CALIFORNIA CHILD WELFARE COUNCIL

BEHAVIORAL HEALTH COMMITTEE POLICY RECOMMENDATIONS 2020

The COVID-19 crisis continues to exacerbate the multiple stressors that put families and youth at risk of child welfare involvement, including poverty, inequitable access to healthcare, caregiver distress, and social disconnection. Concurrently, the crisis brings a renewed focus on the importance of family and child behavioral health and the critical need for accessible behavioral health services and trauma-informed practices to stabilize families and reduce unnecessary child welfare involvement.

The recommendations of the Child Welfare Council's Behavioral Health Committee include vital reform considerations to combat the impacts of the COVID-19 crisis on children and families, while informing the long-term pursuit of a more equitable and accessible behavioral healthcare system for youth and families involved in, or at risk of becoming involved in, the child welfare and probation systems. The policy recommendations center on four themes: (1) improving access to services; (2) setting standards for the comprehensive array of services available for youth and their families; (3) implementing outcomes-based accountability and performance improvement measures; and (4) developing strategies to support effective implementation.

The definition of "families" in this document broadly includes birth families (including parents, siblings and half-siblings), resource parents (including relative caregivers), and other non-related persons with an established relationship that is reasonably considered to be family-like by the child. While the scope of work of the Behavioral Health Committee encompasses reforms of the children's behavioral health system, best practice indicates that regardless of the strength of relationship between a child and their service provider, the inclusion of parents, natural supports, and caregivers in care planning and treatment result in the strongest outcomes for youth. The behavioral health needs of child welfare-involved youth cannot be effectively addressed unless the needs of their families and caregivers are addressed simultaneously.

The successful implementation of these recommendations will require thoughtful and consistent cross-sector state and local leadership, engagement, and dialogue. California has made important strides in recent years, with current efforts underway to facilitate critical behavioral health reforms through state initiatives such as CalAIM and the CalAIM Foster Care Model of Care workgroup, the DHCS Behavioral Health Stakeholder Advisory Committee, the Health and Human Services Behavioral Health Task Force and the Children and Youth System of Care State Team (which oversees SB 2083 implementation). The intended purpose of these recommendations is to inform the ongoing efforts of these workgroups and decision-making bodies.

Strengthening Access to Necessary Behavioral Health Services for Youth and Families

Youth and families who are involved with or at risk of becoming involved with the child welfare system deserve timely and equitable access to behavioral health services that are permanency-oriented, trauma-informed, and designed to provide continuity of care as placement needs change. There must be

universal access to services at a level commensurate with each child's need, regardless of the delivery system that provides those services. Unfortunately, system-level obstacles often prevent youth from receiving responsive behavioral health care. This is true across all service systems, including managed care, county mental health plans, and the substance use disorder treatment system.

While the below recommendation focuses on eliminating barriers to accessing EPSDT SMHS for youth, it should be noted that this does not presume that all child welfare-involved youth will need SMHS. The goal is to ensure that youth who have experienced significant loss and trauma and are presumed to need specialty services access effective intervention before their needs become more acute. The focus on the SMHS service delivery system is merited in light of the CalAIM process, which represents a significant opportunity to secure these reforms and to ensure youth involved in the child welfare system or at risk of child welfare system involvement get timely access to the behavioral health services they are entitled to.

A) New eligibility determination mechanisms for Specialty Mental Health Services (SMHS) for youth

The Behavioral Health Committee fully supports the automatic eligibility determination mechanism presented in the "Joint Behavioral Health Vision for Child Welfare" memo authored by CWDA and CBHDA in August 2020. In alignment with the CWDA and CBHDA proposal, the Committee recommends that any child with a substantiated report of abuse or neglect be automatically eligible for SMHS. In addition to the criteria outlined by CWDA and CBHDA to define "imminent risk" of involvement in the child welfare system, the Committee proposes that a child who receives a threshold score on a CANS assessment or ACEs screen should have immediate access to SMHS that prioritize permanency and address the effects of intergenerational trauma. It is not the intention of the Committee to suggest that youth, parents and families should not have access to necessary behavioral health care *until* a CANS or ACEs screening is given, but rather, that these tools offer additional entry points to care prior to system involvement and the development of more complex behavioral health challenges.

The two proposed mechanisms to facilitate access to care include:

- *Child and Adolescent Needs and Strengths Assessment*: CANS assessment metrics that measure "Suicide Risk" and "Sexual Exploitation" are examples of necessary indicators informing eligibility and referral for EPSDT SMHS. In addition, immediate referral for EPSDT SMHS could be operationalized for any youth given a score of 2 or 3 on a CANS assessment metric relating to "Lack of Relational Permanency" or "Caregiver Disruption." Further, the Permanency extension module should be administered alongside the traditional CANS assessment to every youth who is experiencing their first episode of home removal.
- *Adverse Childhood Experiences*: Stakeholders must leverage the Surgeon General's ACEs Aware Initiative to implement immediate referrals from pediatricians to behavioral health providers for children at imminent risk of child welfare involvement. Children who present with a threshold ACEs score (4 or higher on the Pediatric ACEs and Related Life Events Screener (PEARLS) tool) should be automatically referred to Specialty Mental Health Services when necessary to address their behavioral health needs.

The above recommendations related to the CANS Assessment and ACES PEARLS tool, building alternative referral pathways for youth into SMHS, are examples of the level of specificity needed to create a viable, prevention-oriented mechanism that can be utilized statewide. However, as part of the forthcoming work of the committee to write an implementation plan for these recommendations, the committee will convene a workgroup to discuss the exact CANS domains and ACES score threshold and/or practice algorithm that

should be operationalized.

