Addressing the Behavioral Needs of Children in Care:
Mental Health Services for Foster Youth

Joint Informational Hearing
Assembly Committee on Human Services
and
Assembly Select Committee on Foster Care

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Assemblyman Ken Cooley, Chair

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Background Paper

Mental health includes emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.[i] Different factors can impact individuals' mental health, and to varying degrees depending on the individual and the circumstances. Some of these factors include brain chemistry and genetics, family history of mental health issues, or traumatic life experiences. Furthermore, even for people facing the same mental health diagnosis, treatment plans are, ideally, individualized for each person based on their needs, resources, culture, and community supports. Children in foster care have, by definition, experienced traumatic, negligent, and/or abusive events in their lives that may likely form the basis for short-term and long-term mental health problems. As such, ensuring that this particularly vulnerable population has the proper services, care, and resources while in the foster care system is not only essential to properly caring for them as foster children, but is vital to ensuring that they have the best chances at success once they have left care.

Mental health needs of foster youth

According to the National Alliance on Mental Illness (NAMI), in the United States one in five adults, or roughly 43.8 million people, suffer from some form of mental health problem in a given year. Approximately one-fifth (21.4%) of youth ages 13 to18 experience a severe mental disorder at some point during their lifetimes. For children ages 8 to 15, the estimate is 13%. Suicide is the tenth leading cause of death in the U.S., the third leading cause of death for people aged 10 to 14, and the second leading cause of death for people aged 15 to 24.[ii]

Research on early brain development has demonstrated that infancy and early childhood are critical periods in which youth develop attachments, trust, empathy, problem solving, and impulse control. Early childhood trauma and lack of response to a child's needs by caregivers can result in toxic stress, which interrupts and alters brain development and architecture, factors

that can result in poor emotional regulation, aggression, hyperactivity, and difficulty with impulse control.[iii] Foster youth enter the child welfare system as a result of abuse and neglect and it is this exposure to complex trauma that results in higher mental health needs among the foster youth population. A 2012 publication by the American Psychological Association found that nearly half of youth in foster care were determined to have clinically significant emotional or behavioral problems and children under age 7 who enter foster care show high rates of developmental problems.[iv] Youth who are involved in the child welfare system face poorer outcomes than their non-system-involved peers; specifically, foster youth are more likely to: struggle in school and engage in truancy, face difficulty in finding employment, and experience substance abuse issues, among other things.[v]

Certain sub-populations of foster youth experience particularly high mental health needs. Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) youth are four times more likely to attempt suicide or self-harm as their non-LGBTQ peers. LGBTQ teens are six times more likely to experience symptoms of depression than the general population and can have a particularly difficult time coming out to friends and family.[vi] In the past, there have also been issues of disparity in mental health care for LGBTQ youth and adults given the history of classifying homosexuality as a mental illness.

Of special concern are foster youth who have been commercially sexually exploited children (CSEC). In the United States, three of the "High Intensity Child Prostitution Areas" are located in California: the San Francisco, Los Angeles, and San Diego metropolitan areas.[vii] Youth in foster care are especially vulnerable to exploitation. One study of Los Angeles County CSEC youth found nearly 80% had prior involvement with the child welfare system before their exploitation.[viii] These children are often exploited in multiple ways and will cycle through many stages of exploitation before they are able to leave their harmful relationship. They require specialized services to deal with the trauma and mental health issues stemming from their exploitation.

<u>Mental health services for foster youth</u>

The State of California's responsibilities related to the mental health needs of foster youth are rooted in both state and federal statute. AB 899 (Liu), Chapter 683, Statutes of 2001, codified California's Foster Youth Bill of Rights in Section 16001.9 of the Welfare and Institutions Code, which explicitly states that foster youth in California have the right to receive medical, dental, vision, and mental health services.[ix]

In 2011, Assemblymember Portantino introduced AB 181, which would have codified the Foster Youth Mental Health Bill of Rights, which included the right to: timely access to services, take only medications that are authorized by a doctor, and be informed about the risks of prescribed medications, among others.[x] The bill was intended to highlight the specialized and complex federal and state laws that dictate provision of mental health services to foster youth. While the bill was held, and ultimately died, in the Assembly Appropriations Committee, both the California Department of Social Services (DSS) and the Office of the Foster Care Ombudsman

enumerate the mental health rights of foster youth on their Internet Web sites to ensure foster youth are informed of their rights.[xi]

