



Universal Array of Services for Child Welfare Involved Youth and Youth at Risk of Involvement

In 2020, the Behavioral Health Committee of the Child Welfare Council engaged in a year-long consensus-based decision-making process. The work culminated in a detailed set of policy recommendations, delivered to the Child Welfare Council and the Secretary of Health and Human Services, which seek to improve the system of behavioral health services that are in place to serve children and families involved in, or at risk of involvement in, the child welfare system.

The Committee's 2020 recommendations were organized into four thematic categories: (1) improving access to services; (2) defining and establishing the continuum of behavioral health services and supportive placements that should be provided for child welfare-/probation-involved youth and youth at risk of involvement; (3) implementing outcomes-based accountability and performance improvement measures; and (4) developing strategies to support effective implementation.

Since presenting the recommendations to the full Council in December 2020, the landscape of California's systems serving child welfare-involved youth has shifted significantly. In mid-December of 2020, the California Department of Social Services (CDSS) transferred more than 120 youth with complex care needs back to California from out-of-state placement. The urgent push to return youth to in-home placement or residential care settings in California, near their families and communities, has highlighted the significant variation in the different capacities of counties to appropriately place and support youth with complex needs.

Governor's Children and Youth Behavioral Health Initiative (CYBHI)

In addition to the \$750 million for behavioral health continuum infrastructure funding and the \$400 million for Medi-Cal Managed Care Plans for student behavioral health included in the 2021 Governor's budget, the CYBHI includes significant additional investments in behavioral health services for children and youth. The CYBHI provides funding over the next five years for several elements of the universal array of services outlined below. The initiative will include, among other proposals, funding to underwrite the following:

- **\$680 million for an expansion of CalHOPE, a virtual platform**
The platform will provide: app-based behavioral health information, education, and engagement; a 24/7 warmline; screenings and assessments; texts with peers or behavioral health coaches; and, for youth with more intensive needs, connections to managed care, county mental health, and/or substance use disorder (SUD) services.
- **\$550 million for school-based mental health infrastructure**
Examples of possible funding opportunities include: administrative costs; programs to link plans, counties, and schools with local social services; incentive payments for hiring school behavioral health counselors and coaches; telehealth services; and data sharing services.
- **\$430 million to expand evidence-based practices to support youth experiencing, or facing a high risk of, significant mental health conditions**
Priorities for these grants may include: programs for youth experiencing a first episode of psychosis; interventions tailored to youth living in disproportionately impacted communities and communities of color; youth Drop-In Wellness Centers; Intensive Outpatient Programs; and prevention and early intervention services for youth.

- **\$245 million in grants to strengthen the behavioral health continuum of care infrastructure**
Grants to develop real estate assets would be distributed through a competitive Request for Proposals process, based on an analysis of current service capacities and gaps. Priorities could include building alternatives to institutional settings, such as models delivering trauma-informed crisis intervention and stabilization services in a home-like setting.
- **\$100 million in state General Funds (matched by \$100 million in federal funds) to fund Dyadic behavioral health visits as a new Medi-Cal service**
Dyadic services for a child are delivered in the context of the caregiver and family, enabling screenings for not only behavioral health challenges, but also interpersonal safety, tobacco and substance misuse, and social determinants of health such as food insecurity and housing instability. The initiative's proposal is based on the Healthy Steps model of care. Other examples of dyadic health care include Parent-Child Interaction Treatment and Child-Parent Psychotherapy, which are mentioned below as examples of family systems therapies.
- **\$430 million to educate and train culturally and linguistically proficient behavioral health counselors and coaches to serve school and college-age children and youth**
- **\$430 million in additional investments to expand the state's behavioral health workforce**

Fall 2021

The ongoing work of the Behavioral Health Committee does not take place in a vacuum. Statewide, concurrent dialogue across sectors seeks to identify service and access gaps and determine viable solutions. The California Advancing and Innovating Medi-Cal (CalAIM) Foster Care Model of Care Workgroup's (FCMCWG) scope of work seeks to determine what delivery system and payor will be responsible for meeting the unique behavioral health needs of child welfare-involved youth and youth at risk of involvement.

Given the ongoing progress of other working groups and the acceleration in counties' urgency to place and support youth returning from out-of-state placements, the Behavioral Health Committee's work in the Summer and Fall of 2021 has focused on reaching wide, informed consensus on the continuum of behavioral health services and supportive placements that should be provided for child welfare-/probation-involved youth and youth at risk of involvement. The work to define this continuum begins in this visioning document. The Committee hopes that this paper will be used as a tool for stakeholders seeking to expand available services for all child-welfare-involved youth across the state.

Defining and Implementing a Universal Array of Services

The comprehensive continuum of services described below reflects a minimum array of behavioral health services and programs for youth who are involved in or at risk of involvement in the child welfare system. Optimally, the service continuum described should be made available for each population base of 750,000 to 1,000,000, scaling up as needed for larger geographies and denser urban settings. To achieve cost-effective implementation and address the challenges smaller or more rural counties face, this service continuum can be built on a county-by-county or regional basis. Additional incentives should be offered to programs serving areas and populations that have been historically underserved, such as individuals living in rural communities. Depending upon the jurisdiction and its landscape of services, the same provider or different providers can hold the responsibility for implementation, while maintaining fidelity to specific service model standards to guarantee parity and ensure that service access is no longer determined by a child's zip code. Each continuum component outlined below includes information related to program goals, core services and supports, and recommendations to link each component to relevant services as youth step up/step down.

Program evaluation, accountability, and performance improvement measures are addressed in a separate set of committee recommendations. While each program can and should be tailored to address the unique needs of each jurisdiction and respond to the landscape of each region, there must be clear standards for care and treatment that are consistently upheld statewide.

The following descriptions of continuum components also list current and potential local, state, and federal revenue sources. In some cases, the staff time required to apply for these monies and fulfill ongoing documentation requirements would create significant logistical obstacles for child-serving organizations with limited resources. In addition, some aspects of the programs and services discussed below will not qualify for each of the listed funding sources.

It is important to note that the universal array of services as described would **not** be achievable with existing behavioral health funding levels—and ongoing state funds must be allocated to support these efforts, including and outside of the historic investment made in the Governor’s Children and Youth Behavioral Health Initiative described above. Currently, County 2011 Realignment only covers approximately 65% of the required state/local match for Medi-Cal Specialty Mental Health Services and SUD treatment under the EPSDT mandate.

