FIRST 5 CENTER FOR
CHILDREN'S POLICY

BRIEF
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Funded in Fragments:

How California's Patchwork Mental Health Financing Leaves Young Children Without the Care They Need



Supporting early childhood mental health requires interventions that engage both the adult and the child together.

Medi-Cal covers some of these services, including individual therapy and, more recently, dyadic care and family therapy for a child and caregiver together. But these benefits cannot support the full range of early childhood mental health care across the promotion, prevention, and treatment continuum, nor the variety of settings where the care is delivered. This leaves many services dependent on a patchwork of time-limited and program-specific funding.

WHY THE EARLY YEARS MATTER FOR MENTAL HEALTH

Babies' earliest relationships and experiences shape the architecture of their brain, laying the foundation for future learning and development.

When mental health needs are addressed early, children receive support during the most sensitive and rapid period of brain development leading to stronger social-emotional skills, communication, learning, and overall lifelong well-being. Because the emotional well-being of young children is directly tied to the functioning of their caregivers and families, mental health interventions look different for this population than they do for older children and adults.[i,ii]

Proven Early Childhood Interventions That Support Mental Health Lack Comprehensive, Sustainable Funding

Early childhood mental health supports work through the adults around a child, or serve whole classrooms, programs, or groups of families. They are also sometimes delivered by professionals other than licensed behavioral health practitioners. Therefore, they do not always fit the medical billing system. Some examples include:



- **Infant and early childhood mental health consultation (IECMHC).** A mental health professional partners with the adults who care for young children, such as early educators, home visitors, and parents, to strengthen their ability to support children's social and emotional development. Much of consultation is classroom- or program-level work with early childhood providers rather than a service to an identified child.
- **Home visiting.** A trained professional, such as a nurse, social worker, or parent educator, is paired with a family and visits them regularly from pregnancy through early childhood. Home visitors support mental health by screening for maternal depression, strengthening the caregiver–child relationship, and connecting families to services early.
- **Parenting programs.** Parenting groups, fatherhood engagement programs, and play-based activities help caregivers build skills and confidence, strengthening the relationships that protect young children's mental health.

While each of these approaches has some dedicated funding, it is often tied to specific models, settings, or eligible families, and rarely covers the full scope of the work. These programs also need funding that can support them holistically. This includes services delivered to caregivers, educators, and groups of families rather than to one identified child; training and reflective supervision for the professionals doing this work; delivery in the many settings where young children and families spend time; coordination across those programs; and the infrastructure to sustain services over time.

State Investments and Recent Changes

Over the past several years, California has started to acknowledge the connection between infant and early childhood mental health (IECMH) and the adults who care for young

children, increasing investments and launching initiatives that focus on the quality of those earliest relationships. This includes the:

- **Children and Youth Behavioral Health Initiative (CYBHI)**, a multi-year investment in behavioral health for children and youth from birth to 25, which
  - Provided one-time grant funding to scale evidence-based practices (EBPs) and community-defined evidence practices (CDEPs) in early childhood, including home visiting and IECMHC
  - Set up the Fee Schedule program, an ongoing reimbursement mechanism to support the delivery of behavioral health services for children from birth to 25 in school settings, off-campus clinics, and community organizations
- **California Advancing and Innovating Medi-Cal (CalAIM)**, which
  - Introduced new Medi-Cal dyadic care and family therapy benefits that cover treatment for a child and caregiver in one visit
  - Removed diagnosis as a prerequisite for Medi-Cal mental health services, so children under 21 can receive care based on trauma, risk factors, or a suspected condition, before symptoms are severe enough to diagnose [iii, iv]
- **Passage of AB 2698 in 2018** and subsequent updates, which
  - Introduced early childhood mental health consultation as a reimbursable service for children in California State Preschool Programs and General Child Care and Development Programs, funded through the mental health adjustment factor

These initiatives unlocked new funding sources for IECMH, helping to bolster prior behavioral health investments. Yet, together they do not go far enough to fully support all of the models that communities across California are trying to sustain. Furthermore, new changes starting in 2026 have created significant uncertainty for programs.

