

NCCP National Center for
Children *in Poverty*

Columbia University
MAILMAN SCHOOL OF PUBLIC HEALTH

PROJECT
THRIVE



ISSUE BRIEF
NO. 1

**Early Childhood Comprehensive
Systems that Spend Smarter**
Maximizing Resources to Serve Vulnerable Children

Kay Johnson
Jane Knitzer

February 2006

215 West 125th Street, 3rd floor • New York, NY 10027 • TEL 646-284-9600 • FAX 646-284-9623

www.nccp.org

The National Center for Children in Poverty identifies and promotes strategies that prevent child poverty in the United States and that improve the lives of low-income children and families.

Early Childhood Comprehensive Systems that Spend Smarter: Maximizing Resources to Serve Vulnerable Young Children

by Kay Johnson and Jane Knitzer

This first Project THRIVE Issue Brief looks through the lens of State Early Childhood Comprehensive Systems (ECCS) grant projects to identify ways in which they can promote smarter spending for vulnerable young children as states plan for and implement new, more integrated systems. It has a special focus on promoting social and emotional health and well-being, which is a critical precursor to both later health and school readiness. This analysis will help state officials, community leaders, and advocates take action to ensure the healthy development of children and their families. It builds on the NCCP report: *Spending Smarter: A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness*, which describes strategies to maximize existing funding streams by building on federal programs, and a companion report: *Resources to Promote Social and Emotional Health and School Readiness in Young Children and Families—A Community Guide*, which describes targeted interventions that can help parents and other early care providers, such as home visitors and teachers, be more effective in promoting healthy relationships and reducing challenging behavior in infants, toddlers, and preschoolers.

Project THRIVE is a public policy analysis and education initiative for infants and young children at the National Center for Children in Poverty (NCCP), funded through a cooperative agreement with the Maternal and Child Health Bureau. THRIVE's mission is to ensure that young children and their families have access to high-quality health care, child care and early learning, early intervention, and parenting supports by providing policy analysis and research syntheses that can inform state efforts to strengthen and expand state early childhood comprehensive systems.

AUTHORS

Kay Johnson, M.P.H., M.Ed., is a consultant to NCCP and director of Project THRIVE, which links policies for child health, early learning, and family support. She has broad expertise in many areas of maternal and child health and has led numerous studies of maternal and child health and early childhood policy, finance, and infrastructure issues.

Jane Knitzer, Ed.D., is Director at 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.

ACKNOWLEDGMENTS

NCCP gratefully acknowledges the guidance of the federal Maternal and Child Health Bureau (MCHB) in developing this Issue Brief. Project THRIVE is funded through a cooperative agreement with the Maternal and Child Health Bureau, Health Resources and Services Administration, and the U.S. Department of Health and Human Services.

Table of Contents

Introduction	4
Framing the Challenge: Key Facts About Social and Emotional Health and School Readiness	6
Using State ECCS Projects to Maximize Financing of Services to Promote Social and Emotional Health and School Readiness	8
Selected Federal Financing for Services to Promote Social and Emotional Health and School Readiness	10
Child Health and Mental Health Programs	10
Medicaid and the EPSDT Benefit	
State Children’s Health Insurance Program (SCHIP)	
Title V Maternal and Child Health (MCH) Block Grant	
Community Mental Health Programs for Children and Adults	
Early Childhood Care, Education, and Special Education Funding Streams and Programs	14
The Child Care and Development Fund (CCDF)	
Head Start and Early Head Start	
IDEA Part C: Early Intervention Program for Infants and Toddlers with Disabilities	
IDEA Part B (Section 619): Special Education Preschool Grants	
Programs Serving Young Children and Families at Greater Risk	16
Child Abuse Prevention and Treatment Act (CAPTA)	
Title IV-E Foster Care	
Temporary Assistance for Needy Families (TANF)	
Social Services Block Grant (SSBG)	
Moving Forward: Opportunities for States to Act Now through ECCS	18
Environmental Scans and Critical Analyses of Existing Programs and Resources	
Resources and Commitments to Sustain State-level, Multi-agency Partnerships	
Methods to Align Funding to Support System Development and Effective Integration	
Conclusion	22
Endnotes	23
List of Boxes	
What Types of Interventions Are Needed?	7
Federal Funding Streams to Link the Five Componentets of ECCS	9
Core Public Health Services Delivered by MCH Agencies Using Title V	13
Lessons Learned in Coordination and Integration Efforts	19

Introduction

Building on scientific evidence about the relationship between early experience, brain development, and long-term developmental outcomes and complementing White House initiatives to ensure that children enter school healthy and ready to learn, the federal Maternal and Child Health Bureau (MCHB) developed a Strategic Plan for Early Childhood Health in 2000. This plan specified two goals:

- **Goal 1:** To provide leadership to the development of cross service systems integration partnerships that support children in early childhood in order to enhance their ability to enter school healthy and ready to learn.
- **Goal 2:** To support states and communities in their efforts to build early childhood service systems that address the critical components of access to comprehensive pediatric services and medical homes; social-emotional development of young children; early care and education; and parenting education and family support.¹

To achieve these goals, MCHB funded State Early Childhood Comprehensive Systems (ECCS) planning grants to help develop more comprehensive approaches to early childhood service delivery. During the first three years of grant funding (FYs 2002-2004), states were charged with building partnerships with other stakeholders and developing a State Comprehensive Early Childhood Plan. Some 21 states have now completed such plans and received approval to move forward into the implementation phase of their ECCS project, while others continue to lay the groundwork for a comprehensive plan.

To complement these state ECCS grants, in 2005, MCHB funded Project THRIVE, a public policy analysis and education initiative for infants and young children at the National Center for Children in Poverty (NCCP). THRIVE's mission is to ensure that young children and their families have access to high-quality health care, child care and early learning, early intervention, and parenting supports by providing policy analysis and research syntheses that can inform state efforts to strengthen and expand state early childhood comprehensive systems.

This first Project THRIVE Issue Brief builds on the evidence and recommendations of *Spending Smarter: A Funding Guide for Policymakers to Promote Social and Emotional Health and School Readiness*.² The *Spending Smarter* report was designed to help legislators, agency officials (such as health, child care, mental health, early education, and child welfare professionals), families, and other advocates take steps to maximize the impact of existing funding streams and feel confident that they are using the limited available resources in the most effective ways. The emphasis is on planning for better financing of services to more vulnerable children with social-emotional challenges.

This THRIVE Issue Brief looks through the lens of state ECCS grant projects to identify ways in which they can promote smarter spending for vulnerable young children as they plan for and implement new, more integrated systems. It has a special focus on promoting social and emotional health and well-being, which is a critical precursor to both later health and

Caring parental relationships and other early life experiences equip most young children, including low-income children, with the appropriate tools to support their learning and enable them to succeed in school.

school readiness. This brief provides: 1) a brief overview of the challenge; 2) summaries from the larger analysis (in *Spending Smarter*) of individual funding streams and programs that can be used to build components of a coherent system of supports and services; and 3) some selected promising practices from ECCS projects to illustrate finance strategies. Finally, building on the *Spending Smarter* checklist, the brief focuses on strategies for ECCS leaders and their partner stakeholders to consider for immediate adoption in their own states or communities.