It is the position of this committee that requiring a specific diagnosis to access any medically necessary behavioral health service, including SMHS, is antithetical to the wellbeing of many youth and is inconsistent with the requirements outlined in federal EPSDT statute, regulations, and CMS guidance, as well as California law, Welf. & Instit. Code, Section 14059.5(b)(enacted through SB 1287, Chapter 855 of 2018). Both the 1915(b) waiver and longstanding outdated regulations in CCR Title 9 require youth to be given a specific diagnosis to access SMHS mental health services and supports in a manner that is inconsistent with federal Medicaid law and state law. While this committee's work is focused on a specific population of children and youth, the state of California should endeavor to remove these criteria for all Medi-Cal eligible children as it serves as a barrier to timely and necessary access to behavioral health services, including for those Medi-Cal eligible children and youth involved in the child welfare system. We therefore recommend the requirements of state and federal Medicaid with respect to the criteria for establishing medical necessity for children and youth under age 21 to align behavioral health access with the federal EPSDT standards, as well as current research confirming the importance of addressing childhood trauma and other social determinants of health.

B) Strengthen referrals from the child welfare system to the behavioral health care system

In addition to aggressively shifting automatic eligibility determination to a more proactive system that will ameliorate and prevent a child's trauma from developing into a serious emotional disturbance, it is critical that the referral process from the child welfare system to the behavioral health care system be strengthened and standardized statewide. Child welfare social workers and providers that interact with youth at the early stages of engagement with the child welfare system must be equipped with the knowledge and tools to successfully connect youth to behavioral health services. The development of a statewide referral protocol would help address the disparities that arise for youth in counties where there are lower levels of collaboration between county agencies or systems, which often result in delays or disruptions in service access.

While most counties have developed such protocols, placing agencies frequently place youth out of county, and young people must interact with multiple jurisdictions as their placement needs change or permanency plans are developed. As a result, the requirements for presumptive transfer outlined in AB 1299 (Ridley-Thomas) may create administrative delays and paperwork burdens that obstruct timely and smooth service access. Child welfare workers and others responsible for serving foster youth must follow a clear and consistent protocol in assessing and referring youth to services that are specifically designed to meet their needs. This referral protocol should align with the requirements for the CANS and CFT processes.

Additionally, behavioral health providers who serve children and youth with the physical manifestations of trauma, including toxic stress syndrome, should be equipped to refer youth to pediatricians. Cross system cooperation of behavioral and physical health providers that support traumatized youth must ensure their safety and confidentiality in data sharing.

The Full Continuum of Behavioral Health Services and Supportive Placements Necessary for Child Welfare-Involved Youth and Youth at Risk of Child Welfare Involvement

Currently, a child's access to a comprehensive and responsive array of behavioral health services is dictated more by their zip code than their history of trauma, presenting symptoms, or level of impairment and need. While county mental health plans offer EPSDT SMHS and other services funded by state and local revenue streams like the Mental Health Services Act (MHSA), there is significant variability in the availability of services statewide. Implementation of the Integrated Core Practice Model (ICPM) was a critical step in ensuring that services provided for child welfare-involved youth emphasize cross-system collaboration, strengths-based consensus building, and the centering of youth and family voice in care planning. The next step is to comprehensively define what these services should be and establish a full-service continuum in every county or region of the state.

The comprehensive continuum of services described below reflects a minimum array of behavioral health services and programs for youth who are involved in or at risk of involvement in the child welfare system. This service continuum must be available statewide, with a full complement of services available for each population of 500,000 to 750,000 and scaling up as needed for larger geographies and denser urban settings. To achieve cost-effective implementation and address the challenges faced by smaller or more rural counties, this service continuum can be built on a county-by-county or regional basis. For example, large geographic regions like Northern California or San Bernardino County might have three integrated continuums to meet the needs of their widely-distributed residents. In Los Angeles County, a full continuum of services would be made available for each Service Planning Area. Depending upon the jurisdiction and its landscape of services, the same provider or different providers could hold responsibility for implementation, while maintaining fidelity to specific service models to guarantee parity and ensure that service access is no longer determined by a child's zip code.

The county and regional arrays of mental health and substance use treatment services should always be guided by ongoing feedback from youth, parents and families impacted by the child welfare system. They should include robust in-community services—consistent with federal Medicaid EPSDT requirements—that seek to safely maintain each youth in their family of origin or other permanent family home when it is not safe for them to live in their home of origin. As a matter of equity, behavioral health interventions and service types, especially those included in the crisis continuum, must seek to avoid unnecessary contact between youth in psychiatric distress and law enforcement. Additionally, children and youth must have access to the therapeutic services they need to heal and thrive without having to move homes or placements whenever possible. For example, TFC and ISFC can be provided in the home of an existing caregiver who receives additional training and support to meet the needs of a child who requires this level of support. Likewise, while the TFC and ISFC rates may be time-limited, efforts should be made to maintain children in the same home even after these rates are no longer needed. Finally, it is critical that the specific services and desired outcomes for each youth and family be determined by their Child and Family Team.

Following are descriptions of the services, supports, and program types that should be included in the comprehensive continuum of care for children and youth in each county or region:

Prevention and Early Intervention

- **Universal Access to Childcare/Preschool, Early Childhood Screenings, Home Visiting, and**

Caregiver Supports: Increased access to trauma-informed universal preschool, full-day kindergarten, and early learning and childcare programs will enhance school readiness and success for all children and help to identify the early indicators of childhood trauma or family instability. Expanded access to home visiting and trauma-informed developmental screenings will promote health and wellness for the 0-5 population and provide in-home,full-family supports for multi-stressed parents and families. This should include the expansion of the CalWORKS and California Department of Public Health Home Visiting Programs to support new mothers, reduce health disparities, and promote early intervention and care coordination for families at risk of system involvement.

