To: Senator Ron Wyden, Chair, and Senator Mike Crapo, Ranking Member, U.S. Senate Committee on Finance (mentalhealthcare@finance.senate.gov)

CC: Rebecca Nathanson and Gable Brady

From: Casey Family Programs

Re: Technical Assistance on Access to Health Care Services for Individuals with Mental Health and Substance Use Disorders

Date: November 1, 2021

In response to your letter dated May 6, 2021, requesting technical assistance, we provided technical assistance to the Committee on July 30 and October 1, 2021. We are providing supplemental technical assistance in this memo in response to your request for information on legislative proposals that will improve access to health care services for individuals with mental health and substance use disorders.

Casey Family Programs (Casey) was founded in 1966 and is the nation's largest operating foundation focused on providing and improving – and ultimately preventing the need for – foster care. Casey's perspectives are informed by our own experiences working with child welfare agencies in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and with 16 American Indian tribal nations on child welfare policies and practices to improve outcomes for children and families. Casey partners with child welfare systems, policymakers, youth and families, community organizations, national partners, philanthropy, American Indian and Alaska Native tribes, and courts to support practices and policies that increase the safety and success of children and strengthen the resilience of families.

Below is a summary of policies that Casey believes will improve access to health care services for individuals with mental health and substance use disorders. These recommendations outline policies and practices which are informed by what Casey has learned through our decades of work with states, tribes, children, youth and families. Following the recommendations is a more detailed review of the rationale, research, and data we have used in our analysis.

Improving Access for Children and Young People

- Consider policies that would increase access to, and development of, parent and youth peer support programs, Family Resource Centers, kinship navigator programs, and other community-based prevention services that move children with complex mental and behavioral needs out of residential care and back into their families and communities using a wraparound service model.
- Consider policies that would ensure infants and toddlers receive comprehensive, age-appropriate assessments of their mental health needs, that they and their caregivers have access to the mental health services and supports identified as necessary for their safety, health and well-being, and that ensure infants and toddlers are monitored to confirm the interventions are improving their developmental progress.
- Consider policies that would ensure that trauma-informed principles are used throughout family and child serving agencies, including behavioral health agencies and child protection agencies.

Strengthening Workforce

- Consider policies that support efforts to recruit and retain a diverse pool of behavioral health service providers, who have undergone extensive implicit bias training and can provide culturally competent services. One example would be policy to increase the pipeline of undergraduates into graduate/professional programs through scholarships and loan forgiveness.
- Consider policies that would engage youth and parents with lived experience to identify barriers in accessing services and to co-design solutions alongside service providers and jurisdictions.
- Consider policies that would develop and grow peer support programs such as parent partners, youth support partners and peer recovery coaches to help bridge the cultural and communication gaps that arise between families and child welfare agencies.
- Consider policies that would increase the development of quality family-based residential treatment centers for– specifically those which target specific populations such as formerly-incarcerated parents, fathers, and Native and tribal communities.
- Consider policies that would increase support for, and development of, culturally competent trauma-informed family-based programs to assist survivors of domestic violence. Policies should also include those who have lived experience with domestic violence and child welfare in program design.
- Consider policies that would invest in growing and developing "systems of care" to provide children with mental and behavioral health conditions and their families with the community-based services they need.

Increasing Integration, Coordination, and Access to Care

- Consider policies that would co-locate and co-staff child welfare and mental health professionals, behavioral health, domestic violence, peer parents, and individuals with cultural competency expertise to better integrate and improve transitions between levels of care.
- Consider policies that would implement the recommendations regarding multidisciplinary supports necessary to address the mental health needs of children and families as put forth by the 2016 Commission to End Child Abuse and Neglect Fatalities (CECANF).
- Fully support and implement the congregate care provisions and policies included in the Family First Prevention Services Act (FFPSA). When congregate care is necessary, ensure adequate supports for youth upon exiting such facilities.
- Consider policies that would increase the number of approved programs listed in the FFPSA Title IV-E Prevention Services Clearinghouse.
- Consider policies that would invest in public education campaigns to de-stigmatize mental and behavioral health needs, with particular emphasis on campaigns targeting Black, American Indian and Alaska Native, Latinx, LGBTQ+2S populations.
- Consider policies that would increase data collection and analysis on community indicators such as the social determinants of health, by age, race, gender identity, geography, national origin, sexual orientation, primary language spoken, country of origin, tribal affiliation, and other key characteristics.
- Consider policies that would increase resources to support states and tribes in building evidence-based kinship navigator programs.

- Increase coordination and collaboration across key federal agencies to improve child welfare outcomes including: the Children's Bureau, Substance Abuse and Mental Health Administration, Maternal and Child Health Bureau, Office of Early Childhood Development, Office of Head Start, Office of Child Care, Medicaid, Domestic Policy Council and Office of Management and Budget.
- Consider policies that would develop, expand, and replicate effective community crisis response programs to help communities respond quickly to children and families experiencing mental and behavioral health crises.
- Consider policies that would provide equitable access for at-risk youth and families to community-based whole-family supports and non-clinical services such as Family Resource Centers and Kinship Navigators.

Expanding Telehealth

- Consider policies that would increase funding for and access to telehealth and internet-based therapies to support vulnerable children and families.
- Consider policies that would increase resources and engage those with lived experience to address inequities in access to basic equipment, broadband services and insurance coverage for telehealth treatment.
- Consider policies that would support the development of expanded uses for virtual communication in child welfare including the use of videoconferencing for court hearings, to support regular family time, and improve caseworker engagement with children, youth and families.

