National Town Hall on Child Welfare

Sonali Patel, Moderator

Bryan Samuels

Clare Anderson

Jean Close

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PATEL: [00:00]: Thank you. Good afternoon, everyone. Welcome. My name is Sonali Patel. I'm a policy advisor in the commissioner's office here at the Administration on Children, Youth and Families. And I'll be your moderator for this afternoon's town hall. This is a town hall which has been made possible through the logistical support of the Child Welfare Information Gateway, and we thank you for that. In the interest of time we won't be going through introductions of those who are both here in person and who have joined us online. But we thank you very much for joining us this afternoon and we look forward to a robust conversation, once we get to the Q&A portion.

In the roughly two years that Commissioner Samuels has been at the Administration on Children, Youth and Families, many of you have heard him present at meetings and at conferences and on various webinars. This is the first time that our office is doing a town hall, and it's come about now during National Foster Care Month due to several factors. First, I have to acknowledge that Congress has taken some key actions in the two years that we've been here. Those include requirements to include screening for trauma and improvements in monitoring for psychotropic medication, as well as reauthorizing our ability to grant Child Welfare Waivers. That's given us the opportunity to release further guidance that has been rolling out recently which includes: the recent information memoranda that we've released around well-being, around psychotropic medications, and around the iv-e waivers. All of which will be covered throughout the presentation today. Additionally, we have a series of funding announcements that have begun rolling out and will roll out throughout the spring which will focus on social, emotional well-being. And again you will have the opportunity to hear more about those in-depth during today's presentation. We will at the end of the presentation, as I mentioned, have an opportunity to have a Q&A portion. Our online participants will be able to submit questions in the chat pod, which we will capture and respond to as we get to them. And additionally, our in person participants have note cards on their chairs. They're welcome to write questions as the presentation moves forward. We'll also, during the Q&A portion, ask you to come up to the mike that's in the middle of the room, to ask your question and to engage in a discussion with any of our panelists.

So let's go ahead and get started, given that we've gone a bit beyond the 3:00 mark, but I think we'll have sufficient time to get all our presentations in and to have time to have the discussions.

We're going to go ahead and start off with our partners; giving you all a welcome in addition to the welcome that ACYF has just been able to give you. Our partners from the Centers for Medicaid and Medicare Services as well as the Substance Abuse and Mental Health Services Administration are here and we thank them very much for joining us. They've been true partners in helping us rethink improving behavioral health for children known to Child Welfare so that we can collectively work to get these children and families the right services at the right time. We'll go ahead and start off with our partners from CMS. Let me introduce Jean Close. She's the Technical Director in the Division of Benefits and Coverage at the Centers for Medicare and Medicaid Services. Welcome Jean.

CLOSE: [00:03:40] Our deputy administrator at CMS, as well as Barbara Edwards, our group director with the Disabled and Elderly Health Programs group. We wanted to share our excitement for the demonstrations that you're going to be hearing about today. It's a great opportunity for us to share what we are doing currently in partnership with ACF and SAMHSA and so we're looking forward to telling you about what we're doing now and what we would like to ask for your assistance with going forward. Joining me also on our panel is another of our partners with SAMHSA.

DEVOURSNEY: [0004:25] Hi, I'm David DeVoursney from the Substance Abuse and Mental Health Services Administration. First I have to apologize. My superior, Lark Wong, who's the senior advisor on Children, Youth, and Family Issues, was pulled into a last minute budget meeting so you're stuck with me. But I can tell you that we're really excited about this partnership. At the Administration for Children, Youth and Families this really led and challenged us to think very specifically about the needs of children and child welfare and youth and child welfare and specially related to their behavioral health needs. And I think the push for our real focus on the evidence based, what works for individual youth situations has really been refreshing. And it's been great to have that leadership to drive us in the field forward.

PATEL: [00:05:11] And at this point we'll go ahead and begin the official portion of our presentation. So for the next approximately hour and a half or so, we'll be hearing from ACYF, CMS, and SAMHSA representatives. We're going to go ahead and start off with a presentation by Commissioner Brian Samuels of the Administration on Children, Youth and Family.

SAMUELS: [0:05:32] Great, thanks Sonali. It's actually really exciting to have the opportunity to discuss each of the information memorandums that have gone out over the last four weeks or so. We think that issues related to well-being, psychotropic medication, and the waiver opportunities themselves are really best thought about in conjunction with one another rather than seen as separate and unrelated. We think that there are critical components that the waiver allowed states to address that can move us forward both in effectively using and appropriately using psychotropic medication as well as promoting the social and emotional well-being for children who are engaged in the foster care system or who come in contact with the foster care system. So I wanted to start just briefly by introducing the basic premise around the waivers and then really suggest to you that there's an opportunity to integrate our work. Because again we think that there are close ties between all of this work and a real opportunity to look at them this way. And so when you look at the waivers as an opportunity, Congress really did envision broad meaningful change in child welfare they specifically identified the categories that we typically think of when we think about child welfare and really did expect significant change in one or

more of these areas. So the first area that Congress indicated that the waivers were considered to address is one around increased permanency. So there will be some states that will look at the waivers and see them as an opportunity to realign their resources both federally as well as state and locally to address specifically permanency in increasing the rate at which children move to permanency. Other states will see the opportunity in the waivers to focus on the second dimension which is in home services. Some states that see a significant growth in the number of children entering through its front doors or families entering the door, but if they could provide, enter the foster care system. Those states may in fact take the opportunity under waivers to focus on providing a different set of support outside of the out-of-home care environment and really prevent breaking families apart and bringing their children into out-of-home care. And then the third category that Congress contemplated when laying out the waiver opportunity, was really to look at the issues of prevention of abuse and neglect and the prevention of children who have exited the foster care system from re-entering. Now some states will choose to focus on one of these; states could actually choose to focus on all five. That really is up to states. But I think they will ultimately make that decision based on their current context. And given that it really is a partnership between the federal government and the state government in operating the child welfare system in this country, we think it's totally and completely appropriate for states to be in the position of really making a decision about which of these areas they will focus on and which of these areas they believe they can have the greatest impact.

