

**RESPECTING THE NEEDS OF CHILDREN AND
YOUTH IN TEXAS FOSTER CARE:
ACKNOWLEDGING TRAUMA AND PROMOTING POSITIVE MENTAL
HEALTH THROUGHOUT THE SYSTEM**



**RECOMMENDATIONS OF THE
TEXAS CASA MENTAL HEALTH TASK FORCE**



TEXASCASA
Court Appointed Special Advocates
 **FOR CHILDREN**



**Hogg Foundation
for Mental Health**

ADVANCING RECOVERY AND WELLNESS IN TEXAS



Acknowledgements

This report was prepared by Stephanie LeBleu and Sarah Crockett, with generous support from Cristina Masters, Andy Homer, Elizabeth Krog and Jemila Lea. It would not have been possible without the input of the experts who served on the Texas CASA Mental Health Task Force and volunteered their time to think critically about how to improve the lives and experiences of children and youth in foster care in Texas. This endeavor was facilitated by Texas CASA under the leadership of its CEO, Vicki Spriggs.

This project was made possible through a generous grant from the Hogg Foundation for Mental Health at the University of Texas.



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ADVANCING RECOVERY AND WELLNESS IN TEXAS

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December 2014

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INTRODUCTION

This report summarizes the findings and recommendations of the Texas CASA Mental Health Task Force. Child welfare experts, stakeholders, advocates and former foster youth came together to address the variety of mental health issues facing children and youth in the child welfare system. Membership was comprised of physical and mental health care practitioners, judges, social workers, psychologists, attorneys and state agency personnel.

Texas CASA wanted to ensure that the urgent mental health needs of the children remained a constant focus of the Task Force's work. Therefore, the following vision was developed to guide their work and advocacy:

We envision a system of care that:

- Respects the needs of traumatized children and youth in substitute care;
- Places the utmost importance on ensuring they have access to the best mental health services and systems of support; and
- Provides them with a real opportunity to heal from their traumatic experiences and grow into successful adults.

Task Force members were charged with:

- Identifying problems facing children and youth in state custody in regards to their mental health;
- Developing actionable solutions (recommendations) that will improve the well-being of children and youth in foster care; and
- Advocating for those solutions.

This report represents the Task Force's recommendations around three major issue areas identified by Task Force members as the most impactful issues affecting mental health outcomes of children and youth in foster care in Texas:

1. Diagnosis and treatment of mental health issues in children and youth in substitute care:

There is currently a lack of emphasis on achieving an accurate and appropriate mental health diagnoses for children and youth in substitute care. Furthermore, when diagnoses are assigned, accurate or not, it is unclear whether therapeutic or non-pharmacological strategies or models are available and/or used appropriately.

2. Empowerment and normalization of youth in substitute care:

Systemic obstacles exist for young people in care who wish to participate in normalcy activities. These obstacles can prevent young people in care from engaging in normal adolescent experiences and building social and life skills. This struggle can be made more difficult depending on how restrictive a child's placement is and depending on the child's cultural and spiritual identity and/or what special needs he or she may have.

3. Appropriate caregiving environments for children and youth in substitute care:

Currently, caregivers in Texas are not effectively recruited, screened, prepared or supported to successfully care for children and youth struggling with symptoms of trauma. This challenge is one of many existing obstacles in attempts to achieve a truly trauma-informed system of child welfare.

The Texas CASA Mental Health Task Force also recognized a number of barriers to achieving needed system and care improvements. Predictably, the most prominent barriers recognized by the Task Force are the same as those recognized by many mental health stakeholders and advocacy groups:

- Medicaid reimbursements are too low and discourage well-trained and specialty practitioners from choosing to become Medicaid providers.
- There is a lack of providers overall, especially those who are well-trained in treating trauma and specifically trained to treat trauma experienced by children.

To research and create recommendations around these challenges, Task Force members were divided into sub-committees around the three major issue areas. These sub-committees met individually numerous times over the course of one-and-a-half years and worked as a part of the larger Task Force to produce the recommendations found in this report.

EXECUTIVE SUMMARY

Mental health has found its way to center stage over the last few years in our country. Tragic incidents have occurred across the nation that have forced states and communities to look at issues of mental health and figure out more effective ways to care for people who need help and support.

Texas engaged in this effort as well. Last legislative session Texas appropriated \$2.6 billion toward providing mental and behavioral health services for its residents (approximately a 15% increase from the 2012-2013 budget).¹ The Texas CASA Mental Health Task Force believes that the same emphasis and imperative placed on addressing general mental health should be placed on addressing the unique mental health needs of children and youth in the child welfare system. While it remains to be seen how or if this infusion of funding will impact the children and youth in the Texas child welfare system, research has shown that their need for mental health care and services is great and based on a unique set of needs and complex circumstances.

Children in foster care experience mental illness at a rate almost 30% greater than the average population of children.² Children and youth in care are also less likely to receive adequate treatment and services for their mental health needs.³ Given these facts, it is no surprise that children in care experience negative outcomes at a much higher rate as well.

Child welfare advocates have learned that unresolved trauma plays an enormous role in driving these negative outcomes. Trauma can cause both long and short-term problems for children. "Consequences of trauma include difficulties with learning, ongoing behavior problems, impaired relationships and poor social and emotional competence. Children and youth exposed to trauma, especially violence, experience more learning and academic difficulties and behavioral and mood-related problems."⁴ This means that children who experience trauma may still struggle to attach to caregivers or regulate their emotions and behaviors, even if they are placed in an ideal home, where loving and consistent care is available to them.

The Texas CASA Mental Health Task Force believes that these complex physical and behavioral health needs have been poorly addressed or not addressed at all for children and youth in Texas. There are a number of reasons why children in foster care may not get the care or support they need. These include:

- Frequently changing providers due to placement moves
- Lack of physical and mental health providers who accept Medicaid
- Lack of providers well-trained in trauma, grief and loss

1 Ligon, Katharine. Sizing Up the 2014-15 Texas Budget: Mental Health. Rep. Center for Public Policy Priorities, Sept. 2013. Web. 15 Dec. 2014. <http://forabettertexas.org/images/2013_10_PP_Budget_MentalHealth.pdf>.

2 Texas Medicaid Managed Care and Children's Health Insurance Program: EQRO Summary of Activities and Trends in Healthcare Quality. Rep. Institute for Child Health Policy at the University of Florida Texas External Quality Review Organization, 28 Mar. 2014. Web. 15 Dec. 2014. <<http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf>>.

3 Carrillo, Sarah, and Elisa Ashton. Improving Care Coordination for Foster Children: An Update on California's Audacious Goal. Rep. California Office for Health Information Integrity, 20 Jan. 2013. Web. 15 Dec. 2014.

4 Cooper, Janice L. "Facts about Trauma for Policymakers: Children's Mental Health." National Center for Children in Poverty. Columbia University Mailman School of Public Health Department of Health Policy & Management, July 2007. Web. 4 Dec. 2014.

- Lack of providers who are specifically trained to treat children
- Lack of understanding of the root cause of a child’s behavior
- Overburdened caseworkers and other parties in the case
- Systemic resistance to using non-pharmacological interventions other than therapy
- Systemic inability to make decisions about a child’s outcomes based on their emotional and mental health needs
- Lack of access to normal life experiences that contribute to positive mental health outcomes

The Texas CASA Mental Health Task Force decided to focus its efforts on three major areas of concern and make recommendations about issues within those three areas. A summary of the issues and recommendations are as follows:

I. DIAGNOSIS AND TREATMENT OF MENTAL HEALTH ISSUES IN CHILDREN AND YOUTH IN SUBSTITUTE CARE

Issue 1: Integrated care is the standard, not the reality

Recommendations:

1. The Health and Human Services Commission should activate and publicize Medicaid billing codes that will allow providers to bill for collaborative consultation, which allows practitioners to bill for “peer consults” between primary care physicians (PCPs) and other PCPs; PCPs and Psychiatrists; and PCPs and other mental health practitioners.
2. Ensure the Health Passport is being utilized and includes updated information on the child’s medical history, mental health, developmental and psychosocial functioning—any information pertinent to any course of care for the child.

Issue 2: The term “non-pharmacological interventions” is not well defined or understood

Recommendation:

1. Adoption of the following definition of “non-pharmacological interventions” by the judicial system, medical care providers, insurers, CASA, CPS and others:
 - “Non-pharmacological interventions” is terminology meant to represent an array of strategies, supports and interventions intended to help children recover and heal from trauma, build resilience and meet developmental milestones. Non-pharmacological interventions must be used in lieu of or concurrently with psychotropic medications and should be informed by accurate and continuous assessment and/or diagnosis. Non-pharmacological interventions include both evidence-based interventions, promising practices and those interventions proven effective by peer-reviewed research.

Issue 3: Medical and mental health providers serving this population are not beholden to American Academy of Pediatrics standards and the current Medicaid reimbursement rates in Texas deter providers

Recommendations:

1. Implement, require and train on American Academy of Pediatrics standards for physicians treating children in substitute care on health screenings in foster care.
2. Provide equivalent reimbursement rates for all licensed professionals who provide Medicaid mental health services to children in foster care.

Issue 4: Limited information is available regarding the array of mental health services available under STAR Health and understanding of how to utilize the Medicaid appeals process and other legal options is limited

Recommendations:

1. Revise STAR Health Member Handbook to include:
 - Information on trauma and trauma-informed care
 - Information on behavioral health services, including a list of covered services, definition of services, and information on how to access services and who can provide services
 - A simpler explanation of the Medicaid appeals process
2. Train consumers, attorneys, judges, CASA volunteers, medical consenters and youth (especially those 16 and older) on:
 - What behavioral health services are available through STAR Health, including definitions of services, how to access services and who can provide services
 - The Medicaid appeals process, including how to appeal when a requested medically necessary service is denied
3. Train attorneys, CASA volunteers, judges, medical consenters and youth on how to petition the court for an order related to the medical care for a foster child. This is not a formal Medicaid appeal but the use of the exclusive jurisdiction of the court could help to ensure that foster children receive appropriate medical care, including mental health and behavioral health services.

Issue 5: Texas youth who aged out of care are not auto-enrolled in Medicaid and youth who aged out in other states are not extended coverage in Texas

Recommendations:

1. Create automatic enrollment transfers from STAR Health to STAR when a child turns 21, assuring that former foster children will have Medicaid coverage until age 26 regardless of reapplication.
2. Extend Medicaid eligibility to former foster youth from any state until age 26.

II. EMPOWERMENT AND NORMALIZATION OF YOUTH IN SUBSTITUTE CARE

Issue 1: The current system inhibits caregivers' ability to make decisions about a child's participation in normalcy activities and experiences

Recommendations:

1. Define the Reasonable and Prudent Parenting Standard and include what to consider when caregivers are making decisions.
2. Require DFPS to verify that private contracted agencies promote and protect the ability of a child to participate in normalcy activities by requiring that private agencies have the same provisions of "reasonable and prudent parenting standards" as foster caregivers.