Framing the Challenge: Key Facts About Social and Emotional Health and School Readiness

In 1994, the Educate America Act set forth an ambitious national goal: “Every child shall enter school ready to learn.”³ Since then, research has emerged, painting a rich portrait of the factors that promote or inhibit early learning success. This research makes it clear that caring parental relationships and other early life experiences equip most young children, including low-income children, with the appropriate tools to support their learning and enable them to succeed in school. Thus, social-emotional development has become recognized as an essential component of optimal child development and school readiness.

There are five major reasons that policymakers should invest in young children’s social and emotional school readiness and mental health:

- 1) The earliest years offer a critical window of opportunity, with public investments showing a large payoff.⁴
- 2) There is a powerful body of scientific knowledge showing the consequences of failure to address early signs of risk factors. Children who do not succeed in the first three elementary school grades are often headed for a much longer-term and costly trajectory of failure.⁵
- 3) The knowledge of how to design, implement, and evaluate effective interventions is growing.⁶
- 4) Research tells us that social, emotional, and cognitive learning are intertwined for young children.⁷
- 5) Mental health disorders are being identified in younger and younger children. The impact of trauma, particularly related to exposure to violence and abuse, is as devastating for babies and young children as it is for older children.

The early childhood years are a time of great opportunity for growth and development. Babies are born “wired to feel and to learn,”⁸ and most children are “eager to learn.”⁹ The early years of life are also a time of vulnerability.¹⁰ When a child’s earliest experiences do not provide the kinds of warm and stimulating relationships that are the foundation of early success in school, the odds of early school failure become greater.¹¹ Poor social and emotional skills predict early school failure. This, in turn, predicts ongoing school problems, and, for some, later school failure leading ultimately to involvement in high-cost child welfare, mental health, and juvenile justice systems.¹²

The group of young children who are at risk for early school failure is sizable—somewhere between one-fourth and one-third of all young children.¹³ The risk factors for poor social and emotional development fall into four categories that have been repeatedly identified in research. First, poverty is the greatest risk factor for poor developmental outcomes, whether social, emotional, health related, or academic. The second major set of risks derives from poor quality early care and learning experiences. Unfortunately, the quality of much of the informal or formal child care and early learning experiences for young children is inadequate, especially for those from low-income families.¹⁴ Parental risks and behaviors pose a third set

of risks. Low educational levels, poor parental health, untreated parental trauma, and negative parenting role models all contribute to problematic parenting. Risk factors that receive far less attention than they should include substance abuse, domestic violence, and, especially, parental depression.¹⁵ The fourth set of risk factors shows up among the group of young children who have serious, diagnosable emotional and behavioral problems.¹⁶ Children with chronic health problems or with other disabilities are also at higher risk for emotional and behavioral problems, representing 29 percent of all children with special health care needs.¹⁷

While some young children facing such risks are resilient and are able to thrive despite challenges, many do not fare so well. Child care workers describe too many young children as “mad, bad, and sad,” and even the most skilled and seasoned workers tell of encounters with young children they do not know how to help. Yet much is known about how to intervene. Just as there are deliberate strategies to promote early literacy, so there are strategies to promote healthy early social and emotional development. Such interventions need to be viewed through a family lens, addressing the parents, the parent-child relationship, and, if necessary, any developmental delays experienced by the child.

Because there is no one funding source targeted to young children facing social and emotional threats to school readiness, figuring out how to mix and match the multiple funding streams, eligibility requirements, and administrative requirements to ensure access to developmentally appropriate, family-focused, preventive, early intervention and treatment services has proven to be very challenging. Predictable barriers include: funding restrictions, eligibility criteria that exclude at-risk children, limited financing for parent-child, two-generation interventions, limited investments in training (and retraining) the workforce, and scarce systems for tracking children who are deemed at risk.

But the work of building infrastructure, offering strategic plans, and implementing multi-agency approaches is ideally suited to ECCS projects. Piecing together a coherent funding and service delivery infrastructure requires creative, strategic, and proactive leadership, which can be found among ECCS stakeholders. Moreover, such work on systems development is essential to spending smarter and maximizing scarce resources.

What Types of Interventions Are Needed?

Based on scientific evidence, intervention research, and real-world experience, capacity building should focus on three broad types of interventions.

- **Promotion and prevention strategies targeted to all children.** Such strategies can help families and caregivers foster social skills, emotional health, and positive behaviors as part of a school readiness agenda. These strategies include anticipatory guidance by pediatricians or others, social and emotional skill-building curricula in preschool programs, and mobilizing local community leaders, mentors, and coaches.
- **Early intervention strategies for groups of young children who face special risks.** Young children at special risk include those whose parents are incarcerated or abuse drugs, those in foster care, those with disabilities, and those whose parents face serious mental health issues, particularly depression. Strategies include mental health consultation in child care settings and family support.
- **Treatment strategies sufficiently intensive to help young children with serious social, emotional, and behavioral problems and their families.** These kinds of interventions include access to case management, mental health, and other treatment services that can help families stay together and ensure the safety and healthy development of young children.

Using State ECCS Projects to Maximize Financing of Services to Promote Social and Emotional Health and School Readiness

The state ECCS planning grants offer one opportunity to move the agenda for integrated early childhood systems, providing resources for interagency planning, leadership development, fiscal analysis, and other infrastructure supports.¹⁸ State Title V agencies responsibilities were to build partnerships with other stakeholders, to focus on early childhood outcomes, and to develop an early childhood strategic plan. The five critical components specified for early childhood systems development are: 1) access to “medical homes” (pediatric care providers who coordinate comprehensive health services); 2) services and supports to promote the positive social and emotional development and mental health of young children; 3) early care and education services; 4) parenting education services; and 5) family support services.¹⁹

