systems' cultural and linguistic competence. Overseeing system level changes to cultural and linguistic competence is difficult without base-line data and the ability to measure progress. States also will face challenges managing change without a vision and strategic plan.
- Twenty-two states provide training to improve the state's workforce's level of cultural and linguistic competence but only eight of these states reported that these trainings are competency-based. States may have more success in disseminating knowledge on cultural and linguistic competence by using competency-based trainings.
- States reported that underlying major access gaps are provider shortages, cultural and linguistic competence among providers and low levels of trust of providers, all which are factors amenable to policy fixes.
- Stigma and low mental health literacy and cultural compatibility also emerged as major obstacles to access for children, youth and families from diverse racial/ethnic groups. This reinforces the need for a public health approach to mental health.

Recommendations

The federal government should:

- Require states to report on their efforts to address disparities in access and outcomes for children and youth from diverse racial, ethnic and linguistic backgrounds;
- Establish baseline data and outcomes for children and youth from diverse backgrounds and strategic plans to address disparities;
- Develop and support technical assistance to states to improve their cultural and linguistic competence;

- Develop models and provide guidance to states to bill Medicaid appropriately with the goal of improving the level of mental health-related interpreter services; and
- Annually report on a state-by-state basis efforts to address disparities through the use of nationally-established benchmarks.

States should:

- Develop multi-lingual, multi-cultural anti-stigma strategies and embed them in settings that individuals from diverse cultural groups frequent;
- Review and inventory their training in cultural and linguistic competence and fund ongoing competency-based training;
- Annually report on a county-by-county basis efforts to address disparities through the use of nationally-established benchmarks; and
- Assess their state children's mental health system's level of cultural and linguistic competence, develop a strategic plan and publish regular updates of their progress.

CHAPTER 7

How Well Do States Meet the Need for Family- and Youth-responsive Services and Systems to Meet the Needs of Children, Youth, and their families?

"My son started showing problems at the age of 12, and that was when I started pushing for services and then it wasn't until 14 that I actually got services… I did learn a little bit, like I needed to ask for an IEP (individualized education plan), but all they did was test him for academics… he didn't qualify because his academics were fine, but then tested for ADHD and he was put on medicine… [Mother initially refused medicine.] When I went to a therapist, the first test that he took, it was horrific for me, they were just explaining to me that I had this horrible kid and if I didn't do something quick, he was going to turn into a psychopath and I felt they were slamming me … I took parenting class when he was 15 for parents with an adolescent with behavioral problems and it wasn't until I took that class, that I was able to understand and modify how I treat my child. The reason why the class was so effective, everyone was having trouble with their kids and the normal parenting skills didn't work, I was in a classroom full of parents who had experienced what I experienced so I didn't think that I was a bad parent."

Parent, Alameda County

A major focus of the design of this study, of the system of care movement and of the original *Unclaimed Children* is the need for a strong role for families and youth in their own care planning, decision-making and service delivery. In the over two decades since *Unclaimed Children*, which itself elevated the voices of children and families, the movement to embed family and youth perspectives in practice and policy has been largely credited with the success of family and youth organizations nationwide and with the increased role families and youth take in their own care planning and decision-making.[146] It has also led to prominent roles for family members and youth in policy.[147] Research demonstrates and policy increasingly recognizes (albeit sometimes slowly) the importance of families and youth service users in their own care management and attaining positive outcomes.[148] [149] This chapter reviews data collected from state children's mental health directors and state advocates. In particular, we report on state children's mental health directors and state advocates responses to questions about states' efforts to strengthen the family and youth voice in policy. We report states responses to their efforts to fund advocacy and to support funding for family- and youth-responsive policies and practices at the individual and community service delivery level.

Thirty-nine states reported on a range of efforts they have implemented to strengthen family and youth voices in policy. Table 9 lists the range of strategies that states identified they currently use. UCR investigators queried states on several aspects of family and youth involvement and empowerment. These include state support for family and youth advocacy, family treatment, family support and family and youth in different service delivery roles.

Table 9: **Strategies States Cite That They Use to Foster Family and Youth Empowerment**

	Family/youth regulatory/ legislative body	State mental health authority decision-making	Organized parent network advocacy	Service delivery leadership/ advocacy	Other leadership (local/other)
ALABAMA			✓		
ALASKA				✓	
ARIZONA		✓	✓	✓	✓
CALIFORNIA	✓	✓			✓
CONNECTICUT	✓				
DELAWARE			✓		
DISTRICT OF COLUMBIA			✓	✓	
FLORIDA			✓	✓	
GEORGIA	✓				
IDAHO	✓			✓	
KENTUCKY				✓	
MAINE			✓		
MARYLAND			✓		
MASSACHUSETTS			✓		
MICHIGAN	✓				
MINNESOTA			✓	✓	✓
MISSOURI	✓	✓		✓	
MONTANA	✓			✓	
NEBRASKA					✓
NEVADA				✓	
NEW HAMPSHIRE	✓		✓		
NEW HAMPSHIRE (youth)		✓			
NEW JERSEY			✓	✓	
NEW MEXICO	✓				
NEW YORK		✓	✓		
NEW YORK (youth)			✓		
NORTH CAROLINA	✓			✓	✓
OHIO				✓	✓
OKLAHOMA				✓	
OREGON	✓				
PENNSYLVANIA	✓				
RHODE ISLAND				✓	
SOUTH CAROLINA			✓		
SOUTH DAKOTA			✓	✓	
TEXAS	✓			✓	✓
UTAH			✓	✓	
VERMONT	✓				
WASHINGTON				✓	
WEST VIRGINIA			✓		
WISCONSIN			✓		
WYOMING		✓			
WYOMING (foster youth)					✓

A cluster of states emerge as leaders in family and youth driven service delivery based on their self reports. These include: North Dakota, North Carolina, Vermont, Oregon, Michigan, Missouri, Utah and Minnesota. Factors used to assess states using a family and youth engagement lens included:

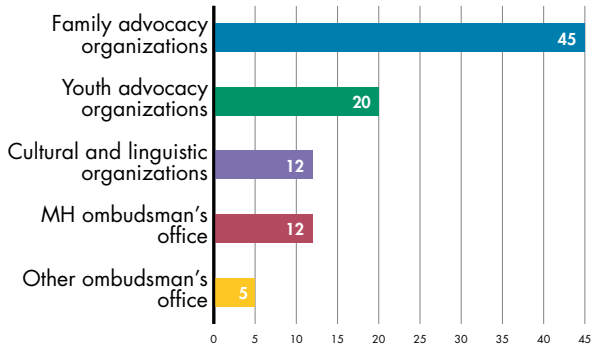
- Number and type of advocacy organizations they reported funding;
- State and Medicaid reimbursement for family members and youth in professional roles; and
- Funding for family treatment and maternal depression.

Below, we explore state responses based on these individual factors.

Family and Youth Advocacy

Overwhelmingly states support family advocacy organizations through funding. Forty-five states reported that they fund family advocacy organizations and 20 states reported that they funded youth advocacy organizations. Additionally as Figure 8 shows, state children's mental health authorities also reported funding cultural and linguistic organizations (N=12), mental health ombudsman's office (N=12) or other ombudsman's offices (N=5). States also reported the name of the family or youth advocacy organization that they funded. Appendix 3 lists those organizations. Figure 9 shows all the state and local family organizations that support children's mental health.

Figure 8: Type of Advocacy Organizations that States Fund

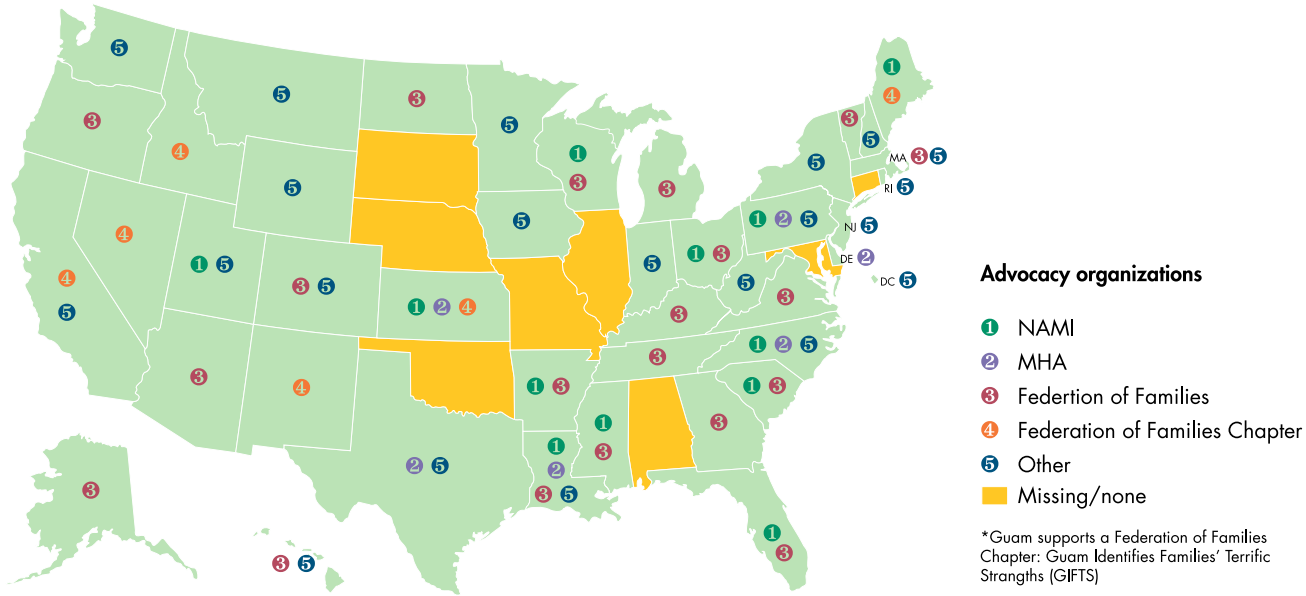


This strong support for advocacy notwithstanding, NCCP's survey of state mental health advocate shows that nearly 79% of respondents reported dissatisfaction with the role of the family/youth voice in children's mental health policy. See Box 20 for a range of concerns that advocates listed. But state advocates did not rest all the blame for the lack of family voice in policy as they perceived it at the feet of policy makers. Some advocates point to "poor family organization" in their state, and another to lack of information. *"The biggest barrier is education to the families. Many of them do not know what to request of the legislature or how to go about making a policy change."*

Family Treatment

An important component of treatment is family-based treatment. Public and private insurance regulations often limit or exclude family treatment.[150 151] States' responses to whether they funded family treatment varied by age-group. State children's mental health authorities reported that they fund family treatment (N=19) and treatment for parental depression (N=8) for parents of young children. Among school-age children and youth slightly more states reported that the children's mental health authority funds services related to family treatment

Figure 9: State Support of Advocacy Organizations



Box 20: Advocates Concerns with the Family and Youth Voice in Policy

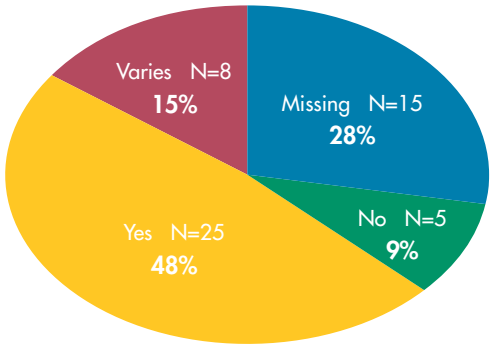
Advocates listed the following concerns with the family and youth voice in policy:

1. The variability and inconsistency when including families
2. Weak commitment to families
3. Poor tools to engage and sustain family engagement
4. Lack of power to backup commitment made to families
5. Inconsistent youth representation

- The variability of the inclusion of families reflected in this respondents' comment:
  "[There is] no consistent state policy/mandate or practice for family voice. Many areas are not represented. [There is] insufficient funding for family organizations. [There is] no significant individual dedicated for Children's Mental Health in Children's Cabinet or youth representation."
- The fragility of the commitment to families as this advocate's response indicated:
  "Funds to support for family involvement are available – but in times of tight resources, administrators now have the flexibility to move those into other needs"
- The inconsistency of support as reference by this response:
  "We do have some youth and family involvement, but it is inconsistent. With 25 local management entities overseeing mental health/developmental disabilities/substance abuse services and supports in [multiple] counties, every area varies in how it involves youth and families. Sometimes they are at the table, but ignored, sometimes they are not included. There is a reluctance to include new ideas and perspectives. Parents/families are worn out from dealing with the needs of their families and dealing with changes in our system – no time to deal with planning and policymaking."*
- The lack of tools and power to "actualize the policy commitment represents a significant challenge" as advocates explained:
  "Nevertheless actualizing the policy commitment is a significant challenge as it requires transformation of historic practice, and a structure, including fiscal appropriations to ensure that families are full partners at every step."
  "The state agency is not very collaborative in taking responses in at the highest level of the state authority. At lower levels of the state agency, the staff has been extremely responsive. But they don't have the ability to make decisions."
- Other barriers to inclusion the disproportional representation between family members and youth:
  "Critical policy affecting family/youth continues to happen with no youth involvement."

* Number deleted to protect confidentiality of respondent.

Figure 10: Number of States that Provide or Permit Reimbursement for Family Support (N=53)



(N=20) and to treatment for parental depression (N=11). In addition, 25 states (48%) reported that they fund family support, eight states fund family support under certain circumstances and five states did not fund family support. (See Figure 10.)

Family and Youth as Service Providers

Nearly half of the state respondents also support or permit reimbursement for youth as providers of services and supports. Table 16 in Chapter 8 shows state children's mental health authorities that support or reimburse for family members and youth as providers by funding source, Medicaid and state funding.

Major Findings and Policy Implications

- Family engagement, advocacy, and leadership have emerged as strong factors and contributors to children's mental health policy since Unclaimed Children in 1982.
- Forty-five states reported that they fund family advocacy and 20 states reported that they fund youth advocacy, but few states reported on the amount of funding and there is variation on funding among states.
- Forty-nine states reported on a range of efforts to strengthen the family and youth voice in policy, but in at least 15 states (representing 79 percent of the advocates reporting) mental health advocates were dissatisfied with the family and youth voice in policy. This suggests that states need to develop mechanisms to sustain and reinforce the family and youth voice in policy.
- Only 20 states reported that they fund family treatment. Despite the evidence of the critical role families play in children's and youth's mental health, their resilience, and their ability to improve their mental health functioning, many states do not reimburse for family treatment, and thus eliminate a key treatment option among those that should be available to families and youth.
- Sixteen states reported permitting reimbursement for family members in professional roles using Medicaid; 12 states also allow similar reimbursement for youth. States' progress in bringing family members and youth to the service planning and treatment table offers opportunities for families and youth to receive help from peers and those with similar experiences, as well as to experience a sense of empowerment. Among the system benefits are the ability to make services more responsive and the ability to anticipate the needs of service users, which are two core components of quality service provision.

Recommendations

The federal government should place empirically-supported, family-based treatment and supports at the center of financing children's mental health care and measure the outcome. A series of short and long-term strategies need to be implemented including the following:

- Provide incentives to ensure that states' strategies solidify and sustain the family and youth voice in policy;
- Remove barriers to reimbursement in Medicaid for family treatment;
- Promote state support for youth advocacy;
- Eliminate obstacles to treatment for parents with mental health conditions including parental depression; and
- Develop guidelines for states to address how they may appropriately bill for family treatment and interventions that require both the family and the child or children.

States should:

- Implement strategies to support family and youth in professional roles using Medicaid; and
- Develop mechanisms to stabilize and sustain family and youth voice in policy.

CHAPTER 8

How Do States Improve Service Delivery Through Infrastructure-related Supports, Fiscal Policy and Accountability Measures?

"I would have still been making decisions by the seat of my pants, making decisions at this level is always scary business because you know it would impact thousands of people... I wanted the data to help make decisions... making [decisions] anecdotally it was scary... having client level data is so powerful, more powerful than any other data we have to make decisions on [before]."

State Children's Mental Health Leader, Michigan, 2008.

Research shows that fiscal incentives alone do not improve quality. It also demonstrates that public accounting and transparency can contribute to improved outcomes. This chapter reviews three major components of infrastructural-related supports for child mental health service delivery: states' responses to questions about their information systems, states' reports on finance policy, and states' efforts to impact quality and accountability through outcomes management.

Table 11: **States Children's Mental Health Authorities' Rating of Information Technology Infrastructure**

Status	Number of states
Missing answer	3
Rudimentary	19
Intermediate	24
Advanced	2
Other	4
Unable to answer	1

Information Technology

"My goal if I were the king would be to develop a web-based information system for evaluation, EMRs [electronic medical records], HIPAA [Health Insurance Portability and Accountability Act] that are also interoperable and also allow access. We spent a lot of money on our network of care (online). You can make a folder and do sort of case management... We are developing a sort of template for information where we track information for kids and all parents. We want to do testing for that for California using the paradigm for public mental health systems… System has to be user friendly and has to be intuitive and not just a gain for MH revenue."

State Mental Health Leader, California, 2008

Essential to service delivery are factors that support infrastructure. These range from workforce development and training, to physical and capital needs, including information technology. Information technology is the linchpin to the infrastructure that supports quality improvement.[152] Through interoperable information systems (those that communicate with each other), individual service user data can be collected from multiple points;[153] clinical decision-making can be facilitated as provider-to-provider communication is enhanced;[154] medical errors can be reduced;[155] access can be enhanced as scheduling is automated;[156] service costs can be reduced as wait times and no-shows are reduced;[157] and paper transactions eliminated and enrollment to programs automated.[158]

Prior research has suggested that mental health information technology and clinical decision supports lag behind general health care.[159] One report suggests

that fewer than 30% of all mental health facilities computerized health care records. There is no baseline information that comprehensively documents the level of penetration of information technology in mental health.[160] The major considerations include the difficulty with expecting connectivity in the myriad settings where children and youth receive care, a lack of technical capacity among the workforce and scant resources for continuous hardware and software upgrades.[161 162 163 164] This chapter reviews states self-assessment of their capacity in information systems.

NCCP asked states to assess the status of their information technology (IT) infrastructure to support children's mental health service delivery and policy by determining whether their information technology infrastructure and supports were rudimentary,[a] intermediate[b] or advanced.[c] Only two states reported described their IT infrastructure as advanced, but 24 states that described their IT system as intermediate, followed closely by 19 states that said their systems were rudimentary. Only one state/territory was unable to rate its IT infrastructure and four states described their infrastructure as fitting into an "other category."

New York, Oklahoma, California, and Florida described IT systems that were highly variable with advanced data warehouses at the state system levels and uneven degrees of automation at the individual clinic or provider level. In the case of Florida, a privatized system, advanced information system from the standpoint of services' quality management and assurance, lacks provider connectivity to support clinical decision making. Two states also reported that they have no means of gauging the level of automation among their providers. One state indicated that clinical automation and IT was a staple of urban centers but that rural and frontier counties "may not even have computers or web-access."

The push for a robust IT infrastructure supports a fundamental shift to a quality improvement focus in the system of care delivery, management and policy support. At the heart of implementation of empirically supported practices are data systems that provide close to real time data exchange, information management and quality monitoring.

Major Findings and Policy Implications

- Nineteen states reported that they have rudimentary information technology (IT) systems, a deficiency which undermines states' ability to improve service quality, manage information, integrate with other health and human services sectors, and advance their systems.
- Only two states described their IT systems as advanced despite the existence of the DS 2000+, an eight-year old SAMHSA-funded initiative that provides support on data standards, provider tools, performance indicators, and outcomes support.
- The mediocre state of child mental health IT undermines states' efforts to improve outcomes, accountability, and quality assurance.

Recommendations

- The federal government should assess the status of children's mental health information technology infrastructure and develop a plan to tap into the national health information technology capital resources to upgrade these systems.
- States should ensure that as they develop information systems for other sectors of their child delivery systems they upgrade the child mental health infrastructure for maximum interoperability across child serving systems.

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a. Rudimentary = at early state of development (majority of clinical records still not automated, few providers using technology).

b. Intermediate = clinical records automated, some information sharing and use of technology to support systems planning, management, and evaluation.

c. Advanced = children's mental health part of the electronic health records, providers routinely using technology for clinical decision making, etc.

