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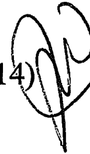
Senate
State of Minnesota

S.F. No. 1374 - Community Education Funding Restoration and Aid Appropriation

Author: Senator Rod Skoe

Prepared by: Joan White, Senate Counsel (651/296-3814)



Date: March 29, 2005

Section 1 amends the community education revenue statute, by changing the formula for fiscal year 2006 and later years. Current law provides $5.23 times the formula for fiscal year 2005 and later. This bill provides $5.95 times the formula for fiscal year 2006 and later.

Section 2 provides the appropriations for community education aid.

JW:rdr

Senators Skoe, Chaudhary, Sparks and Kiscaden introduced--

S.F. No. 1374: Referred to the Committee on Finance.

1 A bill for an act

2 relating to education finance; restoring funding for
3 the basic community education program; appropriating
4 money; amending Minnesota Statutes 2004, section
5 124D.20, subdivision 3.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

7 Section 1. Minnesota Statutes 2004, section 124D.20,
8 subdivision 3, is amended to read:

9 Subd. 3. [GENERAL COMMUNITY EDUCATION REVENUE.] The
10 general community education revenue for a district equals $5.95
11 for fiscal year 2003 and 2004 and $5.23 for fiscal year 2005
12 and <u>$5.95 for fiscal year 2006 and</u> later, times the greater of
13 1,335 or the population of the district. The population of the
14 district is determined according to section 275.14.

15 [EFFECTIVE DATE.] <u>This section is effective for revenue for</u>
16 <u>fiscal year 2006.</u>

17 Sec. 2. [APPROPRIATION.]

18 <u>Subdivision 1.</u> [DEPARTMENT OF EDUCATION.] <u>The sums</u>
19 <u>indicated in this section are appropriated from the general fund</u>
20 <u>to the Department of Education for the fiscal years designated.</u>

21 <u>Subd. 2.</u> [COMMUNITY EDUCATION AID.] <u>For community</u>
22 <u>education aid under Minnesota Statutes, section 124D.20:</u>

23 <u>$3,391,000</u> <u>.....</u> <u>2006</u>

24 <u>$3,143,000</u> <u>.....</u> <u>2007</u>

25 <u>The 2006 appropriation includes $509,000 for 2005 and</u>

1 $2,882,000 for 2006.

2 The 2007 appropriation includes $720,000 for 2006 and

3 $2,423,000 for 2007.

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1374-0 **Complete Date:**

Chief Author: SKOE, ROD

Title: BASIC COMMUNITY ED PROGRAM FUNDING

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Education Department

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		888	1,777	1,935	1,958
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		888	1,777	1,935	1,958
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		888	1,777	1,935	1,958
Total Cost <Savings> to the State		888	1,777	1,935	1,958

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Preliminary

Bill Description

Section 1 increases the Basic Community Education revenue allowance from $5.23 to $5.95 per resident (or 1,335 whichever is greater) effective for FY 2006 revenue. The 2003 legislature reduced the basic rate from $5.95 to $5.23 in FY 2005. The rate increase would inflate both aid entitlements and levy authority on a statewide basis, and require levy adjustments to FY 2006 revenue in the certify 2005 pay 2006 levy cycle.

Section 2 appropriates money from the general fund for Community Education aid. The general fund cost estimates in this fiscal note are Department of Education estimates and do not tie out to the appropriations amounts in the bill.

Assumptions

February 2005 forecast assumptions for calculating revenue:

- 2000 Census populations (as adjusted and reported to the State Demographer for the certify 2004 pay 2005 levy cycle) for FY 2006 revenue, adjusted by 1.2% per year for FY 2007-2009 revenue estimates.
- All population increase occurs among districts with population > 10,000.
- 2003 and 2004 ANTC values for FY 2006 revenue and estimated FY 2007 base revenue.
- Estimated adjusted average fund balances.

The levy adjustment for FY 2006 revenue levied in the Pay 2006 levy cycle will be recognized 100% early in FY 2006 without aid adjustment per M.S. 126C.48, subd. 6.

Levy changes resulting from this bill occurring in the Pay 2006 levy cycle and later, revenue for FY 2007 and later, will affect early levy recognition (tax shift) under M.S. 123B.75, Subd. 5. State aid adjustments related to the early recognition will change the required general education appropriation.

Expenditure and/or Revenue Formula

- FY 2006 Community Education revenue = the sum of:
    a. $5.95 times the adjusted 2000 Census population or 1,335, whichever is greater;
    b. $1.00 per resident (population floor of 1,335) for districts with a Youth Service Program;
    c. $1.85 per resident up to 10,000 population and $0.43 per resident above 10,000 population for districts with an After School Program.
- Levy authority equal to the lesser of 0.985% times 2003 ANTC or Community Education revenue.
- Community Education aid entitlement, which is the difference between formula revenue and levy authority.
- Estimated penalty for excess fund balance = lesser of (greater of (adjusted average fund balance - 25% fund balance limit) or 0) or Community Education Revenue.
- Allocate excess fund balance penalty proportionately to aid and levy adjustments.
- Adjusted revenue = Community Education aid (levy)– excess fund balance aid (levy) adjustment.
- Calculate FY 2007 Community Education base revenue by district using the Census population used for FY 2006 revenue; levy authority equal to the lesser of 0.985% times 2004 ANTC or Community Education base revenue. Calculate levy percentage of state total revenue = levy authority / total base revenue.
- Adjust state total base revenue for estimated population changes of 1.2% per year. Assume population increase occurs in districts with populations above 10,000, generating marginal revenue increase of $7.38 per capita: $5.95 Basic revenue + $1.00 Youth Service revenue + $0.43 After School revenue.
- Estimate aid and levy shares of total revenue adjusted for population change for FY 2007-FY 2009 by applying the levy percentage of FY 2007 base revenue.

NET REVENUE AFTER EXCESS FUND BALANCE ADJUSTMENTS			
REVENUE - MDE Estimate			
Total Net Revenue	Current Law	H 710/ S 1374	Difference
FY 2006	36,259	39,973	3,714
FY 2007	36,792	40,649	3,857
FY 2008	37,682	41,495	3,813
FY 2009	38,140	41,993	3,852
AID ENTITLEMENT - MDE Estimate			
Entitlement	Current Law	H 710/ S 1374	Difference
FY 2006	1,812	2,880	1,068
FY 2007	1,073	1,761	689
FY 2008	1,098	1,795	698
FY 2009	1,110	1,816	706
LEVY AUTHORITY - MDE Estimate			
Levy Authority	Current Law	H 710/ S 1374	Difference
FY 2006	34,448	37,093	2,646
FY 2007	35,719	38,888	3,169
FY 2008	36,585	39,700	3,115
FY 2009	37,030	40,177	3,146
AID APPROPRIATION - MDE Estimate	Difference, H 710/ S 1374 vs. Current Law - Appropriation Basis		
Appropriation	84.3% Current	15.7% Final	Total Appropration
FY 2006	900	-	900
FY 2007	580	168	748
FY 2008	588	108	696
FY 2009	595	110	705

Estimated Tax Shift Cost/(Savings)	Rate		0.486	
in thousands				
Levy Year	Pay 2006	Pay 2007	Pay 2008	**Pay 2009
Revenue Recognition Year	FY 2006	FY 2007	FY 2008	FY 2009
Levy Amt	3,169.0	3,115.0	3,146.0	3,177.3
Early Levy Recognition	1,540.1	1,513.9	1,529.0	1,544.2
Aid Cost (Savings) General Education	(1,540.1)	26.2	(15.1)	(15.2)

** Assumes levy will increase at the same rate as in Pay 2008.

Long-Term Fiscal Considerations

This is a continuing program.

Local Government Costs

The increase in the Basic Community Education formula rate will increase local property

Minneapolis Public Schools
Community Education Youth Programs

Achieving Results Through Learning and Partnering

Youth Programs Change Lives

Youth development research indicates the many benefits associated with providing quality programs. First, programs benefit youth by supporting their brain development, which continues at a rapid rate through adolescence. Second, these programs give youth the exposure they need to a wide range of experiences that help shape who they become in adulthood and give them real experiences in making appropriate decisions. Third, the community benefits because youth who participate in quality programs are more likely to be active citizens by contributing back to their community. These are all measurable benefits. National research confirms that youth programs also change lives by:

- **Increased academic achievement and greater engagement in learning.** *(US Dept. of Education, Mid-continent Research for Education & Learning)*
- **Increased school attendance.** *(National Institute on Out of School Time, US Dept. of Education)*
- **Better emotional adjustment and connection to school and community.** *(Search Institute, National Research Council and Institute of Medicine)*

On the pages that follow are brief overviews of various MPS Community Education programs and a sampling of the results that these programs have had on young people who participated in them.

Hershel Ousley and his son Joshua work together at a spring neighborhood cleanup. Through Community Education Programs, youth learn, grow, and connect with their community.

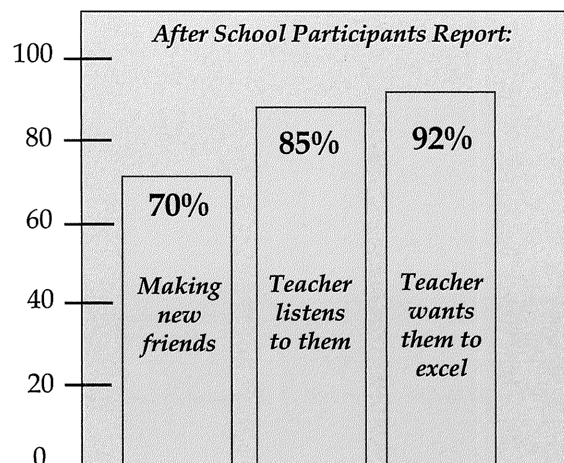
After School Programs for Youth

Community Education provides a secure environment where young people can learn new skills, explore new interests, and make new friends. Some programs are academic; some foster an interest in the arts; and others promote healthy lifestyles. All infuse fun:

Peer Mentoring
Beginning Spanish
Computer Classes
Math
Reading
Chess
Bookmaking
Somali Club
Hoops n' Homework

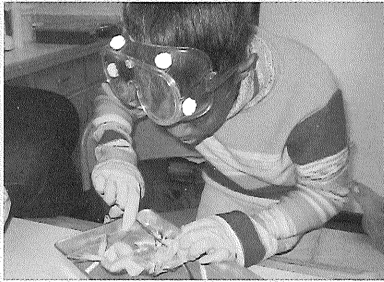
Programs: 22
Youth served: 42,000

Community Education Youth Programs Strengthen Relationships Between Students and Adults



Source: *Children's Survey, 2002-03 After School Program*

Community Education Learning Centers



Marian works intently on a biology project in her after school class at Whittier Community School for the Arts. This class encourages girls to explore math and science and to gain confidence through hands-on projects that are both fun and educational.

Community Education Learning Centers serve students and their families with programs that support academics, enrichment, personal development, and community service. Programs are located in schools where many students' families are experiencing high levels of poverty and many recent immigrants are attending.
Funded in part by U.S. Dept. of Education.

Programs: 7
Youth served: 2151

AmeriCorps/Youthworks

City of Lakes AmeriCorps Member Alicia Smith works with Esdra on his math and reading homework at Andersen Elementary.

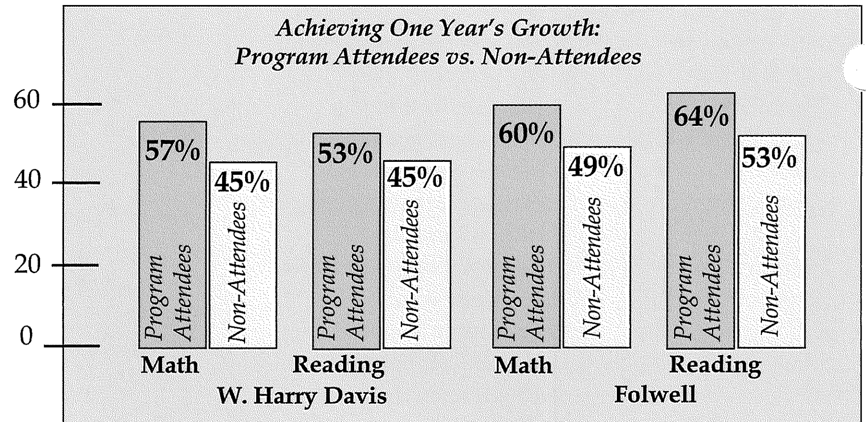
The AmeriCorps Program is considered the domestic Peace Corps. AmeriCorps members commit to a year of service in their communities. They work in classrooms during the school day and lead activities in after school programs.
Funded in part by the Corporation for National Service and Minnesota YouthWorks.

Students tutored: 201
Students served in after school activities: 624

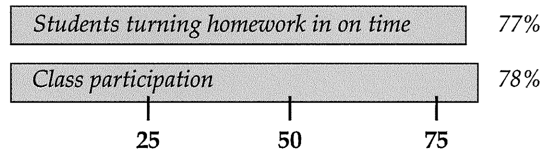
Community Education Achieves Results by...

...Supporting School Success

Community Education staff partner with schools and community organizations to offer programs that extend learning opportunities beyond the K-12 school day.



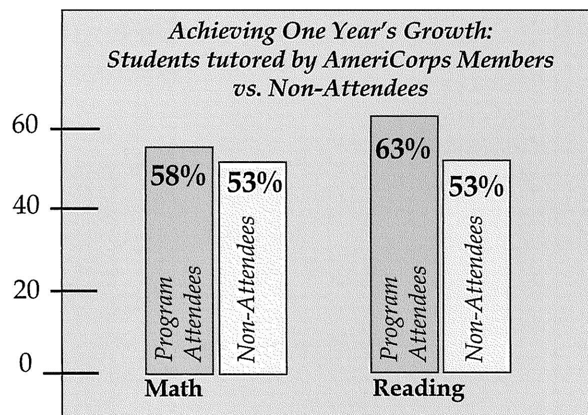
Teachers Report Improvement in:



12 Extra Days School attendance

Students who participate in Learning Center programs attend school an average of 12 days more than those who do not.

Source: *21st Century Learning Centers, 2002-03*



Source: *City of Lakes AmeriCorps, 2003-04*

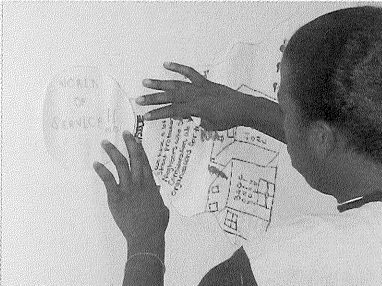
Youth Service/ Service Learning

Jake and Abdi joined the Pratt School and Southeast community members in cleaning up the school, playground and garden on Earth Day, 2004.

Youth Service programs engage young people in service in their schools or the greater community. Service learning is teaching and learning that combines academic work with service to the community.

Programs: 31
Youth participating: 2,445

Developing Leaders



A student creates a "community map" as part of a leadership project at North High. Students learn how to work together to uncover the causes and effects of community issues and then develop service projects to address them.

Community Education staff work to engage young people in being leaders, learners, teachers, and involved citizens through training, youth employment, and councils.

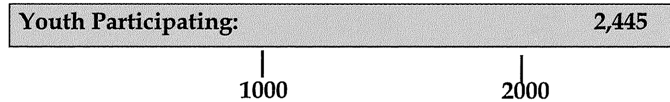
Programs: 28
Youth served: 1,216

Community Education Achieves Results by...

...Connecting Youth and Community

Community Education programs work with young people to identify important school and community issues, and then find ways to address them.

Schools Participating in Youth Service Activities: 31

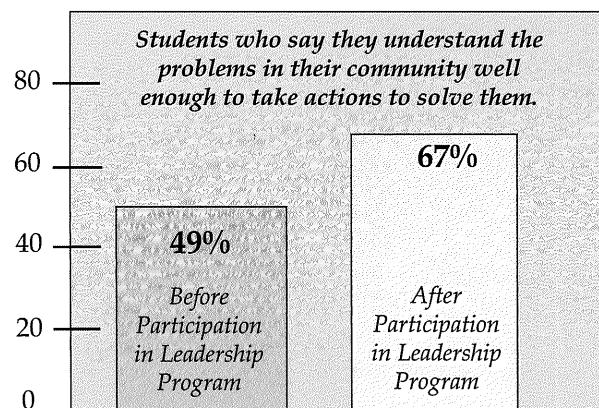


Examples of Youth Service Activities:
- Held Carnival Fundraiser for Charity
- Served Meal at Homeless Shelter
- Visited Seniors
- Created Mural to Celebrate Diversity
- Designed Garden
- Help Build a Home with Habitat for Humanity
- Planted Trees at School
- Tutored Younger Students
- Conducted a Food Drive
- Wrote Letters to Troops
- Visited Childrens Hospital

Source: *Minneapolis Community Education, 2003-04*

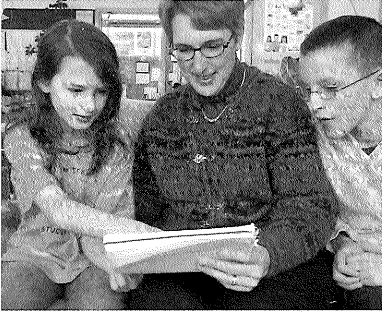
...Building Leadership Skills

Youth learn they can take action to solve community concerns by developing valuable skills such as building teams, conducting research, and thinking critically.



Source: *Community Education Leadership Training (PYLI) Survey*

School Age Child Care

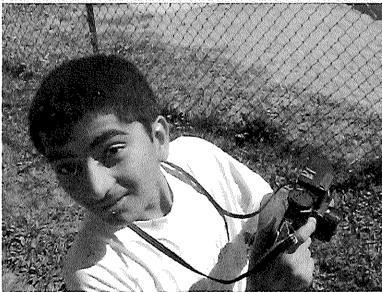


Katie McCreary shows her mother, Cindy, and her brother, Dylan, the projects that she worked on at the Minneapolis Kids School Age Child Care program, including finishing her homework and an art project.

Minneapolis Kids provides childcare for school age children before and after school. Programs support families' work needs, and their children's educational and social development needs.

Number of sites: 16
Number of youth served: 1,400

Summer Programs



Danial views the world through a camera lens at the Green Central Media Arts Camp. He and other students use photography to make a statement about life in their school and community.

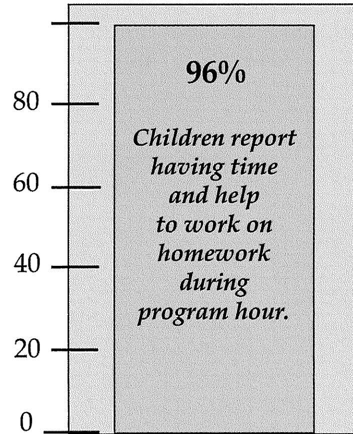
Summer programs allow young people to spend substantial time having fun, making friends, and exploring their interests. Programs include enrichment, leadership development, community service, recreation, and field trips. Staff also infuses reading into activities.

Number of sites: 21
Number of youth served: 5,500

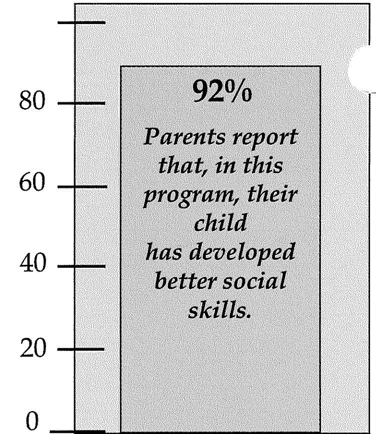
Community Education Achieves Results by...

...Supporting Families

Community Education works with families to provide programs that support their child's growth, and allow parents to join in program activities.



Source: *Minneapolis Kids Participant Survey*



Source: *Community Education Summer Program Parent Survey*

...Collaborating with over 100 Partners

Collaborations are a vital part of delivering youth programming in the Minneapolis Public Schools. Community Education works with over 100 different organizations, including those that serve youth, faith communities, and other governmental jurisdictions to provide young people with a diverse array of after school opportunities.

For More Information, Contact:

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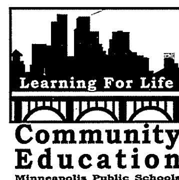

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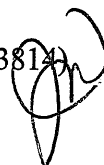
Senate
State of Minnesota

S.F. No. 222 - School Districts Prekindergarten Pupils Extended Home Revenue Eligibility

Author: Senator Wes Skoglund

Prepared by: Joan White, Senate Counsel (651/296-3814)



Date: March 23, 2005

S.F. No. 222 amends the education funding chapter of law, specifically the learning year pupil unit, by allowing a district to count a pupil who is at least four years old, not yet enrolled in kindergaten, and participating in a learning year program, as not more than .2 pupils in average daily membership for purposes of extended revenue only.