Issue 2: Service plans can be too prescriptive and unwittingly block a young person from participating in an activity or experience and caregivers can be discouraged from allowing for participation in normalcy activities

Recommendations:

1. Address service plan limitations by listing normalcy activities and/or experiences the child has/is participating in rather than listing activities as a limited list of activities in which a child can participate.
2. Mandate that the foster parent and/or the associated child placing agency shall not be held responsible for potentially negative outcomes beyond their reasonable control as a result of the child's participation in an age-appropriate normalcy activity, provided the activity is approved by the foster parent using the reasonable and prudent parent standard.
3. Require training for residential staff, child placing agency staff, foster parents, kinship providers and residential child care licensing staff. This training should include instruction on decision-making as a "reasonable and prudent parent", appropriate and trauma-informed ways to deal with a child or youth's misbehavior, the importance of a child's participation in normal adolescent activities and experiences, and the

benefits of such participation to a child's social, emotional and developmental growth, well-being and mental health.

Issue 3: Youth are not empowered to address concerns within their placements or to report abuse and are not aware of their individual rights or what recourse is available to them when rights are violated

Recommendations:

1. Establish an independent Ombudsman office or establish autonomy within the OCA, ensuring that the Department of Family and Protective Services shall have no authority to:
 - Create or change the policy and practice of the Office of Consumer Affairs;
 - Determine the budget of the Office of Consumer Affairs; or
 - Make decisions regarding personnel of the Office of Consumer Affairs
2. Caseworkers and CPA personnel should provide foster children and youth with better access to the Children's Bill of Rights by making copies available at court hearings and at site visits and provide ongoing education around these rights in order to fully empower them.
3. Require Child Placing Agencies and foster care placements to provide access to the OCA or independent Ombudsman's office contact information in private spaces, such as bathrooms or on the back of bedroom doors.
4. Require the OCA or independent Ombudsman's office to establish a written policy on foster youth's provisions and protections from retaliation by a caregiver, including a procedure of investigation of such retaliation and consequences for caregivers who are found to have engaged in retaliation against a child or youth in foster care.
5. Require the OCA to establish a secure form of communication with the child or youth in order to ensure that he or she is made aware of the investigation including the substantiation of any complaints that are brought to the attention of or determined by the OCA.
6. Require the OCA to establish specific procedures for working with youth in foster care who call to make an inquiry or complaint.

III. APPROPRIATE CAREGIVING ENVIRONMENTS FOR CHILDREN AND YOUTH IN SUBSTITUTE CARE

Issue 1: Caregivers are not adequately trauma-informed and efforts to establish a trauma-informed care system are slow, disconnected, and vary in how they are defined

Recommendations:

1. Define trauma-informed care for caregivers within Minimum Standards.
2. Require all residential child care administrators and staff to complete trauma-informed care training, as defined by the Department of Family and Protective Services.
3. Incentivize Child Placing Agencies (CPAs) to incorporate trauma-informed care into their assessments, training and support of caregivers of children with increased reimbursement rates.
4. Evaluate the utilization and effectiveness of implementing trauma-informed care models, as defined by the Department of Family and Protective Services, within the eligible CPAs.

Issue 2: Current practice does not include an assessment for adult attachment for alternate caregivers

Recommendations:

1. Require all agencies that screen potential caregivers to include an attachment screening as a component of the overall assessment to better understand that caregiver's ability to form meaningful and trust-promoting relationships with children who have experienced trauma. There are several free attachment screening options and the Task Force recommends that the Department of Family and Protective Services create a standardized list of tools for agencies to utilize for these screenings.
2. Train Child Placing Agency staff to screen potential caregivers using attachment screening and ensure they have the proper assessment tools, as defined by the Department of Family and Protective Services.
3. Require a set of standardized assessments of prospective caregivers, defined by the Department of Family and Protective Services, across child placing agencies.

I. DIAGNOSIS AND TREATMENT OF MENTAL HEALTH ISSUES IN CHILDREN AND YOUTH IN SUBSTITUTE CARE

Background

Children in care more likely to experience poor mental and physical health

Children and youth in the child welfare system have a higher prevalence of physical, developmental, dental and behavioral health conditions than any other group of children.¹ Physical trauma, such as a blow to the head or body or violent shaking, can result in negative effects on physical development. Neglect, such as inadequate nutrition, lack of adequate stimulation or withholding of medical treatment, can also negatively impact physical development. Additionally, maltreatment in the first few years of life can negatively affect brain development and have repercussions into adolescence and adulthood.² There is also a great body of research, especially the Adverse Childhood Experiences (ACE) Study, that documents the conversion of traumatic experiences in childhood into organic disease later in life, including all of the major causes of adult mortality in the United States.³ The Task Force on Health Care for Children explains the issue this way:

“Children and adolescents in foster care are a group with special health care needs. They are a uniquely disadvantaged group. Prior to foster care, the vast majority lived with families devastated by substance abuse, mental health disorders, poor education, unemployment, violence, lack of parenting skills, and involvement with the criminal justice system. High rates of premature birth, prenatal drug and alcohol exposure, and postnatal abuse and neglect contribute to the extremely poor health status of children and adolescents entering foster care. In addition, health care prior to foster care placement often is inadequate, meaning that children and adolescents entering foster care have multiple unmet health care needs, far exceeding even those of other children who are poor.”⁴

These challenges are reflected in the statistics on this issue, especially when one compares the differences between the three major health insurance programs that serve low-income children: STAR (typical Medicaid), CHIP (the Children’s Health Insurance Program, which is for families with incomes slightly higher than what Medicaid allows), and STAR Health (the Medicaid program exclusively for children in the child welfare system). According to the FY 2012 STAR Health Caregiver Survey, it served a considerably higher percentage of child MSHCN (members with special health care needs) than other programs (48 percent). This was more than double the rates observed in STAR (18 percent) or CHIP (20 percent). In STAR Health, more than one-third of recipients were prescribed

1 “Fostering Health: Health Care for Children and Adolescents in Foster Care.” Task Force on Health Care for Children 2 (2005): n. pag. [Http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FosteringHealthBook.pdf](http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FosteringHealthBook.pdf). 2005. Web. 9 Dec. 2014.

2 Health and Mental Health. Child Welfare Information Gateway, n.d. Web. 9 Dec. 2014. <<https://www.childwelfare.gov/can/impact/longterm/health.cfm>>.

3 Felitti, Vincent J. “The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead.” *Z Psychosom Med Psychother* 48.4 (2002): 359-69. Web. 9 Dec. 2014. <http://www.acestudy.org/files/Gold_into_Lead_-_Germany1-02_c_Graphs.pdf>.

4 “Fostering Health: Health Care for Children and Adolescents in Foster Care.” Task Force on Health Care for Children 2 (2005): n. pag. [Http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FosteringHealthBook.pdf](http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FosteringHealthBook.pdf). 2005. Web. 9 Dec. 2014.

medications for mental illness (35 percent) or had problems that required mental health treatment or counseling (36 percent). More than a quarter of STAR Health recipients also need more medical care, mental health or educational services than is typical for children (29 percent). The percentage of STAR Health recipients who had functional/ability limitations or needed special therapies in 2012 was 16 percent and 14 percent, respectively.⁵

Children in Substitute Care Exist Within Complex Systems

Children in state custody are served simultaneously by many systems, including the child welfare system, the judicial system, the education system, the medical system and mental health systems. All of these systems are structured and function differently. It is difficult to imagine how a child could experience positive outcomes within all of these systems when few people, including those who work with and advocate for these children, understand the intricacies of each of them. This labyrinth of systems, processes and services and the general lack of knowledge about how to navigate them can create significant barriers to children receiving the services they need.

Task Force members found this complexity difficult as they set out to identify specific issues regarding how children in state custody receive mental health diagnoses and how they receive treatment for those issues. The Task Force sought to ensure that each child in the system is receiving an accurate and appropriate mental health diagnosis based on that child's individual needs. However, what Task Force members found was that because of the extremely complex nature of the systems that touch the lives of these children, they would first have to gain a better understanding of how these systems interact.

Due to limited time and resources, Task Force members decided to focus solely on the system of mental health care established to treat children in substitute care, its interaction with the child welfare system and how the functioning of these two systems can discourage appropriate and accurate diagnosis and treatment for individual children in care. Current functioning and interaction between these systems limits the possibility for every child to be accurately and appropriately diagnosed based on their individualized needs.

In order to gain a better understanding of how the mental health care system and child welfare system interact, Task Force members worked with Pamela Baker, Well-Being Specialist, and other Department of Family and Protective Services staff to create a guide to demonstrate the systems' interactions and to identify key points in the systems where a child receives mental health-related services. Figure 1a demonstrates the process of how a child in CPS custody is assessed, diagnosed and treated through the mental health system.

5 Texas Medicaid Managed Care and Children's Health Insurance Program: EQRO Summary of Activities and Trends in Healthcare Quality. Rep. Institute for Child Health Policy at the University of Florida Texas External Quality Review Organization, 28 Mar. 2014. Web. 15 Dec. 2014. <<http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf>>.

Behavioral Health Service/Treatment Planning Overview for Children in DFPS Conservatorship

At the time of removal and entry into DFPS conservatorship (CVS), some children may be in a **Texas Juvenile Justice facility, Inpatient psychiatric hospital** or other setting. During the time the child is in CVS, the child could enter one of these or another unlicensed setting (ex: runaway, state hospital, etc.).

Investigation Phase (INV)

Child could receive a psychosocial, psychological, or psychiatric assessment/evaluation during the investigation (INV) phase.

Child enters DFPS conservatorship (CVS).

Not all children receive a psychological assessment. Other services are accessed as soon as possible if needed (for example, therapy). Some children may already be receiving behavioral health (BH) services or psychotropic medication at removal. All information gathered in the INV stage, received from the parent or collaterals, information about child behaviors, and past medical records if available, are used for treatment planning.

Ongoing Throughout Case

Child's BH needs assessed throughout the case. Information from the child, caregiver(CG), medical consenter (MC), school/ARD Meeting, caseworker (CW), healthcare provider, etc. could result in need for additional behavioral health (BH) evaluation, assessment, testing or treatment services including psychotropic medications. MC provides consent for proposed treatment. DFPS and MC collaborate regarding requests for additional testing if disagreements exist. Regular reviews to Service/Treatment Plans occur to gauge progress, treatment goals, etc.

Most children in DFPS conservatorship have Medicaid provided through STAR Health. Must meet medical necessity for Medicaid to pay. The STAR Health BH provider (Cenpatco) conducts the Psychotropic Medication Utilization Review (PMUR) process for psychotropic medication when indicated. CW and MC have access to Health Passport for healthcare claims data and other health information.

Placed in Licensed Care.* This includes CPA foster homes and General Residential Operations (GRO).

(GRO include operations that provide emergency care and residential treatment services.)

Psychological evaluation required for licensed placement for any service levels above Basic.

Children placed in Residential Treatment (RT) setting have higher service levels, RT may have therapist, Psychiatrist, Psychologist on staff or on contract, CPS serves as medical consenter to these children.

* Governed by Minimum Standards and DFPS Residential Contracts

Child is placed.

Placed in Kinship Care.

Initial 72 Hour Deadline.

Physical and mental health/developmental screenings are given within **30 days** of entering DFPS custody as part of TX Health Steps Checkup.