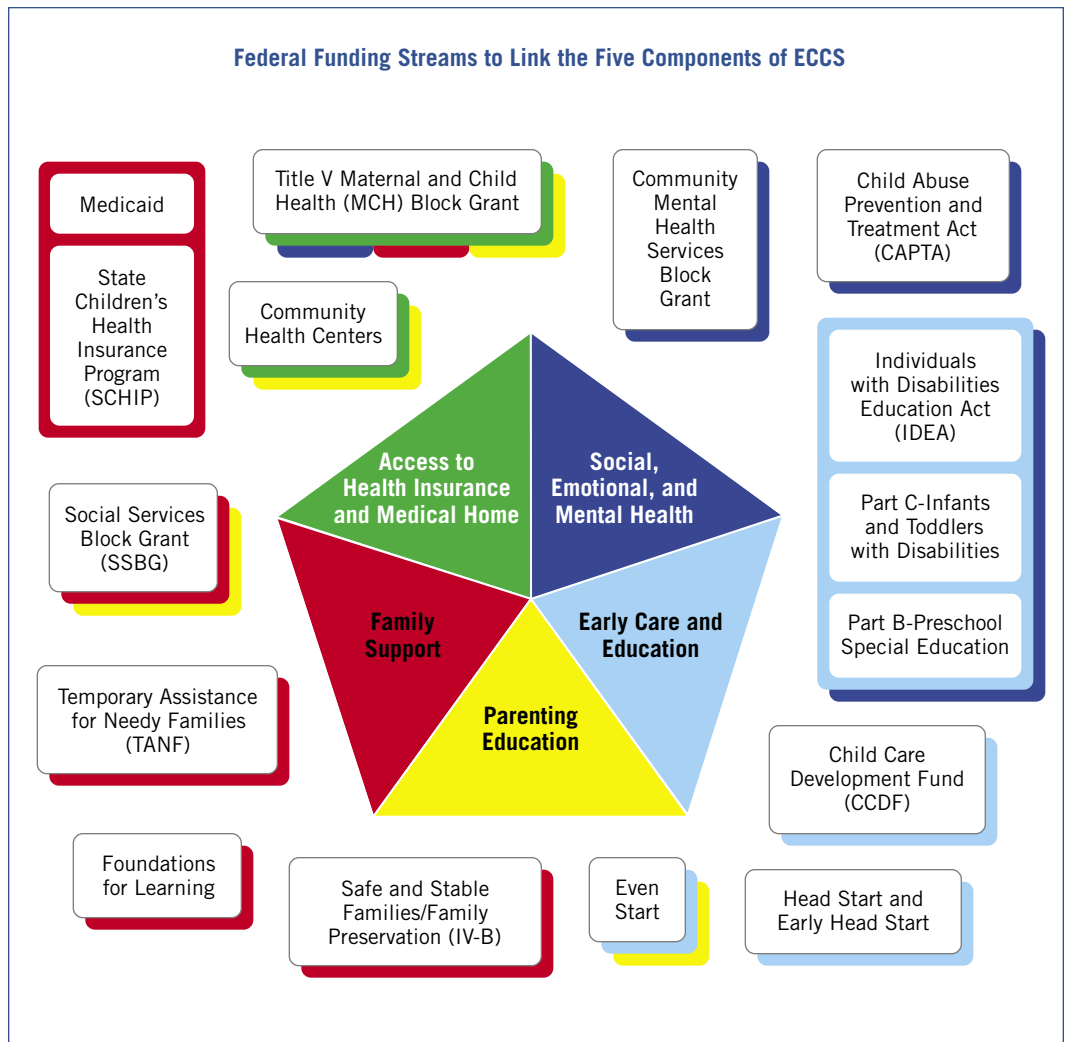
Initial ECCS planning grants allowed states to engage in strategic planning and collaboration building efforts needed to promote the development of comprehensive systems of early childhood services. (ECCS grant funds support only these infrastructure building activities and are not used to directly support service delivery.) States were encouraged to build on existing strengths and to integrate, rather than to duplicate, currently operating initiatives. Where needed early childhood services systems building initiatives do not exist, state ECCS projects were to develop strategies to establish them. Grant requirements called for development of a State Comprehensive Early Childhood Plan.

Among other things, ECCS plans must: be based on a needs assessment/environmental scan, address the five specified critical components for early childhood systems development; reflect the development of strategic alliances among public and private sector leaders; and have a sustainability plan that includes financing and resources leveraging strategies for carrying out the follow-up implementation phase of the project. Implementation grants create additional opportunities for states to spend smarter.

Finance-related products of the ECCS planning process that should be reflected in each state’s plan include:

- Environmental scans and critical analyses of existing early childhood systems and initiatives (both internal and external to Title V).
- Evidence of state-level, multi-agency partnerships among critical stakeholders, including resources to advance and sustain them.
- Development of concrete methods to align funding streams, program resources, and policies to produce and support effective system integration.

Piecing together a coherent funding and service delivery infrastructure requires creative, strategic, and proactive leadership, which can be found among Early Childhood Care System stakeholders.



Selected Federal Financing for Services to Promote Social and Emotional Health and School Readiness

To build a state or community fiscal infrastructure to develop a comprehensive approach to addressing the social and emotional challenges facing young children it is necessary to:

- Use every available funding stream to pay for specific services to promote social, emotional, and behavioral health and early school readiness.
- Modify existing funding and program requirements to ensure that services and supports are appropriate for young children.
- Use fiscal and strategic planning to craft and sustain an infrastructure to support young children’s healthy social, emotional, and behavioral health and early school readiness, ensuring attention to the children themselves, their families, and their caregivers and encompassing prevention of problems, early intervention, and more intensive treatment.

The first step in making this happen is to do a careful analysis of how each state is currently using existing federal (and state) funding streams and programs. This section briefly describes several key federal programs and how they might be used to promote social and emotional health and school readiness in young children. Additional programs and analysis about federal funding streams can be found in *Spending Smarter*.

The funding streams/programs are organized in three sections. The first highlights child health and mental health programs, the second highlights core early education and learning programs that either provide potential funding streams or entry points for services, and the third points to other programs that can be used to meet the needs of subgroups of vulnerable young children and families, such as those transitioning to work, in child welfare, or needing help for parental mental health issues, substance abuse, or domestic violence.

Child Health and Mental Health Programs

Medicaid and the EPSDT Benefit

In theory, Medicaid is the most important potential source of funding for prevention, early intervention, and treatment of the social and emotional challenges facing young children. With approximately 40 percent of infants and 30 percent of toddlers and preschoolers eligible for coverage, the potential impact of Medicaid policy on early childhood health outcomes is far-reaching. Currently, Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides a comprehensive child health benefit that requires states to fund well-child health care, diagnostic services, and medically necessary treatment services to all Medicaid-eligible children from birth through age 21. Under current federal EPSDT law (Section 1905 of the Social Security Act), states must cover any Medicaid-covered service—allowed under the federal Medicaid statute—that would reasonably be considered medically

In theory, Medicaid is the most important potential source of funding for prevention, early intervention, and treatment of the social and emotional challenges facing young children.

necessary to prevent, correct, or ameliorate children's physical and mental conditions. Services to prevent, correct, or ameliorate physical and mental conditions are covered for children, whether or not they are part of the state Medicaid plan for adults.²⁰

New law enacted in January 2006 gives states options for how these services will be delivered and how to shape child health benefits under Medicaid. These changes in law will become effective in mid-2006 and have not been clearly articulated by the Centers for Medicare and Medicaid Services (CMS) that has federal regulatory authority for the program.