Finance Policy

This [situation] is especially a result of the "Medicaiding" of services. In terms of access to and quality of care, the state Medicaid director is perhaps more important than the state mental health director. But the Medicaid director may not appreciate the nuances of mental health and mental illness.[165]

Michael Hogan, PhD, New York State Office of Mental Health, 2008

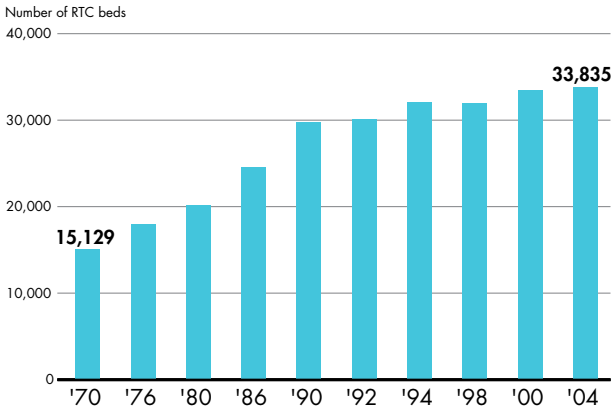
In more than 25 years since *Unclaimed Children*, while the inputs on the financial ledger and underlying fiscal policies have become significantly more complicated, the outputs remain hauntingly simple. Community-based mental health capacity is still lacking. Demand outstrips supply. The services that states and communities purchase often do not meet the needs of children and youth with mental health conditions and their families. States, for the most part, are not paying for high quality services. The outcomes – the promised product – are often poor.[166]

It has been widely acknowledged that addressing these failures in a systematic and sustainable manner requires major reform of current fiscal policies. This chapter presents the opportunities and challenges of financing children's mental health systems from the perspectives of state mental health directors. It explores state expenditures for children's mental health, funding sources and strategies, what services and supports states fund, and how states use fiscal policy to support improvements in service delivery. It begins with a discussion of funding for residential treatment, a costly component of the service delivery system that annually costs over $4 billion. States' responses to questions about their budgets are presented, and the fiscal strategies that states report they use are highlighted. Data on fiscal innovations that states cited supporting children's mental health services are delineated.

State Funding for Residential Services

Two mainstays of the child mental health service system in the United States since *Unclaimed Children* remain: lack of service capacity and over-reliance on residential treatment. (See Figures 11 and 12.) Even among system of care sites whose intrinsic mission is to reduce restrictive placements, over one-third of youth (an admitted

Figure 11: Number of Residential Treatment Beds for Children and Adolescents with SED, 1970-2004

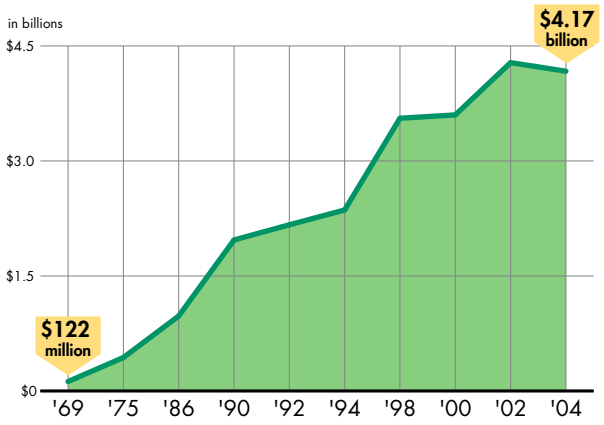


Source: Atay, J.; Survey and Analysis Branch. 2007. 2004 State Tables. Table 7. Patient Census in Mental Health Organizations Providing Residential Care By Organization Type, According to Patient Census Indicators: 2004 IMHO. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Atay, J.; Survey and Analysis Branch. 2006. Table 5. Number, percent distribution, and rate1 of 24-hour hospital and residential treatment residents, by type of mental health organization: United States, selected years, 1969-1982. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Manderscheid, R. W.; Atay, J. E.; Male, A.; Blacklow, B.; Forest, C.; Ingram, L.; et al. 2004. Highlights of Organized Mental Health Services in 2000 and Major National and State Trends. In R. W. Manderscheid and M. J. Henderson (Eds.), Mental Health, United States, 2002. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Figure 12: Expenditures for Residential Treatment for Children and Adolescents with SED, 1969-2004



Source: Atay, J.; Survey and Analysis Branch. 2005. 2002 State Tables. Table 15. Expenditures (in thousands of dollars) by owner according to organization type: 2002 IMHO. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Atay, J.; Survey and Analysis Branch. 2007. 2004 State Tables. Table 15. Expenditures (in thousands of dollars) By Owner According to Organization Type: 2004 IMHO. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

underestimation) experience an out-of-home placement with 73% experiencing multiple placements of this nature.[167] Today, still too few children, youth, and families with mental health needs receive services. Over-reliance on residential treatment facilities was among the top quality-related challenges that state child mental health authorities reported as a concern. Nearly two-thirds of states mentioned over-reliance on residential treatment as a pressing issue with regard to quality. The need for links to community-based service delivery, strong after care components and robust performance-based standards for residential treatment is clear.

Given persistent under-performance, failure to reduce repeated placements, high cost and the lack of will to adopt evidence-based practices and proven strategies to engage families and youth, a state would be remiss not to adopt some lessons from health care it moved to reduce medical errors and poor performance through pay-for-performance. Pay-for-performance is increasingly seen as a successful model for improving quality of care and both states and the federal government might consider demonstration projects in children's mental health (these exist in other areas of health care) that foster improved residential care and better links with communities.[168] [169] [170] Indiana has embarked on performance measurement for their service delivery systems one way of reducing the reliance on residential care.[171] (See Box 21.) It is listed among the innovative fiscal strategies that states reported in the finance section of this report.

Box 21: Pay for Performance in Indiana

Indiana's Mental Health and Addiction Transformation Initiative

Target: Children and Youth with Serious Emotional Disturbance and Adults with Severe Mental Illness

- Establishes performance based contract standards for its 39 contracted providers
- Features phased-in outcome measures
  - Process:
    - Average number of individuals served
    - Functioning level of individuals served
    - Use of the Child and Adolescent Needs and Strengths (a standardized assessment tool) at each episode of care and every six months
    - Timely submission of assessment or re-assessment data
    - Timely and complete data
  - Outcomes
    - 10% of funding based on achieving outcomes
    - 2009: Improved Living Situation
      Measurement: Restrictiveness of Living Environment Scale ROLES – a validated tool to measure restrictiveness of setting
    - 2010 School Attendance/Participation and Juvenile Justice Involvement
    - Increase in proportion of funding based on outcomes

Sources:

Indiana Family & Social Services Administration. 2007. Division of Mental Health and Addiction Performance Based Contracting Begins July 1, 2007. Retrieved October 5, 2008, from http://www.in.gov/fssa/files/PerformanceBasedContracting.pdf.

Division of Mental Health and Addiction. 2007. Performance Measure Definitions. Indianapolis, IN: Indiana Family & Social Services Administration.

States Expenditures for Children's Mental Health

NCCP asked state respondents a range of questions on how they funded their children's mental health systems. Respondents were least likely to respond to questions about fiscal policy than any other area on which they were queried. NCCP asked states to provide information on the total budget for both adult and children's mental health services for 2001, 2003, and 2005. They were also asked to indicate the total funding for children's mental health in their state. Only 18 states provided information on the total budget for 2005. Twenty-one states indicated that they were unable to answer the question, and 14 states had missing answers. With regard to children's mental health budgets, child mental health directors were more likely to report for 2005 than other fiscal years, with 27 states reporting. Seventeen states indicated they were unable to answer the question, and 13 had missing answers. The reported budgets for the 27 states for 2005 ranged from $2 million to over $280 million. The median budget for 2005 among these 27 states was $47 million.

Only 11 states were willing and able to report total funding for children's mental health across sectors for 2005:

Arizona	New Hampshire	Vermont
Arkansas	New Jersey	Virginia
Georgia	New Mexico	West Virginia
Maine	Texas	

States also indicated the sources of funding that support children's mental health. Fourteen states included Medicaid revenues, but 13 states did not. In general, states that reported on funding for children's

mental health were unlikely to report on funding in other sectors. Only one state included education funding. The following table represents the funding streams that states reported.

Table 11: **Funding Sources States Reported**

Type of funding sources	Number of states
Mental health funding	17
Education	1
Local/county funding	5
Community development	2
Vocational rehabilitation	2
Juvenile justice funding	6
Child welfare expenditures	8
Substance abuse funding	8
Cross-agency funding	2

Similar to the response rate for other finance questions, about 40% of states could not or did not respond to this question. Twelve states reported not being able to answer, and 10 states did not respond to the question at all.

Funding Sources and Strategies

Public mental health services for children and youth are financed largely by Medicaid/SCHIP, state appropriation, and federal grants. The importance of Medicaid policy in supporting effective children's mental health services cannot be overstated. Medicaid funded services have been associated with:

- Increased access to services;[172]
- Expanded service capacity between low and high-resourced communities;[173]
- Enhanced access to services for youth with substance-use conditions;[174] and
- Increased likelihood of well-child visits and physician visits.[175]

However, the full potential of Medicaid to make available a comprehensive continuum of interventions from prevention to intensive services is not fully realized in many states. For example, consider the screening essential to early periodic screening, diagnosis, and treatment (EPSDT); despite the increased cost-effectiveness associated with the use of validated screening tools, many state Medicaid programs cannot find a way to pay for such tools.[176] In other cases, the age of the enrollee, the provider type, or the service setting may be incompatible with Medicaid rules. Likewise, significant barriers exist in Medicaid funding for some specific types of interventions. For instance, payment is difficult to obtain for evidence-based practices, different levels of providers, and non-clinical services and supports essential to the effectiveness of the clinical interventions.[177] Increasingly, research shows that as Medicaid funding increases, the proportion of state mental health funding declines, especially funding that supports the uninsured or the non-Medicaid eligible population.[178] Thus, Medicaid substitutes for more state funding and resources available for those that are not Medicaid enrollees dry up.

However, Medicaid reform through the private sector has also impacted access to mental health services for children and youth with mixed results. These include: extracting efficiencies in inpatient mental health care but also shifting service delivery to residential treatment, and often to state budgets.[179] NCCP sought to examine how state mental health authorities addressed these barriers to supporting services identified in the literature. Medicaid plays a vital role in children's mental health policies. NCCP asked states to report on the types of strategies they used to employ Medicaid funding to advance changes in service delivery or practice. Specifically, NCCP looked at how and to what extent states used Medicaid funding to support age-appropriate services; services in settings frequented by children, youth, and their families; and practices and providers that matched or enhanced their service array.

Support for Services That Are Age-Appropriate

Early Childhood

Only 26 states (50% of states) responded to questions about whether they funded services for young children. Twenty-two of these states reported that they did fund early childhood mental health services, while four indicated that they did not. Of those states that reported funding early childhood mental health services, four reported the total amount of funding for FY 2005 ranging from over $390,000 to $2 million. Only a few states indicated sources of funding, and the sources they

listed varied. Five states reported that they used Medicaid, seven said that they used state funding, and nine noted that they used other funding. States were more likely to report on the specific strategies that they funded than they were to talk about the sources of funding that supported these strategies. The types of strategies states most frequently reported that they funded include:

Table 12: Types of Early Childhood Related Services that States Reported They Fund

Type of services for early childhood	Fund	Not fund
Mental health services	22	4
Screening	18	5
Mental health consultation	15	6
Treatment	21	2
Family treatment	19	2
Parent depression	8	9

States differed on whether they funded early childhood mental health consultation, whether they provided or permitted reimbursement or whether they had funding in their budgets earmarked for mental health consultation. When asked whether they funded initiatives or infrastructures for early childhood mental health consultation programs, 26 states reported that they did fund such initiatives. Sixteen states reported that they permit or provide Medicaid reimbursement without a diagnosis for mental health consultation. An additional eight states indicated that under certain circumstances mental health consultation can be reimbursed by Medicaid without a diagnosis. However in 29 states Medicaid reimbursement can only be provided or permitted for young children with a mental health diagnosis. The following states permit reimbursement for mental health consultation to young children irrespective of a mental health diagnosis.

Delaware	New Mexico	Alaska*
Georgia	North Dakota	Kentucky*
Idaho	Ohio	Maine*
Kansas	Oklahoma	New York*
Massachusetts	South Carolina	North Carolina*
Michigan	Utah	Oregon*
Missouri	West Virginia	Rhode Island*
Nevada	Wisconsin	Vermont*

Note: States with * reported allowance for reimbursement that varies by circumstances.

In 17 states, mental health consultation is a part of the state children's mental health budget. These three different ways that states reported they support mental health consultation can be confusing. Overall states' commitment to mental health consultation seems to be growing as evidenced by the number of states that reported support for mental health consultation programs. However, more enduring forms of support such as through third party billing like Medicaid or as part of a state budget appear less common.

Other Services in Settings Frequented by Young Children and Their Families

In addition to providing services for young children, access to services in settings frequented by young children and their families is important. The States children's mental health directors were asked whether state Medicaid policies restrict reimbursement for services delivered in child care settings. While many states did not answer this question (N=22), 21 states reported that they do not restrict reimbursement for service delivered in these settings. However, 10 states did allow reimbursement for services delivered in child care settings. The following states reported they do permit Medicaid reimbursement for services rendered in child care settings.

Arkansas	Missouri	Ohio
Delaware	Montana	Oregon
Florida	Nevada	Pennsylvania
Georgia	New Hampshire	Texas
Illinois	New Mexico	Vermont
Kentucky	New York	West Virginia
Michigan	North Carolina	Wyoming

Reimbursement for interventions and supports in child care settings is enmeshed in a larger Medicaid battle around the rehabilitation option and use of funding flexibly.[180] However, federal policies and, in some cases, state policies that do not allow for reimbursement of services provided in early care and learning settings are missing a huge opportunity to expand capacity, provide developmentally appropriate services, and avert deeper levels of system engagement.

School-age Children and Youth

Services provided in settings normally frequented by children are thought to be particularly accessible. Research suggests that school-age children are more likely to access services, especially mental health services, in these settings than in community health centers.[181] Twenty states (24 states responded) reported that they funded, through their child mental health authority's budget, school-based mental health services. In contrast, four states reported that funding for school-based services for children/youth with mental health conditions was not part of the budget for the children's mental health authority.

Other important community-based services that states reported funding included intensive home and community-based services (N=26), outpatient clinical service (N=25), and medication (N=21). States also provided funding for emergency and inpatient or residential services. While not all states responded, 24 states reported that the children's mental health authority funded emergency services for children (three indicated that they did not). Additionally, states reported that they funded hospital services. States were more likely to report that they funded inpatient psychiatric treatment (N=21) than general acute hospital care (N=11). Many states also reported that they funded residential treatment (N=20). Other services that benefit school-age children and youth include services that take place in non-office-based settings and are delivered by a range of providers.

Fiscal supports for non-physician mental health providers are critical to providing a range of mental health services, given the shortage of physician mental health specialists like child and adolescent psychiatrists.[182] States responded to inquiries on whether they reimbursed for non-office based providers through Medicaid.

A majority of states reported that they permit Medicaid reimbursement for services provided in the home (N=23), and many states also permit reimbursement for services provided in parks or recreation centers (N=19). Only six states reported that they restrict all non-physician providers in non-office-based settings, while another four states reported that they restrict certain types of non-physician providers. Table 13 and Table 14 show Medicaid and State funding for services provided in different non-office-based settings and among diverse provider types.

Table 13: Special Settings in Which State and Children's Mental Health Authority Allow Medicaid Reimbursement

Settings (number of states responded for each category)	Number of states that permit (or do not restrict) reimbursement
Specific settings (N=36)	7
Schools (N=33)	23
Home (N=33)	23
Parks/recreational settings (N=33)	19
Day care centers (N=31)	21
Correctional facilities (N=33)	10
Other special settings (N=16)	13
All non-physician providers in non-office based settings (N=27)	21
Specific non-physician providers in non-office based settings (N=25)	21
Other non-office based settings (N=17)	16

Table 14: Special Settings in Which State and Children's Mental Health Authority Allow State Reimbursement

Settings (number of states responded for each category)	Number of states that permit (or do not restrict) reimbursement
Specific settings (N=37)	19
Schools (N=34)	24
Home (N=34)	26
Parks/recreational settings (N=34)	24
Day care centers (N=33)	22
Correctional facilities (N=34)	20
Other special settings (N=18)	18
All non-physician providers in non-office based settings (N=30)	23
Specific non-physician providers in non-office based settings (N=27)	23
Other non-office based settings (N=20)	17

Youth Transitioning to Adulthood

Compared to financing for services for young children and for school-age children, far fewer state child mental health authorities reported funding for services to young adults over age 18. Twenty-two states responded to the query about whether they funded services for young adults between ages 19 and 21. Thirty-one states did not respond to the question. Of those who answered, six states reported that they did not fund and 16 states reported that they do fund services for young adults.

Family-Centered Treatment and Supports

Based on reports from states, treatment and supports for family-centered care are mixed. As the table above shows, only a minority of states directly supported partnerships with adult mental health, family treatment (36%), or treatment for maternal depression (16%). States reported on whether they permitted reimbursement for therapy and support for families with young children. Thirty-four states permitted reimbursement for family therapy (including two states where allowance for reimbursement varies under specific circumstances), and 33 states permitted reimbursement for family support (including eight states where allowance for reimbursement varies under specific circumstances). Of those states that reimbursed for family therapy for young children, only two reported that they did not reimburse for children [birth to three] and two reported reimbursement for this group varied. These figures may overestimate the proportion of states that fund family therapy and family support for young children since several states did not report.

Other Medicaid Strategies

Through EPSDT, children and youth are entitled to a broad array of prevention, early intervention, and treatment services. Yet, states vary in their use of EPSDT and the other Medicaid related options they use. Table 15 shows the types of Medicaid strategies that states reported they use.

Table 15: Types of State – Implemented Medicaid Strategies

Strategy	Number of states
Rehabilitation option	29
Targeted case management	20
School-based mental health	13
Home and community-based waivers	11
Managed care through 1915 a or b	6
EPSDT	19
Katie Beckett/TEFRA	5
No response	17

As the table shows, rehabilitation option, targeted case management, and school-based mental health services are the most frequently used fiscal strategies.

Funding for Diverse Providers

States also have expanded capacity by extending the range of non-physician providers that can be reimbursed and the types of service settings eligible for payment. The following is the number of states that reported permitting or not permitting reimbursement for family members and youth as providers of services and support. On average, about one-third of states did not respond to this question.

Table 16: State and Federal Support (Medicaid) for Family Members and Youth in Professional Roles

	Medicaid		State	
	Permit	Do not permit	Permit	Do not permit
Family members				
Overall	16	19	28	10
Case/care managers	9	7	10	14
Staff	13	3	17	6
Wraparound facilitators	10	6	17	9
Trainers	6	9	25	4
Others	1	3	5	4
Youth				
Overall	12	21	24	10
Case/care manager	7	7	8	12
Staff	8	6	14	6
Wraparound facilitator	7	6	11	8
Trainers	7	7	17	5
Others	5	2	7	2

Influence of State Mental Health Authority on Types of Services Medicaid funds

Recent reports have attached increasing significance to the role of policymakers in state Medicaid policy for individuals with mental health and substance use conditions. Twenty-two states reported that the State Medicaid authority, in consultation with the state mental health authority, makes decisions about Medicaid policy that impacts services for children and youth with mental health conditions and those at risk. Table 17 documents the levels of responsibility for which services are reimbursed by Medicaid for children and youth with mental health conditions. Only four states reported that the state mental health authority makes the decision about what services are financed, and 12 states reported the decision is made primarily by the Medicaid Director. NCCP's analysis shows that among states that reported that Medicaid reimbursement decisions are made by the state Medicaid authority, fewer exercise the rehabilitation option as part of their state plan. There was no such association with the other Medicaid strategies.

Table 17: **Responsible Party for State Decisions Regarding Reimbursable Child and Youth Mental Health Services Under Medicaid**

Responsible party	Number of states
Primarily the state Medicaid authority	12
Primarily the state mental health authority/ director	4
State Medicaid authority in consultation with state mental health authority	21
Other	7

About EPSDT

States' responses related to Medicaid financing of services for children and youth raised some fundamental questions regarding respondents understanding of the states' obligations under EPSDT in particular and the Medicaid program in general. (See Box 22.) Since these responses are based on self-reports, NCCP wondered whether they reflected a lack of understanding on the part of state children's mental health directors about their Medicaid programs or reflected the realities on the ground which would be in violation of federal law. Indeed, there is ample successful litigation history based on violation of the laws pertaining to EPSDT. Two recently settled suits, *Rosie D. v. Romney* and *Katie A. v. Bonita* were brought based on EPSDT provision.[183] [184]

Innovation in Financing

Twenty-eight states reported that they have implemented innovative fiscal strategies to improve access, services, and/or outcomes for children's mental health, but only 13 states described these strategies. Table 18 shows these states and the strategies they identified. These strategies fit into six basic categories: target community re-investment, enhance service capacity, maximize revenue, blend funding, focus on results, and apply knowledge-based fiscal approach.