Caseworker Provides Form 2279 addressing known Behavioral Health history and needs to Caregiver/ Medical Consenter within **72 hours**.*

*also applies to DFPS Foster/ Adopt (FAD) home placements

The Admission Assessment/Preliminary Service Plan must be completed within **72 hours**.*

*RCCCL Minimum Standard Requirement: Admission Assessments are required to be completed within 40 days of admission, if the placement is an emergency placement or completed prior to the child's non-emergency admission.

Per licensing requirement, operations must complete a Preliminary Service Plan within 72 hrs of admission.

All Initial Service Plans (various names: Service, Treatment, etc.) by CPA/Residential Contractors **must be completed within 40 days**.

Children in Temporary Managing Conservatorship (TMC) must have a Plan of Service (POS) reviewed in the 5th and 9th month and every 4 months thereafter. Children in Permanent Managing Conservatorship (PMC) with therapeutic needs have the POS reviewed every 3 months, and those with a basic service level reviewed every 6 months. Timeframes for completion of Reviews differ and are based on treatment service needs.*

*CPA **Service Plan Reviews** thereafter incorporated into the DFPS plan with DFPS review.

Updates to the Service Plan may be completed any time if significant changes occur.

Any service plan may include psychological and psychiatric testing and follow-up treatment, therapy, and other non-pharmacological interventions, and use of psychotropic medications depending on healthcare provider referrals.

BH Evaluation recommendations (if eval. completed) are incorporated into Service Plans.

*See RCCCL Attachment C 501 Service Planning Timeframes can vary for completion of Reviews as outlined in Minimum Standards, RCC Contract and CPS Policy.

Minimum standards. Service Plan Reviews are required to be completed based on the type of service a child receives. For example, a child with a basic service level is required to have his service plan reviewed and updated at least 180 days from the date of the last service plan.

General Screening completed telephonically by STAR Health **within 30 days** of entering DFPS conservatorship.

For children in STAR Health who receive Service Management (SM), the following assessments are examples of some that may be completed as part of the Service Management process when indicated as necessary:

- Ohio Scales (BH) - completed every 90 days while enrolled in Service Management.
- Child Report of Post-Traumatic Symptoms (CROPS) (BH): completed every 90 days while enrolled in Service Management.

- Intellectual and Developmental Disabilities Services Checklist (BH): completed every 90 days while enrolled in the Intellectual Disability Disease Management Program.
- *SM creates a Health Care Service Plan reviewed every 90 days.

All Initial Service Plans (various names: Child Plan of Service, Case Plan, etc.) **must be completed within 45 days**.

Children in Temporary Managing Conservatorship (TMC) must have a Plan of Service (POS) reviewed in the 5th and 9th month and every 4 months thereafter. Children in Permanent Managing Conservatorship (PMC) with therapeutic needs have the POS reviewed every 3 months, and those with a basic service level reviewed every 6 months.

Service Plan **Reviews** thereafter completed on varying timeframes according to CPS Policy. **Updates to the Service Plan** may be completed any time if significant changes occur.

Any service plan may include psychological and psychiatric testing and follow-up treatment, therapy, and other non-pharmacological interventions, and use of psychotropic medications depending on healthcare provider referrals.

BH Evaluation recommendations (if eval. completed) are incorporated into Service Plans.

Initial DFPS Child Plan of Service (CPOS) developed within 45 days.

Child receives services based on the service plans and as any identified needs arise.

Child receives Medicaid services based on medical necessity for as long as indicated.

Color Key

- Main Process Flow
- Residential Licensing
- Kinship Care
- Informational
- Informational
- Informational

Residential Services

CPS Services

As is demonstrated by Figure 1a, navigating the interwoven systems of mental health care and child welfare can be difficult. The complexity raises the question: How do we know that the best mental health decisions are being made for our state's most vulnerable children?

The Texas child welfare system houses our state's most vulnerable children. Members of the Task Force believe these children face great challenges and deserve the best care. They deserve to heal from the pain and trauma of being abused or neglected. They deserve to grow up feeling normal and safe. They deserve to finish high school and get a college degree. They deserve to grow into healthy adults. Therefore, they deserve the best system and services that exist in order to help them achieve these things.

The Texas CASA Mental Health Task Force believes that the current system that provides medical and mental health care for the children in state custody can greatly improve its services and delivery.

KEY ISSUES

Issue 1: Integrated Care is the standard, not the reality

A major concern that Task Force members identified is that children in state custody often do not receive accurate or appropriate diagnoses. This has been an ongoing concern for Texas and a number of efforts have been employed to address this issue. While those efforts have mostly been beneficial, Texas must not stop short of realizing a system that works effectively for children in care. If Texas wishes to ensure accurate and appropriate diagnoses for children and youth in foster care then it needs to create a truly integrated, collaborative system that is staffed with well-trained, trauma-informed medical and mental health professionals.

The mental health care, medical care and child welfare systems may be independently helping children, however, the situations of children in state custody are extremely complex and thus require a smarter, more flexible, and collaborative integrated system of care.

Current System

STAR Health is the Medicaid program that covers medical and behavioral health care for children in substitute care. Superior Health is the managed care organization for STAR Health. Cenpatico manages the behavioral health benefits for STAR Health. According to STAR Health, their coverage offers each child in their network an "integrated medical home where each foster care child has access to primary care physicians, behavioral health clinicians, specialists, dentists, vision services and more".⁶

Integrated care is defined as:

"The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."⁷

6 Welcome to STAR Health. Superior Health Plan, 2014. Web. 18 Dec. 2014. <<http://www.fostercaretx.com/welcome-to-star-health/>>.

7 "What Is Integrated Behavioral Health Care?" Agency for Healthcare Research and Quality. U.S. Department of Health and Human Services, 2014. Web. 18 Dec. 2014. <<http://integrationacademy.ahrq.gov/atlas/What%20Is%20Integrated%20Behavioral%20Health%20Care>>.

The Texas Department of State Health Services (DSHS) defines a medical home as:

“A partnership between a child, the child’s family, and the place where the child gets primary health care. At a medical home, the child’s family and health care experts are a team. They work together to find and get all the services the child and family need, even if they are not medical services.”⁸

DSHS continues its definition, suggesting a medical home offers “health care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, [and] culturally competent”.⁹

While these are lofty and strong definitions about the current system, the Task Force believes that this is not how the system actually functions. CASA volunteers and staff around the state, as well as other child welfare advocates and professionals on the Task Force, have expressed concern over the ability of the current medical and mental health care system to provide truly integrated, quality care to children based on the child’s specific needs and with the goal of healing as the focus. Concerns raised regarding the integration of mental and physical health care of children include:

- Moving between placements and changing providers interrupts continuity of care. Additionally, new providers may add new diagnoses on top of an already inappropriate diagnosis or they may not appropriately treat or even be made aware of chronic issues.
- Children’s medical histories are often non-existent, unknown or not properly acquired by either caseworkers or the medical and mental health professionals treating the child. Therefore, their histories may not be used to inform the process of continued treatment for the child.
- Children’s medical care information, while shared with caseworkers and courts, is not required to be shared with medical or mental health providers treating the child.
- The Health Passport, while beneficial in some ways, has not historically contained the most important health information, nor does it organize information in a way that is efficient for providers to access and use. It is often under-utilized and not updated, so it can lack in-depth information about the child’s medical history, mental health, developmental and psychosocial functioning—information pertinent to any course of care for the child.

If health conditions, medications and medical events are not recorded, maintained, and delivered to the child’s provider as the child moves between different providers and living situations, the consequences may include missed diagnoses, inappropriate treatment, duplications in therapy and more. “Such complications can lead to significant adverse health outcomes and poor quality of life for the child, as well as increased healthcare costs for the state.”¹⁰ The statistics about this issue reflect the concerns that the Texas CASA Mental Health Task Force laid out above. In fact, on average, children in care experience eleven placements in a three-year period.¹¹

8 Every Child Deserves a Medical Home. Texas Department of Family and Protective Services, 14 May 2014. Web. 18 Dec. 2014. <<http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=29472&id=2019&terms=%22medical+home%22+and+%22definition%22>>.

9 Every Child Deserves a Medical Home. Texas Department of Family and Protective Services, 14 May 2014. Web. 18 Dec. 2014. <<http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=29472&id=2019&terms=%22medical+home%22+and+%22definition%22>>.

10 Carrillo, Sarah, and Elisa Ashton. Improving Care Coordination for Foster Children: An Update on California’s Audacious Goal. Rep. California Office for Health Information Integrity, 20 Jan. 2013. Web. 18 Dec. 2014.

11 Ramshaw, Emily. “Lawsuit Can’t Cover All Kids in Long-Term Foster Care.” The Texas Tribune. N.p., 23 Mar. 2012. Web. 07 Aug. 2014. <<https://www.texastribune.org/2012/03/23/lawsuit-texas-failing-foster-children/>>.

Given the amount of upheaval and the rapid nature in which transitions to new placements must be made, it is often difficult to transfer medical and mental health records or to ensure that providers are communicating the needs of each child to new care providers, especially when those placements are in different cities, counties or states.

Another indication that Texas' integrated system of health care is not functioning as is intended can be seen in the high number of potentially preventable readmissions (PPRs) of children enrolled in STAR Health. These types of readmissions result from "poor coordination of services at time of discharge... or deficiencies in the process of care and treatment, including actions taken or omitted during the initial hospital stay".¹ Children enrolled in STAR Health had PPRs at a rate over ten percentage points higher (15.5%) than children enrolled in CHIP (5.1%).² A truly integrated, coordinated system of care should not experience this high a rate of PPRs, nor should the children in state care be subjected to repeat hospital visits when proper care coordination could have prevented them.

One of the most challenging components of achieving positive outcomes for children in state custody is the ability of the state to create stability and establish continuity across systems as children shuffle through homes, courts, medical and mental health providers and caseworkers. So much is lost for these children along the way, including the rapport and trust they have potentially built with a provider, as well as information regarding their needs, what treatments may have been employed and the success of those treatment options.

The Collaborative Care Model

It is the responsibility of the Department of Family and Protective Services, STAR Health and its managed care organizations to provide care that is thoughtful, continuous, well-coordinated, collaborative, trauma informed and sensitive to the child's experiences and unique needs. Given the problems that were outlined above, this kind of care is not consistently available in the current system in Texas.

While STAR Health is supposed to be an integrated system, there is a lack of consideration for the role that the Department should play in integration efforts. To be a truly integrated care model serving this population, integration must include not only physical and mental health care but also care within the child welfare system. This means doctors and mental health professionals need to collaborate better with each other and they must collaborate with key care partners within the child welfare system such as the CPS caseworker, the judge and the CASA.

The Task Force recommends that Texas consider adopting the Collaborative Care model. Collaborative Care is defined as:

"Ongoing working relationships between clinicians, rather than a specific product of service. Providers combine perspectives and skills to understand and identify problems

1 Texas Medicaid Managed Care and Children's Health Insurance Program: EQRO Summary of Activities and Trends in Healthcare Quality. Rep. Institute for Child Health Policy at the University of Florida Texas External Quality Review Organization, 28 Mar. 2014. Web. 15 Dec. 2014. <<http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf>>.