- **Therapeutic Preschools:** Therapeutic preschools are necessary to support young children with experiences of trauma or loss to prepare for successful integration into mainstream school settings. Therapeutic preschools can offer medication support services, trauma-informed individual and family therapy, individual rehabilitation, case management, assessment, crisis stabilization, and safety planning.
- **Prevention and Early Intervention in Schools (K-12):** In a trauma-informed, comprehensive continuum of services, all schools should offer a multi-tiered system of interventions that identify struggling families and provide effective service linkages to divert them from child welfare involvement, including close collaboration between schools and local county behavioral health partners. Prevention and early intervention in schools depends on building a strong school climate and culture, defined by universal social emotional/trauma screenings of students, data driven identification and referral streams, and coordination of multi-tiered interventions that identify students and families before more intensive intervention, or child welfare involvement, is required. Because 20% of child protective services (CPS) referral calls come from teachers and more than 80% of substantiated CPS reports result from general neglect, schools must be transformed into hubs for integrated and non-punitive early intervention. Teachers must be equipped to make referrals to integrated family support services, including but not limited to case management and Wraparound. Prevention in schools must also be designed to support older child welfare-involved children at the earliest onset of mental health challenges to promote youth resiliency and placementstability.
- **Drop-In Centers:** Integrated drop-in centers, which provide mental health and wellness services for individuals between 12-25 years of age and their parents and families, are key community resources to identify youth needs and provide services or coordinate service linkages. These programs are equipped to meet the behavioral health needs of youth and provide social service case management, including housing, education, and employment support.
- **24/7 Family Urgent Response System:** FURS is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely phone-based response and local in-home, in-person mobile response to situations of youth and family instability (broadly defined to include prevention of a mental health crisis). FURS is designed to preserve the relationship between caregiver and child or youth, provide developmentally-informed conflict management and resolution skills, stabilize the living situation, mitigate the distress of the caregiver or child/youth, connect the caregiver and child or youth to the existing array of local services, and promote a healthy and healing environment for each child, youth, andfamily.
- **Strengths-Building and Other Nontraditional Therapeutic Supports:** Children and youth who have experienced trauma can benefit from, and often express a strong desire for, nontraditional behavioral health supports that promote social and emotional well-being and resilience. Examples include mindfulness, movement, and music programs; certified peer partners, peer supports and mentoring services; extracurricular activities to help manage stress and build self-confidence; and equine therapy. Family Resource Centers are one critical access point through which youth, parents and families can connect to traditional and nontraditional therapeutic

supports. These services are a critical component of a universal service array and most successfully provided by individuals with lived experience as behavioral health consumers, such as peer counselors. MHSA and child welfare dollars should be leveraged at the local level to furnish these supports, and Medicaid waivers should be explored to secure additional funding to implement robust nontraditional therapeutic support services. Current examples ofstrengths-based family support include the California Parent and Youth Helpline and Parents Anonymous® Online Evidence-Based Support Groups, where parents can access emotional support, advice, and crisis de-escalation via phone, text, or live chat hotlines.

Community-Based Supports

- **Family System Therapies to Support and Expedite Reunification:** Whenever possible, family system therapies that can support the reunification of caregivers and children must be readily available. Culturally and linguistically responsive family system interventions should be tailored to the meet the needs of unique and diverse communities and families. Examples of these interventions include, but are not limited to, Parent-Child Interaction Therapy, Strengthening Families, and Parent Cafés.
- **Outpatient and Intensive Outpatient Services:** For children, parents and families involved with or at risk of involvement with the child welfare system, permanency-oriented, trauma-informed, and culturally relevant outpatient services must be available at times and locations accessible to each child and their natural supports. Outpatient services must be individualized, high-quality, and permanency-focused, with the ability to address the family crisis that led to a child's removal. Services should include high-quality, research-informed promising practices and/or evidence-based practices, including individual, family and group therapies, medication support services, and integration with community-based, permanency-focused services such as Wraparound. Outpatient services should also be equipped to support youth with co-occurring substance use and mental health needs. Substance Use Disorder services (SUDS) must be designed to meet the needs of youth and not just replicate adult treatment models. Critical service elements of developmentally-appropriate SUDS include, but are not limited to: ensuring the physical accessibility of services; leveraging the use of telehealth; investing in nontraditional clinical modalities; and building culturally-relevant, peer support models.
- **Intensive Home- and Community-Based Services**: Youth and families may at times require intensive and individualized interventions that promote stability and reduce the risk of out-of- home placement or placement disruption. This suite of services includes the Medi-Cal funded interventions of Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Behavioral Services (TBS). These Medi-Cal services reflect the principles and concepts of Wraparound and are often embedded within Wraparound programs supported by state and federal child welfare funding. Some counties utilize MHSA funding to deliver Wraparound-like services, known as Full Service Partnerships. Regardless of the funding stream or specific terminology used, the key principles of intensive home- and community-based services require that these services be driven by the Child and Family Team (CFT) through a process of collaborative assessment, treatment planning, and action steps to achieve client-identified goals. Depending on the service type, these supports are provided by a treatment team that ideally includes a master's-level clinician, bachelor's-level support counselor, and family partner with lived experience caring for a youth involved in the child welfare, mental health, and/or juvenile probation systems. There is a significant need for increased standardization of intensive home- and community-based practice standards across the state, since there is a high degree of

variability in both definition and practice across these service types. Moreover, Wraparound-based models of services and supports must be made available prior to involvement in the child welfare system, with referral pathways for teachers, natural supports, pediatricians, and others involved in the lives of families and children.