Behavioral Health Transformation Implications for Young Children

In 2024, Californians passed Proposition 1, amending the Mental Health Services Act (MHSA) to what is now called the Behavioral Health Services Act (BHSA). BHSA includes a targeted focus on behavioral health services for people experiencing or at risk of homelessness. In addition, BHSA removes the dedicated prevention and early intervention (PEI) funding stream that existed under MHSA, splitting it into state-led population-based prevention funding and separate county-led early intervention funding. Implementation is now underway. Counties began operating under their first three-year BHSA Integrated Plans in July 2026, and the California Department of Public Health (CDPH) recently released its first population-based prevention funding opportunity.

As the state rolls out these changes, it has used the graphic on the following page to show where population-based prevention programming, led by CDPH, and early intervention programming, administered by counties, fall along the continuum. This complicates the landscape because certain services do not fit neatly into one part of the continuum.

Beyond drawing arbitrary lines of responsibility across the state and counties, this split divides funding sources that have historically supported programs aimed at both prevention and early intervention, without a clear or adequate solution. Combined with an increased emphasis on addressing acute mental illness, it may lead counties to decrease or eliminate funding for early intervention programs serving young children.

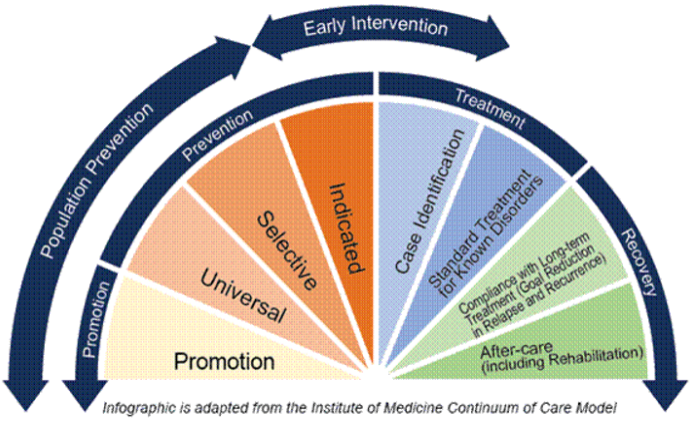


Image: Population-Based Prevention Final Plan, CDPH

While at least 51 percent of CDPH population-based prevention funding must serve people 25 and under, nothing requires a focus on children ages birth to 5. This will mean an overall decrease in investments for California's youngest children compared to the last several years.

WHAT IS IECMHC?

IECMHC is an evidence-based mental health intervention that builds the capacity of adults working with infants and young children to support healthy social and emotional development. IECMHC takes an indirect approach by partnering with the adults in children's lives to create healthy and supportive environments to support child well-being. A central component of IECMHC is the collaborative and trusting relationship developed between the consultant, a mental health professional with knowledge of early childhood development and early childhood mental health, and the adult caregiver, typically an early childhood provider or sometimes family member. Through this relationship, the consultant works with the caregiver to develop the best approach for addressing a child's social and emotional needs.

The consultant uses a combination of interventions and strategies informed by evidence-based behavioral health principles to identify needs and address them collaboratively with the caregivers they support. Consultation can focus on a specific child or family, the classroom environment, or the early childhood program, and can be delivered across a variety of settings. How the core principles of consultation look in practice varies depending on cultural strengths, the integration of consultation with other mental health interventions, and the setting in which it is implemented.

A Note on How Consultation Is Classified in BHSA. Consultation spans the continuum from promotion and prevention to early intervention, but CDPH's **Population-Based Prevention Strategy Resource Guide** has characterized it as an early intervention service. Under BHSA, this points consultation toward county early intervention dollars and away from CDPH's population-based prevention funds, even though much of consultation is classroom- and program-level prevention work.

Infant and Early Childhood Mental Health Consultation (IECMHC) as a Case in Point

The funding landscape for consultation provides a window into the complexity of IECMH funding in California overall. Each funding source focuses on a specific component of consultation, such as workforce development, or on implementing consultation in specific settings within the early childhood ecosystem, limiting both the reach and impact for children and families.