2 Texas Medicaid Managed Care and Children's Health Insurance Program: EQRO Summary of Activities and Trends in Healthcare Quality. Rep. Institute for Child Health Policy at the University of Florida Texas External Quality Review Organization, 28 Mar. 2014. Web. 15 Dec. 2014. <<http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf>>.

and treatments, continually revising as needed to hit goals.”³

Establishing a truly integrated, well-coordinated, collaborative system with a medical home could lead to more positive and healthy outcomes for children. Research suggests that “collaborative care has consistently demonstrated higher effectiveness than usual care”.⁴ “Studies have shown that integrated health care approaches, such as the Collaborative Care model are more effective than usual care for depression, anxiety disorders and more serious conditions such as bipolar disorder and schizophrenia.”⁵

Because of the often mobile nature of a child’s life in state care, an integrated method of health care should include a collaborative element. As a child moves from one provider to the next, past providers should speak with new providers and share all pertinent information about his or her care. Caseworkers, CASA volunteers and court systems should also contribute to this collaborative approach by assisting in the timely transfer of medical and insurance information so that the child’s care is seamless as they transition.

By establishing an integrated, collaborative system, Texas can be sure that a child’s social, behavioral, psychological and medical histories can travel along with them. When practitioners have a fuller understanding of what is going on for a child, they are more likely to make an accurate diagnosis and suggest more useful treatment options. Integrated, collaborative and holistic systems of health care mean all practitioners (medical care providers, mental health professionals, psychiatrists, etc.) are communicating, frequently assessing the progress of the child’s care, regularly re-evaluating the treatment plan and referring to outside, community-based services that may also be useful to the child.

Recommendations:

1. The Health and Human Services Commission should activate and publicize Medicaid billing codes that will allow providers to bill for collaborative consultation, which allows practitioners to bill for “peer consults” between primary care physicians (PCPs) and other PCPs; PCPs and Psychiatrists, and PCPs to other mental health practitioners.
2. Ensure the Health Passport is being utilized and includes updated information on the child’s medical history, mental health, developmental and psychosocial functioning—any information pertinent to any course of care for the child.

Issue 2: The term “non-pharmacological interventions” is not well defined or understood

The 83rd Texas Legislature passed House Bill 915, establishing added protections from the overuse of psychotropic medications for children and youth in state custody. The new law states that the Department of Family and Protective Services (DFPS) and judges are now responsible for ensuring non-phar-

3 Peek, C.J. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. Rep. Agency for Healthcare Research and Quality, Apr. 2013. Web. 18 Dec. 2014.

4 Unutzer, J., Harbin, H., Schoenbaum, M., and Druss, B., The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. 2013. <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf>.

5 Ybarra, Rick. “Our Journey Through Integrated Health Care and What We Have Learned.” Web log post. Hogg Blog. Hogg Foundation for Mental Health, 5 Aug. 2014. Web. 18 Dec. 2014.

macological interventions are considered in lieu of or along with psychotropic medications. Shortly after this bill became law, questions arose regarding the definition of “non-pharmacological interventions”.

The purpose of this law was to ensure that children and youth in state custody are only treated with psychotropic medications when absolutely necessary and that other methods of mental health intervention be employed to assist a child in coping with symptoms of mental health conditions and trauma. Yet, there is no broad understanding between DFPS, the courts, caregivers, stakeholders, practitioners or advocates about what “non-pharmacological interventions” means.

The Texas CASA Mental Health Task Force set out to establish a definition for “non-pharmacological interventions” to provide clarity to those working within the child welfare system and to ensure that children and youth in substitute care have access to a wide array of services that have proven benefits for their mental health outcomes. In developing a definition, the Task Force demanded that space be made for both what professional mental health providers refer to as “evidence-based practices” and for other interventions that have been proven through research to have a positive effect on mental health outcomes.

Recommendation:

1. Adoption of the following definition of “non-pharmacological interventions” by the judicial system, medical care providers, insurers, CASA, CPS and others:

- “Non-pharmacological interventions” is terminology meant to represent an array of strategies, supports and interventions intended to help children recover and heal from trauma, build resilience and meet developmental milestones. Non-pharmacological interventions must be used in lieu of or concurrently with psychotropic medications and should be informed by accurate and continuous assessment and/or diagnosis. Non-pharmacological interventions include both evidence-based interventions, promising practices and those interventions proven effective by peer-reviewed research.

Issue 3: Medical and mental health providers serving this population are not beholden to American Academy of Pediatrics standards and the current Medicaid reimbursement rates in Texas deter providers

Not only does the current functioning and interplay between the child welfare, mental health care and medical care systems raise questions regarding coordination of services for children, there are also challenges around the quality of and access to services.

Like many other states, Texas struggles to host quality medical and mental health providers and that struggle is further complicated as fewer providers choose to serve Medicaid clients. In fact, in 2011, less than 33 percent of Texas’ practicing doctors accepted Medicaid patients.⁶ There are a number of reasons why providers choose not to become a Medicaid provider, including the huge amount of paperwork involved and inadequate reimbursement rates for services. In Texas, licensed clinical social workers and licensed professional counselors are reimbursed at only 70 percent of the rate paid to licensed psychologists and psychiatrists, even though they are providing the majority of the Medicaid mental health services to children and youth in foster care.⁷ Since Texas is already struggling to recruit

⁶ Crisis Point: Mental Health Workforce Shortages in Texas. Rep. Hogg Foundation for Mental Health and Methodist Healthcare Ministries, Mar. 2011. Web. 19 Dec. 2014. <http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf>.

⁷ “Texas Medicaid Fee-For-Service Reimbursement.” Texas Medicaid Provider Procedures Manual 1 (2014): 2-1--11. American Medical Association, Dec. 2014. Web. 19 Dec. 2014.

and maintain quality Medicaid mental health providers, it should not create additional challenges for providers by not reimbursing all licensed professionals at the same rates for the same services.

The Task Force members also believe that mental health and medical providers who care for children in the child welfare system should be expected to adhere to the American Academy of Pediatrics (AAP) standards and recommendations on Health Screenings in Foster Care. The AAP requirements for health screenings in foster care detail information about how to conduct a comprehensive evaluation, how to create a medical home, the importance of preventative health care for this population and how to properly maintain medical records for children and youth in foster care.⁸ In order to meet these standards, physicians need to spend more time with each patient. Allowing more time with the children is imperative because they will be better able to develop a trusting relationship with the child and should (if they adhere to AAP standards) be eliciting important medical and mental health related information from the child throughout their time in state care.⁹ Training on national standards, including the American Academy of Pediatrics standards, is not widely available or required for physicians in Texas, even if they are providing care for the vulnerable children and youth in the foster care system.

Recommendations:

1. Implement, require and train on American Academy of Pediatrics standards for physicians treating children in substitute care on health screenings in foster care.
2. Provide equivalent reimbursement rates for all licensed professionals who provide Medicaid mental health services to children in foster care.

Issue 4: Limited information is available regarding the array of mental health services available under STAR Health and understanding of how to utilize the Medicaid appeals process and other legal options is limited

Task Force members experienced difficulty in attempting to find a comprehensive list of services covered by STAR Health and had further challenges defining the services that are covered. Despite their best efforts, Task Force members were unsuccessful at compiling a list of covered services, and it was even unclear to members what the services entail as there are no easily available definitions of services. Given the difficulty seasoned advocates experienced finding a comprehensive list of mental health services and their definitions, how can caregivers, consenting youth or other medical consenters be expected to understand the variety of options available to the children they care for?

Additionally, Task Force members found that the complexity of the Medicaid appeals process and other legal avenues to challenge denial of services present significant, unnecessary challenges for stakeholders and caregivers in Texas. The basic appeals process overseen by Superior Health Plan is available to all enrollees in STAR Health but it can be difficult to access and to navigate for consumers without experience in the process. The appeals process is important for caregivers to understand because it allows them to seek coverage for services not explicitly covered by STAR Health, as long as the services are deemed medically necessary by the child's physician. Additionally, currently provided services must continue to be provided during an appeal if the appeal is requested in a timely manner. STAR Health

⁸ "Requirements for Health Screenings in Foster Care." Healthy Children. The American Academy of Pediatrics, 03 Oct. 2013. Web. 19 Dec. 2014. <<http://www.healthychildren.org/English/family-life/family-dynamics/adoption-and-foster-care/Pages/Requirements-for-Health-Screenings-in-Foster-Care.aspx>>.

⁹ "Requirements for Health Screenings in Foster Care." Healthy Children. The American Academy of Pediatrics, 03 Oct. 2013. Web. 19 Dec. 2014. <<http://www.healthychildren.org/English/family-life/family-dynamics/adoption-and-foster-care/Pages/Requirements-for-Health-Screenings-in-Foster-Care.aspx>>.

members also have the right to initiate a fair hearing appeal process that is separate from the fair hearing appeals process and adjudicated by the Health and Human Services Commission, rather than Superior Health Plan.

Gaining a better understanding of what services are available under STAR Health and knowledge about how to navigate the Medicaid fair hearing appeals process would allow those making medical decisions for children in care to advocate appropriately for the individual needs of the children they are caring for and promote better health outcomes.

Recommendations:

1. Revise STAR Health Member Handbook to include:

- Information on trauma and trauma-informed care
- Information on behavioral health services, including a list of covered services, definition of services, and information on how to access services and who can provide services
- A simpler explanation of the Medicaid appeals process

2. Train consumers, attorneys, judges, CASA volunteers, medical consenters and youth (especially those 16 and older) on:

- What behavioral health services are available through STAR Health, including definitions of services, how to access services and who can provide services
- The Medicaid appeals process, including how to appeal when a requested medically necessary service is denied

3. Train attorneys, CASA volunteers, judges, medical consenters and youth on how to petition the court for an order related to the medical care for a foster child. This is not a formal Medicaid appeal but the use of the exclusive jurisdiction of the court could help to ensure that foster children receive appropriate medical care, including mental health and behavioral health services.

Issue 5: Texas youth who aged out of care not auto-enrolled in Medicaid and youth who aged out in other states are not extended coverage in Texas

With the passage of The Patient Protection and Affordable Care Act (ACA), states are now required to provide Medicaid coverage to individuals under the age of 26 who were in foster care and receiving Medicaid at the time of aging out of care.¹⁰ According to the Texas Department of Family and Protective Services (DFPS), the changes set forth by the ACA have expanded the Former Foster Care Children Program. So, depending on a child's age, the child will have Medicaid coverage until the age of 26 in Texas. DFPS has altered the structure of the program and has laid out how this Medicaid expansion will be accessible to foster youth.¹¹ While the expansion is well-needed, concern exists regarding the implementation of these changes. The Texas CASA Mental Health Task Force identified two potential barriers that youth might experience when they try to access this program.

10 Deckinga, Audrey. "Former Foster Care Children Program-Medicaid Healthcare Coverage for Former Foster Youth Ages 18 through 25." Memorandum to CPS Regional Directors. 18 Nov. 2013. Texas Department of Family and Protective Services. 1-6. Print.

11 Deckinga, Audrey. "Former Foster Care Children Program-Medicaid Healthcare Coverage for Former Foster Youth Ages 18 through 25." Memorandum to CPS Regional Directors. 18 Nov. 2013. Texas Department of Family and Protective Services. 1-6. Print.