Tiered Therapeutic Placement Options

- **Therapeutic Foster Care**: TFC is a home-based treatment option established through the Katie A. lawsuit as an EPSDT entitlement for foster youth with behavioral health needs. In this model, specialized foster parents are provided with advanced clinical and technical training and support to best serve youth placed in their homes. TFC caregivers bill SMHS directly, and services are guided by each youth's individual treatment plan. TFC services are part of the EPSDT SMHS array of more intensive, non-institutional interventions.
- **Intensive Services Foster Care:** ISFC homes offer family-based stabilization for youth with behavioral health needs who require a higher level of care or supervision. Intensive family finding and engagement work is critical to ensure step-down to a permanent family home if the child or youth is unable to remain in the home once the ISFC rate is no longer available. ISFC parents are specially trained and supported to stabilize and nurture children in a home setting with fully integrated behavioral health supports (which can also be paired with TFC). As part of the universal service array, ISFC homes will achieve the strongest outcomes for placed youth when the setting is integrated with supportive front- and back-end models like MRT and Wraparound.
- **Enhanced ISFC:** Enhanced ISFC homes are built on the same tenets of trauma-informed, permanency-focused behavioral health care but are staffed by caregivers with training that exceeds that of a traditional resource family. The primary distinction between ISFC and Enhanced ISFC is the presence of at least one caregiver who does not work outside the home and is available to support the youth full time. As with ISFC, Enhanced ISFC homes can be supplemented with short-term TFC as needed.
- **Short-Term Residential Therapeutic Programs:** STRTPs are a short-term treatment intervention for dependent youth, offering an integrated program of high-quality therapeutic interventions and 24-hour supervision on a time-limited basis for youth with the most complex and profound service needs. STRTPs are designed to stabilize youth in care for up to 6 months (and in unique cases, can accommodate lengths of stay beyond 6 months). The goal of STRTPs is to support youth to step down into a less restrictive care setting. While the transition to STRTPs as part of Continuum of Care Reform is still underway (and may continue to evolve as a result of FFPSA implementation), these programs are an important component of a comprehensive service continuum for high-needs youth and their families.
- **Enhanced ISFC with STRTP-Level Staffing:** An additional, innovative tiered option is the provision of co-located multiple Enhanced ISFC homes on a single "campus," which can function as a supportive hospital alternative model for youth in out-of-home care who present with the highest acuity behavioral health needs. The campus-based Enhanced ISFC model allows for the provision of 24/7 staffing support in the home utilizing STRTP-level staffing models. This allows for a "neighborhood" of ISFC homes, offering a supportive, pro-social, therapeutic community for youth who require intensive and individualized care.

Crisis Services

- **Mobile Response Team (MRT):** MRT is a key front- and back-end service option across the universal service array, providing 24/7 school-, community- and home-based crisis response services to youth and families. MRTs help prevent placement disruption and unnecessary entries into more acute settings, while also supporting step-down from those settings (e.g. Crisis Stabilization Unit, Psychiatric Health Facility, longer-term treatment programs, and other high-end placement settings). In this model, a team (consisting of two highly trained bachelor's-level staff, master's-level staff, or a combination of the two) responds in-person to the youth and family in crisis within one to two hours, depending on the geographic range served. MRTs have the capacity to provide several hours of crisis intervention in the moment, followed by one or more sessions to ensure youth and family stabilization over a period of up to 30 days.
- **Family Urgent Response System:** FURS will provide 24/7 trauma-informed support to children and youth currently or formerly in foster care and their caregivers in situations of instability that include, but are not limited to, mental health crises. FURS is designed to prevent placement moves; preserve the relationship between the child or youth and their caregiver; provide a trauma-informed alternative for families who previously resorted to calling 911 or law enforcement; reduce hospitalizations, law enforcement contacts, and placement in out-of-home facilities; promote healing as a family; improve retention of current foster caregivers; and promote stability for youth in foster care, including youth in extended foster care. It consists of (1) a statewide hotline available 24/7, staffed by caring counselors trained in conflict resolution and de-escalation techniques for children, youth, and families impacted by trauma, and (2) county or regional mobile response systems with mobile response and stabilization teams available 24/7 to provide in-person de-escalation, stabilization, conflict resolution, and support services when needed.
- **Crisis Stabilization Units:** CSUs provide a 23-hour receiving center for youth who are experiencing high levels of distress. CSUs offer a safe setting for a youth to stabilize, engage in safety planning, link to services and discharge back into their community. Alternatively, CSUs can facilitate a seamless transfer of a youth in distress to a higher level of inpatient care, including a PHF, or hospital alternative such as an STRTP or Children's Crisis Residential Program (CCRP). The CSU includes parents, families, county social workers, and each child's natural supports in the assessment and planning process, recognizing the importance of families in the sustainability of child or youth stabilization.
- **Partial Hospitalization Programs:** Partial Hospitalization programs provide day treatment for youth with mental health or substance use disorder treatment needs who require higher acuity care than traditional outpatient or intensive outpatient services, but who do not require psychiatric hospitalization. Partial hospitalization programs are designed to prevent hospitalization and can also provide transition planning, individual and family therapy, and care coordination services for a youth discharging from an inpatient service setting.
- **Crisis-Focused Short-Term Residential Therapeutic Programs:** As an innovative enhancement to traditional STRTP programs, crisis-oriented STRTPs can represent a short-term hospital alternative setting for youth who require a longer period of stabilization than what is available in a CSU but who do not meet medical necessity for inpatient treatment at a PHF. Traditional STRTPs support court-dependent youth in achieving stabilization for up to six months, though crisis stabilization oriented STRTPs may serve youth for an average of 10-15 days. This setting leverages a multidisciplinary team to work collaboratively with the youth, their caregivers, and community supports to create a sustainable plan for the youth's return home. Structured treatment includes psychiatric care, case management, family finding and engagement, and

individual and family therapy. STRTPs assist youth in their permanency planning or in transitioning to their next form of home-based care, while connecting them to additional supports such as Wraparound, Mobile Response Teams, or Therapeutic Behavioral Services.