Background

In general, about one in five adults in the U.S. live with mental illness.[1] Since the COVID-19 pandemic, these numbers have increased significantly, with more than 40% of adults reporting considerably elevated adverse mental health conditions including anxiety, depression, trauma- and stressor-related disorder, increased substance use, and suicidality. Younger adults, racial and ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation.[2] We know that a parent's or caregiver's mental health disorders can be a risk factor for child maltreatment. Depression, low self-esteem, poor impulse control, anxiety, and antisocial behavior are linked to a heightened potential for child abuse and neglect as these factors can compromise parenting.[3] At the same time, strategies and interventions that promote protective factors, and prevention and early intervention services from trusted providers and partners can help to prevent or reduce negative outcomes.[4]

One in eight children in the United States — 12.5% of the country's total child population — will be confirmed as a victim of abuse and neglect before turning age 18.[5] Studies indicate that

[1] https://www.nimh.nih.gov/health/statistics/mental-illness
[2] https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm
[3] https://www.childwelfare.gov/topics/can/factors/parentcaregiver/mentalhealth/
[4] https://cssp.org/our-work/project/strengthening-families/
[5] Dr. Emily Putnam-Hornstein's presentation to the Commission to Eliminate Child Abuse and Neglect Fatalities (July 10, 2014).

children involved in the child welfare system have significant developmental, behavioral, and emotional problems, so services for these children are an essential societal investment. Youth in foster care and adults who formerly were placed in foster care (foster care alumni) have disproportionately high rates of emotional and behavioral disorders. Among the areas of concern has been the lack of comprehensive mental health screening of all children entering out-of-home care, the absence of ongoing screening and assessments throughout their time in care, the need for more thorough identification of youth with emotional and behavioral disorders, and insufficient youth access to high-quality mental health services.[6]

On average, 8.7 million children in the U.S. (about 12 percent of children under 18) live with at least one parent with a substance use disorder.[7] Untreated substance use disorders among parents contributed to at least 34% of entries into foster care in FY2019.[8] In the past decade, the rate of opioid misuse and dependence has escalated in many communities, including among pregnant and parenting women, which has increased the number of infants born with neonatal abstinence syndrome. During the COVID-19 pandemic, there has been a substantial increase in opioid-related deaths across the country.[9] Increased stress, anxiety, isolation, and financial hardship all combine to make daily life and access to treatment increasingly difficult for those with substance use disorders. Over 81,000 drug overdose deaths occurred in the United States in the 12 months ending in May 2020, the highest number of overdose deaths ever recorded in a 12-month period.[10]

Children, youth, and families involved with child welfare and experiencing mental health disorders may also experience co-occurring issues such as substance use disorder or juvenile justice involvement.[11] At least 41% of children and youth entered foster care in FY2019 due to mental health and substance use disorders.[12] It is critical that we address this epidemic with urgency so that we can mitigate the numerous negative outcomes, including child welfare involvement.

Improving Access for Children and Young People

Research and the voices of youth with lived experience tell us that children and youth do best with family, and in family-like placements. The Family First Prevention Services Act (FFPSA) of 2018 supports this goal. The law is an historic and transformative shift in federal child welfare policy that is grounded in the experiences of youth and families, research, data and outcomes. It allows states and tribes the option to use open-ended Title IV-E funds to provide prevention services and programs for up to 12 months for children at imminent risk of entering foster care, any parenting or pregnant youth in foster care, and the parents — biological or adopted — as well as kin caregivers of these children. Eligible services are evidence-based mental health and substance abuse prevention and treatment services, and in-home parent skill-based services.

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[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3061347/

[7] Lipari, R.N. & Van Horn, S.L. (2017). Children living with parents who have a substance use disorder. The CBHSQ Report: August 24, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

[8] https://www.acf.hhs.gov/sites/default/files/documents/cb/afcarsreport27.pdf

[9] https://emergency.cdc.gov/han/2020/han00438.asp

[10] https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html

[11] https://www.childwelfare.gov/topics/systemwide/bhw/collaboration/mh/

[12] https://www.acf.hhs.gov/sites/default/files/documents/cb/afcarsreport27.pdf

FFPSA also provides open-ended federal funds for evidence-based kinship navigator programs that link relative caregivers to a broad range of services and supports to help children remain safely with them. It also provides important resources and polices to promote family-based settings for all children, and directs that federal resources are available for high quality and appropriate treatment in group care placements when appropriate and necessary.

The goal of FFPSA is permanency – a stable, healthy, culturally appropriate, and lasting living situation with at least one committed adult. It also supports reliable, continuous, and healthy connections with siblings, birth parents, extended family, and a network of other significant adults identified by the youth and the family.

Parent and youth peer support programs, Family Resource Centers, and kinship navigator programs all play a critical role in providing the intensive support necessary to move children with complex mental and behavioral needs out of residential care and back into their families and communities using a wraparound service model. Ensuring families receive necessary post-permanency supports is critical to success. Families need emotional and financial support as they prepare for and experience reunification. Permanency planning and reintegration is a continuous process and takes a significant amount of time before, during, and after returning the child to the home.[13]

Infants and toddlers are most vulnerable to maltreatment – they enter care at higher rates than any other age group[14] – and they also are at an age where interventions can be most effective. Child welfare systems play an important role in helping infants and toddlers cope with and recover from trauma and other stressful experiences. These young children should receive comprehensive, age-appropriate assessments, they and their caregivers should have access to the mental health services and supports identified as necessary for their safely, health and well-being, and they should be monitored to ensure the interventions are improving their developmental progress.