Table 18: Types of Innovative Fiscal Strategies States Reported

Service Capacity Expansion	
CO	Use SSI and tobacco settlement funds for a continuum of services including residential treatment for non-MA eligible (including parents whose insurance does not cover these treatments) through 27-10.3-101, CRS.
GA	Contracted with vendor for statewide crisis/access line.
MT	TANF – targeted family and care givers to facilitate out-of-state services (provide a training-trip).
NM	Operated separate Wraparound programs out of CYFD/Juvenile Justice to serve the paroled and Medicaid-eligible population as they re-enter community life. Value Options, the single managed care entity, has taken on the clinical and administrative functions regarding the use of Wraparound funds for services that cannot be covered by Medicaid funds due to ineligibility or type of service being requested.
NY	Medicaid Clinic Plus provided state aid and enhanced Medicaid funding for screenings, comprehensive assessments, and in-home treatment.
WA	Legislation – Budget attached to HB 1088 legislation fund the mental health division and Medical Assistance authority to implement innovative programs not just in mental health and providers in healthy options [managed Medicaid] plan to provide mental health consultation, identify children under five, prescribed medication, kids receiving inappropriate medicating. HB 1088 opened up provider networks to persons licensed as Masters level professionals (previously only psychiatrist); and permitted services to children not eligible based on diagnosis, and increased number of sessions from 10-20.
Community Reinvestment	
AK	Interagency collaboration – Collaborated with Alaska Mental Health Trust Authority, University of Alaska, and other stakeholders on "Bring the Kids Home Initiative" and workforce issues.
NM	Value Options, through contract obligations with the state, must use three percent of their budget for reinvestment back in to the community. For example, the company funded mini-grants or projects at the local level for purposes of extending access, services, and start-up of programs.
Pooling/Braiding/Blending Funding	
MI	Cross-system funding – Michigan blended braided funds across systems at the local level to support system of care development. Currently, approximately 15 counties are blending and braiding funds across systems to provide services. Of those 15 counties, approximately nine are participating in a 1915(c) home and community-based waiver. Another unknown number of counties share funding to pay for placements of children.
MO	Custody Diversion/Transfer of Custody Protocols to decrease the number of children going into state custody solely to access mental health services partnership between child welfare and mental health in addressing protocol and flexibility within funding streams (access to Medicaid and IV-E funding when diverted from state custody if out of home placement is required).
RI	Interagency collaboration – Collaborated with Medicaid agency (DHS) to establish a funding process to potentially braid state child welfare, mental health, and Medicaid-funded service money.
Performance Contracting	
IN	Created outcome-based funding for children's mental health services through a performance-based or results-based contracting system. Beginning in SFY 2009, 10% of the funding will be based on achieving outcomes related to housing stability. In SFY 2010, outcomes related to school attendance and participation and involvement with the juvenile justice system will be added, and the percentage of funding based on these outcomes will increase.
Knowledge-Based Financing	
NY	Specific rate enhancement for CQI projects, including the use of EBPs as well as for evening and weekend hours.
Revenue/Medicaid Maximization	
DE	Set stage for reinvestment of federal participation dollars (FFP) into treatment/services by successfully negotiating bundled rate/case rate for Medicaid child enrollees served by DCMHS. (Total rate is $4329 per member per month for every child receiving a direct service during the month.) At present, FFP (50%) goes to a central fund in Department of Services for Children and Youth and Families where it becomes state revenue/general funds and is allocated back to the department through the General Assembly's annual budget. Approximately 34% of DCMHS's annual budget allocation comes from this source.
FL	Identified general revenue funds that could be used to bring down Medicaid match. Funds stay in the CMH budget. Medicaid bills the department monthly.
RI	Established a joint Flex Fund managed by an administrative service organization for the Family Coordination Partnership (six programs ranging from Early Start, to CASSP and Title IV-B). It is designed to support a Wraparound service model that uses flexible funds to purchase supports and interventions based on care choices families make. It includes individual, family, and system-level outcomes.

Box 22: Early and Periodic Screening, Diagnosis, and Treatment

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is Medicaid's comprehensive child health and mental health benefit.

Federal EPSDT law requires states to fund well-child health care, diagnostic services, and medically necessary treatment services to all Medicaid-eligible children from birth up until age 21.[1] States must:

- Cover any Medicaid services considered medically necessary to prevent, correct, or ameliorate children's physical or mental conditions.[2]
- Provide periodic screenings to detect physical and mental health conditions, and if a problem is suspected, provide screens at inter-periodic intervals.[3] Screenings must include:[4]
  - Comprehensive evaluation of physical and mental health development
  - Physical examination
  - Laboratory test
  - Lead screening
- Provide services to address the health and mental health conditions detected as a result of screening. Treatment services must include:
  - All medically necessary services available as mandatory or optional services regardless of whether these are part of the state plan or available for adults.[5]
- Provide screening, diagnostic, and treatment services for dental, vision, and hearing.[6]
- Provide health education and anticipatory guidance.[7]
- Inform all Medicaid-eligible persons under age 21 that EPSDT services are available.[8]
- Annually report to the federal government on the number of children and youth screened and provided services related to corrective action and how well the state has fared in meeting federal participation goals.[9]

EPSDT provides a key funding source for prevention services, early intervention services, and treatment for children. However, in 2005 only three states met the national benchmark that 80% of children on Medicaid receive an annual health screening under EPSDT. The national participation rate for children receiving EPSDT screenings is 56%.[10]

Research has shown that many states have poor EPSDT screening tools for behavioral health and many do not address substance abuse.[11] In recent years, states' failure to comply with the law regulating EPSDT have led to two major lawsuits. These suits, *Rosie D. v Romney* and *Katie A. v Bonta*, were settled on the premise that children and youth with mental health needs were entitled to a comprehensive array of services under EPSDT.[12]

Two federally funded investigations reported that poor data collection and reporting compromised the program's ability to accurately measure its impact and track quality.[13] This lack of accountability appeared particularly evident among managed care Medicaid programs.

Sources:

1. Johnson, K.; Knitzer, J. 2005. Spending Smarter: A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness. National Center for Children in Poverty, Columbia University.

2. Ibid.

3. US Department of Health and Human Services, Human Resources and Service Administration. 2008. EPSTD and Title V Collaboration to Improve Children's Health. Retrieved October 29, 2008 from http://www.hrsa.gov/epsdt/default.htm.

4. Centers for Medicare & Medicaid Services. 2008. EPSDT Benefits. Retrieved November 6, 2008, from http://www.cms.hhs.gov/medicaidearlyperiodicscrn/02_benefits.asp.

5. Perkins, J. 2008. Medicaid Early and Periodic Screening, Diagnosis and Treatment Fact Sheet. Chapel Hill, NC: National Health Law Program.

6. See note 3.

7. See note 4.

8. Smith, Alicia. 2005. Medicaid EPSDT and AOD treatment services. Resources for Recovery: State Practices that Expand Treatment Opportunities. Boston, MA.

9. Centers for Medicare & Medicaid Services. 2008. State Agency Responsibilities. Retrieved November 6, 2008, from http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage.

10. Centers for Medicare & Medicaid Services. 2006. Annual EPSDT Participation Report, from http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/downloads/epsdtfy2004.pdf.

11. See note 8.

12. Bazelon Center on Mental Health Law. Katie A. v. Bonta. Retrieved November 8, 2008, from http://www.bazelon.org/incourt/docket/katieA.htm; and, Ponsor, M. A. 2006. Rosie D. Et Al., Plantiffs, v. Mitt Romney Et Al. Defendants [Civil Action No. 01-30199-Map] (pp. 1-104): United States District Court for the District of Massachusetts.

13. Office of Inspector General. 2008. External Quality Reviews in Medicaid Managed Care. Washington, DC: United States Department of Health and Human Services; and, United States General Accounting Office. 2001. Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services (No. GAO-01-749). Washington, DC.

Major Findings and Policy Implications

- Thirty-four states reported that residential treatment is among their top three concerns. Continued reliance on residential treatment despite poor outcomes, evidence of failure to engage families, and/or trauma to children and youth suggest that states need to employ a range of incentives and supports and use outcomes-based strategies to address the need for therapeutic nonresidential treatment. Current federal efforts to address residential treatment and its dominance in children's mental health expenditure are not sufficient.
- Twenty-seven states reported on their budgets for children's mental health, while 13 states reported that they were unable to report on their children's mental health budgets. States are more likely now to be able to report on other funding streams than when Knitzer investigated state funding in 1982 for Unclaimed Children, but a significant number of states still cannot or will not report on their children's mental health budgets. This lack raises questions regarding transparency and the ability of the children's mental health authority leaders to operationalize an effective service delivery system.
- In the absence of multisectoral budget information on children's mental health spending, holistic

fiscal policy is not possible. As the final section of this report shows, states are frustrated by their inability to conduct cross-systems work more effectively, and this inability is rooted in barriers to flexible funding. Yet most states reported that they do not even know the extent to which other systems help to underwrite the cost of care for children with mental health conditions.

- Variation in the Medicaid strategies that states employ is at odds with the federal mandate under EPSDT, which provides for comprehensive coverage based on medical necessity irrespective of the specifics of states Medicaid plan for children up to age 21. For example, only 11 states have exercised the option for home and community-based waivers, only 29 states reported using the Rehab Option, and only 19 states reported that EPSDT is part of their fiscal toolbox.
- States reported gaps in Medicaid coverage for young children and youth transitioning to adulthood, and these gaps also violate the provisions of EPSDT. For instance, five states reported they do not fund early childhood mental health services and 29 states reported they only provide mental health consultation for young children with a diagnosis. The law under EPSDT provides for screening and appropriate assessment and, in cases where awaiting a diagnosis may delay necessary treatment, also for the provision of treatment.
- Twenty-two states reported that the state Medicaid authority makes Medicaid policy decisions that impact services for children and youth with mental health conditions and those at risk in consultation with the state mental health authority. However, in 14 states these decisions are made primarily by the Medicaid director, while the state mental health authority makes the decision in only five states. Restrictive Medicaid policies reflect a lack of understanding of basic child development, neuroscience research, and knowledge of effective mental health practices. While understanding of these concepts is not guaranteed among child mental health specialists in Medicaid policy decision making roles, when present, it may result in policies that are responsive to the needs of children, youth, and their families.

Recommendations

The federal government should act on the recommendations of scores of reports that point to the failure of the public health financing system to maximize flexibility currently afforded under Medicaid/EPSDT to provide timely age-appropriate public health focused interventions. In the long term though, Medicaid and other financing mechanisms should support a change in the way services are funded to propel a public health focus to mental health. Specifically:

- Require child mental health care content expertise in the development of state Medicaid plans and Medicaid policy decision making;
- Provide incentives for states that have not used Medicaid innovatively such as to support mental health consultation, or in non-office-based settings;
- Reward states that are using Medicaid and state funding creatively to improve service delivery and tie these rewards to improved outcomes;
- Establish efforts to standardize states' information technology infrastructure capacity with immediate efforts to upgrade those states' described as rudimentary to facilitate appropriate billing and tracking of associated outcomes;
- Identify a set of individual and system related outcomes for children and youth with mental health conditions and link these to publicly financed public health strategies;
- Reject changes to the rehabilitation option that undermine services in daycare, schools and other settings that children, youth, and their families frequent;
- Require CMS to address variation in EPSDT funding for children's mental health services; and
- Report on benchmark for behavioral health screenings and services funded by EPSDT and establish specific targets for meeting the 80% participation threshold.

States should:

- Annually and publicly report their children's mental health budget;
- Document how they use EPSDT for children and youth with mental health needs and those at risk; and
- Require an inventory of spending across service sectors that support children's mental health.

Outcomes and Accountability

"[Measuring outcomes] creates a fish or cut bait environment. Once you begin to measure outcomes, you are either lucky or it creates a clear call to action about the need to change. Especially if there are evidence based practices that create measurable results, as a manager of a public trust you need to decide what to stay with."

County Mental Health Leader, Michigan, 2007

Children with mental health conditions often do not get served. One study estimates the unmet need for mental health services as high as 80%.[185] The consequences of no or limited access to mental health care and poor mental health care for children, youth, and their families include significant human toll such as suffering and even premature mortality.[186] [187] They also encompass huge societal costs.[188] [189] [190] [191] Since 1982, the topic of outcomes for children and youth with mental health conditions has gradually gained center stage in research, practice and policy.[192] [193]

Following the release of the President's New Freedom Commission, the Commission's Subcommittee on Children and Families released a vision for children that stated: "There should be a clear focal point for responsibility and accountability for children's mental health care. Services and systems should be guided by standards for access to and quality of care and performance measures of service delivery and outcomes in order to reduce inappropriate and ineffective care and to produce data for continuous quality improvement of services and supports."[194]

This chapter reviews state responses to questions about their efforts to promote and their capacity for outcomes-focused management. It also reports on responses from state advocates on their perceptions of states' efforts to make data and analysis available in a comprehensible manner for community planning. Findings from an outcomes-based management project are described using information gathered from a state initiative to mandate the use of a uniform child functional assessment tool in Michigan.

Box 23: Stages of Development in Outcomes-Focused Decision-Making

Rudimentary/at early stages of development State collects, analyzes, and uses demographic and service utilization data. There is no or limited data available on functional outcomes. Use of this data for planning, continuous quality assurance and system outcome assessment still limited or infrequent.	**15**
Intermediate State collects, analyzes, and uses demographic, service-utilization, and child/youth functional outcomes data from the mental health system for planning, continuous quality improvement, and to determine system's outcomes.	**28**
Advanced State collects, analyzes, and uses demographic, service-utilization, and functional outcomes data across the child service sectors for planning, continuous quality improvement, and to determine systems' outcomes.	**8**

UCR investigators queried states to understand their systems' support for and ability to promote the use of processes, outcomes and data to facilitate continuous quality improvement. States rated their systems' capacity for outcomes-based decision-making ranging from a rudimentary stage to an advanced stage. (See Box 23.) Fifteen states rated themselves as rudimentary when it comes to collecting, analyzing and using data for continuous quality improvement. Twenty-eight states considered themselves as having reached an intermediate stage and eight states rated themselves as advanced. One state noted that it could not answer the question.

States also responded to questions about the initiatives underpinning infrastructure related supports for clinical decision making and for system monitoring and evaluation. Table 19 shows states' responses around the special initiatives they have undertaken. States reported on initiatives to improve administrative data and outcomes management (N=45), on system-wide outcomes and indicators (N=41) and making state data and analysis available for community-based planning (N=41). Fewer states reported on initiatives to advance electronic records (N=26), improved automation to support clinical decision-making in children's mental health (N=31) or cross-systems outcomes and indicators (N=28).

Table 19: **State Reported on Special Initiatives in Outcomes Management**

Focus of initiatives	Number of states
Electronic records	26
Improved administrative data/outcomes management	45
Improved automated data information systems for clinical decision-making within children's mental health	31
System wide outcomes and indicators	41
Cross-system outcomes and indicators	28
Access to state data and analysis for community-based planning	41

Of the states that have special initiatives in electronic records, only six identified their system as rudimentary and 13 identified their systems as intermediate. Eleven of the states with no initiatives around electronic medical records also described their IT system as rudimentary.

As with states' descriptions of their efforts in IT infrastructure development states describe wide variability within the states in their ability to make decisions based on outcomes and from our analysis there is some variability across states. Some states describe being at a point where they have designed a system and have begun developing data. Other states have mechanisms in place such as a children's data warehouse, a common tool used to collect data across systems, or an outcome management system that facilitates implementation of evidence-based practices.

Linking Information Systems and Promotion of Evidence-Based Practices

NCCP conducted cross analyses to determine whether any association existed between the number of specific evidence-based practices (EBPs) that a state supported, promoted or required and the level of IT/outcome-based infrastructural development. We limited the analyses to those states that supported, promoted or required these EBPs on a statewide basis. We could not find a strong association.

Linking Information Systems and Movement toward Outcomes and Accountability

States that assessed their level of IT development and outcome-based measurements were combined and plotted from rudimentary to advanced status. Kansas is the only state that reported having advanced status for both IT and advanced outcome-focused decision-making. Among those that reported statewide initiatives they supported, required or promoted (19 states), nearly half (Delaware, Indiana, Kansas, Kentucky, Michigan, New Mexico, North Dakota, and Rhode Island) reported the status of IT and outcome decision making from intermediate to advanced status. All of these states except Kansas are supporting, promoting or requiring the implementation of at least six EBP initiatives. There does appear to be some associations between the number of EBPs that a state supports, promotes or requires and the stage of development of its IT infrastructure and its outcomes-based decision-making capacity. While North Carolina reported the highest number of EBPs that had state-wide reach (N=8) and they rated their outcome-based decision-making as intermediate, they did not report on the status of their IT. In addition Hawaii, which has a long history of implementation of EBPs, reported that they supported, promoted or required seven specific EBPs statewide but they did not reported on their IT capacity or their capacity for outcomes-focused decision-making. Meanwhile, Connecticut, which has six EBPs that the state supports, promotes or requires statewide, assesses both the status of its IT infrastructure and its outcomes-focused decision making as rudimentary.

Major Findings and Policy Implications

- Fifteen states rated their capacity for outcomes-based decision making as rudimentary despite a federal initiative, National Outcomes Measures, designed to focus on outcomes.
- Forty states reported that they had initiatives to improve outcomes management, but it is unclear how deeply rooted these initiatives are and whether they have significant influence over actual improvements to service delivery.
- Forty-one states reported that they make state data and data analysis available for community planning, but 10 state mental health advocates reported that this does not happen in their states.
- Only 31 states reported on initiatives to improve clinical decision making. State mental health authorities have been criticized for inadequate attention to the quality of clinical care for children, youth, and their families. To foster accountability both for services purchased and the quality of care delivered, states need a more active role in clinical decision making.
- Only 29 states reported on initiatives to improve cross-system outcomes. States grapple with how to advance services for children and youth, and the families of children and youth, with mental health conditions involved in multiple systems, including how to pay for services. The inability of child serving systems to develop and track shared outcomes impedes collaboration across systems.

Recommendations

The federal government should:

- Provide incentives and support for states to move toward more outcomes-focused management;
- Design and implement initiatives to support taking state outcomes-based decision making efforts to scale;
- Provide states with models for outcomes-based management and support to achieve these, such as the Michigan model;
- Help states link mental health policy and clinical decision-making initiatives; and
- Track the use and associated outcomes of evidence-based practices.

Focusing on Outcomes: Michigan Case Study of the Level of Functioning Project

A major aim of *Unclaimed Children Revisited* is to identify policy-supported state efforts to promote quality of care for children and youth with mental health conditions in the public mental health system. Below we provide an overview of a case study on Michigan's Level of Functioning Project (LOF). It is a 10-year-old initiative to monitor and improve outcomes for children and youth with severe emotional disturbance (SED), through the use of the Child and Adolescent Functional Assessment Scale (CAFAS) (see Box 24).

In 1998 Michigan mandated contracted providers in the public mental health system to use a functional assessment tool – the Child and Adolescent Functional Assessment Scale (CAFAS) for every child with SED enrolled in county mental health services. Michigan leads a county-run state-supervised public mental health system through the Michigan Department of Community Health. It requires, through its Medicaid Provider Manual, that all children and youth receiving public mental health services receive an assessment using the CAFAS. Data from the CAFAS is used to inform both clinical and administrative decision making. Michigan also uses the CAFAS as a tool to assist determining service entry. While different programs have different standards for entry, in general, home based services require a total CAFAS score of 80 (and 1 caregiver subscale score of 20 or 30) and the state's Medicaid home-and community-based waiver program 1915(c) requires a score of 90 or higher, if the child is age 12 or under, and a CAFAS score of 120 or higher, if age 13 or older.

Michigan's Level of Functioning Project (LOF) couples its CAFAS mandate with a voluntary program of technical assistance, data analysis and support, and a type of learning collaborative to assist counties and their providers in collecting CAFAS data and conducting quality monitoring. The state contracts with Kay Hodges, a Michigan-based researcher and the CAFAS' developer, who collects data from participating community mental health centers (CMHCs). Each individual who administers the CAFAS must undertake competency-based training and receive annual booster trainings. CAFAS coordinators from participating CMHCs participate in quarterly LOF meetings and receive monthly, quarterly, and semi-annual reports as well as a report card on their performance. CAFAS coordinators help providers review client-level data and meet monthly with supervisors to compare their progress with overall state progress and benchmarks. Additionally, the LOF data collection and analysis has been used by state administrators. For instance, the state based its support on which evidence-based practices to introduce using CAFAS data that showed a large number of youth with conditions that could be helped by one type of evidence-based practice. As a result the state implemented training activities for evidence-based practices, such as Cognitive-Behavioral Therapy (CBT) and Parent Management Training-Oregon model (PMTO).[195]

Box 24: Child and Adolescent Functional Assessment Scale

The **Child and Adolescent Functional Assessment Scale** (CAFAS) is a validated assessment tool that measures a child's degree of everyday functioning in contexts such as home, school, and the community. It is essentially a list of behavioral descriptors the rater (provider) selects to describe the youth based on a variety of their informational sources (e.g. intake assessment, clinical intake). The CAFAS is administered at intake, during periodic intervals (quarterly), and at discharge. It generally takes approximately 20 minutes to complete at intake and 10 minutes at each interval assessment. It measures the child's functioning in 8 domains:

- School/work
- Home
- Community
- Behavior toward others
- Moods/emotions
- Self-harmful behavior
- Substance use
- Thinking

Within these domains, 5 scales rate the youth's functioning and two assess the youth's caregivers. For each scale, the rater determines the severity level that best describes the youth's level of functioning during the last month. Scores are then assigned for each level of severity (i.e. 30 for severe, 20 for moderate, 10 for mild, and 0 for minimal or no impairment).* The scores allow for providers to then track changes in functioning over time to help assess treatment progress.

