

# 5 Physical and Behavioral Health Integration

## *Integrating Child and Family Health, including Infant and Early Childhood Behavioral Health Services, Across State Early Learning and Development Systems*

Advances in scientific research have demonstrated how critical children’s physical and mental well-being is to optimal cognitive development. Early experiences shape brain architecture and impact physical and psychological development. New research indicates that these changes can impact the entire life cycle. Foundations of health are built through stable and responsive relationships, safe and supportive environments, and appropriate nutrition.<sup>176</sup> Parents and other primary caregivers are critically important. Young children develop in the context of these relationships, and responsive, nurturing interactions are a foundation for healthy social and emotional development.<sup>177</sup> Maternal depression, which by some estimates occurs in 50 percent of poor mothers with infants, is now understood to threaten mothers’ capacity to respond appropriately to their young children<sup>178</sup> and might even alter fetal development.<sup>179</sup> Adverse experiences in the earliest stages of development (in the pre- and post-natal period) can have particularly strong long-term implications.<sup>180</sup>

During team discussion time at EC 2010, many participants reflected back to the keynote presentation on the long term health implications

of early childhood experiences. Jack Shonkoff called for “reconceptualizing the health dimension of early childhood policy and practice” and “removing the social-emotional barriers to early learning.”

Although the science is clear, the path for states to ensure access for all children and families to appropriate and timely health care services, including those for behavioral health (for a definition of behavioral health, see page 4), is complex. EC 2010 team conversations on this topic often included discussion about how best to secure payment for treatment and whether there are adequate service providers with appropriate skills and training to serve young children in their states. State early care and education leaders may not have established relationships with state Medicaid administrators or the state Children’s Health Insurance Program (CHIP), key sources of funding for health services, including behavioral health services. Many EC 2010 attendees discussed making those connections upon return to their states. In general, lack of information from one service sector to another is a barrier to integration that has been made more pressing with passage of the Affordable Care Act. State leaders in non-health sectors want to better understand how reform will address the needs of

young children and their parents for health care. Other recurring issues involve infant and early childhood mental health needs, family stress, and maternal depression among families.

Critical issues that emerged from EC 2010 discussions and further research include:

- Integrating health promotion, including access to Medicaid and health insurance, a medical home, and good nutrition.
- Developing a coordinated system of screening, referrals, and follow-up services.
- Integrating infant and early childhood behavioral health and identification of maternal depression across systems.

## **Integrating Health Promotion, including Access to Medicaid and Health Insurance, a Medical Home, and Good Nutrition**

Some states are turning their attention to methods of promoting good health and nutrition for all children. Policies are emerging across the country that work to increase access to Medicaid or private health care insurance and primary care meeting the definition of a medical home (defined by the American Academy of Pediatrics [AAP] as health care services that are accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent) and promote good nutrition in early care and education settings and with families. Strategies include:

**Leveraging federal investments in health reform and Medicaid to expand coverage:** EC 2010 participants were aware that changes contained in the Affordable Care Act are important to extending health coverage to more children and their parents, although some were concerned that connections

to state health and Medicaid administration leaders were not strong enough. They are also concerned about the impact of the [recession](#) and state budget shortfalls on expansion plans.

It is important that leaders in child-serving agencies are informed and engaged in outreach activities for implementation about key changes. This includes increased child and parent eligibility for federally funded Medicaid to 133 percent of the federal poverty level (FPL), noting a prohibition on denying health insurance to children with preexisting conditions, and federal financing for higher reimbursement rates for primary care doctors and pediatricians through 2014.<sup>181</sup> State health care exchanges will reach parents beyond those eligible for Medicaid. Increasing parent health insurance coverage not only benefits children by improving parental health, it can also improve children's access to health care.<sup>182</sup> Community-based providers can help with outreach to enroll children and parents. Many states are engaged in planning processes to implement reform that early care and education and other early childhood leaders should try to join.<sup>183</sup> Some states seek similar connections by including health leaders in early childhood system planning. For example, **Texas'** Early Childhood Comprehensive Systems (ECCS) initiative, [Raising Texas](#), includes a representative from the Medicaid authority and health insurance agency in that state.