Beyond those three categories there's certainly lots of opportunity for states to make decisions about what the best approach is. So what we thought we would do today is rather than go through each of the somewhat boring details of the choices that states have, we thought that it might be more interesting for the audience for us to basically organize our presentation around what a state could do with this new authority. To really provide you a sense of the dimensions of change and the type of change that one could achieve using these demonstration waivers. So we have articulated that we think it's important for any of these waiver opportunities really to begin to address issues of well-being typically in the child welfare system we talk about safety, permanency, and well-being. States have made a lot of progress on safety and permanency we're encouraging states to think about the next logical step in the evolution of child welfare which is to build on the success that's been made in safety and permanency and add that third dimension of well-being. We've encouraged states to consider the social and emotional dimensions of child well-being, in large part because when we look at the literature and we look at the impact of maltreatment, abuse, and neglect on the lives of children. We see those social and emotional dimensions as being those most impacted. In addition to that, we are hopeful through these waivers that we can get really big change in child welfare. We're hoping for transformative change. We're hoping for the kind of change that can lead the field in a future direction. We really want something to happen through the waivers that provide congress a blue print for the kind of meaningful change we need across this country in child welfare. And fourthly, we're really encouraging states to look at leveraging the involvement of other partners in their reform and transformational efforts. We know that Medicaid plays a critical role in serving children in foster care. So we'd love to see states give consideration for the role that Medicaid might play in an overall waiver proposal. We think the work that many states have done with SAMHSA around the systems of care grants; we think that's another opportunity to really make big change. There are other federal entities that over the last couple of

months have made funding announcements that specifically include the child welfare system and children served by the child welfare system. And we think other federal entities could also be brought into the fold here in looking for really transforming change in child welfare.

So there are many ways that one could look at the definition of well-being. There are many ways to think about the basic components. But when you look at the level of change that has occurred in the nation you can look at this slide here. This slide here is intended to show you just over the last three years how many states have had decreases in their overall population, versus those states and territories that may have had increases. And as you can see from this slide, it shows you that 47 out of the 50 states plus the two territories, 47 of them actually have had declines over the last three years. If you look at the last 15 years, you see an overall decline of about 30% nationally. And there are some states like Illinois, like Maine and Vermont that have had reductions in the 60 and 70%. So we think in those states, those states that are well along the way of refining their efforts around safety and permanency we think for those states waivers represent an opportunity to move to that next level. Which is really to focus on the well-being of children who they serve through the foster care system. In that context, what we know about serving both the children and their families is that a growing awareness of where states are at and what their capable of addressing in terms of safety permanency and well-being. And so we've highlighted here the two areas where you see states being in the strongest position so as you've seen the overall decline in the population that means there's states that have increased their capacity to really move children to permanency you have also seen them able to maintain rates of safety. So even though you've seen a decline we haven't seen an increase in terms of the rate of safety or problems with maintaining safety for children served by the foster care system. So we think those two movements together say that many states are moving in the right direction. Beyond those two elements of well-being we think there's more work to be done. So when you look at the impact of maltreatment on children we know it has an impact on their self-efficacy. Their belief that they're capable of doing something and doing it effectively. We know that maltreatment has an impact on their own self-image and their understanding of who they are as children and who their parents are as adults. We know that the impact of maltreatment affects an ability of a child to maintain a positive healthy relationship both with their peers as well as with adults. And we know that maltreatment has an impact on their ability to maintain emotional regulation. To be able to calm themselves and to be able to engage in relationships that are mutually reinforcing and reciprocal in nature. And so we think that the child welfare systems in this country can begin to address elements of well-being that I just described and to do it in a manner that begins to reposition children on a positive trajectory even though they will spend a short period of time in child welfare we think that if we can begin to move children and their families in that direction then when they exit the foster care system they'll be well on the road to moving towards positive outcomes. And for those children who we choose not to bring into the foster care system we think by addressing issues of well-being we increase the likelihood that they won't come back to the system that they won't re-enter the system. And so again we think there's an integrated opportunity here to build on what we've already accomplished in terms of safety and permanency but use the waivers as the opportunity to turn towards really beginning to build our capacity to address issues of well-being.

I've said this many times before the progress that we've made around safety and permanency we've made over a 15 year period of time. We don't imagine that the waivers themselves overnight will move a system to issues of well-being. We do believe that we have enough evidence and enough examples, real life examples in child welfare today to begin that movement towards well-being and learn a ton along the way. So we didn't know in 1997 everything that we would be doing today to move children to permanency. We may not know all of the things that we'll be doing 15 years from now to move children to safety, permanency, and well-being, but we think there is ample evidence and states have made ample progress. That this is a logical next step in child welfare and it's one that we see the waivers as being a particularly great opportunity to move in this direction.

Interpersonal trauma, it's a growing understanding in child welfare that many of the children we're serving have experienced interpersonal trauma. Whether we're serving them in their home or serving them in a foster home or living with a relative. We know more and more from the literature that maltreatment, abuse, and neglect have a fundamental and profound effect on a child's ability to function. And many in the field have come to understand it as complex trauma. Others have described it as developmental trauma. Some have described it as toxic stress. Pick whatever name you want to call it, we know it has a tremendous effect on the lives of children. And we know that it follows them long into their adulthood. And so one way to think about the waivers, one way to think about using the waivers to create a different system. A system that is transformed in its capacity to promote well-being for the children and families that it serves. We think one way of doing that would be to focus on interpersonal trauma and really to think about how from the front door to the back door, child welfare systems can use the waivers to really build that capacity.