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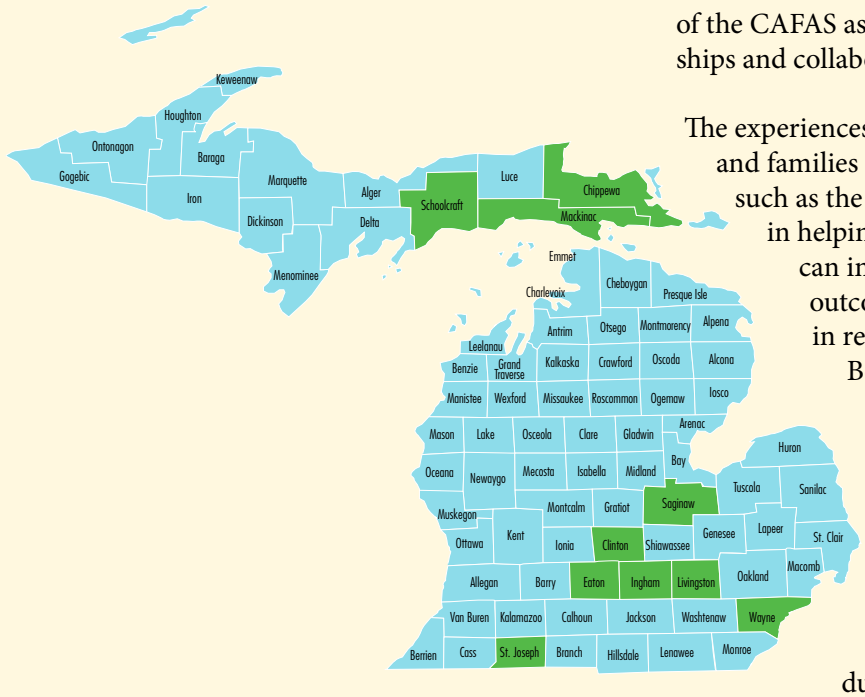
* Bates, M. P.; Furlong, M. J.; Green, J. G. 2006. Are CAFAS Subscales and Item Weights Valid? A Preliminary Investigation of the Child and Adolescent Functional Assessment Scale. *Adm Policy Ment Health & Ment Health Serv Res.* 33: 682-695.

Hodges, K; Wong, MM, Latessa M. Use of the Child and Adolescent Functional Assessment Scale (CAFAS) as an Outcome Measure in Clinical Settings. *Journal of Behavioral Health Services and Research* 25: 325-336, 1198.

The study's aims were to:

- Describe Michigan's efforts to infuse a culture of quality and a focus on outcomes management in its child mental health service delivery system;
- Highlight ways in which outcomes-based management has facilitated:
  - Improved services quality as measured by the implementation of evidence-based practices,
  - Infrastructure-related support for access and quality,
  - Service redesign,
  - Application of system of care principles such as, family and youth empowerment, and cross systems collaboration,
  - Use of a public health age-appropriate services delivery approach, and
- Concrete examples of the lessons learned in Michigan relevant for states interested in leading a quality movement.

Figure 13: **Michigan Case Study Sites**



Our Research Questions

- What are strengths of the use of the CAFAS by Michigan counties to enhance service delivery?
- What major barriers did counties encounter?
- How did the use of the CAFAS promote and assist in improving services?
- How did the use of the CAFAS promote and support other system goals?[196]

Our Research Approach

NCCP investigators interviewed stakeholders at the state and local level across the service delivery catchment area of the following Michigan counties: Detroit/Wayne, St. Joseph's, Saginaw, Livingston, Ingham, and Hiawatha (see Figure 13). These stakeholders include county and state system leaders, service providers, and families and youth in these communities. Interviews were conducted between December 2007 and May 2008. While the majority of system leaders and service providers interviewed were part of the public mental health sector, respondents from the juvenile justice, child welfare, public health, and education sectors were also interviewed to gain a sense of their knowledge of the CAFAS as well as a general sense of relationships and collaboration across systems.

The experiences of the system leaders, providers, and families involved in data monitoring efforts such as the CAFAS give important guidance in helping to understand how such efforts can improve individual and large-scale outcomes and inform others interested in replicating Michigan's approach. Below, we highlight some of the major findings and discuss their implications in order to help guide others interested in implementing an outcome measurement system. (The themes highlighted here are discussed in more detail in the final Michigan case study report due to be released in Early 2009.)

Figure 14: **Type or Respondents**

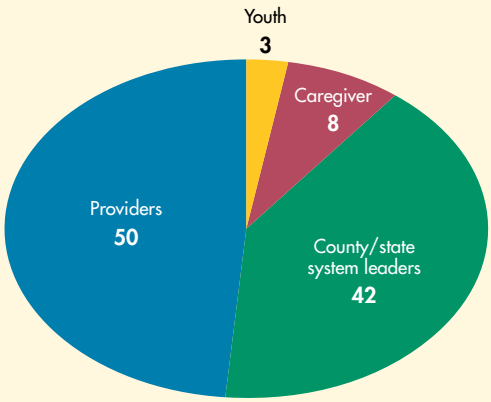
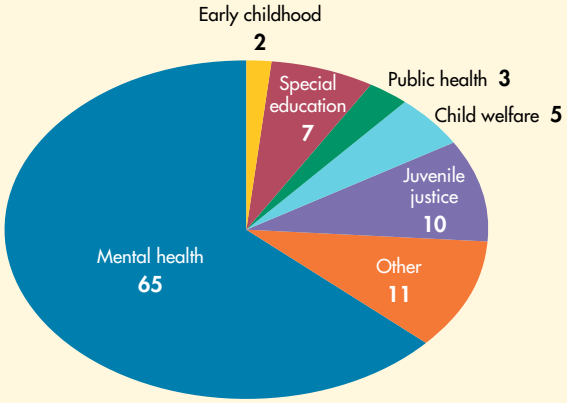


Figure 15: **Respondents by Discipline**



What are strengths of the use of the CAFAS by Michigan counties to enhance service delivery?

Respondents recognized that systematic use of the CAFAS allowed them to better monitor outcomes and guide services. About half of the respondents (49% of those who discussed strengths) recognized the value of having child- and family-level data to help track what was working well and not working well for children served. They saw it as a non-threatening way to help identify needs and weaknesses, to see what progress is being made, and as an aid in decision-making at individual, local, and state levels. One state administrator explained, *"I would have still been making decisions by the seat of my pants. Making decisions at this level is always scary business because you know it will impact thousands of people… I wanted the data to help make decisions… having client-level data is so powerful, more powerful than any other data we have to make decisions on."*

Respondents valued measuring behavioral functioning as an opportunity to improve their system's effectiveness through more objective measuring. Many of the respondents (60%) thought that the CAFAS was useful since it helped them examine and track behavioral functioning to inform treatment plans, which they may have missed through clinical treatment alone.

Lessons Learned

- ***Using data to guide services and track outcomes enhances systems' ability to improve services.*** The majority of respondents thought that the CAFAS is a valuable tool for guiding services and found the tool to be effective and objective. Through outcomes monitoring system leaders can target interventions that work, and address factors that support or impede quality. For example they are better able to identify which providers and intervention strategies consistently lead to positive outcomes for children and youth. The data presented here suggests that Michigan has made great strides in implementing an outcomes-focused approach to serve delivery.

What major barriers did counties encounter?

Concerns about subjectivity and superficiality/inadequacy of the CAFAS tool remain. Respondents displayed some skepticism about the usefulness of CAFAS. Some respondents (36%) found the tool to be subjective, while others (41%) thought the tool was too superficial (particularly around measuring self-harmful behaviors) for determining clinical treatment decisions. They reported that they'd like to see more subscales developed and have greater distinction among the scales. There was some sentiment that they were only using the CAFAS due to the state mandate as one respondent explained, *"Perception is that we have to do this for the state and that is why we are doing it."*

CAFAS scores are a large component of determining eligibility for service. A few respondents (7%) talked about the difficulty with the state establishing CAFAS thresholds for service eligibility. They noted that the result may be that providers are trying to keep youth within certain

scores in order to keep them in services. Some also find that this makes it difficult for "outliers" who need services but may not have a CAFAS score appropriate for eligibility.

The CAFAS can be administratively burdensome. Some respondents (14%) voiced concern that it can be time-consuming to fill out the CAFAS and enter the data into a (sometimes two) computer system(s) in addition to their other responsibilities.

The CAFAS does not adequately capture family functioning. Several respondents (28%) noted that while the caregiver section was helpful, it does not fully capture parental/family functioning. They suggested that in order for services to be even more family-centered there should be a stronger assessment for families. One system leader explained, *"How the family is functioning affects the youth. (It) never makes sense (to have a) family scale with families who have problems and the families who don't have enough resources all thrown in together. (It's) well intentioned, as families who are actively involved with criminal behavior or substance abuse preventing them from being better parents… (but) parent scales are not fine tuned (and) need additional scales."*

There were concerns that the CAFAS is not strength-based. Approximately 20% of respondents expressed concern that the CAFAS measures deficits in functioning.

Lessons Learned

- ***Getting providers invested in assessments and data analysis may help with utilization.*** Respondents expressed concerns about the subjectivity and adequacy of the CAFAS tool, and given their skepticism of the tool, they were worried about service eligibility being linked to CAFAS scores. Some were also concerned that the tool is not congruent with a strengths-based approach, making it difficult to communicate CAFAS outcomes with youth and parents. These concerns may create unintended results, such as fuelling a reluctance to fully use the tool as intended or as tempting providers to adjust a child's score to enter treatment or keep them in services longer.
- These findings suggest that providers may benefit from further information at the outset of CAFAS use on the broad purposes of the CAFAS, the demonstrated effectiveness of the tool for decision making, and how to share CAFAS results using strengths-based approach to youth and families. In one county, significant efforts have been made to train clinicians to conduct strengths-based assessments. Additionally, if the CAFAS is used with all children and youth, compared to just with children and youth with SED (as the case in Michigan), the issue of service eligibility criteria would diminish substantially.
- ***Need to consider providers' responsibilities when implementing the CAFAS.*** A small minority of respondents reported (14%) the CAFAS is burdensome and time-consuming to administer. Since the CAFAS is a quick tool to administer, the responses that it is administratively burdensome may relate more to the gathering of information necessary to administer the tool, which suggests that analysis of the time needed to gather information must be calculated and efforts made to streamline this process. Otherwise, time constraints may prevent some providers from utilizing it. Further analysis is warranted, based on provider profile and background to see whether this response can be generalized across disciplines. Notwithstanding, this preliminary analysis does suggest that those ***considering implementing data measurement systems should consider*** the administrative burden and providers' overall workload.
- ***Additions to the CAFAS tool may be needed to examine overall family functioning.*** Some respondents (28%) were concerned that the CAFAS does not capture family functioning. Given that research suggests engaging the family is critical to treatment success, measuring family functioning is important for effective treatment. Changes to the CAFAS or supplementing it with other assessment measures that could better measure family functioning would further benefit the child and youth's treatment plan.

How did the use of the CAFAS promote and assist in improving services?

There were high levels of awareness and statewide use of evidence-based practices (EBPs). A high percentage (80%) of Michigan respondents was able to identify the EBPs in their community, including 38 percent of parents/caregivers

who were able to identify EBPs they or their child were involved in. Such a high level of awareness in the state about EBPs may not be typical (for example, our case study in California found that 69 percent of community leaders, 11 percent of family members, and 7 percent of youth had heard about evidence-based practices) and may be a result of CAFAS and the LOF project.

The CAFAS helped facilitate the use of EBPs by identifying the need for EBPs and by demonstrating their effectiveness. Client-level data from all participating providers was pooled into a state database revealing to state administrators the large number of youths and parents with conditions that could be treated with evidence based practices. The state therefore, implemented training programs for Cognitive-Behavioral Therapy (CBT) and Parent Management Training-Oregon (PMTO), as well as obtained grant money to study how to disseminate evidence-based treatments in public mental health settings.

Twenty-nine percent of those who discussed the LOF project thought the CAFAS and the LOF project facilitated EBPs. When asked which EBPs had been implemented in their community, 51 percent said PMTO, 30 percent said CBT, 28 percent said Dialectical Behavior Therapy (DBT), 15 percent said wraparound, and 13 percent said Multisystemic Therapy (MST). One county mental health director noted: *"It creates a fish-or-cut-bait environment. Once you begin to measure outcomes, you are either lucky or it creates a clear call to action about the need to change. Especially if there are evidence based practices that create measurable results, as a manager of a public trust you need to decide what to stay with."*

CAFAS data also helped to gain support for additional funding and to market their program's success. Some respondents (11% of those who discussed using empirical evidence of CAFAS) talked about using CAFAS data to apply for continuing program funding. As one respondent reasoned, *"CAFAS has heightened the sensitivity to what you are buying." Another respondent remarked: "We use the CAFAS data to report to the community. The annual meeting of Human Services Collaborative Board meeting [we show to] leaders to signify that wraparound is working well. [We also used for] our 10-year wraparound celebration press release."*

Lessons Learned

- ***Statewide attention to outcomes and encouragement of EBPs helps to facilitate awareness about and implementation of EBPs.*** A vast majority of respondents demonstrated awareness of EBPs, including parents, and a number of respondents thought that the use of CAFAS and the LOF project was directly linked to the use of EBPs. Michigan also implemented a statewide effort to implement two EBPs – PMTO and CBT – as a result of the LOF project. The high awareness of EBPs in Michigan and the higher levels of use of the state-initiated EBPs suggest that Michigan's mandate plus technical assistance approach to outcomes has positively impacted the adoption of EBPs.
- ***Empirical evidence of program effectiveness can help secure financial support of EBPs.*** Respondents talked about how evidence of program effectiveness helped them secure funding for continuing to administer programs. Given often limited monies available to public programs, outcome data is an important tool for program continuation. Programs should utilize outcome data to secure funding.

How did the use of the CAFAS promote and support other system goals?[201]

CAFAS data was a vehicle for cross-agency and cross-system collaboration in some counties, but this is not universal. Respondents (16%) recognized the value of having a "common language" to communicate through both across agencies, and as in the case in some counties – across systems. For example, respondents in one county spoke about how use of the CAFAS across systems has helped facilitate referrals. One provider in one county explained, *"Now we speak about 80 versus 120 and know what it means. We can now to speak as professionals to each other – can use scores to discuss a case. (The CAFAS) is more widely accepted across agencies. It's a common language now."*

However, the use of the CAFAS is still not widespread outside of community mental health. Only about one third of the respondents, who discussed agencies using the CAFAS, could identify entities outside of community mental health that used

the CAFAS. But there are nine places where other sectors are not implementing the CAFAS. Indeed, there have been instances where the community mental health authority has trained personnel from other sectors to use the CAFAS and they still do not use it. In one county, the school-based mental health worker explained, *"A couple of years ago, [we did] the whole piece where we taught schools [to] rate. I thought it was great when we were doing it. [It was] a shorter version; the JIFF, we brought in school counselors, spent a whole day. Teaching them how to rate. Nobody used it."* There has been some cross-system collaboration within individual counties. For example, Mental Health and Juvenile Justice have paired to implement the CAFAS. In Wayne County every juvenile justice-involved youth is screened using the CAFAS or its companion screen tool, the JIFF. In Livingston County, all probation officers and juvenile corrections personnel have been trained in the use of the CAFAS.

The CAFAS was a tool for communicating with families but nearly one-third of providers did not share the CAFAS results with families. The CAFAS scores presented an opportunity to engage family members in treatment planning. A number of the case study respondents (35%) listed this as a major strength of the measurement tool. Providers said they were able to objectively present progress and validate treatment decisions through a mechanism similar to a report card which was easy to communicate for them and easily understood by parents.

Of those who discussed sharing CAFAS with families and youth, the majority of respondents (74%), said that CAFAS scores are shared with families. Despite the benefits of the CAFAS in engaging families however, some respondents (29%) specifically said that CAFAS scores are not shared with families. Only three of the 11 family members interviewed showed any knowledge about the CAFAS. Similarly, a respondent in one county explained that a survey they conducted showed that less than half of the parents they surveyed said they had CAFAS scores shared with them. One system leader noted: "*I think (we're) still seeing, and getting over the more traditional, clinical model where the therapist treats and treats and treats the child. A parent just said that she goes into the center, the therapist takes her child in, she waits, and after 50 minutes (the therapist) sends her child back out and says, 'See you next week!' We were like, 'Does that really still happen?' It's that whole family centered piece that we need to get people on that wavelength – that you can't treat the kid by himself. You treat the whole family.*"

Lessons Learned

- ***CAFAS use across systems and systems coordination should be encouraged.*** Respondents acknowledged that a strength of the CAFAS is its ability to foster cross-system collaboration. The CAFAS can demonstrate clear needs for youth across systems through measurement in domains such as school, community, substance use, and the home, which can flag when youth are struggling in those areas and when referrals to juvenile justice, substance use, or child welfare would be appropriate. Providers across agencies and systems can all understand what CAFAS scores mean and give clear guidelines for service eligibility, thus facilitating referrals. Systems would benefit from the adoption of the CAFAS early on in order to maximize cross-system collaboration and facilitate better coordination.
- ***Providers should be encouraged to share CAFAS scores with youth and families.*** While the majority of respondents said that CAFAS scores are shared with families, this was not universal and few youth and family members interviewed were aware of the CAFAS. Inconsistencies across providers sharing CAFAS scores with youth and family members may be the result of either a lack of training on how to present CAFAS data to youth and families and how they could benefit from this information, or the result of agencies, counties, and the state not encouraging family involvement in the CAFAS. Research demonstrates and policy is increasingly recognizing the importance of families and youth service users in their own care management and attaining positive outcomes.[197] [198] Providers should therefore be educated on how best to share scores with youth and families and given encouragement to involve families through agency, county, or state level policy.

CHAPTER 9
What Policy Barriers and Opportunities Exist for States That Try to Improve Their Service Systems?

"It seems as though the more we learn about how to most effectively target our resources, the fewer resources we have. "

State Child Mental Health Director, 2008

Nearly 10 years following the first *Surgeon General's Report on Mental Health*, policymakers in children's mental health continue to grapple with how to implement policy reforms to advance the hodgepodge of services and supports into a coherent, responsive care delivery system for children and youth with or at risk for mental health conditions and their families. In the midst of changing political environments at the state and federal levels, several factors remain constant. Federal leadership on children's mental health has been largely absent, knowledge on effective practices has continued to grow, and service capacity remains strained.

In 1982 Edelman asked, *"without strong federal direction, will states do what is right and needed for their own children?"* Since the mid-1990s only one response has emerged. States have had to lead. This chapter reviews responses from state children's mental health directors on the policy barriers they anticipate in the next few years from the state and federal perspective. They also identified opportunities for policy reforms they foresaw in the near future.

States' Top Policy Challenges

States most frequently identified funding (N=20) including Medicaid (N=8), workforce (N=16), and cross system collaboration (N=11) as areas where they expected to face the most critical policy challenges at the state level over the next few years. One state pointed to a particular anomaly that it confronts related to workforce, *"[We] have one of the highest number of licensed mental health clinicians in the country, yet one of the lowest number of licensed mental health clinicians that accepted insurance. There are not enough young employees entering the system, and those that enter are not prepared. Most clinicians prefer private practice."*

It is important to note that many of these challenges were inter-related. For example, some of the responses on workforce were linked to the payment system, the lack of preparation of the workforce to implement evidence-based practices, or workforce shortages that impeded collaboration. Table 20 lists the challenges and the states that identified these as one of their top three challenges. A number of states (N=9) also pointed to anticipated challenges focused on the system to engage and support families and youth, address inadequate service capacity (N=10), and implement evidence-based practices (N=8).

Lack of insurance was also mentioned with four states noting that no insurance, under insurance or parity represented significant policy barriers they face and foresee in the future. Two states reported that custody relinquishment in exchange for services posed a challenge for their service delivery systems (not shown).