Prior to passage of national health care reform, some states had already moved beyond federal minimum requirements for Medicaid and CHIP to reach more low-income children and families. As of 2009, 24 states made children eligible for Medicaid and CHIP above 250 percent of the FPL. Some created state-funded expansions. For example, [Illinois All Kids](#) provides health care coverage to all children in the state without regard to family income, preexisting conditions, or

immigrant status. The Family Care program is available to income-eligible parents and relatives caring for children under age 18 who meet certain immigration conditions. Implementation studies<sup>184</sup> found key components of success were developing a simple application form that is accessible online and involving community-based agencies (such as child care and early education programs, schools, faith-based organizations, and medical providers) as “All Kids application agents.” These agencies turn in half of the applications received annually. They receive ongoing training and an incentive of \$50 for each successful enrollment from an application they helped to secure. A study released by the state in July 2010 found that 95.5 percent of children in Illinois had health insurance.<sup>185</sup>

**Raising the quality of primary care for young children:** Many state leaders are engaged in efforts to ensure that the primary care children receive follows national recommendations of the AAP for quality primary care and the schedule of check-ups and immunizations, consistent with [Bright Futures guidelines](#) and [educational resources](#). The guidelines provide standards for care focused on health promotion and disease prevention within the context of family and community. States have used them to set standards for medical practice; review state policy; and educate doctors, community-organizations, and parents. For example, **Virginia** created a state [Bright Futures website](#) to help educate the public on children’s health care and has state-level Bright Futures coordinators in the Department of Health. **Maine** adopted the Bright Futures guidelines as the standard of care for physicians in the state. **Washington** used the Bright Futures framework to assess existing Medicaid and Early Periodic Screening Diagnosis and Treatment (EPSDT) policies to improve coverage of critical services for young children.<sup>186</sup>



### THE PUBLIC HEALTH APPROACH

An EC 2010 presentation by Center for Disease Control and Prevention staff cited 10 essential elements that define a public health approach:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and safety.
7. Link people to needed personal health services and assure provision of health care when otherwise unavailable.
8. Assure a competent workforce for public health and personal health care.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based services.
10. Research for new insights and innovative solutions.

Source: Smith, C., Engaging Parents in Their Children’s Development. Presentation at EC 2010. Retrieved from [http://www.earlychildhood2010.org/NRCFiles/File/engaging\\_parents\\_in\\_promoting\\_children\\_health.pdf](http://www.earlychildhood2010.org/NRCFiles/File/engaging_parents_in_promoting_children_health.pdf).

**Promoting good nutrition and health in early care and education settings:** Recognition that the rate of obesity among children has tripled in 30 years and a [public campaign](#) by First Lady Michelle Obama have focused new attention on nutrition and other choices for young children, including those in child care and early education settings. The Center for Disease Control and Prevention (CDC) is developing trainings and materials for states on how to reduce obesity through child care and early education settings. CDC is recommending that states use multiple strategies, including specific standards in state child care licensing regulations, quality rating and improvement system (QRIS) programs, the Child and Adult Care Food Program (CACFP) requirements, professional certification programs, continuing education and training, curriculum, and program self-assessments.<sup>187</sup> National data on relevant child care licensing policies are limited.<sup>188</sup> A study of such regulations in 2006 focused specifically on opportunities to strengthen obesity prevention through licensing. For example, only 12 states had policies prohibiting or limiting foods of low nutritional value in centers (seven did so for small family child care homes and four for large family or group child care homes).<sup>189</sup> The AAP, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education have collaborated on [new nutrition, physical activity, and screen time standards](#) to inform state policymakers.

Some states and communities are moving quickly to prevent obesity in young children. For example, **Delaware** has implemented comprehensive changes in state licensing and CACFP regulations to promote better nutrition and physical activity. [Findings](#) from focus groups with early care and education directors, family child care home providers, and parents found that while the new standards were viewed positively, it would be important to provide training, technical

assistance, resources, and materials to successfully implement the requirements.<sup>190</sup> Those who need training may include child care health consultants, Head Start and Early Head Start health and nutrition specialists, after school program trainers, and state licensors.<sup>191</sup>

**New York** has used the CACFP program and federal funding for nutritious meals and snacks for low-income children in centers and family child care homes to address childhood obesity and reach more children with healthy food. The [“Eat Well Play Hard in Child Care Settings”](#) initiative provides preschool age children and parents information on nutrition and physical activity, and funding to train early care and education providers on health and nutrition practices. The primary source of funding is the U.S. Department of Agriculture’s Food Stamp Nutrition Education Program. State healthy meal standards for children receiving CACFP were improved to exceed federal standards in October 2009, for example requiring low-fat milk and all breads and cereals to be whole grain.<sup>192</sup> Cross-agency efforts between the CACFP and child care subsidy agency have led to several changes that extend the reach of CACFP to more low-income children by allowing license-exempt family, friend, and neighbor caregivers to receive the funds and use CACFP home visiting funding to provide oversight on health and safety practices. They then share that information with local child care resource and referral agencies responsible for administering subsidies for low-income families.<sup>193</sup>

## **Developing a Coordinated System of Screening, Referrals, and Follow-Up Services**

Even when they have health insurance or coverage from Medicaid or CHIP, children may not receive the treatment they need without a seamless system of screening, referrals, and help to access treatment.

