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DEVELOPING EARLY CHILDHOOD MENTAL HEALTH TREATMENT SERVICES FOR BIRTH TO FIVE YEAR OLDS IN ALAMEDA COUNTY 2002-2007

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in collaboration with EPSDT 0-5 Committee

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INTRODUCTION

Four years ago approximately 484 children birth to five years received mental health services through Early Periodic Screening Diagnosis and Treatment (EPSDT) annually. By the end of June 2007, almost three times the number of children (1,354) received services. This represents an unprecedented and exciting expansion of resources for this vulnerable population. The development of a countywide strategy to increase services has enormously improved our capacity to treat our youngest citizens and hopefully mitigate any lasting mental health problems. Despite this expansion, there are still many children in our county who could benefit from services, but are unable to receive them. They are either not identified early enough, or do not meet the eligibility requirements for EPSDT-funded services. The stigma associated with mental health diagnosis and treatment is especially pronounced for young children and remains an important factor that hampers efforts to engage families.

STATEMENT OF NEED

An estimated 1 in 10 children and adolescents in the United States suffers from mental illness severe enough to cause some level of impairment (Surgeon General's National Action Agenda on Children's Mental Health, January 3, 2001). Fewer than one in five of these children receive treatment (NIMH). Nationwide, early childhood mental health treatment services are growing. Research has shown that the earlier one can intervene to provide mental health support to a child, the greater the cost savings will be later on (Alicia Lieberman Study). At a September 2000 Surgeon General's Conference on Children's Mental Health, it was stated that "Mental Health is a critical component of children's learning and general health. Fostering the social and emotional health in children as part of healthy child development must therefore be a national priority."

Early Childhood Mental Health Treatment is predicated on the assumption that a young child does not exist outside of the context of the family. Young children can exhibit mental health problems as young as a few months old. When treating a young child, the primary caretaker(s) must also be part of the treatment. Research on the development of the child's brain demonstrated that negative interactions between a child and caregiver influence the development of the brain and the child's subsequent ability to form interpersonal relationships and manage emotions (Schore 1994, Siegel 1999).

BEHAVIORAL HEALTH CARE SERVICES 0-5 PROGRAMS PRIOR TO EPSDT EXPANSION

Prior to the expansion of EPSDT funding in 2003, Alameda County Behavioral Health Care Services funded a range of 0-5 services, primarily through Medi-Cal. These services included intensive day treatment at Seneca Center Building Blocks program and East Bay Agency for Children (EBAC) Therapeutic Nursery School. Children's Hospital and Research Center Oakland (CHRCO) was already providing services through the Center for the Vulnerable Child and other early intervention programs. There were also about a dozen community-based providers whose programs included

services for 0-5 year olds, but most of those programs did not specialize in the birth to five population. For example, Parental Stress provided outpatient services to 38 children under six at that time. Most of those programs continue today. However, specialized expertise in mental health services for 0-5 year olds was nascent in its development and not widespread in this county. This report's primary focus is the story of how expansion of EPSDT reimbursement for early childhood mental health hastened the development of a coordinated system for identifying and delivering mental health services to very young children.

PHASE 1 EPSDT EXPANSION

Identifying a County Cohort of 0-5 Providers in the County

In 2003, Behavioral Health Care Services initiated a county-wide expansion of EPSDT services. As part of this expansion, one of the targeted groups for funding was 0-5 year olds. Agencies that had the skills to provide infant and early childhood mental health treatment and the capacity to support an EPSDT infrastructure were identified and funded.

Formation of the EPSDT 0-5 Committee

When agencies serving 0-5 year old children were funded, County Administrators requested that service providers coordinate to develop an effective system for serving young children. As a result, the EPSDT 0-5 Committee began meeting in September 2003. The committee's goal was to ensure county- wide coordination of EPSDT services for the birth to 5 population and to provide support to new EPSDT providers. Committee members also shared knowledge with one another on program development and program monitoring. The group has continued to meet for the last 4 years.

