Psychotropic Medication and Mental Health Services for Foster Youth: Seeking Solutions for a Broken System

A Joint Oversight Hearing of the Senate Human Services Committee and the Senate Health Committee

Senator Mike McGuire, Chair, Senate Human Services Committee
Senator Ed Hernandez, Chair, Senate Health Committee

August 11th, 2015
2:00 p.m. - 4:00 p.m.
Room 3191

California's county-based child welfare system, in assuming responsibility as the acting "parent" for dependent children, seeks to provide a continuum of placement settings, services and supports for children and their biological and foster families. Studies show that childhood traumas associated with a child's involvement in the child welfare system and the situations that led to removal from their families often lead to enduring mental and emotional health challenges due a variety of changes in brain structure and function, as well as stress-responsive neurobiological systems.[1] In caring for the mental health needs of children in the child welfare system, county child welfare agencies and probation departments greatly depend on California's county-based mental health plans for more intensive specialized mental health care services, and increasingly on managed care plans for mild to moderate mental health needs. However, recent informational hearings conducted by the Senate Human Services Committee and the Senate Budget Committee have underscored the challenges that local child welfare, mental health, and education systems face in meeting the mental health needs of children in the child welfare system. Widespread reports from foster youth, caregivers, children's attorney's and others report a lack of or delayed delivery of mental health services that leaves many children without

[1]Anda, R. F., Felitti, R. F., Walker,], Whitfield, C., Bremner, D.], Perry, B. D., Dube, S. R., & Giles, W. G. (2006). The enduring effects of childhood abuse and related experiences: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatric and Clinical Neuroscience,* 256(3), 174-186.

adequate treatment and at risk of failing placements, with deteriorating symptoms, and the foster system with high rates of prescription of psychotropic medication.

Last February, the Senate Human Services Committee and the Select Committee on Mental Health held an informational hearing entitled, "Misuse of Psychotropic Medication in Foster Care: Improving Child Welfare Oversight and Outcomes within the Continuum of Care" that highlighted concerns regarding a statewide trend toward increased prescribing of psychotropic medications. The hearing included testimony indicating that California's child welfare and children's mental health systems are over-reliant on psychotropic medication among foster youth and do not effectively manage the provision of such medication leading to unnecessary prescribing, inappropriately high dosages of medication for children, and inappropriate use of multiple medications, and usage occurring at longer durations than appropriate. In response to these concerns, the hearing focused on oversight of individual cases, including court authorization procedures which informed the development of several bills currently under consideration in the Assembly.

Additionally, the hearing highlighted concerns that breakdowns in the provision of effective trauma-informed psychosocial services has led to system-wide failures in treating children and youth who later suffer from trauma-related behavioral health challenges, for which medication is seen as the only available treatment option. This hearing is intended to look more closely at the system wide standards and oversight tools used by state and local agencies in evaluating the effectiveness of county mental health plans, county child welfare agencies, contracted providers, and individual prescribers in providing access to a broad spectrum of timely, effective, trauma-informed psychosocial services that minimize the need for psychotropic medication.

Case Examples

The following anecdotal reports from children's attorneys reflect system failures that foster children have experienced in attempting to access mental health services:

Two siblings aged 2 and 6 were initially placed in one county but were not referred for mental health services. The placement failed and both children were moved to a second county. This second placement failed due to acting out behaviors such as biting and severe tantrums. The children then moved to a third, where they are on a wait list for traveling therapist. There has been a delay of six months with no services.

An 11-year-old girl was removed from home due to allegations of serious physical and sexual abuse. Her first placement with a relative soon failed due to "acting out behaviors," as did her second placement with a non-relative extended family member. Subsequent to these two failures there have been two or three additional placements. The child experienced a delay of seven months with no services provided until very recently, after 1.5 years in care.

A 16-year-old girl was removed from home due to molestation. The first two placements in one county failed and in her third placement, in another county, she is on wait list for therapy. She has experienced a delay of seven months with no mental health services.