Youth in foster care have particularly high rates of trauma exposure and also are significantly more likely than the general population to have directly experienced violence – specifically abuse and/or neglect.[15] Research indicates that most of the adverse effects of trauma manifest themselves in a child's behavior, interpersonal relationships, and emotional and mental health. If the trauma is left untreated, the trauma will result in negative effects across the lifespan, limiting a person's chances to succeed at school, work, and home. The adverse effects of trauma can be mitigated — or even reversed — with the right services and supports. Trauma-informed caregivers are better equipped to provide children with protective and coping skills to mitigate the impact of being removed from their homes. Regardless of whether children are in their homes of origin or in out-of-home care, when the trauma-related needs of children and families are identified and appropriately addressed, child and family well-being and resilience improve. And when child and family serving agencies, including child protection agencies, infuse trauma-informed care into everything they do, it results in fewer children requiring crisis services, decreased use of psychotropic medications, fewer foster home placements, disruptions, and re-

[13] https://caseyfamilypro-wpengine.netdna-ssl.com/media/TravisCounty_FacilitatorGuide.pdf
[14] https://www.childtrends.org/blog/infants-and-toddlers-are-more-likely-than-older-children-to-enter-foster-care-because-of-neglect-and-parental-drug-abuse
[15] https://www.casey.org/why-become-trauma-informed/

entries, reduced length of stay in out-of-home care, and improved child functioning and increased well-being.[16]

Strengthening Workforce

Barriers

Significant barriers with respect to the provider workforce prevent system-involved children, youth and families from accessing needed behavioral health care services. Central to success is the engagement of families in the casework process. This includes actively collaborating and partnering with the family network, including maternal and paternal relatives and fictive kin. Involvement with the child welfare system often results in vulnerability and stress. Parents who become involved in, or who are at risk of entering, the child welfare system often mistrust child welfare services. This is a result of multiple factors including the inherent power imbalance in the roles of parents, other family members, and social workers in child protection processes. While caseworkers provide support and assistance, they also have the authority and ability to recommend removal of children, which can make the relationship between parents and caseworkers feel investigative and punitive. All of this can result in distrust and unwillingness of parents to ask for help in seeking needed services because of fear of removal. Implicit biases held by caseworkers, supervisors, and others about the families they work with is also a significant barrier to accessing needed services. Caseworkers may be particularly biased towards fathers and unwilling or unprepared to engage them, despite evidence that father involvement can have beneficial impacts on case outcomes.[17]

Over 3 million children and their families are involved in a child protective services (CPS) investigation each year and given that mandatory reporters are part of the social support systems many child-welfare-involved families rely on, members of low-income families may limit their engagement in needed services – including critical behavioral health care services – for fear of triggering a referral to CPS.[18]

Diversity, equity, and inclusion must be considered and interwoven in every aspect of service provision. Based on what Casey has learned through our decades of work with states, tribes, children, youth and families we know that the racial and ethnic diversity within the professional child welfare field does not align with the overrepresentation of Black, Native Alaskan and Tribal, or Latinx youth and families involved in the child welfare system. A variety of targeted recruitment efforts have failed to adequately diversify the workforce. Recruiting and retaining a diverse pool of behavioral health service providers, who have undergone extensive implicit bias training and can provide culturally competent services, must be a priority. The field needs to increase its pipeline of diverse undergraduates into graduate/professional programs with incentives such as scholarships and loan forgiveness.[19]

Peer Support Programs

One effective way to address barriers to accessing services is by connecting families newly involved with the system to peer support programs. Peer support offers a level of acceptance,

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[16] https://www.casey.org/why-become-trauma-informed/
[17] https://www.childwelfare.gov/pubpdfs/f_fam_engagement.pdf
[18] https://www.casey.org/cps-fear-and-service-engagement/
[19] https://www.ncbi.nlm.nih.gov/books/NBK563948/

understanding, and validation not found in many other professional relationships within the child welfare system. By sharing their own lived experience of recovery from a mental health condition or substance use disorder, peer support workers build trust to provide support for those experiencing similar challenges. Peer support workers do not replace therapists, case managers, or other members of a treatment team. Rather, they provide non-clinical, strengths-based support and are "experientially credentialed" by their own recovery journey. They inspire hope that people can and do recover, travel with people on their recovery journeys, and dispel myths about what it means to have a mental health condition or substance use disorder. Peer support workers can help break down barriers of culture, experience and understanding, and power dynamics that may get in the way of working with other members of the treatment team. The peer support worker's role is to assist people with finding and following their own recovery paths without judgment, expectation, rules, or requirements.[20]

Peer support is valuable not only for the person receiving services, but also for behavioral health professionals and the systems in which they work. Peer workers educate their colleagues and advance the field by sharing their perspectives and experience to increase understanding of how practices and policies may be improved to promote wellness and resiliency.