This coordination is especially important for low-income children. Although federal law mandates that all children in Medicaid receive these services through the EPSDT benefit, the Office of the Inspector General for the U.S. Department of Health and Human Services reviewed data from nine states and found that 76 percent of children did not receive one or more of the required EPSDT medical, vision, or hearing screenings; and 41 percent did not receive any required medical screenings.<sup>194</sup> EPSDT is designed to cover costs for any service necessary to promote a child's healthy physical, behavioral, and emotional development. Barriers include complex Medicaid billing codes and procedures and low reimbursement rates, lack of trained providers in the community, language, and transportation challenges for families.<sup>195</sup> Another concern is coordination of services across federal programs (e.g., Medicaid and Part C of the Individuals with Disabilities Education Act [IDEA]) and throughout the system, including in early care and education settings.

The [Assuring Better Child Development](#) (ABCD) project, which is funded by the [Commonwealth Fund](#) and administered by the [National Academy for State Health Policy](#) (NASHP), has produced a significant body of research on state Medicaid and CHIP policy and financing innovations aimed at promoting the healthy development of low-income children birth to age 3 through standardized screening, referrals, and access to treatment. Over the past 10 years, 27 states have participated in the ABCD project. Some strategies that states are using include revising state-determined rules for federal funding streams to address needs of young children and increasing coordination of health care, including behavioral health care, for children. Another approach has been to expand access to Early Head Start, which includes provisions and staffing to link infants and toddlers to screening, referrals, and treatment.



### WAYS STATES MAY LEVERAGE MEDICAID TO PAY FOR EARLY CHILDHOOD SERVICES

- Require an Early Periodic Screening Diagnosis and Treatment (EPSDT) screening schedule that meets AAP recommendations.
- Require or permit EPSDT age-appropriate screening and diagnostic tools for infants, toddlers, and preschoolers that are sensitive to social, emotional, and behavioral issues
- Pay for covered services delivered in a range of community-based settings or through home visiting.
- Include separate definitions and billing codes for developmental assessment or screening and diagnostic evaluations.
- Use state matching funds strategically with Medicaid to support behavioral and mental health consultation in child care and home visiting programs.
- Provide reimbursement for parent-child therapy.
- Use Medicaid administration funds to pay for EPSDT care coordination services.
- Exercise a state option to provide targeted case management to a select population with complex needs, such as children in EPSDT.
- Pay an enhanced rate to primary care providers to enable primary care case management capacity.

Sources: National Center for Children in Poverty, *The Spending Smarter Checklist*, 2005; and National Academy for State Health Policy, *Coordinating Care for Young Children Receiving Intervention Services: Opportunities in Medicaid*, October 2010.

### **Revising state-determined rules for use of Medicaid and CHIP funds to pay for standardized, age-appropriate screening, assessment, and other services:**

States have revised rules that make a critical difference to ensuring access to and payment for necessary screening, referrals, and treatment. The AAP recommends that developmental screening using standardized tools occur at the 9-, 18-, and either 24- or 30-month check-ups in the first three years of children's lives.<sup>196</sup> Health care service providers caring for low-income children are the objects of many states' efforts to [promote or require use of age-appropriate standardized screening instruments](#) such as the Ages and Stages Questionnaire (ASQ), Ages and Stages Questionnaire–Social Emotional (ASQ-SE), Parents' Evaluation of Developmental Status (PEDS), and Pediatric Symptom Checklist.<sup>197</sup> Using a standardized tool can also help with cross-system coordination of services. For example, the **Pennsylvania** Office of Child Development and Learning (OCDEL) purchased the rights to use the ASQ and the ASQ-SE. They recommended its use for birth to age 3 screening in the child welfare, early childhood mental health consultation, or home visiting service systems. This is required within 45 days of enrollment for children entering child care programs rated three or more stars in the Keystone STARS QRIS.<sup>198</sup> The ASQ and ASQ-SE are also recommended assessment tools in the state Medicaid program and Head Start and Early Head Start. **Iowa** created an [online child health and development record](#) resource with forms that doctors can download and complete to guide appropriate screening at set age intervals.