This section is effective for fiscal year 2006 and later.

JW:rdr

Senators Skoglund and Dibble introduced--

S.F. No. 222: Referred to the Committee on Finance.

1 A bill for an act

2 relating to education finance; making four-year-old
3 students eligible for extended time programs; amending
4 Minnesota Statutes 2004, section 126C.05, subdivision
5 15.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

7 Section 1. Minnesota Statutes 2004, section 126C.05,
8 subdivision 15, is amended to read:

9 Subd. 15. [LEARNING YEAR PUPIL UNITS.] (a) When a pupil is
10 enrolled in a learning year program under section 124D.128, an
11 area learning center under sections 123A.05 and 123A.06, an
12 alternative program approved by the commissioner, or a contract
13 alternative program under section 124D.68, subdivision 3,
14 paragraph (d), or subdivision 3a, for more than 1,020 hours in a
15 school year for a secondary student, more than 935 hours in a
16 school year for an elementary student, or more than 425 hours in
17 a school year for a kindergarten student without a disability,
18 that pupil may be counted as more than one pupil in average
19 daily membership for purposes of section 126C.10, subdivision
20 2a. The amount in excess of one pupil must be determined by the
21 ratio of the number of hours of instruction provided to that
22 pupil in excess of: (i) the greater of 1,020 hours or the
23 number of hours required for a full-time secondary pupil in the
24 district to 1,020 for a secondary pupil; (ii) the greater of 935
25 hours or the number of hours required for a full-time elementary

1 pupil in the district to 935 for an elementary pupil in grades 1
2 through 6; and (iii) the greater of 425 hours or the number of
3 hours required for a full-time kindergarten student without a
4 disability in the district to 425 for a kindergarten student
5 without a disability. Hours that occur after the close of the
6 instructional year in June shall be attributable to the
7 following fiscal year. A kindergarten student must not be
8 counted as more than 1.2 pupils in average daily membership
9 under this subdivision. A student in grades 1 through 12 must
10 not be counted as more than 1.2 pupils in average daily
11 membership under this subdivision.
12 (b)(i) To receive general education revenue for a pupil in
13 an alternative program that has an independent study component,
14 a district must meet the requirements in this paragraph. The
15 district must develop, for the pupil, a continual learning plan
16 consistent with section 124D.128, subdivision 3. Each school
17 district that has a state-approved public alternative program
18 must reserve revenue in an amount equal to at least 90 percent
19 of the district average general education revenue per pupil unit
20 less compensatory revenue per pupil unit times the number of
21 pupil units generated by students attending a state-approved
22 public alternative program. The amount of reserved revenue
23 available under this subdivision may only be spent for program
24 costs associated with the state-approved public alternative
25 program. Compensatory revenue must be allocated according to
26 section 126C.15, subdivision 2.
27 (ii) General education revenue for a pupil in an approved
28 alternative program without an independent study component must
29 be prorated for a pupil participating for less than a full year,
30 or its equivalent. The district must develop a continual
31 learning plan for the pupil, consistent with section 124D.128,
32 subdivision 3. Each school district that has a state-approved
33 public alternative program must reserve revenue in an amount
34 equal to at least 90 percent of the district average general
35 education revenue per pupil unit less compensatory revenue per
36 pupil unit times the number of pupil units generated by students

1 attending a state-approved public alternative program. The
2 amount of reserved revenue available under this subdivision may
3 only be spent for program costs associated with the
4 state-approved public alternative program. Compensatory revenue
5 must be allocated according to section 126C.15, subdivision 2.
6 (iii) General education revenue for a pupil in an approved
7 alternative program that has an independent study component must
8 be paid for each hour of teacher contact time and each hour of
9 independent study time completed toward a credit or graduation
10 standards necessary for graduation. Average daily membership
11 for a pupil shall equal the number of hours of teacher contact
12 time and independent study time divided by 1,020.
13 (iv) For an alternative program having an independent study
14 component, the commissioner shall require a description of the
15 courses in the program, the kinds of independent study involved,
16 the expected learning outcomes of the courses, and the means of
17 measuring student performance against the expected outcomes.
18 (c) A school district may count a pupil who is at least
19 four years of age, not yet enrolled in kindergarten, and
20 participating in a learning year program as not more than .2
21 pupils in average daily membership for purposes of extended time
22 revenue only. For purposes of this paragraph, the hours of
23 instruction for a full-time pupil in average daily membership
24 equal 850.
25 **[EFFECTIVE DATE.]** This section is effective for revenue for
26 fiscal year 2006 and later.

Fiscal Note – 2005-06 Session

Bill #: S0222-0 (R) **Complete Date:** 03/29/05

Chief Author: SKOGLUND, WESLEY

Title: PREK PUPILS EXTENDED TIME REV ELIG

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Education Department

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund	0	5,560	9,345	12,615	15,884
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	5,560	9,345	12,615	15,884
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund	0	5,560	9,345	12,615	15,884
Total Cost <Savings> to the State	0	5,560	9,345	12,615	15,884

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund	0.00	0.25	0.25	0.25	0.25
Total FTE	0.00	0.25	0.25	0.25	0.25

Bill Description

This proposal amends M.S. 126C.05 Subdivision 15, which defines average daily membership (ADM) that pupils enrolled in learning year and alternative programs can generate for the purpose of general education revenue. These are the only students eligible to generate more than 1.0 ADM. The bill expands the definition of pupils to allow districts to count pre-kindergarten pupils who are "at least four years of age, not yet enrolled in kindergarten, and participating in a learning year program." The bill would allow districts to report up to 0.2 pre-kindergarten pupils in average daily membership for extended time revenue only, setting the number of instructional hours for a full-time pre-kindergarten pupil at 850.

Assumptions

To provide clarification of intent, there are several related sections of statute that must be changed. A few of the key provisions are listed below, along with the assumptions used in the fiscal analysis.

1. Definition of learning year program is kindergarten through grade 12 and does not include pre-kindergarten (124D.128, subd.1)
   - The fiscal analysis assumes that M.S. 124D.128, subd.1 will be updated to programmatically include pupils at least four years old who are not yet enrolled in kindergarten.
2. Definition of adjusted pupil units, a component of the extended time formula (126C.10, subd.2a), does not include pre-kindergarten pupils, except for those with a disability and those assessed but found not to be disabled. (126C.05 subd.1)
   - The fiscal analysis assumes that M.S. 126C.05, subd.1 will be updated to include pre-kindergarten pupils who are at least four years old and not enrolled in kindergarten, but only for purposes of extended time ADM.
   - It also assumes that pre-kindergarten students with a disability would be ineligible for extended time revenue because they already generate general education revenue for the services specified in their IEP.
3. Definition of ADM, also a component of the extended time revenue formula, only references K-12 pupils and pre-kindergarten pupils with a disability. (126C.05, subd.8)
   - The fiscal analysis assumes that M.S. 126C.05, subd.8 will be updated to include pre-kindergarten pupils without disabilities who are at least four years old but not enrolled in kindergarten.
4. Definition of extended time ADM is the ADM a pupil generates between 1.0 and 1.2 (M.S. 126C.10, subd. 2a). The bill does not specify if a pre-kindergarten pupil must generate more than 850 hours of membership (1.0 ADM) before becoming eligible for extended time revenue.
   - Although not specified in the bill, the fiscal analysis assumes that pre-kindergarten pupils will generate extended time ADM using the formula (hours of instruction / 850 hours) not to exceed 0.20 per pupil and that the pupils will not need to generate 850 membership hours before generating extended time revenue.
5. The learning year law requires program approval and area learning centers are automatically learning year sites. Therefore, there is a cost to the state to approve more learning year applications and collect program participation data for more pupils. The analysis assumes 0.25 FTE for a professional staff.

	Est. Salary	Est. Benefits	**	Total Cost	FTE	Adjusted Cost	Cost
ED Spec II (17)	71,464.64	21,857.67	(2)	93,322.31	**0.25**	23,330.58	23,330.58
Agency Indirect Costs							13,856.00
Total Cost for 0.5 FTE							37,186.58
Cost that agency can absorb							
	Office Space						8,196.00
Net Cost for New Position							28,990.58

Other considerations requiring clarification include program expectations. Would licensed teachers be providing an instructional program? Would these pupils be in classrooms with kindergarten pupils? Could an eligible program be for specific types of children, e.g. LEP? Are children eligible to participate for more than one year? Transportation is not addressed: would pre-kindergarten pupils be eligible to ride a school bus on a regular route or would bus routes be necessary? Would parents be responsible for transportation?

This program eliminates a parent's difficult decision of whether or not to hold a young five year old back from kindergarten enrollment and provides an instructional program for four year olds who need an extra year of education to prepare for kindergarten.

If the ADM of participants is determined to have a pupil unit weighting of other than 1.0, the cost estimates must be adjusted accordingly.

Expenditure and/or Revenue Formula

The fiscal analysis assumes that 5% of the four year olds in the state will participate fully in this program in FY06, 10% will participate in FY07, 15% in FY08 and 20% in FY09. The fall 2004 Birth through Age 4 Census was used as the data source for four-year-old children. The fall 2004 count was held constant as a proxy for all of the years covered by this analysis.

There were 4,471 six-year-old kindergarten students enrolled in Minnesota public schools on October 1, 2004. The analysis assumes that 80% of that number would participate each year in the program when they are five years old. Some of these six year olds would have been repeating kindergarten and it is assumed that for most students 170 hours of instruction during the year prior to enrolling in kindergarten would not be adequate to avoid a grade retention.

The analysis does not assume any cost savings in general education revenue because neither of these groups of students are currently eligible to generate funding under general education revenue. However, there may be fewer kindergarten grade retentions if this program better prepares children for kindergarten. No estimate is made for this possibility.

SF222		FY06	FY07	FY08	FY09
4-year olds from census fall 2004		71,054	71,054	71,054	71,054
Assumed percent participation		0.05	0.1	0.15	0.2
Number of 4-year old participants		3,553	7,105	10,658	14,211
No. of 6 year old KG on Oct. 1, 2004		4,471	4,471	4,471	4,471
Assume 80% of the no. of 6 year olds will participate		3,577	3,577	3,577	3,577
Total Participants		7,130	10,682	14,235	17,788
X 0.20		1,426.00	2,136.40	2,847.00	3,557.60

X $,4601	$ 6,561,026.00	$ 9,829,576.40	$ 13,099,047.00	$ 16,368,517.60
15.7 % prior year		1,030,081.08	1,543,243.49	2,056,550.38
84.3 % current year	5,530,944.92	8,286,332.91	11,042,496.62	13,798,660.34
Total aid	$5,530,944.92	$9,316,413.99	$12,585,740.11	$15,855,210.72
Agency staff required	$28,990.58	$28,990.58	$28,990.58	$28,990.58
Total	$5,559,935.50	$9,345,404.57	$12,614,730.69	$15,884,201.30

Long-Term Fiscal Considerations

This is a continuing program.

Local Government Costs

School districts may experience start-up costs associated with securing or preparing additional classrooms for young children, hiring staff, and adding transportation services.

Agency Contact Name: Peck, Sharon 651-582-8811
FN Coord Signature: AUDREY BOMSTAD
Date: 03/29/05 Phone: 582-8793

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: LISA MUELLER
Date: 03/29/05 Phone: 296-6661

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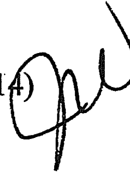
Senate
State of Minnesota

S.F. No. 1826 - Corporate Franchise Tax Credit

Author: Senator Bob Kierlin

Prepared by: Joan White, Senate Counsel (651/296-3814)



Date: March 30, 2005

Sections 1 and 2 amend the income and franchise taxes chapter of law.

Section 1 (290.01, subdivision 19c) amends the statute related to additions to federal taxable income for corporations. This bill requires that the amount deducted under the Internal Revenue Code for contributions to a prekindergarten scholarship granting organization for which a credit is claimed under section 2 must be added to the federal taxable income of the corporation.

Section 2 (290.0676) establishes a program that provides a credit for contributions to scholarship granting organizations.

Subdivision 1 defines the following terms: "statewide median family income," "qualified student," "qualified prekindergarten educational program," and "prekindergarten scholarship granting organization (preK SGO)."

Subdivision 2 requires the Commissioner of Education to maintain a list of preK SGOs, make this list available on the Department of Education's Web site or by other means, develop an application process for preK SGOs, and develop a process for preK SGOs to annually report to the Department of Education as specified under this section. This subdivision allows the commissioner to remove an organization from the list of qualifying preK SGOs for financial mismanagement or violations of the law.

Subdivision 3 allows a credit against the corporate franchise tax due under this chapter equal to 50 percent of the amount contributed to a prekindergarten scholarship granting organization. The maximum credit allowed to any corporation in a taxable year is $100,000. The credit may not be claimed for contributions designated for a specific student, and may

not exceed the corporation's tax liability. The Commissioner of Revenue shall prescribe the manner in which the credit may be claimed.

Subdivision 4 provides that an interested corporation must apply to the Department of Education for a tax credit certification, and will receive a certification if the preK SGO is a qualified preK SGO. The certificates are available on a first-come, first-served basis until the maximum statewide credit amount has been reached. That amount is $0 in 2006, and $3,500,000 in 2007. The commissioner shall issue the tax credit certificate in the amount of ½ of the amount contributed to the preK SGO, and must not issue a certificate for an amount greater that $100,000.

This bill is effective for taxable years beginning after December 31, 2005.

JW:rdr

Senators Kierlin and Hottinger introduced--

S.F. No. 1826: Referred to the Committee on Finance.

1 A bill for an act

2 relating to taxation; income; allowing a credit for
3 contributions to prekindergarten scholarship granting
4 organizations; amending Minnesota Statutes 2004,
5 section 290.01, subdivision 19c; proposing coding for
6 new law in Minnesota Statutes, chapter 290.

7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

8 Section 1. Minnesota Statutes 2004, section 290.01,
9 subdivision 19c, is amended to read:

10 Subd. 19c. [CORPORATIONS; ADDITIONS TO FEDERAL TAXABLE
11 INCOME.] For corporations, there shall be added to federal
12 taxable income:

13 (1) the amount of any deduction taken for federal income
14 tax purposes for income, excise, or franchise taxes based on net
15 income or related minimum taxes, including but not limited to
16 the tax imposed under section 290.0922, paid by the corporation
17 to Minnesota, another state, a political subdivision of another
18 state, the District of Columbia, or any foreign country or
19 possession of the United States;

20 (2) interest not subject to federal tax upon obligations
21 of: the United States, its possessions, its agencies, or its
22 instrumentalities; the state of Minnesota or any other state,
23 any of its political or governmental subdivisions, any of its
24 municipalities, or any of its governmental agencies or
25 instrumentalities; the District of Columbia; or Indian tribal
26 governments;

1 (3) exempt-interest dividends received as defined in
2 section 852(b)(5) of the Internal Revenue Code;
3 (4) the amount of any net operating loss deduction taken
4 for federal income tax purposes under section 172 or 832(c)(10)
5 of the Internal Revenue Code or operations loss deduction under
6 section 810 of the Internal Revenue Code;
7 (5) the amount of any special deductions taken for federal
8 income tax purposes under sections 241 to 247 of the Internal
9 Revenue Code;
10 (6) losses from the business of mining, as defined in
11 section 290.05, subdivision 1, clause (a), that are not subject
12 to Minnesota income tax;
13 (7) the amount of any capital losses deducted for federal
14 income tax purposes under sections 1211 and 1212 of the Internal
15 Revenue Code;
16 (8) the exempt foreign trade income of a foreign sales
17 corporation under sections 921(a) and 291 of the Internal
18 Revenue Code;
19 (9) the amount of percentage depletion deducted under
20 sections 611 through 614 and 291 of the Internal Revenue Code;
21 (10) for certified pollution control facilities placed in
22 service in a taxable year beginning before December 31, 1986,
23 and for which amortization deductions were elected under section
24 169 of the Internal Revenue Code of 1954, as amended through
25 December 31, 1985, the amount of the amortization deduction
26 allowed in computing federal taxable income for those
27 facilities;
28 (11) the amount of any deemed dividend from a foreign
29 operating corporation determined pursuant to section 290.17,
30 subdivision 4, paragraph (g);
31 (12) the amount of any environmental tax paid under section
32 59(a) of the Internal Revenue Code;
33 (13) the amount of a partner's pro rata share of net income
34 which does not flow through to the partner because the
35 partnership elected to pay the tax on the income under section
36 6242(a)(2) of the Internal Revenue Code;

1 (14) the amount of net income excluded under section 114 of
2 the Internal Revenue Code;
3 (15) any increase in subpart F income, as defined in
4 section 952(a) of the Internal Revenue Code, for the taxable
5 year when subpart F income is calculated without regard to the
6 provisions of section 614 of Public Law 107-147; ~~and~~
7 (16) 80 percent of the depreciation deduction allowed under
8 section 168(k) of the Internal Revenue Code. For purposes of
9 this clause, if the taxpayer has an activity that in the taxable
10 year generates a deduction for depreciation under section 168(k)
11 and the activity generates a loss for the taxable year that the
12 taxpayer is not allowed to claim for the taxable year, "the
13 depreciation allowed under section 168(k)" for the taxable year
14 is limited to excess of the depreciation claimed by the activity
15 under section 168(k) over the amount of the loss from the
16 activity that is not allowed in the taxable year. In succeeding
17 taxable years when the losses not allowed in the taxable year
18 are allowed, the depreciation under section 168(k) is allowed;
19 and
20 (17) the amount deducted under section 170 of the Internal
21 Revenue Code that represents contributions to a prekindergarten
22 scholarship granting organization for which a credit is claimed
23 under section 290.0676.
24 **[EFFECTIVE DATE.]** This section is effective for taxable
25 years beginning after December 31, 2005.
26 Sec. 2. [290.0676] [CREDIT FOR CONTRIBUTIONS TO
27 SCHOLARSHIP GRANTING ORGANIZATIONS.]
28 Subdivision 1. [DEFINITIONS.] (a) For purposes of this
29 section, the following terms have the meanings given.
30 (b) "Statewide median family income" means median income
31 for a four-person family in Minnesota used by the United States
32 Department of Health and Human Services in administering the Low
33 Income Home Energy Assistance Program, as most recently
34 published in the Federal Register.
35 (c) A "qualified student" must be:
36 (1) younger than age seven, not yet enrolled in

1 kindergarten or first grade, and a Minnesota resident; and
2 (2) a member of a household with an income less than 75
3 percent of the statewide median family income.
4 (d) A "qualified prekindergarten educational program" must:
5 (1) be one of the following:
6 (i) a prekindergarten program established by a school
7 district under chapter 124D;
8 (ii) a preschool, nursery school, or early childhood
9 development program licensed by the Department of Human Services
10 and accredited by the National Association for the Education of
11 Young Children or National Early Childhood Program
12 Accreditation;
13 (iii) a Montessori program affiliated with or accredited by
14 the American Montessori Society or American Montessori
15 International; or
16 (iv) a child care program provided by a family day care
17 provider holding a current early childhood development
18 credential approved by the commissioner of human services; and
19 (2) accept education scholarship funds granted under this
20 section in payment of tuition for a qualified student under
21 paragraph (c) enrolled in the program.
22 (e) "Prekindergarten scholarship granting organization" or
23 "preK SGO" means a charitable organization that is exempt from
24 federal taxation under section 501(c)(3) of the Internal Revenue
25 Code, is registered with the attorney general's office, and is
26 certified by the commissioner of education as meeting the
27 criteria of this paragraph. To qualify as a preK SGO, the
28 charitable organization:
29 (1) must allocate at least 85 percent of its annual revenue
30 for education scholarship funds to children to allow them to
31 attend any qualified prekindergarten educational program of
32 their parents' choice;
33 (2) must not restrict the availability of scholarships to
34 students of one program;
35 (3) may not charge a fee of any kind to students under
36 consideration for a scholarship;

1 (4) must require a qualified prekindergarten educational
2 program receiving payment of tuition through a scholarship grant
3 funded by contributions qualifying for the tax credit under
4 subdivision 3 awarded by a preK SGO to an enrolled student of
5 the program to sign an agreement that it will not use different
6 admissions standards for a student with a scholarship grant from
7 a preK SGO;
8 (5) must agree to annually report to the Department of
9 Education on:
10 (i) the number of students awarded scholarship grants
11 funded by contributions under the tax credit program;
12 (ii) the total amount of scholarship grant dollars awarded
13 from contributions under the tax credit program;
14 (iii) the total number of programs attended by scholarship
15 grant recipients;
16 (iv) the total amount of contributions received under the
17 tax credit program; and
18 (v) the percentage of contributions received under the tax
19 credit program that was provided as scholarship grants to
20 families; and
21 (6) must provide the Department of Education with the same
22 annual report that the organization must provide the attorney
23 general's office under section 309.53, subdivision 1.
24 Subd. 2. [COMMISSIONER OF EDUCATION.] The commissioner of
25 education:
26 (1) must maintain a list of preK SGOs;
27 (2) must make the list available on the Department of
28 Education's Web site and by other means;
29 (3) must develop an application process for preK SGOs to be
30 recorded as qualifying by the Department of Education under this
31 section;
32 (4) may remove an organization from the list of qualifying
33 preK SGOs, after notifying the organization and providing an
34 opportunity for a public hearing, for reasons of the
35 organization's financial mismanagement or violation of the law;
36 and

1 (5) must develop a process for preK SGOs to annually report
2 to the Department of Education as specified in this section.
3 Subd. 3. [CREDIT ALLOWED.] A corporation is allowed a
4 credit against the corporate franchise tax due under this
5 chapter equal to 50 percent of the amount contributed to a
6 prekindergarten scholarship granting organization. The maximum
7 credit allowed any corporation in a taxable year is $100,000.
8 The credit may not be claimed for contributions designated for
9 the use of a specific student. The credit for the taxable year
10 may not exceed the corporation's liability for tax. The
11 commissioner of revenue shall prescribe the manner in which the
12 credit may be claimed. This may include allowing the credit
13 only as a separately processed claim for refund.
14 Subd. 4. [APPLICATION FOR CREDIT CERTIFICATE.] A
15 corporation shall apply to the Department of Education for a tax
16 credit certificate. A corporation shall receive a tax credit
17 certificate under this section if the preK SGO appears on the
18 list of qualifying preK SGOs maintained by the Department of
19 Education. Tax credit certificates under this section shall be
20 made available by the Department of Education on a first-come,
21 first-served basis until the maximum statewide credit amount has
22 been reached. The statewide credit maximum amount is $0 in
23 fiscal year 2006 and $3,500,000 in fiscal year 2007. A
24 contribution by a corporation to a preK SGO shall be made no
25 later than 60 days following written notification of the
26 approval of an application. The commissioner of education shall
27 issue the tax credit certificate in the amount of one-half of
28 the amount contributed to the preK SGO after the corporation has
29 made the contribution to the preK SGO. The commissioner of
30 education shall not issue a tax credit certificate for an amount
31 greater than $100,000.
32 **[EFFECTIVE DATE.]** This section is effective for taxable
33 years beginning after December 31, 2005.