Peer support workers can have different names. Generally, in the child welfare system, they're referred to as "parent partners"[21] or "youth support partners" (YSPs). YSPs are young adults with lived experience in child welfare, behavioral health, or juvenile justice, who help promote youth empowerment and voice in decision-making at the individual and system level. There are also "peer recovery coaches" and "family, parent and caregiver" peer support. All of these groups serve to support youth, birth parents, and caregivers who navigate a complex and challenging mental health system.

Emerging research shows that peer support is effective in supporting recovery from behavioral health conditions while increasing hope, empathy and acceptance, engagement in self-care and in social support and functioning. Research also shows decreased psychotic symptoms, hospital admission rates, substance use and depression, internalized blame and family isolation.[22]

Some examples of successful peer support programs are:

Allegheny County
Allegheny County has implemented a successful program where youth report that they value their YSP for their shared experience, authenticity, and willingness to share power with them. As a result, very few youth decline YSP services — the program has a greater than 90% engagement rate. Once trust is established, YSPs support youth in a

[20] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf
[21] There is a small but growing number of empirical studies of parent partner programs in child welfare that reveal the following outcomes: Higher rates of reunification for those parents who have participated; Lower rates of reentry for children involved in the program; Increased participation in services and court hearings. *See* https://www.casey.org/parent-partner-program-themes/ Appendix A3 for a snapshot of the research on individual parent partner programs.
[22] YSPs are young adults with lived experience in child welfare, behavioral health, or juvenile justice, and help promote youth empowerment and voice in decision-making at the individual and system level.

myriad of ways, often working on concrete skills that the youth identify, in communicating effectively, and managing difficult situations. YSPs also use their lived experience to help child welfare caseworkers and other system providers by supporting better communication with the youth they are serving.[23]

Kentucky Sobriety Treatment and Recovery Team (START) Program START pairs specially trained child protective service (CPS) workers with family mentors, with at least three years of sobriety and previous involvement with CPS, to work with families. The program also partners with substance abuse treatment providers to ensure START participants have quick access to intensive treatment. Decision-making is shared among all team members, including the family and court. Essential elements of the model include quick entry into START services to safely maintain the child's placement in the home when possible, and rapid access to intensive addiction/mental health assessment and treatment. Each START CPS worker-mentor pair has a capped caseload, allowing the team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity. START is now operating in five counties across the state and has served more than 1,000 families, including 1,690 adults and more than 2,200 children between 2006 and early 2018.[24] Recent research has found that START is effective at keeping children at home: children in families served by START were half as likely to be placed in state custody compared with children in a matched control group. At case closure, more than 75 percent of children served by START remained with or were reunified with their parents.[25] In addition, a 2015 study found that children were less likely to experience a recurrence of maltreatment or re-enter foster care if their parents participated in Kentucky START.[26]

Iowa Parent Partner Program
The Iowa Parent Partner has been implemented statewide. Each local parent partner site matches a parent currently involved with CPS with a parent partner, who has been involved with the child welfare agency and has been successfully reunited with their child for at least a year and/or has healed from the issues that initially brought them to the attention of DHS. Parent partners are compensated to mentor and help parents locate and secure community resources. Parent partners commit to working with a family for a minimum of seven to 10 hours per month and each parent partner can mentor up to 15

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[23] https://www.casey.org/youth-support-partners/
[24] https://www.casey.org/parent-partner-program/
Zero to Three. (2018). Kentucky Sobriety Treatment and Recovery Team (START) program for Parents Involved with the Child Welfare System. Retrieved from: https://www.zerotothree.org/resources/811-kentucky-sobriety-treatment-and-recovery-team-start-program-for-parents-involved-with-the-child-welfare-system
[25] https://www.casey.org/parent-partner-program/
Huebner, R. A., Willauer, T., & Posze, L. (2012). The impact of Sobriety Treatment and Recovery Teams (START) on family outcomes. Families in Society Journal of Contemporary Social Services, 93(3),196-203.
[26] https://www.casey.org/parent-partner-program/
Hall, M. T., Huebner, R. A., Sears, J. S., Posze, L., Willauer, T., & Oliver, J. (2015). Sobriety treatment and recovery teams in rural Appalachia: Implementation and outcomes. Child Welfare, 94(4), 119-138.

parents. Iowa went statewide with its parent partner program in 2012, and as of 2016, there are more than 150 parent partners mentoring 1,800 parents across the state.[27] A 2019 evaluation used a quasi-experimental design to compare families served by the program with similar families who were not provided a parent partner. Results indicated that the children of program participants were significantly more likely to return home to their families than the children of matched non-participants. Additionally, Iowa Parent Partner program participants were significantly less likely to have a subsequent child removal within 12 months of the child returning home than matched non-participants. No significant differences were found between the children of program participants and children of matched nonparticipants in the total time in out of home care or subsequent child removal within 24 months of returning home.[28]

Increasing Integration, Coordination, and Access to Care

Children do best with families. Services and programs that take a whole-family approach and allow children to remain safely at home or in family-like settings are effective ways to improve access to care across the continuum of behavioral health services. Everything possible should be done to keep children safely with family or family members.