Foster youth face immense challenges when they age out of foster care, including lack of family and/or social support, poverty, potential unemployment, inadequate living arrangements and little or no coordination of their physical and mental health services. In spite of the fact that they are supposed to be enrolled in Medicaid services, foster youth are likely to face untreated medical and mental health problems.¹² According to the American Academy of Pediatrics, children who have aged out of state care lack access to health and mental health services, which are critically important and have a significant impact on the child's transition into adulthood.¹³

Under current Texas statute, former foster youth in the initial Medicaid coverage plan, STAR health, are covered until age 21. At that time, the former foster youth must request and apply to be enrolled into the second coverage plan, STAR, extending coverage to age 26. This is Texas' approach to compliance with the Affordable Care Act requirements. The Task Force views the fact that foster youth must reapply for Medicaid benefits at age 21 as a significant barrier that prevents many foster youth from obtaining critical physical and mental medical care. The Task Force recommends changing this practice to include seamless and automatic enrollment transfers from STAR Health to STAR when the child turns 21, assuring that former foster children will have Medicaid coverage until age 26 regardless of reapplication.

Another barrier for foster youth that the Task Force identified is the lack of Medicaid coverage for former foster youth who relocate to Texas after they age out of care. DFPS's recent statutory changes include a provision that alters the eligibility of the Medicaid Transitioning Foster Care Youth (MTFCY) program from including former foster care children from any state to only those who aged out in Texas.¹⁴ This leaves a gap of coverage for former foster youth from other states who newly reside in Texas. For example, if a former foster care youth moves to Texas (to reunite with family, seek employment or pursue educational opportunities), the eligibility change will roll back coverage for the youth. This means that youths in this situation were covered until age 21 in the original program and now they are only covered until age 18.

This change prevents former foster youth from accessing the resources necessary to lead healthy lives and could potentially impact their overall life outcomes.

Recommendations:

- 1. Create automatic enrollment transfers from STAR Health to STAR when a child turns 21, assuring that former foster children will have Medicaid coverage until age 26 regardless of reapplication.**
- 2. Extend Medicaid eligibility to former foster youth from any state until age 26.**

¹² "Health Care of Youth Aging Out of Foster Care." *Pediatrics* 130.6 (2012): 1170-173. Council on Foster Care, Adoption, and Kinship Care and Committee on Early Childhood. American Academy of Pediatrics, 26 Nov. 2012. Web. 19 Dec. 2014.

¹³ "Health Care of Youth Aging Out of Foster Care." *Pediatrics* 130.6 (2012): 1170-173. Council on Foster Care, Adoption, and Kinship Care and Committee on Early Childhood. American Academy of Pediatrics, 26 Nov. 2012. Web. 19 Dec. 2014.

¹⁴ Deckinga, Audrey. "Former Foster Care Children Program-Medicaid Healthcare Coverage for Former Foster Youth Ages 18 through 25." Memorandum to CPS Regional Directors. 18 Nov. 2013. Texas Department of Family and Protective Services. 1-6. Print.

II. EMPOWERMENT AND NORMALIZATION OF YOUTH IN SUBSTITUTE CARE

Background

Normalcy shapes children and youth in the state's care

As children develop into adolescence and then adulthood, their growth is marked by experiences that contribute to their autonomy and their social functioning, shaping who they will become as adults and how successful they may be in life and relationships. These experiences can include things from spending the night at a friend's house, volunteering in the community, having an after school job, playing sports, running for student government, to going on a first date or attending senior prom. The list of activities a young person may experience during their adolescence is extensive. All of these experiences help shape the person this youth will ultimately become.

These types of activities are referred to as "normalcy" activities and are defined as "the opportunity for children and youth to participate in and experience age and culturally appropriate activities, responsibilities, and life skills that promote normal growth and development".¹ The Texas Department of Family and Protective Services has made efforts to ensure that all children/youth in its care have access to normalcy activities. These guidelines are laid out in communication from the agency, within their minimum standards and residential contracts.

Empowerment and normalcy activities are key to mental health and healthy development

Access to normalcy activities and opportunities for empowering young people in substitute care can improve mental health outcomes. Simple experiences such as having friends and spending time with them can vastly improve a young person's disposition. Friendship and socialization are essential in maintaining health and psychological well-being.² Positive relationships are correlated with happiness, quality of life, resilience and cognitive capacity.³ Friendships are essential for foster youths and friendships with peers outside of the foster care program are especially important. Research has shown these friendships may act as a deterrent against victimization, promote social skills and increase emotional health.⁴

The types of experiences offered through friendships are sometimes taken for granted, but it is important to understand that establishing, maintaining and enjoying friendships is not something easily achieved by our young people in foster care. Youth in substitute care move often, change schools frequently and are sometimes housed in isolated facilities. Even in stable placements, youth face prohibitions on simple

1 "Normalcy Recommendations: Improving Well-Being by Addressing Normalcy for Foster Youth." The National Foster Care Youth & Alumni Policy Council. N.p., 16 Apr. 2013. Web. 16 Dec. 2014.

2 Blieszner, R. The Worth of Friendship: Can Friends Keep Us Happy and Healthy? Journal of the American Society on Aging. Spring 2014 Vol. 38. No. 1

3 Fowler, J.H., Christakis, N.A., Dynamic spread of happiness in a large social network: longitudinal analysis over 20 years in the Framingham Heart Study. Dec. 2008.

4 Skrzypiec, G., Slee P, Askel-Williams, H. and Lawson, M. Associations between types of involvement in bullying, friendships and mental health status. Emotional and Behavioral Difficulties Vol. 17, Nos. 3-4, September-December 2012, 259-272.

things like staying the night with friends or having friends stay the night at their home.

In addition to building relationships with friends, young people's mental health is greatly benefited by participating in recreational activities. Age-appropriate recreational activities can promote positive emotions, increase relationship skills and advance mental and physical health. Part of the positive benefit of physical activity on mental health occurs through the socialization that happens when young people engage in physical activities with their peers.⁵ Other social activities such as band, religious involvement, drama club and others contribute to a young person's self-esteem, moral and cognitive development.⁶ These social activities help foster youth create and maintain relationships and help them develop important life skills and coping strategies. Recreational activities that involve play and playfulness have also been shown to reduce defensiveness, enhance well-being and foster maturation in children.⁷

While normalcy and access to age-appropriate activities are important for foster children in general, they are even more critical for foster youth with poor mental health. Due to the stigma associated with mental health issues, many foster youth create coping strategies outside of professional mental health interventions, including many of the normalcy activities described above. Mental health professionals have drastically underestimated the importance of therapeutic lifestyle interventions, including self-help and coping mechanisms. Unlike what occurs in sometimes rigid and highly structured mental health therapies, these activities are free of stigma and have profound effects on self-esteem and quality of life.⁸ Normalcy activities are essential for the mental health of foster youth. In fact, these activities may lessen the need for professional intervention in the mental health of children in state care, providing financial incentive for DFPS and foster care providers to help children and youth access normalcy activities.

The current status of foster youth decision-making and normalcy activities in Texas Department of Family and Protective Services is troubling. In depth-interviews conducted with former Texas foster youth confirm the need of normalcy activities in foster youth lives. This report, entitled *Voices of Experiences*, identified many alarming facts regarding the mental health of children in substitute care in Texas. More than one third of the youth who aged out of care in Texas reported they had no input on their mental health diagnoses or mental health services. Many of the youth also reported they had negative experiences with mental health services while in state custody. Youth in Texas also indicated a desire to have a gradual increase of responsibilities and liberties as their age and maturity increased. They reported that they believe the child welfare system kept them "isolated from the real world".⁹ Similar information was revealed in the youth surveys conducted by Texas Department of Family and Protective Services. Some youth felt they were not given chances to make decisions about their lives as they prepared for adulthood.¹⁰

5 VanKim N., Nelson T. Vigorous Physical Activity, Mental Health, Perceived Stress, and Socializing Among College Students. *American Journal of Health Promotion*. September/October 2013, Vol. 28, No. 1

6 Alexander, C.N. & Langer, E. (1990). *Higher stages of human development: Perspectives on adult growth*. New York, NY: Oxford University Press

7 Walsh, Roger. "Lifestyle and Mental Health." *American Psychologist* 66.7 (2011): 579-92. Web. 16 Dec. 2014.

8 Walsh, Roger. "Lifestyle and Mental Health." *American Psychologist* 66.7 (2011): 579-92. Web. 16 Dec. 2014.

9 Gendron, Christine. *Voices of Experience: Improving Mental Health Supports for Homeless & Transitioning Youth*. Rep. Texas Network of Youth Services, 2011. Web. 16 Dec. 2014.

10 Improving the Quality of Services to Youth in Substitute Care: A Report on Surveyed Youth in Foster Care FY 2007. Rep. Texas Department of Family and Protective Services, Sept. 2008. Web. 16 Dec. 2014.

A recurring challenge in helping children in foster care achieve a sense of normalcy is the lack of consistency in their lives. Numerous personal narratives and testimonies of children shine light on the traumatizing feelings associated with moving from placement to placement. In 2007, focus group studies were conducted in order to examine the mental health of foster youth dealing with the ongoing stresses of substitute care. According to the study, youth interviewed noted the importance of routine and control over life situations:

“[They have a] need for normalcy related to feelings of lack of control and confusion as a result of constant life changes. These feelings affected the informants’ self-esteem, security, and identity. The foster children described the desire for foster care professionals to allow them to participate in decisions about home placements”.¹¹

Foster children have desire for autonomy and involvement in decisions influencing their lives and well-being. They have repeatedly emphasized their wish to be involved in their own mental health decisions.¹² Foster children also expressed a desire to have autonomy over other important decisions, such as placement options and the type of preparation they need for aging out of state custody.

Examining testimonies of former foster children led the Task Force to the conclusion that foster youth may be reluctant to participate in mental health resources or therapy.¹³ Youth in state custody often have resentment about being forced to receive therapy before they feel they are ready for such services.¹⁴ Due to negative experiences in the child welfare and mental health systems, foster youth may distrust mental health professionals, which further elevates the importance of normalcy activities and decision-making for children in care. Children in state custody should be allowed to be actively involved in normalcy activities and have more autonomy to make decisions regarding their care, leading to better mental and physical health outcomes.

The challenge is that access to these activities is difficult to achieve for many young people who are cared for by a system. The system wants youth to be able to participate in normalcy activities but it is set up to discourage such participation.

KEY ISSUES

Issue 1: The current system inhibits caregivers’ ability to make decisions about a child’s participation in normalcy activities and experiences

In the Department of Family and Protective Services (DFPS) literature, normalcy activities are guaranteed to foster youth through a Bill of Rights. This Bill of Rights states “I have the right to attend my choice of community, school, and religious services and activities (including extracurricular activities) to the extent that is right for me, as planned for and discussed by my caregiver and caseworker, and based on

11 Ellermann, Caroline. “Influences on the Mental Health of Children Placed in Foster Care.” Family & Community Health 2nd ser. 30.25 (2007): S23-32. Web. 16 Dec. 2014.

12 Ellermann, Caroline. “Influences on the Mental Health of Children Placed in Foster Care.” Family & Community Health 2nd ser. 30.25 (2007): S23-32. Web. 16 Dec. 2014.

13 Gendron, Christine. Voices of Experience: Improving Mental Health Supports for Homeless & Transitioning Youth. Rep. Texas Network of Youth Services, 2011. Web. 16 Dec. 2014.