- **Children's Crisis Residential Programs:** Children's Crisis Residential Programs, established by AB 501 (Ridley-Thomas), offer a short-term, residential therapeutic alternative to hospitalization for youth in crisis. This tier of service is designed to serve youth who are stepping down from the CSU and do not require treatment in a PHF, but who do require additional intervention prior to transition home with the support of MRT or Wraparound. Treatment includes psychiatric care, case management, family finding and engagement, and individual and family therapy.
- **Psychiatric Health Facilities:** Psychiatric Health Facilities (PHFs) provide stabilization for youth who could not otherwise be safe in a lower level of care, in a secure therapeutic and developmentally appropriate setting for up to 14 days. PHFs provide youth/adolescents with hospital-level stabilization, integrated assessment, and planning services for young people in acute distress. During their time in the program, youth and families receive individualized treatment, psychiatric care, and linkages to community-based supports to ensure ongoing care and treatment for successful discharge. PHFs are designed to support each youth to step down to a lower level of care.
- **Residential/Inpatient Substance Use Disorder Services:** In addition to the SUDS treatment services mentioned above (e.g. outpatient, intensive outpatient or partial hospitalization), the continuum must include standalone service settings that provide SUD services at the American Society of Addiction Medicine (ASAM) Levels 3 to 4. These high-end, residential service options include: Residential Inpatient Services (3); Clinically Managed Low Intensity Residential Services (3.1); Clinically Managed Medium-Intensity Residential Services (3.5); Medically-Monitored High-Intensity Inpatient Services (3.7); and Medically Managed Intensive Inpatient Services (4). ASAM Levels 3 to 4 encompass residential services that can support youth diagnosed with Substance Use Disorder or co-occurring substance use and mental health disorders in developmentally appropriate care settings. ASAM 3 to 4 care levels can provide up to 24-hour care and are staffed by addiction treatment professionals, mental health professionals, and general medical personnel.

Aftercare Services

- **Stabilizing Services Upon Exiting to Adulthood or Returning to Family of Origin:** Treatment gains achieved during out-of-home placement must be maintained with community-based services when youth return to their family of origin or another permanent family, or exit dependency care into adulthood. For youth under 18 who are returning to their homes and communities, care management to ensure provider continuity is necessary to stabilize a child and their family system following separation. For youth who turn 18 while in care, THP-Plus and THP-NMD are critical programs to support the transition to early adulthood by offering comprehensive housing, parenting, health, and educational supports for youth up to age 24. Behavioral health outcomes of youth exiting child welfare custody who are enrolled in THP-Plus and/or THP-NMD are significantly better than those of youth who are not enrolled in extended foster care. THP-NMD and THP-Plus are critical components of a universal service array for child welfare-involved youth who are entering adulthood.

As we build out a full continuum of necessary services, we must acknowledge that there is not a sufficient SUD system of care for youth in California. It is critical that the EPSDT benefit be utilized to develop and ensure access to both SMHS and SUDS. Any barriers to a child or youth accessing the full array of services to meet the EPSDT entitlement must be addressed through this process of integrating

services in one system. Specifically, we recommend that substance use treatment should be formally integrated into the EPSDT benefit and new resources should be provided by the State for the non-federal share of the expenses.

Behavioral Health System Accountability and Performance Improvement

The work to improve access to services and develop a statewide standard of care for child welfare-involved youth must be supported by a strong, State-led data and reporting infrastructure and information management system to build county capacity to measure what matters and guide continuous performance improvement. In addition to federal accountability measures such as the External Quality Review Annual Process that oversees data collection from Medi-Cal Managed Care plans, California has made *significant* progress in recent years to develop more robust data reporting capacity across delivery systems, including the initial scaffolding for an outcomes data collection system based on tools such as the CANS and PSC-35. These existing systems, however, are underutilized, under-resourced, and limited in their scope. More fundamentally, while there is some agreement across the state regarding what kinds of behavioral health outcomes are important for children involved with or at risk of becoming involved with the child welfare system, those outcomes have not been operationalized in any formal way, and there continues to be a significant gap in establishing standardized, measurable outcomes that are directly related to behavioral health interventions.

As the system- and service-level access and quality reforms outlined in previous sections are enacted, there must be a corresponding, committed focus on developing more effective and reliable reporting mechanisms to reflect how youth and families are doing across service systems, whether or not services are working, and whether service systems are achieving intended outcomes. This will require a significant financial investment by the State. There are multiple systems charged with improving the behavioral health outcomes of a child welfare-involved youth, and these systems, including but not limited to education, special education, juvenile probation, child welfare, Regional Centers, immigration, county mental health plans, and Managed Care Organizations, routinely have divergent data and outcome reporting requirements. We must be able to routinely measure, assess, share, and discuss system performance data at every level of the behavioral health system that serves child welfare-involved youth, in collaboration with all key stakeholders.

Any comprehensive set of outcomes that will pursue and achieve lasting equity across service system performance must be disaggregated across categories of race and ethnicity of the populations served. The behavioral health care system and its stakeholders must define, and operate toward, performance outcomes that make progress toward dismantling the racism and inequity that pervade our care system and deleteriously impact many of the youth and families we serve.