In 2008, the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) amended the federal Social Security Act (42 USC § 622) to require state plans for child welfare services to ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, which includes mental health needs.[xii] The plan must include an outline of how health needs are identified by using screenings, steps to ensure continuity of health care services, and oversight of prescription medications, among others. Signed earlier this year as part of the Bipartisan Budget Act of 2018 (P.L. 115-123), the Families First Prevention Services Act seeks to reduce the use of congregate care for foster youth with certain exceptions. These exceptions, known as qualified residential treatment programs, must use a trauma-informed treatment model and further requires youth placed in residential facilities to be assessed within 30 days of placement in order to determine whether his or her needs can be met by family members, in a foster family home, or an alternative setting.[xiii]

Katie A. v. Bonta

In July 2002, a lawsuit, *Katie A. v. Bonta,* was filed on behalf of California foster youth against Los Angeles County and the State of California citing violations of federal Medicaid laws, the American with Disabilities Act, and parts of the Rehabilitation Act, among others.[xiv] The lead plaintiff in the case, Katie A., had never received therapeutic treatment in her home, and by age 14, had experienced 37 separate placements within Los Angeles County's foster care system, in addition to 19 trips to psychiatric facilities.[xv] The lawsuit sought to improve the provision of mental health services to youth placed in, or at risk of placement in, California's foster care system. Litigation at the state level lasted nearly a decade and in December 2011, the Federal District Court issued an order approving a proposed settlement of the case thereby changing the way youth with the most intensive needs, known as the Katie A. subclass, are assessed for mental health services.[xvi]

In order to be considered as part of the Katie A. subclass, a youth must be fully eligible for Medi-Cal; be under 21 years of age; and have an open child welfare services case or be at risk of entering foster care due to a maltreatment investigation. A youth must also be under consideration for wraparound or specialized services, or be currently hospitalized for a behavioral condition, or have been hospitalized three times in the past 24 months for behavioral issues.[xvii] The settlement agreement required subclass members be provided an array of services, including Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC), consistent with the methods outlined in what is now referred to as the Pathways to Mental Health Services Core Practice Model (CPM), which was created in order to provide guidance and establish a uniform standard of care for youth across counties.[xviii]

ICC, IHBS, and TFC are provided through the Medi-Cal (California's version of the federal Medicaid program) Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT, described in further detail below) to all children and youth who are under the age of 21, are eligible for the full scope of Medi-Cal services, and meet the medical necessity criteria for specialty mental health services. ICC and IHBS services must be provided to all children and

youth who meet the medical necessity for those services; however, while the settlement agreement provided ICC, IHBS, and TFC services to subclass members, membership in the Katie A. class or subclass is no longer a prerequisite for receiving these services (a child or youth need not have an open child welfare services case in order to be considered for receipt of these services).[xix]

ICC is responsible for facilitating assessment, care planning, and coordination of services, such as urgent services for youth, while IHBS consists of individualized, strength-based treatment to address mental health issues that interfere with a child's day to day living. Interventions under IHBS are aimed at helping the youth and their support network build the skills necessary for successfully functioning in a home-based setting or the community, while TFC provides highly coordinated, intensive support services to a foster parent or caregiver to enable them to care for youth who are at risk of placement in a residential or hospital setting.[xx]

Early and Periodic Screening, Diagnostic, and Treatment benefit

Medi-Cal makes available free or low-cost health coverage to low-income adults, families, seniors, individuals with disabilities, pregnant women, and foster youth (all children in the foster care system are categorically eligible for Medi-Cal). The Department of Health Care Services (DHCS) is the single state administrative entity responsible for the provision of Medicaid in California, and can sub-contract to counties for provision of services.

The child health component of Medicaid – EPSDT – is a benefit providing comprehensive health care services for children under the age of 21 who have full-scope Medicaid eligibility. EPSDT includes screening, diagnostic, and treatment health care services aimed at ensuring that children and youth receive appropriate health care – including dental, developmental, and mental health care. While EPSDT services are available to all children with full-scope Medicaid eligibility, and not just children and youth in foster care, this program – in that it insures all foster youth – is the primary source of funding for mental health services for youth in care.