The following agencies received EPSDT expansion funding to serve 0-5 year olds and participate in the EPSDT Coordination Committee:

1. A Better Way Alameda County Behavioral Health Care Services/ Early Childhood Consultation and Treatment Program
2. Asian Community Mental Health Services
3. Children's Hospital and Research Center at Oakland Early Childhood Mental Health Program
4. City of Fremont Youth and Family Services- Infant Toddler Program
5. Family Paths (formerly Parental Stress Service)
6. FSSBA-Family Support Services of the Bay Area
7. Jewish Family and Children's Services of the East Bay
8. Kidango
9. La Familia Counseling Services
10. Brighter Beginnings (formerly The Perinatal Council)
11. Through the Looking Glass
12. Tiburcio Vasquez Health Center

The committee focused on a variety of issues to ensure county-wide coordination of services for children 0-5 including:

1. Development of EPSDT documentation to meet auditing guidelines
2. Quality assurance and best practice documentation standards
3. Quality administrative practices for an EPSDT program
4. Outreach and education to the community regarding Early Childhood Mental Health Treatment Services
5. Development of outcome indicators that can be used across programs
6. Coordination of referrals and obstacles to successful entry to treatment
7. Identification of challenges in diagnosing infants and toddlers
8. Coordination with the Behavioral Health Care Services ACCESS system

The committee developed a system for tracking which agencies have openings each month so that waiting lists are minimized. Additionally, this system allows agencies to meet the linguistic, cultural and geographic needs of children and families referred for services.

Intervention Strategies and Successes

Young children often do not have the ability to verbally express their feelings. Instead, their feelings are often communicated by acting-out behavior. Effective intervention strategies help caregivers understand a child's emotional experiences, temperament and behavior and seek to provide the caregiver with tools to assist in interpreting and responding to the child's behavior. These tools include:

- Teaching a parent to label, name and understand a child's behavior
- Helping a parent have developmentally appropriate expectations for their child
- Supporting consistent limit setting and positive discipline strategies
- Establishing structure and routines for young children
- Fostering parent-child interactions that allow the child to learn self- soothing behaviors and to manage his or her emotions in an appropriate manner
- Exploring with a caregiver how their mental health impacts the child's social emotional well being.
- Helping the young child develop resilience in the face of prior trauma

The following vignettes illustrate the successes achieved in the first four years of EPSDT expansion based on the work of committee members that utilized an early childhood mental health relationship-based approach to treatment.

Immigrant Families

A Middle Eastern mother with three very young children sought services for help in dealing with aggressive behaviors and nightmares experienced by her oldest child. Mother is an immigrant with a history of sexual abuse who has been clinically depressed for several years. She wants to make a difference in her children's lives and provide the healthy emotional connections that she did not have growing up. With parent child dyadic therapy, family therapy and collateral services, the mother was able to understand how her behaviors were impacting her children. After intervention, she was able to provide a safer and more nurturing environment for her children. The work between the mother and the oldest child helped to decrease his anxiety, his aggressive behavior and his nightmares have ceased.

Community Violence

A child was identified as having aggressive behavior in his preschool class. He was referred to an EPSDT program. The child's father had been killed in a drive- by shooting six months prior to the referral. The family was grieving, but also in disarray. They were frustrated with this child's behavior and were resorting towards harsh discipline in order to "get him in line." Through a consistent relationship between this family and the early childhood mental health provider, this child is now able to play out themes of grief and loss. The mother has a better understanding of the child's emotional experience and she and his other caretakers are developing a wider range of strategies for dealing with this child's range of emotions.

Foster Care

A 2 ½ year old child had 5 foster care placements in the first 11 months of her life. She was referred to an EPSDT program at 11 months with serious separation anxiety including social withdrawal. She would scream inconsolably when her foster parents left the room. After 18 months of treatment, this child is now able to soothe herself, seems appropriately attached to her new foster parents and has maintained a placement for over six months. She can tolerate anxiety and is able to appropriately seek assistance from adults.

Maternal Depression

A 4 year old girl was referred to an EPSDT provider by a childcare Resource and Referral agency. Her mother, who emigrated 3 years ago from Mexico, reported having difficulty with her child because the child is hyperactive, destructive and incontinent. Mother was an anxious 25 year old who has been depressed for a long time. She has a history of incest and abusive relationships. She has no family in the area and is very isolated. It has been difficult for this mother with her own challenges, to focus on the needs of the child. Through the support of an early childhood mental health provider, the mother has been able to gain a greater understanding about how her trauma is impacting her child. Through the early childhood mental health provider's help, the mother now understands how to play with her child and provide a secure environment. The child's destructive behaviors are decreasing and she is no longer incontinent.

These vignettes clearly illustrate how important it is to provide treatment to the caregiver and child together when treating young children. In every situation, the parents' mental health was impacting the child's mental health.