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1826-0 **Complete Date:**

Chief Author: KIERLIN, BOB

Title: CORP FRANCHISE TAX CR; SCHOLARSHIPS

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Education Department

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Preliminary

Bill Description

Corporate income tax credits would be provided for contributions to qualifying pre-kindergarten scholarship granting organizations (SGOs). These SGOs would be federal tax-exempt charitable organizations that receive private contributions and provide scholarships to families wishing to enroll their children in qualifying pre-kindergarten educational programs, which are defined in the bill.

To be eligible to participate in the tax credit program, a SGO would need to meet a number of requirements, including:

- Must allocate at least 85% of its annual revenue to education scholarship funds that allow families to enroll their children in a qualifying pre-kindergarten education program of the parents' choice.
- Must not restrict the availability of scholarships to students of one program.
- Must not charge a fee of any kind to students applying for a scholarship.
- Must agree to annually report to the Department of Education.

A corporation would be able to claim a tax credit equal to 50% of the amount contribution to an SGO (not to exceed its liability for tax) up to a maximum credit of $100,000. To restrict the potential costs of this program, the statewide maximum amount of tax credit is set at $3,500,000 in FY 2007 and $3,750,000 in FY 2008 and beyond.

The tax credit program would be administered by the Department of Education although corporate tax returns would continue to be processed by the Department of Revenue. An amount of $250,000 per year would be required for the Department of Education's administrative expenses related to certification of qualifying SGOs, program oversight, and the processing of tax credit certificate applications from corporations. The tax credit would be effective for taxable years beginning after December 31, 2005.

Assumptions

It estimated that MDE would need an additional 2.5 FTEs professional staff to certify, monitor, and audit SGOs; monitor qualifying pre-kindergarten educational programs; and process tax credit certificate applications from corporations.

Expenditure and/or Revenue Formula

Additional MDE staff would be required. It is estimated that 2.5 professional FTE would be required. This would be a permanent and on-going cost.

Job Classifications Education Specialist II	Est. Salary	Est. Benefits	**	Total Cost	FTE	Adjusted Cost	Fiscal Note Cost
ED Spec II (17)	71,464.64	21,857.67	(2)	93,322.31	**2.50**	233,305.78	233,305.78
Agency Indirect Costs							37,140.00
Total Cost for 1.0 FTE							270,445.78
Cost that agency can absorb							
	Office Space						20,490.00
Net Cost for New Position							249,955.78

Long-Term Fiscal Considerations

The changes would be permanent.

Local Government Costs

None.

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Senate
State of Minnesota

S.F. No. 1365 - Child Mental Health Screenings and Assessments

Author: Senator David Tomassoni

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 23, 2005

Section 1 (13.32, subdivision 2) amends the data practices act with regard to student health and census data, by adding that results from student mental health screenings must not be maintained in the student record.

Section 2 (121A.17, subdivision 1) amends the early childhood developmental screening statute by targeting children who are between three and four years old, instead of 31/2 and four years old.

Section 3 (121A.17, subdivision 3) amends the school board responsibilities by requiring that the screening program for prekindergarten include a socioemotional development screening. A new paragraph is added to this section of law requiring the socioemotional development screening to be conducted with a screening instrument approved by the Commissioner of Human Services, as the designated state mental health authority. All "other" screening components must be consistent with the standards of the state Commissioner of Health.

Section 4 (121A.17, subdivision 4a) adds a subdivision to the prekindergarten screening statute, providing that if a child in the socioemotional development screening indicates a need for further assessment, the district is not financially responsible for the mental health assessment. The district may notify the child's parents of the results and may provide referrals to community providers. If a child does not have health insurance coverage, the district must refer the child to an appropriate health care provider.

Section 5 (121A.19) modifies the state payments to districts for prekindergarten screenings. Current law pays $40 for each child screened. The bill would provide $50 for each child screened at age three, $40 for each child screened at four, and $30 for each child screened at five years of age.

Section 6 (125A.02, subdivision 1) amends the special education chapter of law and adds to the definition of a child with a disability a child with emotional disturbance.

Sections 7 to 9 amend the truancy chapter of law.

Section 7 (260A.03) modifies the notice to a parent when the child is a continuing truant by adding that an assessment for underlying issues that are contributing to the child's truant behavior, including a mental health screening, may be available.

Section 8 (260A.04, subdivision 2) amends the community-based action projects by adding to the list of services that may be available to truant students and their families mental health screening and classroom modifications and accommodations.

Section 9 (260A.04, subdivision 3) allows truancy service centers, which are established to receive truant students from peace officers, to assist in evaluating the need for and making a referral to a mental health provider.

JW:rdr

Senators Tomassoni, Solon, Hottinger and Anderson introduced--

S.F. No. 1365: Referred to the Committee on Education.

1 A bill for an act

2 relating to children; including socioemotional
3 development in early childhood health and development
4 screening; including possible availability of mental
5 health screening in notice to parents of truant
6 children; amending Minnesota Statutes 2004, sections
7 13.32, subdivision 2; 121A.17, subdivisions 1, 3, by
8 adding a subdivision; 121A.19; 125A.02, subdivision 1;
9 260A.03; 260A.04, subdivisions 2, 3.

10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

11 Section 1. Minnesota Statutes 2004, section 13.32,
12 subdivision 2, is amended to read:

13 Subd. 2. [STUDENT HEALTH AND CENSUS DATA; DATA ON
14 PARENTS.] (a) Health data concerning students, including but not
15 limited to, data concerning immunizations, notations of special
16 physical or mental problems and records of school nurses are
17 educational data. Access by parents to student health data
18 shall be pursuant to section 13.02, subdivision 8.

19 (b) Pupil census data, including emergency information and
20 family information are educational data.

21 (c) <u>Results from student mental health screenings must not</u>
22 <u>be maintained in the student record.</u>

23 <u>(d)</u> Data concerning parents are private data on individuals
24 but may be treated as directory information if the same
25 procedures that are used by a school district to designate
26 student data as directory information under subdivision 5 are
27 followed.

1 Sec. 2. Minnesota Statutes 2004, section 121A.17,
2 subdivision 1, is amended to read:
3 Subdivision 1. [EARLY CHILDHOOD DEVELOPMENTAL SCREENING.]
4 Every school board must provide for a mandatory program of early
5 childhood developmental screening for children once before
6 school entrance, targeting children who are between ~~3-1/2~~ <u>three</u>
7 and four years old. This screening program must be established
8 either by one board, by two or more boards acting in
9 cooperation, by service cooperatives, by early childhood family
10 education programs, or by other existing programs. This
11 screening examination is a mandatory requirement for a student
12 to continue attending kindergarten or first grade in a public
13 school. A child need not submit to developmental screening
14 provided by a board if the child's health records indicate to
15 the board that the child has received comparable developmental
16 screening from a public or private health care organization or
17 individual health care provider. Districts are encouraged to
18 reduce the costs of preschool developmental screening programs
19 by utilizing volunteers in implementing the program.
20 Sec. 3. Minnesota Statutes 2004, section 121A.17,
21 subdivision 3, is amended to read:
22 Subd. 3. [SCREENING PROGRAM.] (a) A screening program must
23 include at least the following components: developmental
24 assessments, <u>a socioemotional development screening,</u> hearing and
25 vision screening or referral, immunization review and referral,
26 the child's height and weight, identification of risk factors
27 that may influence learning, an interview with the parent about
28 the child, and referral for assessment, diagnosis, and treatment
29 when potential needs are identified. The district and the
30 person performing or supervising the screening must provide a
31 parent or guardian with clear written notice that the parent or
32 guardian may decline to answer questions or provide information
33 about family circumstances that might affect development and
34 identification of risk factors that may influence learning. The
35 notice must clearly state that declining to answer questions or
36 provide information does not prevent the child from being

1 enrolled in kindergarten or first grade if all other screening
2 components are met. If a parent or guardian is not able to read
3 and comprehend the written notice, the district and the person
4 performing or supervising the screening must convey the
5 information in another manner. The notice must also inform the
6 parent or guardian that a child need not submit to the district
7 screening program if the child's health records indicate to the
8 school that the child has received comparable developmental
9 screening performed within the preceding 365 days by a public or
10 private health care organization or individual health care
11 provider. The notice must be given to a parent or guardian at
12 the time the district initially provides information to the
13 parent or guardian about screening and must be given again at
14 the screening location.

15 (b)(1) The socioemotional development screening shall be
16 conducted with a screening instrument approved by the
17 commissioner of human services, as the designated state mental
18 health authority, according to criteria that are updated and
19 issued annually to ensure that approved screening instruments
20 are valid and useful for this population.

21 (2) All other screening components shall be consistent with
22 the standards of the state commissioner of health for early
23 developmental screening programs. A developmental screening
24 program must not provide laboratory tests or a physical
25 examination to any child. The district must request from the
26 public or private health care organization or the individual
27 health care provider the results of any laboratory test or
28 physical examination within the 12 months preceding a child's
29 scheduled screening.

30 (c) If a child is without health coverage, the school
31 district must refer the child to an appropriate health care
32 provider.

33 (d) A board may offer additional components such as
34 nutritional, physical and dental assessments, review of family
35 circumstances that might affect development, blood pressure,
36 laboratory tests, and health history.

1 (e) If a statement signed by the child's parent or guardian
2 is submitted to the administrator or other person having general
3 control and supervision of the school that the child has not
4 been screened because of conscientiously held beliefs of the
5 parent or guardian, the screening is not required.
6 Sec. 4. Minnesota Statutes 2004, section 121A.17, is
7 amended by adding a subdivision to read:
8 Subd. 4a. [FOLLOW-UP SOCIOEMOTIONAL DEVELOPMENT
9 SCREENING.] If the results of a school district-conducted
10 socioemotional development screening of a child indicates a need
11 for further assessment, the district is not financially
12 responsible for a mental health diagnostic assessment. The
13 district may notify a child's parents or guardians of the
14 screening results, and may provide referrals to community
15 providers. If a child is without health coverage, the district
16 must refer the child to an appropriate health care provider.
17 This subdivision does not preclude the district from providing
18 educational assessments.
19 Sec. 5. Minnesota Statutes 2004, section 121A.19, is
20 amended to read:
21 121A.19 [DEVELOPMENTAL SCREENING AID.]
22 Each school year, for each child screened according to the
23 requirements of section 121A.17, the state must pay a district
24 ~~$40~~ $50 for each child screened ~~according to the requirements of~~
25 ~~section 121A.17~~ at age three, $40 for each child screened at
26 ages two and four, and $30 for each child screened at age five
27 and older. If this amount of aid is insufficient, the district
28 may permanently transfer from the general fund an amount that,
29 when added to the aid, is sufficient.
30 Sec. 6. Minnesota Statutes 2004, section 125A.02,
31 subdivision 1, is amended to read:
32 Subdivision 1. [CHILD WITH A DISABILITY.] Every child who
33 has a hearing impairment, visual disability, speech or language
34 impairment, physical handicap, other health impairment, mental
35 handicap, emotional/behavioral disorder, specific learning
36 disability, autism, traumatic brain injury, multiple

1 disabilities, or deaf/blind disability and needs special
2 instruction and services, as determined by the standards of the
3 commissioner, is a child with a disability. In addition, every
4 child under age three, and at local district discretion from age
5 three to age seven, who needs special instruction and services,
6 as determined by the standards of the commissioner, because the
7 child has a substantial delay, emotional disturbance, or has an
8 identifiable physical or mental condition known to hinder normal
9 development is a child with a disability.

10 Sec. 7. Minnesota Statutes 2004, section 260A.03, is
11 amended to read:

12 260A.03 [NOTICE TO PARENT OR GUARDIAN WHEN CHILD IS A
13 CONTINUING TRUANT.]

14 Upon a child's initial classification as a continuing
15 truant, the school attendance officer or other designated school
16 official shall notify the child's parent or legal guardian, by
17 first-class mail or other reasonable means, of the following:

18 (1) that the child is truant;

19 (2) that the parent or guardian should notify the school if
20 there is a valid excuse for the child's absences;

21 (3) that the parent or guardian is obligated to compel the
22 attendance of the child at school pursuant to section 120A.22
23 and parents or guardians who fail to meet this obligation may be
24 subject to prosecution under section 120A.34;

25 (4) that this notification serves as the notification
26 required by section 120A.34;

27 (5) that alternative educational programs and services may
28 be available in the district;

29 (6) that an assessment for underlying issues that are
30 contributing to the child's truant behavior, including a mental
31 health screening, may be available;

32 ~~(6)~~ (7) that the parent or guardian has the right to meet
33 with appropriate school personnel to discuss solutions to the
34 child's truancy;

35 ~~(7)~~ (8) that if the child continues to be truant, the
36 parent and child may be subject to juvenile court proceedings

1 under chapter 260C;

2 ~~(8)~~ (9) that if the child is subject to juvenile court
3 proceedings, the child may be subject to suspension,
4 restriction, or delay of the child's driving privilege pursuant
5 to section 260C.201; and

6 ~~(9)~~ (10) that it is recommended that the parent or guardian
7 accompany the child to school and attend classes with the child
8 for one day.

9 Sec. 8. Minnesota Statutes 2004, section 260A.04,
10 subdivision 2, is amended to read:

11 Subd. 2. [COMMUNITY-BASED ACTION PROJECTS.] Schools,
12 community agencies, law enforcement, parent associations, and
13 other interested groups may cooperate to provide coordinated
14 intervention, prevention, and educational services for truant
15 students and their families. Services may include:

16 (1) assessment for underlying issues that are contributing
17 to the child's truant behavior including a mental health
18 screening;

19 (2) referral to other community-based services for the
20 child and family, such as individual or family counseling,
21 educational testing, psychological evaluations, tutoring,
22 mentoring, and mediation;

23 (3) transition services to integrate the child back into
24 school and to help the child succeed once there;

25 (4) culturally sensitive programming and staffing; and

26 (5) increased school response, including in-school
27 suspension, better attendance monitoring and enforcement,
28 after-school study programs, classroom modifications and
29 accommodations, and in-service training for teachers and staff.

30 Sec. 9. Minnesota Statutes 2004, section 260A.04,
31 subdivision 3, is amended to read:

32 Subd. 3. [TRUANCY SERVICE CENTERS.] (a) Truancy service
33 centers may be established as facilities to receive truant
34 students from peace officers and probation officers and provide
35 other appropriate services. A truancy service center may:

36 (1) assess a truant student's attendance situation,

1 including enrollment status, verification of truancy, and school
2 attendance history;
3 (2) assist in coordinating intervention efforts where
4 appropriate, including checking with juvenile probation and
5 children and family services to determine whether an active case
6 is pending and facilitating transfer to an appropriate facility,
7 if indicated; and evaluating the need for and making referral to
8 a health clinic, mental health provider, chemical dependency
9 treatment, protective services, social or recreational programs,
10 or other school or community-based services and programs
11 described in subdivision 2;
12 (3) contact the parents or legal guardian of the truant
13 student and release the truant student to the custody of the
14 parents, guardian, or other suitable person; and
15 (4) facilitate the student's earliest possible return to
16 school.
17 (b) Truancy service centers may not accept:
18 (1) juveniles taken into custody for violations of law that
19 would be crimes if committed by adults;
20 (2) intoxicated juveniles;
21 (3) ill or injured juveniles; or
22 (4) juveniles older than mandatory school attendance age.
23 (c) Truancy service centers may expand their service
24 capability in order to receive curfew violators and take
25 appropriate action, such as coordination of intervention
26 efforts, contacting parents, and developing strategies to ensure
27 that parents assume responsibility for their children's curfew
28 violations.

Senator ..... moves to amend S.F. No. 1365 as follows:

Page 1, line 21, after "screenings" insert "must be released to the child's parents or legal guardians and"

Page 2, line 27, after the comma, insert "screening for autism spectrum disorders,"

Page 2, delete line 29 and insert "when potential needs are identified. For purposes of this section, socioemotional screening means assessing a child's ability, in the context of family, community, and cultural expectations, to (1) experience, regulate, and express emotions; (2) form close and secure interpersonal relationships; and (3) explore the environment and learn.

The district and the"

Page 3, line 15, delete "development screening" and insert " component of the developmental assessment"

Page 4, line 13, delete "may" and insert "must"

Page 4, line 14, after "provide" insert "the child's parents or legal guardians with"

Page 4, line 16, delete "refer the child to" and insert "inform the child's parents and legal guardians of"

Page 5, line 7, before "emotional" insert "serious"

Fiscal Note – 2005-06 Session

Bill #: S1365-0 **Complete Date:** 03/31/05

Chief Author: TOMASSONI, DAVID

Title: CHILDREN MENTAL HEALTH SCREENINGS

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Education Department

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		415	940	708	722
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		415	940	708	722
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		415	940	708	722
Total Cost <Savings> to the State		415	940	708	722

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund			0.50	0.25	0.25
Total FTE			0.50	0.25	0.25

Bill Description

This bill amends multiple sections of Minnesota Statutes to provide for early detection, follow-up and treatment of children with an emotional disturbance.

Section 1 amends M.S. section 13.32 to indicate that results from a mental health screening shall not be maintained in student records.

Section 2 amends M.S. section 121A.17, early childhood screening statute, to lower the targeted age for early childhood screening from 3 ½ years to 3 years old.

Section 3 amends M.S. section 121A.17, early childhood screening statute, to include socioemotional development screening in the required components of early childhood health and developmental screening. It also requires that such screening be conducted with a screening instrument that has been approved by the commissioner of human services. This tool must be updated annually.

Section 4 amends M.S. 121A.17, subdivision 4, which requires that parents be notified of any condition requiring diagnosis or treatment. It adds a new subdivision, 4a, follow-up for socioemotional development screening, which states that the district is not financially responsible for a mental health diagnostic assessment if the results of socioemotional development screening indicate a need for further assessment. Districts <u>may</u> notify a child's parents or guardians of the screening results, provide referrals to community provider and, if a child is without health coverage, MUST refer the child to an appropriate health care provider.

Section 5 changes the reimbursement rate for children screened from $40 for all children to $50 for children screened at age three, $40 for children screened at two and four and $30 for children screened at five.

