MENTAL HEALTH CARE FOR YOUNG PEOPLE IN FOSTER CARE

Monthly Policy Webinar Series

Presented by

ALLIANCE *for* CHILDREN'S RIGHTS

Speakers

- **Dr. Robert Byrd**
  County of Los Angeles, Department of Mental Health
- **Dr. Kaliah Salas**
  County of Los Angeles, Department of Mental Health
- **Brian Blalock**
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- **Kevin Jervik**
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Logistics

- Webinar will be recorded and archived at http://kids-alliance.org/webinars/
- All attendees will be on mute – type any questions you have into the chat box or if you experience technical difficulties email Martha Dietzel at m.dietzel@kids-alliance.org
- A certificate of participation will be posted online after the webinar at http://kids-alliance.org/webinars/
- We will be answering your questions – please submit questions using the “chat” function on your GotoWebinar dashboard

QUALITY AND COMPREHENSIVE MENTAL HEALTH CARE FOR CHILDREN AND YOUTH IN FOSTER CARE

Dr. Robert Byrd & Dr. Kaliah Salas
County of Los Angeles, Department of Mental Health

CONTINUUM OF CARE REFORM

Principles Of Continuum of Care Reform

- All children deserve to live with a committed, nurturing and permanent family that will prepare them for a successful transition into adulthood.
- The child and family voice is important in assessment, placement and service planning. Child and Family Team (CFT) meetings will be the foundation for ensuring these perspectives are incorporated through the duration of the case.
- Children should not have to change placements to get the services and supports they need. CCR ensures that children and youth receive mental health services to meet their treatment needs regardless of the placement setting;
- Universal assessment process to identify the needed services and supports;
- Agencies serving children and youth (i.e. DCFS, Probation, DMH, School, and other community service providers) need to collaborate to effectively provide the family with necessary services and supports to eliminate the family's need to navigate multiple systems.
- The goal for children in foster care is normalcy in development while establishing permanent life-long family relationships.

Continuum of Care Reform - Key Assumptions

- Child Welfare foster children in group home care will transition to alternative placements over 24 months
- LA County DCFS and DMH are working together to identify the youth who can be transitions from lower RCL group homes into appropriate placements (e.g., ITFC, Foster Home with intensive mental health services, family based setting, etc.), as well as the services and supports the youth will to be successful in the placement.
- Countywide workforce development and training on CCR Implementation, Trauma Informed Care, Core Practice Model and Child and Family Teaming.
- All STRTP cases will require a placement review at intervals no greater than six months and require county deputy director approval for placements exceeding six months.
- For probation: requires placement review at intervals no greater than 6 months and requires county deputy director approval for placements exceeding 12 months

Legislative Initiatives

- Rates
- Resource Family Approvals
- Interagency Placement Committee
- Expansion of Core Practice Model and Child and Family Teaming
- Outcomes and Performance Oversight

Shared Responsibility and Accountability

- Culture Shift – Changing our assumptions that probation / child welfare can do this alone and building the success of CCR through inter-departmental collaboration.
- DCFS, DMH and Probation partnership to jointly contribute to achieving the following visionary goals:
  - **Safely preventing removals;**
  - **Placing with kin, if possible, or in homelike settings within community of origin; and**
  - **Supporting children and their caregivers (bio, kin, foster) appropriately to ensure that the first placement is the last placement.**

RATES – Phase One effective Jan 1, 2017

Leveling rate payments for all Resource Families, county foster family homes, Relatives (both Federal and non-Federal regardless of participation in Approved Relative Caregiver Program), Non-related Extended Family Members home, and Non-Minor Dependents in Supervised Independent Living Placements (SILPs)

GH Rate – Existing RCL Rate w/ approved extension

STRTP License yields higher rate with increased responsibilities and expectations to provide services to children and youth with exceptionally high needs, for intensive and short-term treatment.