Table 20. Top State and Federal Challenges States Identified

	Top Challenges (Local/State)							Top Challenges (Federal)						
	Sufficient Funding	Medicaid/SCHIP	Workforce	Service Capacity	Cross Agency Work	EBPs	Family and Youth Involvement	Sufficient Funding	Medicaid/SCHIP	Workforce	Service Delivery	Cross Systems Collaboration	Specific Funding Needs	Funding Flexibility
ALABAMA														
ALASKA			✓			✓		✓						
ARIZONA					✓				✓		✓			
ARKANSAS							✓							
CALIFORNIA			✓						✓					
COLORADO			✓						✓					
CONNECTICUT					✓				✓					
DELAWARE			✓	✓	✓			✓			✓		✓	
DISTRICT OF COLUMBIA							✓	✓						
FLORIDA						✓								
GEORGIA	✓	✓						✓	✓	✓				
GUAM					✓			✓				✓		
HAWAII			✓						✓					
IDAHO			✓	✓								✓		✓
ILLINOIS														
INDIANA		✓							✓					
IOWA			✓		✓					✓				
KANSAS				✓							✓			
KENTUCKY	✓							✓					✓	
LOUISIANA	✓		✓								✓			
MAINE			✓		✓	✓				✓				
MARYLAND														
MASSACHUSETTS		✓	✓		✓			✓		✓		✓		
MICHIGAN	✓							✓						
MINNESOTA		✓							✓					
MISSISSIPPI											✓			
MISSOURI		✓		✓					✓					✓
MONTANA			✓				✓	✓						
NEBRASKA														
NEVADA	✓							✓		✓				
NEW HAMPSHIRE	✓			✓								✓		✓
NEW JERSEY	✓				✓	✓						✓	✓	✓
NEW MEXICO	✓													
NEW YORK				✓		✓				✓	✓			
NORTH CAROLINA			✓			✓	✓		✓					
NORTH DAKOTA			✓				✓		✓				✓	
OHIO	✓				✓				✓					
OKLAHOMA	✓							✓						✓
OREGON					✓	✓			✓			✓		
PENNSYLVANIA						✓	✓							
PUERTO RICO								✓						
RHODE ISLAND	✓	✓							✓					
SOUTH CAROLINA			✓				✓		✓					
SOUTH DAKOTA					✓							✓		
TENNESSEE														
TEXAS	✓													
UTAH				✓			✓					✓		
VERMONT					✓		✓		✓			✓		
VIRGINIA		✓		✓				✓	✓					
WASHINGTON				✓										
WEST VIRGINIA			✓					✓				✓		✓
WISCONSIN			✓	✓										
WYOMING		✓												

Table 21. Top Local and Federal Reforms States Identified

	Top Reforms (Local/State)					Top Reforms (Federal)											
						Funding				Service Delivery Capacity							
	Funding, including Medicaid	Cross-Systems Work	Enhance Capacity	Prevention, Early Intervention	Family and Youth Engagement	Medicaid	Cross-System Funding	Increase Funding	Flexibility	Prevention, Early Prevention	Wraparound	Transition-age Youth	System of Care expansion	Workforce	Federal Approaches	Support EBPs	Family Support
ALABAMA																	
ALASKA	✓						✓	✓							✓		
ARIZONA		✓		✓	✓												
ARKANSAS																	
CALIFORNIA						✓											
COLORADO				✓													
CONNECTICUT		✓				✓											
DELAWARE		✓						✓									
DISTRICT OF COLUMBIA	✓					✓				✓				✓			
FLORIDA																	
GEORGIA		✓	✓		✓	✓		✓						✓			
GUAM														✓	✓		✓
HAWAII		✓					✓						✓		✓		
IDAHO		✓															
ILLINOIS																	
INDIANA																	✓
IOWA	✓						✓								✓	✓	
KANSAS																	
KENTUCKY	✓									✓			✓				
LOUISIANA				✓									✓	✓		✓	
MAINE		✓			✓	✓	✓			✓							
MARYLAND																	
MASSACHUSETTS				✓	✓									✓			
MICHIGAN	✓		✓					✓									
MINNESOTA				✓			✓							✓			
MISSISSIPPI																	
MISSOURI		✓				✓			✓						✓		
MONTANA			✓	✓											✓		
NEBRASKA																	
NEVADA	✓				✓		✓		✓								
NEW HAMPSHIRE	✓	✓							✓								
NEW JERSEY		✓							✓								
NEW MEXICO																	
NEW YORK			✓						✓				✓	✓			
NORTH CAROLINA					✓	✓				✓							✓
NORTH DAKOTA				✓	✓	✓											✓
OHIO			✓	✓	✓	✓											
OKLAHOMA							✓		✓								
OREGON		✓					✓		✓						✓	✓	
PENNSYLVANIA					✓						✓					✓	✓
PUERTO RICO		✓															
RHODE ISLAND										✓	✓						
SOUTH CAROLINA			✓		✓							✓			✓		
SOUTH DAKOTA										✓							
TENNESSEE																	
TEXAS	✓				✓												✓
UTAH	✓																
VERMONT										✓		✓		✓			
VIRGINIA	✓		✓					✓									
WASHINGTON			✓	✓								✓				✓	
WEST VIRGINIA	✓			✓													
WISCONSIN	✓										✓						
WYOMING			✓			✓											

Federal Fiscal Challenges Were Among the Top Faced by States

States were also asked to report on the top three most critical policy challenges that they foresaw from a federal perspective. States' responses coalesced remarkably. States repeatedly identified funding as the major challenge (N=31). Funding barriers ranged from considerations specific to Medicaid and SCHIP and Medicaid regulations in particular (N=17), to funding flexibility (N=6), sufficient funding (N=14), and the need for funding to support specific areas or programs (N=4). States also pinpointed cross-systems collaboration and the lack of a supportive infrastructure for service integration. Workforce also emerged as a challenging factor for some states although not for all states (N=6). Additionally, a few states questioned the roles of federal agencies they described as confusing or conflicting, with one state noting that a challenge was, *"Getting SAMHSA and CMS on the same page."* One state considered a major challenge to be the tension between federal and state mandates.

Top Reforms States Reported They Envisioned

States reported on the top reforms they would implement to improve their ability to meet the needs of children and youth with mental health conditions and their families. States were more likely to list funding as an area that they would reform to enable them to help children, youth, and families than any other area (N=12). However, only three states listed Medicaid as an area they would reform. The three states that identified Medicaid as a target of local reform also mentioned changes to the state plan to expand eligibility, covered services, flexibility, and link recovery-based principles with reimbursement. Another state recognized its own power to redress the funding balance by removing what this state leader referred to as *"the institutional medical assistance incentive to hospitalize kids, and [instead] allow this funding to be used in the community for hospital alternatives, crisis beds, and child psychiatry."*

Besides funding, states were eager to change their systems to be more responsive to working across sectors. Many states saw cross-systems work as an area ripe for local reform (N=12). The responses for more cross-system work ranged from specific efforts to integrate across sectors to calls for leadership integration, such as in the creation of a Children's Cabinet. States also focused on the need to institutionalize or embed a family- and youth-empowerment culture into community level practice (N=11). Workforce, an issue that had featured prominently as a challenge both locally and nationally, was the target for reform in only four states, (Alaska, Louisiana, Oklahoma and Texas). Two states, Alaska and Minnesota, reported that developing and refining an outcomes-based system was a key reform strategy to improve their system. Only one state, South Carolina, listed addressing diversity as a central reform strategy.

From the federal perspective, states most frequently cited federal fiscal reform (N=21), with nearly half of these states (N=10) referencing Medicaid, as where they would like to see changes. An even higher number of states reported that they would like to see federal reforms that centered on service delivery capacity (N=25). These states most often identified prevention and early intervention (N=7), workforce (N=8), and federal approaches (N=8) as areas in which reform was most needed. States generally referred to changes in the federal approach as encompassing consistency in requirements and policies and the need to model the types of cross-systems approaches they expected from states at the federal level. One respondent, who called for a change in the federal approach to technical assistance noted that the federal government should: *"Work with the states on a 'treatment plan basis.' Assign a multi-disciplinary team to work with the state and also with federal resources to identify and make strategic plans as the state identifies priorities. The team should understand the structure, challenges and strengths and politics of the specific state's system. The team should spend time in the state mentoring state workers and work to bring updated evidence base, strategies, and information from other states. Do not provide as much 'brain dump' training, where a lot of information is passed on in a short time with little follow up. This does not create lasting changes in practice. Provide easily accessible, personalized, on-site assistance on issues, such as developing outcomes-based contracting, implementing EBPs, system design, information technology and management, level of care determination (management systems) etc."*

Major Findings and Policy Implications

States identified fiscal barriers as the most critical policy challenge they foresaw to addressing the mental health needs of children, youth, and their families.

- Twenty states found state fiscal barriers as a major challenge, and 31 states identified federal fiscal barriers, including Medicaid, as one of the top policy challenges. States also pointed to challenges with the workforce and the ability to work across systems.

States also offered a ranged of reforms they would like to see implemented to improve children's mental health service delivery.

- Twenty-five states reported that they would like to see federal changes related to service delivery capacity, in particular, the federal approach to working with states; prevention and early intervention; and workforce. At the state level, children's mental health directors identified family- and youth-responsive services and cross-systems work as areas where they would like to see changes.
- Both at the federal and state level (40% and 23% respectively), states wanted fiscal reform.

CONCLUSION
Moving Forward

"The federal government should pass legislation and design incentives to move the children's mental health system toward a universal public health model that begins with cross-system commitment to mental health promotion, prevention and comprehensive treatment."

Cooper, 2008

Central to moving forward in children's mental health policy is defining the vision for a next generation child mental health delivery system and what needs to happen to move us toward that vision. This chapter reviews the lessons learned from states' reports on the challenges they face and the types of reforms they wish to see. A brief review of findings of the report follows. It then lays out a vision for the next generation of child mental health delivery and outlines what needs to happen to advance toward this vision.

Box 25: **Characteristics of a Next Generation Mental Health System**

- Flexible funding that allows rapid response to emerging knowledge about the development of mental health issues in children and research-informed practice
- Attention through the mental health system beyond children and youth with SED, to children and youth at risk of SED
- Dedicated funding for prevention and early intervention
- Increased supports for parenting and for family support services in the context of prevention, early intervention and treatment
- Implementation of core system of care values
- Incentivized systems to improve quality with specific attention to eliminating disparities based on race/ethnicity, culture, language, and age
- Increased workforce capacity and competence, with greater attention to cultural responsiveness
- Use of data to drive clinical and administrative decision-making
- Increased attention to functional outcomes for children and youth
- Integrated delivery systems

This report updates Knitzer's groundbreaking 1982 study of children's mental health systems across the 50 states. It reveals many system advances in the last 25 years – some illuminated below – but also highlights the urgent need for further progress toward improving the mental health service delivery system for America's children.

Major Findings and Policy Implications

Public Health Framework

States' self-reports on the strategies they use to shift their systems toward embracing a public health framework diverged widely, indicating both individual state circumstances and different interpretations of what it takes to advance a public health approach to mental health. Major strategies reported included prevention and early identification, with particular focus on programs aimed at young children; balancing the treatment array between residential and community-based mental health services for children with serious emotional disturbances; providing services and supports in non-medical settings such as in schools or child care; implementing specific targeted initiatives; and changes to policy, funding, and system structure. Some state systems reported improved system capacity for children with intensive mental health needs and difficulty meeting the needs of children with complex needs such as co-occurring disorders or those with multiple-system involvement.

Developmentally Appropriate Services and Supports

Three-fifths of UCR respondents indicated that the child mental health authority funded early childhood mental health services directly. The types of initiatives targeted at young children included the placement of early childhood specialists in community mental health centers, consultation programs,

reimbursement for use of social and emotional screening tools, partnerships with early childhood programs and agencies, and partnerships with state adult mental health systems. Specific strategies that states identified as enhancing services and supports for young children fell into four categories: increased or targeted funding, expanding or enhancing service capacity, workforce development, and standardization.

Forty-seven states reported some support for school-based mental health services, but very few made specific mention of quality-assurance measures. The types of initiatives implemented included Positive Behavioral Interventions and Supports (PBIS/PBS), school-based mental health clinics, partnerships with state Departments of Education, school-wide efforts to promote social emotional learning, and targeted supports for school-based services for children and youth with serious emotional disturbances. Strategies for improvement of service for school-age youth include funding, legislation, workforce development, and enhancement of school-based services.

Forty-four states reported on what steps they were taking to improve services to transition-age youth, an age group that routinely faces barriers to accessing care as service users age out of the public system. The types of initiatives that states reported implementing included providing health insurance or other social supports, allowing young adults to remain in or return to state guardianship after age 18, forging partnerships with businesses to create workforce opportunities, and relaxing SSI-related rules that discourage work participation for this age group.

Evidence-Based Practices

Nearly all of the states reported promoting or requiring some implementation of evidence-based practices (EBPs). The most popular age-appropriate EBPs across state systems included parent child interaction therapy, positive behavioral interventions and supports, functional family therapy, wrap-around, and multi-systemic therapy. NCCP's study also showed poor knowledge of evidence-based practices among family members and youth but especially among primary Spanish-language users.

Cultural and Linguistic Competence

Twenty-seven states reported policies in place to promote access to culturally and linguistically competent services, with five consistently reporting purposeful and effective initiatives such as creating a multicultural taskforce with policy and programmatic responsibility, providing competency-based training, providing infrastructural support to develop and maintain a competent workforce, conducting regular assessments, and developing strategic plans. States relied heavily on workforce training and top-down legislative initiatives and guidelines to effect change.

Family- and Youth-Driven Care

Since 1982, more states have acknowledged the importance of including family and youth in the mental health system on a range of levels including advocacy and steerage to embracing a more holistic family-centered approach to service delivery and care. Thirty-nine states reported efforts toward granting families and youth voices in developing and shaping mental health care policy, including the establishment of family and youth regulatory or legislative bodies and organized parent networks, and reimbursing families as providers of services and supports.

Information Technology

About half of the states that responded characterized their information technology infrastructures as "intermediate," with 18 describing their systems as "rudimentary" and only two describing their systems as "advanced." NCCP further evaluated associations between IT infrastructure status and implementation of other outcomes-based decision-making initiatives but did not find a strong association.

The vast majority of states are taking tangible steps to improve their mental health delivery systems for children. While a quick glance at system improvements over the last 25 years suggests a real shift in the culture of care and numerous commendable advancements, particularly stemming from strong state leadership, more in-depth analysis reveals that these changes, while promising, are often severely

limited in scope and shallow in depth due to lack of concerted strategic plans.

Among the broad range of factors NCCP evaluated in this study of children's mental health policies and their impact on systems, several clearly identifiable and widely applicable areas for improvement emerged. First, state children's mental health directors stated the major policy challenges they face and foresee in the coming years: financing, the capacity to collaborate across systems and infrastructure-related challenges such as workforce development.

Second, despite past rhetoric the last decade did not usher in public health oriented programming, nor did policies show a significantly greater commitment to a public health approach to mental health services and supports. Instead states struggled to address the strain on their capacity to provide adequately for the neediest of children and youth as exhibited by a continued overreliance on less than effective treatment in general and residential treatment in particular, especially for school-age and transition-age youth. This last group is particularly vulnerable as youth out of the mental health system with few if any services and supports for them.

Underpinning these challenges is the need for increased and more flexible funding to support children and youth in the families, schools, and communities in which the live, learn, work, and play. States need to balance the investment they make in children's mental health so that systems can provide prevention and early intervention across the developmental spectrum. Similarly, while many respondents acknowledged the importance of taking a whole-family approach to treatment, funding restrictions and infrastructure limitations prevented most from effectively providing family-centered care.

Change appears slow in coming. The pace of the change does not match the magnitude of the problem or the urgency of the task. Most states surveyed report making tangible changes to their child mental health systems, starting with regulations, benchmarks, legislative mandates, and policy changes. Yet where innovative programs and policies exist, their funding, capacity, and reach are often limited to specific geographic areas and ultimately a limited number of children, youth and families, thus threatening the long-term viability and efficacy of even the most well-designed program or policy.

The next generation child and youth mental health system requires services and supports that range from universal strategies designed to promote mental health and prevent mental health problems, to intervention strategies and aftercare for children and youth with the most intensive mental health conditions. Such a system requires financing, service-delivery- and infrastructure-related supports for effective, family-, youth-, culturally and linguistically-responsive and research-informed practices. Most of all, an advanced child mental health system that is worthy of an advanced industrialized society requires a different approach to public policymaking.

The long history of child mental health policy is riddled with fragmented and piecemeal approaches. Knitzer's wake-up call was a case in point. Instead of addressing how a comprehensive policy approach might respond to the needs of all children and youth, subsequent policy responses cordoned off a group of children and youth with the most severe conditions and attempted to address their needs. The results were that large groups of children and youth continued to be left out, and families were forced to relinquish custody of their children in exchange for services after years of struggle to get help. Rarely during this time was there federal leadership to intentionally tie children's mental health policy to a larger health and human services agenda.

The policy prescription for the next generation of children's mental health policy is strong federal leadership accompanied by a strong federal framework for action working in conjunction with states, communities, and community stakeholders. The federal government should pass legislation and design incentives to move the children's mental health system toward a universal public health model that begins with cross-system commitment to mental health promotion, prevention, and comprehensive treatment. It should develop a framework and intentional steps to create a developmentally appropriate, family- and youth-responsive, culturally and linguistically competent system for

interventions and supports that is empirically based and outcomes-focused.

The urgency of the moment requires bold federal and state action. NCCP recommends the following:

Congress and the Executive branch should codify into law a public health approach to children's mental health services. Specifically they should:

- Provide a legislative framework for incentives and support for states to implement a public health approach for mental health for all children and youth. These can take the form of special incentive grants, a set-aside in current funding streams, and technical assistance;
- Establish a prevention funding set-aside as part of the mental health block grant mirroring a practice in substance-abuse funding and provide training, guidance, and technical assistance to states to implement a public health framework; and
- Create legislative authority that requires state child mental health authorities, child welfare authorities, and state juvenile courts to work collaboratively with the Substance Abuse and Mental Health Services Administration (SAMHSA), Agency for Children and Families, the Department of Justice, and the Department of Education to develop a comprehensive strategy to address the mental health needs of children, youth, and their families in these systems with the view to providing increased access to mental health promotion, prevention, and treatment interventions.

Support an age- and developmentally-appropriate focus to serving children and youth with mental health problems, their families, and children and youth at risk for mental health conditions and their families. Specifically they should:

- Provide incentives for statewide approaches to improving age-appropriate services; and
- Support states and professional organizations in their efforts to improve the competencies of all providers (including teachers) who work with children and youth with mental health conditions and at risk for mental health conditions so they are prepared to meet the needs of children in an age-appropriate manner. In addition:

For young children

- Direct the Centers for Medicare and Medicaid Services (CMS) to develop a comprehensive strategy to support the provision of prevention, early intervention, and treatment services for young children.

For school-age children and youth

- Direct the Department of Education and SAMHSA, in conjunction with CMS where applicable, to develop a comprehensive strategy to support the provision of prevention, early intervention, and treatment services for school-age children.

For youth transitioning to adulthood

- Remove federal prohibitions that govern federal funding of services to youth in juvenile justice; and
- Make available at the state option enhanced federal Medicaid participation rates for all youth with mental health involvement up to age 25.

Implement a comprehensive plan that finances the delivery of empirically supported effective practices through payment structures like Medicaid, private insurance, grants, and incentives. Specifically:

- Contribute to the financing of more widespread adoption of evidence-based practices in states by organizing efforts to reduce the cost of proprietary-based practices through bulk-purchasing and other types of initiatives; and
- Increase research on best practices models, especially those designed for diverse populations, for example, by appropriately funding entities like the National Network for the Elimination of Disparities, which focuses on developing culturally and linguistically competent evidence-based practices.

In conjunction with states:

- Systematically track the use of and outcomes associated with the implementation of evidence-based practice.
- Create initiatives that educate youth service users and their family members on evidence-based practices.

Take bold action to reduce disparities in access to mental health services and mental health outcomes based on race/ethnicity and limited English proficiency. Specifically:

- Require states to report on their efforts to address disparities in access and outcomes for children and youth from diverse racial, ethnic, and linguistic backgrounds; and
- Annually report on a state-by-state basis efforts to address disparities through the use of nationally established benchmarks.

Place empirically supported family-based treatment and supports at the center of financing children's mental health care. Specifically:

- Remove barriers to reimbursement for family treatment through Medicaid;
- Eliminate obstacles to treatment for parental mental health conditions;
- Provide incentives for states to buttress and sustain the family and youth voice in policy; and
- Develop guidelines for states to address how they may appropriately bill for family treatment and interventions that require both the family and the child or children.

Tackle the poor information systems capacity of children's mental health delivery systems and stimulate strategic planning and development. Specifically:

- Assess the status of children's mental health information technology infrastructure; and
- Develop a plan to tap into national health information technology capital resources to upgrade these systems.

Develop and implement a comprehensive financing strategy that supports a public health focus to mental health. Specifically:

- Require child mental health care content expertise in the development of state Medicaid plans and Medicaid policy decision making;
- Provide incentives for states that have not used Medicaid innovatively, such as to support mental health consultation, or care in non-office-based settings;
- Reward states that are using Medicaid and state funding creatively to improve service delivery and tie these rewards to improved outcomes;
- Identify a set of individual and system related outcomes for children and youth with mental health conditions, and link these to publicly financed public health strategies;
- Reject changes to the rehabilitation option that undermine services in day care, schools, and other settings where children, youth, and their families frequent;
- Require CMS to address variation in EPSDT funding for children's mental health services; and
- Report on benchmarks for behavioral health screenings and services funded by EPSDT, and establish specific targets for meeting the 80% participation threshold.

Require an outcomes-focused approach to service delivery in children's mental health. Specifically:

- Provide incentives and support for states to move toward more outcomes-focused management; and
- Help states link mental health policy and clinical decision-making initiatives.

State governments, territories, and the District of Columbia should support strategic planning to address unmet need in public mental health systems. Begin by:

- Documenting periodically and make publicly available estimates of unmet needs across the age span and states' plans to address those needs.

Address racial and ethnic disparities in access to mental health services and mental health outcomes by:

- Annually reporting on a county-by-county basis efforts to address disparities through the use of nationally established benchmarks; and
- Assessing their state children's mental health system's level of cultural and linguistic competence, developing a strategic plan, and publishing regular updates of their progress.

Create mechanisms to sustain the family and youth involvement in practice and policy by:

- Implementing strategies to support family and youth in professional roles using Medicaid; and

- Providing long-term funding for family and youth advocacy and support.

Attend to the urgent need for updated information systems by:

- Ensuring that as they develop information systems for other sectors of their child delivery systems they upgrade the child mental health infrastructure for maximum interoperability across child serving systems.

Address poor fiscal accountability by:

- Annually and publicly reporting their children's mental health budget; and
- Documenting how they use EPSDT for children and youth with mental health needs and those at risk.

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Unclaimed Children Revisited: State Profiles

ALABAMA

Poverty rate[1] among children and youth under 25 (CY07): 22%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: No limit, however prior authorization for admission and continued stay required.