PHASE 2 EPSDT EXPANSION- PERINATAL ALCOHOL AND DRUG (AOD) PROGRAMS

Shortly after completing the initial expansion of EPSDT 0-5 services, a Request for Proposal (RFP) was released for the second phase of expansion. The second phase was designed to pair an early childhood mental health agency with a Perinatal alcohol and drug residential treatment facility to provide a comprehensive approach to treating children residing in those environments. It was later expanded to include children whose mothers have substance abuse issues, but who may be in outpatient or "alternative" treatment. The following agencies received Phase 2 contracts:

- Children's Hospital Early Intervention Services
- The Perinatal Council (Brighter Beginnings)
- A Better Way
- Asian Community Mental Health

The implementation of Phase 2 EPSDT strategies has been challenging. Building partnerships between the drug treatment world and the mental health world takes a great deal of perseverance. Often, the service models used for drug treatment and those used for early childhood mental health are quite different. Additionally, the number of perinatal residential facilities in Alameda County is small. Early Childhood Mental Health Providers are "guests" in the residential facilities and even with partnerships, there are many factors impacting the ability of the early childhood mental health providers to deliver consistent services to the children and their mothers. This further impacts the ability to build and subsequently, the ability of these programs to be sustainable.

In order to work effectively with the Asian community, Asian Community Mental Health implemented a different service model for their AOD funding. Many of the families they want to reach would not utilize traditional drug treatment services. As a result, their model is based on expanding existing work in community-based outpatient services.

A Better Way and the Perinatal Council are still in the process of building partnerships with residential and outpatient drug treatment programs.

CHRCO's Early Childhood Mental Health implemented their program in 2005. The Families in Recovery Staying Together (FIRST) program partners with two perinatal residential drug treatment programs: East Bay Community Recovery Project-Project Pride and Solid Foundation.

DATA ON EPSDT EXPANSION

EPSDT expansion has significantly increased the number of young children and their primary caretakers who receive mental health services. Day treatment utilization has remained fairly steady. From 2002-2003 (pre-expansion) to 2003-2004 the number of children served outside of day treatment increased by 55%. From 2003-2004 to 2004-2005, there was another 45% increase. Growth continued in subsequent years with a

35% increase from 2004-2005 to 2005-2006 and a 3% increase in 2006-07. In summary, there are now more than three times as many young children receiving services than **prior** to the EPSDT expansion.

* Table 1 below shows the increase in children served in outpatient services as a result of the expansion. Chart 1 shows the expansion of service hours. There may be a correlation between the increase in the number of children served in outpatient settings and decrease in the number of children served in day treatment. The observation requires further research.