Resource Family Approval(RFA) *RFA in LA*

- LA County has begun implementing the consolidated process for all foster parents, relatives, and adoptive parents to apply and be approved through one single process. This new process is called Resource Family Approval and will refer to all applicants as resource families;
- LA County has contracted with community organizations that will provide supportive services to relative caregivers as they transition to meet the standards of RFA;
- LA County is working to procure a public-facing website/case management system that will allows DCFS to track and monitor RFA approval process and also allows families to submit RFA documents to DCFS;

CCR and the effects on our Foster Family Agencies

- Implementation of RFA processes for all FFA recruited families;
- Must be contracted with Mental Health or ensure access to directly delivered EPSDT Mental Health services.
- Requires the development of new plans of operations, training, and program statements that reflect the changed practices of the FFA program.
- Must be nationally accredited.
- Must make available Core Services:
  - Specialty Mental Health Services
  - Transitional Services
  - Education, Physical, Behavioral, MH and Extracurricular Supports
  - Transition to Adulthood
  - Permanency Supports
  - Active efforts for ICWA eligible children

Intensive Services Foster Care & *NEW* TFC Specialty Mental Health Service (SMHS)

- **Foster Care rates no longer based on age but Level of Care**
  - Four Levels of Care based on support resource parent will need to provide to meet the child/youth's needs (e.g., educational, medical, mental health, etc.).
- **Child Welfare Level of Care: Intensive Services Foster Care ISFC**
  - *Replaces* Intensive Treatment Foster Care as of 1/01/2018
  - One rate $6003 with $2321 to ISFC Caregiver
  - Exact care & supervision requirements not yet released by State for this Level of Care
- **Child Welfare ISFC is the platform** upon which the new state mental health Therapeutic Foster Care Services Model can be added if all requirements are met.
- **Current LA County ITFC Contractors will continue** until a new solicitation can take place.

CCR and Groups Homes: Short-Term Residential Therapeutic Program (STRTP)

- Group Homes must develop a plan to transition from being a Group Home and develop a program to meet the licensing requirements of a Short-term Residential Therapeutic Program – STRTP, and must have an approved STRTP Program Statement.
- Group Homes or new facilities seeking to become a STRTP must meet the treatment level of children to provide “core services” including Mental Health services in order to assist the child’s transition back to home-based placement.
- Must be certified with Mental Health or have a Mental Health contract and directly deliver EPSDT Mental Health services.
- Requires the development of new plans of operations, training, and program statements that reflect the changed practices of the GH program.
- Must be nationally accredited.
- Must develop a plan to assist in stepping down youth to lowest level of care from the initial entry into the program.

Interagency Placement Committee

- The purpose of the IPC is to review and evaluate the needs of children and adolescents of Los Angeles County and make referrals for placement.
- The IPC consists of members of DMH, DCFS, Probation, and other interested parties (e.g., Regional Center, Education, Mental Health Service Providers) when appropriate and necessary.
- The IPC will screen all youth entering STRTPs, and youth being considered for entry into Intensive Services Foster Care.
- The IPC reviews all available information (mental health, child welfare, probation, education, etc.) to help determine if a youth is eligible for placement in an STRTP or ISFC.

Integrated Core Practice Model and Child and Family Teams (CFT)

- Katie A. and the Core Practice Model recognizes that a team approach to case planning and care delivery is critical to effectively care for all children and youth in foster care.
- The **New* **Integrated Core Practice Model** expands on the requirements of CPM and CFT decision-making.
- LA County's goal is to ensure that all children will receive a child and family team meeting. CFT is our approach to supporting strengths-needs practice, case planning, and provisions of individualized, intensive home-based mental health services.
- Placing agencies will utilize CFTs for all out-of-home placement case planning purposes and in an effort to continuously assess needs.
- The needs of the child will determine the duration/frequency of CFTs.

What this looks like…

CCR was loosely structured after the Res-Wrap 2004 / RBS model

- Infusing Wraparound-like services in residential treatment
- Ensuring full Continuum of Care across placement settings
- Following the youth into the community once youth is stable and able to transition into a community home environment with a resource parent or relative.

Reducing Re-entry rates

- In RBS, for children who successfully graduated, re-entry decreased to 10%.
- For the life of the pilot, which is now a little over 4 years the median time is 10.96 months.

What this looks like for LA County…

- DMH has provided extensive Technical Assistance (TA) to group home providers to help prepare them for the transition to STRTP
  - DCFS, DMH and Probation have had multiple meetings with the group home providers to support the culture shift expected with CCR, including taking youth with high needs
- Rolling out TA for FFAs to help prepare FFAs for providing and/or linking children and family to specialty mental health services
- DMH is working with the state, DCFS, Probation and providers to identify the training needs to develop our workforce for CCR implementation
  - Trauma Informed Care
  - Integrated Core Practice Model
  - Child and Family Teaming
  - Understanding the underlying needs of youths' behaviors and responding accordingly