Section 6 amends M.S. 125A.02, the definition of a child with a disability, to include children under age three who need special instruction and services because of an "emotional disturbance." Current law includes children under age three who need special instruction and services because of a "substantial delay" or "identifiable physical or mental condition known to hinder normal development.."

Section 7 amends M.S. 260A.03, which requires notices to parents or guardians of a child who is a continuing truant, to add that an assessment for underlying issues contributing to the child's truant behavior, including a mental health screening, <u>may</u> be available.

Section 8 amends M.S. 260A.04, subdivision 2, to add "mental health screening" and "classroom modifications and accommodations" to the list of services that community-based action projects <u>may</u> provide.

Section 9 amends M.S. 260A.04 subdivision 3, to add mental health provider to the list of programs/services to which a truancy service center <u>may</u> make a referral.

Assumptions

Section 3

- The Minnesota Department of Education (MDE) would need to research and identify an appropriate tool for socioemotional development screening. This tool would need to be presented to the Department of Human Services for approval and updated on an annual basis.
- School districts would need to be trained on the new screening tool.
- The screening brochure would need to be updated, translated into 11 languages and reprinted.
- Districts will assume costs of screening for socioemotional development that exceed the amount of state aid provided by statute.

Section 5

- All children screened are at least 2 years old. The bill would set a rate for children screened at age two, but Early Childhood Screening Annual Report no longer includes this age category.
- Constant sized population cohorts of 70,980 each for children ages 3 through 5. Calculation is based upon the average of the Fall 2004 0-4 Census cohorts, and the Fall 2003 0-4 Census 4-year-old cohort (proxy for 5-year-old count).

- Percentages of population cohorts screened based on the number screened by age as reported in the 2003-2004 Early Childhood Screening Annual Report. Children screened at age 5 are combined with those screened at kindergarten entrance through a catch-up program.
- Districts do not report children for whom they have already claimed screening aid reimbursement, as is the practice under current law. When reporting their screening totals, districts must assure that "no reimbursement has been claimed for more than one screening per child."
- The number of children entering kindergarten who have been screened through other providers, e.g. Head Start, private clinic, public health, and the number of children entering kindergarten with no screening, due to parent exemption for conscientiously held beliefs, are held constant at the numbers reported in the 2003-04 Screening Annual Report.
- Districts will respond to the higher reimbursement rate for three-year-olds and the lower reimbursement rate for five-year-olds and kindergarteners by increasing the percentage of three- and four-year-old populations screened. It is assumed that the impact will be greater in the second year than the first, to allow time for districts to be notified of the change in policy and adapt their screening programs and administrative practices accordingly. There is no precedent to inform the following estimated annual change in the percentage of each age cohort screened: 1) three-year-olds: by 10 points in FY06, 15 points in FY07 and 10 points in FY08, 10 points in FY09. Four-year-olds: by 5 points in FY06, and 10 points in FY07 (before offsetting impact of increase in three-year-olds screened in the prior year). The increase in the shares of three- and four-year-old populations screened reduces the percentage of the four- and five-year-old populations screened, respectively, in the following year, but it is assumed that 5% of the five-year-old population will continue to receive screening at or before kindergarten entrance, due to in-migration, and parent responsiveness to the outreach effort districts are able to mount within available resources.
- The total number of children screened increases only because of the shift in the age at screening. Once the effect of these shifts in the age distribution of children screened is completed, in FY 2010, the percentage of the total population ages 3 through 5 receiving early childhood screening through a school district returns to the percentage assumed in the November 2004 forecast under current law.
- Districts will continue to screen children at ages four, five, and kindergarten entrance.

Section 6 –

- The bill's term "emotional disturbance" means emotional behavioral disorder, as defined in Minnesota Rules Chapter 3525, part 1329 (see http://www.revisor.leg.state.mn.us/arule/3525/1329.html). Subpart 3 of this rule states that "children not yet enrolled in kindergarten are eligible for special education and related services" if they meet these criteria. The evaluation "must show developmentally significant impairments in self-care, social relations, or social or emotional growth."
- Minnesota's December 1, 2004, Child Count reported no children age one or younger and only one two-year old child with an emotional behavioral disorder among a total of 1,875 two-year-olds found eligible for special education services. The low number may reflect a resistance among Individualized Family Service Plan (IFSP) team members to label a very young child as EBD, as well as a prevailing philosophy among special education professionals that an infant or toddler labeled as EBD is not educationally disabled but requires treatment for a mental health problem or mental illness, not special education.
- The identification and treatment of EBD infants and toddlers is a relatively new field of research. While efforts are underway to build clinical capacity, there are currently only a few licensed therapists trained to treat EBD infants and toddlers, and most of them practice in the Twin Cities metro area.

Expenditure and/or Revenue Formula

Section 3:

- A .5 FTE professional level employee would need to be dedicated in FY 2007 to research an appropriate tool, obtain approval of the tool from the Department of Human Services, and provide training to school districts on the use of the tool = $52,321 (see table below).
- 15 trainings of district staff at a cost of $25/participant (40 participants) per training = $15,000
- Translation of the early childhood health and developmental screening brochure into 11 languages at a rate of $200 per language = $2,200
- Reprinting of three cohorts of the updated and translated early childhood health and developmental screening brochure: $18,000

Total FY 2007 Cost: $87,521

Professional	Est. Salary	Est. Benefits	Total Cost	FTE	Adjusted Cost	Fiscal Note Cost
ED Spec II (17)	71,464.64	21,857.67	93,322.31	**0.50**	46,661.16	46,661.16
Agency Indirect Costs						13,856.00
Total Cost for 0.5 FTE						60,517.16
Cost that agency can absorb						
	Office Space					8,196.00
Net Cost for New Position – FY 2007						52,321.16
Net Cost for New Position – FY2008-09						
ED Spec II (17)	71,464.64	21,857.67	93,322.31	0.25	23,330.58	23,330.58
Agency Indirect Costs, net of Office Space						5,660.00
Total Costs, 0.25 FTE						$28,990.56

Section 5 – The number of children screened times the reimbursement rate as follows: $50 per child age 3; $40 per child age 4; $30 per child age 5 and older.

Forecast Number Screened, by Age

	Age 3	Age 4	Age 5	Total	Screened by Other& Not Screened	Total Screened	% of Total Est. Population Age 3-5
Est. Population Cohort	70,980	70,980	70,980	212,940			
Current Law - Feb05 Forecast							
FY05 - FY09	14,760	36,474	15,291	66,525	8,920	75,445	35%
FY-06	21,858	40,023	15,291	77,172	8,920	86,092	40%
FY-07	32,505	40,023	11,742	84,270	8,920	93,190	44%
FY-08	39,603	29,376	4,644	73,623	8,920	82,543	39%
FY-09	46,701	22,278	4,644	73,623	8,920	82,543	39%
FY-10	46,701	15,180	4,644	66,525	8,920	75,445	35%
FY-11	46,701	15,180	4,644	66,525	8,920	75,445	35%

Aid Entitlement Calculation

	Age 3	Age 4	Age 5	Total	Change vs. Current Law
Current Law	$ 40.00	$ 40.00	$ 40.00		
FY05 - FY09	590,400	1,458,960	611,640	2,661,000	
S.F. 1365	$ 50.00	$ 40.00	$ 30.00		
FY-06	1,092,900	1,600,920	458,730	3,152,550	491,550
FY-07	1,625,250	1,600,920	352,260	3,578,430	917,430
FY-08	1,980,150	1,175,040	139,320	3,294,510	633,510
FY-09	2,335,050	891,120	139,320	3,365,490	704,490

Change in Appropriation vs. Current Law

Current Payment @ Final Payment @ Total Change in

	84.3%	15.7%	Appropriation
FY-06	415,000	-	415,000
FY-07	774,000	77,000	851,000
FY-08	535,000	144,000	679,000
FY-09	594,000	99,000	693,000

Section 6 –The change in statute would not increase the number of children age birth to three eligible for special education, so would have no impact on general education or special education revenue.

Long-Term Fiscal Considerations

Section 3 - The Department will require ongoing staffing costs of .25 FTE to update and train districts on the updated tool on an annual basis.

Local Government Costs

Section 5 – Districts will incur additional costs to provide the new required screening component for socioemotional development.

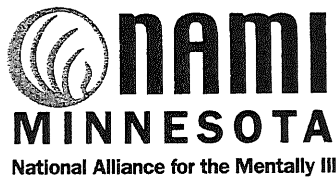
Section 7 – Requires that a district notify parents of a truant child, in addition to current notification requirements, that an assessment, including a mental heath screening, may be available. Costs to implement this, if any, are likely to be small.

Agency Contact Name: DeRemee, Lisa - 651-582-8467
FN Coord Signature: AUDREY BOMSTAD
Date: 03/31/05 Phone: 582-8793

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: LISA MUELLER
Date: 03/31/05 Phone: 296-6661



March 30, 2005

Dear Members of the Early Childhood Policy and Budget Division:

The National Alliance for the Mentally Ill of Minnesota (NAMI-MN) strongly supports SF 1365. This bill would expand mental health screening efforts to preschool children and children who are truant. The tragic consequences of our failure to identify youth through early assessment and to intervene with appropriate mental health treatment and services are well documented.

Suicide is the 3rd leading cause of death for 10 to 14 year olds and second leading cause of death for 15 – 19 year olds. In Minnesota, between 1998 and 2002, 30 children ages 10 – 14 took their lives and 170 youth ages 15 to 19 years of age took their own lives. According to the Surgeon General, 90% of those who take their lives by suicide have a diagnosable and treatable mental disorder. In addition, approximately 10% of children and adolescents live with a mental illness and yet, only about 20% of them are identified and in treatment.

Youth with mental illnesses have the highest school dropout and failure rates of any disability group in Minnesota and across the nation. When their mental illness is untreated, it affects their ability to learn and to develop relationships with other students.

Screening for the health and well being of children is a well-established practice in the United States. We screen for vision, lead poisoning, hearing, scoliosis, tuberculosis, appropriate developmental progress and more. Mental health screening is essential to address the gross under-identification of youth with mental illnesses and the tragic consequences that often follow. Research shows that early identification and intervention leads to improved outcomes and may lessen long-term disability. Many NAMI families also recount that it promises to avoid years of unnecessary suffering and lost opportunities.

Please support SF 1365, it will add to our efforts over the past three years to increase the awareness of mental illness in children, identify children early and work towards success in their home and school life.

Sincerely,

Sue Abderholden
Executive Director

Member

Community Solutions Fund

NAMI-MN National Alliance for the Mentally Ill of Minnesota
800 Transfer Road, Suite 7A, St. Paul, MN 55114 Tel: 651-645-2948 or 1-888-473-0237 Fax 651-645-7379

NAMI Supports Screening Children and Adolescents
For Mental Illnesses in Child Serving Agencies and Settings

NAMI strongly supports Goal 4 of President Bush's New Freedom Commission report on mental health calling for early mental health screening. In this nation, approximately 10% of children and adolescents have mental illnesses, yet only 20% of them are identified and receiving services. Mental health screening is essential to address this gross under-identification of youth with mental illnesses. Research and science are solidly on our side. Research shows that early identification and intervention leads to better outcomes and may lessen long-term disability. It also avoids years of unnecessary suffering.

Screening for the health and well being of children is a well-established practice in this country. We screen for vision, lead poisoning, hearing, scoliosis, tuberculosis, appropriate developmental progess and more. Campaigns of misinformation, stigma and fear must not stand in the way of appropriately identifying youth with mental illnesses and intervening with appropriate services.

NAMI calls on federal, state and local leaders to immediately take affirmative steps to implement mental health screening for children and adolescents, **with the following guidelines and protections in place**:

1. Mental health screening must be voluntary and available for all children.
2. Parental consent or consent from legally authorized surrogates must be obtained for all mental health screening.
3. Mental health screening must not be used in a discriminatory manner.
4. All individuals administering mental health screening must be appropriately trained and qualified both to administer the screening instruments and to interpret the results.
5. All information related to screening must be kept strictly confidential and the privacy of youth and their families must be protected.
6. All mental health screening instruments must be shown to be reliable and effective in identifying children in need of further assessment.
7. Validity studies must be done to ensure that screening instruments are culturally and linguistically appropriate and administered in a manner appropriate for culturally and racially diverse communities.
8. Schools must never use mental health screening results or the refusal to consent to screening as a basis for any adverse action against a child or family.
9. All children identified through screening as potentially requiring mental health services must be referred for an immediate comprehensive mental health evaluation by a qualified and trained professional.
10. Children ultimately identified as requiring mental health services must be immediately linked to and offered appropriate treatment and services and provided with comprehensive information about treatment options, the mental health treatment system, and family and community support resources.

NAMI calls on national leaders to build a comprehensive children's mental health system of care for the millions of children and adolescents who require these services and their families. These families deserve nothing less.

Mental Health Screening

Why Screen?
The President's New Freedom Commission on Mental Health stated in their report issued July 2003, that "for consumers of all ages, early detection, assessment, and links with treatment and support will help prevent mental health problems from worsening." They believe that by intervening early, we will improve outcomes including school success. The Commission recommended that quality screening occur in schools and where children are at greater risk such as juvenile justice and child welfare systems.

What is Screening?
The use of effective and efficient mental health screening instruments is fundamental in identifying the mental health problems of children and adolescents. Identifying the need for further assessment is the primary purpose for screening. Mental health screening instruments are not used for making a diagnosis, but instead to inform parents and those working with families whether there is a need for further assessment.

Mental health screenings are **not diagnostic** assessments and are not used to diagnose children. They are used to identify children or adolescents who may be at risk of having a mental health disorder. A diagnostic assessment is more comprehensive, expensive and time consuming. Diagnostic assessments identify the type and extent of the mental health disorder. A mental health screening does not make a diagnosis or suggest treatment.

What are the screening instruments?
To effectively implement and screen for mental health issues, adoption of a standardized screening tool is important. The instrument used should be effective and efficient. The ideal screening tool is sensitive, specific, reliable and valid. Additionally, the tool needs to easy to administer, time efficient and cost neutral.

The Department of Human Services recommends the Ages and Stages Questionnaire: Social Emotional (ASQ: SE). The ASQ:SE is a series of questionnaires designed to be completed by parents and interpreted by professionals. The questionnaires are specific to eight different age groups. The tool addresses covers five key developmental areas: communication, gross motor, fine motor, problem solving, and personal-social. There are seven behavioral areas: self regulation, compliance, adaptive functioning, autonomy, affect and interactions with people. For the younger children, the parents, teachers, and other caregivers administer the questionnaire. There are 30 questions and it can be completed in just 10 – 15 minutes.

Professionals then use scoring sheets to determine a child's developmental progress. The ASQ User's Guide offers clear guidelines for determining whether children are at high or low risk in the various domains. ASQ keeps costs down by providing photocopiable forms. For instance, each school district could purchase a kit and recopy all the forms at no cost.

Points to Consider

▪ 21 % of children have a diagnosable mental, emotional or behavioral disorder.
Source: (1999) Mental Health: A report of the Surgeon General. US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Heath Services, National Institute of Mental Heath. Children's Partnership, 2000.

▪ National prevalence rates estimate that 5% of children ages 5 through 8 and children ages 9 to 17 have a serious/severe emotional disturbance. Source: Citizens League, 2001

▪ Mental health problems interfere with normal development and functioning.

▪ Children and families suffer as a result of missed opportunities for prevention and early identification. Source: Children's Mental Health: Developing a National Action Agenda. Office of Surgeon General (conference 2000).

▪ Research indicates that identification and treatment of mental disorders in childhood can reduce symptoms, improve adaptive functioning and buffer long-term impairment.

▪ Early Intervention is essential to reducing negative effects on academic and social adjustment.

▪ Unmet mental health needs is one source leading to truancy.

▪ Research on truancy suggests a relationship between certain personal characteristics such as low self-esteem and anxiety. Source: Journal of Youth and Adolescents, Vol. 27, No. 5, 1998.

▪ Truancy has been identified as one of the early warning signs of students headed to other delinquent behavior, social isolation, and educational failure.
Source:Huizinga, D., Loeber, R., Thornberry, T. P. & Cothern, L. (2000, November). Co-occurrence of delinquency and other problem behaviors. Juvenile Justice Bulletin, OJJDP. and Morris, J. D., Ehren, B. J., & Lenz, B. K. (1991). Building a model to predict which fourth through eighth graders will drop out in high school. Journal of Experimental Education, 59(3), 286-292.

▪ The American Academy of Pediatrics believes that a full assessment for social, medical and mental health problems should be conducted on students.

▪ It has long been acknowledged that a variety of psychosocial and health problems affect learning and performance in profound ways.

▪ The mission of schools is to educate all students. However, when students are not doing well at school because of mental health concerns the school cannot achieve its goal for such students without addressing factors interfering with progress.

Conclusion

By using an effective mental health screening tool, schools will be helping identify mental health disorders earlier leading to better outcomes for students. Schools will not be diagnosing mental disorders but rather gathering information to inform parents. What a screening can provide are reasons as to why a child might not be succeeding at school. Addressing mental health issues is important for school success and development.

Contemporary
PEDIATRICS

Never too soon: Identifying social-emotional problems in infants and toddlers

Mar 1, 2003
By: Jane Squires, PhD, Robert Nickel, MD
Contemporary Pediatrics

Never too soon:
Identifying social-emotional problems in infants and toddlers

Jump to: Choose article section... Go

By Jane Squires, PhD, and Robert Nickel, MD

The earlier that social-emotional problems are recognized, the better the outcome is likely to be. Several recent screening tools for children from birth to 3 years can facilitate this process using parent-completed questionnaires that are quick, easy, and economical in office practice.

An estimated 13% of preschool children have mental health problems, and prevalence has increased over the last two decades.[1,2] Prevalence is even higher among preschool children living in an environment of risk, with estimates ranging from 17% to 25%.[3] Infants, toddlers, and preschoolers living in poverty—an increasing number over the last decade—have twice the rate of mental health problems of other children.[4]

Although some physicians believe that infants and toddlers are too young to have social and emotional problems, many researchers have concluded that identifying infants and toddlers at risk of a mental health disorder is crucial for improving developmental outcomes.[5] Early identification is essential for three reasons. First, in terms of brain development, quality early relationships and experiences can positively affect gene function, neural connections, and the organization of the mind, having lifelong positive effects.[6] Second, once established, social and emotional problems are highly resistant to change.[7] It is not surprising that a strong relationship exists between childhood social and emotional problems, delinquency, and later criminality.[7] Third, the costs associated with antisocial and criminal behavior are staggering. Targeted interventions may improve outcomes and save subsequent social costs, such as those incurred in juvenile justice programs.[8]

Primary care physicians are in a unique position to identify social-emotional problems, yet pediatricians and family practitioners underidentify children with such problems.[9,10] Studies also have reported a lower level of recognition of social and emotional problems in preschool children and girls compared with older children and boys.[11]

This article focuses on identifying infants and toddlers—birth to 3 years of age—with a potential social-emotional problem as part of health promotion in a primary care office. We use "social-emotional" to include behavioral, conduct, psychiatric, psychosocial, and general mental health disorders. We review selected screening tools and make some recommendations, including the use of parent-completed early childhood

social-emotional screening tests for children from risk environments or whose caregivers indicate concerns in social-emotional areas.

The goal of the recommended screening process is to promote optimal mental health and development by helping parents to assess their own child's skills. Eliciting information from parents about areas of concern enables physicians to identify problems early and provide appropriate supports to families.

Barriers to identifying problems

Underidentification of infants and toddlers with a mental health problem often occurs because parents have limited opportunities to state their concerns during a well-child visit and are reluctant to share behavioral and mental health concerns with the primary care physician. In one study, 81% of parents said that they believed it is appropriate to discuss four or more of six hypothetical situations with their child's physician, yet only 41% of parents had actually discussed such situations when they occurred.[12] It is estimated that only 24% to 31% of parents express nonmedical concerns to their child's pediatrician.[13] Time constraints on physicians often prevent them from eliciting concerns from parents and families. When parents do voice concerns, physicians are more likely to identify social-emotional problems in children and make appropriate referrals.[12–14]

Other factors contributing to underidentification of problems in infants and toddlers include:[12,14,15]

- lack of reimbursement for screening and identification of mental health problems and counseling of families
- need for additional training of primary care health professionals and office staff
- lack of community mental health resources for infants and toddlers and their families.

Table 1 summarizes barriers to early identification.

TABLE 1 **Barriers to identifying social-emotional problems**
Limited time during well-child visits
Reluctance of families to share concerns
Lack of reimbursement for screening and identification
Need for additional training for physicians and office staff
Limited availability of mental health resources

Potential solutions

Many parents do not feel comfortable voicing their concerns unless the physician initiates a conversation. Parent-completed screening questionnaires provide an optimal structure for parents to identify and focus concerns about their child. Failure to use structured screening tests has been cited specifically as a reason for delayed identification of developmental disorders such as autism in young children.[16] Parent-completed

questionnaires not only provide a framework for parents to discuss concerns but also enable the physician to elicit detailed information regarding the child's development. Table 2 summarizes the benefits of parent-completed screening tests.