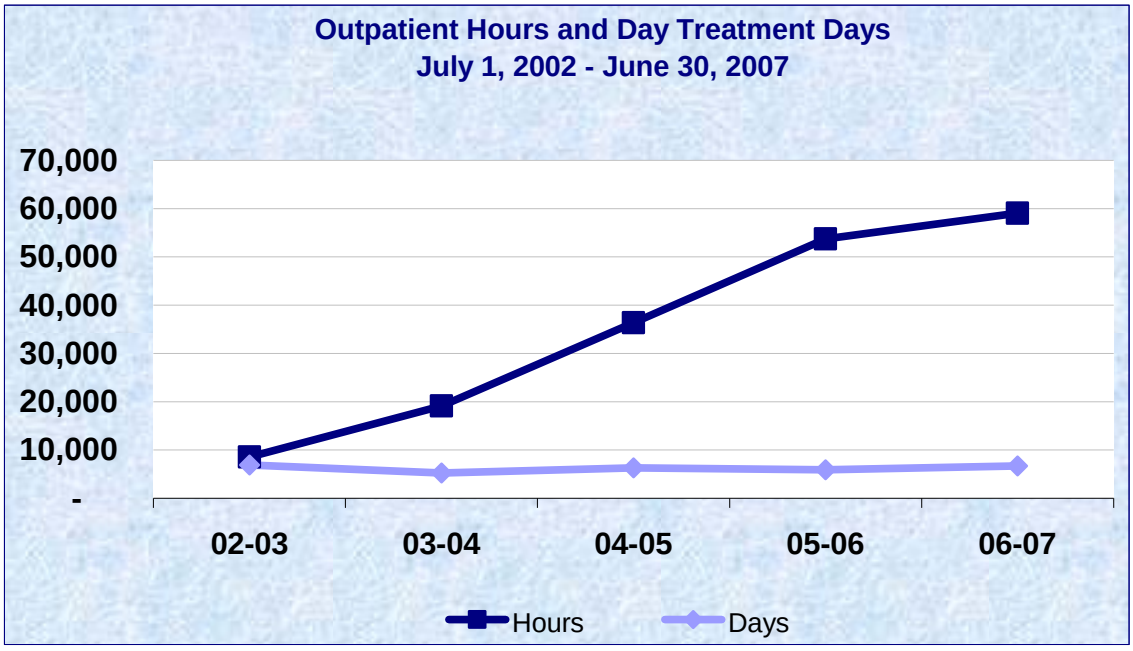
PHASE 1 PROGRAMS

TABLE 1

Children Served July 2002 - June 30, 2007

FISCAL YEAR	CHILDREN SERVED IN OUTPATIENT SETTINGS	CHILDREN SERVED IN DAY TREATMENT
2002-2003 (Pre-EPSDT Expansion)	420	64
2003-2004	652	41
2004-2005	946	40
2005-2006	1,276	44
2006-2007	1,317	37

CHART 1



Behavioral Health Care Services (BHCS) administrative data, extracted October 2007

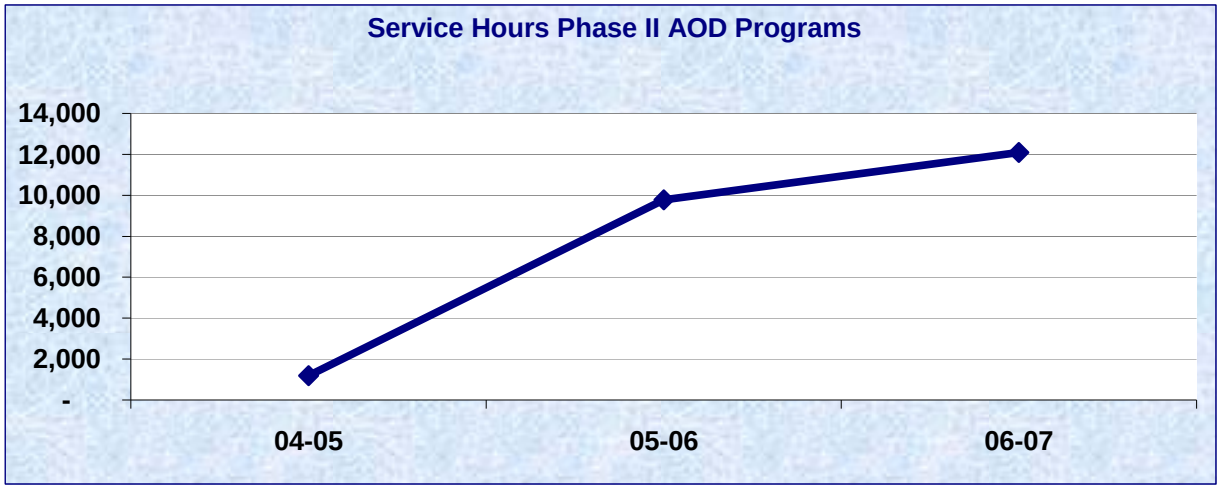
PHASE 2 PROGRAMS

Linking mental health services with alcohol and drug services proved to be challenging, as discussed above. Despite the challenges involved, Table 2 and Chart 2 (below) show that the Phase II contracts did begin to bridge the gap in the system of services that integrate alcohol and drug services with mental health services[1]. While these programs are still small, the progress that has been made suggests that there is receptiveness to these types of partnerships and room for further development as we move forward.

TABLE 2
Children Served in Mental Health/AOD Programs
July 2004 - June 30, 2007

FISCAL YEAR	CHILDREN SERVED
2004-2005	34
2005-2006	95
2006-2007	139

CHART 2



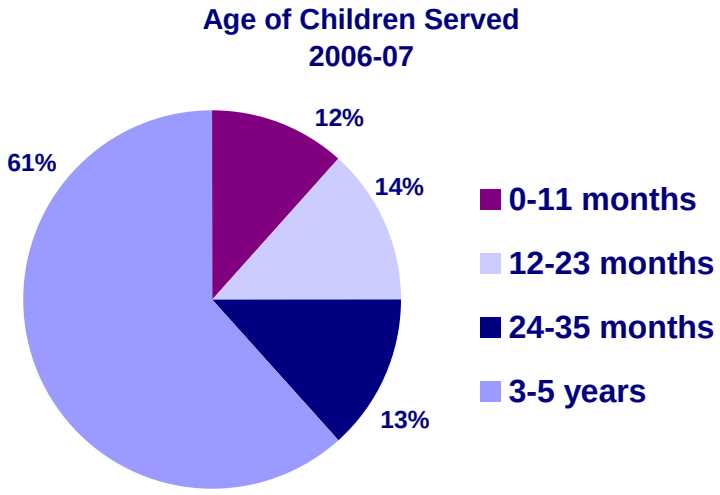
BHCS Administrative data, extracted September 2007