Inpatient substance abuse: 30 days / calendar year.

Outpatient mental health and substance abuse: 20 visits / calendar year (mental health and substance abuse combined).

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,276,016	1,272,435	1,282,101
Number of children under 21 years old, with SED served[6]	25,004	24,088	27,144

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

☐*Primarily the State Medicaid Authority/Director

☐*Primarily the State Mental Health Authority/Director

☐*The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director

☐*Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority does not currently fund early childhood services directly.

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

☐ Positive Behavioral Interventions and Supports (PBIS/PBS)

☐ School-based mental health clinics/school-based health clinics

☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE

☐ School-wide efforts that promote social and emotional learning

☑ Targeted support for school-based services to children/youth with SED

☑ Other

The nature of the state children's mental health authority involvement:

☐ Funding

☐ Shared staffing

☐ Planning and program development

☐ Policy development

☐ Contracting through local schools

☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

☐ Health insurance and/or other social supports for young adults

☐ Transition age young adults can remain and/or return to state guardianship after age 18

☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation

☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds

☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority is not currently implementing specific strategies to promote the appropriate use of evidence-based strategies.

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 6

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.

2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).

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5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.

6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp

7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*

8. Ibid.

9. Ibid.

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11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

ALASKA

Poverty rate[1] among children and youth under 25 (CY07): 12%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☑	☐	☐
Children age 1-5	☐	☑	☐	☐
Children age 6-19	☐	☑	☐	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	218,349	215,831	211,595
Number of children under 21 years old, with SED served[6]	7,963	10,549	4,106

Total State Children's Mental Health budget (FY05):[7] $3,711,800

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (question not answered)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

ARIZONA

Poverty rate[1] among children and youth under 25 (CY07): 21%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☐	☑	☐
Non-working parents age 20 and older	☐	☐	☑	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: 30 days / admission, when medically necessary .

Outpatient mental health and substance abuse: No limit when medically necessary.

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,734,716	1,794,964	1,838,802
Number of children under 21 years old, with SED served[6]	19,609	21,773	29,706

Total State Children's Mental Health budget (FY05):[7] $278,800,000

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

☐*Primarily the State Medicaid Authority/Director

☐*Primarily the State Mental Health Authority/Director

☐*The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director

☐*Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

☑ Early childhood mental health specialists in community mental health centers

☑ Early childhood mental health consultation programs

☑ Reimbursement for use of social and emotional screening tools

☑ Partnerships with early childhood programs and agencies

☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness

☐ Other

School-Based Children

The state children's mental health authority is not actively involved in the support of school-based mental health services and supports.

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

☐ Health insurance and/or other social supports for young adults

☑ Transition age young adults can remain and/or return to state guardianship after age 18

☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation

☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds

☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

☐ Legislative or administrative mandate

☐ Fiscal incentives (i.e., higher reimbursement rates)

☑ Funds for associated start-ups costs

☑ Funds for implementation

☐ Umbrella mechanism for bulk purchasing

☑ Training for providers

☑ Technical assistance

☑ State dissemination infrastructure

☐ Academic partnerships (workforce development)

☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 6

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.

2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).

3. Ibid.

4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.

5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.

6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp

7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*

8. Ibid.

9. Ibid.

10. Ibid.

11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

ARKANSAS

Poverty rate[1] among children and youth under 25 (CY07): 22%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☐	☑	☐
Non-working parents age 20 and older	☐	☐	☑	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	679,213	679,785	687,872
Number of children under 21 years old, with SED served[6]	16,588	18,242	19,329

Total State Children's Mental Health budget (FY05):[7] $4,764,384

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☑ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has not developed special initiatives for youth transitioning to the adult system or to independent living.

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (question not answered)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance. Data pertain to children, birth through 17 years old. FY06 figure: Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp; FY04 and FY05 figures provided by state contact.
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

CALIFORNIA

Poverty rate[1] among children and youth under 25 (CY07): 18%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: No limit (SED); 30 days / benefit year (at-risk children and youth).

Inpatient substance abuse: Detox only.

Outpatient mental health: No limit (SMI); 20 visits / benefit year

Outpatient substance abuse: Crisis intervention and 20 visits.

	FY04	FY05	FY06
Number of children under 21 years old[5]	11,120,000	11,100,000	11,140,000
Number of children under 21 years old, with SED served[6]	208,995	181,183	181,659

Total State Children's Mental Health budget (FY05):[7] Unable to answer

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

☐*Primarily the State Medicaid Authority/Director

☐*Primarily the State Mental Health Authority/Director

☐*The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director

☐*Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

☐ Early childhood mental health specialists in community mental health centers

☐ Early childhood mental health consultation programs

☐ Reimbursement for use of social and emotional screening tools

☐ Partnerships with early childhood programs and agencies

☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness

☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

☐ Positive Behavioral Interventions and Supports (PBIS/PBS)

☑ School-based mental health clinics/school-based health clinics

☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE

☐ School-wide efforts that promote social and emotional learning

☑ Targeted support for school-based services to children/youth with SED

☑ Other

The nature of the state children's mental health authority involvement:

☑ Funding

☐ Shared staffing

☐ Planning and program development

☐ Policy development

☐ Contracting through local schools

☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

☑ Health insurance and/or other social supports for young adults

☐ Transition age young adults can remain and/or return to state guardianship after age 18

☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation

☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds

☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

☐ Legislative or administrative mandate

☐ Fiscal incentives (i.e., higher reimbursement rates)

☐ Funds for associated start-ups costs

☐ Funds for implementation

☐ Umbrella mechanism for bulk purchasing

☑ Training for providers

☑ Technical assistance

☑ State dissemination infrastructure

☐ Academic partnerships (workforce development)

☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 4

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.

2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).

3. Ibid.

4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.

5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.

6. SED – Serious Emotional Disturbance; FY06 figure: Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp; FY04 and FY05 figures: CA DMH Client and Services Information System (CSI). http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp

7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*

8. Ibid.

9. Ibid.

10. Ibid.

11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

COLORADO

Poverty rate[1] among children and youth under 25 (CY07): 15%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: 45 days / year (or 90 days of day treatment).

Inpatient substance abuse: Detox only.

Outpatient mental health and substance abuse: 20 visits / calendar year (mental health and substance abuse combined)

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,324,311	1,337,636	1,350,414
Number of children under 21 years old, with SED served[6]	20,313	20,753	21,226

Total State Children's Mental Health budget (FY05):[7] Unable to answer

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☑ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is not actively involved in the support of school-based mental health services and supports.

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☐ Training for providers
- ☐ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (question not answered)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

CONNECTICUT

Poverty rate[1] among children and youth under 25 (CY07): 12%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☐	☑
Children age 1-5	☐	☐	☐	☑
Children age 6-19	☐	☐	☐	☑

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: No limit.

Inpatient substance abuse: 60 days for drug abuse treatment; 45 days for alcohol abuse treatment.

Outpatient mental health and substance abuse: No limit (with some exceptions).

	FY04	FY05	FY06
Number of children under 21 years old[5]	989,029	971,343	954,839
Number of children under 21 years old, with SED served[6]	23,532	17,375	20,290

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☐ Partnerships with early childhood programs and agencies
- ☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☑ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 6

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

DISTRICT OF COLUMBIA

Poverty rate[1] among children and youth under 25 (CY07): 30%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☐	☑
Children age 1-5	☐	☐	☐	☑
Children age 6-19	☐	☐	☐	☑

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☐	☑	☐
Non-working parents age 20 and older	☐	☐	☑	☐
Pregnant women age 20 and older	☐	☐	☐	☑

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	130,290	128,497	130,116
Number of children under 21 years old, with SED served[6]	1,396	1,786	1,319

Total State Children's Mental Health budget (FY05):[7] Unable to answer

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has not developed special initiatives for youth transitioning to the adult system or to independent living.

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 8

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

DELAWARE

Poverty rate[1] among children and youth under 25 (CY07): 13%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: 30 days (mental health and substance abuse treatment combined). Additional treatment provided by state mental health agency.

Outpatient mental health and substance abuse: 20 units (mental health and substance abuse combined).

	FY04	FY05	FY06
Number of children under 21 years old[5]	228,989	230,025	232,371
Number of children under 21 years old, with SED served[6]	Not available	2,078	167

Total State Children's Mental Health budget (FY05):[7] $35,200,000

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority does not currently fund early childhood services directly.

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☐ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☑ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☑ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] *

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp. For 2006, the number of kids served includes only 18-20 years old.
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

FLORIDA

Poverty rate[1] among children and youth under 25 (CY07): 17%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: 30 days (mental health and substance abuse treatment combined).

Outpatient mental health and substance abuse: 40 visits (mental health and substance abuse combined).

	FY04	FY05	FY06
Number of children under 21 years old[5]	4,565,004	4,644,983	4,714,219
Number of children under 21 years old, with SED served[6]	Not available	55,639	64,193

Total State Children's Mental Health budget (FY05):[7] $94,000,000

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☐ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☐ Planning and program development
- ☐ Policy development
- ☐ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☐ Training for providers
- ☐ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (question not answered)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

GEORGIA

Poverty rate[1] among children and youth under 25 (CY07): 20%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: 30 days.

Outpatient mental health and substance abuse: 30 visits / year.

	FY04	FY05	FY06
Number of children under 21 years old[5]	2,602,761	2,654,254	2,727,269
Number of children under 21 years old, with SED served[6]	40,687	40,032	42,873

Total State Children's Mental Health budget (FY05):[7] $66,599,652

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☑ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 3

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; FY06 figures: Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp; FY04 and FY05 figures provided by state contact.
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

GUAM

Poverty rate[1] among children and youth under 25 (CY07): Not available

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08) Not available

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08) Not available

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Not applicable

	FY04	FY05	FY06
Number of children under 21 years old[5]	Not available	Not available	Not available
Number of children under 21 years old, with SED served[6]	Not available	Not available	225

Total State Children's Mental Health budget (FY05):[7] Unable to answer

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☑ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☐ Funding
- ☑ Shared staffing
- ☐ Planning and program development
- ☐ Policy development
- ☐ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☑ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

HAWAII

Poverty rate[1] among children and youth under 25 (CY07): 11%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☐	☑
Children age 1-5	☐	☐	☐	☑
Children age 6-19	☐	☐	☐	☑

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	351,819	345,152	338,317
Number of children under 21 years old, with SED served[6]	1,375	1,195	2,908

Total State Children's Mental Health budget (FY05):[7] Unable to answer

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☑ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☑ Legislative or administrative mandate
- ☑ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 3

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp. Hawaii currently has a combination of Medicaid and SCHIP programs. Kaiser Family Foundation. State Health Facts. SCHIP Program Type. http://www.statehealthfacts.org/comparemaptable.jsp?cat=4&ind=238
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; FY06 and FY04 figures: Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp; FY05 figure provided by state contact.
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

IDAHO

Poverty rate[1] among children and youth under 25 (CY07): 13%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☑	☐	☐
Children age 1-5	☐	☑	☐	☐
Children age 6-19	☐	☑	☐	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	375,599	384,254	393,554
Number of children under 21 years old, with SED served[6]	2,731	7,824	8,812

Total State Children's Mental Health budget (FY05):[7] $15,500,000

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☐ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp. Idaho currently has a combination of Medicaid and SCHIP programs. Kaiser Family Foundation. State Health Facts. SCHIP Program Type. http://www.statehealthfacts.org/comparemaptable.jsp?cat=4&ind=238.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Data pertain to children, birth through 17 years old. FY06 figure: Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp; FY05 and FY04 figures provided by state contact.
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

ILLINOIS

Poverty rate[1] among children and youth under 25 (CY07): 15%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: No limit, however treatment must be medically necessary.

Outpatient mental health: No limit.

Outpatient substance abuse: 30 days / year of day treatment.

	FY04	FY05	FY06
Number of children under 21 years old[5]	3,775,612	3,785,304	3,772,484
Number of children under 21 years old, with SED served[6]	12,185	12,876	14,011

Total State Children's Mental Health budget (FY05):[7] $66,368,631

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☐ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ iscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☐ Technical assistance
- ☐ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] *5*

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

INDIANA

Poverty rate[1] among children and youth under 25 (CY07): 17%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☐	☑	☐
Non-working parents age 20 and older	☐	☐	☑	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: No limit, however treatment must be medically necessary.

Outpatient mental health and substance abuse: 30 office visits / year (or up to 50 office visits with approval).

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,838,972	1,839,763	1,844,451
Number of children under 21 years old, with SED served[6]	25,398	28,256	32,817

Total State Children's Mental Health budget (FY05):[7] $14,000,000

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☑ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority does not currently fund early childhood services directly.

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☐ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☐ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☑ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 5

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables*. http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp; http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp; FY04 and FY05 figures provided by state contact
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

IOWA

Poverty rate[1] among children and youth under 25 (CY07): 16%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☐	☑	☐
Non-working parents age 20 and older	☐	☐	☑	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: 60 days / year.

Inpatient substance abuse: Up to $9,000 per calendar year (or $39,000 lifetime).

Outpatient mental health: 20 office visits / year.

Outpatient substance abuse: Up to $9,000 per calendar year (or $39,000 lifetime).

	FY04	FY05	FY06
Number of children under 21 years old[5]	833,833	812,814	809,155
Number of children under 21 years old, with SED served[6]	28,725	30,422	30,934

Total State Children's Mental Health budget (FY05):[7] Unable to answer

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

☐*Primarily the State Medicaid Authority/Director

☐*Primarily the State Mental Health Authority/Director

☐*The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director

☐*Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority does not currently fund early childhood services directly.

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

☑ Positive Behavioral Interventions and Supports (PBIS/PBS)

☐ School-based mental health clinics/school-based health clinics

☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE

☐ School-wide efforts that promote social and emotional learning

☐ Targeted support for school-based services to children/youth with SED

☐ Other

The nature of the state children's mental health authority involvement:

☐ Funding

☐ Shared staffing

☐ Planning and program development

☑ Policy development

☐ Contracting through local schools

☐ Other

Transition-Age Youth

The state children's mental health authority has not developed special initiatives for youth transitioning to the adult system or to independent living.

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

☑ Legislative or administrative mandate

☐ Fiscal incentives (i.e., higher reimbursement rates)

☐ Funds for associated start-ups costs

☐ Funds for implementation

☐ Umbrella mechanism for bulk purchasing

☐ Training for providers

☑ Technical assistance

☐ State dissemination infrastructure

☐ Academic partnerships (workforce development)

☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.

2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).

3. Ibid.

4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.

5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.

6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp

7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*

8. Ibid.

9. Ibid.

10. Ibid.

11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

KANSAS

Poverty rate[1] among children and youth under 25 (CY07): 19%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: No limit, however treatment must be medically necessary and approval required prior.

Inpatient substance abuse: 60 days per year.

Outpatient mental health and substance abuse: No limit, however treatment must be medically necessary and approval required prior.

	FY04	FY05	FY06
Number of children under 21 years old[5]	816,687	812,814	798,009
Number of children under 21 years old, with SED served[6]	19,032	20,444	19,649

Total State Children's Mental Health budget (FY05):[7] Unable to answer

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

☐*Primarily the State Medicaid Authority/Director

☐*Primarily the State Mental Health Authority/Director

☐*The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director

☐*Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

☑ Early childhood mental health specialists in community mental health centers

☑ Early childhood mental health consultation programs

☑ Reimbursement for use of social and emotional screening tools

☑ Partnerships with early childhood programs and agencies

☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness

☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

☐ Positive Behavioral Interventions and Supports (PBIS/PBS)

☐ School-based mental health clinics/school-based health clinics

☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE

☐ School-wide efforts that promote social and emotional learning

☐ Targeted support for school-based services to children/youth with SED

☑ Other

The nature of the state children's mental health authority involvement:

☑ Funding

☐ Shared staffing

☑ Planning and program development

☑ Policy development

☑ Contracting through local schools

☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

☑ Health insurance and/or other social supports for young adults

☐ Transition age young adults can remain and/or return to state guardianship after age 18

☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation

☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds

☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

☐ Legislative or administrative mandate

☐ Fiscal incentives (i.e., higher reimbursement rates)

☐ Funds for associated start-ups costs

☐ Funds for implementation

☐ Umbrella mechanism for bulk purchasing

☑ Training for providers

☑ Technical assistance

☐ State dissemination infrastructure

☑ Academic partnerships (workforce development)

☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.

2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).

3. Ibid.

4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.

5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.

6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp

7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*

8. Ibid.

9. Ibid.

10. Ibid.

11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

KENTUCKY

Poverty rate[1] among children and youth under 25 (CY07): 22%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: No limit, however treatment must be medically necessary.

Outpatient mental health and substance abuse: No limit, however treatment must be medically necessary.

	FY04	FY05	FY06
Number of children under 21 years old[5]	988,618	996,191	992,791
Number of children under 21 years old, with SED served[6]	19,594	20,899	19,705

Total State Children's Mental Health budget (FY05):[7] $44,020,377

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☑ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☑ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☑ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has not developed special initiatives for youth transitioning to the adult system or to independent living.

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 3

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance. Data pertain to children, birth through 17 years old. All data (FY04-06) was provided by the state contact.
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

LOUISIANA

Poverty rate[1] among children and youth under 25 (CY07): 24%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid/SCHIP

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,371,709	1,323,759	1,295,167
Number of children under 21 years old, with SED served[6]	7,191	7,674	7,465

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

☐*Primarily the State Medicaid Authority/Director

☐*Primarily the State Mental Health Authority/Director

☐*The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director

☐*Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

☑ Early childhood mental health specialists in community mental health centers

☑ Early childhood mental health consultation programs

☑ Reimbursement for use of social and emotional screening tools

☑ Partnerships with early childhood programs and agencies

☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness

☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

☐ Positive Behavioral Interventions and Supports (PBIS/PBS)

☑ School-based mental health clinics/school-based health clinics

☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE

☐ School-wide efforts that promote social and emotional learning

☐ Targeted support for school-based services to children/youth with SED

☐ Other

The nature of the state children's mental health authority involvement:

☑ Funding

☐ Shared staffing

☑ Planning and program development

☑ Policy development

☐ Contracting through local schools

☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

☐*Health insurance and/or other social supports for young adults

☐*Transition age young adults can remain and/or return to state guardianship after age 18

☐*Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation

☐*Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds

☐*Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority is not currently implementing specific strategies to promote the appropriate use of evidence-based strategies.

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 5

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

MAINE

Poverty rate[1] among children and youth under 25 (CY07): 15%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☐	☑	☐
Non-working parents age 20 and older	☐	☐	☑	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: 60 days (mental health and substance abuse treatment combined) Extra days can be authorized.

Outpatient mental health and substance abuse: 60 days (mental health and substance abuse treatment combined). Extra days can be authorized.

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	FY04	FY05	FY06
Number of children under 21 years old[5]	332,019	339,216	343,175
Number of children under 21 years old, with SED served[6]	9,738	10,278	12,164

Total State Children's Mental Health budget (FY05):[7] $104,532,818

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☐ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 2

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

MARYLAND

Poverty rate[1] among children and youth under 25 (CY07): 12%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☐	☑
Children age 1-5	☐	☐	☐	☑
Children age 6-19	☐	☐	☐	☑

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: No limit.

Inpatient substance abuse: 5 days ambulatory Detox; 30 sessions / 6 months / episode of care of individual or group therapy; 30 calender days of intensive outpatient; 2 days partial hospitalization; 26 weeks of opioid treatment.

Outpatient mental health and substance abuse: No limit.

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,603,233	1,594,084	1,592,610
Number of children under 21 years old, with SED served[6]	34,345	33,184	32,744

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

☐*Primarily the State Medicaid Authority/Director

☐*Primarily the State Mental Health Authority/Director

☐*The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director

☐*Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

☑ Early childhood mental health specialists in community mental health centers

☑ Early childhood mental health consultation programs

☐ Reimbursement for use of social and emotional screening tools

☑ Partnerships with early childhood programs and agencies

☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness

☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

☑ Positive Behavioral Interventions and Supports (PBIS/PBS)

☑ School-based mental health clinics/school-based health clinics

☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE

☑ School-wide efforts that promote social and emotional learning

☑ Targeted support for school-based services to children/youth with SED

☐ Other

The nature of the state children's mental health authority involvement:

☑ Funding

☑ Shared staffing

☑ Planning and program development

☑ Policy development

☑ Contracting through local schools

☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

☐ Health insurance and/or other social supports for young adults

☐ Transition age young adults can remain and/or return to state guardianship after age 18

☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation

☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds

☐ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

☐ Legislative or administrative mandate

☑ Fiscal incentives (i.e., higher reimbursement rates)

☐ Funds for associated start-ups costs

☐ Funds for implementation

☐ Umbrella mechanism for bulk purchasing

☑ Training for providers

☑ Technical assistance

☑ State dissemination infrastructure

☑ Academic partnerships (workforce development)

☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 8

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.

2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).

3. Ibid.

4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp. However, Maryland now has a Medicaid expansion program. Kaiser Family Foundation. State Health Facts. SCHIP Program Type. www.statehealthfacts.org/comparemaptable.jsp?cat=4&ind=238

5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.

