CBHDA and CWDA – Joint Behavioral Health Vision for Child Welfare

Jointly, CWDA and CBHDA seek to build out a proposal which could be put forward as part of the state's CalAIM process to establish **automatic eligibility for child welfare system-involved children and youth and their families to a minimum, mandatory set of behavioral health services**. It is our belief that children and youth impacted by abuse, neglect and exploitation warrant our collective, upmost attention as a target population for Specialty Mental Health Services (SMHS), and that the entitlement under the Early, Periodic, Screening, Diagnostic and Treatment Program (EPSDT) warrants such an approach.

CBHDA and CWDA members attempted to flesh out **what a minimum, mandatory scope of services** that met the goals of automatic eligibility for foster youth might look like. Most of the services are existing Medi-Cal billable services refined to better serve child welfare system-involved populations. This document details those services, in an attempt to initiate a conversation about a **concrete set of minimum mandatory services that should be available to foster children/youth and their families**.

I. ELIGIBILITY

County behavioral health and county child welfare agencies are committed to ensuring access to behavioral health services for foster children/youth, their families and caregivers. The behavioral health needs of foster children and youth cannot be adequately addressed unless the needs of their families and caregivers are addressed simultaneously. Additionally, county behavioral health and county child welfare believe that meaningful coordination and collaboration must continue to take place between child welfare, probation and county behavioral health agencies, and other family-serving agencies as appropriate, to meet the unique needs of foster children/youth, their families and caretakers.

Automatic Eligibility and Eligible Populations:

This joint CWDA/CBHDA proposal would provide for "automatic eligibility" for children/youth served by the child welfare system to receive Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) Services. This would include:

1. Children/youth who come into foster care (under juvenile court order) and who are served by a child welfare or probation agency.
2. Children/youth 6 months post-permanency (reunification, guardianship or adoption).
3. "Candidates" for foster care under the "imminent risk" definition, as defined below.

The parents and caregivers of all of the above would also be entitled to receive behavioral health services independent of their children as needed to support their ability to provide a safe and nurturing environment for their children. We believe that the minimum mandatory services outlined benefit the child welfare system-involved child/youth, including when the services are delivered to their parents and caregivers.

Further, we believe that the minimum mandatory services outlined will help stabilize and prevent out-of-home placements for candidates and those post-permanency. Preventing out-of-home placements by supporting and stabilizing families reduce the need for more intensive, higher cost behavioral health service interventions and reduces placement disruptions that cause more trauma for the child and are costly to the delivery system.

Because Medi-Cal is a provider of last resort, any privately insured individual will not be automatically eligible for services covered by their private insurance.

Candidacy definition (pending definition under FFPSA):
A child who is identified as being at **imminent risk** of entering foster care, but **who can remain safely at home as long as prevention services are provided**.
"Imminent Risk" may be determined by the caseworker based upon an in-person assessment and includes one or more of the following criteria:

- The child's risk assessment score is high or very high or the child' safety assessment indicates the presence of at least one safety threat. [1]
- The child has one or more siblings or half-siblings placed into foster care.
- The child's adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.
- The youth is a nonminor under the age of 21 who is eligible for extended foster care, and their living arrangement is at risk of a disruption that would result in the youth re-entering foster care.
- Other criteria includes referral from a tribe if the child is an Indian child, if the child is under the supervision of a juvenile court pursuant to a Section 300 petition and under a family maintenance plan, and if the probation department has determined that a child subject to a Section 602 petition needs prevention services to prevent the child's entry into foster care.

"Automatic" indicates that a child is eligible for services no matter what. Children and youth will be eligible for a broad range of services based on the needs of a child/youth, along a continuum that includes resiliency building and wellness oriented services to prevent the onset of behavioral health issues later, to primary intervention services that include clinical therapies, to intensive "full service partnership" type approaches that embody a "do whatever it takes" approach to child safety, permanency and well-being. The set of services outlined in this paper will serve as a demonstration framework to provide child welfare involved children, youth and families with a necessary system of support.

We prefer the term automatic because we believe every child who is served by the child welfare services system has experienced a significant enough degree of trauma that they meet the new standard for medical necessity, as proposed under CalAIM.