So some have wondered what exactly are the essential elements that a state might consider as it tries to build a waiver proposal around issues of interpersonal trauma? So we've put together a short list here. we have stolen this list from experts in the field, we do not claim that we are the makers of this list, but we think that the field of interpersonal trauma has progressed to a level that we think that it is fully integrateable into the work that is being done around child welfare. So some of the essential elements focus on maximizing a child's sense of safety and that's not just physical safety, but that's psychological safety. We have learned a lot about comprehensive assessment that knowing a child's trauma history is a critical component to serving a child. Well it's also important to understand a family's exposure to interpersonal trauma, because often the parents of abused and neglected children have themselves been exposed to trauma. And so fully incorporating that in our understanding of our work with families would be important. Assisting children in reducing the overwhelming sense of emotion that they experience. Addressing issues of the impact of trauma and subsequent changes in child behavior. We think are important and so do other experts. And helping children create new meaning around their trauma histories. And their current experiences all could be folded into a waiver proposal under the new authority. [00:21:18]

Above and beyond that we think there are a number of other really critical steps that states could take to take work that they're doing and make it really trauma informative. But I'm going to talk a little bit about that movement. So one of the things that we think is really important as states try to build a system that makes sense. So as states take the core understanding of maltreatment and really try to

build a plan around it, we would suggest that one of the things that they would want to do is first really build a clear understanding throughout the system about the impact of trauma and really begin to help everybody in the system appreciate what a trauma informed set of practices would look like. We think a second component to building a plan around interpersonal trauma is really changing the way we do assessments throughout the system. A third component would really be building a different set of case plans and doing a different form of case management in supporting children and their families. The fourth component would be to really contract for a different set of services than are currently available in a foster care system. And then fifth to really focus on those cross-systems partnerships that have to be established. Medicaid being a good example of one. Within a state to enable you to really take a child welfare system to a different level. So we would see all of these components as one that could be incorporated into a five year plan. Again, we encourage states as they look at each of these components to not think of the waiver as a waiver that a plan has to be implemented in year one and it has to be the exact same plan for all five years. But instead to really help states look at each of these components. Lay them out in a phased approach to implementation. And to make sure that each of the components are in place at the end of the five years. We think that's a far more rational approach than trying to do all of this work all within the first year.

So the next component that states could move to once they have this larger strategy is to really think about how they would train all of their staff across they system in a trauma informed approach. And this slide here lays out the basic components of that. So building an empathetic understanding of trauma and the nature of its effect on children is critical. Raising their clinical reasoning is really important to the work that's being done here. To recognize that evidence based practices can play a role in identifying the availability of those evidence based practices in communities is really critical. Thinking about bringing research friendly ideas into practice is critical. Again because we haven't figured out all of the things we need to do to get to well-being. Paying attention to the research is important, and translating some of the research into practice will be a critical component to the work. And then just making sure that families, that everybody in the system takes a strength based approach to working with families. We think all of those things are a part of a core training strategy around taking advantage of the waiver.

Next, we would focus on some of the issues related to neglect. When you think about the child welfare system in general you really have the families come in, it's not a great way to describe it, but we'll just keep it simple by saying that in large part you have children who enter foster care because of physical neglect as the primary reason. Some who enter because of sexual abuse as the primary reason and then you have a very large group that enters the foster care system under the term of neglect. So as states really sit down and try to figure out where did they target their resources, we would think in a trauma informed approach one area that they might focus is on the category of neglect. It's the largest category and therefore if they can figure out how to get services and supports right there they can have a large effect. The second reason is reflected in this slide here, which is there was a study that was published recently that showed as it relates to trauma, that children who come in to foster care under the type of neglect category, they have the greatest rate of trauma. It doesn't suggest to you that in domestic violence there isn't trauma, related symptoms, or emotional neglect, or physical neglect, or sexual neglect. All of those categories come with some form of trauma related to them. But when you look at

the broad categories, it appears that the children who are affected by neglect also show the highest number of symptoms related to trauma. So in our thinking taking the trauma informed approach could focus specifically on the category of neglect and really build the states capacity to address that issue. And again if we can address that issue we can get a very large bang for our buck. Next slide. Not everybody is comfortable with the idea that a family that is found to have neglected their child ought to be a candidate for being served differently or being served in a in-home setting. We think it's important for states to move in that direction. Not all families will be able to be served in home. We think there are an increasing number of families that could be served in home. We think the waiver provides a unique opportunity for that. So we've provided here just what we would describe as a tiered approach to focusing on neglect, recognizing that some children and some families are more impacted. So if you took a tiered approach you would see that from tier four down you have some families that are primarily impacted in the social and environmental risk issues related to neglect. Some are also then affected at the third tier around caregiver risk around substance abuse, domestic violence, mental health issues. In the second tier the focus is really around families where there's a harmful child and caregiver interaction. And then in the first tier those children that are really struggling to function because of neglect. We would suggest that if a state was going to build a strategy around trauma that they would start at tier one and begin to think about how they would serve those families in an in-home setting and then work their way down the tiers rather than starting with those children who might be the most challenging and families that might be the most challenging in tier one. States could really build their capacity starting at tier 4 and working their way in. Next slide.

So that then provides us an opportunity to talk about. So, if we started there what else could we do in a child welfare waiver to be able to address issues of trauma. We think the next opportunity is to really think about investigation in a different way. Most child welfare systems go out and do investigations, when they do those investigations they're primarily focused on confirming whether the allegation of abuse and neglect can be documented. If they can document it that becomes a substantiated case of abuse and neglect and then they have to make a decision about whether a child should be removed. We think that there is a real opportunity to add a trauma focus to the investigation. We think that by doing that it could really change the nature of the relationship with the family from day one. We think it can change the impact that we are having on the child from day one, and we have the benefit of a great example that 5 counties in California undertook to take a trauma informed approach to investigation. We think it's got a great deal of potential and it's one step in the context of a waiver that child welfare agencies could take to begin to move their system to a trauma informed approach.