Another important opportunity to expand access to screening and referrals comes through the Part C of IDEA early intervention program. States have the option of expanding these services

to children “at risk” of delay although only a handful of states currently do so. The number has been decreasing since the recession began.<sup>199</sup>

Because Medicaid guidance does not define child development services, securing payment through Medicaid and CHIP is complicated but crucial. For example, Iowa [clarified Medicaid billing codes](#) for comprehensive preventative child health screening; family risk assessment and social-emotional and developmental screening; and testing and diagnosis. The state encourages medical providers to use a [crosswalk](#) (originally developed in Maine) between the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0–3) and Medicaid codes to ensure funding of age appropriate services.

Easing access to Medicaid for pregnant women and new mothers is another strategy to promote healthy early childhood development. Thirty-five states allow presumptive eligibility for pregnant women so that they may access health service immediately while their eligibility is being confirmed, and 15 states do so for children.<sup>200</sup> Thirty-one states allow infant care education services to be covered by Medicaid funding.<sup>201</sup>

### **Coordinating systems of care to ensure effective referrals and access to services:**

States are trying different approaches to help link families to referrals and access to follow-up services that children need, through primary care providers and other strategies. A 2010 report by the Commonwealth Fund profiled initiatives in five states (**Colorado, Connecticut, Iowa, North Carolina, and Rhode Island**) that have been innovators in addressing the need for a coordinated system of care.<sup>202</sup> For example, the key components of Connecticut's Help Me Grow initiative, now being [replicated](#) in five states, are

improving physician training to systematically consider children's development during visits; developing a toll-free call center to help link parents to services their children need; maintaining an inventory of services available in communities for use by care coordinators at call centers; maintaining an inventory of services available in communities for use by hotline staff; utilizing community liaisons between central call centers and local services to provide a communications loop; and instituting an annual evaluation of outcomes to improve the initiative.<sup>203</sup> Help Me Grow in Connecticut is primarily funded by the Children's Trust Fund. Several more states indicated that they would adopt the Help Me Grow approach in their Early Childhood Advisory Council (ECAC) plans.

**North Carolina's** Assuring Better Child Health and Development initiative builds on the state's Medicaid managed care system. Primary care doctors that participate in one of 14 community care networks receive funding per child per month to provide case management services. This funding is used to hire case managers, provide medical homes, coordinate referrals to specialists, provide 24-hour coverage, and improve the quality of primary care.<sup>204</sup> Through this initiative, North Carolina changed its Medicaid policy in 2004 to require use of a valid, standardized, developmental screening tool at certain well-child visits.<sup>205</sup>

Federal grants have promoted localities as laboratories for systems innovation in partnership with state leaders. Seventeen states and seven communities and Tribes have federally funded **Project LAUNCH** (Linking Actions for Unmet Needs in Children's Health) grants that are designed to promote systemic child health promotion and prevention strategies in a specific community and translate relevant implications for state leaders. Project LAUNCH strategies include

developmental assessments in a range of child-serving settings; integration of behavioral health into primary care settings; mental health consultation; home visiting; and family strengthening and parent skills training. Grantees form cross-system Child Wellness Councils that conduct environmental scans and cross-system planning. For example, **Massachusetts'** collaborative initiative is coordinated by a management team that includes state-level staff from the state health and public health agencies, the Boston Public Health Commission, and the local agencies' key staff. This group coordinates two Substance Abuse and Mental Health Services Administration (SAMHSA) grants in the state: Project LAUNCH and a Systems of Care grant focused on addressing needs of children with serious emotional disorders (SEDs). Teams consisting of an early childhood mental health clinician and a family partner have been placed at five key community-based health care locations in Boston. Screening on behavioral health, family risk, and maternal depression are integrated into well-child visits. The initiative taps Medicaid to pay for infant and early childhood mental health services, using a crosswalk with the Diagnostic Classification of Early Childhood (DC 0-3 R) as well as care coordination.<sup>206</sup>