[1] As determined by the Structured Decision Making (SDM) tool, which is a tool mandated by CDSS and used in all counties during the in-person investigation.

This new standard allows for service delivery so long as any behavioral health symptom or "condition" is present. The proposed CalAIM changes allow Medi-Cal managed care plans, including behavioral health plans, to provide children with limited benefits regardless of diagnosis or impairment. We believe that the minimum mandatory services outlined below should be available for child welfare system-involved child/youth, their parents and caretakers as well as the other child welfare-linked populations defined previously.

A diagnosis will still be determined to inform clinical treatment needs, but it is not the precursor to obtaining services.

"Family" Defined

The definition "Family" as used in this proposal includes resource parents (including relative caregivers), birth families (including siblings and half-siblings), other caring adult who is a significant support to the foster child/youth, and other non-related persons with an established relationship that is reasonably considered family by the person served. CWDA and CBHDA recommend the following considerations to enable these important supports to receive Medi-Cal funded SMHS:

- Use "identified client" versus "child" in billing/claiming.
- DHCS should update policies and/or provide technical assistance so that if it is identified that a caregiver needs a mental health service, family therapy could be provided even if the identified client is not present.
- Medi-Cal income and eligibility requirements will need to be updated to ensure this inclusive definition of "family" can be served under Medi-Cal.

II. MINIMUM MANDATORY SCOPE OF SERVICES

Our approach provides timely behavioral health services that are sufficient to maintain the child/youth's functioning at home, in school, and with others. This also helps to reduce the need for more intensive, higher cost behavioral health service interventions and reduces placement disruptions that cause more trauma for the child and are costly to the child welfare system. Most importantly, this improves outcomes for children, youth and families and meets the federal Title IVE mandate of "safety, permanency, and well-being".

Both the behavioral health and child welfare systems must work together to lift up the child and family strengths and build resiliency in families. Models of care must embrace both the *Integrated Core Practice Model*[2] as well as the *Strengthening Families/Youth Thrive Frameworks*.[3]

[2] https://www.dhcs.ca.gov/services/MH/Pages/Manuals_And_Guides.aspx
[3] For more information: https://cssp.org/our-work/projects/protective-factors-framework/ and https://cssp.org/our-work/project/youth-thrive#framework

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CWDA and CBHDA propose that a child's entry into the child welfare system will be the trigger for a true "team-based" approach to serving the child, youth and his/her caregivers as envisioned by the Katie A. Settlement Agreement, the Integrated Core Practice Model and AB 2083 (Cooley, States of 2018). CWDA and CBHDA jointly recommend that the State Departments of Health Care (DHCS) and Social Services (DSS), in collaboration with the Juvenile Court System and County Counsels Association of California, work together to (including across counties) facilitate information sharing and joint planning and support for the child, youth and family.[4]

A. <u>Expand Intensive Care Coordination (ICC) to all children, youth and families:</u>
CWDA and CBHDA propose that all families who are involved with the child welfare system shall qualify for, and be provided ICC services, and that a behavioral health/mental health coordinator or case manager is assigned to work with the social worker. The behavioral health provider can serve as the ICC coordinator who is responsible for working with the Child and Family Team (CFT), including the child welfare social worker, to coordinate services and activities to the child, youth and/or family, ensure all system partners (including those from special education, CWS and MH) are coordinated, and comprehensively address needs. ICC can be delivered by the county MHP or a contract provider overseen by the county MHP.

The ICC coordinator, working with the social worker, would engage and establish relationships with the child/youth and family as part of the Child and Family Team (CFT). Specific deliverables include:

- Joint visitation of the child/family in their home/community within 30 days of the child coming to the attention of the CPS hotline.
    - This may include, rapid response system based on identification of need from any stakeholder (youth, family, SW, school)
- Immediate and on-going engagement of the youth and caregivers to gather information, monitor the child/youth and the family unit and potentially deliver "on demand" clinical or supportive services as warranted in the community.
    - For kids/families not in treatment, screenings/review at intervals to be agreed upon with expedited and timely MH assessment based on screening/review
- Conduct joint assessments with social work staff to gather information necessary to inform the child's/youth's treatment plan, including completion of the Child Adolescent Strengths and Needs Assessment (CANS). In addition, utilize CANS "watch/prevent" to develop a plan to link the child/family to non-clinical services and supports in coordination with the social worker and CFT.