State ECCS projects should include Medicaid/EPSTDT in their external environmental scans and address Medicaid financing in their planning and implementation efforts. Several challenges might be tackled by ECCS projects. The first challenge is to make screening more effective by assuring that screening tools are age-appropriate and include developmental, emotional, and behavioral measures,²¹ and that provider reimbursement mechanisms are in place. The second major challenge is to finance services to promote healthy development before problems start. Since current federal Medicaid guidance does not specifically define child development services,²² states have the task of financing these services under existing, sometimes awkward benefit categories. A specific cross-system challenge is that multiple public programs, including those for early intervention, mental health, or children with special health needs, are involved in the delivery of child development services, making it difficult to sort out which program rules apply and who should pay. Better planning and interagency agreements are part of the solution. Some advocates report barriers to coverage for parent-child therapy for the youngest children, but no federal law prohibits state Medicaid programs from electing to finance so-called "family therapy." Another barrier is lack of reimbursement for early childhood health and mental health services delivered by qualified providers in nonmedical settings where the children, families, and caregivers routinely receive early childhood services, such as in Early Head Start, child care, and home visiting programs.²³ Finally, Medicaid managed care offers clear opportunities to promote optimal early development and develop effective care models, but few states have stressed quality child development services in their Medicaid managed care contracts.²⁴

State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program is a federal-state program designed to help states provide health insurance coverage to uninsured children whose family income is up to 200 percent of the federal poverty line (FPL—\$40,000 for a family of four in 2006) and with federal approval well above that level. State SCHIP plans either expand eligibility for children under Medicaid or create a separate children's health insurance program managed by

the state and typically operated by private insurance companies.²⁵ If SCHIP is part of Medicaid, the benefits must be comparable. In the case of separate SCHIP programs, states could promote social, emotional, and behavioral readiness by offering coverage of key services, using a broad definition of medical necessity, and covering child development services. Covering parents—an option in SCHIP—is another strategy to finance services essential for family health and mental health. States could also ensure mental health parity in SCHIP coverage, even if they do not require mental health parity for all privately insured adults.

Title V Maternal and Child Health (MCH) Block Grant

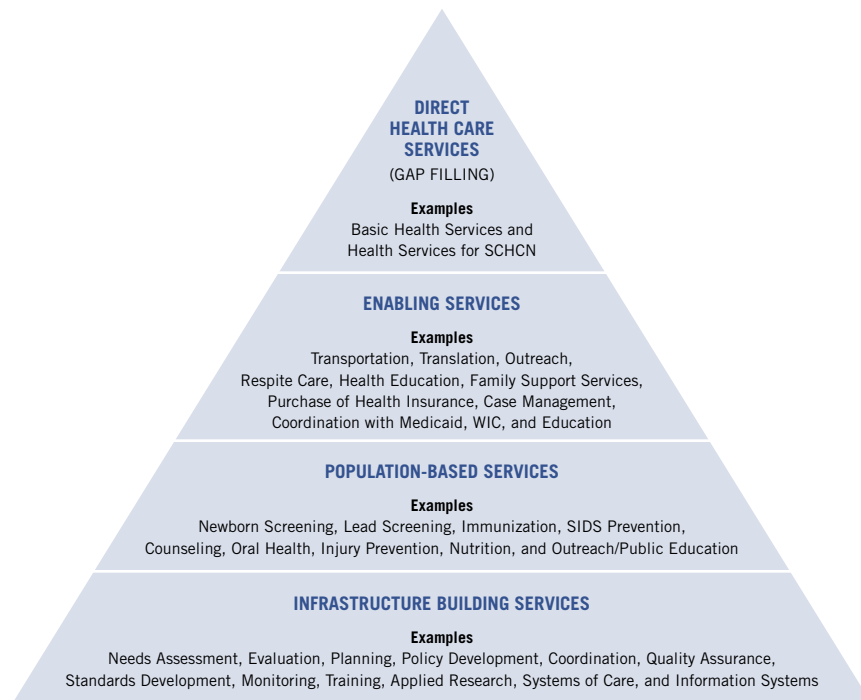
Title V funding can be used for direct services, enabling case management, population-based screening, and infrastructure improvements. (See box: Core Public Health Services Delivered by MCH Agencies.) For example, states' Title V funds can be used strategically to balance the Medicaid medical model with a public health model that can address risk factors through both population-based services, such as promoting healthy child development, and enabling services to support outreach to families and family support. Title V funds can be used to improve the infrastructure through support of activities such as cross-system training for a range of professionals serving young children. It is also possible to purchase direct services, for example, maternal depression screening.

In the context of Title V, young children with social and emotional risk factors may be considered among those with special health needs. CSHCN (children with special health care needs) are defined as: “children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.”²⁶ Because Title V funds are limited, however, each state defines which categories of special-needs children will be eligible for the programs and services for CSHCN. Typically, these categories include children with chronic illnesses, genetic conditions, and physical disabilities, but not children with social and emotional disabilities. Therefore, it is important that each state's definition of children with special health care needs explicitly include children who have or are at risk for chronic developmental, behavioral, or emotional conditions.

Community Mental Health Programs for Children and Adults

Although the recently released President's New Freedom Commission on Mental Health report explicitly calls for the development of early childhood mental health services,²⁷ federal funding streams do not provide any targeted support for early childhood mental health. Other than Medicaid, the major mental health funding stream explicitly targeted to children is the Comprehensive Community Mental Health Services Program for Children with Serious Emotional Disturbances, which provides multi-year grants to communities to develop systems of care for children with, and sometimes at risk for, serious emotional and behavioral disorders. Several states (for example, Vermont and Colorado) and some communities (such as Los Angeles, California and Sarasota, Florida) have successfully sought approval to use the funds for early childhood mental health initiatives aimed at creating systems of care to prevent serious disorders. State ECCS projects should consider how mental health dollars and services fit into their system plan.

Core Public Health Services Delivered by MCH Agencies



Direct health care services are those services generally delivered one-on-one between a health professional and a patient in an office, clinic, or emergency room that may include primary care physicians, public health or visiting nurses, medical social workers, dentists, sub-specialty physicians who serve children with special health care needs, and others. State Title V programs provide support by directly operating programs or by funding local providers to deliver services, such as children's developmental screening, maternal depression screening, and early childhood health or mental health consultation. For CSHCN, direct services include specialty and sub-specialty care for conditions requiring access to highly trained specialists, sophisticated technology, or an array of services not generally available in most communities.

Enabling services allow or provide for access to the array of health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC (federal Women, Infant, and Children nutrition program), and education. These services are especially required for the low income, disadvantaged, geographically, or culturally isolated, and those with special and complicated health needs. Enabling services for CSHCN typically include transportation, care coordination, translation services, home visiting, and family outreach, and family support activities such as parent support groups and family training.