An effective and healing-centered service system for youth that replaces California’s historical pattern of sending youth out of state is urgently needed. The service array outlined below reflects a tiered approach, with significant investment in prevention and early intervention to divert youth and families from higher levels of care whenever possible. Some of the services reflected below are geared toward all youth to effectively offer tiered diversion from more intensive systemic involvement. However, as California’s out-of-state facility usage reflects, the most intensive end of the continuum is also essential for a minimal number of youth with acute behavioral health needs. In addition, the closure of many juvenile justice facilities throughout the state will further increase the need for alternative rehabilitative interventions for youth with complex behavioral health challenges. As such, the entire service array described here cannot be divided up or implemented piecemeal. Youth and families must have access to every element of this continuum across California.

Core Competencies Across the Array

Guiding details around types of services and interventions must be accompanied by thoughtful dialogue determining the ideal core competencies of providers delivering these services. While this visioning document is prescriptive by nature regarding model types, continued discussion surrounding ideal core competencies is needed.

Most notably, the need for further exploration of established core competencies was raised by committee members during the drafting process regarding working with youth impacted by commercial sexual exploitation in the child welfare system. Experts relayed that while unique services (e.g., Supportive Housing) were particularly beneficial to support the well-being of youth impacted by CSE, the reality remains that youth impacted by CSE are currently in every component of the service continuum. To that end, a through-thread of core competencies for providers across the continuum supporting youth impacted by CSE is crucial.

Experts relayed that across prevention and early intervention, community-based supports, tiered therapeutic supports, and crisis services, core competencies needed to support CSE-impacted youth included (but were not limited to): ability to identify involvement in and screen for risk of CSE involvement (exp. West Coast Children’s Clinic’s CSE-IT Training and Tool); cultural humility; ability to deliver gender-affirming health and mental health care; ability to deliver intersectional, SOGIE-inclusive programs; trauma-informed care; harm reduction framework-based care.

Finally, the core competency of intensive coordination of services for youth moving throughout the continuum should be upheld wherever possible. Too often, families and youth are asked to engage with multiple care teams at once, or do not receive seamless coordination services as their needs change and they move from one continuum setting to the next.

Addressing White Supremacy and Diversity, Equity and Inclusion Within and Across the Behavioral Health and Child Welfare Systems

Too often, Black, Indigenous and children and families of color involved in child welfare are offered behavioral health intervention for trauma, while providers and workers throughout the child welfare and behavioral health systems collectively fail to explore how this trauma may be a result of white supremacy. Instead of treating the disease of systemic racism, we are treating the symptoms.

While responsive care to address the myriad trauma resulting from ongoing oppression is crucial, so is naming, exploring and abolishing the roles white supremacy and racism play in enacting this continuing trauma for many system-involved children and families. Much of this harm and resulting trauma is borne from interactions, both historic and present-day, with the behavioral health and child welfare systems.

As we move together toward safer care systems that act on the lives of children and families, we must continue to shine a light on racism and considerations of diversity, equity and inclusion wherever and whenever they exist.

Prevention and Early Intervention

Early Childhood Education (ECE) and Developmental Screenings

Goal: To provide universal preschool and early learning and childcare programs to every infant, toddler, and child (ages 0-5), enhancing school readiness and positioning early childhood education sites as hubs for referral to early intervention and preventative behavioral health services.

Services and Supports: Quality early education sites and services provide developmentally appropriate social-emotional learning, play, and early academics for children at times and locations that accommodate working parents. Educational services and support should include but are not limited to early literacy support; alphabetic awareness; exposure to complex text; social development and socializing with peers; play to learn and practice problem-solving; and learning socio-emotional skills such as cooperation, empathy, self-regulation, and persistence.

While high-quality ECE provides a robust learning environment in which children gain social-emotional skills, one of the most critical elements of ECE is strong adult-child interactions and attachment, created over time by responsive caregiving, predictable routines, and consistent, stable staffing patterns. Universally, students with experience in pre- and transitional- kindergarten are better prepared to succeed in kindergarten and early elementary school. In addition to equipping early learners with stronger academic and social-emotional tools for school readiness, universal preschool and pre/transitional kindergarten sites link families to developmental, behavioral health, physical, and dental screenings.

Linkage to Other Continuum Components: Early childhood education sites link families struggling with unmet ecological needs to community-based services and supports, and where more intensive behavioral health and service coordination is needed, service models like Wraparound. Early education sites must also be equipped to refer children with more acute behavioral health needs to therapeutic preschool settings and clinical or community-based specialized mental health services. Finally, ECE sites are well-positioned to support pregnant and parenting teens, especially those involved in the foster care system, and can provide service linkage to this population to basic needs support, childcare, and home visiting.

Fiscal Structure: To achieve quality early childhood education that is affordable to all families, significant investments must be made to secure a living wage for early childcare workers to reduce turnover rates in the

early childcare workforce. Family share of cost must reflect a family's ability to pay and a sustainable portion of their income.

Potential funding streams to be leveraged include:

- Head Start
 - Child Care Development Fund (CCDF)
 - Child Care Development Block Grant
 - Every Student Succeeds Act Funds (ESSA)
 - First 5 Funds
 - Child and Dependent Care Credit
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- Mental Health Services Act (MHSA) Funds
 - Medi-Cal EPSDT (Early and Periodic Screening, Diagnostic and Treatment) / Specialty Mental Health Services (where medical necessity criteria is met)
 - Individuals with Disabilities Education Act, Part C (For children age 0 to 3)

Therapeutic Preschools or Therapeutic Preschool Classrooms

Goal: To support preschool-age students who benefit from school-based behavioral health services in accessing their education and prevent the need for more intensive or segregated special education services as they enter K-12.

Services and Supports: Therapeutic preschools offer full-day preschool with highly integrated, individual, and classroom-wide behavioral health intervention to support students ages two and nine months to five years old. Therapeutic preschool classrooms are supported by one teacher, one licensed clinician, and one to two bachelor's level mental health counselors. The structure of therapeutic preschool activities mimics that of a traditional preschool and offers similar activities such as outdoor play, circle gatherings, free play, activities to engage with the alphabet and complex text, and snack time.

Clinicians provide one hour of developmentally appropriate individual therapy per child each week, as well as group therapy and small group social skills practice multiple times each week. Clinicians and mental health counselors support students in the classroom through individual social skills support and coaching; strategies and tools for de-escalation; helping students to name and identify feelings; and promoting a trauma-informed classroom environment. Therapeutic preschool classrooms can nimbly integrate other supports students may need to succeed in a school setting, including but not limited to occupational therapy and speech therapy.