**Expanding access to Early Head Start:** Some states are expanding access to services that meet federal Head Start Performance Standards for at-risk infants, toddlers, and their families. Federal Head Start and Early Head Start grantees are mandated to provide developmental screenings within 45 days of enrollment and follow-up to help families' access referrals and treatment,<sup>207</sup> but other early care and education settings serving low-income children may not have standards, staff, or resources to do so. For example, the **Kansas** and **Missouri** Early Head Start programs require partnerships between federal Head Start

and Early Head Start grantees and existing community-based child care centers or family child care homes. They use state or Child Care and Development Fund (CCDF) funds to pay for eligible children to access the full range of federally required comprehensive services. Both states partner with their federal Regional Office of Head Start to leverage that system's federally funded professional development and technical assistance for the state-funded Early Head Start grantees.<sup>208</sup> In a different approach, Oregon is piloting the **Oregon** Program of Quality (OPQ) initiative which assists community child care centers and family child care homes to [meet a set of standards](#) aligned with the federal Head Start Performance Standards. These enable facilities to serve as “community placement” agencies that provide services for Early Head Start, Head Start, and IDEA Part C–eligible children.<sup>209</sup>

## **Integrating Infant and Early Childhood Behavioral Health and Identification of Maternal Depression Across Systems**

A number of states are focusing on infant and early childhood behavioral health and maternal depression at the same time that the scientific research and understanding of the importance of social and emotional development have become established. A [report](#) prepared by the National Research Council and the Institute of Medicine highlighted the issue and prevalence of parental depression and its connection to child development, and made a set of recommendations. Federal grants and technical assistance for states to attend to these issues from the behavioral health (through SAMHSA) and child care and early education (through the Office of Head Start and Office of Child Care) sectors may have played a role in spurring action at the state-level (see

Appendix D: Federally Funded National Technical Assistance Centers, p. 127). For example, the [Center on the Social and Emotional Foundations for Early Learning](#) (CSEFEL) is a national resource center that provides information on current research and evidence-based practices in promoting social and emotional development. CSEFEL partners with **California, Colorado, Hawaii, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, Vermont** and **Wisconsin**. The [Technical Assistance Center on Social Emotional Intervention for Young Children](#) (TACSEI) partners with **Alaska, Minnesota, Nevada, and West Virginia** to help with planning and implementing professional development systems that improve the capacity of the early childhood workforce to meet the needs of young children, particularly those with or at risk for delays or disabilities. The work of CSEFEL and TACSEI is guided by the Pyramid Model, a conceptual framework for promoting social emotional competence in infants and young children (see Figure 1, p. 69).

**Assessing gaps in infant and early childhood and behavioral health services:** Some states are documenting barriers to infant and early childhood and behavioral health services, especially in more rural areas. For example, in **Maine**, the [Maine Rural Health Research Center](#) at the University of Southern Maine conducted a [study of access to mental health services for children](#) based on parent reporting. Researchers found that rural children were less likely to receive all needed mental health care as compared to children in urban settings. Rural families reported spending more time coordinating their children's care compared to their urban counterparts.<sup>210</sup> The center is funded by the federal [Office of Rural Health Policy](#), which funds similar centers in **North Carolina, South Carolina**, the Upper Midwest (**Minnesota** and **North Dakota**), **Washington**, and **West Virginia**.

**Integrated infant and early childhood behavioral health planning and financing across all child-serving agencies:** Effective statewide planning across sectors often evolves over years as stakeholders build relationships and learn to leverage multiple funding resources to move toward shared goals. For example, **Colorado** built on a number of initiatives, including successful implementation of four county early childhood mental health pilots partly funded by a Systems of Care grant from SAMHSA, to pull together a Blue Ribbon Policy Council for Early Childhood Mental Health with high-level leadership from the lieutenant governor. At the same time, a public-private interagency team was developing a comprehensive [Policy Framework](#) to guide development of an

early childhood system. In 2008, the [statewide early childhood mental health plan](#) laid out a blueprint to increase public engagement, build professional and workforce development, coordinate funding and financing, expand availability of services, and form a system of care that supports promotion, prevention, and intervention. To promote opportunities to put diverse funding sources together, state administrators put together a website with information on all relevant federal, state, and local public and private funding streams that can be used to pay for early childhood services called [Blending Revenues Across Interagency Departments \(BRAID\)](#).<sup>211</sup> Colorado's new [Center for Social Emotional Competence and Inclusion](#) has funding from the Colorado Department of

**FIGURE 1.**  
**CSEFEL/TACSEI Pyramid Model**  
**for Supporting Social Emotional**  
**Competence in Infants and**  
**Young Children**



Human Services, Division of Child Care, Division for Developmental Disabilities Early Intervention Program, and Division of Behavioral Health. The center combines train-the-trainer efforts using the federally funded CSEFEL Pyramid model and the SpecialQuest birth-to-5 inclusion model.