[1] Note that the AOD data is also included in Table 1 and Chart 1 as part of the overall analysis of EPSDT expenditures. Table 2 and Chart 2 simply carve out the numbers that were specifically for the MH/AOD programs.

AGES OF CHILDREN SERVED WITH EPSDT 0-5 FUNDING (2006-07)

Chart 3 (below) indicates that the majority of children served are in the 3-5 year old age category. Providers report that most of the children referred to them are identified in early care and education settings. Because the research cited earlier suggests that even earlier intervention is desirable, one of the challenges for this developing system is to identify and/or create pathways for the youngest children to access services – for example, through stronger linkages with primary health care providers.

Chart 3



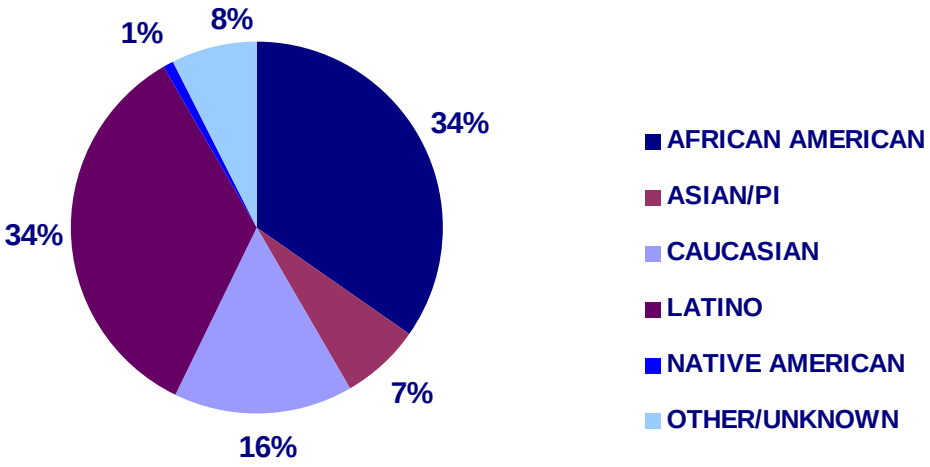
BHCS administrative data, extracted October 2007

RACE/ETHNICITY (2006-07 DATA)

Although we serve a diverse population through EPSDT, it is important to note that when compared with the population of Medi-Cal beneficiaries, we significantly under-serve Latinos and Asian/Pacific Islanders. For example, in comparing Charts 4 and 5 (below), 34 percent of the children receiving services in the spring of 2007 were Latino, but they made up 45 percent of the Medi-Cal population in that age group for the same period. When considered in light of the significant number of uninsured children who do not qualify for EPSDT services, the county faces an significant challenge to support culturally appropriate mental health services for our diverse community. The 0-5 community is particularly challenged in this regard because finding and retaining staff who are both bi-cultural/bi-lingual and have specialized expertise in early childhood mental health is rare. Supporting workforce development initiatives to address this gap could be one step forward on this issue.

Chart 4

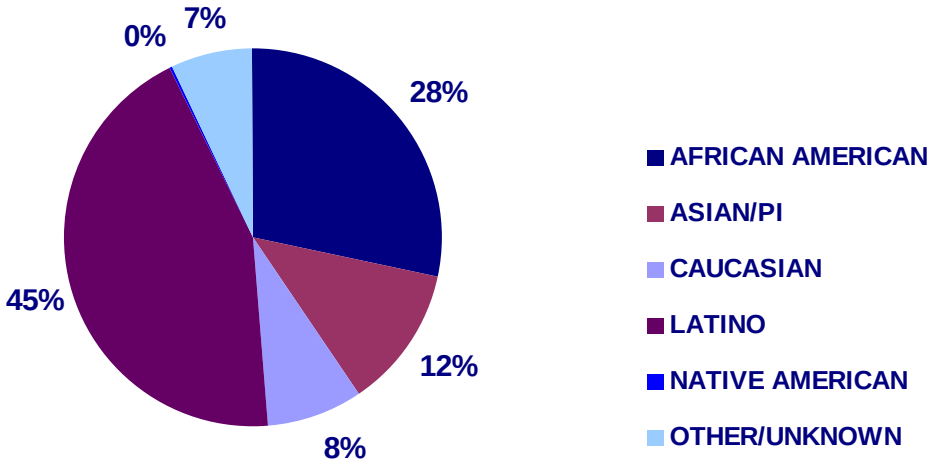
Ethnicity of Children Served 0-5
2006-07