Mental health services provided under Medicaid include "specialty mental health services," which are available for children (through the EPSDT benefit) and adults who meet medical necessity criteria.[1] It is important to note that that these "medical necessity" eligibility criteria differ between children/youth under the age of 21 (and therefore covered under EPSDT) and adults, with the standard being less strict for children and youth:

- Under EPSDT, children and youth must have a covered diagnosis and meet both of the following criteria: 1) have a condition that would not be responsive to physical health care based treatment, and 2) the services are determined to be necessary to correct or ameliorate a mental illness and condition discovered by a screening that has been conducted by a qualified provider. This means that children with low levels of impairment may meet medical necessity criteria for specialty mental health services.

[1] EPSDT also covers "non-specialty" mental health services for children or youth; these services are typically delivered through a managed care or fee-for-service provider.

- Adults must have a significant level of impairment to meet the medical necessity criteria for specialty mental health services.[xxi]

In California, of the 124,875 children with an open child welfare case (including those with a foster care placement as well as other youth receiving child welfare services while living in their own homes) during the one-year period between April 2016 and March 2017, 42.3% received some form[2] of specialty mental health service.

Of the 82,665 children in foster care in California during the same one-year period of April 2016 through March 2017, 47.3% received some form of Medi-Cal specialty mental health service.[xxii] Broken out by age category, the percentages of children in foster care receiving some form of specialty mental health service during this time period were:

- 0 to 2 – 22.2%
- 3 to 5 – 41.9%
- 6 to 11 – 58.1%
- 12 to 17 – 62.8%
- 18 to 20 – 38.2%

The percentage of children in foster care receiving some form of mental health service broke out by race/ethnicity is as follows:

- Black – 51.1%
- White – 45.3%
- Latino/Hispanic – 46.5%
- Asian – 46.6%
- Native American – 38.2%

Specialty mental health services include, grouped under "mental health services," the following: therapy, rehabilitation (which includes skills training), collateral (working with a caregiver or other significant support person to help address a youth's mental health needs), assessment, and plan development. They also include the following, among others: crisis intervention, crisis stabilization, medication support, psychiatric health facility services, psychiatric inpatient hospital services, targeted case management, and Katie A.-related services (intensive case coordination, intensive home-based services, and therapeutic behavioral services). These specialty mental health services, in their breadth and ability to be tailored to the needs of individual children, youth, and families, can provide essential supports to foster youth who have experienced abuse or neglect. A continuum of mental health services provides tools and resources for addressing and mitigating the negative long-term impacts of this trauma on the

[2] N.B.: the underlying data for these percentages include only Medi-Cal specialty mental health services paid claims, and do not reflect mental health services that may have been received through Mental Health Services Act programs, counseling offered at schools, and other programs and services. Additionally, while it is possible to use these data to observe penetration rates and categories of services approved for payment, the use of Medi-Cal claims data based on billing categories likely obscures the full picture regarding specific interventions received, and duration and frequency of receipt of specific mental health services by foster youth.

social, emotional, developmental, and physical health of children and youth with experiences in the child welfare services system.

Three systems provide mental health services to Medi-Cal beneficiaries: managed care plans, fee-for-service providers, and county mental health plans. Some children and youth in foster care in California receive Medi-Cal through a Medi-Cal managed care provider, while others receive Medi-Cal through fee-for-service providers. Typically, a beneficiary will receive non-specialty mental health services through his or her managed care plan or fee-for-service provider, while specialty mental health services are provided through a referral to a county mental health plan.[3]

The accompanying document entitled "Overview of Mental Health Services and Funding for Foster Children," prepared by the Legislative Analyst's Office for this hearing, contains additional information on EPSDT as well as other programs, funding streams, and state and local roles and responsibilities related to the provision of mental health services for foster youth.

Recent reforms regarding the provision of mental health services for foster youth

In order to provide for the ongoing needs of foster youth throughout the state, California's child welfare system has undergone multiple reforms in recent years to ensure that, among other things, youth receive the timely and adequate behavioral health services to which they are entitled. Some key areas of reform and recently adopted pieces of legislation are described below.