Next slide. So for those children for which there was a determination that abuse and neglect did occur, a state could then introduce a trauma and assessment screen that would allow you to from day one determine whether there are trauma symptoms that are best addressed early in the life of the case. And so we are encouraging states and one state could take the approach of first introducing a trauma screen, that every child in every family with a substantiated case of abuse and neglect could be screened for, to determine whether there are appropriate interventions to address their needs. For those children who appear to be struggling or families that appear to be impacted by trauma states could go deeper in doing a trauma assessment at that point they would be trying to determine what would be the most

appropriate means for intervening for that child or that family. And for some families, during that trauma assessment a determination may be made that there's actually a mental health diagnosis that might be appropriate for the child or the family. And they could then go to that third level of doing that kind of mental health evaluation which would allow them to determine whether there was a mental health diagnosis that ought to be addressed. Again we have a good example of doing this work in states. The state of Illinois introduced a screening regiment that was directly related to this. We think that it pays great dividends in terms of the child welfare systems understanding of where families needed support and where they didn't need support. And with the trauma screen in the state of Illinois really became the starting point for the redesign of all the services delivered within that system. And so we think a trauma screen and assessment is a logical step to take under a waiver opportunity.

Next slide. Again based on making a determination about whether abuse and neglect has occurred as well as making a determination about whether trauma is affecting the family's ability to function. We think that one of the promising interventions is one that focuses on prevention. And that prevention is done in light of the existence of trauma for families. So there's a really promising practice around trauma adapted family connections. It's a program that's had a preliminary evaluation and has positive results. It takes those earlier trauma elements and integrates them into a structured program of working with families. It's been shown to reduce risk factors significantly for abuse and neglect. And it represents one of the early interventions that a state could introduce to really being to prevent families from having to be moved into out-of-home care. We think that an intervention like this could be tied to the assessment that I just described and could be tied to the results of an investigation. So that even though a family has been found as a substantiated case of neglect a screen and assessment could be done to determine that we could serve this family in the home, providing this as an intervention. So again, it's a promising practice. It's an evidence-informed practice, it's not an evidence-based practice. But it's one that the state could consider introducing at the front end of their system to really begin to take on issues of trauma. Next slide.

In addition, when we look at the past waivers, one of the issues that emerges out of looking at those prior evaluations of waivers, is that most of those waivers focused on systems level changes didn't necessarily focus on building the skills and competencies of case workers to work in a different way with families. And so we think a trauma, I'm sorry; a solution based case work model is very adaptable to a trauma environment. So when you look at solution focused case work it's defined by having a developmental focus; which we think is really critical, it has a strength based approach that we think is really critical. And it has a collaborative approach and interdisciplinary approach. All of that could be tweaked and adjusted but could be well integrated with a trauma agenda. And really reshape the way we do case work, in child welfare. Next slide.

We think what's really attractive about a solution focused approach is that it's already has demonstrated to have dividends in the child welfare environment. And so as you can see from this slide here, it's been evaluated to have really meaningful changes in child welfare. And therefore, we think it provides a great next step in terms of building on an evidence-based case work approach and adding to it that trauma intervention approach. Next slide.

The waiver talks quite a bit about evidence-based intervention. Both the waiver around well-being as well as the waiver around, I'm sorry the information memorandum around the waivers. And so there are a growing body of evidence-based interventions for states to choose from. Those are services that they might offer for families outside of the out-of-home care scenarios, so they could provide these services in the home. But they could also deliver them in the out-of-home care environment. We've identified 5 of them that are here we think it's interesting for states to think about these 5 because of two reasons. One, is some of them have already been documented to have the impact that we're interested in achieving on issues of well-being. The other two have also been of evaluated to have impact on safety and permanency. So we think these are five interventions, all that have an evidence-based slant to them each of which could be done in a trauma based environment and they could synch well together to really create a continuum of interventions that starts at the front door of the system but then moves inside the system. In each of these interventions what's exciting about them is that they're designed around a curriculum that staff in private agencies could be trained to deliver. And done in a way with high fidelity, we could rely on producing the kinds of results that we hope to get through the waiver. Next slide.

We think that much of this work could be done in the context of Medicaid. This slide here shows you by age groups. The percentage of children who are in the foster care system and receiving either a mental health prescription, meaning medicine, or services funded by Medicaid. So as you can see about 36% of children 0-5 are receiving some services under Medicaid around mental health issues. When you look at the 6-11 population it moves to over 50% and when you look to the 12 and over population it moves to over 60%. So Medicaid has a role in each of the services that I described on the page above. Those are serving families that would likely qualify for Medicaid services, and so we think looking at evidence-based strategies that are appropriate for children and families in foster care that all require a clinical intervention such that they would qualify under the federal definition of medical necessity. We think there's a real opportunity here to combine the two to think about evidence-based strategies but think about it by introducing those services that would also be supported by and subsidized by the federal program for Medicaid. So we don't just want to introduce evidence-based strategies but we want to build them onto the existing infrastructure using the current authority under Medicaid. Such that they're sustainable beyond the life of the waiver. So we think about the waiver as the transition point onto an evidence-based strategy but it's one that we think ought to be tied to Medicaid so that they're sustainable in the long term. Next slide.

We think there's also an opportunity taking a trauma informed approach to re-think the way we do residential treatment in foster care also. So you know, in most states where you have children in out-of-home care you have somewhere in the category of 3-7% of them are actually in a residential treatment at any point in time during the year. And so in those instances we think that states can increase the efficacy of those treatment interventions by adding a trauma component. So this slide here describes an initiative that was undertaken back in early 2005, 2006 to introduce a trauma based approach to a more generic approach to residential treatment. And by taking those basic principles that I described earlier in my presentation and integrating them into a residential treatment program this collaborative was able to identify some really significant improvements in overall performance. So by combining the residential

treatment with a trauma informed approach they were able to increase the problem reduction in those residential treatments by almost 35%. They were able to reduce the amount of time spent in residential treatment by almost 40%, and they were able to double the number of positive discharge outcomes. Said differently they were able to double the positive outcomes that happen after a child exited residential treatment. Again this doesn't completely dismantle the work that residential treatment programs do it doesn't suggest that all residential treatment programs would be appropriate for a trauma informed approach. But where appropriate we believe that a state could integrate into the programs that it purchases around residential treatment a trauma component and by doing so improve performance which means that children spend less time in residential treatment and the benefits to the state is that they get a good outcome for the child. But more importantly they actually achieve a savings. So combined better outcome and savings that states can take and reinvest we think is another reason why a state could take a trauma informed approach, apply it throughout the major components of their work, including residential treatment and collectively done together over a five year period of time could in a meaningful way transform the work being done in child welfare. And so again we're excited about the opportunity for waivers. We're not suggesting that everybody would take a trauma informed approach to their waivers, but they could, and if they chose to we've provided one pathway from where most agencies are at today and where they could be five years from now, if they pursue the waiver. We anticipate that there will be other pathways to transformative change in child welfare that will also be proposed by states. And we welcome the opportunity to consider all of the waiver applications that really do propose meaningful change and are prepared to support states as they both propose them, refine their plans and ultimately we're prepared to support states as they move forward in implementing a waiver demonstration project.