[4] While this document is focused on child welfare and behavioral health, AB 2083 also encourages teaming and information-sharing across other child and family-serving agencies including education and developmental disabilities.

  - This should include, joint response and timely assessment at time of entry, including option to expedite assessment for urgent needs (this is already a Medi-Cal expectation)
  - Timely linkage to MH assessment when more than resiliency building and wellness-oriented services are needed, as indicated by the CANS assessment.
- Participate in the CFT, and coordinate the CFT pursuant to local protocols, to the extent possible
- Assist the social worker in developing the case plan.
  - "Assist" will need to be defined, including a description of the roles and responsibilities of the respective agencies
  - Further consideration will need to be made to not duplicate the agencies efforts and the child welfare agency should continue to lead the development of the case plan, as the appropriate entity.
- Linking the child/family to therapies or other direct clinical services and supports in coordination with the social worker and CFT.

A precursor to this requires that the behavioral health system is made aware of the child/youth's entry into the child welfare system. In our model, the child welfare agency staff will be responsible for notifying the county behavioral health services staff so that they are aware of the child/youth's entry and establish the necessary documentation for Medi-Cal behavioral health services eligibility and commencement of services (for example: signed consents and releases of information). County Child Welfare staff will need to assist in obtaining these. The county child welfare staff will establish Medi-Cal eligibility and take any other necessary actions to initiate the child/youth's Medi-Cal services.

Importantly, the assessment of children and youth should be an ongoing process, and not a one-time event. A child/youth's trauma-induced behavior can be "triggered" at any time and is expressed in ways unique to the child/youth, and caregivers can similarly be "triggered", which can lead to inappropriate adult-responses. This is why it is critical to establish rapport, through active engagement, throughout the life of the child's involvement with the child welfare system – in order to build trust, mutual understanding, and a shared commitment to serving children, youth and families.

B. <u>Front-End Minimum Mandatory Scope of Behavioral Health Services:</u> In addition to the team-based approach described above, the following more specific behavioral health and child welfare linked services are recommended to be available to all children, youth and families across all counties. Note that further discussion will be necessary to determine whether these services can be eligible for federal Medicaid funding match under the Medi-Cal Program. The first section describes the resiliency building and wellness-oriented services referred to in the previous section.

1. Trauma-informed, Resiliency-building Therapeutic Services for Children and Families: Both CWDA and CBHDA agree that building resiliency in all children and youth creates a necessary buffer to the impact of trauma and is consistent with the Strengthening Families and Youth Thrive Frameworks which embraces a resiliency model. Resiliency in children and youth is associated with three primary factors: cognitive development and problem-solving skills, self-regulation, and ability to establish relationships with caring adults. These three factors should be present in children and youth of all ages, yet they are disrupted by traumatic events including separation from primary caregivers.

   We also believe that programs should be trauma-informed, culturally responsive and evidence-based to address the unique needs of this population. The California Evidence-Based Clearinghouse and the federal Prevention Clearinghouse have identified a number mental health treatment programs that provide education, support and treatment to children, youth and families to address their trauma experiences and build resilience that should be included in the array of services, based on the individualized needs of children, youth and families. Examples may include the 3-5-7 Model, Parent/Child Interactive Therapy (PCIT), Trauma-Focused Cognitive Behavioral Therapy, Multi-Systemic Therapy, Functional Family Therapy, or other culturally relevant practices unique to children and families.

2. Individual Child and Family Therapy: Providing therapy for the child and entire family jointly and/or separately, with or without the child present, is an important intervention. Often, this therapy is delivered in 50-minute increments in an office setting, rather than in the home and in the community and we would like to encourage that these services are provided within the home and community, if the child, youth and family is comfortable with the setting. We also believe that therapy should be trauma-informed, culturally responsive, readily available and offered to children/youth and families who have a need and desire to receive therapy delivered in this manner. Therefore, we recommend that the DHCS and DSS work with counties to increase capacity of therapists who work with child welfare-involved youth and families to provide trauma-informed, evidence-based care, and to expand the workforce diversity.[5] We suggest that individual therapy is expanded to be provided for caregivers since the parent/caregiver/sibling would be provided services within the context of the identified client. Additionally, there are other needs of family members that aren't directly tied to the identified client and individual therapy should be allowed in these cases as well since it will benefit the family system to work with each member who needs the service.