Population-based services are preventive interventions and personal health services, developed and available for the entire MCH population of the state rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. These services are generally available whether the child or family receives care in the private or public system, and whether they are insured or not.

Infrastructure building services are the base of the pyramid and form its foundation. They are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and resources, including development and maintenance of health services standards/guidelines, training, data, and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, and systems of care. In the development of systems of care, it should be assured that the systems are family centered, community-based, and culturally competent.

Early Childhood Care, Education, and Special Education Funding Streams and Programs

The Child Care and Development Fund (CCDF)

Child Care and Development Fund dollars go to states on a formula basis and 70 percent of their CCDF monies must be used to provide child care services for families on or transitioning off the Temporary Assistance for Needy Families (TANF) program or at risk for welfare dependency. States have considerable flexibility in creating child care programs and policies that help working parents make informed choices about child care and that implement state health, safety, licensing, and registration standards. State ECCS planners should consider designating CCDF allocations to increase access to services that promote the social, emotional, and behavioral health and school readiness of young children. For example, states have used the 4 percent quality set-aside, state-appropriated, and/or TANF funds to finance early childhood mental health consultation in child care settings. By blending federal, state, and local child care quality funds, states also might finance training for child care professionals in the area of social and emotional development.

Head Start and Early Head Start

Helping Head Start programs access other funding streams to support activities that strengthen staff capacity to promote positive social and emotional outcomes and to respond more effectively to families could be part of a state strategy to serve higher-risk young children and families. State ECCS projects should include Head Start assets and resources in their planning and implementation efforts. For example, Head Start programs place specific emphasis on parent involvement, parent support, and parent education, as well as focusing day-to-day on child development. Head Start programs also have early childhood mental health consultants who might be used as part of an overall strategy.

Although Early Head Start improves outcomes for most of the enrolled babies, toddlers, and parents, research shows that it is not as effective for mothers with high levels of depression²⁸ or for parents and young children with four or more demographic risk factors. As a result, Early Head Start programs are trying to embed more intensive mental health supports into the program. Similarly, national initiatives such as Free To Grow²⁹ are helping Head Start redesign programs to better serve families with different levels of needs. State ECCS projects can help to support, evaluate, and expand these efforts.

IDEA Part C: Early Intervention Program for Infants and Toddlers with Disabilities

Part C of the Individuals with Disabilities Education Improvement Act (IDEA) gives limited funds to assist states in developing and implementing statewide, comprehensive, coordinated, multidisciplinary, interagency systems to provide early intervention services for infants and toddlers with disabilities and their families. There are at least four major barriers that states might address: 1) Too few states actually include at-risk infants and toddlers. 2) Neither the required Child Find screening nor comprehensive evaluations to determine eligibility generally do enough to identify and measure social and emotional delays. 3) Too few states have

Helping Head Start programs access other funding streams to support activities that strengthen staff capacity to promote positive social and emotional outcomes and to respond more effectively to families could be part of a state strategy to serve higher-risk young children and families.

developed tracking programs for those at risk. 4) There has been no focus on infants and toddlers with serious emotional delays and disabilities, even though the law requires it.

ECCS planners might consider how early intervention programs could be made more responsive to infants and toddlers with social and emotional disabilities and developmental delays, as well as to those at risk for delays and disabilities. States could monitor program performance to ensure that appropriate social and emotional assessments and evaluations are conducted. States might also deem young children exposed to domestic violence, substance abuse, or maternal depression as eligible for services, rather than categorize them merely as at risk.³⁰ In addition, states must now report on the number of infants and toddlers enrolled in Part C who demonstrate improved positive social-emotional skills, including social relationships, acquisition and use of knowledge and skills, and use of appropriate behaviors to meet their needs.³¹

IDEA Part B (Section 619): Special Education Preschool Grants

As this program is currently structured, there is no possibility of reaching out to and serving at-risk children. This means that there is no continuity for at-risk children served under Part C when they become preschool-aged, although states do have the option to merge Part C and Part B preschool programs to provide a continuum of services and early interventions for all children from birth to age 5. The 2004 reauthorization of IDEA gives states the option—that is, gives parents the choice—to allow a child to stay in the Part C program until kindergarten instead of moving to the Part B Preschool Special Education Program at age 3.³² This creates an opportunity for ECCS planners. Such continuation programs would apply only to children and their families who had previously participated in Part C, and there must be services in place to promote school readiness until the children enter (or are eligible under state law to enter) kindergarten. Under this approach, state dollars, which already comprise more than one-third of most Part C programs, can be used to facilitate continued coverage of at-risk children. Such a consolidated and more continuous special education program might be one core element of an early childhood comprehensive system.

Programs Serving Young Children and Families at Greater Risk

Child Abuse Prevention and Treatment Act (CAPTA)

The Child Abuse Prevention and Treatment Act (CAPTA) is a formula-funded, state grant program that provides flexible funding to improve child protective service systems. In 2003, Congress amended CAPTA (through the Keeping Children and Families Safe Act) to require that states have “provisions and procedures for referral of a child under age 3... in substantiated cases of abuse or neglect to early intervention services funded under Part C” of IDEA.³³ In most states, responding to the intent of new CAPTA rules will require a substantial change in practice for staff in local child welfare, TANF, Medicaid, and Part C programs. Some states are using this requirement as an opportunity to restructure the linkages between child welfare, the Part C Early Intervention program, and Medicaid. The amendments also call for states to support enhanced “collaboration among public health agencies, the child protection system, and private community-based programs to provide child abuse and neglect prevention and treatment services (including linkages with education systems).” The Community-Based Child Abuse Prevention Program (CBCAP), authorized in 2003 by Title II of CAPTA, also provides funding to states to develop, operate, expand, and enhance community-based, prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect. Clearly, this language fits with the principles and purposes of ECCS projects. While the amount of funding available through CAPTA is not large, these provisions create a window of opportunity and leverage for ECCS planners.

Title IV-E Foster Care

As a group, young children in foster care are among the most vulnerable, and data suggest that more children are entering foster care at younger ages. Title IV-E provides funds to states to assist primarily with the administrative costs of foster care and does not provide funding for the cost of services provided to children and families. All the same, Title VI-E foster care programs should be included in ECCS planning to ensure that this group of high-risk young children receives appropriate screening and intervention services to reverse early emotional damage and/or promote healthy relationships with their current caregivers through both EPSDT and Part C Early Intervention programs. For example, states might require that all children from birth to age 3 entering the foster care system be evaluated through the Part C program to determine whether they have delays or risk factors that meet state eligibility rules for early intervention services. This would parallel efforts under CAPTA to better serve children exposed to abuse and neglect. For ECCS projects, this is another example of how to foster interagency collaboration and systems integration.