A) Identify a clear and simple set of core statewide goals, with corresponding outcomes for youth, parents and families involved in or at risk of becoming involved in the child welfare system

By establishing co-created goals alongside outcomes and corresponding metrics, California public systems will be able to shift accountability infrastructures toward outcome-based measurements of success, rather than primarily fiscal accountability. Statewide goals clearly define our aim and purpose, while quantifiable outcomes ensure we are measuring the results of our efforts. This includes distinguishing and differentiating outcomes we wish to see for youth, parents, and families, as well as

for the system overall, and those we can measure and use for performance and quality improvement. Implemented alongside the enhanced statewide standards of care described above, these can be used to improve and ensure adequate service access, intensity, duration, and scope.

Outcomes should be collaboratively identified by key stakeholders, including youth, parents, and families. Ideal outcome metrics should be useful to stakeholders, from policy makers, to mental health authorities, to providers, advocates, and families in assessing the performance of the mental health system and the social and emotional well-being of children and youth. These outcomes should build upon—though not be limited to—the outcomes already codified in statute by the Mental Health Services Act, including reduced rates of suicide and attempted suicide, incarceration, school dropout or failure, unemployment, prolonged suffering, homelessness, removal of children from their homes, and involuntary psychiatric hospitalization.

B) Develop and enhance the infrastructure necessary to collect, synthesize and monitor outcome data

A system committed to performance and outcomes-based accountability requires mechanisms for measurement, information management, and data transparency. While California does have some infrastructure in place for data collection and reporting, significant work remains. This is an opportunity to develop a set of foster care mental health data, and we must begin with what youth, parents and families need (the set of statewide goals and outcomes as described above), identifying what data measures those outcomes, and an assessment of which data sources currently exist and where we must fill in the gaps.

California's current data collection capacity is primarily limited to service data and built around the EQRO and Performance Outcomes System for Medicaid healthcare services. In recent years, there has been a push toward collecting assessment data (via the CANS) for youth who are involved in the child welfare, juvenile justice, or behavioral health systems. However, there are significant problems with collecting, reporting, assessing, communicating, and utilizing currently available behavioral health system data, especially as it relates to children served by multiple systems and not solely Specialty Mental Health Services. For example, the data that is reported to DHCS by mental health plans is different from the data made publicly available by DHCS. Further, 90% of Medi-Cal child beneficiaries in California are served by Managed Care Plans, approximately 44% of children with child welfare involvement are served by Managed Care Plans, and 56% are served by fee-for-service Medi-Cal. However, the data available on the behavioral health outcomes of MCO enrolled child beneficiaries is not consistently reported to DHCS; nor does it disaggregate data on foster or probation youth, making population specific outcomes impossible to track. For child welfare-involved youth served by fee-for-service Medi-Cal, data is not available for services rendered outside of Specialty Mental Health Services. Data currently available does not reflect services funded with Mental Health Services Act dollars for child welfare-involved youth or youth at risk of system involvement.

In addition to simply building the data collection and reporting infrastructure, achieving data transparency must mean broad access to useable data for all stakeholders, including the consumer. Advocacy groups nationwide have led the effort to develop "report cards" for behavioral health system and service performance indicators, which enable parents and families to exercise agency in reviewing and evaluating the quality of care available. Currently, interested individuals must spend an outsized amount of time interpreting data and presenting it in ways that are meaningful for different stakeholders. Enhancing the usability of available data must be funded by the State and performed by neutral third parties (e.g. universities or non-profits).

A renewed investment in data sharing agreements is an essential ingredient in the pursuit of a robust data collection and reporting infrastructure, as well as interoperable systems that work in conjunction to meet the needs of youth, parents, and families. Without strong working partnerships between multiple systems serving the same child, there is a risk of dissolution of responsibility, inefficient care coordination, and avoidable service delays. Cross-system data sharing agreements at the state- and county-levels are necessary to effectively coordinate services for multi-system-involved youth and understand and manage the broader system of care needed to treat young people. Any construction of data sharing agreements must build upon a foundation of client privacy and confidentiality and ensure that information sharing across systems protects the rights of youth and families and does not stigmatize them.

State- and local-level data sharing agreements must be developed to facilitate stronger individual and population-level performance and outcome management. As noted above, efforts must be made at the state level to illuminate the inadequacies and strengths of current available data, including Performance Outcomes System quarterly reports and CANS data, and to define processes for legal and streamlined data sharing.

C) Develop and mandate a robust quality improvement process for children's behavioral health statewide

Following the model of other California public systems to embrace rigorous, continuous quality improvement (CQI), there must be a statewide outcomes and accountability process for behavioral health services available to child welfare impacted youth. Today, decisions about service provision are often driven by fears of fiscal audits and fiscal compliance, rather than youth and family outcomes or a well-supported process of continuous improvement. The CalWORKS Continuous Quality Improvement Model should be considered as one possible replicable option to support the development, evaluation, and refinement of outcome-capturing policies and programs. The implementation of this model, or any statewide commitment to CQI, would reflect a shift from a compliance-based review system to a performance- and outcomes-based review system. The implementation of any CQI model will require state-level, and not solely county-by-county, investment and leadership.

A CQI framework should consist of four core components: established performance indicators; local county-level self-assessment; corresponding system improvement plans; and the continuous evaluation of results against the established performance indicators. CQI assessment and review processes traditionally take place over set cycles—for example three-year cycles—and involve collaboration with all relevant stakeholders in the self-assessment and self-improvement planning processes.