Two of the state's' more established funding sources for consultation are only available in child care settings. The **mental health adjustment factor** is a recurring funding source, but only for state-contracted child care programs, leaving out Family Friend or Neighbor care. **Consultation services** provided through the WestEd IECMHC Network, a statewide infrastructure, are currently limited to early childhood professionals working within the child care system. This leaves a large gap in reaching children who may benefit from consultation in home visiting, early intervention, or child welfare.

Even within child care, access is uneven. Consultant availability varies across regions, with some smaller and more rural counties having none available. Counties that do not have a sufficient mental health provider workforce may have one provider wearing multiple hats, operating as a part-time consultant, therapist, and preschool quality improvement coach all in one week.

One-time investments like **CYBHI** are insufficient to sustain the IECMHC workforce and program infrastructure over time. Counties need to know they can recruit, train, and retain a consultation workforce to be deployed wherever children and families are served. For smaller and more rural counties, the post-grant cliff is steeper. They have smaller budgets, and less capacity to piece together the patchwork of funding options.

There is also interest in **Medi-Cal billing pathways**, such as direct billing, Medi-Cal Managed Care Plan Community Reinvestment Funds, and leveraging Children's Health Insurance Program Health Services Initiatives. The Department of Health Care Services (DHCS) has even listed Medi-Cal billing codes that could be used to reimburse specific components of IECMHC in its Evidence-Based Practices and Community-Defined Evidence Practices Resource Guide. However, it is yet to be determined if these pathways are workable in practice. Some would require state involvement or policy change.



Furthermore, even if individual billing could work in theory, a consultant would need to be an eligible Medi-Cal provider, the child would need to be a Medi-Cal member eligible for the service rendered, and the program would need consent to bill the child's Medi-Cal for services rendered in addition to collecting the child's Medi-Cal information. The administrative burden and startup costs of Medi-Cal billing may outweigh the reimbursement available, especially in rural environments.

Consultation reaches some children and families but not others, and programs struggle to sustain it over time. The bottom line is there are few recurring funding sources available to support IECMHC, and what remains is not comprehensive enough to support a consultation infrastructure across the early childhood ecosystem.

SPOTLIGHT ON TEHAMA

First 5 Tehama launched a regional IECMHC workforce development investment funded by a CYBHI grant, training a cohort of consultants. It is now also using Title IV-E funding (federal child welfare dollars that can pay for training child welfare staff and foster and kinship caregivers), in partnership with Chabot College, to continue training those consultants, with a focus on trauma-informed consultation for the adults who support children in out-of-home placement, including social workers, foster families, and educators.

This funding covered training, but not the ongoing cost of delivering consultation. Tehama hopes to make consultation available to family child care providers, home visitors, foster parents, transitional kindergarten classrooms, and center-based child care. For now, funding for consultation services is pieced together from several sources, including the remaining funding from CYBHI Round 3 grants, First 5 Proposition 10 dollars, and the county school-based mental health team, with no single source able to fund a consultant full time.

The county is interested in Medi-Cal sustainability pathways, but more guidance from the state is needed to operationalize those ideas.

CONSULTATION'S IMPACT: A STORY FROM TEHAMA COUNTY

When four-year-old David started preschool, he spent much of his day alone. He rarely spoke. Transitions were hard. When he felt overwhelmed, his behavior could escalate quickly. His family and teachers wanted to help, but they weren't sure what he needed.

Through IECMHC, David's family, teachers, and a consultant began working together. They looked at what his behavior might be communicating and found ways to support him consistently at school and at home. They also started with something David already loved: music and trains.

By mid-year, his teachers saw a change. "Now he plays alongside other children, uses more language, and even asks peers for help. Kids aren't scared of him anymore, and we've learned how to support his interests like music and trains to help him connect and stay engaged."

David's story reminds us that supporting a young child often means bringing the people around that child together.

A Path Forward for State Leaders

To build a robust early childhood mental health infrastructure, county leaders need to understand what funds are available, where the dollars can be spent, and who can bill for those dollars. Often, local First 5 county commissions play the role of braiding together different funds to support IECMH, identifying which programs need support in their communities or what new programs the community needs. California is fortunate to have First 5s in this role. However, continually braiding new funding is inefficient and leaves programs exposed whenever a funding source shifts or ends.