Continuum of Care Reform

A broad and significant series of changes to the state's child welfare services system has been adopted in recent years. Referred to as Continuum of Care Reform (CCR), these changes have been aimed, fundamentally, at ensuring that every child has the opportunity to live in a safe, loving, permanent family home in which he or she can receive the individualized services and supports necessary for healthy development and outcomes in childhood and adolescence, with positive impacts carrying on into adulthood. Changes brought about by CCR in support of this crucial goal involve reducing California's reliance on congregate care while strengthening the continuum of care for children and youth.

SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, among other things, called on DSS to convene a working group to examine the use of group homes in California and to report recommendations to the Legislature. The resulting report, submitted in January 2015, contained a number of recommendations aimed at reforming the foster care

[3] California currently, through June 30, 2020, administers a Section 1915 (b) Freedom of Choice waiver to provide specialty mental health services. This waiver program is administered at the local level by each county's mental health plan whereby the specialty mental health services program is "carved out" of the overall Medi-Cal program and the mental health plan provides, or arranges for, the provision of specialty mental health services to Medi-Cal beneficiaries that meet medical necessity criteria. Also, as discussed later, as a result of the Continuum of Care Reform, some short-term residential therapeutic programs and foster family agencies can be contracted with for the provision of certain specialty mental health services. DHCS is the single state entity responsible for the provision of specialty mental health services. The provider, such as STRTPs, can have a contract to deliver these services but they must receive individual authorization.

system and reducing California's reliance on group homes as a tenable placement for foster youth. Initially named "Congregate Care Reform," the resulting efforts were later renamed "Continuum of Care Reform" to better reflect the need for a strong system of home-based care and supports to complement and support the decreased reliance on group homes. AB 403 (Stone), Chapter 773, Statutes of 2015, AB 1997 (Stone), Chapter 612, Statutes of 2016, AB 404 (Stone), Chapter 732, Statutes of 2017, and AB 1930 (Stone), Chapter 910, Statutes of 2018, adopted many of the CCR report recommendations into law, including enacting a sunset date for existing licensure, rate-setting, and other provisions for group homes and providing for a new licensure category of short-term residential therapeutic programs (STRTPs) to offer temporary housing and intensive up-front services for youth prior to placing them with a family.

A key goal of CCR is the improved integration of foster care and mental health care. CCR seeks to ensure that, regardless of placement, every foster youth can have his or her mental health needs met with the appropriate, coordinated provision of services. Some of the key CCR reforms designed to meet this objective include:

- *Child and Family Teaming:* A key tenet of CCR is that the delivery of child welfare services is most effective when conducted in a child- or youth- and family-centered process with shared responsibility for making the best decisions for the child or youth and family. While the vital importance of inclusion of a child's or youth's and his or her family's voice in assessment, planning, and decision-making has been recognized for many years, the use of child and family teams (CFTs) was formalized in the adoption of CCR legislation. Section 16501 of the Welfare and Institutions Code defines a CFT as "a group of individuals who are convened by the placing agency and who are engaged through a variety of team-based processes to identify the strengths and needs of the child or youth and his or her family, and to help achieve positive outcomes for safety, permanency, and well-being," and stipulates that activities of the CFT must include providing input into: a) the development of a child and family plan that is strengths-based, needs-driven, and culturally relevant, and b) the placement decision made by the placing agency and the services to be provided in order to support the child or youth. The CFT is also required to include representatives who provide certain formal supports to the child or youth and family (such as the caregiver, caseworker, county mental health representative, and others), and may include other individuals who provide other formal or informal support. The child or youth and his or her family may also request additional specific individuals to participate. Generally, for children and youth without an existing CFT, a CFT meeting must be convened within 60 days of a child or youth coming into foster care, and then at least once every six months. For children or youth receiving ICC, IHBS, or TFC, CFT meetings must occur at least every 90 days. Meetings may also be convened on an as-needed basis, such as to discuss any placement changes and service needs.[xxiii]

- *Functional assessment of needs:* CCR emphasizes the importance of using a single, comprehensive assessment to identify any needs of each foster child or youth, to be used initially to inform decisions related to placement and service provision, and then periodically to ensure the ongoing appropriateness of those placements and services, including mental health services. DSS selected the Child and Adolescent Needs and