Clinicians support parents and caregivers in navigating the challenges and successes of supporting a young child with complex behavioral health needs. Clinicians also provide collateral support and case management to caregivers as well as parent-child interaction therapy. Parent partners can also be integrated into this model.

In some geographic locations with small target populations for this service, a therapeutic classroom within a well-established preschool setting is more administratively and financially appropriate.

Linkage to Other Continuum Components: Therapeutic preschools or therapeutic preschool classrooms can provide linkage to higher-acuity outpatient and intensive outpatient mental health services for young children and families. Therapeutic preschools receive referrals from other early education sites and, where appropriate, support early learners and their families in navigating the IEP process and transitioning to Non-Public Schools.

Fiscal Structure: Potential funding streams to be leveraged include:

- Medi-Cal EPSDT/Specialty Mental Health Services
- Local Control Funding Formula
- State Preschool Funding

K-12 Whole School Approaches

Goal: To empower an entire school community with the skills and resources required to implement a multi-tiered or holistic system of academic, behavioral, and social-emotional supports with a focus on promoting a safe, healthy, and inclusive climate and culture at each school that is responsive to the needs of *all* students and their families.

Services and Supports: Schools implementing school-based multi-tiered systems of supports (MTSS) and/or Community Schools models coordinate general education, special education, and mental health resources and professionals across the site to deliver multi-tiered interventions, reorganize resources to deliver trauma-informed prevention and early intervention services to support students before they fail and provide data-driven and coordinated services to students with individualized needs.

Whole-school approaches can remove many logistical barriers to care. For example, when they are located in schools in rural communities, they offer easy access to services that otherwise might require extensive travel.

While MTSS/Community school models vary in practice, thoughtful coordination of resources is required to shift away from patterns of intervention that focus solely on students with the highest acuity needs. Rather, interventions that support school culture and climate and on-campus adults, targeted groups of students with emerging needs, *and* students with acute needs drive limited resources upstream.

Some MTSS/Community School models leverage a single coordinator position, who works with schools to develop the capacity to assess and improve the overall school culture and climate, to ensure that school is a place where students and families feel safe and engaged. This coordinator also provides professional development opportunities and ongoing coaching that prepare staff to meet the diverse needs of students within their classrooms.

In addition to a coordinator that supports school climate and culture and the coordination of services, school sites benefit from robust mental health staff to support integrated mental health supports on a school campus. Coordinators have the opportunity to implement holistic strategies for concerns unique to their school communities, such as commercial sexual exploitation of youth. Strategies to implement CSE prevention and response within the school ecosystem include: trainings for staff, teachers, and clinicians to identify and respond to situations of trafficking in a trauma-informed way; age-appropriate trafficking education delivered through the classroom to support prevention and safe disclosure; and connecting parents/caregivers of youth involved with trafficking to group supports.

Linkage to Other Continuum Components: Staff at schools that implement MTSS and/or Community School frameworks can refer families struggling with urgent, unmet ecological needs to preventative social service supports and, where appropriate, avoid contact with the child welfare system. School staff are also equipped with the tools necessary to successfully refer students to other programs that can provide social-emotional and trauma screenings, such as the Adverse Childhood Experiences (ACEs) screen. Whole-school approaches require collaborative partnerships among Local Education Agencies (LEAs) and county mental health plans, commercial insurers, county social services, and county probation departments.

Fiscal Structure: Potential funding streams to be leveraged across the tiers include:

- LEA Medi-Cal
- Medi-Cal EPSDT, Specialty Mental Health Services
- Medi-Cal Administrative Activities
- Mental Health Services Act (MHSA) Funds
- Educationally Related Mental Health Services (AB 114)
- Local Control Funding Formula
- General Education Funds
- Special Education Funds
- Federal/State MTSS and Community School Grants

Family Resource Centers

Goal: Family Resource Centers (FRCs) are community and/or school-based multi-service centers that offer culturally relevant family support services and care navigation. FRCs increase parent engagement and knowledge of early childhood care, family linkage to public health resources, and school readiness for children. Taken together, the preventative services and interventions available from Family Resource Centers significantly decrease family entries into homelessness and child welfare involvement.

Services and Supports: FRCs vary in unique services offered but produce the strongest outcomes when they are highly attuned to the cultural and social needs of the local community. FRCs are especially effective at engaging immigrant, refugee, and mixed-status families by utilizing peer navigation, outreach, and counseling. There is no one distinct service array offered by every FRC. Still, a high-quality FRC should be parent and family-driven and provide case management, linkage to emergency resources such as food and clothing, parenting workshops, mental health services and referrals for children and adults, and insurance enrollment and benefits navigation. Depending on unique community needs, services can include legal counseling, dental care, prenatal education and supports, education support and tutoring, housing and homelessness interventions, and other relevant linkages to community services.

Linkage to Other Continuum Components: FRCs help families enroll in insurance and government benefit programs and support them in navigating the behavioral health care resources available to them, including community-based outpatient and intensive outpatient mental health services. FRCs are also able to refer youth and adults to higher acuity care settings, as insurance allows. FRCs are typically well-integrated with local school districts and can refer eligible children and families to additional supportive mental health services, including school-based programs or other community-based programs, such as Wraparound.

Fiscal Structure: Despite their relatively low operating costs but impactful proven outcomes, including significant diversion rates from the child welfare system, Family Resource Centers struggle to maintain sustainable funding sources. Many FRC programs began with significant First 5 and Healthy Start Funds, which are now widely depleted. Other potential funding streams to be leveraged include:

- Medi-Cal Administrative Activities (MAA)
- County General Funds
- Foundation funding
- Mental Health Services Act (MHSA) Funds
- Connecting Kids to Coverage Outreach and Enrollment Grants

Family System Therapies to Prevent Adjudication and Expedite Reunification

Goal: Family system therapies and parent training models seek to improve caregiver-child relationships, reduce parental stress, and reduce future risk of abuse, neglect, or maltreatment. While family system therapies and parent training models can include a wide range of interventions, modalities, and treatment settings, they all seek to support and maintain stability among many family configurations, including child and biological parent, and child and adoptive, foster, or kin caregiver.

