Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 2841 - Delete-everything amendment (SCS2841A-2)

Author: Senator

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

Date: March 9, 2006

S.F. 2841 amends the early childhood screening statute by requiring the social/emotional component of the developmental assessment be completed using a screening instrument approved by the commissioner of education and consistent with the standards of the commissioners of health and human services.

Early Childhood Policy and Budget Division

March 9, 2006
4:00 p.m. Room 123
Chair, Senator John C. Hottinger

Present:	Absent:
Hottinger, Chair	Gary Kubly
Bob Kierlin	
Sean Nienow	
Sandy Pappas	
Linda Scheid	
Dan Sparks	
Betsy Wergin	

Senator Hottinger called the meeting to order at 4:10 p.m.

A quorum was present.

AGENDA ITEM #1: **Minnesota Dept. of Human Services**, Overview of Family, Friend and Neighbor (FFN) Studies:

- Child Care Use in Minnesota: Report of the 2004 Statewide Household Child Care Survey;
- FFN Caregivers: Report of the 2004 Minnesota Statewide Household Child Care Survey;
- FFN Caring for Children Through the Minnesota Child Care Assistance Program: A Survey of Caregivers and Parents;
- Observations of FFN Care in Minnesota;
- FFN Child Care Provider in Recent Immigrant and Refugee Communities.

Presenters

- Deb Swenson-Klatt, Manager, Child Development Services, Minnesota DHS
- Richard Chase, Senior Consulting Scientist, Wilder Research
- Kathryn Tout, Program Director, Applied Research in Early Care and Education, Child Trends

AGENDA ITEM #2: **S.F. 2841-Hottinger:** Expanded Early Screening

Sen. Hottinger introduced the bill. Sen. Hottinger also moved the A-2 Amendment, which was adopted unanimously. The bill makes sure that the screening devices are approved by the Commissioner of Education.

- Andrea Ayres, Policy Advocate, Family and Children's Services, supports the bill. Ms. Ayres gave the committee hand-outs relating to the topic.
- Suzette Scheele, Parent, supports the bill. Ms. Scheele is a parent of a child with mental illness. She told her story, and explained how having the early screening would have helped her understand her child much sooner.
- Dr. Karen Effrem, Ed Watch, opposed the bill. Dr. Effrem does not support government mental health screening. Her concerns lies in the parental consent form, Dr. Effrem does not think it goes far enough.
- Tom Pritchard, Minnesota Family Council, opposed the bill. Mr. Pritchard does not think

the consent form goes far enough in protecting parental consent.

- Dr. Willard Harley, Ph.D. and psychologist, stood in opposition to this bill. He is concerned that pediatricians are over-prescribing drugs to our young people.
- Ed Frickson, Licensed Psychologist, Ramsey County Human Services, supported the bill. He works with many high risk children. Mr. Frickson clarified comments from previous witnesses. Mr. Frickson explained that the screening is like a thermometer, it is not a given that children will be recommended drugs.
- Karen Cadigan, School Psychologist, Research Associate, University of Minnesota, supported the bill. Ms. Cadigan gave perspective from the field of child psychology. She noted that both nature and nurture matter when raising a child, and it is always good to get an early picture of a child's development.
- Sue Abderholden, Executive Director, National Association for the Mentally Ill –MN, supported the bill.

Senator Nienow raised his objections to the bill, namely, that schools would pressure parents into the screening. He also passed out a consent form that did not let parents know the screening was optional.

MOTION: Senator Scheid moved that S.F. 2841, as amended, be recommended to pass to the full Finance Committee.

Motion prevailed.

Senator Hottinger adjourned the meeting at 6:30 p.m.

Respectfully submitted:

John C. Hottinger
Senator John C. Hottinger
Division Chair

Jane Bowman
Jane Bowman
Division Secretary

Senators Hottinger, Scheid and Kelley introduced–

S.F. No. 2841: Referred to the Committee on Finance.

A bill for an act

relating to early childhood education; expanding screening to include socioemotional developmental screening; amending Minnesota Statutes 2004, section 121A.17, subdivision 3.

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

Section 1. Minnesota Statutes 2004, section 121A.17, subdivision 3, is amended to read:

Subd. 3. **Screening program.** (a) A screening program must include at least the following components: developmental assessments, a socioemotional development screening, hearing and vision screening or referral, immunization review and referral, the child's height and weight, identification of risk factors that may influence learning, screening for autism spectrum disorders, an interview with the parent about the child, and referral for assessment, diagnosis, and treatment 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, control, and express emotions; (2) form close and secure interpersonal relationships; and (3) explore and experience surroundings and learn from them.

The district and the person performing or supervising the screening must provide a parent or guardian with clear written notice that the parent or guardian may decline to answer questions or provide information about family circumstances that might affect development and identification of risk factors that may influence learning and that the socioemotional development part of the early childhood screening is voluntary as described in paragraph (b). The notice must clearly state that declining to answer questions or provide information does not prevent the child from being enrolled in kindergarten or

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

(b) The socioemotional component of the developmental assessment may be included in the early childhood developmental screening if the parent or guardian has been provided with a clear written notice that this component of the screening is voluntary, and the parent or guardian has signed a document developed and approved by the commissioner either allowing or declining the socioemotional development component of the early childhood developmental screening. The socioemotional development screening component of the early childhood developmental screening shall be conducted with a screening instrument approved by the commissioner of human services, as the designated state mental health authority, according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for this population.