BHCS administrative data, extracted October 2007

Chart 5

Ethnicity of Medi-Cal Beneficiaries Aged 0-5
June 2007

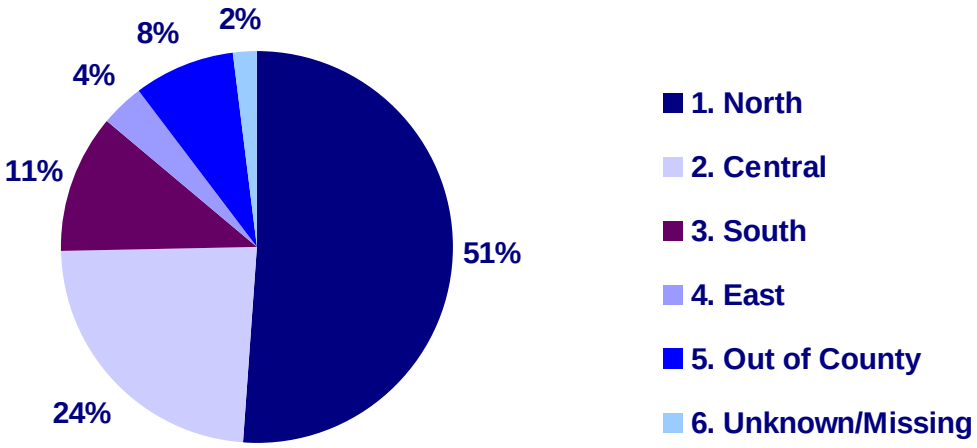


Medi-Cal administrative data, California Department Social Services, 2006-2007

Geographic Location of Clients Served based on 2006-07 data

Chart 6

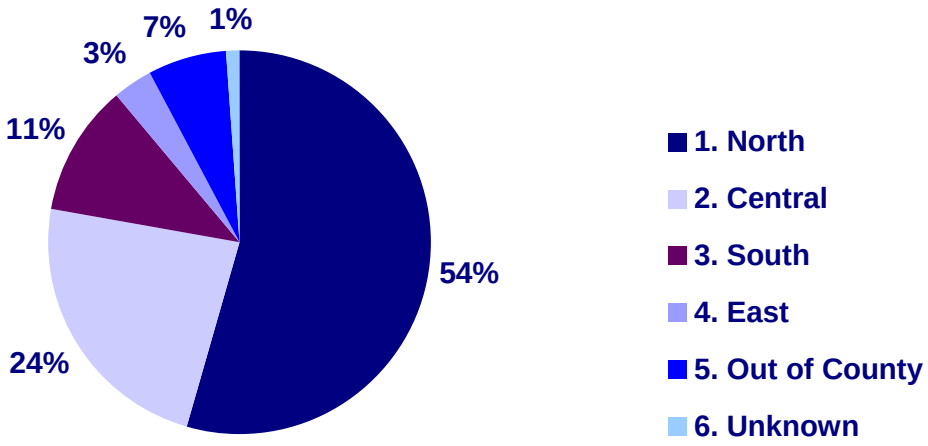
Geographic Region of Children Served
2006-07



BHCS administrative data, extracted October 2007

Chart 7

Geographic Region of 0-5 Medi-Cal Beneficiaries
January-March 2007



Medi-Cal administrative data, California Department Social Services, 2006-2007

Penetration Rate of 0-5 Services Compared to Alameda County Other Age Groups

The percentage of individuals served through EPSDT as a proportion of the total number of beneficiaries is called the "penetration rate". As Table 3 below reflects, the 0-5 population had a lower penetration rate than other age groups in the Spring 2007. Often, the penetration rate is analyzed in the context of the "prevalence rate". The prevalence rate is a percentage of the population that is believed to have a serious mental illness or a serious emotional disturbance. For youth under the age of 18, the prevalence rate is thought to be between five and thirteen percent. Five percent represents the range of children with severe functional impairment.