14 Ellermann, Caroline. “Influences on the Mental Health of Children Placed in Foster Care.” Family & Community Health 2nd ser. 30.25 (2007): S23-32. Web. 16 Dec. 2014.

my caregiver’s ability”.¹⁵ DFPS published the **Guidelines of Normalcy Activities**, setting expectations and providing examples of normalcy activities for residential contract caseworkers and foster caregivers. The same activities parents can arrange for biological children should be considered and arranged for every child, youth and young adult in foster care.¹⁶ Some of the activities mentioned and outlined in this document are: boy scouts, dating, cheerleading, etc. According to the **Guidelines**, in order to deem an activity age-appropriate and allow a foster youth to participate, caseworkers and caregivers must apply the “reasonable and prudent parent standard”, asking, “What information would I require before I gave my biological child permission to engage in an activity?”¹⁷

A significant issue identified as a roadblock to normalcy is concern for foster youth in Residential Treatment Centers (RTCs) and other restrictive settings. Many of these children and youth attend unique settings of education, such as a charter school or home-schooling. In these instances, these settings may not offer sports or social recreation, the placement is more restrictive and the opportunities to participate in activities with other youth are lacking, ultimately depriving foster youth of the opportunity to be social and meet children not in state care.

Although DFPS has provided guidelines for normalcy activities, the reality and implementation of these activities into foster youth’s lives is inconsistent and, in many cases, is not creating opportunities for foster youth to participate in these activities. With the importance of normalcy activities becoming more evident in scholarly research, the implementation of normalcy activities in foster care is crucial to improve children’s lives.

Many child welfare agencies throughout the United States have already increased discussion of the importance of normalcy activities for foster youth. This issue has been researched and evaluated in the child welfare sector throughout the country and legislative momentum has increased dramatically. Not only has the federal government examined the lack of normalcy in foster youth’s lives, many state legislatures have examined the issue and a few states have passed legislation to try to reduce the barriers to normalcy in this population. These states (Florida, Utah and Washington) all passed legislation with similar language.

In 2014, Congress enacted Federal H.R. 4980, which requires the Secretary of Health and Human Services to provide assistance to states on best practices for devising strategies, in order to assist foster parents in applying a reasonable and prudent parent standard in a manner that promotes child safety and normalcy activities. According to the bill, state child welfare agencies will be required to establish standards of reasonable and prudent parenting for the child’s participation in age or developmentally appropriate extracurricular, enrichment, cultural and social activities.¹⁸ These standards will extend to foster family homes and child care institutions and will be required to include policies related to the liability of foster parents/institutions using a reasonable and prudent parenting standard.

The Task Force recognizes the need for state-level legislation to address the lack of normalcy activities in foster youth’s lives. With federal legislation being implemented around this issue, Texas legislators should prepare for the need to update the Department’s policies in order to stay in compliance with

15 Rights of Children and Youth in Foster Care. Texas Department of Family and Protective Services, n.d. Web. 16 Dec. 2014. <https://www.dfps.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/rights.asp>.

16 Deckinga, Audrey. “Normalcy Activities for Children.” Letter to Residential Contractors. 8 Aug. 2013. Texas Department of Family and Protective Services, 8 Aug. 2013. Web. 16 Dec. 2014. <http://www.tffa.org/wp-content/uploads/2013/08/Normalcy-Activities-for-Children-Final_8-8-2013.pdf>.

17 Deckinga, Audrey. “Normalcy Activities for Children.” Letter to Residential Contractors. 8 Aug. 2013. Texas Department of Family and Protective Services, 8 Aug. 2013. Web. 16 Dec. 2014. <http://www.tffa.org/wp-content/uploads/2013/08/Normalcy-Activities-for-Children-Final_8-8-2013.pdf>.

18 H.R. 4980, 113th Cong. (2014) (enacted). Print.

federal standards. Legislation should also specify what things to consider when deciding if an activity is appropriate for a foster child. The normalcy legislation passed in Florida, HB215 or “The Quality Parenting for Children in Foster Care Act”, provides helpful language on requirements for decision-making:

“When using the reasonable and prudent parent standard, the caregiver shall consider:

- The child’s age, maturity, and developmental level to maintain the overall health and safety of the child.
- The potential risk factors and the appropriateness of the extracurricular, enrichment, and social activity.
- The best interest of the child based on information known by the caregiver.
- The importance of encouraging the child’s emotional and developmental growth.
- The importance of providing the child with the most family-like living experience possible.
- The behavioral history of the child and the child’s ability to safely participate in the proposed activities, as well as with any other child.”¹⁹

If Texas were to pass legislation with similar language, it would provide caregivers with a guideline to help them assess if activities are appropriate for foster children in their care. Due to the complexity of Texas’ foster care system, it is important for any legislation on this issue to require that these normalcy standards are implemented in private contracted agencies throughout the state, including child placing agencies and residential treatment centers.

Recommendations:

1. Define the Reasonable and Prudent Parenting Standard and include what to consider when caregivers are making decisions.
2. Require DFPS to verify that private contracted agencies promote and protect the ability of a child to participate in normalcy activities by requiring that private agencies have the same provisions of “reasonable and prudent parenting standards”.

Issue 2: Service plans can be too prescriptive and unwittingly block a young person from participating in an activity or experience and caregivers can be discouraged from allowing for participation in normalcy activities

Secondly, the Task Force believes that the prescriptiveness of service plans is limiting foster children’s access to normalcy. For foster youth living in foster care placements, a service plan is designed by the foster parent and caseworker to “meet the child’s needs for safety, permanency and well-being while the child is in substitute care”.²⁰ Service plans include exploring what is in the best interest of the child

¹⁹ Florida House of Representatives. Quality Parenting for Children in Foster Care Act. 2013. Web. <http://www.flsenate.gov/Session/Bill/2013/0215/BillText/er/PDF>

²⁰ Texas Department of Family and Protective Services Program Handbook: The Child’s Service Plan, § 6251 (2014). Web. http://www.dfps.state.tx.us/handbooks/cps/files/CPS_pg_6240.asp

based on development level, discussing the foster youth's input and determining the necessary level of supervision. According to the guidelines set forth by DFPS, foster parents and caseworkers should have a discussion about the expectations for allowing the child to participate in age-appropriate activities and should ensure these activities are referenced in the service plan at a level that allows for flexibility yet provides guidance as to which activities a child is ready to participate.²¹

Although DFPS has established these guidelines of flexibility in the service plan, the implementation of this practice has not been consistent. Service plans are meant to set standards for activities that are appropriate, but the Task Force found that many caseworkers or contracted agencies have practices that establish and maintain very prescriptive service plans. The challenge stems from the words of the service plan itself. The child's service plan currently lists the activities a child is allowed to participate in. In the event a child participates in an activity other than one outlined on their service plan, the caregiver faces the potential for a licensing violation.

Additionally, when foster care children are allowed to participate in normal, age-appropriate activities, Child Care Licensing may reprimand agencies, contractors or foster parents if the child is injured during these normalcy activities, even if the parent used a "reasonable and prudent standard" in deciding the appropriateness activity. For example, if a foster youth's plan states that he/she may participate in football but then gets hurts playing basketball, a foster parent could be punished for not following the service plan, even though the activities are very similar in nature and appropriateness. It is important for caregivers to have some leniency when using a "reasonable and prudent standard" to assess the appropriateness of activities for foster children and youth. Without this leniency, caregivers may fear child care licensing punishments or the increased liability. In order to fully empower caregivers to use a reasonable and prudent parent standard, which is essential for ultimately increasing normalcy activities in foster youth's lives, they must be granted protection from liability of injury sustained during normalcy activities. Moreover, in order for everyone to understand these sometimes complex issues, residential staff, child placing agency staff, foster parents kinship providers and residential child care licensing staff should be trained on them.

Recommendations:

1. Address service plan limitations by listing normalcy activities and/or experiences the child has/is participating in rather than listing activities as a limited list of activities in which a child can participate.
2. Mandate that the foster parent and/or the associated child placing agency shall not be held responsible for potentially negative outcomes beyond their reasonable control as a result of the child's participation in an age-appropriate normalcy activity, provided the activity is approved by the foster parent using the reasonable and prudent parent standard.
3. Require training for residential staff, child placing agency staff, foster parents, kinship providers and residential child care licensing staff. This training should include instruction on decision-making as a "reasonable and prudent parent", appropriate and trauma-informed ways to deal with a child or youth's misbehavior, the importance of a child's participation in normal adolescent activities and experiences, and the benefits of such participation to a child's social, emotional and developmental growth, well-being and mental health.

²¹ Texas Department of Family and Protective Services Program Handbook: The Child's Service Plan, § 6250 (2014). Web. http://www.dfps.state.tx.us/handbooks/cps/files/CPS_pg_6240.asp

Issue 3: Youth are not empowered to address concerns within their placements or to report abuse and are not aware of their individual rights or what recourse is available to them when rights are violated

It is important for the health, safety and well-being of foster youth to feel empowered and to have their voices heard. However, due to the nature of Child Protective Services and the foster care system, many foster youth feel they have little to no control over their lives and have no safe place to voice concerns about their care. With this in mind, it is extremely important for the Department of Family and Protective Services (DFPS) to equip youth in foster care with the tools and resources to voice their concerns about the treatment they receive while they are in state custody.

In order for youth to be fully empowered, they must be educated about their rights and have control and decision-making power in matters that impact their care. Empowerment of foster children refers to the level of choice, influence and control that youth can exercise over events in their lives. In order for youth to access necessary resources and gain a sense of empowerment over their lives and outcomes, formal and informal structures may need to be dismantled. According to research published by the Child Welfare Consensus Conference, ensuring youth empowerment is considered best practice for positive mental health outcomes for children in the child welfare system.²² Best practice guidelines state that “child welfare agencies and their partners [should] strive to help children and youth understand, at their level of functioning, their rights, entitlements, and opportunities, by providing a range of communications, engagements, and supports”.²³ Research also suggests that child welfare agencies should be held accountable through measurable outcomes related to youth empowerment.

Some resources currently exist for youth in the Texas foster care system to express concerns about their care while in state custody and to ask questions regarding their case. One of these resources is the Office of Consumer Affairs (OCA), the purpose of which is to serve as an independent office that answers inquiries and takes complaints regarding Adult Protective Services, Child Care Licensing and Child Protective Services. The OCA is considered an independent office although its policies, personnel choices and budget are under the purview of DFPS. The Office is mentioned in the Foster Youth Bill of Rights, created by the Department of Family and Protective Services:

“I have the right to complain to the DFPS Consumer Affairs Office at 1/800/252/5400 to report abuse, neglect, exploitation, or violation of personal rights without fear of punishment, interference, coercion, or retaliation.”²⁴

While the OCA is currently in the process of creating pamphlets aimed at educating youth in foster care, the Task Force believes it is necessary to increase these efforts so youth understand the purpose of the OCA and how to access it. The Task Force found that there are many roadblocks that deter youth in foster care from making reports to the OCA. Some of the deterrents identified were a lack of knowledge about the OCA, lack of access to OCA information, lack of trust in reporting to a system that oversees their care and the fear of retaliation if they file complaints and/or report concerns.