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

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

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

~~(e)~~ (f) If a statement signed by the child's parent or guardian is submitted to the administrator or other person having general control and supervision of the school that the child has not been screened because of conscientiously held beliefs of the parent or guardian, the screening is not required.

Senator ..... moves to amend S.F. No. 2841 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 121A.17, subdivision 3, is amended to read:

Subd. 3. **Screening program.** (a) A screening program must include at least the following components: developmental assessments, hearing and vision screening or referral, immunization review and referral, the child's height and weight, identification of risk factors that may influence learning, an interview with the parent about the child, and referral for assessment, diagnosis, and treatment when potential needs are identified. The district and the person performing or supervising the screening must provide a parent or guardian with clear written notice that the parent or guardian may decline to answer questions or provide information about family circumstances that might affect development and identification of risk factors that may influence learning. The notice must clearly state that declining to answer questions or provide information does not prevent the child from being enrolled in kindergarten or first grade if all other screening components are met. If a parent or guardian is not able to read and comprehend the written notice, the district and the person performing or supervising the screening must convey the information in another manner. The notice must also inform the parent or guardian that a child need not submit to the district screening program if the child's health records indicate to the school that the child has received comparable developmental screening performed within the preceding 365 days by a public or private health care organization or individual health care provider. The notice must be given to a parent or guardian at the time the district initially provides information to the parent or guardian about screening and must be given again at the screening location.

(b) <u>The social/emotional component of the developmental assessment must be completed using a social/emotional screening instrument approved by the commissioner</u>

of education, and consistent with the standards of the commissioners of health and human services.

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

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

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

~~(e)~~(f) If a statement signed by the child's parent or guardian is submitted to the administrator or other person having general control and supervision of the school that the child has not been screened because of conscientiously held beliefs of the parent or guardian, the screening is not required."

Amend the title accordingly

A Synthesis of Family, Friend and Neighbor Studies

Deb Swenson-Klatt
MN Department of Human Services

Richard Chase
Wilder Research

Kathryn Tout
Child Trends

Department of Human Services Reports on Family, Friend and Neighbor Care

- *Child Care Use in Minnesota: Report of the 2004 Statewide Household Child Care Survey*, Richard Case, Wilder Research Center (representative sample)
- *Family, Friend and Neighbor Caregivers: Report of the 2004 Minnesota Statewide Household Child Care Survey*, Richard Chase, Wilder Research Center (representative sample)
- *Family, Friends and Neighbors Caring for Children Through the Minnesota Child Care Assistance Program: A Survey of Caregivers and Parents*, Richard Chase, Wilder Research Center (non-representative sample)
- *Observations of Family, Friend and Neighbor Care in Minnesota*, Kathyrn Tout, Child Trends. MN Child Care Policy Research Partnership report (41 cases, non-representative sample)
- *Family Friends, and Neighbor Child Care Provider in Recent Immigrant and Refugee Communities*, Chia Youyee Vang, CHIA Consulting, Inc. (60 participant focus group, non-representative)

Do you know?

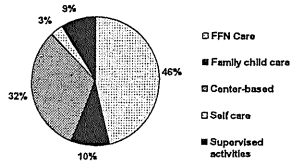
- What is Family, Friend and Neighbor child care?
- What percentage of families regularly use FFN child care?
- What is the relationship of the FFN caregiver to the child in care?
- How much time children spend in FFN child care?
- Who are FFN child care providers?
- How many hours of care do FFN caregivers provide in a typical week?
- What are the strengths and areas of concern in FFN care?

What is Family, Friend and Neighbor Care?

- FFN is informal and legal unlicensed home-based child care provided to children age 12 and younger.
- FFN caregivers include grandparents, aunts, siblings, cousins and non-relatives such as friends and neighbors.
- FFN care takes place during the day, evening or overnight in the child's home or the home of the caregiver.
- FFN care may be free, paid for with a fee or extended in exchange for care or other compensation.

Primary Child Care Arrangements

Primary Child Care Arrangements for Children 12 and younger



FFN Care is the most common type of child care

- An estimated 150,000 households in Minnesota provide FFN care.
- 46% of parents use FFN care - 24% *exclusively* and 22% as their *primary* arrangement. Another 25% use FFN as a secondary arrangement.
- FFN care is most common for children 0 - 2 (48%) and 6 -12 (50%)
- The number of children using CCAP FFN care grew from 9,244 to about 30,094 between 1997 to 2003.
- The number of FFN caregivers registered with CCAP grew from 4,784 to 13,270.

Why families choose FFN care

- Overall, parents choose their primary care arrangement based on convenient location, quality of care and cost.
- For FFN care, the main reasons also include preference of care by a family member, trust and having a place where children will be cared for when they are sick.
- The most common reason that FFN caregivers have for providing care is to help a family member or friend (59%).