A teen girl placed in a group home in one county received a seven-day eviction notice immediately after beginning therapy. She was then placed in a group home in a second county, with a resulting a two-month delay in accessing care. Soon after, she was subject to a 5150 placement order in a psychiatric unit, and then received another seven-day eviction notice before receiving specialty mental health services. She was next placed in a group home in a third county. The changes in county placement led to another delay in beginning therapy, and before therapy began she was held under another 5150 psychiatric order and another eviction notice. The child went AWOL for a few months after that.

A four-year-old boy referred for therapy was put on waitlist for three months. He has been diagnosed with numerous illnesses ranging from schizophrenia to autism. Therapy was finally approved, but as a result of his placement out of county, lack of transportation has prevented therapy from starting.

A 14-year-old-girl was diagnosed with depression and possible post-traumatic stress disorder. Although the case came in almost six months ago, due to her frequent placement changes in numerous counties, she only recently started therapy.

County Mental Health System

California's county-operated mental health system, operated by mental health plans, provide a range of services and supports to Medi-Cal beneficiaries and other vulnerable individuals under a contract enacted between the mental health plan and the Department of Health Care Services (DHCS). Statewide, the system is operated under a Medi-Cal Specialty Mental Health Services 1915(b) waiver, which was recently renewed through June 30, 2020. Pursuant to federal and state law, and their contract with DHCS, county-based mental health plans must ensure provision of covered services to all Medi-Cal beneficiaries who meet medical necessity criteria, as defined.[2] County mental health plans may provide "specialty" mental health services directly, or by contracting with local providers, Services for individuals with mild to moderate mental health needs, which are not covered by county mental health plans, are intended to be provided by Medi-Cal managed care plans.

Foster youth, like all children under the age of 21 enrolled in Medi-Cal, are eligible for the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit, which provides for periodic screenings to determine a child's needs and, based upon the identified health care need, treatment services that are to be provided. Though EPSDT was initially created to provide medical services, the program has added a continuum of mental health services including:

[2] See California's Medicaid State Plan and Title 9, California Code of Regulations (CCR), Section 1810.247.

- Mental health assessment;
- Crisis Intervention/Stabilization;
- Day Rehabilitation/Day Treatment Intensive;
- Intensive Care Coordination;
- Medication support services;
- Targeted case management; and
- Therapeutic behavioral services.

Like all Medi-Cal services, EPSDT is an uncapped entitlement, however the benefit additionally provides children an exceptionally high standard of care that is intended to "ensure that children in Medi-Cal receive age-appropriate screening, preventive services, and treatment services that are medically necessary to correct or ameliorate any identified conditions – the right care to the right child at the right time in the right setting.[3]" According to the U.S. Department of Health and Human Services:

> "While there is no federal definition of preventive medical necessity, federal amount, duration and scope rules require that coverage limits must be sufficient to ensure that the purpose of a benefit can be reasonably achieved.... Since the purpose of EPSDT is to prevent the onset of worsening of disability and illness and children, the standard of coverage is necessarily broad ... the standard of medical necessity used by a state must be one that ensures a sufficient level of coverage to **not merely treat an already-existing illness or injury but also, to prevent the development or worsening of conditions, illnesses, and disabilities**." [4]

However, a disconnect exists between the preventative ideal of EPSDT and California law which limits eligibility for EPSDT specialty mental health to children who have 1) a specified covered diagnosis; 2) a specific impairment that would not respond to physical health-care based treatment and; 3) that the interventions are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

In the context of foster care, extensive research has documented that the conditions leading to a child's involvement in the child welfare system are strong indicators for later behavioral and mental health challenges. Emerging best practices in serving the mental health needs of foster youth indicate the need for a specialized set of mental health services including trauma-informed practice, clinical permanency services, and other "promising practice" approaches to meeting their varied needs. Without firm diagnoses that identify an existing serious mental health disorder, foster youth who may exhibit warning signs often are not served by the county-based specialty mental health system until their condition deteriorates.