TABLE 2 **Benefits of parent-completed mental health screens**
Invite the parent to discuss questions about the child's social and emotional development
Are efficient, requiring limited use of professional time
Review the development of specific competencies as well as behavior concerns
Provide cutoffs at specific ages to identify atypical behavior
Help determine the need for further information and referral

Parent-completed screens offer a partial solution to the lack of reimbursement for screening. They are low-cost because they involve little professional time to score and review. The cost of using the Ages and Stages Questionnaires[17] has been reported to be $8.50 per questionnaire, including postage and professional time.[18] Other solutions to the lack of reimbursement for screening services include using appropriate procedural and diagnostic codes and advocating for improved mental health benefits and reimbursement. These issues are reviewed in the American Academy of Pediatrics' *Diagnostic and Statistical Manual for Primary Care* (*DSM-PC*) *Child and Adolescent Version*[19] and *Bright Futures in Practice: Mental Health*.[15]

The *DSM-PC* and *Bright Futures* offer excellent training materials for physicians and office staff. The *DSM-PC* outlines a process to follow to determine if a behavioral concern is a developmental variation, a problem, or a disorder; to identify important environmental situations or stressful events; and to classify the severity of the specific behavior concern. *Bright Futures* offers a variety of tips for the promotion of optimal mental health in children of all ages as well as tools for health-care professionals to use with families, such as age-specific observations of the parent-child interaction and recommendations for interventions for specific disorders. The surveillance process that we recommend is consistent with, and complementary to, both of these resources.

Health promotion activities such as screening for social-emotional problems can be incorporated into a busy primary care practice. The authors of *Bright Futures* recommend the following strategies to maximize the time for health promotion:[12,20]

- have parents complete surveys in the waiting room
- train staff to elicit information from families and provide follow-up
- assist the family in prioritizing needs
- schedule follow-up appointments.

Primary care professionals can use parent-completed screens to initiate a conversation with families, provide a relatively complete review of the child's competencies and potential problems, and help determine whether a particular concern is a developmental variation, problem, or disorder. They can use the materials in *DSM-PC* and *Bright Futures* to clarify the area of concern, review contributing factors, and decide next steps.

An additional resource for health-care professionals is the *Diagnostic Classification of Mental Health and*

Developmental Disorders of Infancy and Early Childhood (DC:0-3).[21] DC:0-3 was specifically developed to address problems with the use of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*)[22] in young children. DC:0-3 defines a process for organizing observations and information from other assessments to help with diagnosis and development of a treatment plan with families.

Community-based mental health resources for children and families are limited. Collaborative community-based approaches can help conserve resources and provide more comprehensive services.[23] Primary health-care professionals need to establish partnerships with families and community providers, including early intervention programs, to develop integrated services for young children with social-emotional problems and their families.

Using screening tests in surveillance

To improve the accuracy and efficiency of developmental surveillance, it is important to use formal screening measures in addition to observation and interview.[24] Screening tests also need to be repeated over time to improve the effectiveness of the screening process. Having parents complete a simple questionnaire may improve the accuracy of the screening process while empowering them and conserving valuable professional resources.[25] Parents may provide information that they would not otherwise share and may provide more complete information with a small investment of professional time.

A formal screening measure should adhere to psychometric standards so that accurate and efficient management decisions are made. In general, the management recommendations presented in *DSM-PC* are:

- reassurance for a developmental variation
- short-term counseling and follow-up for a problem
- referral for evaluation by a mental health professional for a disorder.

A formal screening test that has established psychometric properties, including a normative sample with cutoffs to clearly identify atypical behavior at specific ages, is essential to help differentiate a developmental variation from a problem or a disorder.

In the past decade, several mental health screening tools have been developed for the birth to 3-year-old population. These tools are broadly based and assess social and emotional behaviors as well as adaptive and play skills.[26] Table 3 describes the characteristics of selected social-emotional screening tools, including age range, administration time, number of items, content, administrator, and psychometric data. All the tools described target the birth to 3-year-old age range, assess social or emotional domains, or both, are completed by parents or caregivers, and have acceptable psychometric studies to support their use. (Social-emotional tests with adequate psychometric properties for the 3- to 5-year-old preschool population are reviewed elsewhere.[27] They include the Pediatric Symptom Checklist[1] and the Social Skills Rating Scale.[28])

TABLE 3
Selected social-emotional screening tools for infants and toddlers

Name	Author(s)/ date/publisher	Age range	Administration time/no. of items	Person who completes tool	Psychometric data	Comments
Ages and Stages Questionnaires: Social-Emotional (ASQ:SE)	Squires JK, Bricker D, Twombly E 2002 Brookes Publishing PO Box 10624 Baltimore, MD	3–66 mo	10–15 min Varies; 21–32 items, depending on age interval	Parent, caregiver	National normative sample with adequate validity and reliability in supporting	Areas: self-regulation communication autonomy, coping relationships

	21285				studies	
Brief Infant/Toddler Social Emotional Assessment (BITSEA)	Carter A, Briggs-Gowan M 2001 Available from the authors by e-mail (TSEA@yale.edu) or telephone (203-764-9093)	12–36 mo	10–15 min 60 items	Parent, caregiver, child-care provider	Adequate validity and reliability; normative sample not geographically represented	Available online items taken from Infant/Toddler Social Emotional Assessment-Revised (ITSEA-R) Areas: problem and competence, including activity, anxiety emotionality
Devereux Early Childhood Assessment Program (DECA)	Devereux Foundation 1998 Kaplan Press PO Box 609 Lewisville, NC 27033	2–5 yr	10 min 37 items	Parent, caregiver	National normative sample with adequate validity and reliability studies	Assesses 27 positive and 10 problem behaviors; includes guidelines for supportive interactions and partnerships with families
Eyberg Child Behavior Inventory (ECBI)	Eyberg S, Pincus D 1999 Eyeberg & Pincus Psychological Assessment Resource Odessa, FL 33556 800-321-0378	2–16 yr	10 min 36 items	Parent, caregiver	Small normative sample; adequate validity and reliability studies	Focuses on oppositional behaviors Norms include children to 16 yr of age
Infant/Toddler Symptom Checklist	DeGangi G, Poisson S, Sickel R, Wiener AS 1995 Therapy Skill Builders 38 E. Bellevue Tucson, AZ 85716	7–30 mo	10 min 21 items in general screening version	Parent	Small normative sample not ethnically diverse; adequate validity and reliability	General screen is appropriate for clinic use Five checklists target children 13–18 mo 19–24 mo and 25–30 mo of age Areas: self-regulation self-care, communication, vision, attachment
Temperament and Atypical Behavior Scale Screener (TABS Screener)	Bagnato SJ, Neisworth T, Salvia J, Hunt J 1999 Brookes Publishing PO Box 10624 Baltimore, MD 21285	12–71 mo	Not reported 15 items	Parent, professional	Studied only in relation to full TABS; adequate agreement with TABS	Focuses on regulatory disorders Used as a prescreener for TABS

Recommendations

We recommend that all infants and toddlers be assessed at regular intervals with a parent-completed general developmental screen such as the Ages and Stages Questionnaires. We recommend using a social-emotional screening tool when:

- parents express a concern in social, emotional, or behavioral areas
- a general developmental screen indicates potential problems in the personal-social or social-emotional areas
- the physician has a concern about child behavior or parent-child interactions (Table 4).

TABLE 4 Recommendations for using social-emotional screens
Use a behavioral screen when
Parents have a concern
Child exhibits delay on personal-social section of the general screen or physician notes concern about child's behavior or parent-child interaction
If screen does not identify potential problem
Review issues at next well-child visit, or sooner, based on family choice
If screen identifies potential problem
Obtain further information to clarify management issues
Use in-depth, parent-completed tool (e.g., Child Behavior Checklist)
Observe parent-child interaction
Review situational factors *(DSM-PC)*
Request information from day-care and preschool providers
or
Refer to mental health provider

We also recommend that physicians follow the guidelines for mental health promotion described in *Bright Futures*.

For children from birth to 3 years of age, we specifically recommend using the Brief Infant-Toddler Social

Emotional Assessment (BITSEA)[29] or the Ages and Stages Questionnaires: Social-Emotional (ASQ:SE)[30] because these instruments are broad-based, meet established psychometric standards, and are easy to use in office settings. Additional tools for 2- to 3-year-olds include the Devereux Early Childhood Assessment (DECA)[31] and the Eyberg Child Behavior Inventory.[32] All these questionnaires are brief, easily scored, and can be completed in the waiting room before the examination or mailed to parents before an appointment. Office assistants can score the questionnaires before the examination in a minute or two.

If a parent-completed social-emotional tool elicits concerns, follow-up can include in-office administration of an in-depth social-emotional assessment, such as the Child Behavior Checklist[33] or Infant Toddler Social Emotional Assessment,[34] or referral to an early intervention team or mental health professional for further evaluation and services. In-depth assessments, described in Table 5, provide more complete information on social- emotional competence and can help with referral decisions. Additional information such as observation of the parent-child interaction, review of the situational factors listed in the *DSM-PC*, and information from day-care and preschool providers also may help determine an appropriate management strategy.

TABLE 5
In-depth social-emotional assessment tools for infants and toddlers

Name	Author(s)/ date/publisher	Age range	Administration time/no. of items	Person who completes tool	Psychometric data	Comments
Child Behavior Checklist/11/2-5 (CBCL)	Achenbach T, Rescorla L 2000 Child Behavior Checklist 1 South Prospect St. Burlington, VT 05401	1 1/2–5 yr	10–15 min 100 items	Parent (teacher report form also available)	Standardized, norm-referenced Strong validity and reliability findings Well respected	Assesses externalizing and internalizing behaviors: reactivity aggression, withdrawal attention, sleep 4–18-yr version available
Functional Emotional Assessment Scale (FEAS)	DeGangi G, Greenspan S 2000 Appendix B of DeGangi G: *Pediatric Disorders of Regulation in Affect and Behavior*. San Diego, Academic Press, 2000	7 mo–4 yr	15–20 min 6 versions range from 27–61 items	Professional	Small (N = 468) normative sample, mostly white middle class Moderate support for validity and reliability	Assesses caregiver's strengths and areas of need in supporting child's emotional and play skills Professional observes parent-child interactions
Infant/Toddler Social Emotional Assessment Revised (ITSEA-R)	Carter A, Briggs-Gowan M 1999 Available from	12–36 mo	40 min 200 items	Parent	1,280 in normative sample (all from Connecticut); significant	Available online Provides in-depth social-emotional

	authors e-mail: ITSEA@yale.edu Phone: 203-764-9093				correlations with CBCL No national standardization yet	assessment Areas: externalizing internalizing, dysregulation maladaptive behaviors social-emotional competence
Temperament and Atypical Behavior Scale (TABS)	Bagnato SJ, Neisworth JT, Salvia J, Hunt J 1999 Brookes Publishing PO Box 10624 Baltimore, MD 21285	2–71 mo	Not reported 55 items	Parent, professional	833 in normative sample Strong findings for test-retest reliability and internal consistency	Evaluates regulatory disorders Asks about dysfunctional behaviors Areas: temperament attention, attachment self-stimulation self-injury, social play movement, vocal/oral
Vineland Social-Emotional Early Childhood Scale	Sparrow S, Balla D, Cicchetti D 1998 American Guidance Service 4201 Woodland Rd. Circle Pines, MN 55014	Birth–5 yr, 11 mo	15–20 min Varies by domain, age	Professional (interview) skills	Standardized, norm-referenced, based on 1984 data	Items taken from Vineland Few items at younger ages Areas: relationships play and leisure, coping

The earlier the better

Because of the complexity of social-emotional issues and the frequent presence of a constellation of family issues, it is important for the physician to have a menu of options for families, including mental health, family support, and special education services. Physicians need to keep a current list of community referral sources, including telephone numbers, insurance information, and approximate cost for services such as counseling and substance abuse prevention. Including a pediatric mental health provider either near or within a medical clinic is one strategy that some pediatricians have pursued in order to facilitate consultation and referral to mental health services.[20]

As recommended, infants and toddlers should be assessed using a social-emotional screening test when parents or providers have concerns or when a general developmental assessment indicates problems in

social-emotional skills. Using a parent-completed screening tool provides a forum for the parents to discuss their concerns and provides the physician with in-depth developmental information on the child.

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The earlier that social-emotional problems are recognized, the better the outcome is likely to be. Several recent screening tools for children from birth to 3 years can facilitate this process using parent-completed questionnaires that are quick, easy, and economical in office practice.

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KEY POINTS

Early screening for social-emotional problems

- Several valid, reliable screening tools designed for infants and toddlers can be used in the pediatrician's office to help identify behavioral problems early.
- Helping parents find services when their children are young may help prevent a myriad of problems later in childhood—including antisocial, violent, and destructive behaviors.[35]
- Early intervention for social-emotional disturbances will save families and society countless dollars and promote more positive developmental outcomes for youngsters with social-emotional problems.

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Ages & Stages Questionnaires: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By **Jane Squires, Diane Bricker, & Elizabeth Twombly**
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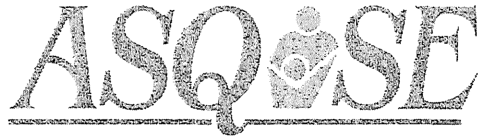
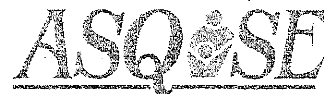


30 Month Questionnaire

(For children ages 27 through 32 months)

Important Points to Remember:

- ☑ Please return this questionnaire by ______________________ .
- ☑ If you have any questions or concerns about your child or about this questionnaire, please call: ______________________ .
- ☑ Thank you and please look forward to filling out another ASQ:SE questionnaire in ______ months.



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30 Month ASQ:SE Questionnaire

(For children ages 27 through 32 months)

Please provide the following information.

Child's name: ______________________

Child's date of birth: ______________________

Today's date: ______________________

Person filling out this questionnaire: ______________________

What is your relationship to the child? ______________________

Your telephone: ______________________

Your mailing address: ______________________

____

City: ______________________

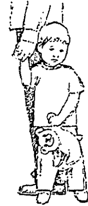
State: ______________________ ZIP code: ______________________

List people assisting in questionnaire completion: ______________________

____

Administering program or provider: ______________________

Please read each question carefully and
1. Check the box ❑ that best describes your child's behavior *and*
2. Check the circle ❍ if this behavior is a concern

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
1. Does your child look at you when you talk to him?	❑ z	❑ v	❑ x	❍
2. Does your child like to be hugged or cuddled?	❑ z	❑ v	❑ x	❍
3. Does your child cling to you more than you expect? 	❑ x	❑ v	❑ z	❍
4. Does your child greet or say hello to familiar adults?	❑ z	❑ v	❑ x	❍
5. Does your child seem happy?	❑ z	❑ v	❑ x	❍
6. Does your child like to hear stories and sing songs?	❑ z	❑ v	❑ x	❍
7. Does your child seem too friendly with strangers?	❑ x	❑ v	❑ z	❍
8. Does your child seem more active than other children her age?	❑ x	❑ v	❑ z	❍
9. Can your child settle himself down after periods of exciting activity?	❑ z	❑ v	❑ x	❍
10. Does your child cry, scream, or have tantrums for long periods of time?	❑ x	❑ v	❑ z	❍
11. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or ______________________ . (You may write in something else.)	❑ x	❑ v	❑ z	❍

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	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
12. Can your child stay with activities she enjoys for at least 3 minutes (not including watching television)?	☐ z	☐ v	☐ x	○
13. Does your child do what you ask him to do?	☐ z	☐ v	☐ x	○
14. Is your child interested in things around her, such as people, toys, and foods?	☐ z	☐ v	☐ x	○
15. When upset, can your child calm down within 15 minutes?	☐ z	☐ v	☐ x	○
16. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or ______________________ ? (You may write in another problem.)	☐ x	☐ v	☐ z	○
17. Do you and your child enjoy mealtimes together?	☐ z	☐ v	☐ x	○
18. When you point at something, does your child look in the direction you are pointing?	☐ z	☐ v	☐ x	○
19. Does your child sleep at least 8 hours in a 24-hour period?	☐ z	☐ v	☐ x	○
20. Does your child let you know how he is feeling with either words or gestures? For example, does he let you know when he is hungry, hurt, or tired?	☐ z	☐ v	☐ x	○

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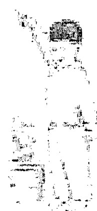
	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
21. Does your child follow routine directions? For example, does she come to the table or help clean up her toys when asked?	❑ z	❑ v	❑ x	○
22. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	❑ z	❑ v	❑ x	○
23. Can your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	❑ z	❑ v	❑ x	○
24. Does your child stay away from dangerous things, such as fire and moving cars?	❑ z	❑ v	❑ x	○
25. Does your child destroy or damage things on purpose? 	❑ x	❑ v	❑ z	○
26. Does your child hurt himself on purpose?	❑ x	❑ v	❑ z	○
27. Does your child play alongside other children?	❑ z	❑ v	❑ x	○
28. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	❑ x	❑ v	❑ z	○

TOTAL POINTS ON PAGE ___

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	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
29. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:	☐ X	☐ V	☐ Z	○

30. Do you have concerns about your child's eating and sleeping behaviors or about her toilet training? If so, please explain:

31. Is there anything that worries you about your child? If so, please explain:

32. What things do you enjoy most about your child?

TOTAL POINTS ON PAGE ___

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30 Month ASQ:SE Information Summary

Child's name: ______________________ Child's date of birth: ______________________

Person filling out the ASQ:SE: ______________________ Relationship to child: ______________________

Mailing address: ______________________

Telephone: ______________________ City: __________ State: ______ ZIP:

SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box	= 0 points
V (for Roman numeral V) next to the checked box	= 5 points
X (for Roman numeral X) next to the checked box	= 10 points
Checked concern	= 5 points

Add together:

Total points on page 3	= ____
Total points on page 4	= ____
Total points on page 5	= ____
Total points on page 6	= ____
Child's total score	= ____

SCORE INTERPRETATION

1. *Review questionnaires*
   Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.
2. *Transfer child's total score*
   In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
30 months	57	

3. *Referral criteria*
   Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.
4. *Referral considerations*
   It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.
   - Setting/time factors
     (e.g., Is the child's behavior the same at home as at school?)
   - Development factors
     (e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
   - Health factors
     (e.g., Is the child's behavior related to health or biological factors?)
   - Family/cultural factors
     (e.g., Is the child's behavior acceptable given cultural or family context?)

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"School Readiness for Our Highest Risk Preschoolers"

Steve Lepinski, Executive Director
Washburn Child Guidance Center
March 2005

Introduction:
The issue of school readiness has been of increasing interest in Minnesota and nationally. Art Rolnick, economist at the Minneapolis Federal Reserve, has made the case that supporting school readiness is one of the best investments of public dollars. Ready 4 K, a non profit organization has spent years developing a policy framework to support school readiness. In December, 2004, the Minnesota School Readiness Business Advisory Council (MSRBAC) issued a report, "Ready for School?" that endorsed a strategy for improving school readiness.

There seems to be agreement that thousands of children in Minnesota are not "school ready" when entering kindergarten. There also seems to be agreement that this is a very important social and economic issue and that we have the capacity to improve school readiness for many of these children. This issue is enormously important. Early school success is highly correlated with later success in life and conversely, early school failure is highly correlated with school drop outs, involvement in the juvenile justice system, increased mental health problems, and unemployment as an adult.

Research also continues to emphasize children's social and emotional development, their ability to regulate their behavior and emotions, as critical to school readiness. Self-regulation is a key developmental skill strongly connected with school readiness and academic achievement (Blair, 2002). Children need to learn their letters and colors, but they also need to know how to follow directions, how to express anger safely, how to play with other children.

Too many children do not start school with the social and emotional skills they need to be successful in Kindergarten. In 2001, 4,000 Minnesota children in kindergarten, first and second grades were suspended for behavior problems including threats and acts of violence; 16% of these suspensions involved weapons.

Discussions of school readiness need to include the children who are at greatest risk for school failure – children with serious emotional and behavioral difficulties. Children with emotional and behavioral difficulties have the highest rate of school failure and absenteeism of any special education category. Their dropout rates are twice the rate of the general school population, with only 22% graduating (Dikel, 1999). The Children's Defense Fund estimates that 73% of children with serious emotional and behavioral disorders who drop out of school are arrested within five years. The Child Mental Health Foundations and Agencies Network report, "A Good Beginning: Sending America's Children to School with the Social and Emotional Competence They Need to Succeed" identified five primary causal risk factors for school failure: cognitive deficits; early behavior problems; parental psychological problems; problematic parenting practices; and, difficulties with teachers and peers.