[5] This could be modelled after the Adoption Competency Training efforts that began several years ago and is available in California to build competence for behavioral health providers serving children, youth and families involved in the child welfare system.

3. Therapeutic Relationship-Building Services for Families: These services would be provided to a parent/caretaker who needs therapeutic intervention to strengthen their ability to engage and respond to their child in ways that build safe and healthy relationships. These services, which often include therapeutic visitation between the child and parent(s), would enable the behavioral health professional to support, intervene and redirect caretaker or parental behaviors, while assisting them in better understanding their child's communication and cues and being responsive to those. An example of this is Parent-Child Interactive Therapy (PCIT). In addition, therapeutic parent visitation services should be considered for inclusion in this service category. It should be noted that this is intended to be a clinical service which may differ than services provided by the county welfare agency, such as parental visitation or parent education classes focused on improving parenting skills and should not replace this service. This service should also not be confused with Behavioral Treatment which is the responsibility of Managed Care Plans (MCPs) for youth on the autism spectrum.

4. Broaden Eligibility for Therapeutic Behavioral Services (TBS): Currently, TBS is restricted to intensive, one-to-one services designed to help beneficiaries and their parents/caregivers manage specific behaviors using short-term measurable goals based on the beneficiary's needs. TBS could be expanded to include less restrictive criteria to provide coaching and other therapeutic behavioral services for caretakers (i.e. resource parents) to meet the needs of the family and youth. TBS should continue to be an adjunctive, short-term service but it may be appropriate to expand criteria of who can receive the service in a manner that would benefit the family. In addition:

    - Trauma-based training specific to meeting the needs of children with co-occurring developmental disabilities is needed so that TBS can be effective for this population.

5. Substance Use Disorder (SUD) Services: The CANS assessment and collaborative work of the Child and Family Team should include the evaluation of SUD for caregivers as well as youth served by the child welfare system. To increase integration and coordination for those children, youth and caregivers with mental health, SUD and co-occurring MH and SUD, allocation of funds should be identified to build out this system of care and to provide all necessary SUD services to those who are involved in the child welfare system.

6. Family Reunification Partnership Program (potential best practice): FRP is a model based in Monterey County that utilizes a fully integrated and collaborative Behavioral Health/Child Welfare approach designed as one unified working team, jointly staffed by BH therapists and CW social workers who are cross-trained to

each other's jobs, and co-supervised and managed by CW and BH. This approach is specifically targeted for children, youth and families in Family Reunification. FRP therapists and social workers jointly share responsibility for case planning, provision of intensive therapeutic and support services, case monitoring, decision-making, planning and leading Family Team Meetings, parent orientation and other groups. FRP provides intensive levels of supports, services and case management to families as they begin FR services. Potential best practices could be developed locally with guidance from programs and counties who are successfully implementing various models. There must be particular care and focus on maintaining the varied and critically unique scopes of work for each of the professions involved to maintain the important and distinct roles of both.

   a. Additionally, any potential best practice model that is mandated should share program evaluation data.

7. Peer Supports: Youth and Parent Partners who provide peer support are valuable members of the Child and Family Team in the counties that currently utilize these resources. They help prepare youth for CFT meetings, provide mentorship and support to caregivers and bio families, and through their engagement work can help youth and families connect to needed services in ways that other service-providers cannot.

8. Intensive Home-Based Services (IHBS): IHBS are intensive, individualized, strength-based, needs-driven intervention activities that support the engagement of the child/youth and his/her significant support persons, and help the child/youth develop skills and achieve the goals and objectives of their treatment plan. Currently, IHBS is limited to youth who are currently in, or are being considered for, high-level care institutional settings, such as a congregate care setting, or for an intensive level service such as Therapeutic Behavioral Services (TBS), who have been discharged within the last 90 days from a hospital/MH facility, or who met other defined criteria.[6] This criteria should be broadened to ensure all children/youth who may need IHBS will receive it. Also, services should not be capped on a daily basis, but rather should be based on the needs of the child and caregiver.