Temporary Assistance for Needy Families (TANF)

ECCS projects should give particular attention to TANF training and family support funding, as well as to the flexibility this program provides for transfer to other activities. Jurisdictions have used TANF dollars to address the social and emotional needs of young children and to improve the quality of child care as a work support for parents transitioning off

Flexible funding for cross-system activities might be particularly helpful to fill gaps in ECCS plans as a result of federal limits on entitlement or direct service funds.

TANF. For example, many states have used TANF dollars to support child care activities, either through TANF or by transferring funds (up to 30 percent per year) to either the Child Care and Development Fund (CCDF) or the Social Services Block Grant (SSBG). States also might use TANF grant dollars for two-generation strategies, such as: 1) family counseling, service coordination, and family support activities; 2) intensive home visiting for families with young children at risk, or 3) substance abuse treatment for parents, as part of their efforts to reduce dependency and prepare for work.

Social Services Block Grant (SSBG)

Another source of flexible funding is the Social Services Block Grant, under which a state may transfer up to 10 percent of funds to preventive health and health services, alcohol and drug abuse, mental health services, maternal and child health services, and low-income home energy assistance block grants. SSBG funds are flexible and can be used in combination with other programs to improve the social, emotional, and behavioral health and school readiness of young children, particularly for professional training, family services and supports, tracking at-risk children, or other related activities. Such flexible funding for cross-system activities might be particularly helpful to fill gaps in ECCS plans as a result of federal limits on entitlement or direct service funds.

Moving Forward: Opportunities for States to Act Now through ECCS

ECCS stakeholders are in an especially good position to move forward and spend smarter. The development of state and community infrastructure for fiscal and service strategies to promote social, emotional, and behavioral health in young children as part of a school readiness agenda requires detailed knowledge of how individual programs and funding streams work. It also requires thoughtful planning to build a common vision, identify priorities, address barriers, and promote research-informed practices. (See *Spending Smarter* Appendix 2 for questions policymakers and advocates should ask.)

As noted above, MCHB provides guidance to states on ECCS planning calls for several key finance-related activities. These include:

- Environmental scans and critical analyses of existing early childhood programs, resources, and systems (both internal and external to Title V).
- State-level, multi-agency partnerships, including resources and commitments to advance and sustain them.
- Concrete methods to align funding streams, program resources, and policies, to produce and support effective system integration.

The action steps below are organized under these headings to focus on key opportunities in the ECCS planning process.

Environmental Scans and Critical Analyses of Existing Programs and Resources

1) Include finance mapping in the ECCS planning process.

In the context of ECCS and other efforts to strengthen early childhood systems, all states (and the U.S. territories) have begun to use strategic planning efforts to create a vision and build a common purpose across multiple agencies, stakeholders, and funding streams. Some states, such as California, Colorado, Connecticut, Florida, Iowa, Illinois, Maryland, Minnesota, Utah, and Vermont, have given particular focus to issues related to social and emotional health and school readiness.

In these cross-system planning efforts, many states have used a “system-mapping” approach to identify gaps within and between systems. A next step is to be able to map existing financing, not just services or program names. Using the programs identified in this document, states can begin to identify gaps and opportunities to “spend smarter,” and then use this analysis to develop state-specific priorities and action strategies. It is important to conduct analyses both within individual programs as well as across programs to identify current opportunities and barriers. The State Early Childhood Policy Technical Assistance Network has compiled a useful bibliography of resources on financing school readiness.³⁴

Lessons Learned in Coordination and Integration Efforts

- Build partnerships that include those inside and outside of government.
- Engage in strategic planning, using “system mapping” and “finance mapping” as part of environmental scans and cooperative needs assessments.
- Use structural mechanisms (for example, children’s cabinets, work groups, memoranda of understanding) to foster and sustain comprehensive system development.
- Identify specific policies that need to be modified and take incremental steps to enact changes.
- Explore opportunities to remove narrow eligibility requirements and to combine funding streams (in other words, “decategorize”).
- Share and pool flexible funds to support activities such as cross-system training, an integrated child health data system, or efforts to implement a “no-wrong-door” enrollment policy.

The next step is to begin to restructure programs and financing in ways that promote social and emotional health and school readiness for more children. One core task is to engage in fiscal strategizing to support early childhood health and mental health consultation, building on the models and approaches emerging around the country. Innovative state and local programs reach children and their caregivers at child care centers, family day care homes, Head Start centers, family resource centers, shelters, and other settings. Different federal funding streams are being used, including mental health, child care, TANF, Medicaid, Title V MCH Block Grant, and Social Services Block Grant, as well as state general funds, county tax dollars, and private foundation support.

2) Use the ECCS planning process to create a statewide definition of factors that place young children at high risk for social, emotional, and behavioral delays and conditions.

Some state ECCS projects have turned their attention to state definitions (for example, Colorado, Connecticut, Illinois, Iowa, and Washington). The reevaluation of state definitions is valuable for ECCS planning.

Once states have reviewed definitions for young children at risk for social and emotional problems across programs, the next step is to explore a common definition that can streamline administrative burdens and promote simplified access. States that secure ECCS implementation grants will be well positioned to adopt statewide definitions and frameworks for an early childhood system if they have grappled with the challenges of developing common, cross-system definitions.

The Foundations for Learning Grant Program sets out one possible framework that can be used on behalf of children under age 7 who are at social and emotional risk for school failure. Young children are eligible if two or more of the following factors are present: 1) abuse, maltreatment, or neglect; 2) exposure to violence; 3) homelessness; 4) removal from child care, Head Start, or preschool for behavioral reasons or at risk for being so removed; 5) exposure to parental depression or other mental illness; 6) family income below 200 percent of the federal poverty level; 7) exposure to parental substance abuse; 8) early behavioral and peer relationship problems; 9) low birth weight; or 10) cognitive deficit or developmental disability.

Resources and Commitments to Sustain State-level, Multi-agency Partnerships

3) Support priority financing strategies with interagency plans and written agreements.

State and local governments have many, often untapped opportunities to maximize flexibility and streamline administration. The Finance Project³⁵ suggests pooling (or blending) funds across agency or program lines, decategorizing funds by removing eligibility requirements and allocation rules, and coordinating (or braiding) categorical funds to better support an array of services within a single program.

Once opportunities for flexible financing or administrative changes have been identified, interagency agreements are valuable implementation tools. Interagency memoranda of understanding and similar agreements clarify the terms for sharing fiscal or personnel resources, specify roles and responsibilities, and institutionalize changes. Practically, such agreements also serve as documentation of how the state intends to carry out integration of federal programs.

Contracts are another important type of written agreement to support and sustain public-private partnerships, particularly with providers. For example, researchers at George Washington University have prepared model managed care purchasing specifications to assist states in efforts to finance child development and mental health services through Medicaid and SCHIP.³⁶

4. Use opportunities created when Congress makes changes in federal programs.

Recent and pending federal policy actions call upon states to change the way they finance and manage programs for children and families. Whether it is a reduction in child care or Title V funding, approval of a Medicaid waiver, or a change in TANF rules, states are called upon to respond and change. In some ways, given the many cuts in core federal programs, this is a difficult time to engage in comprehensive system planning. Looked at in another way, however, it is a very important time to ensure that the resources that are available are used most wisely. Moreover, some states are expanding their investments in young children and prevention. State circumstances vary considerably, and state policymakers and advocates can learn from one another about options to respond to federal policy changes.