The CalWORKS CQI model represents a strong option for consideration given its legislative codification, stakeholder process, and most importantly, strong state agency leadership and investment to ensure sustainability and impact. Beginning in 2017, California statute required CDSS to convene a stakeholder work group to develop the CalWORKS Outcomes and Accountability Review (Cal-OAR) to support individual counties to assess the baseline of CalWORKS program effectiveness, identify areas for improvement, and facilitate opportunities to share solutions and best practices (WIC §5880). The CQI process follows a three-year cycle and consists of a County Self-Assessment (Cal-CSA), a County System-Improvement Plan (Cal-SIP), and completion of annual County Cal-SIP progress reports. The process and performance measures, identified by the Cal-OAR workgroup in accordance with CalWORKs goals, provide baseline and ongoing data to drive and inform each county's CQI process. Most notably, throughout the process, CDSS provides technical assistance through webinars, Cal-OAR forums, in-

person regional trainings, and one-to-one coaching and support. Beginning in fiscal year 2019-20, up to two million dollars was allocated from the General Fund to counties to complete the requirements of Cal-OAR.

An alternative outcomes-based accountability framework could be a statewide commitment to the consistent use of the Transformational Collaborative Outcomes Management suite of tools to provide meaningful data for stakeholders and support the success of any true CQI process. The TCOM tools developed by the Praed foundation can be used in behavioral health as an integrated approach to address the needs and strengths of youth and families based on comprehensive, actionable assessment data. TCOM operates from the understanding that in complex care systems, different entities approach decision-making with potentially divergent desired outcomes. The use of TCOM tools, especially the CANS, will support CQI processes wherein stakeholders continuously come together in a structured fashion to engage with specific questions, define measurement and monitoring processes, and continue to revisit and experiment with interventions while continuously course-correcting to improve care systems at every level. However, the same CANS modules are not used consistently across child-serving systems or across child welfare systems in neighboring counties. The leveraging of CANS data to uphold a successful CQI process would require an initial process of consensus building regarding which modules to consider, what scoring benchmarks would reflect significance, and the creation of a cross-system information management database to support meaningful engagement with CANS data that accurately reflects changes in child well-being. While the Behavioral Health Committee is in support of the construction of any meaningful statewide CQI process to measure youth and family outcomes and success, it posits that the use of the TCOM tools will serve to strengthen any adopted CQI process.

California spends billions of dollars annually on behavioral health care, yet our current data and accountability system does not adequately capture the efficacy of our investment. There continues to be a substantial disconnect between the amount of money spent on Medi-Cal behavioral health services that counties report in their Supplemental Cost Reports and the data available on services rendered that DHCS makes publicly available; the result is an incomplete data picture regarding how money is spent on EPSDT services. While there is consensus that the EPSDT service arrays available to child welfare-involved youth should not be designed based on punitive financial accountability, it is critical to note that a transparent and accountable behavioral health care system will be able to adequately and consistently track dollars spent.

A State agency with the capacity to advance a meaningful spending transparency and CQI process should be tasked with this responsibility by the legislature. Given the population focus on youth involved with or at risk of involvement with the child welfare system, as well as their existing investment in supporting county CQI efforts, it is recommended that this responsibility be held by CDSS, in partnership with DHCS, CDE and children's services stakeholders. This statewide CQI process must be supported with state resources to both incentivize county participation and to support meaningful data collection and analysis. A robust behavioral health CQI effort will support and incentivize performance improvement and outcomes-based innovation and capacity building across public systems, based on a clear and simple set of core outcomes for children's behavioral health

Strategies to Support the Successful Implementation of a Universal Array of Behavioral Health Services for Child Welfare-Involved Youth and Youth at Risk of Involvement

An accessible behavioral health care system for youth involved with or at risk of involvement with the child welfare system requires committed and ongoing cross-sector collaboration, the aggressive leveraging of funds at every level of government, and the implementation of creative service modalities to close the access gaps that keep some youth from receiving necessary care. It is critically important that stakeholders and advocates learn from historic trends that had led to insufficient and inequitable access and center youth and family voice in ongoing initiatives to reform the public-facing systems that support the behavioral health outcomes of child welfare-involved youth and youth at risk of involvement.

This committee recognizes that the recommendations included in this document will require a range of fiscal, statutory, regulatory and practice considerations and reforms. To name just one example, implementing the standardized universal array of behavioral health services described would likely require both changes in statute and robust fiscal investment at the local and state level. It is the intention of the committee to turn the group's future efforts toward developing operational guidance related to the fiscal, statutory, and regulatory changes necessary to achieve the reforms described in this document.

A) Leverage Family First Prevention Services Act (FFPSA) funds

Family First Prevention Services Act funds can and should be used to complete service gap analyses that identify county and/or regional gaps in available prevention services. FFPSA dollars must be leveraged so substance use treatment, in-home parent education, and mental health services are made available to caregivers and family systems. A holistic and sustainable set of services available to child welfare- involved children, parents and families, and those at risk of child welfare involvement, *must* frontload prevention care that is funded by FFPSA dollars. The opportunity presented by FFPSA funds to support the provision of prevention and intervention services for children *and* their parents and/or caregivers to avoid formal entry into the child welfare system is unprecedented. However, effective implementation of FFPSA-funded services cannot be operationalized as a county opt-in opportunity: the process will require real state level investment and leadership for local child-serving systems to see substantial benefits from FFPSA-funded interventions.

It will be imperative for state agencies to jointly offer guidance to counties on how to utilize funds for provisions outlined under FFPSA. Under FFPSA, Title IV-E is the payer of last resort and counties must utilize Medi-Cal prior to receiving Title IV-E funds. FFPSA related guidance should encourage partnership at the local level for county child welfare and behavioral health agencies to coordinate care for FFPSA target populations. The State should also issue guidance that sets forth the parameters to receive funds under FFPSA, including how components of a program/service could be reimbursed through Title IV-E.