Families using family, friend and neighbor care like the flexibility and more individualized attention that their children receive

Caregiver Relationship to the Child in Care

Statewide Characteristics

- 52% of caregivers are the child's grandparents
- 15% are other relatives
- 16% are friends
- 9% are neighbors

These relationships are similar for children receiving child care assistance in FFN care.

Relationship between FFN Caregiver and the Family

- 82% of FFN caregivers say they frequently share information with parents regarding the children.
- 87% of FFN caregivers feel that the match between their childrearing values and parents is "excellent" (47%) or "good" (40%).
- 85% of FFN caregivers report that they and the parents cooperate and work together "very well."
- 91 percent of FFN caregivers strongly agree, or agree that taking care of the child is the best part of their day.

FFN Care Meets the Needs of Families

Exclusive use of FFN care is higher for:

- Parents with less than college educations
- Households with children under age 2 and younger
- Those with a special needs child
- Households of color
- Low-income households

Family, friend and neighbor care is the most common type of non-standard hour care, followed by supervised activities

Families needing more hours of care per week are more likely to use a center or family care setting than FFN care

Payment for FFN Child Care

- Only 24% of FFN caregivers receive payment for taking care of the randomly selected child, averaging $63 a week.
- Non-relatives are more likely than relative caregivers to receive payments.
- Of those paid caregivers, 84% are paid by parents. 18% are paid by the county or state.
- 20% of caregivers trade off caregiving with another family; 18% receive meals; and 10% get the use of a car for caregiving.

FFN Caregiver Profile

Statewide FFN Caregivers:

- 86% female
- Average age 48-49 with 52% age 50 or older
- 61% married
- 60% employed outside of FFN
- 79% own their own home
- Mean number of hours per week providing care: 19

CCAP Caregivers

- 94% female
- Average age 49 with 40% - age 50 and older
- 50% married
- 37% employed outside of FFN
- 52% own their own home
- Mean number of hours per week providing care: 38

FFN want to provide high-quality care

- 81% of FFN caregivers are eager for or open to support and interaction for quality improvement in their caregiving.
- 52% of CCAP FFN say they are interested in getting licensed as a child care provider, compared with 18 percent of FFN caregivers overall.
- 30% say they would find it very helpful to have access to the child care food program.

Observational Study - Caregiver Interactions with Children

Interactions were a clear strength of FFN care observed in this study

- Caregiver responsiveness
- Verbal interaction
- Warmth and encouragement
- No harsh words or actions
- Appropriate supervision and opportunities to play and explore.

Growth areas can support school readiness

Caregivers missed opportunities:

- To talk about and address feelings and teach self regulation;
- To consistently foster cooperative play and teach sharing and turn taking;
- To teach new activities and work on specific skills (letters, shapes, numbers etc) that help prepare a child for school.

Observational Study - Activities and Materials for Children

Finding: FFN care settings contained adequate age specific toys, materials and opportunities to explore.

Growth Areas: Caregivers missed opportunities to engage children in a variety of activities including reading, music, math and art.

- In about one-third of settings, children had the opportunity to engage in music, dance, creative movement or learning about shapes or sounds.
- While some books were available in most homes, 10 age level books or more were available in about one-third of the settings.
- Basic art materials were available in fewer than half of the settings.
- Children were encouraged to use math (or pre-math) in everyday contexts in about one-fifth of settings.

Observational and Immigrant Studies- Physical Safety and Routines

Finding: Safety precautions and positive routines were observed:

- Smoke detectors;
- Equipment in good repair;
- Ample and comfortable spaces for children;
- Conversation and self-help skills learned during meals.

Growth areas:

- Target safety issues including access to hazardous items or spaces.
- Focus on consistent hand washing.

Immigrant/Refugee:

- Most caregivers felt that the locations were safe. However, when probed few caregivers had basic supplies such as first aid kits, smoke detectors, fire extinguishers and latches on cupboards with medicines or dangerous chemicals.

All Reports on Child Care Provided by Family, Friend and Neighbor Caregivers are available on the Department of Human Services website

- http://www.dhs.state.mn.us/main/groups/children/documents/pub/DHS_id_000151.hcsp

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.

Early Childhood Social-Emotional Screening

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

Why are mental health screenings important to young children?

- Mental health screens are completed by or with parents and any referral or follow-up assessment is dependent on the informed consent and approval of the parent.
- The screen gives parents information about their child's development and empowers them to make choices.
- Children are not "diagnosed" based on the results of a mental health screen. The screen is based on the parents' own responses to questions about their child. In most cases the screen does not indicate any need for follow-up. In some cases the screen serves as an "alert" to parents that they may want to take further action.
- Early identification and intervention is linked to improved outcomes for children and may prevent or lessen the effects of an untreated long-term disability.
- Children with untreated social-emotional or behavioral issues are more at risk for dropping out of school, being held back in school, or entering the juvenile justice system.
- The intent of a mental health screen is to quickly and accurately identify and recommend follow up for children who may be dealing with mental health issues that affect their academic or social functioning. It is similar to vision or hearing and is one component of a child's developmental screening
- Treatment for mental health conditions can take many forms and work best when they are specifically tailored for the child. They may include parent education or social skills training and family support, as well as psychotherapy or behavioral management training.
- Instruments used (such as the Ages and Stages Questionnaire: Social-Emotional) are valid and reliable for screening. 97% of parents who have used them report they are easy to use and take very little time to complete.
- Mental health disorders can now be diagnosed as reliably and accurately as most common physical disorders.