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[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

[4] http://mchb.hrsa.gov/epsdt/mednecessity.html

Children whose needs fall into the "mild to moderate" need category may be served by managed care plans, however currently there is little availability of these highly specialized services for foster children.[5] As a result, young children who enter the child welfare system following traumatizing life events often receive little to no mental health services until they exhibit serious behavioral disorders, often in adolescence.

Oversight tools for Specialty Mental Health

Foster youth who do meet the existing standard for medical necessity are entitled to a broad range of services and supports covered under Medi-Cal, and often receive additional services provided for under the Mental Health Services Act (MHSA).

A 2015 analysis prepared by the Senate Budget Subcommittee No. 3 on Health and Human Services summarized the funding for mental health services, including adult services, with the following chart which notes a recent substantial increase in expenditure of mental health services (a large portion is accounted for by the recent expansion of Medi-Cal eligibility for adults):

Fund Source	2013-14	2014-15	2015-16
	Total	Total	Total
1991 Realignment			
Mental Health Subaccount (base and growth)*	$41,690,000	$64,636,000	$125,386,000
2011 Realignment			
Mental Subaccount Health Account (base and growth)*	$1,129,700,000	$1,136,400,000	$1,134,700,000
Behavioral Health Subaccount (base)**	$992,363,000	$1,051,375,000	$1,198,071,000
Behavioral Health Growth Account	$60,149,000	$146,696,000	$140,885,000
Realignment Total	$2,223,902,000	$2,399,107,000	$2,599,042,000
Medi-Cal Specialty Mental Health Federal Funds	$1,425,814,863	$2,153,244,000	$2,772,568,000
Medi-Cal Specialty Mental Health General Fund	$5,803,134	$117,209,000	$138,004,000
Mental Health Services Act Local Expenditures	$1,246,741,000	$1,392,014,000	$1,362,650,000
Total Funds	$3,476,446,134	$6,061,574,000	$6,872,264,000

*2011 Realignment changed the distribution of 1991 Realignment funds in that the funds that would have been deposited into the 1991 Realignment Mental Health Subaccount, a maximum of $1.12 billion, is now deposited into the 1991 Realignment CalWORKs MOE Subaccount. Consequently, 2011 Realignment deposits $1.12 billion into the 2011 Realignment Mental Health Account. **Reflects $5.1 million allocation to Women and Children's Residential Treatment Services. Includes Drug Medi-Cal.

Specialty mental health services are provided pursuant to contracts established between DHCS and mental health plans that intend to define the scope of benefits to be provided by the plan, the

[5] National Child Traumatic Stress Network http://nctsn.org/nctsn_assets/pdfs/CAC_Directors_Guide_Final.pdf

provision of services, operational requirements, access, timeliness, authorization procedures, provider selection and certification, assessment procedures, grievance procedures, privacy provisions, and other standards of care and overall quality. Though a model contract exists, each county establishes its own unique contract with the department.

California has an extensive series of accountability and oversight tools including:

- Triennial reviews conducted by DHCS Program and Compliance Branch to review plans' compliance with its contract with DHCS and with the 1915(b) waiver. Counties found to be out of compliance must submit a plan of correction which will be made publicly available pursuant to the federally imposed special terms and conditions of the new specialty mental health waiver.
- External Quality Review Organization (EQRO) reports which are conducted annually by a contracted organization. These reports include basic information including "penetration rates," which specify the percentage of certain populations that are receiving any behavioral health service, and average claim amount per beneficiary.
- County Mental Health Plan Attestations submitted by the county plans that certify compliance with Medi-Cal compliance at least 60 days prior to the triennial review.
- Annual audits by the Audits and Investigations Branch to ensure the fiscal integrity of the health programs.
- Performance Outcome System intended to develop a plan for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services to support the improvement of outcomes at the individual, program and system levels and to inform fiscal decision-making related to the purchase of services.
- Katie A. compliance reports which evaluate county implementation of the Katie A settlement agreement which required the establishment of three new Medi-Cal specialized mental health services aimed at meeting the needs of the high-risk youth who are covered under the settlement.[6]