While the intention of the FFPSA Prevention Services Clearinghouse is to ensure the quality and efficacy of interventions, the restriction of prevention funding to research-based and evidence-based practices unnecessarily excludes many of the types of peer-support models and nontraditional therapies outlined above in the prevention services section. State and federal advocacy is needed to initiate dialogue about

FFPSA Clearinghouse requirements and opportunities to expand and broaden allowable prevention services. Furthermore, operationalizing the prevention-based intent of this legislation in California should include a referral pathway wherein families can access Wraparound and/or Full-Service Partnership services that leverage FFPSA prevention funding through a behavioral health referral alone and without any formal contact with the child welfare system.

Finally, the Behavioral Health Committee is in full support of the recommendations outlined in the Child Welfare Council's Prevention and Early Intervention (PEI) Committee's "Family First Prevention Services Act Recommendations for California's Implementation," released in July 2020. The PEI Committee urges the State to allocate a minimum of 80% of Family First Transition Act funds to counties for the development of "Child and Family Well-Being System" plans. These plans will outline how all family-serving systems, especially those outside of county child welfare, will work in conjunction to provide a comprehensive array of prevention and early intervention supports for children, parents and families. The Behavioral Health Committee is in alignment with any proposal that will leverage all available federal funds to frontload services, supports, and intervention that successfully divert children and families from formal involvement with the child welfare system and support them to thrive over the long term.

B) Strengthen interagency collaboration and integration

Stakeholders, led by State agencies, must identify opportunities to blend and braid funding across systems at the local level to achieve a universal set of services for child welfare-involved youth, parents and families and those at risk of future involvement. It is imperative to build on the important work and momentum of AB 2083 (Ridley-Thomas), which requires each county to develop and implement a Memorandum of Understanding outlining the roles and responsibilities of the various local entities that serve children and youth involved with child welfare, or at risk of involvement, who have experienced severe trauma.

Interagency MOUs are a critical first step in coordinating the services of child-serving systems in a young person's life. While progress is being made, there still does not exist a comprehensive suite of services in the lives of most youth with severe trauma histories. More work must be done to clarify interagency responsibility and strengthen cross-sector partnerships to leverage all funding available to serve youth. This can be achieved by identifying fiscal and policy mechanisms to incentivize county child welfare agencies, mental health plans, probation departments, local education authorities, regional centers, and managed care organizations to participate and collaborate. Interagency MOUs should be written to secure the statewide, co-created outcomes for the behavioral health system, discussed in the following recommendations section, "Behavioral Health System Accountability and Performance Improvement."

C) Invest in enhancing the behavioral health workforce

Prior to the COVID-19 pandemic, California met just 30% of the statewide need for professionally trained behavioral healthcare workers. The severe economic impact of the COVID-19 crisis is twofold: while provider agencies are forced to tighten budgets and lay off frontline staff, more children and families, impacted by rising unemployment and requiring behavioral healthcare, are enrolling in Medi-Cal.

It is more imperative than ever to address the structural obstacles that contribute to the behavioral health workforce shortage in California. Opportunities to strengthen the pipeline to fill workforce shortages include: pilot BSW programs on all UC and CSU campuses to attract undergraduates to a

streamlined, professional degree program; augmented financial resources for UC/CSU BSW/MSW programs to achieve better socioeconomic and cultural diversity among the population seeking licensure; and expanded eligible Title IV-E job placements so MSW graduates can fill a diverse array of stipend-supported child-serving roles. Finally, the role the Community College system can play in training non-licensed staff, peer and parent partners should be strengthened significantly.

The shortage in behavioral health care providers can also be addressed by investing in initiatives to fund non-licensed mental health provider roles that operate in evidence-based modalities and are Medi-Cal reimbursable. One recent example is the enactment of SB 803 (Beall) to establish the Peer Support Specialist Certification, which directs DHCS to seek necessary changes to the Medi-Cal State Plan to establish the work of Peer Support Specialists as a distinct, reimbursable service type. Other non-licensed provider roles, including but not limited to Community Health Workers and Promotorxs, are necessary to strengthen the workforce and connect historically disconnected populations to culturally relevant behavioral health care.

Paying adequate wages to clinicians and non-licensed providers is also critical. Focusing on reimbursement policies at the state- and local-level would provide important information to legislators and stakeholders. Investigating how the scope, duration, and intensity of services, unit costs of care, and payment methods and systems align with system goals and priorities offers important opportunities for building and maintaining an adequate and competent mental health workforce that can maintain long-term relationships with the youth, parents and families they serve.

D) Enhance internet connectivity for youth and caregivers

COVID-19 has illustrated the vast disparities in internet connectivity for foster youth and caregivers. A readily available pool of technology resources (e.g. cell phones, laptops, and tablets) should be compiled at the state level, so child welfare-involved youth and those at risk of involvement have ready access to the technology required to engage in telehealth behavioral health services. Furthermore, this technology must be made available to a child's biological family, resource family, and educational providers, so foster youth can stay connected to their natural supports across placement changes or during periods of social disconnection. The iFoster program model is invaluable in providing foster youth with cell phones to stay connected to their natural supports and advocates, and there should be augmented and ongoing funding dedicated to the provision of this resource.

E) Youth and stakeholder input

The voices of current and former foster youth must be included at every level of decision making that impacts the provision of, and access to, behavioral healthcare. Youth, parents and caregivers with lived experience navigating the child welfare and public behavioral health systems should be consistently involved in the processes of program design, service implementation, and definition of service outcomes. Without effective and sustained stakeholder input, an equitable behavioral health system will remain out of reach.

California's public-facing, child-serving systems have historically excluded or under-included substantive input from consumers, especially children and families from low-income communities and communities of color. This must change by ensuring all community beneficiaries take direct control of new service system planning processes, as well as the design of processes for continuous improvement. The Mental

Health Student Services Act Listening Sessions are a successful and replicable example of continuous consumer engagement and input to inform program design and outcomes.