Congressional Research Service

Memorandum December 15, 2004

SUBJECT: President's New Freedom Commission on Mental Health: Recommendations for Screening and Treating Children and Subsequent FY2005 Appropriations

FROM: C. Stephen Redhead
Domestic Social Policy Division
Fran Larkins
Information Research Division

In its July 2003 final report, the President's New Freedom Commission on Mental Health concluded that the U.S. mental health care system is fragmented and inadequate and beyond simple repair.[1] The Commission recommended a wholesale transformation of the nation's approach to mental health care involving consumers and providers, policymakers at all levels of government, and both the public and private sectors.

Early detection of mental illness is one of the goals of a transformed mental health system. However, the Commission did not recommend mandatory screening of all children to identify those at risk of mental health problems because the research on screening for children is inadequate.[2] Dr. Michael Hogan, Chairman of the New Freedom Commission, reiterated the Commission's position on mental health screening in a recent letter to the *Washington Times*.[3]

> The commission did not call for mandatory universal mental health screening for all children.... Recognizing the need to balance suicide-prevention and access to medical care with the rights and responsibilities of parents, and being aware of the devastating impact of youth suicide, the commission proposed broad screening only in settings where many

[1] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003. The report is available at [http://www.mentalhealthcommission.gov].

[2] Screening for depression in adults was recommended in 2002 by the U.S. Preventive Services Task Force (USPSTF). The USPSTF recommended "screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up." The USPSTF concluded, however, that "the evidence is insufficient to recommend for or against routine screening of children or adolescents for depression." Further information on these recommendations is available at: [http://www.ahrq.gov/clinic/uspstf/uspsdepr.htm].

[3] Michael Hogan, "Long-Term Study Needed," *Washington Times,* October 21, 2004.

> children are known to have untreated behavioral problems. Beyond this, the commission promoted programs that provide voluntary screening only with parental consent.

The Commission's final report includes the following language that relates to mental health screening for children.

> The Commission supports implementing systematic screening procedures to identify mental health and substance use problems and treatment needs in all settings in which children, youth, adults, or older adults are at high risk for mental illnesses.... [Recommendation 4.3]

> Clearly, school mental health programs must provide any screening or treatment services with full attention to the confidentiality and privacy of children and families. [Recommendation 4.2]

> In this *Final Report*, whenever *child* or *children* is used, it is understood that parents or guardians should be included in the process of making choices and decisions for minor children. This allows the family to provide support and guidance when developing relationships with mental health professionals, community resource representatives, teachers, and anyone else the individual or family invites. [Footnote to Executive Summary]

In addition to screening, the Commission's final report also discussed medication treatment of mental illness. The Commission did not recommend mandatory medication treatment for children and teens, citing the complexities of treatment and the need for greater knowledge about the long-term effects of psychotropic medications. Recommendation 5.4, in part, reads:

> Since many psychotropic medications are treatments and not cures, some individuals with chronic illnesses, including children, must use them on a long-term basis. Current knowledge of their long-term clinical and economic effects is limited and must be expanded. With that goal in mind, the Commission recommends that NIH undertake a sustained program of research on the long-term positive and negative effects of psychotropic medications for maintenance treatment of mental disorders — including children with serious emotional disturbances.

The Commission cited Columbia University's TeenScreen Program as a model for early intervention. TeenScreen, which has been implemented at sites in 41 states nationwide, identifies and connects kids suffering from mental illness or who may be at-risk for suicidal behavior with treatment providers in their area. The program is flexible in its application and has been successfully developed in a variety of settings including juvenile detention facilities, high schools, juvenile shelters, and youth drop-in centers. Screening requires parental consent and the results are confidential.[4]

FY2005 Appropriations (P.L. 108-447)

State Incentive Grants for Transformation. The Substance Abuse and Mental Health Services Administration's (SAMHSA) budget request for FY2005 included $44 million for State Incentive Grants for Transformation. This new competitive grant program, which was established in response to the New Freedom Commission's final report, supports

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[4] Information on TeenScreen is available at [http://www.teenscreen.org].

the development of comprehensive state mental health plans to reduce system fragmentation and increase services and support available to people living with mental illness. The House-passed appropriations legislation (H.R. 5006, H.Rept. 108-636) included $20 million for this grant program, while the Senate bill (S. 2810, S.Rept. 108-345) provided the full amount requested by the Administration (i.e., $44 million). The conference agreement (H.R. 4818, H.Rept.108-792) provided $20 million for State Incentive Grants for Transformation.

Mental Health Screening. Both the House and Senate appropriations reports included language that specifically addresses mental health screening. The House report did not include a specific dollar amount for screening, but noted that "SAMHSA is overseeing a very promising pilot study utilizing evidence-based[5] screening techniques and tools to screen and identify teenagers who are at risk." The study in question, which is jointly run by the University of South Florida and Columbia University, has implemented TeenScreen in two schools in the Tampa area. The House report urged SAMHSA "to evaluate the effectiveness of [the] study and ... report on concrete steps being taken to promote early screening and detection programs available in schools prior to the fiscal year 2006 appropriations hearings."