Strengths (CANS) functional assessment tool to be used within the CFT process in order to support case planning and coordination of care by building on a child's or youth's strengths to address his or her needs. The CANS assessment also measures the resources and needs of the caregiver. Youth, family, and other CFT members must be involved in the assessment, which must be completed prior to finalizing a family's case plan, and results are required to be shared with and discussed and used by the CFT. County placing agencies and county mental health plans must both ensure that a single CANS assessment is conducted for each child or youth in foster care. A CANS assessment should be conducted in coordination with development of the case plan (typically required within 60 days of a child or youth entering the foster care system), and conducted again every six months thereafter, in collaboration with the CFT. Children and youth in care who are receiving specialty mental health services are assessed by CANS certified providers and certified county staff every six months.[xxiv]

- *Short-term residential therapeutic programs (STRTPs):* In moving away from reliance on congregate care, CCR legislation established a new category of residential care to replace traditional group homes for children and youth requiring intensive support. This category – short-term residential therapeutic program (STRTP) – is a residential facility licensed by DSS and operated by a public agency or private organization to provide short-term, 24-hour care and supervision and an integrated program of specialized and intensive care and supervision, services and supports, and treatment. STRTPs are not a long-term placement option, but are intended to provide mental health interventions and to stabilize, support, and transition children and youth with high-level mental health needs to lower levels of care in a manner consistent with the child's or youth's needs and case plan. STRTPs are required to make available a core set of trauma-informed, culturally relevant services, including specialty mental health services. Interim Licensing Standards issued by DSS on January 27, 2017, require an STRTP to obtain in good standing a mental health program approval within 12 months of licensure; this approval may be obtained from DHCS or a delegated county mental health plan, and must be maintained in good standing throughout licensure.[xxv] Section 1562.01 of the Health and Safety Code requires this program approval to include a Medi-Cal mental health certification. Per the interim standards, STRTPs are required to "provide or ensure access to mental health services, including specialty mental health services and mental health supports, as appropriate to the needs of the child or nonminor dependent in care."[xxvi] An STRTP without a current mental health program approval is prohibited from directly providing specialty mental health services and must instead provide access to specialty and other mental health services and supports, as appropriate.

- *Foster Family Agency (FFA) requirements:* Children and youth should receive needed services regardless of placement, including receiving in-home mental health services for those children and youth placed in family settings. Per state law, FFAs are public or private agencies that are engaged in any of the following: recruiting, certifying, approving, training, and providing professional support to foster parents and resource families; coordinating with county placing agencies to find homes for foster children and youth in need of care; and providing services and supports to licensed certified foster

parents, county-approved resource families (a term adopted under CCR to encompass all caregivers), and children.[xxvii] Like STRTPs, FFAs are also required to make available a core set of services, including specialty mental health services. Interim Licensing Standards issued by DSS on March 23, 2018, require an FFA to have a current Medi-Cal certification as an organizational provider of a county mental health plan in order to directly provide specialty mental health services.[xxviii] An FFA that has not acquired a Medi-Cal certification is required to provide access to appropriate mental health services. (The difference here, then, between FFAs and STRTPs is that an STRTP is required to have a Medi-Cal certification and a contract for licensure, while an FFA has a choice: it must obtain Medi-Cal certification and a contract to provide specialty mental health services, or it can opt to forego direct provision of these services [and therefore is not required to obtain certification and a contract], but is still responsible for ensuring that a youth receives specialty mental health services from a provider.)

- *Intensive Services Foster Care:* Adopted as part CCR follow-up legislation AB 404 (Stone), Chapter 732, Statutes of 2017, Intensive Services Foster Care (ISFC) was created as a new licensure category to provide services and supports to children and youth requiring intensive treatment, which includes treatment for behavioral and specialized health care needs. The creation of an ISFC category is intended to ensure that children and youth in care can receive necessary services in a home-based family setting or avoid or exit congregate care settings. ISFC requires resource parents to be specially trained, and includes professional and paraprofessional support. Under the program, which can be run by an eligible FFA or county, core services and supports – including access to mental health treatment, trauma-informed care, and transitional support from foster placement to permanent home placement – are provided.[xxix]