To maximize the opportunity that FFPSA provides to increase behavioral health support for children and families at risk of entering foster care, we ask the Committee to consider the following:

- Ensure the Title IV-E Prevention Services Clearinghouse is reviewing a robust array of eligible evidence-based mental health programs that have demonstrated improved outcomes in communities, including those with demonstrated outcomes for populations overrepresented in the child welfare system. Ensure the Clearinghouse is transparent and timely in its communication and reviews.
- Encourage and support through technical assistance the engagement of youth, parents, kinship caregivers, foster/resource parents and other community stakeholders in the development and implementation of Title IV-E Prevention plans to ensure the services and supports most needed by community members are included.
- FFPSA provides states, territories and tribes unlimited federal resources to support evidence-based preventions, including family resource centers and kinship navigator services, to keep children safe and strengthen families. Additional approvals of kinship navigator programs by the Title IV-E Clearinghouse, investments in tools and training to increase the capacity of states, territories and tribes to identify kinship placements, and additional resources for Family Resource Centers will increase access to key non-clinical community-based resources and services that will serve to

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[27] Child Welfare Information Gateway. (2016). Developing a Parent Partner Program (Podcast Transcript). Retrieved from: https://www.acf.hhs.gov/sites/default/files/documents/cb/cw_podcast_parent_partner_program_transcript.pdf

[28] https://www.casey.org/parent-partner-program/
Chambers, J., Lint, S., Thompson, M., Carlson, M., Graef, M. (2019). Outcomes of the Iowa Parent Partner program evaluation: Stability of reunification and re-entry into foster care. Children and Youth Services Review, 104, 1-11. Retrieved from: https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1020&context=ccflfacpub

maintain and/or enhance behavioral health for system-involved youth and their caregivers.
- Increase coordination and collaboration across the federal government to improve child welfare and child and family well-being outcomes. Key agencies to include are the Children's Bureau, Substance Abuse and Mental Health Administration, Maternal and Child Health Bureau, Office of Early Childhood Development, Office of Head Start, Office of Child Care, Medicaid, Domestic Policy Council and Office of Management and Budget.

There are several strategies to provide family and parent support, including family-based residential substance use treatment, parent partners, home visiting, in home services, wraparound services, and mobile crisis response, as discussed below.

Family-Based Residential Treatment

Parents who experience substance use disorders often benefit from programs that address the difficulties of both parenting and recovery.[29] Unfortunately, many substance use disorder programs focus solely on adults and their substance use, not their role as parents. When parents seek treatment they may have limited access to programs that provide child care, have visitation policies that support regular contact with their children, or include residential options that allow their children to reside with them during treatment.[30] This all results in significant barriers to both entering and completing treatment, which is not ideal given that the parent-child relationship is often a primary motivation for parents to achieve and maintain sobriety and has been found to positively impact success during treatment.[31] Family-based residential treatment is an example of a coordinated intervention being used by child welfare agencies and substance use disorder programs for parents who need intensive levels of support. While receiving services, parents and children reside together in a safe, supervised living situation and receive wraparound services including physical health services, parent education, early childhood programming, individual and group therapy, parent-child therapy, vocational services, case management, childcare, respite care, recovery coaching, and access to safe drug-free housing.[32]

Under FFPSA, federal Title IV–E foster care maintenance payments can be made for a child in foster care placed with a relative in a licensed residential family-based treatment facility for up to 12 months, making this the most opportune time to examine and invest in family-based

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[29] https://ctfalliance.sharefile.com/share/view/s6e2a482825794517af777b8fc79d94b8

[30] Wiegmann, W. (2016). Impact of residential versus outpatient substance abuse treatment on child welfare outcomes: A secondary analysis of NSCAW II data (Doctoral Dissertation).

[31] Wiegmann, W. (2016). Impact of residential versus outpatient substance abuse treatment on child welfare outcomes: A secondary analysis of NSCAW II data (Doctoral Dissertation).

[32] Rivera, M., & Sullivan, R. (2015). Rethinking child welfare to keep families safe and together: Effective housing-based supports to reduce child trauma, maltreatment recidivism, and re-entry into foster care. Child Welfare, 94(4), 185-204.

Hammond, GC, McGlone, A. (2013). Residential family treatment for parents with substance use disorders who are involved with child welfare: two perspectives on program design, collaboration, and sustainability. Child Welfare, 92(6), 131-50.

residential treatment programs for parents with substance use disorders.[33] Investing in programs such as Native American Connections, that provide targeted care for specific populations such as formerly-incarcerated parents, fathers, and Native and tribal communities, could make significant advances in decreasing inequities experienced by underserved populations throughout the child welfare system. Native American Connections is a residential substance use treatment center where participants connect with the program's traditional healing practices and participate in culturally appropriate services, including Sweat Lodge, Talking Circles, and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). After conclusion, participants move into transitional housing, secure employment and often regain custody of their children.[34] Family-based treatment centers like Native American Connections focus on the parent-child relationship, which results in positive impacts on parental recovery and child welfare outcomes.[35]

Domestic Violence

Domestic violence is a serious public health issue that requires a strong network of community-based prevention and support. Approximately 30 million children in the United States will be exposed to some type of family violence prior to turning 17, and research suggests that 30% to 60% of the families where domestic violence is identified also experience some form of child maltreatment.[36] Exposure to domestic violence can be traumatic for children and lead to negative outcomes including: behavioral, social, and emotional issues, including depression, low self-esteem, anxiety, anger, an inability to sustain good relationships, and higher rates of substance use. The existence of protective factors can help ameliorate the effects of domestic violence. Research shows a consistent, secure attachment with a parent or caregiver can help a child heal from the effects of domestic violence, as can neighborhood support and connectedness, and the coordination of resources among community agencies. Accessing support may be even more complicated for families of color because culturally appropriate services may be challenging to find or nonexistent. And negative experiences or perceptions of law enforcement and social services may lead to fear and mistrust, further complicating access to services for communities of color. It's always important to include cultural considerations in training and referral services and to collaborate with people who have lived experience when identifying needs, barriers, and solutions.[37]