Services and Supports: Family system therapies often include live coaching of parents or caregivers while they interact with or manage their child’s challenging behaviors. Services are typically provided in an outpatient clinic or a family’s home and can occur during the family reunification process, or be delivered to children and caregivers at risk of formal child welfare adjudication as part of a suite of diversion services such as differential response. These supports can also be used to help strengthen attachment and bonding between a resource parent and child in foster care, supporting trauma-responsive caregiving and helping to reduce placement instability. Examples include but are not limited to Parent-Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP), and Multidimensional Family Therapy (MDFT). Family reunification efforts can be further strengthened by programs that train foster parents to work collaboratively with birth parents to build stronger family relationships. Services proven to meet specific evidence-based standards can qualify for funding from the Family First Prevention Services Act.

Additionally, respite care is crucial to provide parents and other caregivers with short-term childcare services that offer temporary relief, improve family stability, and reduce the risk of abuse or neglect. Respite can be planned or offered during emergencies or times of crisis. Respite may be available to foster, kinship, and adoptive families, as well as birth families in need of support. Respite has been cited as reasonably improving placement stability for children and youth. Appropriate screening and referral pathways should also be considered within the respite care framework if appropriate. This model could also be connected to other home-based service models when needed.

Finally, warm lines, helplines, and parent groups serve as critical opportunities to support overall family well-being and are especially impactful in reaching rural, socially isolated, immigrant, and underserved communities. Evidence-based examples of these program types include the California Parent and Youth Helpline® and the Parents Anonymous® Online Evidence-Based Groups®.

Linkage to Other Continuum Components: Family system therapies can support family reunification once a child returns to their family of origin from out-of-home placement or a higher-acuity care setting. As a preventative service, family system therapies and parent training models are especially effective for caregivers and children younger than seven and can work in conjunction with school-based services.

Fiscal Structure: Many evidence-based and promising family system therapies are included in the Family First Prevention Services Clearinghouse or are under review for inclusion. Potential funding streams to be leveraged include:

- Medi-Cal EPSDT, Specialty Mental Health Services
- Mental Health Services Act (MHSA) Funds
- Philanthropic dollars
- First 5 Funds
- Family First Prevention Services Act Funds
- In Lieu of Services Benefit provided by Medi-Cal Managed Care Plans (can be provided at the discretion of MCP)

Drop-In Centers

Goal: To provide accessible and affordable mental and physical health care services to youth ages 12-25 in a community-based setting while targeting groups from historically marginalized communities, including but not limited to homeless, LGBTQ, and Indigenous youth. The primary goals of Drop-In Centers are to (1) promote overall youth wellness that is self-directed and (2) connect youth to community supports. Drop-In Centers seek to reduce suicide, suicidal ideation, and substance use disorders among youth; reduce youth homelessness; reduce unemployment through linkage to vocational training; and reduce school failure through linkage to educational support services.

Services and Supports: Drop-In centers models such as the Allcove model require the ongoing integration of youth feedback and participation in program design. Youth Drop-In Centers are culturally responsive local nexus points of social service linkage and individual and family mental health services. Mental health services provided at Youth Drop-in Centers include outpatient individual and group therapy delivered by licensed or license-eligible mental health professionals (LMHPs), as well as peer support counseling and services. Social service linkage can include but is not limited to housing, employment, and education support. Drop-In centers should also include basic needs support, like clothing, food, and hygiene.

Drop-In Centers can offer centralized low threshold supports to youth impacted by CSE and youth impacted by CSE who are pregnant or parenting. These supports can include on-site childcare, resources for young children, connection to reproductive health supports, and pre/post-natal care.

Linkage to Other Continuum Components: The mental health services provided in Youth Drop-In Centers are available to any youth, regardless of insurance status or ability to pay. To that end, Youth Drop-In Centers must be highly integrated with a range of other community-based supports across delivery systems and payors. Drop-In Center mental health providers are equipped to facilitate access for youth to higher-level behavioral health care settings in the service continuum when needed, such as Crisis Stabilization Units (CSUs).

Fiscal Structure: Because Youth Drop-In Centers serve diverse populations, including youth who are uninsured or underinsured, this model requires a sophisticated blending of state and county funding. The 2019-2020 state budget allocated \$14.5 million to the Mental Health Oversight and Accountability Commission to award contracts to five county, city, or multi-county mental health or behavioral health agencies or partnerships to establish Youth Drop-in Centers. Other potential funding streams to be leveraged include:

- State General Funds
- County General Funds
- Mental Health Services Act (MHSA) Funds
- Medi-Cal/EPSDT, Specialty Mental Health Services

Family Urgent Response System (FURS)

Goal: To provide 24/7 trauma-informed support to current and former foster youth and their caregivers to address situations of instability that include, but are not limited to, mental health crises. FURS is intended to prevent placement disruption; preserve the relationship between the child or youth and their caregiver; provide a trauma-informed service alternative for families who previously resorted to calling 911 or law enforcement; reduce hospitalizations, law enforcement contacts, and placement in out-of-home facilities; promote healing as a family; improve retention of current resource caregivers, and promote stability for youth in foster care, including youth in extended foster care.

Services and Supports: The FURS infrastructure is built on two components: (1) a statewide hotline available 24 hours a day, seven days a week that is staffed by counselors trained in conflict resolution and de-escalation techniques for children, youth, and families impacted by trauma; and (2) county or regional mobile response systems (with mobile response and stabilization teams) that are available 24/7 to provide in-person de-escalation, stabilization, conflict resolution, and support services when needed. The mobile response and stabilization teams provide each family with a plan to address identified support or ongoing stabilization needs and connect them to ongoing services through the local network of service systems and providers. Mobile response and stabilization teams should include youth and parent partners with lived experience navigating the child welfare system, wherever possible. Both current and former foster youth can qualify for FURS services.

Linkage to Other Continuum Components: County/regional mobile response and stabilization teams support families in creating a plan of action to address ongoing stabilization needs and connect them to ongoing services, such as outpatient mental health services, Therapeutic Behavioral Services (TBS), Wraparound, etc. Mobile response and stabilization teams are equipped to connect youth in acute distress to Crisis Stabilization Units, where necessary. Mobile response and stabilization teams are also equipped to link children and youth to additional trauma-informed and culturally and linguistically responsive family support services and youth and family wellness resources.