It is important to consider these numbers in the context of the broader system. EPSDT services do not represent the only mental health services delivered to children on Medi-Cal. There are services funded through other sources such as Child Welfare and First 5 Alameda County Every Child Counts. However, the difference between a penetration rate of two percent and a prevalence rate of at least five percent is substantial. It suggests that services could be expanded to many 0-5 year olds before approaching a saturation point, or the place where every child with a serious emotional disturbance accessed services at least once a year.

Table 3

January 1 - March 31, 2007 (ONE QUARTER ONLY) Community-Based Outpatient Care Only[2]			
Age Group	Total Medi-Cal Beneficiaries	Total Persons Served	Penetration Rate
0-5	33,168	707	2.1%
6-17	49,244	3,939	8.0%
18-24	16,291	679	4.2%
25-58	55,911	6,165	11.0%
59+	43,815	1,075	2.5%

BHCS administrative data, extracted October 2007

Referrals

The source of referrals for the first round of EPSDT came from the following:

- Department of Social Services Children and Family Services
- ACCESS
- Early Head Start and Head Start sites throughout the county
- Other Early Care and Education Sites throughout the County
- Pediatric Clinics
- Parents
- Internal referrals from family support programs within the same agency

[2] Persons served does not include hospital, crisis stabilization, juvenile justice or jail services

DIAGNOSES

Diagnosing young children by utilizing DSM diagnoses continues to be challenging. Most agencies utilize the DC 0-3 crosswalk define what this is in determining diagnoses for young children.

Table 4 – Diagnoses for Children 2006-2007

PRIMARY DIAGNOSIS	OUTPATIENT	PERCENT	DAY TREATMENT	PERCENT
Adjustment Disorders	304	23%	4	11%
Anxiety Disorders	214	16%	14	38%
Attention-Deficit Disorders	67	5%	4	11%
Bipolar Disorders	1	0%	.	
Depressive Disorders	34	3%	.	
Diagnosis Deferred	54	4%	.	
Disorder of Infancy, Childhood or Adolescence NOS	438	33%	10	27%
Disruptive Behavior Disorder NOS	71	5%	.	
Encopresis Without Constipation and Overflow Incontinence	2	0%	.	
Enuresis (Not Due to General Medical Condition)	2	0%	.	
Expressive Language Disorder / Mixed Receptive-Expressive Language	1	0%	1	3%
Feeding Disorder of Infancy or Early Childhood	5	0%	.	
Impulse Control Disorders	29	2%	.	
Learning Disorder NOS	1	0%	.	
Mental Disorders Due to Medical Condition	0	0%	.	
Oppostional Defiant Disorder	19	1%	1	3%
Other Conditions	5	0%	.	
Pervasive Developmental Disorders	15	1%	1	3%
Psychotic Disorders	1	0%	.	
Reactive Attachment Disorder of Infancy or Early Childhood	23	2%	2	5%
Reading Disorder	1	0%	.	
Separation Anxiety Disorder	30	2%	.	
TOTAL	**1,317**	**100%**	**37**	**100%**