Additionally California has established two interagency tools created by DHCS and the California Department of Social Services pertaining to the quality of care that is provided to California foster youth including:

- The Core Practice Model, established as part of the Katie A settlement agreement that is intended to be utilized by all agencies and individuals who serve class members and their families. The model envisions the establishment of child and family teams and the provision of services that are individualized and tailored to the strengths and needs of each child and family.

[6] "Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC) for Katie A. Subclass Members." DHCS and CDSS. 2013.

- Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, which states that "the use of psychotropic medication for children and youth is considered a non-routine intervention, used under specified circumstances and as only one strategy within a larger, more comprehensive treatment plan to provide for that child's safety and well-being."

Although the spectrum of oversight and accountability tools involves an extensive effort on the part of the counties, the department, and other stakeholders, it is unclear that these collective efforts have been successful at identifying the breakdown in the system of care provided to foster youth. These tools may not correlate with the larger vision for an improved system of care articulated in the core practice model or guidelines for the use of psychotropic medication.

Specifically, with regard to foster youth, these tools often fail to identify the practical gaps in services that are experienced by advocates of foster youth on the ground. For example, in one Bay Area county, child welfare mental health advocates write that it is a common occurrence for the referral system to repeatedly refer children to providers who are not accepting new clients, resulting in a significant barrier to care. While the 2013 EQRO report briefly noted an observation that nearly 75 percent of the referrals from that system did not successfully initiate services, it did not evaluate the reason for this problem.

Additionally, contacts between DHCS and the mental health plans, the triennial review process, and the EQRO process incorporate few oversight questions or indicators that evaluate a plan's compliance with the availability of psychosocial services for foster youth pursuant to EPSDT. They do not monitor for adherence to the recently released core practice model of care pertaining to Katie A, nor the guidelines governing the prescribing of psychotropic medication for foster youth (DHCS has proposed several new indicators pertaining to psychotropic medication). Although, such quality components may be outside the scope of these oversight tools, the extent to which enactment of these and other quality-related policies are within the sphere of influence of the mental health plans, it may be useful to consider amending these tools to evaluate the plan's performance.

Provider Oversight by Mental Health Plans

The model mental health plan contract with DHCS requires the mental health plan to monitor the performance of its subcontractors on an ongoing basis and subject the subcontractors to periodic review, and requires plans to distribute a booklet that notifies beneficiaries of the scope of benefits to which they are entitled, the extent to which, and how beneficiaries may obtain benefits from out of county providers. Additionally, the model contract requires mental health plans to provide a directory of providers, as well as a means by which a beneficiary can identify which providers are not accepting new beneficiaries.

The model contract further describes basic requirements for the establishment of subcontracts with providers. Prior testimony[7] identified a problem in some counties whereby subcontracts are structured as a capped allocation, coupled with provisions disallowing the subcontractor to turn away youth or to establish wait lists. In other circumstances, subcontracts are subject to a capped allocation and overflow needs are directed to other alternative providers, instead of expanding the contract with the initial provider, effectively limiting access to certain providers who treat clients with specialized needs or those that are in high demand, potentially including commercially sexually exploited children, LGBT youth, or trauma-informed practitioners.

The model contracts and other existing statewide monitoring tools such as the triennial review protocol or EQR reports do not include a review of the financial arrangement of the types of subcontracts and how the structure of those subcontracts might affect the provision of services to children. Although the model contracts and review protocol do include language prohibiting the structure of "utilization review" entities from being paid in a manner that incentivizes reduction in medically necessary services, it is unclear if this standard applies to the subcontracted providers. Additionally the model contracts and review tools also include references to standards for timeliness and access to care; it is unclear how these standards are defined and whether they are actively enforced.