And so this last slide here just gives you a timeline that states are on, so as you already know we've released the waiver we did that last week so states have all of the information they need to make an application for a waiver. We have requested that states that intend to apply for the first 10 waivers give us a letter of intent by June the 4th. We're not requiring that states who don't submit a letter, that does not prevent them from actually applying for a waiver. If there is a state that can't meet the June 4th letter of intent requirement but can in fact, prepare a proposal and submit it by July the 9th, we will consider that. We have told states that we will review all of their proposals on a rolling basis. We hope to get 10 proposals that we can work through and negotiate with states and reach an agreement by the end of the fiscal year, but here's an important point. If a state submits a plan, if that plan does not meet our timeline, but it is a viable plan we will begin working with a state as soon as their plan is submitted, and as soon as we can work with that state where we can get to a place where the plan is implementable we will do that and we will approve the plan then. So if it's the first day of the next fiscal year that we reach that agreement that's when we will sign that agreement and that state can start then to move forward with their plan. This isn't the same as the competitive process where if you don't win the first year then you have to reapply the second year. Instead we'll do this on a rolling basis and as soon as those states plan meets the requirements laid out by Congress and is moving in the direction that we think is correct in meeting the overall set of priorities we're prepared to work with the state to get those plans agreed upon and moving forward, because we think all states have an interest here. And we are encouraging all states to consider moving in a direction that ultimately results in them submitting

a waiver plan. So again this is one pathway but we thought it would be valuable to think about all of the components so that as states and others consider making applications they have some concrete examples of steps that a state might take to achieve the kind of reform we'd love to see.

PATEL: [00:47:23] Thank you Commissioner. We're now going to hear from the Deputy Commissioner at the Administration on Children, Youth, and Families, Clare Anderson, and she'll be presenting on two topics; Improving Management of Psychotropic Medications for Children in Foster Care, and Upcoming Funding Opportunity Announcements from ACYF. Thank you.

ANDERSON: [00:47:43] Thank you so much. As the commissioner has laid out, a vision for change and how states might go about addressing trauma for children known to child welfare and their families, an important component to consider is the use of psychotropic medication, in this population. As we have an evolving understanding of trauma and the overlap with mental health symptoms, it's increasingly clear that it's really impossible to tease the two out. And so when you think about the use of psychotropic medications to address mental health diagnoses, one really has to consider the trauma that children have experienced and the symptoms that are related. So, next slide, please.

We recognize as has Congress that there are higher rates of psychotropic use among this population as compared to the general Medicaid child population. We see that in the literature as you're working in states you know that on a day-to-day basis. And as Sonali recognized at the beginning the opening of the conversation, Congress passed the Child and Family Services Innovation Act in 2011, which provided additional authority for states to again to think about how to oversee and monitor the use of psychotropic medication differently. We have put out an information memorandum which is noted here on the slide as well as two program instructions providing detailed information about the use of psychotropics and how states should begin to put together a plan in their annual State plan amendment that comes to us and these are the five components. The first is a comprehensive and coordinated screening, assessment, and treatment planning to address the use of psychotropic medication. Really to ask states to do a comprehensive screening much like the Commissioner noted previously and functional assessment to determine what are the needs and how are they related to the treatment that is being considered? The second is informed and shared decision making among all of the members of the team so that there is a coordinated approach that everyone understands what is being treated and why, and what the approach being taken will be. We want to make sure really that everyone; prescribers, care givers, case workers, the child as age appropriate, are involved in that decision making process. The third is effective medication monitoring both at the child level and at the agency level. So that individual children are being tracked comprehensively so that as their health care provider change there is clarity about what the prescription is and why it is there. But also at the agency level so that there is the ability at the system level to identify red flags; the children are being prescribed multiple medications that may interact or may not be an evidence base for using the multiple medications. So both at the child level and at the system level. That there is expert consultation from child and adolescent psychiatry available at the system level so that states are able to make good decisions as they are tracking and monitoring and when to go back to the original prescriber and have a conversation about why a medication is being chosen and in what constellation. And the fifth is mechanisms for information sharing more broadly and for providing educational materials so a bit of a dual process here so that there is clarity among all team

members but also so that people are informed decision makers when they are actually being prescribed a medication.

I also want to tie this back to the Commissioner's remarks about the use of evidence-based practices to promote social and emotional well-being and to address trauma, as many of those effective practices are considered first line treatments or concurrent treatments when psychotropics are being prescribed. So that there is a psychosocial behavioral intervention being used in addition to either considering or when a prescription has been made in conjunction so that there is a multi-pronged approach to improved functioning.

Thanks Kate. I want to shift gears here a bit and talk a little bit about our funding announcements and our discretionary monies that we have released this year and how they relate to the overall approach to supporting and promoting social and emotional well-being and addressing trauma. We recognize that all states are not in the same place around applying for a waiver either developmentally they might not be ready or it's not the right decision for their system when they assess what their strengths and needs are. And so we've tried to provide either a conjunctive or an alternative route for states to take to access resources in a way that allows them to build capacity to promote social and emotional well-being and address trauma. so, you can go ahead and change slides.