Fiscal Structure: County FURS programs should leverage existing mobile response services for any Medi-Cal eligible youth to maximize financial sustainability at the local level. Other funding sources to be maximized include:

- State FURS allocation
- Mental Health Services Act (MHSA) Funds
- Medi-Cal/EPSDT, Specialty Mental Health Services
- County General Fund

Non Clinical Supports

Goal: Children and youth who have experienced trauma can benefit from, and often express a strong desire for, non-clinical behavioral health supports that promote social and emotional well-being and resilience. Intended outcomes and goals vary given the diverse set of interventions in this category, but overarching goals include increasing protective factors; building healthy coping skills; managing stress and building self-confidence; addressing social determinants of health that impact adolescent mental health; providing psychoeducation related to health and wellness; and increasing connectedness to peers and community.

Services and Supports: Strength-building and other non-clinical therapeutic supports, including community-defined practices, can include mindfulness, music and movement programs, mentorship and peer counseling activities and restorative justice spaces, art therapy, and equine therapy. These are often most successfully provided by individuals with lived experience as behavioral health consumers, individuals from the target community, and individuals with shared cultural and linguistic identities to the target consumers.

Linkage to Other Continuum Components: Child welfare-involved youth and youth at risk of future involvement express the need for strengths-building, culturally relevant supports outside of the traditional 50-minute session with a clinician. Non-clinical social supports can scaffold outpatient community-based services for youth stepping down from higher acuity placements and provide service linkage for youth who demonstrate a need for higher intensity services, including Specialty Mental Health Services.

Fiscal Structure: The non-clinical nature of this continuum component necessitates the blending of multiple funding sources and significant responsiveness to local needs. Like other universal prevention services, non-clinical supports present an opportunity for lower-cost, tiered diversion from higher-cost, higher-acuity care settings. Medicaid waivers should be explored to secure additional funding to implement robust non-clinical therapeutic support services. Other funding sources to be considered include:

- Mental Health Services Act (MHSA) Funds
- Medi-Cal EPSDT, Specialty Mental Health Services
- County General Funds
- Family First Prevention Services Funds

Family Finding

Goal: Family finding can support children in foster care in forging caring relationships and achieving physical and legal permanency. Goals of family finding programs include increasing child/youth connectedness, increasing the number of children and youth with permanent legal placement with family members or caring

adults in their lives, reducing the overall time spent in foster care, and reducing the number of children and youth in restrictive care settings.

Services and Supports: Family finding teams vary by program but consistently seek to support youth in forming relationships with caring adults in their lives with the goal of achieving physical or legal permanency. Youth engaged in Family finding have often experienced attachment disruptions and significant trauma. The work of family finding programs includes locating caring adults or family members in a child’s life and supporting the development of new and meaningful relationships.

Family finding teams can be made up of clinicians or bachelor’s level staff and work with referring child welfare social workers, youth, caregivers, and other service providers to introduce the family finding process. Initial meetings seek to establish rapport, obtain historical information about a family, and center youth voice and choice. Family finding practices, including file mining, genograms, and online searches, are completed to locate additional family members in a child’s life. Family finding teams prepare youth and their caregivers for in-person or virtual meetings with new connections, following a comprehensive engagement plan (or existing safety plan) that includes triggers and de-escalation techniques to support youth.

As more connections are located, family finders prepare each youth and their adult supports for in-person or virtual meetings. Family finding staff collaborate with the client and care team to develop a comprehensive engagement plan (or utilize an existing safety plan) that includes triggers and de-escalation techniques. Once all parties feel prepared to meet, the family finding team facilitates supervised visitations and supports relationship building between the youth and existing or new connections through relational coaching and therapeutic activities. Once possible connection networks grow, teams support youth and caregivers in discussing options for permanency, including potential barriers and strengths. Teams support potential connections in reviewing their readiness and identifying their natural supports. Family finding teams remain in a child and new connections life to implement therapeutic practices where needed to support a youth’s placement transition and any behavioral health needs of the youth or caregiver.

Linkage to Other Continuum Components: Optimally, family finding programs link youth directly to kinship care homes. Children, youth, and newly identified caregivers involved in family finding often benefit from outpatient mental health services.

Fiscal Structure: Funding sources to be leveraged include:

- Title IV-E Prevention Services
- Medi-Cal EPSDT, Specialty Mental Health Services

Community-Based Supports

Outpatient and Intensive Outpatient Mental Health Services

Goal: To achieve strong permanency outcomes and meet the behavioral health needs of youth in their communities by providing an array of evidence-based and promising behavioral health services and, where necessary, case management and intensive case management.

Services and Supports: Outpatient and intensive outpatient mental health services include an array of permanency-focused treatment and case management services available at locations and times that are accessible to youth and their families and/or natural supports. These supports include home visiting programs, such as the Healthy Families America program, which has received the highest Evidence-Based Practices rating of “well supported” from the FFPSA Clearinghouse. Outpatient and intensive outpatient services offer highly individualized packages of culturally and linguistically responsive mental health services driven by a

comprehensive, data-driven assessment of youth and family goals, interests, strengths, and needs.

Diverse at-risk populations are well served by outpatient and intensive outpatient services, including youth who are at risk of delinquency, substance abuse, sexual exploitation, running away, and other conditions associated with complex mental health needs. These services should also be available to help children and youth heal following trauma, while remaining in their homes and communities.

Linkage to Other Continuum Components: Outpatient and intensive outpatient services are critical to support youth transition from out-of-home placements and/or higher acuity tiers of care to their families or communities of origin. Additionally, outpatient and intensive outpatient services can seamlessly refer youth with behavioral health needs that cannot be safely met in their homes and communities into higher tiers of care, including a Crisis Stabilization Unit.

Fiscal Structure: Funding sources to be leveraged include:

- Mental Health Services Act (MHSA) Funds
- Medi-Cal EPSDT, Specialty Mental Health Services
- County General Funds
- Title IV-E/ Family First Prevention Services Fund (e.g., Healthy Families America home visiting program)

Intensive Home and Community-Based Services

Goal: To provide individualized and intensive interventions that promote permanency and reduce the risk of placement disruption. The name of these services varies largely by funding stream but is best described as Wraparound. Intensive home- and community-based Wraparound services are critical front-end and back-end supports to youth and families across the entire children's continuum of services, sustaining treatment gains made in any program.

Services and Supports: Youth and families may at times require intensive and individualized interventions that promote stability and reduce the risk of out-of-home placement or placement disruption. Following a high-fidelity Wraparound model, intensive home and community-based supports are provided by a treatment team that ideally includes a master's level clinician, bachelor's level support counselor, and family partner with lived experience caring for a youth involved with the child welfare, mental health, and/or juvenile probation systems. There is a significant need for increased standardization of intensive home- and community-based practice standards across the state since there is a high degree of variability in both definition and practice across these service types.