The future of IECMH should not be a patchwork of funding sources that places the burden on counties to piece them together. Here are three actionable steps for the state to address what the system needs, and how consultation can serve as a place to start.

1. TRACK BHSA INVESTMENTS, PROGRAMS, AND OUTCOMES FOR CHILDREN AGES BIRTH TO 5

The division of the former PEI funding stream into state-led prevention and county-led early intervention has created barriers to funding and drawn lines of responsibility limiting the reach and sustainability of certain IECMH programs.

As BHSA implementation gets underway, the state should monitor funding changes for young children, including how counties are allocating early intervention dollars for the birth to 5 age group and which programs are no longer being funded because of the transition from MHSA to BHSA. SB 326 requires counties to report annually on spending for children and youth and on age-related disparities (W&I Code §5963.04), but leaves the form and

detail of that reporting to DHCS. Current guidance breaks out expenditures only for children and youth under 21. The state should also monitor the allocation of population-based prevention dollars for the birth to 5 age group.

If the state finds that young children are underinvested, it should adjust its approach to ensure that both prevention and early intervention dollars reach children ages birth to 5 and the adults who care for them. Strategies could include recognizing IECMHC as an approach that spans multiple parts of the continuum, rather than solely an early intervention service, and allowing First 5 county commissions to apply for CDPH population-based prevention funds.

2. OPERATIONALIZE MEDI-CAL BILLING AS PART OF THE SOLUTION

Medi-Cal is a promising long-term pathway for some IECMH services, such as the dyadic services benefit, which supports the child and caregiver relationship and provides reimbursement for evidence-based models such as HealthySteps. But billing requirements and startup costs can outweigh reimbursement, especially in smaller and more rural counties, and the reimbursement amount may not cover the full cost of care.

The state has published the Children and Youth Evidence-Based Practices and Community-Defined Evidence Practices Resource Guide, including IECMHC, but additional guidance and technical assistance opportunities are needed to help local leaders and Medi-Cal managed care plans understand what this looks like in practice. At the same time, Medi-Cal billing should be paired with funding for indirect, population-based work that Medi-Cal is not designed to cover. For consultation, this would include funding for classroom- or program-level consultation and reflective supervision.

3. ESTABLISH CLEAR OWNERSHIP OF IECMH

The patchwork funding landscape described earlier reflects a governance problem. No single state entity owns IECMH. Responsibility is spread across agencies and initiatives, and each covers a specific setting, service, or part of the continuum. The work of piecing them together falls to counties, and often to local First 5s. State leadership and cross-agency coordination are needed to ensure that IECMH services reach all child- and family-serving settings and that funding supports IECMH across the continuum. With a new administration taking office in January 2027, now is the time to establish leadership that can hold a full state vision for IECMH across departments.

Next Steps: California's IECMH Financing Policy Project

Earlier this year, the First 5 Center for Children's Policy started leading a group of more than 20 stakeholders across the state in the ZERO TO THREE IECMH Financing Policy Project (FPP). The FPP provides a dedicated space for states to tackle how they can sustainably finance IECMH across settings. Our group is honing in on consultation as a concrete starting point while also exploring the broader IECMH financing landscape. Our goals are:

1. Assess the infant and early childhood mental health landscape in California to understand where consultation fits in as well as potential funding avenues.
2. Create shared understanding and language about infant and early childhood mental health consultation for the purposes of statewide expansion and billing in partnership with the FPP team and state/county leaders.
3. Identify and support opportunities to utilize billing and financing pathways for consultation across all early childhood settings.

California has already shown it can pay for relationship-based care, as dyadic services demonstrate. The next step is a full state vision for IECMH, and consultation offers a concrete place to start. Getting it right would move IECMH financing from a patchwork that counties must piece together to a system that reaches young children, and the adults who care for them, wherever they are. The First 5 Center looks forward to working with partners and the incoming administration to build it.

ACKNOWLEDGMENTS

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CITATIONS

i. ZERO TO THREE: Infant and Early Childhood Mental Health
ii. Center on the Developing Child at Harvard University
iii. DHCS BHIN 26-002: Access Criteria
iv. Medi-Cal Provider Manual: Non-Specialty Mental Health Services