What this looks like for LA County…

- Mental Health will be a member of the Child and Family Team (CFT)
- Client services and supports, including specialty mental health services and ISFC will be determined through the CFT
- Placement will also be determined by CFT, including what services and supports are needed to keep the client in the community and/or whether the client needs to be placed in an STRTP
- Recommendations for placement in an STRTP and for ISFC services will need to be presented at the Interagency Placement Committee
- Placement in STRTPs will be “short-term” during which the client will be able to receive the appropriate intensive services to stabilize the client to prepare for transition into the community
- When client needs to remain in the STRTP for a longer period of time, the decision will be made by the CFT and the placing agency will need to approve the extension every six months

What this looks like for LA County…

- DMH staff will be on-site at STRTPs on a regular basis and participating in CFT meetings
- DMH staff will be reviewing the STRTPs programs on an annual basis to ensure the STRTPs are meeting requirements established by the DMH contract and CCR legislation
- In addition to the intensive services provided while the youth are placed in the STRTP, CCR requires aftercare services to ensure continuity of care and clients have access to necessary services to increase the successful transition into the community
- CCR requires performance oversight and outcomes, and DMH will be requiring STRTPs and FFAs to complete outcomes once the measures are identified by the state

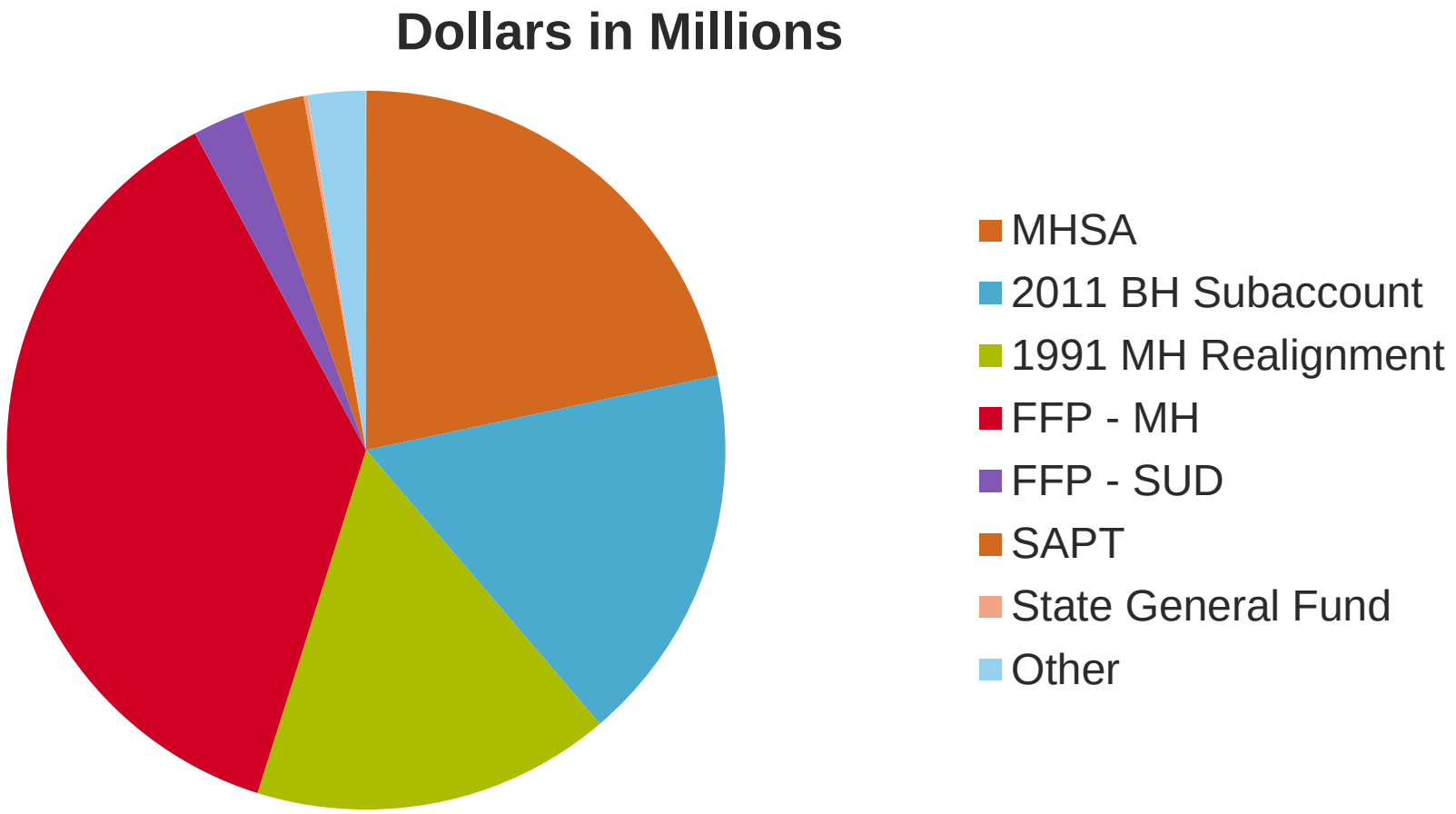
CCR AND MENTAL HEALTH – THE INTERSECTION OF LEGAL ENTITLEMENTS AND FUNDING STREAMS