Performance Outcome System

SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012 and AB 82 (Committee on Budget), Chapter 34, Statutes of 2013 required DHCS to establish a Performance Outcome System to better understand the statewide outcomes of specialty mental health services provided, and to ensure compliance with federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements. The Performance Outcomes System is intended to establish outcome measurements for clients receiving managed care or specialty mental health services. It also required the development of measures for screening and referring Medi-Cal beneficiaries to mental health services. Thus far, the data made available by the process is largely limited to demographic claims-based data that is aggregated across the county systems, however a separate foster care report is underway.

[7] http://www.youngmindsadvocacy.org/ca-senate-budget-committee-review-epsdt-funding-challenges-under-realignment/

The most recent statutorily mandated legislative Performance Outcome System report from May 2015 noted that the "Measures Task Force," established to review measurement systems that the counties and providers use to assess client clinical and functional status over time, recently stated that "finding a way to accommodate the counties' use of multiple assessment tools and differing electronic records systems would make comparisons difficult, if not impossible." Faced with these and other challenges, barriers remain to being able to systematically evaluate outcomes for California's Medi-Cal mental health system.

Global Data Sharing Agreements

DHCS and CDSS have recently reported on efforts to establish a new data-use agreement between the departments and with individual counties that would permit sharing of critical data that would enable new ways of assessing the performance of the child welfare and mental health systems. Though the departments have finalized and initiated a state level agreement, it is unclear which counties intend to participate.

Recently the departments have undertaken state-level matches between foster care data in the Child Welfare Services/Case Management System (CWS/CMS) and Medi-Cal pharmacy paid claim records for all children in foster care (under 18 years-of-age) The departments state that these matches "have demonstrated the urgent need to for a multifaceted, data-informed approach to address this issue at systemic and individual case levels, and across disciplines and branches and levels of government." [8]

This global data-sharing agreement is intended to support efforts underway in the Psychotropic Medication Quality Improvement Project, which is establishing specific data measures for psychotropic medication use in foster care such as:

- The number of foster children who had a claim for a psychotropic medication;
- The number of foster children who had a claim for an antipsychotic medication;
- The use of multiple concurrent medications;
- The use of first-line psychosocial care;
- Metabolic screenings for foster youth taking a newly prescribed psychotropic medication;
- Ongoing metabolic monitoring for foster youth on antipsychotic medications; and
- Follow-up visits with the prescribing physician.

The departments will then make the information available to counties; however it is not clear that the information will be used to evaluate county performance. It also is unclear whether the global data sharing agreement will be used to review the recently published psychotropic medication guidelines or the core practice model, or for use in ensuring compliance with other existing contract standards such as access to timely EPSDT services. Other data-based information that has been sought by the legislature and advocates, but is not yet available includes:

[8] http://www.dss.cahwnet.gov/lettersnotices/EntRes/getinfo/acin/2015/I-36_15.pdf

- The type of prescribers that are initiating psychotropic medication, adding new medications or increasing dosages;
- The extent to which psychosocial services been provided to children who are prescribed psychotropic medications prior to a psychotropic prescription;
- The medications which are being prescribed, and at what dosages for which diagnosis;
- The dosages which children at various ages are being prescribed medication;
- The placement setting in which children initially are receiving prescriptions for psychotropic medication;
- Whether second opinions are initiated and fulfilled;
- The duration of prescription regimens, and
- Which providers are successfully initiating a tapering plan, pursuant to the guidelines.

Such data sharing agreements may also be useful in identifying individual subcontractors or prescribers who, or to be reported to other oversight bodies such as the Medical Board of California. Currently, the departments have established an agreement with the Medical Board and made a large amount of data available, however it is unclear whether the information provided will be analyzed by DHCS prior to release to the Medical Board and whether the Board will have timely access to individual medical records in order to take action.