Regulating the use of psychotropic medication

In August 2014, the *San Jose Mercury News* published a series of articles entitled "Drugging our Kids," which examined the rates at which psychotropic medications are prescribed for youth placed in California's child welfare system. The article reported that, at the time of publication, nearly one in every four adolescents in California's foster care system – nearly three and a half times the rate for adolescents nationwide – were receiving psychiatric medications.[xxx] These drugs, which include antidepressants, mood stabilizers, and antipsychotics, are often untested on, and not approved for use by, children, and can cause adverse side effects in children, such as rapid-onset obesity, diabetes, and lethargy. Long-term effects can include an increased risk of suicide, brain shrinkage, and persistent tics.[xxxi]

In 2016, the California State Auditor conducted an audit to examine the use of psychotropic medications on foster youth in the state and the resulting report found that counties failed to adequately oversee the prescribing of medications, prescription quantities and dosages often exceeded the state guidelines, and youth did not receive follow-up visits for psychosocial services in conjunction with prescribed medication, among other findings.[xxxii] The Auditor recommended that DSS and counties collaborate in order to develop and implement an oversight structure that addresses the over-prescribing of psychotropic medications to foster youth.

In response to the news articles, Audit report, and a series of Senate Committee hearings, California legislators introduced several measures aimed at addressing the over-prescribing of psychotropic medications to foster youth, including SB 1174 (McGuire), Chapter 840, Statutes of 2016, which required annual monitoring of high-prescribing doctors and authorized the California Medical Board to take action against physicians who violate the law as it pertains to the prescribing of psychotropic medications, and SB 238 (Mitchell), Chapter 534, Statutes of 2015, which required certification and training programs for foster parents, child welfare workers, group home administrators, and dependency court judges to include training on trauma and behavioral health. SB 238 also required the Judicial Council to amend and adopt rules of court and develop appropriate forms related to the authorization of psychotropic medication for foster youth.

In April 2018, the *San Jose Mercury News* published a follow-up article examining the rates at which psychotropic medications were prescribed to foster youth. The article found that the number of foster youth prescribed antipsychotic drugs fell by almost half, from 5,076 during the 12 month period between June 2013 and June 2014, to 2,778 between June 2016 and June 2017. The article also found that the number of foster youth prescribed multiple antipsychotics dropped by 73% from 264 during the 2013-14 timeframe, to 70 during 2016-17.[xxxiii]

Additional recent state legislation related to mental health services for foster youth

In addition to the adoption of CCR-related changes and measures aimed at reducing the over-prescribing of psychotropic medications to foster youth, legislators in recent years have also introduced measures related to the assessment of need and coordinated provision of mental health services for foster youth, including:

- *AB 1299 (Ridley-Thomas), Chapter 603, Statutes of 2016*, which requires the presumptive transfer (the prompt transfer of responsibility for the provision of, or arrangement and payment for, behavioral health services) for specialty mental health services from a foster youth's county of jurisdiction to the youth's county of residence. The legislation sought to ensure that all foster youth receive timely access to specialty mental health services regardless of their physical placement. In July 2017, DSS and DHCS issued an All County Letter detailing implementation of presumptive transfer, instances in which it can be waived, and the role of CFTs in the presumptive transfer process.[xxxiv]

- *AB 340 (Arambula), Chapter 700, Statutes of 2017*, which requires screening services provided under EPSDT to include screening for child and youth beneficiaries (not just those in foster care) for trauma and requires DHCS and DSS to convene a working group comprised of stakeholders to update, amend, or develop tools and protocols in order to screen children for trauma. The bill also required the working group to report findings and recommendations to DHCS and the Legislature's budget subcommittees no later than May 1, 2019. Thus far, the working group has conducted several meetings to discuss existing tools used to screen for trauma in order to determine whether an existing tool will meet the needs of youth, or if a new tool should be created. The working group is expected to meet at least once more prior to the end of 2018 in order to continue developing recommendations to the Legislature.

- *AB 1006 (Maienschein), Chapter 714, Statutes of 2017*, which defines "specialized permanency services" to mean services designed for and with a child or youth to address a child's or youth's history of trauma, separation, and loss and that may include medically necessary mental health services, permanency support core services, and services designed to prepare an identified permanent family to meet the child's or youth's needs, set appropriate expectations before and after permanency is achieved, and stabilize the placement. This measure includes specialized permanency services in the existing range of service-funded activities offered by child welfare services and requires that, when a child has been in care for three or more years, documentation in the child's case plan must include a description of the specialized permanency services used and a statement explaining why the agency chose not to provide services in the event that these services were not utilized. It also requires a social worker or probation officer to provide a prospective adoptive family or certain guardians of a dependent child or ward of the court with information about the importance of working with mental health providers that have specialized adoption or permanency clinical training.