Brian Blalock
Tipping Point Community

OVERVIEW: Funding for Mental Health Services

- Medi-Cal /EPSDT
- Mental Health Services Act (MHSA)
- SAMHSA and other grants
- General Fund
- Special Education / Prop 98
- Realignment(s)

Behavioral Healthcare Funding(2016-2017)



The Multiple Meanings of Medical Necessity

For a full outline of medical necessity criteria according to beneficiary demographic, see

- **9 CCR §1820.205** — Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services;
- **9 CCR §1830.205** — Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services; and
- **9 CCR §1830.210** — Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.

Medicaid/EPSDT – Who is eligible?

"Such other necessary health care, diagnostic services, treatment, and other measures … to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."

42 U.S.C. § 1396d(r)

OVERVIEW: EPSDT Specialty Mental Health Services Medical Necessity Criteria

- Eligible for MHP services if he or she meets all of the following:
  - Has an included diagnosis
  - The services are necessary “to correct or ameliorate defects and physical and mental illnesses”
  - The focus of the proposed treatment is to address the impairments
  - The condition would not be responsive to physical health care-based treatment

Lawsuits affecting the provision of EPSDT specialty mental health services in California:

- **TL v. Belshe, settled in 1995**
  - **resulted in California's implementation of expanded EPSDT mental health services not included in the state Medicaid plan for adults.**
- **Emily Q. v. Belshe, settled in 2001**
  - **created therapeutic behavioral services (TBS), an intensive EPSDT mental health service.**
- **Katie A. v. Bontà, settled in 2011**
  - **required statewide implementation of intensive, individualized mental health services. Initially targeted to children in foster care.**
  - **Clarification by State that these services should be available to all youth with Medicaid/EPSDT who meet the criteria.**

Mental health services menu

- Individual Therapy
- Group Therapy
- Family Therapy
- Case Management
- Psychiatric services including medication prescribing and monitoring
- Therapeutic Behavioral Services (TBS)
- Intensive Care Coordination and In Home Based Services
- Therapeutic Foster Care

Mental health services menu

- Wrap Around
- Evidence-Based Programs
  - Multi-Systemic Therapy
  - Multi-Dimensional Family Therapy
  - Motivational Interviewing
  - Cognitive Behavioral Therapy (CBT)

How does CCR Change Delivery of Mental Health Services for Foster Youth?

- STRTPs and FFAs must be able to demonstrate ability to deliver specialty mental health services as condition of licensure
- STRTPs and FFAs must be able to demonstrate that children in need of specialty mental health services are receiving them
- Counties are encouraged to engage in cross-agency discussions about anticipated placement needs and adequacy of services

CCR Relies on Access to Quality Mental Health Services

If the goal of Community Care Reform is to reduce unnecessary stays in congregate care and increase the numbers of youth in family like settings, there must be access to sufficient and appropriate high quality community based mental health services.

Alameda County

- ACCESS
- School-based behavioral health care
- Birth to five services
- Underserved ethnic language populations
- TBS
- Services to Probation
- Services to Child & Family Services
- Special Education
- Crisis Stabilization
- Psychiatric Hospitalization
- ICC and IHBS

Alameda County Behavioral Health Care Services

Alameda county programs developed for probation youth

- All programs developed in collaboration with Probation Department
- Probation involved in developing the programs from RFP to roll-out of services
- Programs for youth at risk of Probation Involvement
  - Sheriff Dept. Youth Services
  - Truancy Courts

Alameda County Behavioral Health Care Services

- Current programs for probation high needs/high risk youth
  - Wrap Around
  - Multi-Dimensional Family Therapy
  - Collaborative Court Intensive Case Management
  - Multi-Systemic Therapy
  - First three programs are Blended Funding programs