Early aggressive behavior and school problems are highly predictive of more serious problems later in childhood and life. As Raver (2002) notes, "aggressive young children who are rejected by their classmates in their first years of schooling are at grave risk for lower academic achievement, greater likelihood of grade retention (being 'held back'), greater likelihood of dropping out of school, and greater risk of delinquency and of committing criminal juvenile offenses in adolescence."

Many of these children have been traumatized by early experiences of abuse, neglect and exposure to violence. There are children who by age three and four already have serious emotional and behavioral problems that are interfering with their lives. They have diagnosable mental health problems. We must develop a better understanding of how to help these children succeed and identify the most efficacious treatment interventions.

Without intensive intervention and treatment it is almost certain that these children will experience early school failure, and that they subsequently will experience increasingly severe emotional and behavior problems and will be at high likelihood to become involved in expensive deep end public systems.

A Promising Intervention Strategy:
At-risk children, especially those at highest risk for early psychopathology, are often known by their aggressive and disruptive behaviors. Treatment has traditionally focused on imposing external control, using contingent rewards and consequences. This approach has presumed that these children have developed reasonable (internal) self control, and so are acting with intention or failure of inhibition; in other words, responding to the imposed external controls, they can choose to behave differently in the treatment situation and in other settings.

A paradigm shift is proposed based on the convergence of current research in several areas (attachment, neuropsychological development, child trauma, and risk and resiliency) into a focus on self-regulation as the foundation for intervention. While group safety and security are paramount, external consequences are not seen as the means for meaningful, sustainable change.

Washburn Child Guidance Center has been implementing and evaluating an intensive early treatment program with a focus on self regulation. The conceptual framework is based on the work of Anne Gearity Ph.D. LICSW in her recent doctoral dissertation. The program is based on the following assumptions:

1. *There is a population of young children who are on a negative trajectory and can be identified between age 3 and grade 3 with a fairly high certainty as children who will later present with serious emotional and behavior problems and who will become high cost users of services as adolescents.*
2. *Effective and intensive treatment at an early age – using a treatment approach that focuses on deficits in self regulation – can change the trajectory that these children are on.*

3. *The gains made during treatment can be sustained by the periodic use of appropriate services following intensive treatment (case management, outpatient therapy, etc.)*
4. *An effective evaluation can demonstrate the impact of treatment and the capacity to sustain treatment gains over time. Routine evaluations can help maintain fidelity to the treatment model and identify ways to improve the effectiveness and efficiency with which it is implemented.*
5. *The outcome of this approach will be a reduction of emotional and behavioral problems; improved functioning at home, in the community and/or in school; and reduction of long term public expenditures for these children.*

Preliminary Results:
Funding from the Bush Foundation has enabled Washburn Child Guidance Center to engage Trish Beuhring Ph.D. from the University of Minnesota as the project evaluator. The first year of the evaluation focused on developing the evaluation design and a preliminary analysis of existing data. The findings obtained in the preliminary evaluation indicated that this intervention produced meaningful improvements in emotional status, behavior and adaptive skills among preschool children with moderate to serious problems who received day treatment for a minimum of three months. It provided suggestive evidence that the same may be true among elementary school-age children. The most intriguing finding was that the intervention appeared to be most effective with the most seriously disturbed children.

Funding from the Carolyn and Cargill Foundations has supported the development of the process that helps transition children from treatment to school. The program outcomes from 2004 and the individual success stories from the children who received this transition support also support the effectiveness and importance of this model. First, 83% of children (15 out of 18 completing the program during 2004) completed the program successfully and graduated. One child's family abruptly moved out of state and another child was withdrawn by the family due to transportation problems. Most importantly, all 18 children were able to transition to a less restrictive setting when they left the day treatment classroom; not a single child had to move into more intensive services such as residential or full-day treatment. 14 children are now attending a Kindergarten or first grade school program and are maintaining successfully in that setting. Two other children are attending community child care or preschool centers. This is a population that is 80% male, 76% children of color, and 90% low income children. This is a remarkable accomplishment since these children were identified as some of the community's highest risk preschoolers who had very high levels of stress and high numbers of significant risk factors.

Conclusion:
Assuring school readiness for all of our children is extremely important. There are social, economic and humane reasons for this. Different strategies will be necessary to support school readiness depending on the needs of the children. As we pursue this community goal, it will be very important not to neglect those children who are at highest risk for school failure, preschool age children with serious emotional and behavior problems. While the interventions necessary for these children will be intensive and expensive, the

potential pay off is huge. Some would contend that the greatest economic return will come from assuring school readiness for our highest risk children.

Washburn Child Guidance Center's intensive early treatment model is one way to serve these high risk children. The initial outcome data is very promising. Further evaluation of this approach is needed. Longer term follow up of these children will provide a better understanding of the impact of intensive early treatment. A commitment from public systems such as the schools and the county, continued interest by health plans, and continued philanthropic support will be necessary to effectively evaluate this effort. The current work here provides some evidence and strong likelihood that this population can be helped to be more successful in school and in life.

Early Childhood Social-Emotional Screening
Early Childhood Committee
March 31, 2005

The importance of providing early childhood mental health screening and appropriate follow-up services has become an increasingly important subject in the past five years, at the federal, state and local levels. Many studies and reports are available to provide more in-depth information – several will be referenced at the end of this report.

The purpose of this statement is to address several main themes regarding mental health screening with young children.

What is mental health screening: Mental health screening is a brief, culturally sensitive process designed to identify children who may be at risk for impaired mental health functioning. The intent of a mental health screen is very similar to vision screenings or hearing screens currently done in pre-K settings, to efficiently and accurately identify and recommend follow-up for children who may be dealing with an impairment that could impact their academic or social functioning. Identification of a youth with possible mental health concerns does *not* automatically lead to a diagnosis, medication or other more intensive interventions. Mental health screens for pre-K children may only be completed by a parent, *never* a child, and a referral for follow-up assessment should only happen with the informed consent and approval of the parent.

Who completes a screening instrument: For pre-school children, the parent or guardian would complete a questionnaire. There are no instruments available for young children to complete. There is a misconception that mental health screenings are administered directly to young children, thereby circumventing parents – this is simply not the case.

Are there instruments available that are valid and reliable for screening Pre-K children:

The *Ages & Stages Questionnaire: Social – Emotional, (ASQ:SE)* is a screening instrument specifically developed for use with parents of pre-K children. For 4-5 year old children, parents would answer no more than 33 questions, generally taking less than six minutes for most adults to complete. The validity (accurate identification of children likely dealing with mental health issues) is 93% based on national norms; reliability (consistency over time) is 91%. The ability of this tool to accurately screen out children who likely are not struggling with social-emotional issues is very high, at 95%, while sensitivity to correctly identifying young children who would go on to be found to have a mental health disorder is about 78%. This particular instrument was designed to be administered either individually or in large settings, such as pre-K screenings – 97% of parents report it is easy to understand; most report it takes very little time to complete.

There are several other instruments available, however the time needed to administer and score them, purchase price, level of training needed, lack of specificity for this population, etc, make them less viable options.

Diagnosis or "labeling": A child cannot be diagnosed based on the results of a mental health screen. Similar to vision or hearing screens, a mental health screen simply serves as an 'alerting' mechanism, indicating that a parent, based on their own responses to questions about their child, may want to consider consulting with a mental health professional to get more information about their child.

Supporting Documents and Reports

Blueprint for a Children's Mental Health System of Care: Minnesota Children's Mental Health Task Force, August 2002. www.dhs.state.mn.us/childint/publications/default.html

Meeting the Mental Health Needs of Minnesota's Children, Citizen's League Study, conducted on behalf of the Minnesota Department of Human Services and Minnesota Department of Health, January 2001. http://www.citizensleague.net/studies/mental-health/children/charge.html

Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Department of Health and Human Services, May 2001. http://www.surgeongeneral.gov/cmh/childreport.html

Ages & Stages Questionnaire: Social Emotional. Paul H. Brookes Publishing Company. P.O. Box 10624. Baltimore, Maryland 21285. www.brookespublishing.com

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Ed Frickson is responsible for Children's Mental Health Early Intervention Services for Ramsey County, which includes mental health screening and assessment services across Child Welfare/Child Protection, Juvenile Justice; as well he facilitates coordination of early intervention mental health programs with Head Start, and is working with primary medical care facilities to design effective mental health screening in pediatric medical settings.

Why Mandatory Mental Health
Screening Is Based On False Premises

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The current proposal for mandatory mental health screening now before congress may on the face of it sound like a good idea, but it is based on seriously flawed premises and will have tragic consequences especially for our nation's children. It is hard to imagine how this proposal which heavily stresses the use of psychotropic drugs could still be seriously considered given recent evidence that in the case of children many of these drugs pose potentially dangerous risks and are of questionable benefit. Almost all of the frequently used SSRI antidepressants have now been banned in Great Britain for use with children due to increased suicide risk and lack of demonstrated effectiveness, and the FDA has also now concluded that these drugs increase suicide potentia! l in children and adolescents. Yet this proposal would in effect result in ever greater numbers of children taking these very same drugs. While there is much justifiable concern over the potential risks this would pose to children there is an even more fundamental objection to this proposal which is that it is based on faulty assumptions and in fact lacks a valid scientific rationale.

This proposal with its heavy emphasis on the use of psychotropic drugs rests on two core assumptions. The first is that mental disorders have a biological cause such as a biochemical imbalance in the brain and are therefore biological medical disorders for which psychotropic drugs are essential treatments. This provides a theoretical rationale for the use of drugs as treatments of choice. The second assumption which provides an empirical rationale is that psychotropic drugs are highly effective and specific treatments for mental disorders and are usually the best treatments available. Another implicit assumption which follows is that screening for mental disorders is essentially comparable to screening for validated! medical diseases such as diabetes and tuberculosis. Because of their acceptance of these widely held assumptions well meaning people are willing to overlook the problems and risks of psychotropic drugs even for children, because they believe them to be necessary treatments.

However contrary to common belief the idea that most mental disorders have a biological cause has no good scientific support, and there is even some overwhelming scientific evidence against it. In addition the effectiveness of psychotropic drugs tends to be significantly exaggerated, and their effectiveness with children is even less well established. Furthermore for most nonpsychotic problems there are much better treatments available with at least equal and often far superior long-term effectiveness without the risks and problematic side effects of drugs. And rather than being specific treatments psychotropic drugs actually fit the profile of nonspecific symptomatic treatments.

By looking at the most common mental disorders in America today, the anxiety disorders, it is easy to demonstrate that the assumptions of biological etiology and superior drug effectiveness are scientifically untenable. It is beyond scientific dispute that drugs are not the best treatments available for these disorders and are in fact comparably ineffective treatments. Cognitive-behavior therapy a psychological therapy which focuses on changing irrational thinking patterns and desensitizing anxiety through exposure to feared situations is a far superior treatment with vastly better long-term results, often far greater effect sizes, no problematic side effects and no real safety concerns. In a 1989 study conducted at the University of Pennsylvania School of Med! icine and published in *The Journal of Mental & Nervous Disease* seventeen out of seventeen people suffering from panic disorder were panic free after treatment with cognitive therapy, and not one person had relapsed at one year follow-up.(1) Today most people are panic free within five to twelve sessions with lasting results. Some people are able to permanently overcome a clinical phobia in as little as one session of exposure therapy (2), while approximately 80% of people suffering from agoraphobia will have no more agoraphobic avoidance after a four day program of intensive exposure therapy (3). In contrast the great majority of people who take psychotropic drugs for anxiety disorders and who experience some symptomatic relief relapse soon after discontinuing the drug with many remaining on drugs for years or even for life. Drugs are not capable of achieving what is necessary to overcome these disorders which is corrective learning, and they clearly fit the profile of symptomatic treatments. While they may provide some relief of symptoms they are unable to resolve the problem on a more fundamental level.

The remarkable success of cognitive-behavior therapy also shows that these disorders could not possibly be biologically caused. How could a psychological therapy treat a real biological problem with such extraordinary effectiveness and consistently achieve excellent long-term results when no drug can even come close to achieving this? Moreover the psychological nature of these problems is clear. Panic attacks for example typically result from a belief that bodily sensations of anxiety will lead to catastrophic consequences such as choking or fainting, and a correction of this mistaken belief eliminates the panic. A drug cannot change a belief but can at best only blunt th! e anxiety created by that belief.

Nevertheless drugs are heavily marketed for anxiety disorders by claiming that they are caused by a "biochemical imbalance" in the brain. The effectiveness of cognitive-behavior therapy itself makes this is a ludicrous claim, but the very notion of a biochemical imbalance can in fact be shown to be an impossibility in the case of these disorders. Anxiety disorders are typically under stimulus control that is the anxiety occurs in specific situations, and a real biochemical imbalance could never be situation specific. Could diabetes or hypothyroidism only flare up say in a high place or when speaking in front of an audience? Also anxiety disorders are often the result of fear conditioning a specific form of classical conditioning where the stimuli present in a highly frightening situation become associated with the fear and subsequently elicit that fear. Classical conditioning was discovered by Ivan Pavlov a Nobel prize winning physiologist and is a scientifically validated paradigm with almost a century of research support. To claim that anxiety disorders are caused by a biochemical imbalance is

equivalent to saying that Pavlov's dogs salivated to a bell, because they had a biochemical imbalance. This is ignoring the real science and substituting pseudoscience.
The anxiety disorders show that those promoting the use of psychotropic drugs will use a pseudoscientific theoretical rationale to promote a far inferior and problematic treatment.

While there is no valid theoretical rationale for using drugs as preferred treatments for anxiety disorders, there is also no good empirical rationale, since cognitive-behavior therapy achieves better long-term results alone than when combined with drugs. However this is simply too large a market to pass up and while it clearly has no scientific validity the biochemical imbalance idea with its implication that a "chemical balancer" is needed is the perfect marketing device for psychotropic drugs with the supposed imbalance always being in the action of the drugs being promoted. In this way such widely different problems as depression, social phobia, panic disorder, and eating disorders are now said to be caused by the same supposed "imbalance" in serotonin. Th! is provides a spurious rationale for using the same class of drugs today, the serotonergic antidepressants, for almost every conceivable emotional problem making these drugs the very epitome of nonspecific treatments. Furthermore the real specificity is in the environment such as what the person is anxious or depressed about, and not in the brain. The only treatment specificity of these drugs is the fictional one of specifically targeting a biochemical imbalance never demonstrated to exist.

While it is clear that the claim that anxiety disorders are biological disorders is insupportable there is also no good scientific evidence to substantiate claims that other mental disorders are biologically based. While it is possible that some mental disorder such as bipolar disorder may turn out to be biologically caused there is thus far no clear scientific evidence of a biological cause for any mental disorder. No objective causal biological pathology has yet been found either macroscopically, microscopically including at autopsy, or biochemically such as by blood test for any mental disorder. No biochemical imbalance has ever been measured or scientifically validated for any mental disorder. What passes for evidence is based on logical errors such as claiming that brain scans show a biological cause when they show only a biological correlate of a psychological/emotional state. It is a basic error of logic to infer causality from correlation, since the brain scans may simply represent the physiological consequences or underpinnings of a psychological process. In no way do brain scans establish a biological pathology or a biological cause.

While psychotropic drugs are comparably poor treatments for anxiety disorders, their effectiveness for depression is equivocal, and they frequently do not do significantly better than placebos in drug company sponsored trials despite frequent methodological biases which favor the drug. (4) And when significant the mean difference in effect size is small and of questionable clinical significance. (5) In the case of children there is even less support for their effectiveness. In testimony before the FDA based on a meta-analysis of published drug trials Kirsch and Antonuccio found that clinically meaningful benefits

have not been adequately demonstrated in depressed children. (6) And without the unsupported assumption of biological causation the very idea of a dr! ug's effectiveness becomes a debatable point in that the drugs might be seen as only blunting the symptoms of psychological and life problems without addressing their real cause.

Furthermore the great majority of nonpsychotic problems can only be understood in relation to their environmental context. For example symptoms in children are frequently a manifestation of a problem in the family which is best addressed with family therapy. Seeing the problem as a brain disorder in the child has no scientific justification and stigmatizes the child while missing the real source of the problem. This can be psychologically damaging and can foster a loss of self-confidence as well as a psychological dependence on psychotropic drugs. And of course taking drugs exposes the child to numerous potential drug side effects including insomnia, agitation, and manic episodes as well as risks which should be considered prohibitive. The FDA determined that ! studies link all the SSRI antidepressants to heightened suicidal thoughts and actions among youth at an increase of about 2% over a placebo. Put in numerical terms if mandatory screening results in one million more children taking these drugs this could translate into ten to twenty thousand more children at a heightened risk of suicide. This should be reason enough to reject this proposed screening, especially since evidence of significant benefit is weak and far safer treatments are available. Another potential danger is the possibility of unknown long-term risks. For example a particular class of psychotropic drugs, the atypical psychotics, was recently found to increase the risk of diabetes. For children especially the cost-benefit ratio for using psychotropic drugs for common problems such as anxiety ! and depression is overwhelmingly on the cost side with little or nothing clearly established on the benefit side.

This is not to say that the widespread use of psychotropic drugs is not also problematic for adults. For example some studies report that over 50% of adults taking the commonly used SSRI antidepressants experience sexual dysfunction. While there is a role for the use of psychotropic drugs such as for bipolar disorder or in some cases of depression, there is neither a valid theoretical rationale nor a good empirical one for their widespread use as frontline treatments. Given the equal and often superior efficacy of psychosocial treatments without the prohibitive costs, there is no valid reason to expose people to the side effects and risks of psychotropic drugs for most nonpsychotic problems.

This proposal for mandatory mental health screening will come at a great cost to our society by further legitimizing the medicalization of human problems based on an untenable reductionism and a spurious unsupportable scientific rationale, and the increasingly widespread use of drugs in our population can only have tragic consequences. Particularly tragic is that an ever increasing number of children including preschoolers will be given drugs of poorly established benefit thereby exposing them to problematic side effects, potentially dangerous risks, and possible psychological damage when far safer and often superior treatments are available. The real benefit in this proposal is clearly not on the side of the public but on the side of drug companies who will reap a financial windfall by having an ever increasing percentage of the American

public on psychotropic drugs. This proposal appears to be an attempt by drug companies to bypass the public's growing concerns and reservations about psychotropic drugs by lobbying the government to promote and possibly even mandate their use. While government intervention to screen for life threatening medical diseases may be justified no parallel exists here when for problems never scientifically established as biological medical problems, treatments with no convincing scientific rationale and a relatively poor cost-benefit ratio are being promoted by powerful financial interests over far safer and often more effective psychosocial treatments at the public's expense. Our legislators should place the health and welfare of the public above the interests of drug companies and reject this dangerous proposal.

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Myths and Facts Regarding Mental Health Screening Programs and Psychiatric Drug Treatment for Children

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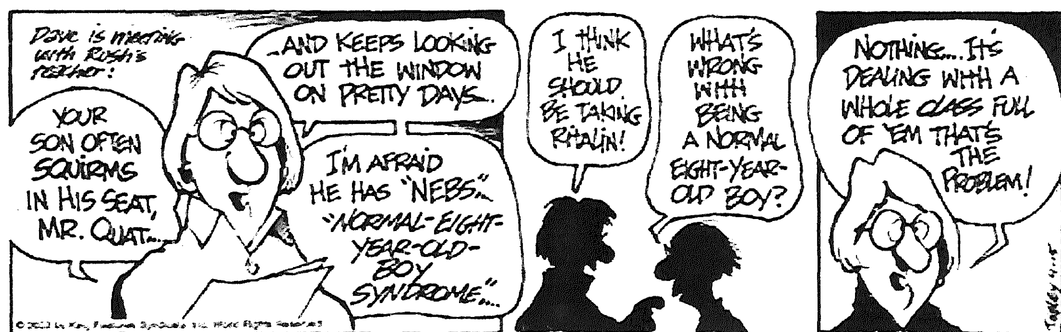
***Myth*:** The President's New Freedom Commission on Mental Health is not advocating widespread mental health screening. "…The commission proposed broad screening only in settings where many children are known to have untreated behavioral problems." (Michael Hogan – NFC chairman, Washington Times, 10/21/04)

Fact: **The New Freedom Commission report frequently recommended universal mental health screening and treatment for children.**
(http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf

- "For consumers of all ages, early detection, assessment, and linkage with treatment and supports can prevent mental health problems from compounding…" (p. 19)
- "Since children develop rapidly, delivering mental health services and supports early and swiftly is necessary to avoid permanent consequences and to ensure that children are ready for school." (p. 65)
- "Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports." (p. 65)
- "Because of this important interplay between emotional health and school success, schools must be partners in the mental health care of our children" (p. 66)



Myth: Informed parental consent is an important component of programs recommended by the NFC.