Methods to Align Funding to Support System Development and Effective Integration

5. Use the more flexible block grant or smaller federal grant programs to strengthen cross-system linkages and fill gaps.

Federal programs such as TANF, SSBG, Title MCH Block Grant, Community Mental Health Services Block Grant, and Community-based Family Resources and Support Grants provide flexible funding that can fill gaps left by Medicaid, Part C, and other more service-specific funding streams.

For example, flexible funding for training is available in many programs and often can be used on an interagency basis. Some states have made specific efforts to provide training related to early childhood social and emotional development, including efforts to create common, core training curricula for early childhood mental health. In Vermont and Michigan, core principles and a training approach aimed at system development infused these principles into a variety of settings. Other states, such as Connecticut, Illinois, Iowa, Ohio, and Colorado, are planning for or implementing training projects.

Flexible block grant funds also can be particularly helpful in financing collocation of social work or child development staff in pediatric offices and clinics, early childhood mental health program consultation, and/or programs for maternal depression or substance abuse. State funds can also be used for similar purposes.

6. Clarify eligibility and payment mechanisms between Medicaid’s EPSDT child health component, the IDEA Part C Early Intervention program, child welfare, mental health, and other programs.

States should clarify eligibility rules and financing (for example, who pays for what) when children have dual or multiple eligibility in Medicaid and Part C, or Medicaid and foster care. Too often, low-income and high-risk families go without services because the mechanisms for coverage are not clearly stated and are difficult to navigate. ECCS leaders can play an essential role in convening key stakeholders to discuss and clarify such eligibility and payment mechanisms. Translating such policy decisions into easy to understand materials for parents, providers, and case managers is another step in this process.

7. Adopt policy and billing mechanisms that encourage providers to perform developmental screening with age-appropriate tools and follow-up referrals and treatment in nonoffice-based settings.

For states to spend smarter, screening must use appropriate tools, be appropriately reimbursed, and, where indicated, lead to follow-up steps. States could promote the use of the same tools across programs as well as ensure that there are follow-up evaluations, referrals, and, above all, access to timely and appropriate early services. A most important strategy is to adopt clear billing codes. Existing billing codes may need to be modified to reflect the services needed by young children. This challenge is complicated by rules under the Health Insurance Portability and Accountability Act (HIPAA), which calls for billing code standardization that appears to have shortcomings for pediatric care.³⁷ Some states have found that billing codes tailored to young children’s conditions—using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0–3)³⁸—helps to reduce unnecessary spending, minimize fraud, and maximize early intervention. Under the Assuring Better Child Health and Development II (ABCD II) projects, five states (California, Illinois, Iowa, Minnesota, and Utah) are piloting Medicaid strategies to promote healthy mental development.³⁹

No state can fulfill the vision of its ECCS plan without such strategic fiscal planning, and optimal health and development depends on the outcome of such plans.

Conclusion

State ECCS projects are working with their partner stakeholders to develop and implement comprehensive plans. Fiscal challenges affect planning and action across a broad range of programs and service systems. At the same time, federal support is shrinking for certain programs that are the lifeline for low-income and more vulnerable children and their families. Yet, in every state, considerable resources are and will be targeted to young children in need. Often, these dollars are focused on services for older children, with too little investment in early interventions for infants, toddlers, and preschoolers. Strategic fiscal planning to maximize the impact of these resources as well as to target funds for intentional interventions before serious problems escalate is key. No state can fulfill the vision of its ECCS plan without such strategic fiscal planning, and optimal health and development depends on the outcome of such plans. Preventing early school failure in young children at risk for poor social and emotional development is too important for their future and the future of this country to leave to chance.

Endnotes

1. Maternal and Child Health Bureau, Health Resources and Services Administration <www.mchb.hrsa.gov>.
2. Johnson, K. & Knitzer, J. (2005). *Spending smarter: A funding guide for policymakers to promote social and emotional health and school readiness*. New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health <www.nccp.org>.
3. Educate America Act. (1994).
4. Institute of Medicine; Shonkoff, J. P. & Phillips, D. A. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.
5. Knitzer, J. & Raver, C. C. (2002). *Ready to enter: What research tells policymakers about strategies to promote social and emotional school readiness among three- and four-year-old children* (Promoting the Emotional Well-being of Children and Families Policy Paper 3). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health <www.nccp.org>.
6. Knitzer, J. & Lefkowitz, J. (2005). *Resources to promote social and emotional health and school readiness in young children—A community guide*. New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health <www.nccp.org>.
7. See Knitzer and Raver in endnote 5.
8. See Shonkoff and Phillips in endnote 4.
9. National Research Council, Committee on Early Childhood Pedagogy, Commission on Behavioral and Social Sciences; Bowman, B. T.; Donovan, M. S.; & Burns, M. S. (Eds.). (2001). *Eager to learn: Educating our preschoolers*. Washington, DC: National Academy Press.
10. Thompson, R. A. (2001). Development in the first years of life. *Future of Children*, 11(1), and Thompson, R. (2002). The roots of school readiness in social and emotional development. In: *Set for success: Building a strong foundation for school readiness based on the social-emotional development of young children*. Kansas City, MO: The Ewing Marion Kauffman Foundation.
11. See Shonkoff and Phillips in endnote 4.
12. See Knitzer and Raver in endnote 5.
13. Ibid. Also see: Brown, B.; Weitzman, M.; Bzosek, S.; Kavanaugh, M.; Aufseeser, D.; Bagley, S.; Berry, D.; & Auinger, S. (2004). *Early child development in social context: A chartbook*. New York, NY: Commonwealth Fund, Child Trends, and the Center for Child Health Research, American Academy of Pediatrics.
14. Helburn, S. W.; Culkin, M. L.; & Morris, J. R.; & Clifford, R. M. (1995). *Cost, quality, and child outcomes in child care centers study: Public report*. Denver, CO: University of Colorado, Department of Economics. Also see: Gilliam, W. S. (2005). *Prekindergartens left behind: Expulsion rates in state prekindergarten programs* (FCD Policy Brief Series 3). New York, NY: Foundation for Child Development <www.fcd-us.org/PDFs/NationalPreKExpulsionPaper03.02_new.pdf>; and Capizzano, J. & Main, R. (2005). *Many young children spend long hours in child care* (Snapshots III of America's Families No. 22). Washington, DC: Urban Institute, Assessing the New Federalism.
15. Luthar, S. (In press). Resilience in development: A synthesis of research across five decades. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Risk, disorder and adaptation, Vol. 3, 2nd ed.* New York, NY: Wiley and Knitzer, J. & Lefkowitz, J. (2005). *Pathways to early school success: Helping the most vulnerable infants, toddlers, and families*. New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health <www.nccp.org>.
16. Knitzer, J. (2001). *Building services and systems to support the healthy emotional development of young children—An action guide for policymakers* (Promoting the Emotional Well-being of Children and Families Policy Paper 1). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.
17. Bethell, C. D. & Read, D. (2005). Mental health in the United States: Health care and well-being of children with chronic emotional, behavioral, or developmental problems—United States, 2001. *MMWR Morbidity and Mortality Weekly Report*, 54(39), pp. 985-9.
18. Halfon, N.; Uyeda, K.; Inkelas, M.; & Rice, T. (2004). *Building bridges: A comprehensive system for healthy development and school readiness* (Building State Early Childhood Comprehensive Systems Series 1). Los Angeles, CA: National Center for Infant and Early Childhood Health Policy, University of California at Los Angeles, Center for Healthier Children, Families, and Communities <www.healthychild.ucla.edu/NationalCenter>.
19. Ibid.
20. Rosenbaum, S. & Sonosky, C. (2000). *Federal EPSDT coverage policy*. Washington, DC: Prepared by the George Washington University Center for Health Services Research and Policy under contract to the U.S. Health Care Finance Administration, U.S. Department of Health and Human Services. See Centers for Medicare and Medicaid Services for federal regulations <www.cms.gov>.
21. Bergman, D. (2004). *Screening for behavioral developmental problems: Issues, obstacles, and opportunities for change*. Portland, ME: National Academy for State Health Policy.