Systems of Care

The "system of care" approach was developed as a way to better serve children and youth with serious mental health conditions, and their families. The goal is to provide children and their families with the services they need in their homes and communities in order to avoid the need for inpatient and residential treatment. A system of care is not a specific type of program; rather, it is an approach that combines a broad array of services and supports with a set of guiding principles and core values. Services should be community-based, family-driven, youth-guided, and culturally and linguistically

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[33] https://www.acf.hhs.gov/cb/title-iv-e-prevention-program
[34] https://www.casey.org/patina-wellness-center/
[35] https://www.casey.org/family-based-residential-treatment/
[36] Hamby, S., Finkelhor, D., Turner, H., & Omrod, R. (2011). Children's exposure to intimate partner violence and other family violence. Juvenile Justice Bulletin: Children's Exposure to Intimate Partner Violence and Other Family Violence.
[37] https://www.casey.org/child-protection-domestic-violence/

competent. Most important, services and supports are individualized to address the unique strengths and needs of each child and family. Both the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Children's Bureau have funded evaluations of systems of care, and these along with other evaluations have found that systems of care are associated with a range of positive outcomes. These include increased cross-system collaboration and improved use of Medicaid and other resources; decreased suicide rates, substance abuse, juvenile justice involvement, and inpatient or residential stays; improved family functioning and reduced caregiver stress; and increased family and youth involvement in services.[38]

Integration of Services

Another way we can improve access to care across the continuum of behavioral health services is to find ways to advance the connection between primary health care providers (which is many times the first point of access for any health-related issues and also where many people receive their psychotropic medications) and behavioral health services. In many instances, Medicaid & private insurance reimbursement processes may act as a barrier to integrated mental health services, which acts as a disincentive to integrated care planning, which is foundational tenet of behavioral health services, though this has gotten better during the pandemic as policies regarding coverage have shifted.[39]

Based on our work with youth and families across the country, supporting efforts to increase the capacity of child welfare agencies to partner with experts in other relevant fields for the case management and decision-making process as well as child welfare assessments, is very promising. The Commission to End Child Abuse and Neglect Fatalities included several recommendations and examples in their report of how multidisciplinary support could contribute to better outcomes for children at risk of abuse and neglect fatalities and near fatalities. Among the policies included, the report spoke to the importance of co-locating and co-staffing child welfare and mental health professionals and professionals with other relevant expertise, such as behavioral health, domestic violence, peer parents, and individuals with cultural competency expertise, to improve outcomes and patient transitions between levels of care.[40]

This is particularly relevant when youth are placed in congregate care settings. While children in foster care should be in the most family-like setting whenever possible, youth across the country have shared their experiences about being in unnecessary group homes, in lieu of a family setting. While some youth may benefit from the specialized treatment services available in certain congregate care placements, most of these services can also be provided through therapeutic foster care or wraparound and mobile treatment in family-based settings. If therapeutic residential care is deemed necessary, jurisdictions should have a structured decision-making process to ensure that only specific youth who can most benefit are placed in this setting; that it offers the most appropriate, evidence-based interventions; and that it is used for the shortest amount of time necessary to achieve key safety, therapeutic, and permanency

[38] https://www.casey.org/can-you-tell-us-about-a-few-agencies-that-have-systems-of-care/
[39] https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf
[40] https://www.acf.hhs.gov/cb/report/within-our-reach-national-strategy-eliminate-child-abuse-and-neglect-fatalities

goals.[41] Young adults who have left group care tend to be less successful than their peers in foster care.[42] They're more likely to become delinquent, have poorer educational outcomes, are less likely to graduate high school, and are at greater risk for further physical abuse than their peers who were placed in families.[43] FFPSA is designed to reduce the number of youth placed in inappropriate congregate care settings. While continued investments are needed to ensure the safe and appropriate reduction of congregate care, investment and supports also may be required for youth exiting congregate care facilities to return to their families.

Equity

Advancing equity and supporting underserved communities impacted by the child welfare system is complex and requires comprehensive systems-focused strategies. The federal government has an important role and the opportunity to identify and address policy and practice barriers that contribute to disparate outcomes and inequities in funding and resources across communities. Public education campaigns to de-stigmatize mental and behavioral health needs, with particular emphasis on campaigns targeting Black, American Indian and Alaska Native, Latinx, LGBTQ+2S and other populations who are traditionally underserved and overrepresented in the child welfare system would help remove some of those barriers. Data collection and analysis is another powerful tool in advancing equity and supporting underserved communities. Collecting and reporting out on community indicators, such as the social determinants of health, are necessary to obtain an aggregate understanding of how communities and the individuals within them are faring. In collecting community, individual and program performance variables, it is essential that they be disaggregated by age, race, gender identity, geography, national origin, sexual orientation, primary language spoken, country of origin and tribal affiliation and other key characteristics. This offers the opportunity to clearly see the experiences of subpopulations and provides information to the federal government to inform changes to policy or the administration of programs.[44]

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[41] Pecora, P. J., & English, D. J. (2016). Elements of effective practice for children and youth served by therapeutic residential care. p. 2. Retrieved from https://www.casey.org/media/Group-Care-complete.pdf