6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp

7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*

8. Ibid.

9. Ibid.

10. Ibid.

11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

MASSACHUSETTS

Poverty rate[1] among children and youth under 25 (CY07): 14%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☐	☑
Children age 1-5	☐	☐	☐	☑
Children age 6-19	☐	☐	☐	☑

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: Beneficiaries may receive behavioral health services provided in acute general hospital psychiatric units and non-IMD facilities, as long as medically necessary. Hospital services in an IMD up to a maximum of 30 consecutive days per admission.

Outpatient mental health and substance abuse: Beneficiaries may receive behavioral health services provided in acute general hospital psychiatric units and non-IMD facilities, as long as medically necessary. Hospital services in an IMD up to a maximum of 30 consecutive days per admission.

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,743,571	1,756,659	1,748,814
Number of children under 21 years old, with SED served[6]	3,500	3,414	3,181

Total State Children's Mental Health budget (FY05):[7] $2,577,331

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☑ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority does not currently fund early childhood services directly.

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☑ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 4

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp; FY05 and FY04 figures provided by state contact.
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

MICHIGAN

Poverty rate[1] among children and youth under 25 (CY07): 17%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: No limit, however treatment must be medically necessary.

Outpatient mental health and substance abuse: No limit, however treatment must be medically necessary.

	FY04	FY05	FY06
Number of children under 21 years old[5]	2,965,198	2,953,953	2,914,052
Number of children under 21 years old, with SED served[6]	32,756	32,727	39,306

Total State Children's Mental Health budget (FY05):[7] $119,174,175

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☑ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☐ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☐ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

MINNESOTA

Poverty rate[1] among children and youth under 25 (CY07): 13%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☐	☑	☐
Non-working parents age 20 and older	☐	☐	☑	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: 30 days / year (or 60 days/year for partial hospitalization).

Inpatient substance abuse: $8,000 in combined inpatient and outpatient substance abuse treatment services / calendar year ($16,000 / lifetime).

Outpatient mental health and substance abuse: 52 visits / year.

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,439,794	1,439,664	1,464,811
Number of children under 21 years old, with SED served[6]	23,550	23,771	23,177

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☑ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☑ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 6

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

MISSISSIPPI

Poverty rate[1] among children and youth under 25 (CY07): 29%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: No limit, however approval required prior to treatment, and every 30 days thereafter.

Outpatient mental health and substance abuse: No limit.

	FY04	FY05	FY06
Number of children under 21 years old[5]	888,914	886,681	897,479
Number of children under 21 years old, with SED served[6]	30,568	31,386	32,483

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ *Early childhood mental health specialists in community mental health centers
- ☐ *Early childhood mental health consultation programs
- ☐ *Reimbursement for use of social and emotional screening tools
- ☐ *Partnerships with early childhood programs and agencies
- ☐ *Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ *Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☐ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☐ Training for providers
- ☐ Technical assistance
- ☑ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 5

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp. Mississippi currently has a Medicaid expansion program. Kaiser Family Foundation. State Health Facts. SCHIP Program Type. www.statehealthfacts.org/comparemaptable.jsp?cat=4&ind=238
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

MISSOURI

Poverty rate[1] among children and youth under 25 (CY07): 19%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☐	☑
Children age 1-5	☐	☐	☐	☑
Children age 6-19	☐	☐	☐	☑

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,626,260	1,618,597	1,607,101
Number of children under 21 years old, with SED served[6]	8,672	9,719	10,356

Total State Children's Mental Health budget (FY05):[7] $59,700,000

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☑ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (question not answered)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

MONTANA

Poverty rate[1] among children and youth under 25 (CY07): 20%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☑	☐	☐
Children age 1-5	☐	☑	☐	☐
Children age 6-19	☐	☑	☐	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: No limit for specified disorders. 21 days / benefit year (mental health and substance abuse treatment combined). 2 partial hospitalization days / inpatient day**.**

Inpatient substance abuse: 21 days / benefit year (mental health and substance abuse treatment combined).

Outpatient mental health and substance abuse: No limit, however treatment must be medically necessary.

	FY04	FY05	FY06
Number of children under 21 years old[5]	254,037	249,907	254,004
Number of children under 21 years old, with SED served[6]	9,454	9,990	9,776

Total State Children's Mental Health budget (FY05):[7] $62,000,000

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority does not currently fund early childhood services directly.

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☐ Funding
- ☑ Shared staffing
- ☐ Planning and program development
- ☐ Policy development
- ☑ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has not developed special initiatives for youth transitioning to the adult system or to independent living.

Evidence-Based Practices (CY06):[10]

The state children's mental health authority is not currently implementing specific strategies to promote the appropriate use of evidence-based strategies.

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (question not answered)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

NEBRASKA

Poverty rate[1] among children and youth under 25 (CY07): 14%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☑	☐	☐
Children age 1-5	☐	☑	☐	☐
Children age 6-19	☐	☑	☐	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	517,879	509,460	508,038
Number of children under 21 years old, with SED served[6]	2,838	2,946	4,180

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☑ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☐ Partnerships with early childhood programs and agencies
- ☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 4

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

NEVADA

Poverty rate[1] among children and youth under 25 (CY07): 14%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: 5 days for the development of a treatment plan more days must be justified on a day-to-day basis.

Outpatient mental health: 6 hours daily, however treatment must be medically necessary.

Outpatient substance abuse: Methadone only.

	FY04	FY05	FY06
Number of children under 21 years old[5]	677,258	699,891	720,417
Number of children under 21 years old, with SED served[6]	1,550	1,611	3,983

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☐ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☐ Training for providers
- ☐ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (question not answered)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

NEW HAMPSHIRE

Poverty rate[1] among children and youth under 25 (CY07): 7%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☐	☑
Children age 1-5	☐	☐	☐	☑
Children age 6-19	☐	☐	☐	☑

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: 15 days / year.

Inpatient substance abuse: Detox only.

Outpatient mental health and substance abuse: 20 visits / year (mental health and substance abuse treatment combined).

	FY04	FY05	FY06
Number of children under 21 years old[5]	360,137	358,400	350,899
Number of children under 21 years old, with SED served[6]	4,869	5,376	8,896

Total State Children's Mental Health budget (FY05):[7] $23,801,663

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☑ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

NEW JERSEY

Poverty rate[1] among children and youth under 25 (CY07): 10%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☐	☑
Children age 1-5	☐	☐	☐	☑
Children age 6-19	☐	☐	☐	☑

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: 35 days / year.

Inpatient substance abuse: No limit.

Outpatient mental health: 25 visits / year (mental health and substance abuse treatment combined).

Outpatient substance abuse: No limit on the number of days, but $25 co-payment per outpatient visit.

	FY04	FY05	FY06
Number of children under 21 years old[5]	2,494,239	2,506,744	2,482,712
Number of children under 21 years old, with SED served[6]	20,925	21,106	22,226

Total State Children's Mental Health budget (FY05):[7] Unable to answer

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☑ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority does not currently fund early childhood services directly.

School-Based Children

The state children's mental health authority is not actively involved in the support of school-based mental health services and supports.

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☐ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☑ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☐ Training for providers
- ☐ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

NEW MEXICO

Poverty rate[1] among children and youth under 25 (CY07): 22%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☐	☐	☑
Non-working parents age 20 and older	☐	☐	☑	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	564,558	574,429	588,616
Number of children under 21 years old, with SED served[6]	Not available	7,058	3,342

Total State Children's Mental Health budget (FY05):[7] $159,000,000

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☑ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☑ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☑ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 5

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

NEW YORK

Poverty rate[1] among children and youth under 25 (CY07): 20%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: 30 days / year (mental health and substance abuse treatment combined).

Outpatient mental health and substance abuse: 60 visits / year (mental health and substance abuse treatment combined).

	FY04	FY05	FY06
Number of children under 21 years old[5]	5,421,675	5,376,213	5,358,777
Number of children under 21 years old, with SED served[6]	110,764	110,764	110,938

Total State Children's Mental Health budget (FY05):[7] $293,787,000

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers

Early childhood mental health consultation programs

- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☑ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☑ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☑ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (question not answered)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

NORTH CAROLINA

Poverty rate[1] among children and youth under 25 (CY07): 20%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: Treatment must be approved prior.

Outpatient mental health and substance abuse: 60 days / year.

	FY04	FY05	FY06
Number of children under 21 years old[5]	2,435,308	2,499,352	2,544,369
Number of children under 21 years old, with SED served[6]	47,335	53,097	49,357

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☑ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☑ Legislative or administrative mandate
- ☑ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☐ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (question not answered)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

NORTH DAKOTA

Poverty rate[1] among children and youth under 25 (CY07): 16%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☑	☐	☐
Children age 1-5	☐	☑	☐	☐
Children age 6-19	☐	☑	☐	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: 60 days / year (or 120 days for partial hospitalization -mental health and substnace abuse combined.

Outpatient mental health and substance abuse: Not Available.

	FY04	FY05	FY06
Number of children under 21 years old[5]	174,520	173,159	174,189
Number of children under 21 years old, with SED served[6]	Not available	2,037	1,792

Total State Children's Mental Health budget (FY05):[7] Unable to answer

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☑ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☑ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (question not answered)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

OHIO

Poverty rate[1] among children and youth under 25 (CY07): 18%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	3,329,847	3,259,596	3,216,519
Number of children under 21 years old, with SED served[6]	Not available	Not available	Not available

Total State Children's Mental Health budget (FY05):[7] $218,850,137

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☑ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☑ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☑ Contracting through local schools
- ☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐*Health insurance and/or other social supports for young adults
- ☐*Transition age young adults can remain and/or return to state guardianship after age 18
- ☐*Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐*Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☐*Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 5

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

OKLAHOMA

Poverty rate[1] among children and youth under 25 (CY07): 20%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☑	☐	☐
Children age 1-5	☐	☑	☐	☐
Children age 6-19	☐	☑	☐	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☐	☑	☐
Non-working parents age 20 and older	☐	☐	☑	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,026,796	1,009,287	1,022,181
Number of children under 21 years old, with SED served[6]	3,328	3,900	4,028

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☑ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☐ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 5

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

OREGON

Poverty rate[1] among children and youth under 25 (CY07): 17%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☑	☐	☐
Children age 1-5	☐	☑	☐	☐
Children age 6-19	☐	☑	☐	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: No limit, however treatment must be medically necessary.

Inpatient substance abuse: Detox only.

Outpatient mental health and substance abuse: No limit, however treatment must be medically necessary.

	FY04	FY05	FY06
Number of children under 21 years old[5]	984,895	996,891	1,006,457
Number of children under 21 years old, with SED served[6]	29,416	30,208	31,603

Total State Children's Mental Health budget (FY05):[7] $83,632,811

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☐ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☑ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 3

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

PENNSYLVANIA

Poverty rate[1] among children and youth under 25 (CY07): 16%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☐	☑
Children age 1-5	☐	☐	☐	☑
Children age 6-19	☐	☐	☐	☑

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☐	☑	☐
Non-working parents age 20 and older	☐	☐	☑	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: 90 days (mental health and substance abuse treatment combined).

Outpatient mental health and substance abuse: 50 visits / year (mental health and substance abuse treatment combined).

	FY04	FY05	FY06
Number of children under 21 years old[5]	3,338,895	3,332,463	3,325,672
Number of children under 21 years old, with SED served[6]	35,797	28,854	46,951

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☑ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority does not currently fund early childhood services directly.

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☑ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☑ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☐ Training for providers
- ☐ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 5

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

PUERTO RICO

Poverty rate[1] among children and youth under 25 (CY07): Not available

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08) Not available

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08) Not available

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Not applicable

	FY04	FY05	FY06
Number of children under 21 years old[5]	Not available	Not available	Not available
Number of children under 21 years old, with SED served[6]	Not available	2,216	3,155

Total State Children's Mental Health budget (FY05):[7] Unable to answer

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

☐*Primarily the State Medicaid Authority/Director

☐*Primarily the State Mental Health Authority/Director

☐*The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director

☐*Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority does not currently fund early childhood services directly.

School-Based Children

The state children's mental health authority is not actively involved in the support of school-based mental health services and supports.

Transition-Age Youth

The state children's mental health authority has not developed special initiatives for youth transitioning to the adult system or to independent living.

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

☐ Legislative or administrative mandate

☐ Fiscal incentives (i.e., higher reimbursement rates)

☑ Funds for associated start-ups costs

☐ Funds for implementation

☐ Umbrella mechanism for bulk purchasing

☑ Training for providers

☑ Technical assistance

☑ State dissemination infrastructure

☑ Academic partnerships (workforce development)

☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.

2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).

3. Ibid.

4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.

5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.

6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp; FY05 figure provided by commonwealth contact as cited in Canino, et al 2004.

7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*

8. Ibid.

9. Ibid.

10. Ibid.

11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

RHODE ISLAND

Poverty rate[1] among children and youth under 25 (CY07): 15%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	292,001	297,492	294,281
Number of children under 21 years old, with SED served[6]	3,759	3,885	3,988

Total State Children's Mental Health budget (FY05):[7] $80,000,000

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☑ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☑ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☑ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

SOUTH CAROLINA

Poverty rate[1] among children and youth under 25 (CY07): 19%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,199,936	1,194,830	1,183,405
Number of children under 21 years old, with SED served[6]	32,905	33,116	31,963

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☑ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☑ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 4

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

SOUTH DAKOTA

Poverty rate[1] among children and youth under 25 (CY07): 16%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: No limit, however treatment must be medically necessary.

Inpatient substance abuse: Detox only.

Outpatient mental health and substance abuse: No limit.

	FY04	FY05	FY06
Number of children under 21 years old[5]	229,692	225,968	223,381
Number of children under 21 years old, with SED served[6]	4,136	4,283	4,500

Total State Children's Mental Health budget (FY05):[7] $5,656,115

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☑ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is not actively involved in the support of school-based mental health services and supports.

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☐ Health insurance and/or other social supports for young adults
- ☑ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

TENNESSEE

Poverty rate[1] among children and youth under 25 (CY07): 20%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,637,091	1,645,867	1,654,876
Number of children under 21 years old, with SED served[6]	28,952	32,924	31,850

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

☐*Primarily the State Medicaid Authority/Director

☐*Primarily the State Mental Health Authority/Director

☐*The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director

☐*Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

☐ Early childhood mental health specialists in community mental health centers

☑ Early childhood mental health consultation programs

☐ Reimbursement for use of social and emotional screening tools

☑ Partnerships with early childhood programs and agencies

☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness

☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

☐ Positive Behavioral Interventions and Supports (PBIS/PBS)

☐ School-based mental health clinics/school-based health clinics

☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE

☐ School-wide efforts that promote social and emotional learning

☐ Targeted support for school-based services to children/youth with SED

☑ Other

The nature of the state children's mental health authority involvement:

☑ Funding

☐ Shared staffing

☑ Planning and program development

☑ Policy development

☐ Contracting through local schools

☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

☐ Health insurance and/or other social supports for young adults

☐ Transition age young adults can remain and/or return to state guardianship after age 18

☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation

☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds

☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

☑ Legislative or administrative mandate

☐ Fiscal incentives (i.e., higher reimbursement rates)

☐ Funds for associated start-ups costs

☐ Funds for implementation

☐ Umbrella mechanism for bulk purchasing

☐ Training for providers

☐ Technical assistance

☐ State dissemination infrastructure

☐ Academic partnerships (workforce development)

☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.

2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).

3. Ibid.

4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.

5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.

6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp

7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*

8. Ibid.

9. Ibid.

10. Ibid.

11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

TEXAS

Poverty rate[1] among children and youth under 25 (CY07): 23%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: 30 days / year.

Inpatient substance abuse: 5 days / year (or 30 days residential).

Outpatient mental health and substance abuse: 30 visits / year (mental health and substance abuse treatment combined).

	FY04	FY05	FY06
Number of children under 21 years old[5]	7,114,864	7,247,673	7,364,346
Number of children under 21 years old, with SED served[6]	42,724	45,089	47,037

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☑ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED

Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☑ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has not developed special initiatives for youth transitioning to the adult system or to independent living.

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☑ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☐ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 6

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

UTAH

Poverty rate[1] among children and youth under 25 (CY07): 13%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: 30 days / year.

Outpatient mental health and substance abuse: 30 visits / year.

	FY04	FY05	FY06
Number of children under 21 years old[5]	871,206	869,873	883,600
Number of children under 21 years old, with SED served[6]	8,361	9,103	9,961

Total State Children's Mental Health budget (FY05):[7] $8,026,381

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

☐*Primarily the State Medicaid Authority/Director

☐*Primarily the State Mental Health Authority/Director

☐*The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director

☐*Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

☑ Early childhood mental health specialists in community mental health centers

☑ Early childhood mental health consultation programs

☐ Reimbursement for use of social and emotional screening tools

☑ Partnerships with early childhood programs and agencies

☑ Partnerships with state adult systems to address the needs of children and youth in families with mental illness

☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

☑ Positive Behavioral Interventions and Supports (PBIS/PBS)

☑ School-based mental health clinics/school-based health clinics

☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE

☐ School-wide efforts that promote social and emotional learning

☑ Targeted support for school-based services to children/youth with SED

☐ Other

The nature of the state children's mental health authority involvement:

☑ Funding

☐ Shared staffing

☑ Planning and program development

☑ Policy development

☐ Contracting through local schools

☑ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

☑ Health insurance and/or other social supports for young adults

☑ Transition age young adults can remain and/or return to state guardianship after age 18

☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation

☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds

☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

☐ Legislative or administrative mandate

☐ Fiscal incentives (i.e., higher reimbursement rates)

☐ Funds for associated start-ups costs

☐ Funds for implementation

☐ Umbrella mechanism for bulk purchasing

☑ Training for providers

☑ Technical assistance

☑ State dissemination infrastructure

☐ Academic partnerships (workforce development)

☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 6

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.

2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).

3. Ibid.

4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.

5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.

6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp

7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*

8. Ibid.

9. Ibid.

10. Ibid.

11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

VERMONT

Poverty rate[1] among children and youth under 25 (CY07): 10%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☐	☑
Children age 1-5	☐	☐	☐	☑
Children age 6-19	☐	☐	☐	☑

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☐	☑	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: No limit.

Outpatient mental health and substance Abuse: 5 visits / month (or otherwise authorized).

	FY04	FY05	FY06
Number of children under 21 years old[5]	161,406	162,606	161,724
Number of children under 21 years old, with SED served[6]	Not available	Not available	2,371

Total State Children's Mental Health budget (FY05):[7] $47,435,275

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☑ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☑ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☑ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☐ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 5

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

VIRGINIA

Poverty rate[1] among children and youth under 25 (CY07): 13%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health: 30 days / year.

Inpatient substance abuse: 90 days.

Outpatient mental health and substance abuse: 50 visits / year (mental health and substance abuse treatment combined).

	FY04	FY05	FY06
Number of children under 21 years old[5]	2,103,305	2,118,690	2,122,721
Number of children under 21 years old, with SED served[6]	13,492	14,807	15,425

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority does not currently fund early childhood services directly.

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☐ School-based mental health clinics/school-based health clinics
- ☐ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☑ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has not developed special initiatives for youth transitioning to the adult system or to independent living.

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not completed)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

WASHINGTON

Poverty rate[1] among children and youth under 25 (CY07): 13%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☐	☑	☐
Non-working parents age 20 and older	☐	☐	☑	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: Beneficiaries may not remain in the hospital beyond a length of time specified by the State without the permission of the Medicaid agency or it's designated agent. The length of time varies by diagnosis and is based on the average length of stay for Western states.

Outpatient mental health and substance abuse: Not Available.

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,753,995	1,739,015	1,744,139
Number of children under 21 years old, with SED served[6]	10,012	26,272	33,120

Total State Children's Mental Health budget (FY05):[7] *

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

☐ Primarily the State Medicaid Authority/Director
☑ Primarily the State Mental Health Authority/Director
☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority does not currently fund early childhood services directly.

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

☐*Positive Behavioral Interventions and Supports (PBIS/PBS)
☐*School-based mental health clinics/school-based health clinics
☐*Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
☐*School-wide efforts that promote social and emotional learning
☐*Targeted support for school-based services to children/youth with SED
☐*Other

The nature of the state children's mental health authority involvement:

☐*Funding
☐*Shared staffing
☐*Planning and program development
☐*Policy development
☐*Contracting through local schools
☐*Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

☑ Health insurance and/or other social supports for young adults
☑ Transition age young adults can remain and/or return to state guardianship after age 18
☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

☑ Legislative or administrative mandate
☐ Fiscal incentives (i.e., higher reimbursement rates)
☑ Funds for associated start-ups costs
☑ Funds for implementation
☐ Umbrella mechanism for bulk purchasing
☑ Training for providers
☑ Technical assistance
☐ State dissemination infrastructure
☑ Academic partnerships (workforce development)
☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 6

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

WEST VIRGINIA

Poverty rate[1] among children and youth under 25 (CY07): 21%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: 30 days / calendar year (or 60 days for partial hospitalization).

Outpatient mental health and substance abuse: 26 visits / calendar year.