Fact: **The NFC report never uses the word "voluntary" in the context of screening and treatment and uses the phrase "parental consent" just once to describe a program that uses passive, opt-out parental consent.**

- "Parents at Penn and other schools could withhold their children from the screening by returning a form mailed to their houses. Parents who did not sign the form and return it were considered to have given permission for TeenScreen…'We would probably see the level of participation drop way off (if active consent were required),' he said." (Rumbach, South Bend Tribune, 1/19/2005)

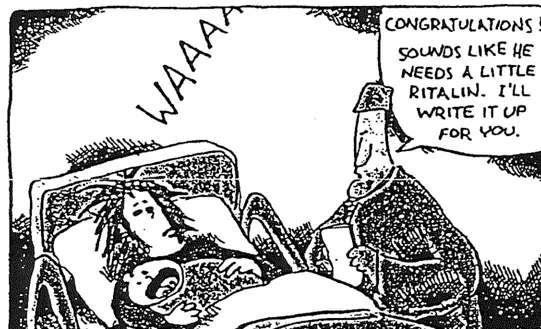
Myth: Psychiatric diagnostic criteria are scientificially validated and non-controversial among experts in the field.
Fact: **Mental health diagnostic criteria are very vague and subjective. The very studies and reports cited by proponents of universal screening are full of contradictions. These experts admit the lack of science underlying psychiatric labels.**

- "In other words, what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures." (Surgeon General Report on Mental Health. 1999. p. 1-5 http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c1.pdf)
- "The diagnosis of mental disorders is often believed to be more difficult than diagnosis of somatic or general medical disorders since there is no definitive lesion, laboratory test or abnormality in brain tissue that can identify the illness." (Surgeon General, p. 2-18, http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c2.pdf)
- "No consistent structural, functional, or chemical neurological marker is found in children with the ADHD diagnosis as currently formulated." (Attention Deficit Hyperactivity Disorder State of the Science - Best Practices, Peter S. Jensen and James R. Cooper, Eds, Civic Research Institute, Kingston, N.J. 2000, p. 3-7)
- "DSM-IV criteria remain a consensus without clear empirical data supporting the number of items required for the diagnosis . . . Furthermore, the behavioral characteristics specified in DSM-IV, despite efforts to standardize them, remain subjective . . . " (American Psychiatric Association Committee on the Diagnostic and Statistical Manual (DSM IV- 1994), pp.1162-1163)

SIGNE WILKINSON/WASHINGTON POST WRITERS GROUP

Myth: It is possible to accurately diagnose mental illness in young children, even infants. "Even before their first birthday, babies can suffer from clinical depression, traumatic stress disorder, and a variety of other mental health problems." (Florida Strategic Plan for Infant Mental Health)
Fact: **Due to rapid developmental changes, it is very difficult to accurately diagnose young children.**

- "Childhood and adolescence being developmental phases, it is difficult to draw clear boundaries between phenomena that are part of normal development and others that are abnormal." (World Health Organization, World Health Report, 2001)
- "The science is challenging because of the ongoing process of development. The normally developing child hardly stays the same long enough to make stable measurements. Adult criteria for illness can be difficult to apply to children and adolescents, when the signs and symptoms of mental disorders are often also the characteristics of normal development." (Surgeon General, 1999)



Myth: Children would never be labeled potentially violent or mentally based on their worldview or politics.
Fact: **Federally funded school violence prevention programs do label children based on their beliefs. A federally funded study held that people of a particular political philosophy had hallmarks of mental illness.**

- A school violence prevention program funded by the federal government called Early Warning, Timely Response lists "intolerance for others and prejudicial attitudes" as an early warning sign for violence and mental instability, saying, "All children have likes and dislikes. However, an intense prejudice toward others based on racial, ethnic, religious, language, gender, sexual orientation, ability, and physical appearance when coupled with other factors may lead to violent assaults against those who are perceived to be different."(U.S. Department of Education - Early Warning, Timely Response Action Guide http://www.ed.gov/admins/lead/safety/actguide/action_guide.txt)
- "In August 2003, the National Institute of Mental Health and the National Science Foundation announced the results of their $1.2 million taxpayer-funded study. It stated, essentially, that traditionalists are mentally disturbed. Scholars from the Universities of Maryland, California at Berkeley, and Stanford had determined that social conservatives, in particular, suffer from 'mental rigidity,' 'dogmatism,' and 'uncertainty avoidance,' together with associated indicators for mental illness."
(Eakman, Chronicles, 10/04. See full study at http://facultygsb.stanford.edu/Jost/_private/Political_Conservatism_as_Motivated_Social_Cognition.pdf)

Myth: Mental health screening instruments are scientifically validated and screening programs are effective at preventing suicide.
Fact: **Screening instruments are not validated or effective and fail to prevent suicide.**

- "[TeenScreen has] reasonable specificity identifying students at risk for suicide. A second-stage evaluation would be needed to reduce the burden of low specificity.... As with other suicide risk instruments, the CSS has the potential of having high (0.88) sensitivity at the expense of specificity [false positives]..." (Journal of the American Academy of Child & Adolescent Psychiatry, 2004, v. 42, 71-79)
- "USPSTF found no evidence that screening for suicide risk reduces suicide attempts or mortality. There is limited evidence on the accuracy of screening tools to identify suicide risk in the primary care setting, including tools to identify those at high risk."(US Preventative Services Task Force http://www.ahrq.gov/clinic/3rduspstf/suicide/suiciderr.htm#clinical)

Myth: Children are not adequately treated for mental illness.
Fact: **Children are over diagnosed and over treated with psychiatric medications and both problems will increase with wide spread screening programs.**

- 300% increase in psychotropic drug use in 2-4 year old children between 1991-1995
- 300% increase in psychotropic drug use in children between 1987 and 1996
- More spent on psychiatric medications for children than on antibiotics or asthma medication in 2003

Myth: The decision to treat a child with psychotropic medications is always between a parent and their physician.
***Fact:* Parent all over the country have been coerced with threats of child abuse or to place their children on or continue psychiatric medications prompting over 20 state legislatures and the US Congress to introduce or pass legislation prohibiting coercion.**

- Both Matthew Smith and Shaina Dunkle died of medication toxicity after their parents were coerced to place their children on drugs by the schools. (http://ritalindeath.com/homepage.htm)
- Paul Johnston was institutionalized with drug-induced psychosis after his parents were coerced to put him on 16 different psychiatric medications over seven years. (http://www.eagleforum.org/educate/2002/june02/drug-induced.shtml)

Myth: Psychiatric drug treatments are effective in children.
***Fact:* Neither antidepressants like Prozac nor stimulants like Ritalin are effective in children, but pharmaceutical companies, with the approval of the FDA, only published positive studies despite having evidence for years of their ineffectiveness.**

- "More than two-thirds of studies of antidepressants given to depressed children, for instance, found the medications were no better than sugar pills, but companies published only the positive trials" (Vedatam, Washington Post, 9/9/04, p. A02)
- "No antidepressants have demonstrated greater efficacy than placebo in alleviating depressive symptoms in children and adolescents"(Baker (1995) as quoted in Breggin, P. and Cohen, D. (1999) Your Drug May Be Your Problem: How and Why to Stop Taking Psychiatric Medications, Perseus Books, Reading, MA)
- "However, psychostimulants do not appear to achieve long-term changes in outcomes such as peer relationships, social or academic skills, or school achievement." (Pelham, et. al. as quoted in Surgeon General, 1999)

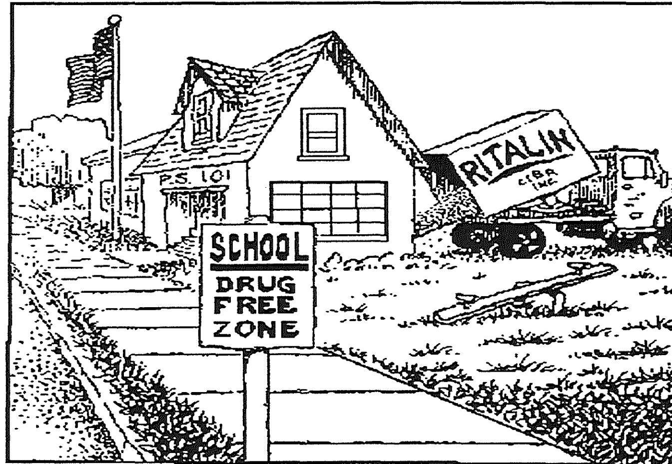
Myth: Psychiatric drugs are safe for children.
***Fact:* Evidence of dangerous and sometimes deadly side effects of psychiatric medication has been covered up for years by the pharmaceutical manufacturers, sometimes with the help of the FDA.**

- "Dr. Robert Temple, director of the FDA's office of medical policy, said after an emotional public hearing here that analyses of 15 clinical trials, some of which were hidden for years from the public by the drug companies that sponsored them, showed a consistent link with suicidal behavior." (Harris, New York Times, 9/14/04, p. A01)
- "TCAs [tricyclic antidepressants] have been linked to cardiac arrhythmias, and "sudden death." (Wilens TE, et al, 1996. Cardiovascular effects of therapeutic doses of tricyclic antidepressants in children and adolescents. Journal of The Association Of American Child & Adolescent Psychiatry. 35: 1491-501)
- "These drugs also impair flexible problem-solving and divergent thinking. James Swanson, a researcher for the U.S. Department of Education and leading Ritalin advocate, stated in a 1992 review of the medical literature that this type of 'cognitive toxicity' may occur at commonly prescribed clinical doses of stimulants, and in up to 40% of patients." (Breggin, P., (2001) Talking Back to Ritalin, Cambridge, Massachusetts, Perseus, pp. 49-50)
- Zyprexa linked to Diabetes (Eli Lilly's Big Seller, Zyprexa, Can Help Schizophrenics; Is It Linked to Diabetes? --- Warnings Abroad, Not in U.S. – Wall Street Journal, 4/11/03, http://www.ahrp.org/infomail/0403/11.php)

Myth: The pharmaceutical industry has no vested interest in the treatment recommendations made by the NFC.
***Fact:* The pharmaceutical industry steered TMAP treatment recommendations toward their products and have profited mightily from those recommendations, despite the fact that the drugs are more expensive, less effective and have severe side effects.**

- "...Dr. Peter J Weiden, who was a member of the project's [TMAP] expert consensus panel, charges that the guidelines are based on 'opinions, not data' and that bias due to funding sources undermines the credibility of the guidelines since 'most of the guideline's authors have received support from the pharmaceutical industry.'" (Lenzer, Jeanne (5/15/04) British Medical Journal, http://bmj.bmjjournals.com/cgi/content/full/bmj;328/7449/1153)
- KEYE Investigation (Wilson N. KEYE News Investigates. Psychiatric drugs (July 23, 2004); Drugs and your tax dollars (September 30, 2004). http://keyetv.com/investigativevideo)

Drug Company	**Expenditures on the Texas Medication Algorithm Project**	**Profits from Texas Medicaid involving that Company's Psychiatric Drugs**
Pfizer	$232 thousand	$ 233 MILLION
Janssen	$224 thousand	$ 272 MILLION
Eli Lilly	$109 thousand	$ 328 MILLION



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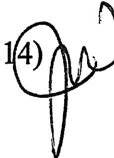
Senate
State of Minnesota

S.F. No. 1853 - Early Childhood Development Screening and School Readiness Programs Provisions

Author: Senator Betsy Wergin

Prepared by: Joan White, Senate Counsel (651/296-3814)



Date: March 29, 2005

Section 1 (121A.17, subdivision 1) amends early childhood developmental screening by targeting children between three and four years old, instead of three and one-half to four years old. Also, a student identification number, as defined by the commissioner, must be assigned at the time of the early childhood screening or at the time of the provision of health records indicating comparable screening. Each school district must provide essential data as defined in statute to the Department of Education.

Section 2 (121A.19) amends the developmental screening aid statute by paying $50 for each three year old screened, $40 for each four year old screened, and $30 for each five year old screened prior to kindergarten. Existing law provides $40 for each child screened.

Sections 3 to 11 amend statutes related to the school readiness program.

Section 3 (124D.15, subdivision 1) clarifies that the purpose of the school readiness program is to prepare children to enter kindergarten, and specifies that the program is for children age three to kindergarten entrance.

Section 4 (124D.15, subdivision 3) modifies program requirements. The program must:

(1) conduct a child development assessment on each child to guide intentional curriculum planning and promote kindergarten readiness;

(2) adopt and implement department early learning standards;

(3) demonstrate use of comprehensive curriculum based on early childhood research and professional practice that prepares children for kindergarten;

(4) arrange for early childhood screening and appropriate referral;

(5) involve parents in program planning and decision making;

(6) coordinate with relevant community-based services; and

(7) cooperate with adult basic education programs and other adult literacy programs.

Section 5 (124D.15, subdivision 3a) provides school readiness application and reporting requirements. A school readiness program must submit a biennial plan to the commissioner for approval to receive aid. A school district must submit a biennial plan by April 1 to the commissioner for approval to receive aid. One-half of the districts must submit the plan by April 1, 2006, and one-half of the districts by April 1, 2007.

Also, programs receiving school readiness funds must submit an annual report to the department.

Section 6 (124D.15, subdivision 5) amends the statute dealing with coordinating services with new or existing providers by stating that the district may contract with a charter school or community-based organization to provides services. Current law "encourages" a district to contract with a "public or nonprofit organization" to provide services. Also, a copy of the contract must be submitted to the commissioner with the biennial plan.

Section 7 (124D.15, subdivision 10) strikes language requiring the program to be supervised and staffed according to the terms of the contract.

Section 8 (124D.15, subdivision 12) requires, instead of allows, a district to adopt a sliding fee schedule. Strikes language that requires that fees charged be designed to enable eligible children of all socioeconomic levels to participate in the program.

Section 9 (124D.15, subdivision 14) adds a new subdivision requiring the department to provide assistance to districts with school readiness programs.

Section 10 (124D.16, subdivision 2) modifies the amount of aid a district is eligible to receive. A district is eligible for aid "for eligible prekindergarten pupils enrolled in a school readiness program" if the biennial plan has been approved by the commissioner. This section also strikes language consistent with other changes made in this section.

Section 11 (124D.16, subdivision 3) changes the amount of aid that can be used for the cost of administering the program. Under current law, not more that five percent of aid may be used for administration; the proposed language provides that not more than five percent of "program revenue"

under subdivision 5 may be used for administration. Program revenue includes aids, fees, grants and all other revenues received by the district school readiness programs.

Section 12 appropriates money for school readiness, early childhood family education aid, health and developmental screening aid, and the Head Start program.

Section 13 repeals obsolete school readiness sections of law.

JW:rdr

Senator Wergin introduced--

S.F. No. 1853: Referred to the Committee on Finance.

1 A bill for an act

2 relating to education; providing for early childhood
3 family support; modifying developmental screening
4 provisions; modifying school readiness provisions;
5 appropriating money for school readiness, early
6 childhood family education aid, health and
7 developmental screening aid, and Head Start; amending
8 Minnesota Statutes 2004, sections 121A.17, subdivision
9 1; 121A.19; 124D.15, subdivisions 1, 3, 5, 10, 12, by
10 adding subdivisions; 124D.16, subdivisions 2, 3;
11 repealing Minnesota Statutes 2004, sections 124D.15,
12 subdivisions 2, 4, 6, 7, 8, 9, 11, 13; 124D.16,
13 subdivisions 1, 4.

14 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

15 Section 1. Minnesota Statutes 2004, section 121A.17,
16 subdivision 1, is amended to read:

17 Subdivision 1. [EARLY CHILDHOOD DEVELOPMENTAL SCREENING.]
18 Every school board must provide for a mandatory program of early
19 childhood developmental screening for children once before
20 school entrance, targeting children who are between ~~3-1/2~~ <u>three</u>
21 and four years old. This screening program must be established
22 either by one board, by two or more boards acting in
23 cooperation, by service cooperatives, by early childhood family
24 education programs, or by other existing programs. This
25 screening examination is a mandatory requirement for a student
26 to continue attending kindergarten or first grade in a public
27 school. A child need not submit to developmental screening
28 provided by a board if the child's health records indicate to
29 the board that the child has received comparable developmental

1 screening from a public or private health care organization or
2 individual health care provider. A student identification
3 number, as defined by the commissioner of education, shall be
4 assigned at the time of early childhood developmental screening
5 or at the time of the provision of health records indicating a
6 comparable screening. Each school district must provide the
7 essential data in accordance with section 125B.07, subdivision
8 6, to the Department of Education. Districts are encouraged to
9 reduce the costs of preschool developmental screening programs
10 by utilizing volunteers in implementing the program.

11 Sec. 2. Minnesota Statutes 2004, section 121A.19, is
12 amended to read:

13 121A.19 [DEVELOPMENTAL SCREENING AID.]

14 Each school year, the state must pay a district ~~$40~~ $50 for
15 each three-year-old child screened; $40 for each four-year-old
16 child screened; and $30 for each five-year-old child screened
17 prior to kindergarten according to the requirements of section
18 121A.17. If this amount of aid is insufficient, the district
19 may permanently transfer from the general fund an amount that,
20 when added to the aid, is sufficient.

21 Sec. 3. Minnesota Statutes 2004, section 124D.15,
22 subdivision 1, is amended to read:

23 Subdivision 1. [ESTABLISHMENT; PURPOSE.] A district or a
24 group of districts may establish a school readiness program
25 for ~~eligible~~ children age three to kindergarten entrance. The
26 purpose of a school readiness program is to ~~provide-all-eligible~~
27 ~~children-adequate-opportunities-to-participate-in-child~~
28 ~~development-programs-that-enable-the-children-to-enter-school~~
29 ~~with-the-necessary-skills-and-behavior-and-family-stability-and~~
30 ~~support-to-progress-and-flourish~~ prepare children to enter
31 kindergarten.