Currently, child-serving professionals sometimes feel obligated to file reports with child welfare primarily in order to obtain services for the family. To avoid these unnecessary reports, wraparound-based models of services and supports must be made available prior to involvement with the child welfare system through referral pathways for teachers, natural supports, pediatricians, and others involved in the lives of families and children.

This suite of services includes the Medi-Cal funded interventions of Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Behavioral Services (TBS). These Medi-Cal services reflect the principles and concepts of Wraparound and are often embedded within Wraparound programs supported by state and federal child welfare funding. Alternately, for non-Medi-Cal eligible youth, counties utilize MHSA funding to deliver Wraparound-like services, known as Full-Service Partnerships. Regardless of the funding stream or specific terminology used, the key principles of intensive home- and community-based services require that these services be driven by the Child and Family Team (CFT) through a process of collaborative assessment, treatment planning, and action steps to achieve client-identified goals. CFTs are convened by the placing agency or, for youth not involved in the child welfare or juvenile probation systems, the county mental

health plan.

Linkage to Other Continuum Components: Services reflecting the principles and concepts of Wraparound are central to a comprehensive continuum of services since they provide youth and families with seamlessly integrated mental health services capable of supporting ongoing stability and permanency throughout the treatment and placement process. Wraparound is an essential prevention service to reduce out-of-home placements, but it is also a critical component for supporting transition between intensive treatment settings or from a crisis program to the family setting (such as the Expedited Transition Services model currently utilized by CDSS).

Fiscal Structure: Wraparound services use both child welfare and behavioral health funding to increase flexibility and ensure that all enrolled youth and families receive the level of support necessary to address their needs.

Funding streams to be leveraged include:

- Social Services Wraparound Rate
- Medi-Cal/EPSDT, Specialty Mental Health Services
- Mental Health Services Act (MHSA) Funds
- Family First Prevention Services Act Funding (*pending inclusion of High-Fidelity Wraparound in the FFPSA Clearinghouse*)

Substance Use Disorder Services

Goal: To prevent the development of and meet the care needs related to, Substance Use Disorders (SUDs) in children, youth and adolescents, across a range of developmentally appropriate interventions and acuity settings.

Services and Supports: Primary SUDs services for children and youth include formal, developmentally-appropriate curriculum and psychoeducation related to drug use and decision-making, such as Toward No Drugs and the Botvin Life Skills Training programs. Informally, experts and youth identify non-clinical supports that build protective factors and increase youth agency, including but not limited to employment training, educational supports, social activities and events, arts and mindfulness, and mentorship, as invaluable preventative services that keep youth from engaging in substance use. Peer-to-Peer support models reduce stigma related to substance use and build trust with youth who may avoid seeking help due to fears of law enforcement involvement.

Services for youth using drugs or alcohol or with co-occurring SUDs and mental health needs should include outpatient and intensive outpatient services at locations that are accessible and youth friendly. Youth often do not feel comfortable accessing SUDs services on their school campuses. These youth may be more willing to seek care at alternative venues, such as Drop-In Centers. Individual and group cognitive behavioral therapy for youth living with substance use disorder should be provided by clinicians with SUDs treatment experience. These clinical services should be accompanied by modalities delivered by individuals with lived experience and those in long-term recovery. Training and education for parents and caregivers can help them better support youth with SUDs.

The state must develop program models that reliably incorporate SUD into the treatment and planning for the child, youth, or family. Dependent upon the youth's level of need, this may include programs that provide co-located and/or clinically integrated mental health and SUD treatment.

Where medically necessary, inpatient substance use disorder services must be youth and adolescent-specific and provided in settings that do not also serve adults. These high-end, residential service options include: Residential Inpatient Services (ASAM level 3); Clinically Managed Low-Intensity Residential Services (ASAM level

3.1); Clinically Managed Medium-Intensity Residential Services (ASAM level 3.5); Medically-Monitored High-Intensity Inpatient Services (ASAM level 3.7); and Medically Managed Intensive Inpatient Services (ASAM level 4). ASAM Levels 3 to 4 encompass residential services that can support youth diagnosed with SUDs or co-occurring substance use and mental health disorders in developmentally appropriate care settings. ASAM 3 to 4 care levels can provide up to 24-hour care and are staffed by addiction treatment professionals, mental health professionals, and general medical personnel.

Linkage to Other Continuum Components: There are not sufficient substance use disorder services, at every level of acuity, available for youth in most California counties. School-based mental health staff and juvenile probation officers are equipped to refer youth to high-acuity SUDs inpatient services when these service settings exist.

Fiscal Structure: Potential funding streams to be developed include:

- Drug Medi-Cal
- County General Funds
- Juvenile Justice Crime Prevention Act Funds
- Mental Health Services Act (MHSA) Funds
- Family First Prevention Services Act Funding

Tiered Therapeutic Placement Options

Therapeutic Foster Care

Goal: Therapeutic Foster Care (TFC) services are designed to provide home-based, unconditional, flexible, and individualized support for youth who struggle with persistent, complex challenges. TFC is an adjunct service designed to prevent step-up to and/or support step-down from more restrictive placements, as well as maintain placement stability.

Services and Supports: TFC resource parents are key providers of trauma-informed interventions, such as coaching and skill-building to help youth build their social and/or emotional skills, independent living skills, and ability to develop and sustain a network of support. TFC caregivers are supported in providing trauma-informed care to higher needs youth by a master's level TFC clinician, who also supports TFC caregivers in billing Medi-Cal directly. TFC services are guided by the Child and Family Team meeting process, and progress is reviewed at CFT meetings. Respite care is critical in order to avoid burnout and support the mental health of TFC parents.

Linkage to Other Continuum Components: It is essential to position TFC as an adjunct service to any home-based placement setting so permanency for youth with high needs can be achieved or maintained. TFC can be provided on a short- and long-term basis in a traditional or Intensive Services Foster Care (ISFC) resource family home where youth are receiving Specialty Mental Health Services. TFC clinicians can provide linkage to higher

acuity care settings, such as ISFC, a Short-Term Residential Treatment Program (STRTP) or CSU, or support transition planning for youth who are returning to their biological families or emancipating from foster care.