- *AB 2083 (Cooley), Chapter 815, Statutes of 2018*, which requires county-level and state-level Memorandums of Understanding (MOUs) between agencies directly responsible for the most traumatized children in foster care in order to better provide placement and services. These MOUs help set county expectations for who will take the lead in providing services among multiple agencies, require interagency teams to review placement options and work together to find caregivers who can provide trauma-informed care, and require the state to provide technical assistance to counties as they establish their MOUs. This bill was signed on September 27, 2018, and will take effect on January 1, 2019. The bill requires, by June of 2019, the Superintendent of Public Instruction and the Secretary of Health and Human Services to establish an interagency resolution team with members from each agency and requires, no later than January 1, 2020, those agencies to make recommendations to the Legislature and create a multiyear plan for increasing the capacity and delivery of trauma-informed care to foster children.

Recent federal legislation: Family First Prevention Services Act

On February 9, 2018, President Trump signed H.R. 1892, the Bipartisan Budget Act of 2018 (P.L. 115-123), which included the Family First Prevention Services Act. One of the largest impacts of Family First is the way Title IV-E funds can be used; originally, Title IV-E funds could be used to supplement the costs of foster care programs for eligible children, administrative expenses to manage foster care programs, and training for staff, foster parents, adoption assistance, and kinship guardianship assistance. Under Families First, however, Title IV-E funds can be used to fund prevention services to allow "candidates for foster care" to remain with their parents or relatives. Families First also reduces the reliance on the use of congregate care for children and places an emphasis on foster family homes.[xxxv] Residential treatment programs, under the Act, are required to use a trauma-informed treatment model and use registered or licensed clinical staff. Children placed in these settings must be formally assessed for mental health needs within 30 days of placement to determine if the youth's needs may be met by family members, in a foster family home, or in another approved setting.

On July 9, 2018, the U.S. Department of Health and Human Services Administration for Children and Families released program instructions to states with information on the changes made to Title IV-E plan requirements as a result of the Families First Prevention Services Act and associated deadlines.[xxxvi]

Improving outcomes

The mental health needs of children and youth in foster care, and the services appropriate to meet those needs and mitigate negative impacts, can been seen as existing across a spectrum of three stages:

- First, what are the immediate needs of children and youth upon entering care? When children and youth enter foster care, they are assessed for potential mental health issues. This helps to establish immediate needs and referrals to service providers and appropriate placements, but this is by no means an end point. As children remain in care, experience multiple placements, or exhibit behaviors not previously recognized in the initial assessments, further assessments and services may be needed.

- Second, what are the intermediate needs of children and youth placed in foster care? Children with mental health needs often require more services, which can be a challenge for finding stable placements. CCR and other reforms have helped counties to add a number of other supports to help keep placements stable, provide family maintenance services, and provide more high-needs mental health services such as ICC, IHBS, or TFC.

- Third, what are the needs of children and youth in foster care for longer periods of time? While a key goal of our child welfare system is to reunite families after a child has been removed from the home, some children will remain in care for extended amounts of time and eventually "age out" of the system at 18 years old or 21 if they participate in AB 12 extended foster care programs. For the children who remain in care long-term or transition out of care, they will likely experience multiple placement disruptions, lack of stability in education and mental health providers, and may develop further mental health or behavioral issues due to their time in care. It is critical that children who remain in foster care for longer periods of time have stability and continuity of services to reduce the possibility of further trauma or development of mental health problems.

As California strives to reform and improve its system of providing mental health services to children and youth in foster care, it is important to recognize both the urgency of meeting immediate needs, as well as the vital importance of addressing longer-term needs in order to ensure the greatest chances at successful outcomes for California children and youth involved in the child welfare system.

[i] https://www.mentalhealth.gov/basics/what-is-mental-health
[ii] https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
[iii] http://pediatrics.aappublications.org/content/pediatrics/136/4/e1142.full.pdf
[iv] https://www.apa.org/pi/families/resources/newsletter/2012/01/winter.pdf
[v] http://pediatrics.aappublications.org/content/138/5/e20161118
[vi] https://www.nami.org/Find-Support/LGBTQ
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