22 Romanelli, L.H., Hoagwood, K.E., Kaplan, S.J., Kemp, S. P., Hartman, R.L., Trupin, C., et al. (2009). Best Practices for Mental Health in Child Welfare: Parent Support and Youth Empowerment Guidelines. *Child Welfare* 88(1), 189-218.

23 Romanelli, L.H., Hoagwood, K.E., Kaplan, S.J., Kemp, S. P., Hartman, R.L., Trupin, C., et al. (2009). Best Practices for Mental Health in Child Welfare: Parent Support and Youth Empowerment Guidelines. *Child Welfare* 88(1), 189-218.

24 Rights of Children and Youth in Foster Care. Texas Department of Family and Protective Services, n.d. Web. 16 Dec. 2014. <https://www.dfps.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/rights.asp>.

In order to ensure that quality care and effective accountability are being provided to children within the child welfare system, an independent or autonomous agency should be established to review all complaints about placement and care. According to the World Health Organization, in order to fulfill user empowerment in mental health, an agency must ensure that independent review bodies are in place to review the lawfulness of treatment and services.²⁵ The Office of Consumer Affairs is currently housed at the Department of Family and Protective Services and does not have autonomy from the Department, including the lack of a separate budget.

Establishing an independent or autonomous ombudsman's office would give youth in foster care a secure outlet to voice their concerns and grievances, which would ultimately result in greater empowerment for the youth as well as assurance that the state is appropriately protecting youth in its care. Children and youth in foster care also need private access to information about their rights and about how to make a complaint to the OCA or ombudsman's office in order for them to feel safe enough to seek help or information. When they do call the OCA, their inquiries or complaints should be handled with special care given that these children are under the state's authority. Along with private access to OCA information and strengthening foster youth protections, this Task Force identified the need for the complaint process to be transparent. In order for youth to be empowered, they must be informed about the actions taken to investigate and resolve their complaints. This transparency should be incorporated into all of the OCA's processes and every complaint report should have an element of transparency, including investigation movements and actions taken or not taken. This information should not only be reported to the Health and Human Services Commission and DFPS, but also to the legislature in a yearly report that details findings, underlying causes and systemic remedies.

This Task Force also noted concern over the lack of child protections against caretaker retaliation after a foster youth reports his/her concerns to the OCA. The Texas Department of Family and Protective Services Rights of Children and Youth in Foster Care currently states that foster children have the right to complain to DFPS Consumer Affairs Office or Disability Rights of Texas if the youth feels that his/her rights have been violated or ignored.²⁶ It also states that the youth cannot be punished or threatened with punishment for making such complaints. Other than this statement, there are no specific policies that guarantee youth are protected from retaliation. There are also no consequences in place to address retaliation by staff or caregivers.

Recommendations:

1. Establish an independent Ombudsman office or establish autonomy within the OCA, ensuring that the Department of Family and Protective Services shall have no authority to:

- Create or change the policy and practice of the Office of Consumer Affairs;
- Determine the budget of the Office of Consumer Affairs; or
- Make decisions regarding personnel of the Office of Consumer Affairs.

2. Caseworkers and Child Placing Agency personnel should provide foster children and youth with better access to the Children's Bill of Rights by making copies available at court hearings and at site visits and provide ongoing education around these rights in order to fully empower them.

25 User Empowerment in Mental Health: A Statement by the WHO Regional Office for Europe. Rep. World Health Organization Europe, 2010. Web. 16 Dec. 2014. <http://www.euro.who.int/__data/assets/pdf_file/0020/113834/E93430.pdf?ua=1>.

26 Rights of Children and Youth in Foster Care. Texas Department of Family and Protective Services, n.d. Web. 16 Dec. 2014. <https://www.dfps.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/rights.asp>.

3. Require Child Placing Agencies and foster care placements to provide access to the OCA or independent Ombudsman's office contact information in private spaces, such as bathrooms or on the back of bedroom doors.
4. Require the OCA or independent Ombudsman's office to establish a written policy on foster youth's provisions and protections from retaliation by a caregiver, including a procedure of investigation of such retaliation and consequences for caregivers who are found to have engaged in retaliation against a child or youth in foster care.
5. Require the OCA to establish a secure form of communication with the child or youth in order to ensure that he/she is made aware of the investigation including the substantiation of any complaints that are brought to the attention of or determined by the OCA.
6. Require the OCA to establish specific procedures for working with youth in foster care who call to make an inquiry or complaint.

III. APPROPRIATE CAREGIVING ENVIRONMENTS FOR CHILDREN AND YOUTH IN SUBSTITUTE CARE

Background

Children in substitute care have experienced trauma

All children that enter the child welfare system have experienced trauma. They experience trauma when they are abused or neglected, when they are removed from their home and in countless other ways as they negotiate the child welfare system in Texas. Perhaps most damaging to children in the child welfare system is the relational trauma that they experience—the trauma of being hurt or neglected by the person or people they trust the most. This type of trauma often occurs in families across generations and can be especially difficult to overcome.¹ Numerous research articles and studies detail the impact of trauma on developing children and youth. Trauma can cause both long and short-term problems for children. “Consequences of trauma include difficulties with learning, ongoing behavior problems, impaired relationships and poor social and emotional competence. Children and youth exposed to trauma, especially violence, experience more learning and academic difficulties and behavioral and mood-related problems.”²

Part of the reason that trauma has such a detrimental and potentially long-lasting effect is that chronic, prolonged and sustained trauma actually alters brain development, especially in young children. When children grow up in chaotic environments where they are in physical danger or they are not getting what they need to survive on a consistent basis, the “child’s brain may be hyper-alert for danger...if this environment persists and the child’s brain is focused on developing and strengthening its strategies for survival, other strategies may not develop as fully. The result may be a child who has difficulty functioning when presented with a world of kindness, nurturing and stimulation.”³ This means that children who experience trauma may still struggle to attach to caregivers or regulate their emotions and behaviors, even if they are placed in an ideal home where loving and consistent care is available to them.

Trauma can have profound and life-long detrimental impacts on individuals

The widely renowned Adverse Childhood Experiences (ACE) Study, clearly demonstrates the long-term, costly impact of trauma and maltreatment in childhood. The study was a collaboration between the Centers for Disease Control and Prevention and the Kaiser Permanente’s Health Appraisal Clinic in San Diego, California and is the largest examination of the correlation between childhood maltreatment and adult health and well-being outcomes. Findings from the study indicated that some negative experiences in childhood are risk factors or causes for various illnesses and poor health. Indeed, the study found that the more adverse experiences that individuals had in childhood, including abuse and neglect by their caregivers, the more likely they were to experience a wide variety of health and social problems as adults. These range from liver and heart disease to increased risk for intimate

1 Children and Relational Trauma. Ackerman Institute for the Family, 2014. Web. 12 Dec. 2014. <<https://www.ackerman.org/centers/children-and-relational-trauma/>>.

2 Cooper, Janice L. “Facts about Trauma for Policymakers: Children’s Mental Health.” National Center for Children in Poverty. Columbia University Mailman School of Public Health Department of Health Policy & Management, July 2007. Web. 4 Dec. 2014.

3 “Understanding the Effects of Maltreatment on Brain Development.” Child Welfare Information Gateway. U.S. Department of Health and Human Services Administration on Children and Families, Nov. 2009. Web. 4 Dec. 2014.

partner violence, adolescent pregnancy and illicit drug use⁴.

The study found that the more adverse childhood experiences that a child faced, the greater their likelihood of experiencing health and social problems as an adult.

The chart below demonstrates the impact of these types of experiences over a lifetime⁵:



In spite of these daunting facts, there are many factors that help to bolster resiliency in children and youth and could help to combat the long-term impact of trauma. Research has shown that if children are surrounded by protective factors, or developmental assets, they are more likely to develop a sense of resiliency that might alter the impact that trauma has on their development and long-term outcomes.⁶

These factors occur across different aspects of the child's daily life and occur at the community, relationship and individual levels. At the community level, factors like a positive school environment, positive community environment and economic opportunities are all considered protective factors that help to promote resiliency in children. At the relationship level, parenting competencies, positive peers and caring adults are all important. And, finally, at the individual level, self-regulation skills, problem solving skills, relational skills and involvement in positive activities all contribute to protecting children and youth from the effects of trauma in their lives.⁷

All of these protective factors are interrelated and impact each other, which adds to the challenges of those trying to understand the impact of trauma and how to help children who have experienced trauma in their lives.

4 ACE Study: Major Findings." Injury Prevention & Control: Division of Violence Prevention. Centers for Disease Control and Prevention, 13 May 2014. Web. 4 Dec. 2014.

5 ACE Study." Injury Prevention & Control: Division of Violence Prevention. Centers for Disease Control and Prevention, 13 May 2014. Web. 4 Dec. 2014.

6 "40 Developmental Assets for Adolescents." Discovering What Kids Need to Succeed. Search Institute, 2007. Web. 4 Dec. 2014.

7 "Promoting Protective Factors for In-Risk Families and Youth: A Brief for Researchers." The Administration on Children, Youth and Families, 2014. Web. 4 Dec. 2014.

KEY ISSUES

Issue 1: Caregivers are not adequately trauma-informed and efforts to establish a trauma-informed care system are slow, disconnected, and vary in how they are defined

As more and more research comes out about trauma and its impact on the brain development of young children, professionals have increased their efforts to address trauma in their practices. The Texas CASA Mental Health Task Force found that the term “trauma-informed care” has become a buzzword that is beginning to be overused and misunderstood among professionals and policy makers. In order to effectively address the impact of trauma in homes, communities and systems, it is essential to establish a common definition for trauma-informed care. The Substance Abuse and Mental Health Services Administration National Center for Trauma-Informed Care defines trauma-informed care as “an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives”.⁸

Trauma-informed care focuses on the provision of developmentally appropriate, gender-specific care through the lens of research and evidence of effective practice for children and youth who have experienced events that are psychologically overwhelming.⁹

The Department of Family and Protective Services (DFPS) does not require any annual training on trauma or trauma-informed care, but does list the following as a best practice suggestion for annual training: “Special needs of children in care, which may include areas such as sexualized behavior, trauma, medical needs, and/or developmental disorders”.¹⁰

Since the State of Texas does not require training on the impact of trauma, it is safe to assume that many foster parents have not received any training on it. Additionally, those who have been trained on trauma may be trained to understand its impact, but not necessarily on how to interact and help children who have experienced trauma heal. Given the list of challenges that children who have experienced trauma face, it is essential for those who interact with children and youth in the foster care system to understand trauma and its impact so that they can understand the meaning behind challenging behaviors and relationship deficits that children and youth in the child protection system struggle with. Once foster parents have this foundational knowledge, they should then be given tools and strategies to utilize in their interactions and relationships with the children in their care in order to help them heal and improve long-term outcomes.

To date, there have been numerous efforts to train different types of professionals, advocates, service providers and parents about trauma and how to be trauma-informed. Some notable examples identified by the Mental Health Task Force are: The Texas Children Recovering from Trauma Initiative, a Department of State Health Services grant project; the Travis County Collaborative for Children, a Texas Christian University Institute of Child Development pilot project; the Trauma-Informed Care Consortium of Central Texas, led by the Austin Child Guidance Center; the Trauma and Grief Clinic for Youth, a University of Texas Health Science Center at Houston initiative; and others. Even domestic violence

8 “About NCTIC.” National Center for Trauma-Informed Care & Alternatives to Seclusion and Restraint. Substance Abuse and Mental Health Services Administration, 17 Oct. 2014. Web. 17 Dec. 2014. <<http://www.samhsa.gov/nctic/about>>.