   Specifically, IHBS should be available to children and youth to prevent removal from the home (i.e. candidates of foster care) and youth/families who generally indicate a need for a higher-level of care coordination and services in order to reunify, remain stable in their current foster care placement, and/or to achieve other permanency (guardianship/adoption). This service need should continue to be driven by the Child and Family Team.

[6] The ICC, IHBS and TCC Manual can be found here: https://www.dhcs.ca.gov/services/MH/Pages/Manuals_And_Guides.aspx

9. Adopt "Full-Service Partnerships" and "Wraparound Programs" for Families (including parents) in the Child Welfare Services System. All families who come to the attention of the child welfare program face their own challenges in providing a safe, nurturing environment that allows for normal child development. This can be for many reasons. Many families come to the attention of child welfare services due to untreated substance abuse issues. Many studies also find intergenerational effects, in that parents who experienced childhood maltreatment are, as a group, more likely to have children who are abused or neglected and therefore require the skills necessary to protect their children and help them to thrive.

C. Inclusion of Z and V Codes. The specified codes should be eligible billing codes in Medi-Cal under the EPSDT benefit. Inclusion of these "other conditions that may be a focus of clinical attention" (see DSM 5 starting on pg715… abuse and neglect start on 717), would enable counties to provide important services for their clients. The other conditions (as specified above) conforms to the intent of the EPSDT mandate, but they are currently excluded from billing. The purpose of EPSDT mandate is to cover all medically necessary needs of a child or youth which would include those other conditions that would require clinical attention and should be eligible for billing.

D. Crisis or Urgent-Oriented Services

1. Family Urgent Response System (FURS): FURS will provide a state-level and in-person mobile response for foster children/youth, families or caretakers to address moments of crisis and instability that may lead to a placement disruption and is a critical component to the behavioral health services array.

III. OTHER CONSIDERATIONS

A. Workforce and Funding Considerations

To ensure children/youth, their families and their caregivers can access the full range of behavioral health services, workforce capacity must be expanded. Services must be culturally responsive and reflective of the diversity of our population. The State must establish workforce development as a priority and should partner with county agencies to expand the workforce, including peer advocates and other para-professionals (which may also include non-credentialed professionals) who are trained in providing trauma-informed care for children served by the child welfare system.

In addition, further discussion is needed to determine the appropriate level of funding for county MHPs and county child welfare agencies to support the aforementioned strategies to jointly serving children, youth and families.

B. Training

To support these recommendations, CWDA and CBHDA are prepared to jointly advocate for cross training of county welfare agency and county behavioral health staff (including contracted staff) to strengthen the system's ability to jointly serve this population.

C. Explore Alternative Funding and Program Models for Intensive-Needs Youth:

Although this document outlines the scope of services needed to support child welfare involved children, youth and families, we recognize that further consideration will need to take place related to the acute care delivery system for high needs children and youth. Currently, children/youth with more intensive needs can receive services through the Therapeutic Foster Care (TFC), Intensive Home-Based Services (IHBS) or Therapeutic Behavioral Services (TBS) in home-based settings. We must also ensure there is suitable treatment options for children and youth who require out of home care across the continuum which may include increased capacity to existing treatment models, such as Short-Term Residential Treatment Programs (STRTP), Community Treatment Facilities (CTFs) and Children's Crisis Residential Treatment Programs for children and youth based on their unique treatment needs. Building out the continuum may also include critically examining whether current treatment models are able to provide the most appropriate behavioral health treatment for youth who need specialized care, such as those who are Commercially Sexually Exploited Children (CSEC), youth who may be developmentally delayed and have mental health needs, and youth who may have Substance Use Disorder (SUD). If these facilities are unequipped to provide specialized behavioral health treatment youth may be placed out-of-state or may even be hospitalized. The COVID-19 crisis has intensified the needs of those child welfare involved families and potentially triggered severe trauma that children may have experienced in their lives. We understand that to support our children, youth and families, it is also critical that we identify the appropriate continuum of care for the unique treatment needs of our children across the state. This may include exploring and implementing integrated, coordinated care and funding models of care for potential inclusion into statewide efforts.