The Senate report also recognized the pilot study, adding that "[s]everal promising screening techniques to identify youth at risk exist but they need further testing." Unlike the House, the Senate included $4.5 million "to make grants to local education systems ... to further test the use of screening mechanisms and to identify evidence-based practices for facilitating treatment for youth at risk."

The following language appeared in the conference report. "The conference agreement provides $2 million, rather than $4.5 million as proposed by the Senate, to make grants to local educational systems ... to further test the use and identify evidence-based practices for facilitating treatment for teenagers suffering from mental, emotional or behavioral disorders."

Other Legislation

H.Con.Res. 292 was introduced in the 108th Congress in support of the recommendations of the New Freedom Commission to "help ensure affordable, accessible, and high quality mental health care." Other bills addressed concerns that the Commission's recommendations could lead to mandatory mental health screening for all Americans. An amendment to the House-passed appropriations legislation, H.R. 5006, was offered by Representative Ron Paul to prevent funding for "any new universal mental health screening program." The amendment was debated and rejected on a vote of 315 to 95. Mr. Paul later introduced H.R. 5236, which forbid "federal funds from being used for any universal or mandatory mental-health screening of students without the express, written, voluntary, informed consent of their parents." H.R. 5236 was referred to several committees, but received no further action.

For additional information please call Steve Redhead (7-2261) or Fran Larkins (7-8723).

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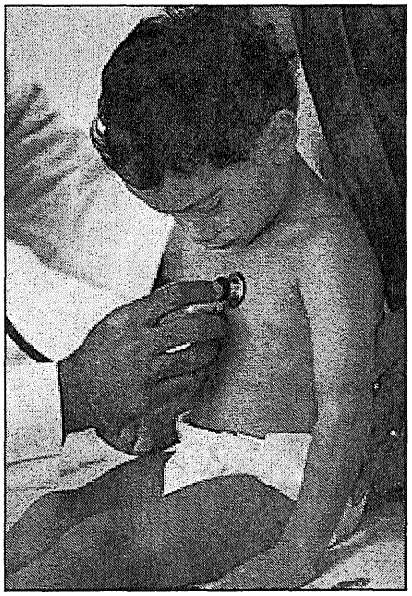
[5] In its 2001 report, *Crossing the Quality Chasm*, the Institute of Medicine defined evidence-based practice as "the integration of best research evidence with clinical expertise and patient values."

Published on Connect for Kids (http://www.connectforkids.org)

Making Early Developmental Screenings Routine

Published: February 20, 2006

by: Amy Coutee



Dane Fliedner has a simple message for parents: "You know your child better than anyone."

Fliedner, a pediatrician who works at a clinic just south of Los Angeles, is part of a growing number of pediatricians who see parental observation as a powerful tool for predicting a child's possible disabilities, developmental delays and other challenges.

It is the same message that the Los Angeles County Early Identification & Intervention Group has been trying to spread for the last two years. The group, which now collaborates with roughly 100 agencies in the sprawling county of Los Angeles in Southern California, is a strong advocate for a three-pronged approach: early screening using high-quality tools based on parent observation; quick follow-up from health care providers; and help for families in finding and accessing the resources they need.

"I think that families need to understand that appropriate and timely screening is important," said the Long Beach-based Fliedner. The earlier a problem is identified, he added, the earlier a child gets help. And if a child is not being routinely screened, parents need to feel empowered to speak up.

Lunch-table Discussion Launches County-Wide Campaign

The idea for the L.A. group began simply enough over lunch in October of 2003. A group of ten friends and colleagues—experts in the fields of mental health, education, philanthropy and advocacy—talking about what they knew about early identification of children with disabilities, developmental delays or other problems. The group was called together by Margaret Dunkle, senior fellow at the Center for Health Services Research & Policy of George Washington University, and included educational therapist Cynthia Landes, developmental pediatrician Mike Regalado of Cedars-Sinai Medical Center,

Madeline Hall of the Los Angeles County Office of Education, Karen Kirsche of the LA Unified School District, Zelna Banks of the Early Intervention program, Dorothy Fleisher and Annalei Klump of the W.M. Keck Foundation, and Sam Chan and Ilda Rueda De Leon of the County Mental Health Department.

The conversation addressed the critical importance of catching problems early, especially in under-served populations – and ended with everyone looking at Dunkle.

"When do we start?" they asked her.

Dunkle's answer was simple: right away. So she became the convener of the Los Angeles County Early Identification & Intervention Group. Dunkle is well aware that the scope of her group's mission is enormous.

"Very few places are as big as Los Angeles," said Dunkle. Los Angeles County has a population greater than 42 states and is home to at least 37,000 children, age five and under, who have or will develop a disability or mental or behavioral disorder. In all, there are more than 2.7 million children under age 18 in the county.

"When Los Angeles does something, it has a tremendous impact on the state, and when California does something it has a national effect," said Dunkle.