22. Perkins, J. & Olson, K. (1999). *Medicaid Early and Periodic Screening, Diagnosis, and Treatment as a source of funding early developmental services*. New York, NY: Prepared by the National Health Law Program for the Commonwealth Fund. See also: Rosenbaum, S.; Proser, M.; Schneider, A.; & Sonosky, C. (2002). *Room to grow: Promoting child development through Medicaid and CHIP*. New York, NY: Commonwealth Fund; and Perkins, J. (2002). *Medicaid Early and Periodic Screening, Diagnosis, and Treatment as a source of funding early intervention services*. Los Angeles, CA: National Health Law Program.
23. Johnson, K. & Knitzer, J. (2001). *Making dollars follow sense: Financing early childhood mental health services to promote healthy social and emotional development in young children* (Promoting the Emotional Well-being of Children and Families Policy Paper 4). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health <www.nccp.org>.
24. See George Washington University, Department of Health Policy. (2000). *Purchasing specifications for child development services in Medicaid Managed Care, July, 2000*. Washington, DC: Georgetown University, Department of Health Policy <www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/child>.
25. As of October 2004, more than 20 states were using both Medicaid and non-Medicaid SCHIP plans, sometimes referred to as combination programs. Only 18 states have only separate SCHIP plans, that is, these states do not enroll the near-poor, uninsured children who qualify for SCHIP into Medicaid. For the latest SCHIP plans, see the official federal government map at <www.coms.hhs.gov/schip/chip-map.pdf>.
26. McPhearsan, M. (1998). A new definition of children with special health care needs. *Pediatrics*, 102(1), pp. 137-140.
27. New Freedom Commission on Mental Health. (2003). *Achieving the promise: transforming mental health care in America. Final report*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
28. U. S. Department of Health and Human Services, Head Start Bureau. (2000). *Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start, Vol. 1: Final technical report*. Washington, DC: Administration on Children, Youth and Families, Head Start Bureau, U. S. Department of Health and Human Services.
29. See <www.freetogrow.org>.
30. Cohen, E. & Walthall, B. (2003). *Silent realities: Supporting young children and their families who experience violence*. Washington, DC: The National Child Welfare Resource Center for Family-Centered Practice.
31. New IDEA requirements for infants and toddlers with disabilities and their families mandate that indicators for these risk factors, one of which deals with children and their social-emotional skills, are to be incorporated in new state 6-year plans and reported on annually to the U.S. Department of Education. Similar requirements apply to preschool-aged children. For more information, see Part C Annual Performance Reports at <www.ed.gov/policy/speced/guid/idea/capr/index.html>. See also: Federal code: 20 USC 1416(a)(3)(A) and 1442. Also see: National Early Childhood Technical Assistance Center (NECTAC). (2006). *State and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA* (NECTAC Notes No. 20). Chapel Hill, NC: NECTAC <www.nectac.org/-pdfs/pubs/nnotes20.pdf>.
32. IDEA 2004 reauthorization. The 1997 IDEA amendments (restated in the 2004 reauthorization of IDEA) encouraged states “to expand opportunities for children under 3 years who would be at risk of having substantial developmental delay if they did not receive early interventions services.” 20 USC Section 1431(b)(4).
33. P.L. 108-36. (June 25, 2003) Keeping Children and Families Safe Act of 2003. Amendment to Section 106(b) of the Child Abuse Prevention and Treatment Act (42 USC 5105a(b)).
34. Bruner, C.; Floyd, S.; & Copeman, A. (2003). *State Early Childhood Policy Technical Assistance Network—Financing school readiness strategies: An annotated bibliography*. Des Moines, IA: Child and Family Policy Center.
35. Fisher, H.; Cohen, C; & Flynn, M. (2000). *Federal funding for early childhood supports and services: A guide to sources and strategies*. Washington, DC: The Finance Project. Also see: Flynn, M. & Hayes, C. D. (2003). *Blending and braiding funds to support early care and education initiatives*. Washington, DC: The Finance Project.
36. See George Washington University in endnote 24.
37. Markus, A. R.; Rosenbaum, S. R.; & Stewart, A. (2005). *How Medical claims simplification can impede delivery of child developmental services*. New York, NY: The Commonwealth Fund.
38. Zero to Three: National Center for Infants, Toddlers, and Families. (1994). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood (DC: 0-3)* and Lieberman, A. F.; Wieder, S.; & Fenichel, E. (Eds.). (1997). *The DC 0-3 casebook: A guide to the use of Zero to Three's Diagnostic Classification of Mental Health & Developmental Disorders of Infancy & Early Childhood in assessment*. Washington, DC: Zero to Three: National Center for Infants, Toddlers, and Families.
39. See Johnson, K. & Kaye, N. (2004). *Using Medicaid to support young children's healthy mental development*. Portland, ME: National Academy for State Health Policy; VanLandeghem, K.; Curtis, D.; & Abrams, M. (2002). *Reasons and strategies for strengthening childhood development services in the healthcare system*. Portland, ME: National Academy for State Health Policy; and Rosenthal, J.; & Kaye, N. (2005). *State approaches to promoting young children's healthy mental development*. Portland, ME: National Academy for State Health Policy.