Keys to collaboration

- Ethos of these are collectively our youth
- Having resources helps
  - EPSDT Expansion
  - IV-E Waiver
- Understanding the mandates, rules, strengths and limitations of each other's agency
- Imbedding BHCS managers and staff in Probation
- Always be willing to help out when a partner agency reaches out to you
- Relationships, relationships, relationships
- Each agency/department gives something – not one-sided
- Face time
- Collaborative Projects
- Sharing Resources: trainings, conferences (Beyond the Bench)
- Return calls and email

Therapeutic Foster Care and the TPC Parent

- State Plan Amendment in 2016.
- Short term, intensive, highly coordinated, trauma informed, and individualized rehabilitative service
- Home based alternative to high level care in institutionalized setting
- Role of the TFC parent:
  - Key participant in treatment and client plan.
  - Plan development (limited to when it is part of the CFT)
  - Participation as a member in the CFT in care planning, monitoring, and review processes.
  - Observe, monitor, and alert the TFC Agency and members of the CFT about changes in the child's or youth's needs.

TFC Parent and Delivery of Services

- **Rehabilitation**: Implement in-home informed practices which include trauma-informed rehabilitative treatment strategies set forth in the child's or youth's client plan.
  - Examples skills-based interventions (including coaching and modeling); developing functional skills to improve self-care; and improving self-management in areas of anger management or self-esteem or peer relations;
- **Collateral**: helping support youth in achieving his or her client plan goals by reaching out to significant support person(s) and providing consultation and/or training for needed medical, vocational, or other services to assist in better utilization of SMHS by the child or youth.

Intensive Care Coordination (ICC)

- Available to **all children, youth, and young adults under the age of 21** who are eligible for full scope Medi-Cal, meet medical necessity for specialty mental health services, and who meet service criteria.

- Intensive form of care coordination that identifies ancillary supports and systems which assist with client stabilization delivered through the Child and Family Team (CFT), which requires active, integrated and collaborative participation by provider(s), family, and natural supports to ensure that the complex behavioral health needs of the client are being met.

Intensive Home Based Services (IHBS)

- Intensive Home Based Services are mental health rehabilitative services that are available to beneficiaries under 21 who are receiving ICC.

- IHBS are medically necessary individualized, strength-based interventions designed to improve mental health conditions that interfere with a child, youth, or young adult's functioning and are aimed at helping the client build skills necessary for successful functioning in the home and community

- Primarily delivered in the home, school or community and outside an office setting.

THERAPEUTIC APPROACHES AND COLLABORATION

Kevin Jervik, Ph.D.
Children's Law Center of California

CONTINUUM OF CARE REFORM

Primary Principle

- Permanency and stability are a fundamental right of all children, not a privilege to be earned
- Children with mental health challenges are less likely to be given permanency.
- Support is necessary for children and their caregivers to ensure that this right is granted

Think Different

Think Different

- Child-Centered vs Agency-Centered Systems
  - Agency-centered systems meet the needs of the bureaucracy
  - Child-centered systems meet the needs of children
- All agencies involved in meeting a child's needs have an obligation to that child
- Disagreements about funding, agencies of primary responsibility, etc. are not a child's problem and should not negatively impact delivering the services a child needs

Think Different

- Trauma-informed systems
  - Trauma-informed systems focus on what happened to a child, not what is wrong with a child
  - Trauma-informed systems understand the many ways in which trauma manifests itself in children
  - Trauma-informed systems prioritize safety and stability for children as requisite for healing