32 Sec. 4. Minnesota Statutes 2004, section 124D.15,
33 subdivision 3, is amended to read:

34 Subd. 3. [PROGRAM ~~ELIGIBILITY~~ REQUIREMENTS.] A school
35 readiness program must ~~include-the-following~~:

36 (1) ~~a-comprehensive-plan-to-anticipate-and-meet-the-needs~~

1 ~~of-participating-families-by-coordinating-existing-social~~
2 ~~services-programs-and-by-fostering-collaboration-among-agencies~~
3 ~~or-other-community-based-organizations-and-programs-that-provide~~
4 ~~a-full-range-of-flexible,-family-focused-services-to-families~~
5 ~~with-young-children~~ Conduct a child development assessment on
6 each child to guide intentional curriculum planning and promote
7 kindergarten readiness. This assessment must be conducted on
8 each child at entrance into the program and once prior to exit
9 of the program and be maintained as part of a child's cumulative
10 record;
11 (2) ~~a-development-and-learning-component-to-help-children~~
12 ~~develop-appropriate-social,-cognitive,-and-physical-skills,-and~~
13 ~~emotional-well-being~~ adopt and implement department early
14 learning standards;
15 (3) ~~health-referral-services-to-address-children's-medical,~~
16 ~~dental,-mental-health,-and-nutritional-needs~~ demonstrate use of
17 comprehensive curriculum based on early childhood research and
18 professional practice that prepares children for kindergarten;
19 (4) ~~a-nutrition-component-to-meet-children's-daily~~
20 ~~nutritional-needs~~ arrange for early childhood screening and
21 appropriate referral;
22 (5) ~~parents'-involvement-in-meeting-children's-educational,~~
23 ~~health,-social-service,-and-other-needs~~ involve parents in
24 program planning and decision making;
25 (6) ~~community-outreach-to-ensure-participation-by-families~~
26 ~~who-represent-the-racial,-cultural,-and-economic-diversity-of~~
27 ~~the-community;~~ coordinate with relevant community-based
28 services; and
29 (7) ~~community-based-staff-and-program-resources,-including~~
30 ~~interpreters,-that-reflect-the-racial-and-ethnic-characteristics~~
31 ~~of-the-children-participating-in-the-program;-and~~
32 ~~(8)-a-literacy-component-to-ensure-that-the-literacy-needs~~
33 ~~of-parents-are-addressed-through-referral-to-and-cooperation~~
34 cooperate with adult basic education programs and other adult
35 literacy programs.
36 Sec. 5. Minnesota Statutes 2004, section 124D.15, is

1 amended by adding a subdivision to read:
2 Subd. 3a. [APPLICATION AND REPORTING REQUIREMENTS.] (a) A
3 school readiness program must submit a biennial plan to the
4 commissioner for approval to receive aid under section 124D.16.
5 The plan must document that the program will meet the program
6 requirements under subdivision 3. A school district shall
7 submit the biennial plan by April 1 to the commissioner on a
8 form prescribed by the commissioner. One-half of the districts
9 shall first submit the plan by April 1, 2006, and one-half of
10 the districts by April 1, 2007.
11 (b) Programs receiving school readiness funds must submit
12 an annual report to the department.
13 Sec. 6. Minnesota Statutes 2004, section 124D.15,
14 subdivision 5, is amended to read:
15 Subd. 5. [SERVICES WITH NEW OR EXISTING PROVIDERS.] A
16 district ~~is-encouraged-to~~ may contract with a ~~public~~ charter
17 school or ~~nonprofit~~ community-based organization to provide
18 eligible children developmentally appropriate services that meet
19 the program requirements in subdivision 3. In the alternative,
20 a district may pay tuition or fees to place an eligible child in
21 an existing program. A district may establish a new program
22 where no existing, reasonably accessible program meets the
23 program requirements in subdivision 3. A copy of each contract
24 must be submitted to the commissioner with the biennial plan.
25 Services may be provided in a site-based program or in the home
26 of the child or a combination of both. The district may not
27 restrict participation to district residents.
28 Sec. 7. Minnesota Statutes 2004, section 124D.15,
29 subdivision 10, is amended to read:
30 Subd. 10. [SUPERVISION.] A program provided by a board
31 must be supervised by a licensed early childhood teacher, a
32 certified early childhood educator, or a licensed parent
33 educator. ~~A-program-provided-according-to-a-contract-between-a~~
34 ~~district-and-a-nonprofit-organization-or-another-private~~
35 ~~organization-must-be-supervised-and-staffed-according-to-the~~
36 ~~terms-of-the-contract.~~

1 Sec. 8. Minnesota Statutes 2004, section 124D.15,
2 subdivision 12, is amended to read:
3 Subd. 12. [PROGRAM FEES.] A district ~~may~~ <u>must</u> adopt a
4 sliding fee schedule based on a family's income but must waive a
5 fee for a participant unable to pay. ~~The fees charged must be~~
6 ~~designed to enable eligible children of all socioeconomic levels~~
7 ~~to participate in the program.~~
8 Sec. 9. Minnesota Statutes 2004, section 124D.15, is
9 amended by adding a subdivision to read:
10 <u>Subd. 14.</u> [ASSISTANCE.] <u>The department must provide</u>
11 <u>assistance to districts with programs described in this section.</u>
12 Sec. 10. Minnesota Statutes 2004, section 124D.16,
13 subdivision 2, is amended to read:
14 Subd. 2. [AMOUNT OF AID.] (a) A district is eligible to
15 receive school readiness aid <u>for eligible prekindergarten pupils</u>
16 <u>enrolled in a school readiness program under section 124D.15</u> if
17 the ~~program~~ <u>biennial</u> plan required by ~~subdivision 1~~ <u>section</u>
18 <u>124D.15, subdivision 3a,</u> has been approved by the commissioner.
19 (b) For fiscal year 2002 and thereafter, a district must
20 receive school readiness aid equal to:
21 (1) the number of ~~eligible~~ four-year-old children in the
22 district on October 1 for the previous school year times the
23 ratio of 50 percent of the total school readiness aid for that
24 year to the total number of ~~eligible~~ four-year-old children
25 reported to the commissioner for the previous school year; plus
26 (2) the number of pupils enrolled in the school district
27 from families eligible for the free or reduced school lunch
28 program for the ~~second~~ previous school year times the ratio of
29 50 percent of the total school readiness aid for that year to
30 the total number of pupils in the state from families eligible
31 for the free or reduced school lunch program for the ~~second~~
32 previous school year.
33 Sec. 11. Minnesota Statutes 2004, section 124D.16,
34 subdivision 3, is amended to read:
35 Subd. 3. [USE OF AID.] School readiness aid shall be used
36 only to provide a school readiness program and may be used to

1 provide transportation. Not more than five percent of ~~the~~
2 ~~aid~~ program revenue, as defined in subdivision 5, may be used
3 for the cost of administering the program. Aid must be used to
4 supplement and not supplant local, state, and federal funding.
5 Aid may not be used for instruction and services required under
6 sections 125A.03 to 125A.24 and 125A.65. Aid may not be used to
7 purchase land or construct buildings, but may be used to lease
8 or renovate existing buildings.
9 Sec. 12. [APPROPRIATIONS.]
10 Subdivision 1. [DEPARTMENT OF EDUCATION.] The sums
11 indicated in this section are appropriated from the general fund
12 to the Department of Education for the fiscal years designated.
13 Subd. 2. [SCHOOL READINESS.] For revenue for school
14 readiness programs under Minnesota Statutes, sections 124D.15
15 and 124D.16:
16 $8,893,000 2006
17 $8,888,000 2007
18 The 2006 appropriation includes $1,638,000 for 2005 and
19 $7,255,000 for 2006.
20 The 2007 appropriation includes $1,603,000 for 2006 and
21 $7,285,000 for 2007.
22 Subd. 3. [EARLY CHILDHOOD FAMILY EDUCATION AID.] For early
23 childhood family education aid under Minnesota Statutes, section
24 124D.135:
25 $12,187,000 2006
26 $12,558,000 2007
27 The 2006 appropriation includes $2,150,000 for 2005 and
28 $10,037,000 for 2006.
29 The 2007 appropriation includes $2,217,000 for 2006 and
30 $10,341,000 for 2007.
31 Subd. 4. [HEALTH AND DEVELOPMENTAL SCREENING AID.] For
32 health and developmental screening aid under Minnesota Statutes,
33 sections 121A.17 and 121A.19:
34 $2,984,000 2006
35 $3,413,000 2007
36 The 2006 appropriation includes $481,000 for 2005 and

1 $2,503,000 for 2006.
2 The 2007 appropriation includes $552,000 for 2006 and
3 $2,861,000 for 2007.
4 Subd. 5. [HEAD START PROGRAM.] For Head Start programs
5 under Minnesota Statutes, section 119A.52:
6 $17,100,000 2006
7 $17,100,000 2007
8 Sec. 13. [REPEALER.]
9 (a) Minnesota Statutes 2004, sections 124D.15, subdivisions
10 2, 4, 6, 7, 8, 9, 11, and 13; and 124D.16, subdivision 4, are
11 repealed.
12 (b) Minnesota Statutes 2004, section 124D.16, subdivision
13 1, is repealed effective July 1, 2006.

APPENDIX
Repealed Minnesota Statutes for 05-3223

124D.15 SCHOOL READINESS PROGRAMS.

Subd. 2. **Child eligibility.** (a) A child is eligible to participate in a school readiness program offered by the resident district or another district if the child is:

(1) at least 3-1/2 years old but has not entered kindergarten; and

(2) receives developmental screening under section 121A.17 within 90 days of enrolling in the program or the child's fourth birthday.

(b) A child younger than 3-1/2 years old may participate in a school readiness program if the district or group of districts that establishes the program determines that the program can more effectively accomplish its purpose by including children younger than 3-1/2 years old.

Subd. 4. **Program goals.** School readiness programs are encouraged to:

(1) prepare an individualized service plan to meet each child's developmental and learning needs;

(2) provide parent education to increase parents' knowledge, understanding, skills, and experience in child development and learning;

(3) foster substantial parent involvement that may include having parents develop curriculum or serve as a paid or volunteer educator, resource person, or other staff;

(4) identify the needs of families in the content of the child's school readiness and family literacy;

(5) expand collaboration with public organizations, businesses, nonprofit organizations, or other private organizations to develop a coordinated system of flexible, family-focused services available to anticipate and meet the full range of needs of all eligible children and their families;

(6) coordinate treatment and follow-up services for children's identified physical and mental health problems;

(7) offer transportation for eligible children and their families for whom other forms of transportation are unavailable or would constitute an excessive financial burden;

(8) make substantial outreach efforts to assure significant participation by families with the greatest needs, including those families whose income level does not exceed the most recent update of the poverty guidelines required by sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35);

(9) use community-based, trained home visitors serving as paraprofessionals to provide social support, referrals, parent education, and other services;

(10) create community-based family resource centers and interdisciplinary teams; and

(11) enhance the quality of family or center-based child care programs by providing supplementary services and resources, staff training, and assistance with children with special needs.

Subd. 6. **Coordination with other providers.** (a) The district must coordinate the school readiness program with existing community-based social services providers and foster collaboration among agencies and other community-based organizations and programs that provide flexible, family-focused services to families with children. The district must actively encourage greater sharing of responsibility and accountability among service providers and facilitate children's transition between programs.

(b) To the extent possible, resources must follow the children so that children receive appropriate services in a stable environment and are not moved from one program location to another. Where geographically feasible, the district must actively promote colocating of services for children and their families.

Subd. 7. **Advisory council.** Each school readiness program must have an advisory council composed of members of existing early education-related boards, parents of participating children, child care providers, culturally specific service organizations, local resource and referral agencies, local early intervention committees, and representatives of early childhood service providers. The council must advise the board in creating and administering the program and must monitor the progress of the program. The council must ensure that children at greatest risk receive appropriate services. If the board is unable to appoint to the advisory council members of existing early education-related boards, it must appoint parents of children enrolled in the program who represent the racial, cultural, and economic diversity of the district and representatives of early childhood service providers as representatives to an existing advisory council.

Subd. 8. **Prioritizing services.** The district must give greatest priority to providing services to eligible children identified, through a means such as the early childhood screening process, as being developmentally disadvantaged or experiencing risk factors that could impede their school readiness.

Subd. 9. **Child records.** (a) A record of a child's progress and development must be maintained in the child's cumulative record while enrolled in the school readiness program. The cumulative record must be used for the purpose of planning activities to suit individual needs and shall become part of the child's permanent record. The cumulative record is private data under chapter 13. Information in the record may be disseminated to an educator or service provider only to the extent that that person has a need to know the information.

(b) An educator or service provider may transmit information in the child's cumulative record to an educator or service provider in another program for young children when the child applies to enroll in that other program.

Subd. 11. **District standards.** The board of the district must develop standards for the school readiness program that reflect the eligibility criteria in subdivision 3. The board must consider including in the standards the program characteristics in subdivision 4.

Subd. 13. **Additional revenue.** A district or an organization contracting with a district may receive money or in-kind services from a public or private organization.

124D.16 SCHOOL READINESS AID.

Subdivision 1. **Program review and approval.** A school district shall biennially by May 1 submit to the commissioners of education and health the program plan required under this subdivision. As determined by the commissioners, one-half of the districts shall first submit the plan by May 1 of the 2000-2001 school year and one-half of the districts shall first submit the plan by May 1 of the 2001-2002 school year. The program plan must include:

(1) a description of the services to be provided;
(2) a plan to ensure children at greatest risk receive appropriate services;
(3) a description of strategies to coordinate and maximize public and private community resources and reduce duplication of services;
(4) comments about the district's proposed program by the advisory council required by section 124D.15, subdivision 7; and
(5) agreements with all participating service providers.
Each commissioner may review and comment on the program, and make recommendations to the commissioner of education, within 90 days of receiving the plan.

Subd. 4. **Separate accounts.** The district must deposit school readiness aid in a separate account within the community education fund.

1 Senator .... moves to amend S.F. No. 1853 as
2 follows:

3 Page 3, line 11, strike "(2)"

4 Page 3, line 13, delete the new language

5 Page 3, line 14, delete the new language and strike the
6 semicolon

7 Page 3, line 15, strike "(3)" and insert "(2)"

8 Page 3, line 19, strike "(4)" and insert "(3)"

9 Page 3, line 22, strike "(5)" and insert "(4)"

10 Page 3, line 25, strike "(6)" and insert "(5)"

11 Page 3, line 29, strike "(7)" and insert "(6)"

Fiscal Note – 2005-06 Session

Bill #: S1853-0 **Complete Date:** 03/31/05

Chief Author: WERGIN, BETSY

Title: SCHOOL READINESS PROVISIONS

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Education Department

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		415	851	679	693
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		415	851	679	693
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		415	851	679	693
Total Cost <Savings> to the State		415	851	679	693

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		2.00	2.00	2.00	2.00
Total FTE		2.00	2.00	2.00	2.00

Bill Description

Sections 1 and 2 amend the Early Childhood Developmental Screening Statutes, M.S. Chapter 121A, sections 17 and 19, respectively, to:

- Lower the targeted age range for screening from between 3 and ½ and 4 years to between 3 and 4 years of age;
- Require districts to assign a student identification number to a child at screening; and
- Change the amount of state aid paid per child screened from a flat rate of $40 per child to a variable rate schedule paying $50 for each 3-year-old, $40 for each 4-year-old, and $30 for each 5-year-old child screened prior to kindergarten.

Sections 3 through 9 and 13 amend the School Readiness Program statute, M.S. 124D.15, to:

- Change the program's purpose to preparing preschool children age three and above for kindergarten;
- Set new program requirements for participating districts, effective in FY 2007, including
  - Conducting a child development assessment on each child at program entrance and once prior to exit;
  - Adopting and implementing the MDE early learning standards;
  - Using a comprehensive, research- and professional-practice-based curriculum;
  - Submitting a biennial plan that documents the district's program meets the requirements, for commissioner's approval as a condition of receiving state aid; and
  - Submitting an annual report to MDE.
- Change current law to make the adoption of a sliding fee schedule a requirement, rather than an option, while maintaining the requirement that fees be waived for participants unable to pay.
- Require the Department to provide assistance to districts with School Readiness Programs (Section 9).

Section 10 amends the School Readiness aid allocation formula in M.S. Chapter 124D.16 to make the year of data collection for the formula's two allocation factors—four year old district residents and pupils enrolled from families eligible for free or reduced school lunch—synchronous.

Section 11 amends M.S. Chapter 124D.16 to change the limitation on the use of School Readiness funds for program administration from 5 percent of aid to 5 percent of program revenue, which includes state aid, fees, grants and all other revenue the district receives for the School Readiness program.

Section 12 appropriates money from the general fund to MDE for School Readiness, ECFE, Early Childhood Screening, and Head Start. The appropriations reflect November 2004 forecast estimates under current law for ECFE and Head Start.

Assumptions

Sections 1 and 2:

- Constant sized population cohorts of 70,980 each for children ages 3 through 5. Calculation is based upon the average of the Fall 2004 0-4 Census cohorts, and the Fall 2003 0-4 Census 4-year-old cohort (proxy for 5-year-old count).
- Percentages of population cohorts screened based on the number screened by age as reported in the 2003-2004 Early Childhood Screening Annual Report. Children screened at age 5 are combined with those screened at kindergarten entrance through a catch-up program.
- Districts do not report children for whom they have already claimed screening aid reimbursement, as is the practice under current law. When reporting their screening totals, districts must assure that "no reimbursement has been claimed for more than one screening per child."
- The number of children entering kindergarten who have been screened through other providers, e.g. Head Start, private clinic, public health, and the number of children entering kindergarten with no screening, due to parent exemption for conscientiously held beliefs, are held constant at the numbers reported in the 2003-04 Screening Annual Report.
- Districts will respond to the higher reimbursement rate for three-year-olds and the lower reimbursement rate for five-year-olds and kindergarteners by increasing the percentage of three- and four-year-old populations screened. It is assumed that the impact will be greater in the second year than the first, to allow time for districts to be notified of the change in policy and adapt their screening programs and administrative practices accordingly. There is no precedent to inform the following estimated annual change in the percentage of each age cohort screened: 1) three-year-olds: by 10 points in FY06, 15

points in FY07 and 10 points in FY08, 10 points in FY09. Four-year-olds: by 5 points in FY06, and 10 points in FY07 (before offsetting impact of increase in three-year-olds screened in the prior year). The increase in the shares of three- and four-year-old populations screened reduces the percentage of the four- and five-year-old populations screened, respectively, in the following year, but it is assumed that 5% of the five-year-old population will continue to receive screening at or before kindergarten entrance, due to in-migration, and parent responsiveness to the outreach effort districts are able to mount within available resources.

- The total number of children screened increases only because of the shift in the age at screening. Once the effect of these shifts in the age distribution of children screened is completed, in FY 2010, the percentage of the total population ages 3 through 5 receiving early childhood screening through a school district returns to the percentage assumed in the February 2005 forecast under current law.
- Districts will continue to screen children at ages four, five, and kindergarten entrance.

Section 9 – Because the proposal reduces annual aid entitlements for School Readiness by $200,000 and reallocates the appropriation to the Agency Administration budget to cover the costs of Section 9, there is no impact on the general fund. Assuming an 84.3%-current 15.7%-final payment schedule, this provides $168,600 in FY 2006 and $200,000 in FY 2007 and later years for costs of administering the new program, including:

- 2.0 FTE professional staff to review and approve district plans and program reports, and to monitor districts for compliance with program requirements. Staff would be hired in mid-October; the Agency will not absorb compensation and associated indirect costs.
- Conduct regional training workshops for districts on the new plan requirements. Half of districts would be trained in FY 2006 and submit Plans under the new requirements for FY 2007; the balance would be trained during FY 2007 and submit new Plans for FY 2008.
- The Agency will absorb the costs of a .25 FTE supervisory and a .25 FTE support staff position.

Expenditure and/or Revenue Formula

Sections 1 and 2 – The number of children screened times the reimbursement rate as follows: $50 per child age 3; $40 per child age 4; $30 per child age 5 and older.

Forecast Number Screened, by Age

	Age 3	Age 4	Age 5	Total	Screened by Other& Not Screened	Total Screened	% of Total Est. Population Age 3-5
Est. Population Cohort	70,980	70,980	70,980	212,940			
Current Law - Feb05 Forecast							
FY05 - FY09	14,760	36,474	15,291	66,525	8,920	75,445	35%
FY-06	21,858	40,023	15,291	77,172	8,920	86,092	40%
FY-07	32,505	40,023	11,742	84,270	8,920	93,190	44%
FY-08	39,603	29,376	4,644	73,623	8,920	82,543	39%
FY-09	46,701	22,278	4,644	73,623	8,920	82,543	39%
FY-10	46,701	15,180	4,644	66,525	8,920	75,445	35%
FY-11	46,701	15,180	4,644	66,525	8,920	75,445	35%

Aid Entitlement Calculation

	Age 3	Age 4	Age 5	Total	Change vs. Current Law
Current Law	$ 40.00	$ 40.00	$ 40.00		
FY05 - FY09	590,400	1,458,960	611,640	2,661,000	

	$ 50.00	$ 40.00	$ 30.00		
FY-06	1,092,900	1,600,920	458,730	3,152,550	491,550
FY-07	1,625,250	1,600,920	352,260	3,578,430	917,430
FY-08	1,980,150	1,175,040	139,320	3,294,510	633,510
FY-09	2,335,050	891,120	139,320	3,365,490	704,490

Change in Appropriation vs. Current Law

	Current Payment @ 84.3%	Final Payment @ 15.7%	Total Change in Appropriation
FY-06	415,000	-	415,000
FY-07	774,000	77,000	851,000
FY-08	535,000	144,000	679,000
FY-09	594,000	99,000	693,000

Because the proposal reduces annual aid entitlements for School Readiness by $200,000 and reallocates the appropriation to the Agency Administration budget to cover the costs of Section 9, there is no impact on the general fund. Assuming an 84.3%-current 15.7%-final payment schedule, this provides $168,600 in FY 2006 and $200,000 in FY 2007 and later years for costs of administering the new program.

Agency Administration Costs - Section 9.

Compensation Costs		FY 2006	FY 2007	FY 2008	FY 2009
ED Spec II (17)		71,465	71,465	71,465	71,465
FICA+Retirement @ 11.65%		8,326	8,326	8,326	8,326
Health Benefits, Dependent		13,532	13,532	13,532	13,532
Total Annual Compensation		93,322	93,322	93,322	93,322
	Months/Year	8.5	12	12	12
	Pro-rate @	71%	100%	100%	100%
Adjusted Compensation Costs		66,103	93,322	93,322	93,322
	x 2.0 FTE =	132,207	186,645	186,645	186,645
Agency Indirect Costs		$ 52,585	$ 29,747	$ 29,747	$ 29,747
Less Indirect Costs Agency Can Absorb		$ (16,392)	$ (16,392)	$ (16,392)	$ (16,392)
Total, Compensation & Net Agency Indirect Costs		168,400	200,000	200,000	200,000

Long-Term Fiscal Considerations

None.

Local Government Costs

Sections 1 and 2. School districts may incur some costs for assigning a student identification number at the time of screening, which will require changes in current administrative and data reporting practices. Currently, districts report only the total number of children screened to MDE.

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EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

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