Fiscal Structure: TFC services are part of the Katie A. Settlement suite of services alongside Intensive Care Coordination and Intensive Home-Based Services. The unit of service for TFC is a calendar day, and TFC is a Medi-Cal Specialty Mental Health Service (SMHS), although it must be provided alongside other SMHS. Funding streams to be leveraged include:

- Medi-Cal/EPSDT, Therapeutic Foster Care

Intensive Services Foster Care (ISFC)

Goal: To support youth who present with emotional and behavioral health needs that exceed the capacity of traditional resource family homes but who will benefit from a home-like care setting.

Services and Supports: ISFC homes offer family-based stabilization for youth with behavioral health needs who require a higher level of care or supervision than that available in traditional resource family homes. ISFC homes are designed to offer higher acuity care and do not serve more than two ISFC- eligible youth at one time. Intensive family finding and engagement work takes place to ensure step-down to a permanent family home if the child or youth is unable to remain in the home once the ISFC rate is no longer available. However, wherever and whenever possible, youth should not be required to move to access the supports and services they need to achieve permanency: in some cases, traditional resource parents may want and require support in achieving ISFC certification to meet the needs of youth in their care. ISFC parents are specially trained and supported to stabilize and nurture children in a home setting with fully integrated behavioral health supports (which can also be paired with TFC) and play an integral role in ongoing Child and Family Team meetings.

Linkage to Other Continuum Components: ISFC homes are intended to be linked directly with supportive community-based services like Wraparound and Mobile Response to prevent placement disruption and build natural support systems around youth with intensive needs. Youth can step down from ISFC to traditional Foster Family Agency (FFA) homes and step up from traditional ISFC homes to Enhanced ISFC homes or Enhanced ISFC homes with 24/7 staffing.

Fiscal Structure: ISFC homes must receive ISFC certification to access the ISFC placement rate. Other funding sources to be leveraged include:

- Medi-Cal/EPSDT, Specialty Mental Health Services
- Medi-Cal/ EPSDT, Therapeutic Foster Care
- County General Funds

Enhanced Intensive Services Foster Care (ISFC)

Goal: To provide a more intensive tier of ISFC placement to allow for home-based care for youth with complex and challenging emotional and behavioral health needs. This service option is designed to serve youth who are stepping down from a residential treatment program or whose needs have exceeded the traditional resource family home or ISFC options available.

Services and Supports: Enhanced ISFC homes include additional staffing supports for youth with the most complex and challenging emotional and behavioral needs to allow them to live in a home-based placement. Each home has a dedicated ISFC-approved resource parent who has prior experience supporting youth that helps them to understand and respond to the needs of youth placed in their care (e.g., social workers, teachers, nurses, etc.) This model is designed to serve youth with complex needs who need extensive caregiver support, are more easily triggered, or are less likely to be successful with other youth in the home.

Enhanced ISFC parents differ from ISFC parents in several key ways, including (1) experience in a field relevant to the helping professions, as well as prior experience working with youth with complex needs; (2) capacity for 24/7 availability to respond to youth needs, with at least one parent acting full-time as a caregiver and not working outside the home; (3) a commitment to providing care for the youth regardless of any behavioral challenges that emerge; and (4) successful completion of rigorous supplemental training and continuing education. Accordingly, these caregivers are compensated with a salary and benefits package that reflects these unique qualifications and commitment to full-time caregiving for enrolled youth.

Linkage to Other Continuum Components: Enhanced ISFC homes are intended to be linked directly with supportive community-based services like Wraparound and Mobile Response to prevent placement

disruption and build natural support systems around youth with intensive needs. Because Enhanced ISFC is designed to be short-term (up to six months), youth often “step down” from Enhanced ISFC homes to traditional ISFC or FFA homes. However, wherever and whenever possible, needed services and supports should be brought to youth to avoid an additional placement change.

Fiscal Structure: Enhanced ISFC homes must receive ISFC certification to access the ISFC placement rate. Other funding streams to be leveraged include:

- Medi-Cal/EPSTDT, Specialty Mental Health Services
- Medical/EPSTDT, Therapeutic Foster Care
- County Fund

Enhanced ISFC with 24/7 Staffing

Goal: To support court-dependent youth experiencing acute behavioral and permanency needs to thrive and succeed in a highly-individualized program focused on stabilization, permanency planning, and building a strong network of natural supports. The primary goals of Enhanced ISFC with STRTP-Level staffing are to (1) decrease the use of psychiatric hospitalization and placement in locked settings for youth with acute behavioral health needs and (2) increase the number of family-like care settings designed to serve youth with intensive needs.

Services and Supports: These programs are best implemented on a campus of *co-located* Enhanced ISFC homes, creating a community that can integrate these home-based service environments with shared staffing and therapeutic resources able to address acute and complex needs. Designed to be short-term with an average length of stay of 30 days to six months, Enhanced ISFC with 24/7 staffing is designed to support youth who are experiencing intense challenges by (1) stabilizing emotional and behavioral needs, (2) preparing youth for success in home-based care, and (3) developing a permanency plan for each youth that is sustainable over the long term.

Like the Enhanced ISFC model, this program utilizes full-time, highly trained caregivers with additional qualifications that are distinct from traditional resource parents, and each home serves one ISFC-eligible youth at one time, except in the case of sibling sets. This program differs from the Enhanced ISFC program model through the campus configuration of multiple ISFC homes, which allows for the inclusion of STRTP-level, highly-trained staff into a home-based placement 24 hours per day, seven days per week. Staff provide mental health services, planned or crisis stabilization support, permanency services including family finding and engagement, and psychiatric medication evaluation and monitoring. Youth placed in this type of therapeutic environment will have access to shared recreational activities and education supports. All services are individualized to address the unique needs of the youth and their family, with intensive interventions designed to support stabilization and preparation for continued success in home-based care.

Linkage to Other Continuum Components: Enhanced ISFC with STRTP-level staffing should be considered a step-down from locked inpatient settings like Psychiatric Health Facilities or other hospital-based care, and a step-up from STRTP, ISFC, or Enhanced ISFC placement. To support a successful transition from this level of care, mobile response and Wraparound are critical program components to have in place as a youth discharges to a home-based placement with fewer in-home resources.

Fiscal Structure: This program blends and maximizes available funding streams to provide short- or longer-term care for youth who do not require inpatient care but who are not currently able to succeed in a family-based setting and need intensive highly-individualized services. This includes certifying the individual homes as ISFC homes to access the ISFC placement rate. Other funding streams to be leveraged include:

- Medi-Cal/EPSTDT, Specialty Mental Health Services
- Medi-Cal/EPSTDT, Therapeutic Foster Care
- County General Funds

Short Term Residential Therapeutic Program (STRTP)

Goal: To stabilize children, youth, and non-minor dependents in care for up to six months (and in unique cases, accommodate lengths of stay beyond six months). The goal of STRTPs is to support youth in stepping down to a less restrictive care setting.