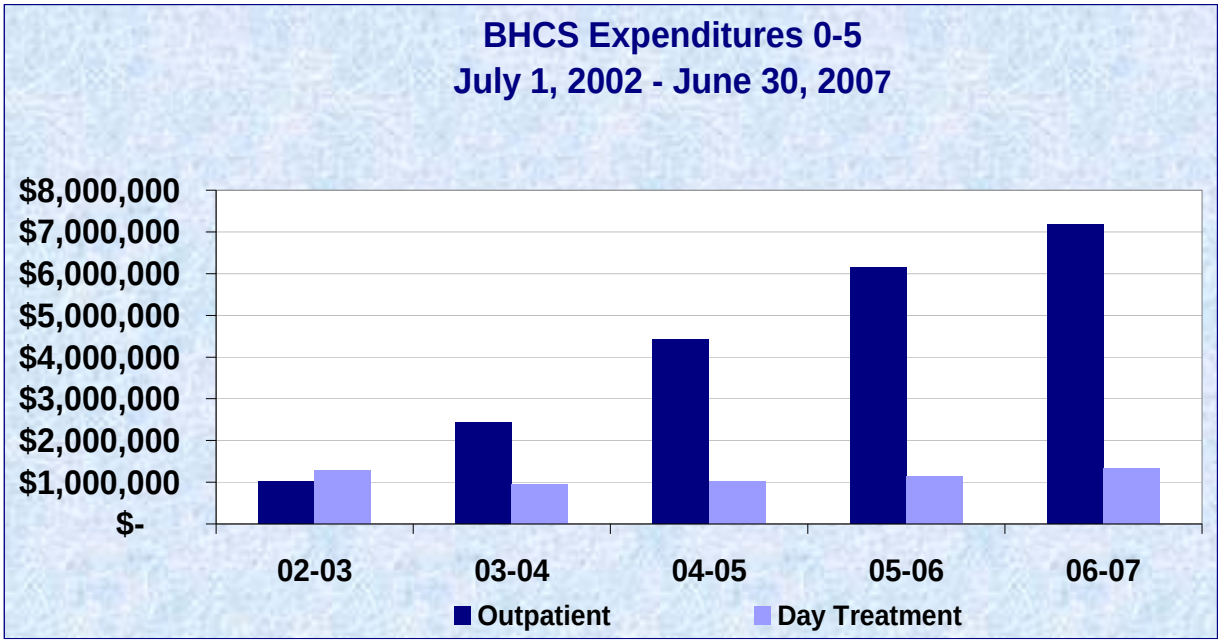
BHCS administrative data, extracted October 2007

Additionally EPSDT providers are seeing children with a variety of secondary diagnoses such as communication disorders, developmental disorders and other related developmental concerns.

FINANCES

The County has steadily increased resources for 0-5 services as the system's capacity has expanded. As Chart 8 below shows, Day Treatment costs have remained fairly stable over the past five years. However, the dramatic increase in the commitment of dollars to other intensive outpatient services is apparent: from approximately one million dollars in fiscal year 2002-2003 to over seven million dollars in 2006-2007.

Chart 8



BHCS administrative data, extracted October 2007

SYSTEMS CHALLENGES

The expansion of EPSDT resources for the 0-5 population has led to many more children receiving care. A system for referrals and coordination has developed and the clinical and administrative capacity for 0-5 work has blossomed.
However, our work is not done. There remain many challenges:

1. EPSDT funding does not cover preventative services for example: mental health consultation, consultation to childcare, parent support groups and developmental play groups.
2. There are not enough providers in our county trained in early childhood mental health treatment.
3. On average, it takes of six months longer to hire a trained bilingual clinician than a monolingual speaker. Bi-lingual/bi-cultural clinicians are vital to meeting the linguistic and cultural needs of the diverse children and families living in our county.
4. Clinicians who are bi-lingual often have not had early childhood mental health training.

5. There are children still being turned away from treatment in our county because:
    - They lack insurance
    - Their insurance does not cover parent child therapeutic services
6. EPSDT funding does not cover treatment of children where environmental (parent/child relationship) risk is high, but children are not presently showing symptoms
7. It is difficult for the more grassroots community based organizations to retain skilled early childhood mental health providers.
8. There is no funding to build the bridges and relationships that would ensure successful perinatal drug treatment and mental health partnerships. Many mothers in drug treatment are not in traditional perinatal residential programs. Frequently, they reside in homeless shelters, transitional housing or faith based recovery homes. Those services often have bare bones funding and thus lack the infrastructure to develop partnerships with community based organizations providing early childhood mental health services.

RECOMMENDATIONS

1. Funding streams should be developed to serve children who are not on full scope Medi-Cal and therefore cannot receive services through EPSDT
2. There should be a stronger connection between adult programs serving mentally ill parents and services for their children
3. Funding streams need to be developed to serve children at high risk for mental health conditions due to environmental (parent/child relationship) and biomedical risk, but who are not showing symptoms
4. The county should explore the ability to utilize the DC 0-3 diagnostic classifications for young children as utilized in other counties and states
5. The EPSDT funding needs to be re-aligned so that programs that have been successful and have waiting lists can serve more children
6. The AOD 0-5 funding should be evaluated to ensure that the service delivery model is flexible enough to reach the intended population and still remains financially feasible for programs implementing the model
7. More funding is needed for mental health consultation to early care and education, pediatric providers and Community-Based Organizations

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To download additional copies of the report as well as the Early Childhood Mental Health and Parenting Services Interagency Referral Guide, please visit Every Child Counts website at http://www.first5ecc.org/fss/fssreports.htm