I'm just going to give you a little bit of an overview of the discretionary funding announcements that we have out on the street currently or will shortly be there. This is not the full array, but I think the array that I'm going to walk through, provides a really good example of how it connects to addressing trauma. So the first one is the child welfare early education partnership to expand protective factors for children involved in the child welfare system. And this really allows states to develop a partnership among child welfare and early childhood providers to improve health and mental health of children who are very young and need additional developmental support. We really are hoping that states are thinking about how to build protective factors for this early group of children so that we are beginning early to think about meeting their social and emotional well-being needs.

The regional partnerships to expand protective factors with children with child welfare involvement, this announcement really is an enhancement of the approach that has been taken previously and really builds on the knowledge that has been gained through the work to date. We think the trauma literature really can provide an important understanding of how to address the substance used and abuse needs of parents and that there are trauma interventions and trauma informed approaches that can be taken to support not only the substance abuse treatment that occurs in the regional partnership grant but also the interventions that are needed to build parenting capacity and the interventions that are needed to promote well-being and improved functioning for parents and for children. Next slide.

The comprehensive support services for families affected by substance abuse and or HIV/AIDS is quite similar in so far as we are hoping that states will begin to think comprehensively about how to package a set of interventions that improve parenting capacities, social-emotional well-being, and address the substance abuse issues that are seen in this population. We really think that it is possible to think strategically with your partners in looking at the literature around what are the strategic interventions

that are most likely to improve functioning? It's important I think to note with these two grant opportunities and one that I will talk about in a moment around supportive housing, about how important addressing the needs of parents are in this work. Sometimes I think when we talk about improving social and emotional well-being for children that people don't always hear that we are promoting social and emotional well-being and targeting parents for healing and recovery as well. And the grant the discretionary grant opportunity that we have made available really do get at this issue of how do you promote social and emotional well-being within a family context? You'll note many of the interventions that we think actually improve functioning for children, almost all of those interventions involve parents and or their caretakers in the healing and recovery process and identify opportunities for enhanced nurturing and enhanced parenting capacity.

The initiative to improve access to needs driven, evidence-based or evidence-informed mental health and behavioral health services in child welfare. We're really hoping that states will take advantage of this funding announcement in so far as it does a few really interesting things. It helps states to begin to organize it's thinking around screening and assessment, and aligning the service array to meet those identified needs. So that you are really beginning to think strategically about what are the effective mental health and behavioral health services that we need to put in place to address the needs that are identified through our screening and assessment process. In addition making sure the case planning like the Commissioner identified earlier, is trauma informed is meeting the needs that are identified and that the service array is configured consistent with what you're finding.

And then the last one that I want to highlight is the partnership to demonstrate effectiveness of supportive housing for families in the child welfare system. Really what we are trying to do here is help states begin to think about a real prevention approach that allows for the identification of families early on when their housing needs are high and their risk for involvement in the child welfare system is high and or they have become involved with the child welfare system. Thinking through what partnerships are necessary to provide not only the traditional child welfare support but really bringing housing to the table in a way that provides more comprehensive array of services that creates a case management approach that involves multiple partners to address the whole needs that this group of families bring to the table and really again a core component around assessment of their needs so that the service array is coordinated and meets their needs.

As I talked initially about the way that psychotropics fit into the overall trauma approach I just want to make note here that you consistently hear a number of pieces of what we think is an overall approach and this slide in an interesting way looks at how trauma screening and assessment, evidence-based practices, psychotropic medications, the funding announcements and the waivers are all tributaries into the larger river of social and emotional well-being. That we think leads to the much larger body of improved outcomes and improved functioning for children and families. And so we just want to make sure that as people hear any individual component that they are recognizing and we hope to explain how they are interrelated, how they connect to each other, why we are asking people to consider these as a comprehensive whole. To achieve social and emotional well-being and then how to get to improved outcomes, improved functioning so rather than an approach that allows us to say that we've provided a service and therefore we've been successful or us to monitor that that service has been provided to

really begin to think about what will it take over the next 15 years to get to a place where we're showing that because of our intervention, because of the effective practice or because of a demonstration grant that we've provided on the discretionary side or because of the waiver demonstration that those interventions have made a functional difference for children and teens. [silent]

PATEL [01:03:25]: Thank you, Clare. We're going to spend the next 20 minutes or so, hearing both about the role of Medicaid as well as the role of mental health from our partners that have joined us here today and then we'll get to the question and answer portion of our afternoon. So I'm going to go ahead and hand it over to Jean Close to start off with the role of Medicaid.

CLOSE [01;03:48]: Thank you, Sonali. Again it's a pleasure to be here about a year or so ago Commissioner Samuels and his staff brought a number of federal agencies together to focus on the issues of psychotropic use in children in foster care and the core group was in CMS, ACF, SAMHSA as well as a number of other federal agencies in that endeavor and one thing I was struck when we initiated the beginning of our work together was the personal commitment of everyone who was involved with that initiative it was striking because compared to a number of other initiatives I've been involved with as part of our regular work in working together with other agencies. I believe each of these organizations took and looked at what they were doing and tried to identify what are we doing personally that can be brought to bear on this issue. And it started to inform our plan going forward. Looking at our vantage point and moving ahead with this. A memorandum was published with a complete listing of those activities going forward, but a couple of those that CMS was engaged with and also continues to be with our partners surrounded an issue to look at eligibility what difference does it make or what are the barriers of children moving in and out of foster care that we can identify and do something about. Are certain states doing this well? Working with children moving in and about of the system and can we disseminate those practices, we began to frame our actions according to our triple aim in our center we tried to use a frame work to organize our work. We're trying to think what can we do for the individual children? What can we do for the whole population of children? And what can we do to ultimately lower cost and increase quality? So our activities began to focus on the big picture as far as our population. Electronic health records were a big part of what the Affordable Care Act put forward to help providers to develop their infrastructure for communicating the care and the treatment of individuals within their care. In addition, we looked at drug utilization review, what are some of the best practices that our states are using. Particularly as they surround the monitoring of medication for children in foster care. But as far as the larger population as well. [silent]Over the many months we've learned more about the issues surrounding psychotropic use and again much credit goes to ACF for making some of the latest research available to us so that as we move forward with implementing some if these activities that we could be informed about what is going to make a difference? What is the true problem? We began to understand the role of the impact of trauma on children and that impact how we moved forward with some of our activities both our federal partners and also through Medicaid in partnership with our states as well. Going forward we thought, are there some authorities available through the Affordable Care Act who would help promote and also address some of the core issues that were presented today. We're actively looking at how can the new health homes authority bring children and families together in an integrated situation where not only the primary care but the behavioral