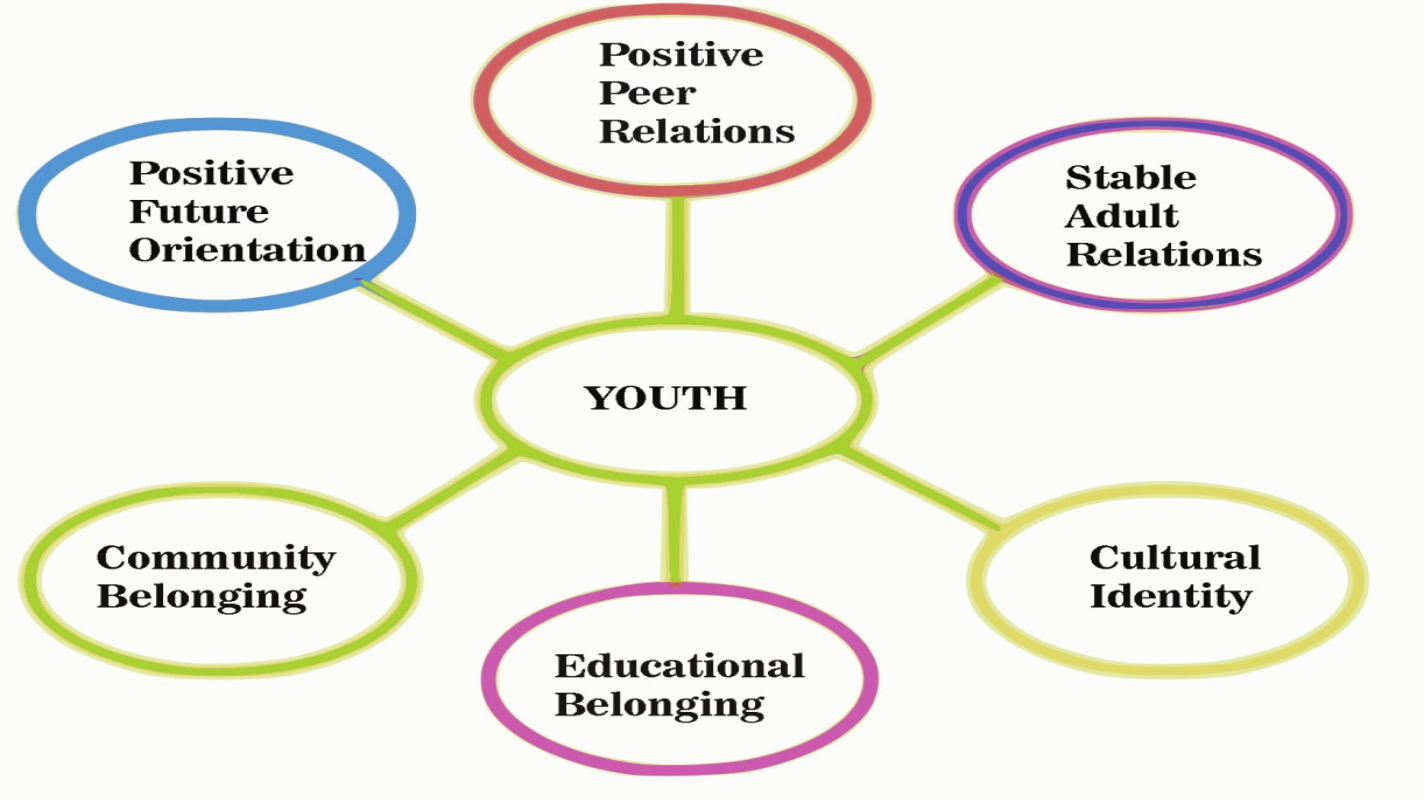
Think Different

- The need for mental health informed systems
  - Mental health literacy still remains at very low levels
  - Stigma and misinformation about mental health are extremely prevalent
  - Misinformation and stigma can lead to misguided decisions which impact a child's need for stability and permanency.

Think Different

- A mental-health informed system goes beyond mental health services to address the myriad factors which impact mental health
- In a mental health informed system, everyone involved with the child takes responsibility for supporting a child's progress toward greater psychological health

Implications



Implications

- Child and Family Team Meetings
  - Strength-based
  - Solution-focused
  - Child and family viewed as expert consultants on their own needs and best practices to fulfill those needs
  - True collaboration requires we talk with, not about, child and family.

Implications

- Short-Term Residential Placement
  - Treatment must have a sense of urgency
  - The discharge plan should be part of the admission process
  - Discharge planning goes beyond the treatment goals of the child
  - Question is not “Are they ready to leave?”
  - Question is “Why must they stay?”

Implications

- Realistic view of goals and progress
  - Treatment progress is not a strictly linear process but one in which progressions and setbacks co-exist.
  - Transitions and novelty are stressful for all children, but especially for those with mental health challenges
  - Under stress, we regress
  - Some return to previous and less functional coping strategies should be expected and prepared for, not viewed as proof the child needs to return to congregate care

Implications

WEATHER THE STORM

CCR and Mental Health

Risks

- More out of state placements
- More DJJ, camp/ranch placements for juvenile justice involved youth
- More unmet need
- More homelessness
- More push to other systems (juvenile justice, school districts, regional centers)
- Fragmentation of funding sources and contracting processes could be real barrier to service creation/delivery.

Opportunities

- More collaboration to build more comprehensive service delivery
- More community based mental health services
- More family based placements in the community
- Less unnecessary placements in congregate care or institutions

QUESTIONS?

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