The group began meeting monthly, each meeting hosted by a different organization: one month at the 100-year-old nonprofit Children's Institute Inc., another at the County Health Department and another at the Westside Children's Center. Between meetings, Dunkle's e-mail newsletters keep everyone in the know. The group has been sustained by, and has grown through, old-fashioned word of mouth, she said.

"It's really quite amazing," Dunkle said. "At every meeting there are new people. For all of its diversity and complexity people in Los Angeles County are on the same page about early identification and intervention. The issue touches almost everyone personally." The sales pitch or "elevator statement" as Dunkle calls it, is clear and concise: "We want every child in Los Angeles County to be screened for developmental delays and (we want) follow-up for each child who needs it," she said.

Using Parents as Experts

To that end, the group wants pediatricians and parents to have access to and to use age-appropriate, culturally sensitive, accurate, reliable and valid screening tools—specifically the Parents' Evaluation of Developmental Status (PEDS) and Ages and Stages Questionnaires (ASQ).

"Some tests like the Denver (Denver Developmental Screening Test), while

they were an innovation in their day, have not kept up with today's standards. They don't do a good job of picking out the kids with or without problems," Dunkle said.

The Denver misses up to 50 percent of mental retardation and 70 percent of language impairments according to Dunkle and to Frances Glascoe, an adjunct professor of pediatrics at Vanderbilt University and the developer of PEDS. Glascoe said some pediatricians still believe that they can judge children by looking at them, but informal observations "miss actually about 70 percent of kids."

The ASQ was developed by Diane Bricker and Jane Squires, to flag possible social-emotional, behavioral and mental health problems as well as problems with learning.

Ages and Stages Questionnaires (ASQ)

• Designed for children up to 60 months (five years) of age

• Addresses developmental areas of communication, gross and fine motor skills, problem solving, personal and social development

• Questions are age-specific

• Comes in English, Spanish, French, Korean and other languages.

• Parents indicate child's developmental skills on 25 to 35 items at each well-child visit

• Depending on age being screened, reading level ranges from third- to 12th-grade comprehension

• Gives a single pass/fail score

• Takes 10 to 15 minutes to complete)

Glascoe and other experts say that pediatricians must learn to value parents' observations, know how to evaluate a parent's answers on a screening and know how to identify red flags. Parent-based screening tools like the PEDS and ASQ also get parents involved in a meaningful way, they are less subject to bias based on ethnicity and gender and are low-cost and effective.

"Parents are around their children all the time so they notice things that other people don't," notes Glascoe.

Bringing Pediatricians On Board

Getting pediatricians to buy into that, though, is difficult. Physicians are not

taught that parental observations are a good indicator of a potential problem, and in some institutions they are still taught to rely on the outdated Denver.

But Long Beach's Fliedner says using these tools helps him in his practice, by enabling him to make the best of the very short time he gets with patients. The screens can be done at home, in a waiting room or with the help of a nurse practitioner, aide, receptionist or office manager during a well-child visit. Pediatricians are pressured to see as many patients as they can and Fliedner admits that when time is short, patients only get the basics.

Parents' Evaluation of Developmental Status (PEDS)

• Consists of 10 questions for parents

• Designed for children aged nine and under

• Identifies children as at low, moderate or high risk for various disabilities and developmental delays

• Determines whether physician should refer; do further screening; provide parent/patient education; or monitoring

• Comes in English, Spanish, Vietnamese and several other languages

• Written at a fifth-grade comprehension level

• One page long, takes about two minutes to complete.

But when a parent brings a completed screening to Fliedner, he can quickly see if the child has been flagged for a delay. If there is a red flag on the PEDS, he administers the ASQ and guides the family toward useful interventions. If there are no flags, Fliedner knows he can focus on the next issue.

"It allows you to spend more time on other things," said Fliedner.

In the past, physicians were not reimbursed for using these tools, but just over a year ago a CMS Relative Value Unit (a special code on medical forms) was assigned to the developmental screens. That means that physicians can now be reimbursed, eliminating at least one excuse to skip the screening.

A Parent Champions Early Screening

What's even better about tests like the PEDS is that they are so parent-friendly.

"It's not intimidating and actually you can do it right on-line," said Nancy Wiseman, a Massachusetts mother. Wiseman's daughter was diagnosed with

autism at age two, and she remembers how hard it was to find help with screenings, referrals and treatment.

Seeing the difference early, intensive intervention has made for her daughter motivated Wiseman to start First Signs, Inc., an agency focused on improving early identification of, and interventions for, autistic children and children with other developmental disorders. Wiseman's group teaches parents how to advocate for their children and points them to the resources that can help them once a diagnosis has been made. When problems are not identified early, Wiseman said, the long-term effects can be devastating.

Dunkle points to Wiseman as an example of how widespread the need for early identification is. There are other advocates working in North Carolina, Tennessee and Louisiana to help make people more aware of the need for early intervention.

In a question and answer session for her new book, *"Could It Be Autism? A Parent's Guide to the First Signs and Next Steps"*, Wiseman said that her daughter has made "profound progress over the years, thanks to early identification and intensive intervention."