health needs are addressed. A comprehensively and as a family. We began to look at what kind of services is Medicaid reimbursing? And also to get an idea of what is effective, what is not so effective, what can we advise states, what would be the kind of services that really would make a difference that are the right services and would be provided at the right time to individuals. A key theme I'm also seeing it in the issues that are presented today, is the issue of screening. Through EPSDT which is Medicaid program for certainly health care needs in children screening as a requirement for every child and I'm also hearing through this initiative of looking at children who have been impacted by trauma the screening is such an important component so again we're actively working to try to understand what are the best screens? How can they be integrated into current practice that states are currently using, as well. So we have a lot of different missions here but the common thread is that we're trying to serve children particularly children, vulnerable children who are in the foster care system. I think that's what brings all of our agencies together in these efforts. It's going to be an ongoing activity that we are truly committed to. But I also advise and I'm hoping that participating in this webinar are agencies that are actively pursuing their applications for some of these new grant opportunities or the title 4E waivers. To continue your work. It's not easy to partner with these other organizations, the other entities it's foreign territory but again the common thread is children who need additional services, need access to the right services at the right time so it may be the most difficult part of this whole piece is trying to connect with your partners at the local level in moving forward. And as Commissioner Samuels mentioned there is technical assistance available along the way to help make those important connections. [silent]Go to the next slide. That's it, okay great.

Moving forward again just to summarize I think improving access is an area that we really need some help with. You are the providers you are in contact with the children, with the systems of care, to borrow your frame of reference and so if you really need help there is reimbursement available for many of these services through Medicaid through other sources and indeed understand what a good benefit is what really works, we really need to focus on identifying what are those outcomes that we're all seeking to achieve. And actually making it happen, we have excellent research available at this point, but going forward the task is partnering with our agencies and Medicaid in actually making some of these best practices happen. And improving the quality as well. We can do a lot of work but ultimately I think our goal is to improve the quality of care. [silent]

One of our important partners in this endeavor is the mental health entities led by these mental health services administration. I'd like to invite my colleague here David DeVourney in talking a little bit more about [inaudible].

DEVOURSNEY [01:12:06]: Okay, thanks so much Jean. And I should say we are coordinating fields which do provide leadership but the states play such a huge role in mental health that they do with Medicaid that we are there as a supportive function as well as trying to provide leadership and direction to the field. And I think we left off in a great place for me to pick up because in my talk I'm actually gonna start my talk by discussing quality and then moving a little bit to what SAMHSA is doing and some of our efforts to try to improve the quality of behavioral health services. [missing audio] By behavioral health I'm talking about both mental health and substance use which are both underneath SAMHSA's mission. So when I think of quality the first thing I think of is work force because in the behavioral health field we

are our instruments. Literally [missing audio] that will help them reach where they need to be and address their behavioral health.

So it's important to realize we have a very stretched workforce in the behavioral health system this is a map from our colleagues at the health resources and services administration and you can't see the detail on it, but the important part to realize is those little yellow spots you see on the map, those are the areas were we don't have a mental health service provider shortage. The rest of the area in that map is where we do, so there's 94 million Americans, and a lot of those are rural areas so people are not evenly distributed across the country, but 94 million Americans live in areas designated as Mental Health Professional Shortage Areas what that means is there are not professionals to provide services for 69 million of the people who live in those areas. And that's the general population that's the entire population of the US. It is actually worse for children, and worse for populations who are at higher needs, for a variety of reasons. So that is actually an under characteristic that this problem is bigger for the population that we're working with and discussing today. So I just want to really put home workforce is very important. Fortunately services are going to be hopefully expanding in 2014 with the Affordable Care Act, that means the same workforce is going to have a broader mandate to provide services. So in all of our efforts it's important that we think about work force first. And any successful efforts will involve the training of the workforce providing support for the workforce and really focusing on implementation. So I'd just like to highlight that first of all. But there are a lot of bright spots in trying to help us meet these challenges. First I'd like to talk about electronic health records, these are not just ways to improve the coordination of individual care and store information about peoples services or the supports they are receiving, they actually provide us with great opportunities to provide physician supports for clinicians and for professionals working with individuals and they also provide the opportunity for us to look across systems and looking at data inside of systems to see what's really going on. And this is one of SAMHSA's key efforts around improving the quality of services we are working with our partners at CMS, with the people at the department of health and human services and the office of the secretary and the office of the national coordinator to identify quality measures around behavioral health issues and get those moved into systems so we can better measure the quality, better ensure the quality of behavioral health services being provided. As I said when I started there's a lot that we can do at the federal level, but there's a whole lot that can be done at the state level. Increasingly states are moving to large contracts to provide state services, and this is under Medicaid, but it's also to their general funds and through funds they receive through a variety of block grants and other grant mechanisms. And in those contracts that they make with providers and groups of providers they can really define what they're requiring as far as the quality of services and the types of services that are provided, so it's really important that we engage states and I think it's just remarkable the leadership we've seen from both the Administration on Children Youth and Families and the centers for Medicare Medicaid services in that direction so it's been great to have them as partners through this partnership. So health reform really does provide us with a really great opportunity and SAMSHA is trying to meet that challenge by defining what we call a Good and Modern service system, none of us really like that term, but it stuck so we're stuck with it [laughter], it basically is a set of services that we think should be a part of a modern system for providing behavioral health services and this includes a range of preventative services, treatment services, and recovery and support services with people with