	FY04	FY05	FY06
Number of children under 21 years old[5]	458,734	453,793	453,811
Number of children under 21 years old, with SED served[6]	Not available	18,174	17,633

Total State Children's Mental Health budget (FY05):[7] $2,000,000

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☑ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☐ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐*Early childhood mental health specialists in community mental health centers
- ☐*Early childhood mental health consultation programs
- ☐*Reimbursement for use of social and emotional screening tools
- ☐*Partnerships with early childhood programs and agencies
- ☐*Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐*Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☑ Shared staffing
- ☑ Planning and program development
- ☐ Policy development
- ☑ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☑ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☐ Funds for associated start-ups costs
- ☐ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☐ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☑ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 4

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

WISCONSIN

Poverty rate[1] among children and youth under 25 (CY07): 16%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☐	☑	☐	☐
Non-working parents age 20 and older	☐	☑	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4] Medicaid expansion

	FY04	FY05	FY06
Number of children under 21 years old[5]	1,559,937	1,540,680	1,527,606
Number of children under 21 years old, with SED served[6]	Not available	7,756	6,677

Total State Children's Mental Health budget (FY05):[7] $2,908,300

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☐ Early childhood mental health specialists in community mental health centers
- ☐ Early childhood mental health consultation programs
- ☐ Reimbursement for use of social and emotional screening tools
- ☐ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☑ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☐ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☑ School-wide efforts that promote social and emotional learning
- ☑ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has not developed special initiatives for youth transitioning to the adult system or to independent living.

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☑ Legislative or administrative mandate
- ☑ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☑ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] * (survey not answered)

* Missing answer.

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

WYOMING

Poverty rate[1] among children and youth under 25 (CY07): 16%

Children's Medicaid/SCHIP eligibility[2] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Children under age 1	☐	☐	☑	☐
Children age 1-5	☐	☐	☑	☐
Children age 6-19	☐	☐	☑	☐

Adult Medicaid/SCHIP eligibility[3] as a percent of the Federal Poverty Level (CY08)

	Less than 100%	100-199%	200-299%	300% or more
Working parents age 20 and older	☑	☐	☐	☐
Non-working parents age 20 and older	☑	☐	☐	☐
Pregnant women age 20 and older	☐	☑	☐	☐

Mental health coverage by non-Medicaid, SCHIP (CY03):[4]

Inpatient mental health and substance abuse: No limit, however treatment must be approved prior.

Outpatient mental health and substance abuse: No limit, however treatment must be medically necessary.

	FY04	FY05	FY06
Number of children under 21 years old[5]	140,844	139,857	140,516
Number of children under 21 years old, with SED served[6]	Not available	7,510	1,706

Total State Children's Mental Health budget (FY05):[7] $24,227,113

Responsible party for state decisions regarding reimbursable child and youth mental health services under Medicaid (CY06):[8]

- ☐ Primarily the State Medicaid Authority/Director
- ☐ Primarily the State Mental Health Authority/Director
- ☑ The State Medicaid Authority/Director in close consultation with the state Mental Health Authority/Director
- ☐ Other

Developmentally Appropriate Services (CY06):[9]

Young Children

The state children's mental health authority currently funds early childhood services directly, including:

- ☑ Early childhood mental health specialists in community mental health centers
- ☑ Early childhood mental health consultation programs
- ☑ Reimbursement for use of social and emotional screening tools
- ☑ Partnerships with early childhood programs and agencies
- ☐ Partnerships with state adult systems to address the needs of children and youth in families with mental illness
- ☐ Other

School-Based Children

The state children's mental health authority is actively involved in the support of school-based mental health services and supports including:

- ☑ Positive Behavioral Interventions and Supports (PBIS/PBS)
- ☑ School-based mental health clinics/school-based health clinics
- ☑ Partnerships with state Department of Education (DOE) and/or Department of Special Education within DOE
- ☐ School-wide efforts that promote social and emotional learning
- ☐ Targeted support for school-based services to children/youth with SED
- ☐ Other

The nature of the state children's mental health authority involvement:

- ☑ Funding
- ☐ Shared staffing
- ☑ Planning and program development
- ☑ Policy development
- ☐ Contracting through local schools
- ☐ Other

Transition-Age Youth

The state children's mental health authority has developed special initiatives for youth transitioning to the adult system or to independent living including:

- ☑ Health insurance and/or other social supports for young adults
- ☐ Transition age young adults can remain and/or return to state guardianship after age 18
- ☐ Federal or state demonstration or program that relaxes some of the SSI-related rules that discourage work participation
- ☐ Partnerships with businesses/private organizations to create workforce opportunities for 18-21 year olds
- ☐ Other

Evidence-Based Practices (CY06):[10]

The state children's mental health authority evidence-based strategies include:

- ☐ Legislative or administrative mandate
- ☐ Fiscal incentives (i.e., higher reimbursement rates)
- ☑ Funds for associated start-ups costs
- ☑ Funds for implementation
- ☐ Umbrella mechanism for bulk purchasing
- ☑ Training for providers
- ☑ Technical assistance
- ☐ State dissemination infrastructure
- ☑ Academic partnerships (workforce development)
- ☐ Other

Cultural and Linguistic Competence Self-Assessment Level (CY08):[11] 4

1. NCCP analysis of the Current Population Survey, March Supplements 2006, 2007, and 2008. A three-year average was used due to small sample sizes.
2. Cohen Ross, Donna; Horn, Aleya; Marks, Caryn. 2008. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008. Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/upload/7740.pdf (accessed July 24, 2008).
3. Ibid.
4. Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *State Profiles of Mental Health and Substance Abuse Services in Medicaid.* mentalhealth.samhsa.gov/publications/allpubs/state_med/default.asp.
5. NCCP analysis of the Current Population Survey, March Supplements 2003-2007. Three-year averages were used due to small sample sizes.
6. SED – Serious Emotional Disturbance; Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. *Center for Mental Health Services Uniform Reporting System Output Tables.* http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp
7. National Center for Children in Poverty. 2006. *Unclaimed Children Revisited Survey of State Children's Mental Health Directors.*
8. Ibid.
9. Ibid.
10. Ibid.
11. On a scale of 1 (not doing well at all) to 10 (doing exceptionally well). National Center for Children in Poverty. 2008. *Unclaimed Children Revisited: Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health.*

Appendix 1: Advisors

National Advisors

Mary Lee Allen, MSW
Director of Child Welfare and Mental Health
Children's Defense Fund

William Arroyo, MD
Medical Director
Child Youth and Family Program Administration
Los Angeles County Department of Mental Health

Marc Atkins, PhD
Associate Professor of Psychology
Department of Psychiatry, College of Medicine
University of Illinois at Chicago

Doreen A. Cavanaugh, PhD
Research Associate Professor
Health Policy Institute
Georgetown University

Shannon Crossbear
Co-Director of Training and Evaluation
Federation of Families for Children's Mental Health

Sheri Falvay
Director
Mental Health Services to Children and Families
Michigan Department of Community Health

Robert Friedman, PhD
Department of Child and Family Studies
Louis de la Parte Florida Mental Health Institute

Barbara Friesen, PhD
Director
Research and Training Center on Family Support and Children's Mental Health
Regional Research Institute
Portland State University

Sherry A. Glied, PhD
Department Chair, Health Policy and Management
Mailman School of Public Health, Columbia University

Michael F. Hogan, PhD
Commissioner
Office of the Commissioner
New York State Office of Mental Health

Larke Huang, PhD
Office of the Administrator
SAMHSA

Chris Koyanagi
Director of Policy
The Bazelon Center for Mental Health Law

Suniya Luthar, PhD
Professor of Psychology and Education
Department of Human Development
Teachers College, Columbia University

Kenneth Martinez, PsyD
Mental Health Resource Specialist
Technical Assistance Partnership
for Children and Families Mental Health
American Institutes for Research

Joanne Nicholson, PhD
Associate Professor of Psychiatry and Family Medicine
Center for Mental Health Services Research, Department of Psychiatry, University of Massachusetts Medical School

Sandra Spencer
Executive Director
National Federation of Families for Children's Mental Health

Cynthia Wainscott
Board Member
National Mental Health Association
World Federation of Mental Health

John Weisz, PhD
President
Judge Baker Children's Center

California Advisors

William Arroyo, MD
Medical Director
Child Youth and Family Program Administration
Los Angeles County Department of Mental Health

Bill Carter, LCSW
Deputy Director
California Institute for Mental Health

Sai-Ling Chan-Sew, LCSW
Section Director
Community Behavioral Health Services
Child, Youth and Family System of Care
San Francisco Department of Public Health

Jennifer Clancy, MSW

Rachel Guerrero, LCSW
Chief, Office of Multicultural Services
State Department Mental Health

Perry Jones
Youth Advocate

John Landsverk, PhD
Senior Research Scientist
Child and Adolescent Services Research Center
Children's Hospital of San Diego

Rosa Ana Lozada-Garcia, LCSW
Chief Executive Officer
Harmonium, INC

Abram Rosenblatt, PhD
Professor, Department of Psychiatry
University of California, San Francisco

Gale Walker
Bronze Triangle
Community Development Corporation

Rosa E. Warder, MFA
Family Relations Manager
Alameda County Behavioral Health Care Services

Constance M. Weisner, DrPH, MSW
Professor, Department of Psychiatry
University of California, San Francisco

Captain Young
Youth Advocate

Michigan Advisors

Sheri Falvay
Director
Mental Health Services to Children and Families
Michigan Department of Community Health

Dean Fixsen, PhD
Co-Director
National Implementation Research Network
Louis de la Parte Florida Mental Health Institute
University of South Florida

Shari Goldman
Evidence-Base Practice Coordinator
Easter Seals

Kay Hodges, PhD
Professor
Eastern Michigan University

Malisa Pearson
Impact Lead Family Contact
Impact, Ingham County System of Care Initiative
Ingham Counseling Center

Carrie Banks-Patterson
Coordinator, Children's Initiatives
Detroit-Wayne County Children and Family Services

Cynthia Smith
Executive Director/President
Juvenile Assessment Center

Matthew A. Vergith
Director, Children's Services
Livingston County Community Mental Health Authority

James Wotring, MSW
Director
National Technical Assistance Center for Children's Mental Health
Georgetown University Center for Child and Human Development

Advisors/Consultants to Other Studies

Special Study on States' Knowledge and Practices for Cultural and Linguistic Competence in Children's Mental Health

Renata J. Henry, MA
Deputy Secretary for Behavioral Health and Disabilities
Maryland Department of Health and Mental Hygiene

Cathy Cave
Former Cultural Competence Coordinator
New York State Office of Mental Health

Kathy Jefferson, MA, LISCW
State-Local Liaison/Mental Health Program Consultant
Minnesota Department of Human Services

David Nielsen, MSW
Deputy Director, Program Services Division
California Department of Alcohol and Drug Programs

Unclaimed Children Revisited: Survey of State Affiliates Mental Health America

Raymond Crowel, PsyD
Former Vice President, Mental Health and Substance Abuse Services
Mental Health America

Luanne Southern, MSW
Deputy Commissioner
Texas Department of State Health Services

David Shern, PhD
President and Chief Executive Officer
Mental Health America

Cynthia Wainscott
Former Board President
Mental Health America

Appendix 2

Table A: Racial Ethnic Minority Groups States Report They Serve Well and Struggle to Serve

	Racial/Ethnic Minority Groups Served Well				Racial/Ethnic Minority Groups Struggled to Serve Appropriately			
	African-American/Blacks/Africans	Asians/Pacific Islanders	Hispanics/Latin	American-Indians/Alaskan Natives	African- American/Blacks/Africans	Asians/Pacific Islanders	Hispanics/Latinos	American-Indians/Alaskan Natives
ALABAMA			✓					
ARKANSAS	✓	✓	✓	✓	✓	✓	✓	✓
ARIZONA					✓	✓	✓	✓
CALIFORNIA	✓	✓	✓	✓	✓	✓	✓	✓
COLORADO							✓	
CONNECTICUT	✓	✓	✓					
DISTRICT OF COLUMBIA	✓	✓	✓	✓		✓	✓	✓
DELAWARE	✓						✓	✓
FLORIDA	✓				✓	✓	✓	✓
GEORGIA	✓					✓	✓	
HAWAII		✓				✓		
ILLINOIS	✓		✓			✓		
INDIANA	✓						✓	
KENTUCKY[1]	✓						✓	
LOUISIANA	✓	✓	✓					✓
MAINE[2]	✓	✓	✓	✓				
MARYLAND	✓	✓	✓					
MASSACHUSETTS[3]	✓	✓	✓		✓	✓	✓	
MINNESOTA	✓	✓	✓	✓	✓	✓	✓	✓
MISSISSIPPI	✓						✓	✓
MONTANA				✓				✓
NEBRASKA							✓	
NORTH CAROLINA	✓			✓			✓	
NORTH DAKOTA								✓
OHIO	✓				✓	✓	✓	✓
OKLAHOMA	✓			✓		✓	✓	
OREGON			✓			✓		
PENNSYLVANIA					✓	✓	✓	✓
SOUTH CAROLINA					✓		✓	✓
TEXAS			✓			✓		
UTAH[4]				✓	✓	✓	✓	
VERMONT[5]			✓		✓		✓	✓
WEST VIRGINIA	✓	✓	✓	✓	✓	✓	✓	

1. Indicated groups from Appalachia served well.
2. Indicated deaf or hard of hearing groups served well.
3. Indicated struggled to serve refugees with low incidence languages.
4. Indicated struggled to serve deaf or hard of hearing groups.
5. Indicated struggled to serve groups from Croatia or Bosnia.

Table B: Language Groups States Report They Serve Well and Struggle to Serve

	Language Groups with Limited English Proficiency Served Well											Language Groups with Limited English Proficiency Struggled to Serve Appropriately										
	Spanish	Chinese (Mandarin/Cantonese)	French/French Creole	German	Tagalog	Vietnamese	Italian	Korean	Russian	Polish	Arabic	Spanish	Chinese (Mandarin/Cantonese)	French/French Creole	German	Tagalog	Vietnamese	Italian	Korean	Russian	Polish	Arabic
ARKANSAS	✓																					
ARIZONA												✓	✓									✓
CALIFORNIA	✓											✓										
COLORADO	✓	✓			✓	✓		✓								✓				✓		✓
CONNECTICUT	✓	✓								✓												
DISTRICT OF COLUMBIA[1]	✓					✓							✓						✓			✓
DELAWARE												✓										
FLORIDA	✓												✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GEORGIA	✓											✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HAWAII													✓	✓		✓	✓		✓			
ILLINOIS	✓												✓		✓		✓		✓			✓
INDIANA												✓										
KENTUCKY												✓										
LOUISIANA	✓		✓														✓					
MAINE[2]	✓		✓			✓			✓													✓
MARYLAND																						
MASSACHUSETTS[3]	✓	✓							✓					✓			✓					
MINNESOTA[4]	✓					✓																
MISSISSIPPI	✓											✓					✓					
MISSOURI[5]																						
MONTANA																						
NEBRASKA	✓												✓				✓					
NEW MEXICO	✓																					
NORTH CAROLINA						✓						✓										
NORTH DAKOTA												✓										
OHIO[6]												✓										
OKLAHOMA												✓										
PENNSYLVANIA												✓					✓					
SOUTH CAROLINA	✓											✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
TEXAS	✓												✓				✓		✓			
UTAH[7]	✓					✓																
VERMONT[8]												✓		✓								
WASHINGTON	✓																			✓		
WEST VIRGINIA[9]												✓										
WYOMING	✓															✓						

1. Indicated Amharic speaking groups served well.
2. Indicated American sign language groups served well, but struggled to serve Somali speaking groups.
3. Indicated struggled to serve low incidence languages with newcomer groups.
4. Indicated Hmong speaking groups served well.
5. Indicated struggled to serve deaf groups.
6. Indicated struggled to serve Somali speaking groups.
7. Indicated struggled to serve refugee groups.
8. Indicated struggled to serve Croatian speaking groups.
9. Indicated struggled to serve hearing impaired groups.

Appendix 3

Advocacy Organizations States Report They Fund and Type of Services They Provide

State	Organization	Advocacy	Training	Education	Family Support*	Treatment and Direct Service
AK	Federation of families: Alaska Youth and Family Network	✓	✓	✓	✓	
AR	Federation of Families for Children's Mental Health	✓	✓	✓		
AR	NAMI	✓		✓	✓	
AZ	Family Involvement Center	✓			✓	
AZ	Mentally Ill Kids in Distress (MIKID)	✓	✓	✓	✓	✓
CA	United Advocates for Children of California	✓	✓	✓	✓	
CA	Pacific News Services	✓		✓		
CO	Jefferson Family Support Network (JFSN)/ Federation of Families for Children's Mental Health-Colorado Chapter	✓		✓	✓	
CO	Family Agency Collaboration (FAC)	✓		✓	✓	
CO	Federation of Families for Children's Mental Health	✓		✓	✓	
CT	FAVOR	✓	✓		✓	
DC	Family Advocacy and Support Association (FASA)	✓	✓	✓	✓	
DC	Total Family Coalition	✓	✓		✓	✓
DE	MHA	✓		✓	✓	
FL	Federation of Families	✓	✓	✓		
FL	NAMI	✓	✓	✓		
GA	Georgia Parent Support Network	✓	✓	✓	✓	
GUAM	Guam Identifies Families Terrific Strengths (G.I.F.T.S.)	✓				
HI	Hawaii Families as Allies	✓	✓	✓	✓	
HI	Wai Aka,- Young Adult Support org. (Part of Youth Community Center)				✓	
IA	Mid-Iowa Family Therapy					✓
ID	Federation of Families	✓	✓	✓	✓	
IN	Family Action network of Lake Co.	✓		✓	✓	
KS	Keys for networking		✓	✓	✓	
KS	MHA	✓	✓	✓	✓	
KS	NAMI	✓		✓	✓	
KY	Kentucky Partnership for Families and Children		✓	✓	✓	
LA	Families Helping Families	✓	✓	✓	✓	
LA	Federation of Families	✓			✓	
LA	MHA	✓		✓		
LA	NAMI	✓	✓	✓	✓	
MA	Parent Professional Advocacy League	✓		✓	✓	
MA	M-Power	✓				
ME	Autism Society of Maine	✓		✓		
ME	GEAR Parent Network	✓		✓	✓	
ME	Maine Parent Federation	✓	✓	✓	✓	
ME	NAMI	✓		✓	✓	✓
MI	Association for Children's Mental Health	✓	✓	✓	✓	
MN	Minnesota Parent Leadership Network	✓		✓	✓	
MN	PACER	✓	✓	✓	✓	
MS	Families as Allies	✓	✓	✓	✓	✓
MS	NAMI	✓		✓	✓	
NC	Families United, Inc	✓		✓	✓	

Advocacy Organizations States Report They Fund and Type of Services They Provide (cont)

State	Organization	Advocacy	Training	Education	Family Support*	Treatment and Direct Service
NC	MHA	✓		✓		✓
NC	NAMI	✓	✓	✓	✓	
NC	Powerful Youth	✓			✓	
NC	Young Family Network		✓	✓		
ND	Parent to Parent Support Contract- MHSA Division				✓	
NH	Contract specific to youth leadership development		✓	✓	✓	
NH	Casey Family Services					✓
NH	NH funds family and youth support and education activities and does not fund advocacy			✓	✓	
NH	The Federation of Families for Children's Mental Health	✓				
NH	The Foster and Adoptive Parents Association	✓		✓		
NJ	Funded 5 areas that cover the state, the locally contracted groups are known Family Support Organizations and Youth Partnerships.	✓		✓	✓	
NM	Parents for Behaviorally Different Children	✓	✓	✓	✓	
NV	Parents Encouraging Parents (Nevada PEP)	✓	✓	✓		
NY	Families Together in New York State (FTNYS)-	✓	✓	✓	✓	
NY	Puerto Rican Family Institute	✓				✓
OH	Federation of Families for children's MH	✓		✓	✓	
OH	NAMI	✓		✓	✓	
OR	Family Support Network	✓	✓	✓	✓	
PA	MHA	✓		✓		
PA	NAMI	✓		✓	✓	
PA	Provide non-financial support to the SAMHSA funded statewide network project, Pennsylvania families, Inc.	✓		✓		
RI	International Institute	✓	✓	✓	✓	
RI	Narragansett Tribe -Indian Health Center					✓
RI	Parent Support Network	✓	✓	✓	✓	
RI	Youth Pride	✓	✓	✓	✓	
RI	Project Hope					✓
RI	Positive Education Partnership		✓	✓		
SC	Federation of Families	✓		✓	✓	
SC	NAMI	✓				
TN	Federation of Families: Voices for Children	✓	✓	✓	✓	
TX	MHA	✓		✓		
UT	Allies with Families	✓	✓	✓	✓	
UT	LINCS (Liaison for Individuals Needing Coordinating Services)	✓	✓	✓	✓	✓
UT	NAMI	✓		✓	✓	
UT	New Frontiers for families	✓	✓	✓	✓	✓
VA	Federation of Families (Medical Home Plus)	✓	✓	✓	✓	
VT	Federation of Families for Children's Mental Health	✓		✓	✓	
WA	SAFE- Statewide Advocacy for Family Empowerment	✓	✓	✓	✓	
WI	Family Ties for Youth Family Advocacy	✓		✓		
WI	NAMI	✓	✓	✓	✓	
WV	Legal Aid of West Virginia, Inc.	✓				
WY	UPLIFT	✓		✓	✓	✓
WY	WAY	✓			✓	

* Family Support is defined as providing family member and youth support, including, but not limited to peer to peer support

National Center for Children in Poverty
Mailman School of Public Health
Columbia University

215 West 125th Street, New York, NY 10027
TEL 646-284-9600 ■ FAX 646-284-9623
www.nccp.org