"It's absolutely critical to get the word out about the importance of early childhood screenings," said Wiseman. "We are encouraging parents to take the screening and bring it to their well visit... We need to create a kind of push-pull kind of effect so that parents are asking for a screening at every well-child visit."

By the Numbers

High-quality screening tools immediately identify 70 to 80 percent of children with problems, but fewer than 15 percent of pediatricians routinely use any kind of screening tool, according to Dunkle.

Nationwide, one in six children have a developmental delay, disability or a learning, behavioral or social-emotional problem and five to eight percent of children under five years of age have a disability or chronic condition like autism, cerebral palsy, epilepsy, mental retardation or orthopedic problems.

"Early screening and intervention are not magic bullets that can fix everything. But they do make the future of that child and his or her family a hell of a lot better," said Dunkle. "Intervention in early childhood really does work best and cost less over the long haul."

Dunkle is proud to say that the Los Angeles-based group has already made its presence known on Capital Hill. It is playing a significant role in drafting the newest Head Start legislation and now due to its recommendations, high-quality screens are part of the bill that has passed the House of Representatives. "If you have early intervention you can make a big

difference."

Resources

- For more information about early developmental screenings and becoming an advocate for your child visit First Signs [1].
- Publisher Random House has an excerpt from Nancy Wiseman's book, "Could it Be Autism [2]" on-line.
- For information on upcoming events, links and articles about early identification and screening contact Developmental Behavioral Pediatrics Online or The American Academy of Pediatrics [3].
- For more information or to get involved in the Los Angeles County Early Identification & Intervention Group Margaret Dunkle, Convener, Los Angeles County Early Identification & Intervention Group, and Senior Fellow, Center for Health Services Research & Policy, George Washington University. Mcd729@aol.com [4] or MargaretDunkle@gmail.com [5].

Source URL:
http://www.connectforkids.org/node/3939

Links:
[1] http://www.firstsigns.org
[2] http://www.randomhouse.com/broadway
[3] http://www.aap.org/
[4] http://www.connectforkids.org/mailto:Mcd729@aol.com
[5] http://www.connectforkids.org/mailto:MargaretDunkle@gmail.com

PROJECT ASSIST
RAMSEY COUNTY HUMAN SERVICES – CHILDREN'S MENTAL HEALTH
MENTAL HEALTH SCREENING
WITH ASQ:SE FOR AGES 0-5
AUGUST 2004 TO FEBRUARY 2006

* **177** completed ASQ:SE

104 (59%) males:

Asian 4 (5%)
African American 38 (36%)
Caucasian 26 (36%)
Native American 3 (4%)
Hispanic 3 (4%)
Multi-racial 10 (14%)
Unknown 3 (4%)

73 (41%) females:

Asian 4 (5%)
African American 24 (33%)
Caucasian 26 (36%)
Native American 3 (4%)
Hispanic 3 (4%)
Multi-racial 10 (14%)
Unknown 3 (4%)

92 (52%) with elevated scores:

57 (62%) males
35 (38%) females

83 (90%) referred to Project ASSIST

57 (69%) opened with Project ASSIST

40 (70%) males:
Asian 2
African American 15
Caucasian 9
Hispanic 5
Multi-racial 8
Unknown 1

17 (30%) females:
Asian 3 (18%)
African American 5 (29%)
Caucasian 5 (29%)
Native American 1 (6%)

Hispanic 2 (12%)
Multi-racial 1 (6%)

30 (53%) have diagnostic code(s), the others are still active

Diagnostic Code 1:
V61.21 (1); V71.09 (4); FASD (1); 300 (1); 309.21 (1); 309.24 (1); 309.4 (3); 309.81 (1); 312.9 (3); 313.89 (8); 313.9 (1); 314.01 (2); 315.4 (1);
201 DC0-3 (1); 206 DC0-3 (1)

Treatments recommended: (some received multiple recommendations)

Child – individual therapy (16)
Child and parent – in-home individual and family therapy (1)
Child and parent – evaluation for Fetal Substance Exposure (4)
**Child – medication evaluation (3)
Child – Occupation Therapy evaluation for speech/language (5)
Child – involve in constructive community activities (3)
Child – Neighborhood House to maintain regular school attendance (1)
Child – Spell Program, St. Paul Early Language and Literacy (1)
Child – Special Education Services (1)
Child and parent – Early Head Start enrollment (3)
Child and parent – regular schedule of contacts with non-present family (2)
Family therapy (3)
Parent – full physical examination (1)
Parent – individual therapy (4)
Parent – medication management (1)
Parent – day care assistance (1)
Parent – domestic abuse education (1)
Parent – alcohol treatment (1)
Parent – parenting classes (8)
Parent – classes and groups at Resource Center for Fathers and Families (1)

* For 2005, 1301 parents declined a mental health screening for all children, age 0-18; specific declines for children age 0-5 not available; points to the importance of screening process being voluntary.

**For these three children, one was already on medication, and was referred back to the primary care physician with recommendation that medication be discontinued based on the new mental health assessment. Two others (siblings) were referred to a mental health therapist, with recommendations in the report that "once the children have begun therapy, their current therapist will be able to make recommendations regarding possible co-occurring conditions, and if relevant can make a referral for medication evaluations".