9 “About NCTIC.” National Center for Trauma-Informed Care & Alternatives to Seclusion and Restraint. Substance Abuse and Mental Health Services Administration, 17 Oct. 2014. Web. 17 Dec. 2014. <<http://www.samhsa.gov/nctic/about>>.

10 Texas Department of Family and Protective Services. Licensing Division. Minimum Standards for Child-Placing Agencies. N.p., Sept. 2014. Web. 5 Dec. 2014.

and juvenile justice providers are thinking critically about how to utilize the research on trauma with the populations that they serve. The challenge is that none of the initiatives have the scope or funding to create a consistent, coordinated and evidence-based trauma-informed system for children and youth in foster care in Texas. These efforts have been largely disjointed, slow and focused on narrow groups, who often only see children and youth in foster care for short periods of time and not daily.

An Ideal Trauma-Informed Care System

The Task Force asserts that Texas will not have a truly trauma-informed system until professionals and policy makers begin to think of “caregivers” as anyone involved in the life of a child who has experienced trauma. This would include anyone who is with the child in the home, school, community, medical or mental health system, child protection system and the legal system. A successful trauma-informed system of care would share a common culture of supportive, consistent interactions with the child by all individuals and systems that touch that child. The majority of the training efforts to date have focused on providing training to mental health providers and direct service staff. These professionals are important to a child’s healing, but they often only interact with the child for two or fewer hours each week. While it is the case that some aspects of trauma-informed care practices are more easily accessible if an individual has formal training in counseling or social work, “there are a few consistent propositions that much of the healing from trauma can take place in non-clinical settings...[and] there is some evidence to suggest that trauma-informed living environments in which healing and growth can take place are a necessary precursor to any formal therapy that might be offered to a traumatized child.”¹¹

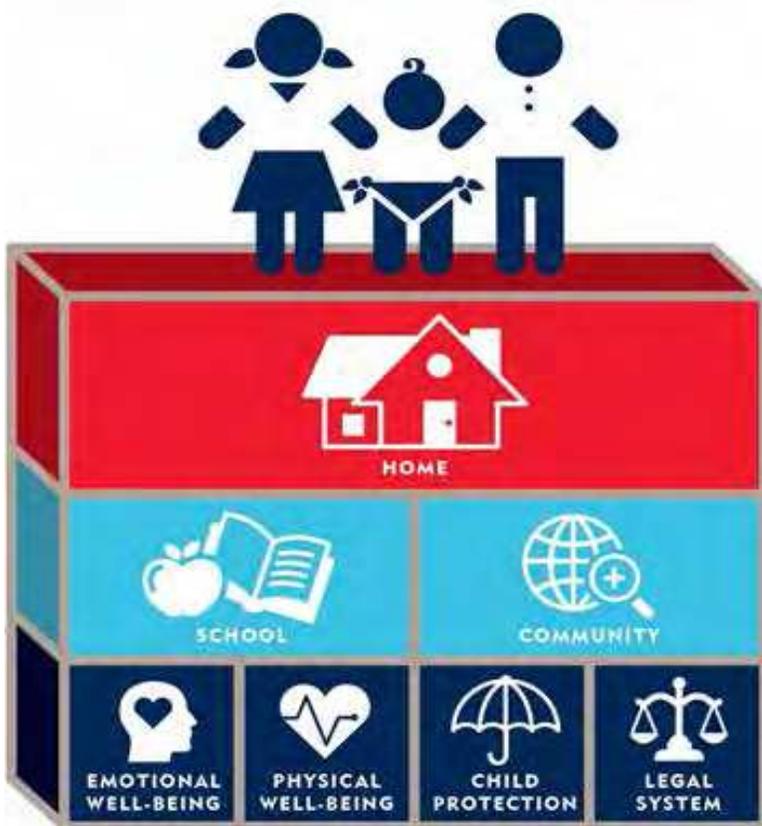
Some researchers believe that without trauma-informed living environments, the child cannot truly heal or fully engage in the therapeutic process. Dr. Howard Bath argues that children need three primary things in order to begin to heal from trauma, none of which require an intensive training in mental health interventions: the development of safety, the promotion of healing relationships and the teaching of self-management and coping skills.¹²

These three “pillars” of trauma-informed care have been widely adopted by researchers and trauma experts around the world. Feelings of safety and self-regulation skills are both highly dependent on the connections that children and youth are able to form with the adults in their lives. The individuals who most impact the child are those that the child spends the most time with, including adults who live with the child and teachers at school. The Task Force believes that the approach to trauma-informed care must shift to training and working with those individuals who are in the home and school environment, while continuing to train mental and physical health providers, legal professionals and advocates, and child protection system staff. Individuals in the community where the child plays and interacts must also be considered, including coaches, religious leaders, child care providers, mentors and others. If Texas could begin to think of everyone that interacts with a child in the foster care system as a “caregiver” for the child, an approach to a truly trauma-informed system could begin. The Task Force developed the diagram below to illustrate the type of trauma-informed care system that the members envision for the children and youth in foster care in Texas:

11 Bath, Howard. “The Three Pillars of Trauma-Informed Care.” *Reclaiming Children and Youth* 17.3 (2008): 17-21. 2008. Web. 5 Dec. 2014. <https://reclaimingjournal.com/sites/default/files/journal-article-pdfs/17_3_Bath.pdf>.

12 Bath, Howard. “The Three Pillars of Trauma-Informed Care.” *Reclaiming Children and Youth* 17.3 (2008): 17-21. 2008. Web. 5 Dec. 2014. <https://reclaimingjournal.com/sites/default/files/journal-article-pdfs/17_3_Bath.pdf>.

The Building Blocks of an Ideal Trauma-Informed Care System



Home: Biological family, kinship caregivers, foster family, adoptive family, residential staff, siblings

School: Teachers, administrators, foster care liaisons, pre-k

Community: Coaches, religious leaders, mentors, child care providers

Emotional Well-Being: Psychiatrists, psychologists, therapists, social workers, mental health professionals

Physical Well-Being: Pediatricians, nurses, medical doctors

Child Protection: CPS investigators, caseworkers, case supervisors, child placing agency staff

Legal System: Judges, attorneys, guardian ad litem, law enforcement officers, juvenile justice system staff

While Task Force members would like to see the term “caregiver” expanded as mentioned above, they recognize the importance of starting with tangible first steps in an effort to create an ideal trauma-informed system. For the purposes of the Task Forces’ recommendations, the term “caregiver” will be used to refer to anyone serving in a parenting role for the child, including biological parents, kinship caregivers, adoptive caregivers, foster parents and residential staff.

With this in mind, the Task Force developed a list of principles that it would like to apply to every caregiver of a child in foster care in an ideal trauma-informed care system. The Task Force recommends that eventually all caregivers serving children in the Texas child welfare system will be recruited, selected, trained, supported and expected to:

- Understand the complex needs of the children with histories of trauma and understand the comprehensive damage to brain, body, biology and beliefs that drive behaviors.
- Understand specific challenges of children who’ve suffered trauma, such as fear, flashbacks, aggression and other symptoms of PTSD.
- Employ effective methods of response to behavioral problems helping them recognize trauma-driven behaviors (fear, sadness, loss, pain) and to respond appropriately without reactivating the original trauma.
- Create comprehensive environments that disarm fear and help children heal, including the children’s need of a “safe base” relationship with caregivers.

- Recognize parenting strategies that are effective vs. those that drive further aberrations in behavior.
- Prevent secondary trauma that is often induced by behavioral intervention approaches that exacerbate fear.
- Spend quality one-on-one time with each child in the home.
- Create a meaningful connection and nurturing, trusting relationship with each child in the home.
- Collaborate effectively with the various systems that impact the child, such as medical, mental health, education, judicial, etc.

While many efforts have already begun and there is much focus by policy makers and stakeholders around this issue, the Task Force had a few additional recommendations to offer as first steps to a new kind of approach to a trauma-informed care system in Texas.

Recommendations:

1. Define trauma-informed care for caregivers within Minimum Standards.
2. Require all residential child care administrators and staff to complete trauma informed care training, as defined by the Department of Family and Protective Services.
3. Incentivize Child Placing Agencies (CPAs) to incorporate trauma-informed care into their assessments, training and support of caregivers of children with increased reimbursement rates.
4. Evaluate the utilization and effectiveness of implementing trauma-informed care models, as defined by the Department of Family and Protective Services, within the eligible CPAs.

Issue 2: Current practice does not include an assessment for adult attachment for alternate caregivers

Frequent placement changes have historically been a challenge for the Department of Family and Protective Services. In 2013, Texas children in permanent foster care for more than three years would, on average, experience eleven placement changes.¹³ Obstacles in placement stability have led the Department and child welfare professionals to study better methods to evaluate if a child is a good fit for his/her caregiver. Currently, the system fails to observe a caregiver's ability to attach to individual children.

The attachment style of a foster parent or caregiver has significant implications on the care of children and these implications follow children and youth into adulthood. According to research conducted in coordination with The Attachment Style Interview (an assessment used to determine caregiver's attachment style), a child's caregiver's attachment style has been linked to the child's attachment style, choice of partner and ability to access emotional support. Research shows that there is a clear correlation between the adult attachment styles of those parenting a child and their capacity to promote

13 Ramshaw, Emily. "Lawsuit Can't Cover All Kids in Long-Term Foster Care." The Texas Tribune. N.p., 23 Mar. 2012. Web. 07 Aug. 2014. <<https://www.texastribune.org/2012/03/23/lawsuit-texas-failing-foster-children/>>

well-being and safety for children who have been traumatized.¹⁴ Given this research, understanding a caregiver’s attachment style can help the system predict if a child will be successful in a particular placement and whether the caregiver can, with proper support, employ trauma-informed interventions to assist the child in his/her healing. Ideally, policies and procedures should exist to properly screen caregivers and to match children to caregivers who are best equipped to provide such involved care. In referencing the necessity for caregiver assessments and training, all adults qualifying as a “caregiver” are subject to recommendations.

Recommendations:

- 1. Require all agencies that screen potential caregivers to include an attachment screening as a component of the overall assessment to better understand that caregiver’s ability to form meaningful and trust-promoting relationships with children who have experienced trauma. There are several free attachment screening options and the Task Force recommends that the Department of Family and Protective Services create a standardized list of tools for agencies to utilize for these screenings.**
- 2. Train child placing agency staff to screen potential caregivers using attachment screening and ensure they have the proper assessment tools, as defined by the Department of Family and Protective Services.**
- 3. Require a set of standardized assessments of prospective caregivers, defined by the Department of Family and Protective Services, across child placing agencies.**

¹⁴ Bufulco, Antonia, Catherine Jacobs, Amanda Bunn, Geraldine Thomas, and Karen Irving. “The Attachment Style Interview: A Support-based Adult Assessment Tool for Adoption and Fostering Practice.” *Adoption & Fostering* 32.3 (2008): 33-45. Print.



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