In another approach, **Florida** convened a cross-section of public and private stakeholders in 2000 that developed a [statewide plan explicitly focused on infant mental health](#). Later, with funding received under the ECCS grant to its Department of Health, the state moved forward with several strategies, including training for medical professionals on developmental screening and maternal depression and screening.<sup>212</sup>

**Providing mental health consultation to child-serving programs:** At least 29 states have statewide or regional early childhood mental health consultation projects to enhance awareness and capacity among child care and early education providers, with a few also including unlicensed family, friend, and neighbor caregivers.<sup>213</sup>

Analysis of these programs has found systemic challenges, such as a need for more infant and toddler mental health clinicians and bilingual consultants and a lack of sustainable funding for this prevention-oriented activity. To be effective, national research indicates that these initiatives need strong leadership and strategic partnerships at the state and local levels.<sup>214</sup> **Connecticut** started its now statewide Early Childhood Consultation Partnership (ECCP) in 2002. ECCP is designed to prevent suspensions and expulsions of children birth to age 5 from early childhood settings by providing consultation and supports to providers. The state issued a request for proposals (RFP) and awarded the ECCP contract to a nonprofit behavioral health

management company, which in turn subcontracts with 10 nonprofit community-based agencies. ECCP consultants work with child care centers, Early Head Start and Head Start programs, licensed family child care homes, foster care settings and intermediate safe homes, kinship care homes, substance abuse residential facilities, and community resource centers.<sup>215</sup> They provide consultation at the child-specific, classroom, and site levels. ECCP is funded primarily by \$2.1 million in state funding from the Department of Children and Families, Early Intervention Unit, and the Department of Education.<sup>216</sup>

**Innovative strategies to identify and address parental depression:** Low-income infants and toddlers are disproportionately likely to live with depressed parents, most of whom are unlikely to receive professional treatment.<sup>217</sup> Parental depression can be harmful to children because it impairs the capacity of parents to be responsive to children, and it can harm family economic and household stability.<sup>218</sup> Addressing maternal depression alone will not necessarily improve chances for healthy development of children, but research shows that joint parent-child treatment is more promising.<sup>219</sup> Persistent maternal depression and experiences of interpersonal trauma can compromise the effective delivery of support services such as home visiting to first-time mothers.<sup>220</sup>

States have opportunities to reach depressed mothers when they and their families are identified through other programs and services. The majority of mothers of young children suffering depression also access the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), health care services, food stamps, or Temporary Assistance for Needy Families (TANF).<sup>221</sup>

A recent expansion of federal investments in Early Head Start and the Maternal, Infant, and Early Childhood Home Visiting program offers the opportunity to connect depressed mothers with services. For example, the Family Connections Project in Boston, **Massachusetts**, has resulted in Early Head Start, child care, community health center, and Harvard Graduate School of Education participation in a partnership that trains staff to work with depressed parents, offers support, and provides appropriate referrals and treatment.<sup>222</sup> Two federal Evidence-Based Home Visiting (EBHV) grantees are examining the benefits of adding enhanced mental health services for caregivers with identified mental health needs, such as maternal depression and those at greatest risk of child maltreatment. The Rochester, **New York**, EBHV project will use a comprehensive screening process that identifies whether the family needs more intensive mental health services. Based on the initial screening, the family may receive additional evidence-based mental health and parenting programs. These may include the Interpersonal Psychotherapy, Child Parent Psychotherapy, or the Incredible Years programs, which all focus on depression, attachment, and trauma-related issues. In **Tennessee**, the LeBonheur EBHV project provides enhanced mental health training and consultation to nurses in their role as home visitors to help them better address needs of the parents they serve, many of whom suffer from maternal depression.

States can also provide information and guidance to physicians who take Medicaid patients to make treatment of the parent-child “dyad” possible. **Illinois’ Department of Healthcare and Family Services** funds a **Perinatal Mental Health** project at the University of Illinois–Chicago that offers toll-free physician-to-psychiatrist phone consultation about screening and treatment, physician training, and several online resources to aid in delivering appropriate mental health services, including billing codes for Medicaid.

States are **integrating child and family health, including mental health, services across state early learning and development systems by:**

- Integrating health promotion, including access to Medicaid and health insurance, a medical home, and good nutrition.
- Developing a coordinated system of screening, referrals, and follow-up services.
- Integrating infant and early childhood mental health and identification of maternal depression across systems.