For more information, contact:
Ed Frickson, M.S., L.P.
Mental Health Supervisor
Project ASSIST/Early Intervention
Ramsey County Human Services
160 E. Kellogg Blvd, Ste 7000
St. Paul, MN 55101
Ed.frickson@co.ramsey.mn.us

PARENT CONSENT
CHILD HEALTH & DEVELOPMENTAL SCREENING

Child's Name	Birth Date	*(For office use)* *Child's Record No.*_____
Parent's Name		

A. This screening includes:
- ❖ Review of your child's immunization record
- ❖ Check of your child's growth such as height and weight
- ❖ Tests for possible hearing problems
- ❖ Tests for eye health, including how well your child can see
- ❖ Review of any other factors that might interfere with your child's health, growth, development, or learning
- ❖ Check of your child's development
- ❖ Your report on your child's growth and learning
- ❖ Information about your child's health care and insurance
- ❖ Information about community resources and programs based on your child's or family's needs

B. If this screening is a Child and Teen Checkups, Head Start, or other equivalent screening, it may also include:
- ❖ Check of your child's present, past, or other family health
- ❖ Check of your child's pulse, respirations and blood pressure
- ❖ Unclothed physical screening of your child's skin, head, eyes, ears, nose, throat, neck, chest, heart, lungs, abdomen, genitals, arms, legs, spine, and muscles
- ❖ Check of your child's teeth, gums, and mouth
- ❖ Test for exposure to tuberculosis
- ❖ Urine tests for possible problems
- ❖ Blood tests for anemia
- ❖ Blood test for lead
- ❖ Other_____

This screening **does not** replace on-going care from your health care provider or dentist.

Child and Parent Rights, Obligations, and Assurances

1. The standards for screening are the same for every child regardless of race, income, creed, sex, national origin, or political beliefs.
2. Screening is required for your child's entry into public school kindergarten or first grade. This requirement is met if your child has participated in a screening through Head Start, Child and Teen Checkups, or equivalent screening through another provider within the past year. The screening summary results must be given to your child's school district.
3. Screening is not required for your child's entry into kindergarten or first grade if you are a conscientious objector to screening.
4. You have the right to refuse any of this screening for your child and still receive any of the other screening parts.
5. You have the right to refuse referral for assessment, diagnosis, and possible treatment for your child.
6. Your child's medical assistance eligibility or eligibility in any other health, education, or social service programs will not be affected if you refuse this screening or any parts of this screening.

I give permission for the Child Health & Developmental Screening checked below for _____.
(Child's Name)

Check one (v)
☐ Complete screening as described in A & B above.
☐ Screening described above except _____.

Parent/Guardian Signature	Date	Relationship To Child

MINNESOTA MDH DEPARTMENT OF HEALTH Minnesota Department of Education Minnesota Department of Human Services

Revised 07/03/03

Parental Consent

For the Early Childhood Health and Development Screening (ECS)

Child's Name

Description of Program The screening components included in Early Childhood Screening that are required are;

1. Family circumstances which might affect learning readiness;
2. Immunization assessment which includes a review of the immunization status of the child in relation to the following diseases:
   diptheria, pertussis, tetnus, polio, haemophilus influenzae, measles, mumps and rubella;
3. A developmental screening test which assesses the child's development in the areas of cognitive, fine and gross motor skills,
   speech and language, social-emotional behavior and self-help skills;
4. Hearing screening, including procedures which test for deviation from the normal range of auditory acuity;
5. Vision screening which includes testing for eye health, including the normal range of visual acuity and muscle balance;
6. A summary interview.

Participant's Rights, Obligations and Assurances

1. The standards for the program are the same for everyone regardless of race, income, color, creed, national origin, political belief or sex.
2. The parent or guardian has the right to refuse referral for evaluation, diagnosis and possible treatment for their child.
3. The parent or guardian has the right to refuse participation for their child, in any component of the screening program, and still be eligible for any other component; however, Minnesota Law requires parents to have children screened before school entrance.

Authorization

I hereby authorize the screening package indicated above _____
Name of Child

with the exception of the following component(s): _____

Signature	Relationship to Child	Date

INFORMATION COLLECTION, USE AND RELEASE CONSENT OF SCREENING RESULTS

Summary data or individual data may be used by the school district for the following purposes:

1. To facilitate counseling or other follow-up services which you may wish to obtain after the screening;
2. To transmit helpful information to another provider of services if a referral is made for further evaluation;
3. To permit evaluation of the screening program by the local school district, or the Minnesota Department of Education or Health
   (for the latter purpose your child's identity remains anonymous);
4. To provide access to and accountability for government funds paid to the local school district for providing the required ECS services;
5. To plan for school entry.

Signature	Relationship to Child	Date

By signing this statement, I release the results of the screening to the school district to be used for permanent school health and development records in addition to the above stated purposes.

Information obtained in this screening is classified as private and is available only to the child's parent(s) or guardian in accordance with the Family Educational Rights and Privacy Act (1974). Legally you are not required to release this information to anyone. Private information and records cannot be discussed or released to anyone except as authorized by the parent(s) or guardian.

REV 12/01