[42] Barth, R. P. (2002). Institutions vs. foster homes: The empirical base for the second century of debate. Retrieved from http://bettercarenetwork.org/sites/default/files/Institutions%20vs%20Foster%20Homes.pdf

[43] Annie E. Casey Foundation. (2015). Every kid needs a family: Giving children in the child welfare system the best chance for success. Retrieved from http://www.aecf.org/m/resourcedoc/aecf-EveryKidNeedsAFamily-2015.pdf

Ryan, J. P., Marshall, J. M., Herz, D., & Hernandez, P. M. (2008). Juvenile delinquency in child welfare: Investigating group home effects. Children and Youth Services Review, 30, 1088-1099. https://doi.org/10.1016/j.childyouth.2008.02.004

[44] Children's Bureau, Administration On Children, Youth And Families, Administration For Children And Families, U. S. Department Of Health And Human Services (2020). *AFCARS Foster Care File, 6-month periods (FY2015B - 2020A)*

Fish, J. N., Baams, L., Wojciak, A. S., & Russell, S. T. (2019). Are sexual minority youth overrepresented in foster care, child welfare, and out-of-home placement? Findings from nationally representative data. *Child Abuse & Neglect, 92*, 230.

The Office of Planning, Research and Evaluation. (2015). LGBT youth and services to support them: A snapshot of the knowledge base and research needs. Retrieved from https://www.acf.hhs.gov/sites/default/files/documents/opre/chapter_brief_youth_508_nologo.pdf

Increased support is needed to employ geo-spatial analysis to understand community dynamics, like the Community Opportunity Map,[45] an interactive tool informed by significant evidence of the community factors correlated with child maltreatment and a healthy community framework developed by the U.S. Department of Housing and Urban Development.[46]

Crisis Intervention

Communities need more resources to be able to respond in real time to crises that children, youth and their caregivers may have to prevent disrupting family-based placements and unnecessary entries into foster care. Development, expansion, and replication of effective community crisis response programs can help communities respond quickly to children and families experiencing behavioral health crises. Examples of two such programs are:

> New Jersey's Mobile Response and Stabilization Services (MRSS) is an innovative approach to supporting and stabilizing children during a crisis so they can stay with their families and/or current living situation. MRSS are available 24 hours a day, seven days a week, and are designed to provide on-site intervention to help children/youth and their families who are experiencing an emotional or behavioral stressor by interrupting immediate crisis and ensuring the youth and their families are safe. When there is a crisis, an MRSS worker is available within one hour to help de-escalate, assess, and develop a plan together with the child and family. MRSS is accessible through a toll-free phone number, which serves as a single point of entry to a range of services. Any child up to age 21 is eligible for services. MRSS operates through a trauma-informed lens to understand what the child has experienced and then help the child feel better. MRSS is initially available during the 72 hours following the request for help, with a focus on de-escalating, assessing, and planning, but can be extended for up to eight weeks of stabilization services Based on a 2018 Casey Family Programs report, MRSS had consistently maintained 94 percent of children in their living situation at the time of the report since its inception in 2004, including children who are involved with the child welfare system. Between 2014 and 2018, between 95 percent and 98 percent of children served by MRSS have remained in their current living situations.[47]
>
> Children's Crisis Outreach Response System (CCORS) is a 24/7 support system provided across King County by Accelerator Y that helps young people and their families when they are going through a crisis. Trained interventionists work with families to provide short-term solutions and tools to help work through complex issues like suicide or violent behavior. Families develop the skills to improve communication, understand warning signs, and be more prepared when a dangerous situation arises.[48]

Connecting With Non-Clinical Services

Those with lived experience in child welfare tell us that meaningful and equitable engagement and service provision at the community level is lacking.[49] Providing equitable access for at-risk

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[45] https://caseyfamily.caimaps.info/cailive?location=Seattle&tab=family&searchType=city
[46] https://caseyfamilypro-wpengine.netdna-ssl.com/media/COM-2.0-information-sheet-October2020.pdf
[47] https://www.casey.org/nj-mobile-response-stabilization-services/
[48] https://www.seattleymca.org/node/4021
[49] https://ctfalliance.sharefile.com/share/view/s449607ca020440229cbbb23890e4f0ff

youth and families to community-based whole-family supports and non-clinical services is essential to avoiding entry into the child-welfare system.

Family Resource Centers

In addition to the parent and youth peer support programs mentioned above, which provide critical one-on-one connections for at-risk youth and parents, Family Resource Centers (FRCs) can help families strengthen their protective factors before approaching the crisis point of entry into the child welfare system. FRCs are community-based hubs (located in apartment complexes, schools, health centers, libraries, community centers, storefronts, or churches), where families can access formal and informal supports to promote their health and well-being. FRC services vary widely depending on the needs of the local community, but they typically include some combination of parent skills and job training, substance use prevention, mental health services, housing support, crisis intervention services, literacy programs, and concrete supports such as food or clothing banks. FRCs are distinct from other programs in that they are uniquely community-focused, driven by family needs, and offer a variety of programs and resources with the aim to be one-stop shops for children and parents that address all five protective factors (Parental Resilience; Social Connections; Concrete Support in Times of Need; Knowledge of Parenting and Child Development; Social and Emotional Competence of Children).[50] FRC's are designed to provide whole-family services in the communities where they are located and often are better equipped to provide culturally-competent and appropriate services to meet the needs of otherwise underserved communities. Because they are located in the communities, the physical barriers to access such as travel time and cost, hours of operation, and lack of child care may be eliminated. In communities where they operate, FRCs have proven incredibly effective in strengthening protective factors and reducing child maltreatment and entry into care.[51]

Kinship Navigators

While some child protection agencies are shifting toward a "kin first" culture and practice that prioritizes supporting kin caregivers, many may still get lost in the competing demands of caseworkers. Evidence-based kinship navigator programs fill that gap by connecting relative caregivers to a broad range of services and supports including information, education, and other services to help children remain safely with them.