behavioral health problems and we have put out initial definitions for some of these services and we are working right now to provide more information about what are the evidence-based components of those services what are the most effective aspects of them so that we can inform decision making leading up to 2014 and through waivers and block grants and other mechanisms. So that's a major part of the work that we're doing around health reform. I also like to highlight two other aspects around health reform that are really important there are ten essential benefits that are going to be covered for populations who are getting expanded services through the result of the Affordable Care Act in 2014, and while these services have not yet been defined, so I'm not going to say we know exactly what they are going to look like there is a requirement that the mental health and substance abuse be included within them according to the law. And one of the populations that is going to be receiving services as a result of the service extension is youth who have exited the foster care system and who were in the foster care system for 6 months or more, when they were younger. And so there's that huge opportunity to see and meet the needs of those youth and do service coordination on that end of the service spectrum. Especially considering many behavioral health problems emerge in that 18-24 age range and it's actually the peak age range for substance use. And so there is a lot of opportunities to improve services for that population through the Affordable Care Act. Another statistic I like to highlight is looking at coverage for parents. What you see on this graph here, which is very small, I apologize in the room you probably can't read it, that this is a graph looking at the level of coverage in 2008 for just basic insurance without getting into the specifics of what's covered. So I think the take away here is that 42% of parents of children in poverty, families in poverty don't have insurance coverage. And 33% of children between 100% and 200% of the party lines don't have insurance coverage. That's for health and it's probably worse for behavioral health. So we're working with a lot of parents who don't have coverage for needed services, and this is a major risk factor for child maltreatment and for improving the efforts to reunify families and create stable placement. So we really need to understand that this is a huge opportunity coming in 2014, not only to work with children but also to engage parents and provide them with an increased range of services. So SAMHSA is already doing quite a bit work to focus on these issues, we have two large block grants that we put out to the states one focused on mental health issues and one focused on substance abuse prevention and treatment. This last year for the first time we actually asked states to provide their responses to us in a combined application so we want to see increased coordination and implementation of services under this block grant, we understand the people don't come to us in silos so we should try and switch our funding stream so they don't go out in silos as well. So we're encouraging joint planning in that way. We have several individual programs also that are designed to improve the quality and the services provided and the infrastructure around those services. The first I'll talk about is called the Children's Mental Health Initiative. You may have heard of these grants also known as the Systems of Care grants. Basically what we're trying to do is to get communities we've done this since 1991, to coordinate services to paint wrap around services that are family focused and individually focused on the needs of the few, so that they can decide the services that they need and to really get the support that they need. And traditionally we put these out to communities but along with the state focus I've mentioned we've now moved to. Last year we let out the grant to have a focus on state wide planning and now were moving into a phase where we're moving out state wide implementation grants to really take the practices that were effective in the community level and the state level around coordinating services for children with serious emotional

disturbances. So we have a similar focus in our assertive adolescent and family treatment program which is really focused on substance use, treatment needs for adolescents and that program we have for the first time identified state coordinators across the country to focus efforts on adolescent treatment on substance abuse issues and so we are also trying to focus on the quality of services there. We have a burgeoning project actually to help focus on purchasing around those areas. Also we have project launch which is an early childhood program, has a similar state focus, helping to coordinate services, especially that program is focused on moving what we know about behavioral health into other systems. Primary care, into child care, into child welfare. And so we are really focused on trying to not just look at how we can improve services for children receiving treatment, but also what we can do around prevention and promotion in behavioral health as well.

The final grant on this page that I'd really like to highlight and it's really important for you is the National Child Traumatic Stress Network. And I'm sure many of you are familiar with this grant program, but basically it is a provider researcher partnership and we've funded grantees all across the country some of them are research institutions with expertise in serving children who have experienced trauma, and some of them are practitioners who have experience working with that population as well. And basically they've partnered together to create and then to implement and test and refine implementations for serving these children. They have a wealth of information around working with children who've experienced trauma and it's been cited several times in earlier presentations that you've seen today. And they have a lot of information on their website which is here at www.nctsn.org so I would encourage all of you to go check that out.

And actually they've been a key part of our partnership so far, between these three agencies represented here today, we've worked heavily to link the National Child Traumatic Stress Network resources with other agency efforts just like the Administration on Children, Youth, and Families integrating trauma into child welfare programs. We have a number of partnerships that we're working on with the other agencies too that I think are really important working to look at develop a high priority trauma goal around children and youth. And youth in the child welfare system too have experienced trauma. We're very happy to be working with the other agencies on that. The focus on psychotropic medications that you've heard about we are definitely invested in and SAMHSA is looking forward to the summit in August. And bringing together state leadership from mental health, Medicaid, and Child Welfare to improve services and practices around psychotropic medication. We are bringing together an expert panel to focus on treatment or therapeutic foster care in order to understand what are the key components of that type of intervention and what do we need to know to inform state level purchasing and to inform practice around therapeutic or treatment foster care. SAMHSA has a number of ongoing partnerships with the Administration on Children, Youth, and Families and other agencies that are also important. We jointly operate the National Center on Substance Abuse and Child Welfare which has a lot of information on children in the child welfare system who are in families that are affected by substance abuse and also resources for serving the parents in those families which is I think a great resource and a great ongoing partnership to support our work. And then also we have a number of interagency programs which I think really can help support and guide our work across agencies even broader than just those represented here at the table including the Interagency Work Group on Youth

Programs, which includes representatives from 14 departments, that's not just sub agencies inside HHS, but departments across the federal government. We have a lot of leadership from the Office on Child Abuse and Neglect. They bring together federal employees from across the government to focus on that issue through their Interagency Work Group on Child Abuse and Neglect. And then finally there is a number of partnerships focused on early childhood. One especially which has lasted since 2007 focused on staff level partnerships around early childhood but most recently the development of the Early Childhood Health and Development Coordinating Council at HHS which is bringing together leadership from across the different HHS agencies to guide our work in early childhood. With that I will pass it over for questions.