FFPSA provides states, territories, and tribes unlimited federal resources to support evidence-based preventions, including family resource centers and kinship navigator services, to keep children safe and strengthen families. Additional approvals of kinship navigator programs by the Title IV-E Clearinghouse, investments in tools and training to increase the capacity of states, territories and tribes to identify kinship placements, and additional resources for FRCs will increase access to key non-clinical community-based resources and services that will serve to maintain and/or enhance behavioral health for system-involved youth and their caregivers.

Expanding Telehealth

Youth in foster care have disproportionately high rates of emotional and behavioral disorders, and they are at increased risk of not receiving the services necessary to address their needs, a

[50] https://www.casey.org/family-resource-centers/
[51] https://www.casey.org/family-resource-centers-appendix/

risk that has heightened during the COVID-19 pandemic. Telehealth has the potential to offer many children and families a lifeline to essential physical and behavioral health services that would not otherwise be accessible. Although the use of telehealth in child welfare practice has been of interest for many years, particularly in rural areas, COVID-19 has led more jurisdictions to expand its use to support child and family access to critical services. Telehealth has the potential to:

- increase access to specialized medical and mental health expertise,
- ameliorate client transportation and time barriers,
- enhance staff capacity by reducing travel time in remote areas,
- increase acceptance of services by some clients who may be more comfortable participating remotely, and
- realize cost savings that may help to offset anticipated post-pandemic budget shortfalls.[52]

Equitable access to telehealth and internet-based therapies may help to address disparate outcomes in mental health. Telehealth service access has been expanded through the passage of policies that promote telehealth uptake like the Bipartisan Budget Act of 2018[53] which included provisions to improve access to telehealth services. More recently and in response to the COVID-19 Public Health Emergency, the Department of Health and Human Services took steps to make it easier for providers to offer telehealth services.[54] Telehealth can also expand the network of providers. Telehealth services often are provided in real time through videoconferencing, chat, and text messaging. Telehealth also includes services provided through email, online training, automated computer programs, and mobile apps, or through a client video recording that a professional reviews remotely at another time.

Some examples of how telehealth can be used to support children and families involved with the child welfare system include:

- Using telemedicine technology to conduct remote medical examinations for suspected child abuse and neglect. This approach can make investigations more accurate and timely, and less burdensome for families, when there is no child abuse pediatrician practicing in the area.[55]
- Conducting standardized behavioral health assessments and remote counseling, monitoring, and medication management.
- Providing “virtual home visits.” Most of the national early childhood home visiting models have endorsed the use of videoconferencing and other technologies during the COVID-19 crisis and provided related guidance for these visits.
- Facilitating completion of service plans by offering remote access to some required services, such as parent education, support groups, and substance use disorder treatment.

[52] https://www.casey.org/telehealth-strategy-brief/
[53] https://www.congress.gov/bill/115th-congress/house-bill/1892/text?overview=closed
[54] https://www.hhs.gov/coronavirus/telehealth/index.html
[55] https://www.casey.org/telehealth-strategy-brief/

- Offering enhanced mental health support to youth in foster care via text or video chat. Given that many youth are comfortable in virtual environments, providing services this way may reduce stigma and enhance engagement.[56]

Digital Equity

Increased use of telehealth is a viable solution to gaps in provider networks for underserved communities, but only if there is digital equity. Right now, technology-related inequities in terms of both access to basic equipment and access to broadband service are significant and must be addressed to ensure all families have an equal opportunity to connect with virtual supports and essential services.[57]

Another challenge has been insurance coverage for telehealth treatment, though this has slowly changed with insurance providers recognizing the effectiveness of this approach at increasing access to evidence-based care. Additionally, the policies around coverage have shifted significantly due to COVID-19 and the Public Health Emergency declaration.[58]

Leveraging Technology Beyond Telehealth

Other uses for virtual communication in child welfare also are being explored due to the COVID-19 crisis, including the use of videoconferencing for court hearings, to support regular family time, and caseworker engagement with children, youth, and families. Additionally, a growing number of internet-based therapies for anxiety, depression, and somatic disorders (such as Cognitive Behavioral Treatment) also have been shown to be effective.[59]

Expanding telehealth and other internet-based treatment options will result in expanding the networks of behavioral health providers in underserved communities. While these virtual programs need to be implemented carefully, they may provide additional options previously unavailable to families and youth, particularly in rural, tribal, and other underserved communities, thereby increasing access and eliminating inequities.

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[56] https://www.casey.org/telehealth-strategy-brief/

[57] https://store.samhsa.gov/product/In-Brief-Rural-Behavioral-Health-Telehealth-Challenges-and-Opportunities/SMA16-4989

[58] https://www.hhs.gov/coronavirus/telehealth/index.html

[59] https://pubmed.ncbi.nlm.nih.gov/19675956/