Services and Supports: STRTPs are a short-term treatment setting for court-dependent youth, offering an integrated program of high-quality therapeutic interventions and 24-hour supervision on a short-term basis for youth with complex needs that cannot be addressed in a home-based family setting but do not require hospitalization. STRTP services are designed to stabilize, support, and transition children and youth to a lower level of care on a case-by-case basis, consistent with the young person’s needs and services plan.

STRTPs provide core services and supports, driven by a youth’s unique needs and their service and transition plans, which include medically necessary Specialty Mental Health Services, services to achieve permanency , including family finding and transition support, and extracurricular, educational, and social activities for placed youth. This service option can also be implemented as an “STRTP for one” to effectively serve a young person with particularly complex needs when a milieu-based setting is clinically inappropriate, but the youth does not require a secure or inpatient treatment setting.

Linkage to Other Continuum Components: STRTPs are a vital component of the high-end crisis continuum for youth with complex behavioral health needs and can serve as a step-up option for youth in a home-based care setting who require a short period of stabilization or a step-down for youth who are exiting a Psychiatric Health Facility or Crisis Stabilization Unit.

Fiscal Structure: Short Term Residential Treatment Programs offer time-limited services to help youth stabilize and return to a less restrictive care setting. The “STRTP for one” model is one example of a program that can be achieved by taking advantage of the option to establish individualized programs and interim rates as outlined in AB 2944 (Stone). STRTP settings are funded via the following sources:

- Social Services STRTP Placement Rate
- Medi-Cal EDPST, Specialty Mental Health Services
- County General Funds
- Individualized rate using AB2944 flexibilities for youth with complex needs

Crisis Services

Mobile Response Team (MRT) Services

Goal: To provide 24/7 community- and home-based crisis response services to youth and families, as well as reduce unnecessary calls to law enforcement, visits to the emergency room, hospitalization, and/or placement disruptions. Crisis response through MRT ensures that the youth and family can stabilize, that they are linked with appropriate community services and supports, and that they can be served in the least restrictive, most nurturing setting possible.

Services and Supports: Mobile Response Teams provide mobile crisis response for youth and their caregivers/parents who are experiencing an acute crisis in the community. MRT is the first opportunity to respond in a crisis with the goal of preventing further escalation and the need for more restrictive interventions or placement changes. In this model, a team consisting of one or two highly trained clinicians or counselors respond in-person to the youth and family in crisis within one to two hours depending on the geographic range served. Teams of two are recommended to allow responders to separate the youth and

other individuals involved in the crisis (such as a parent/caregiver or another individual) to facilitate effective de-escalation and therapeutic intervention. Staff can be master's level or bachelor's level; however, the use of master's level staff allows for easier Medi-Cal billing for services beyond Crisis Intervention and improves the quality of clinical assessment and intervention.

MRT offers the capacity to provide several hours of crisis intervention in the moment, followed by one or more sessions to ensure stabilization over a period of up to 30 days. MRT responds to youth in crisis wherever they may be, including a home, school, emergency room, or any service setting in the proposed service continuum. Most new referrals for MRT across counties are for youth who are discharging from inpatient psychiatric care, which clearly highlights the importance of this service option as a step-down support to prevent inpatient readmission in a crisis continuum of care.

Linkage to Other Continuum Components: MRT is a key front- and back-end service across the crisis continuum, preventing unnecessary entries into more acute settings and supporting step-down support from those settings (e.g., Crisis Stabilization Unit, Psychiatric Health Facility, longer-term treatment programs, and high-end placement settings).

Fiscal Structure: MRT is one of the most critical components of any service continuum but can be challenging to fund with only one revenue stream since the program cost includes the time staff spend waiting to receive calls (especially overnight). MRT programs that serve Medi-Cal-eligible youth can bill Assessment and Crisis Intervention for services delivered, and successful programs are able to fund 60-65% of program costs through Medi-Cal EPSDT. Funding sources for MRT include:

- Medi-Cal/EPSDT, Specialty Mental Health Services
- Mental Health Services Act (MHSA) Funds
- CHFFA Investment in Mental Health Wellness Grant Program (Personnel)
- Family Urgent Response System (for foster youth specifically)
- County General Funds

Crisis Stabilization Units

Goal: To provide short-term assessment and stabilization services to prevent more intensive intervention such as hospitalization or inpatient psychiatric treatment wherever possible; to link to community-based resources like MRT and outpatient treatment; and to effectively assess the best treatment option for youth who require longer-term stabilization services.

Services and Supports: CSU services include a 23-hour receiving center for youth, ages six to 17, who are experiencing high levels of distress. CSUs prevent more intensive intervention by stabilizing youth and ensuring they are connected to sufficient resources to be safely discharged to the community. The CSU provides each youth with a multidisciplinary assessment, including medical clearance, risk-oriented diagnostic assessment, and a level of care assessment, as well as individualized mental health interventions such as the development of a Safety Plan and a Discharge and Aftercare Plan.

The CSU incorporates family members into the assessment and planning process, recognizing their importance in sustaining the long-term stability of youth who have experienced acute distress. CSU staff coordinate with psychiatric inpatient staff and law enforcement personnel to keep clients and the community as safe as possible. While most youth are stabilized and quickly return to their communities, those who are

experiencing heightened or persistent mental health issues (but do not require hospitalization) may transition to a crisis residential program for a longer period of stabilization services. It is critical to keep CSU programs small in order to offer highly-individualized service capacity for each youth who is experiencing a crisis.

Linkage to Other Continuum Components: CSUs represent a critical diversion point from emergency rooms and psychiatric hospitals for youth who need to be assessed for a WIC 5585 involuntary hold. For youth who do require additional stabilization, the CSU can provide an assessment and entry point for admission into a crisis residential program or psychiatric health facility. For youth who do not require more intensive services and are able to stabilize in the 23-hour program, step-down options can include outpatient mental health services with additional support from mobile response, partial hospitalization, or Wraparound programs.

Fiscal Structure: CSUs rely on behavioral health funding but can achieve cost efficiencies by (1) co-locating with a Psychiatric Health Facility (PHF), Children’s Crisis Residential Program (CCRP), or STRTP, (2) utilizing regional collaboration to maintain consistent census, and (3) serving privately-insured youth to leverage third-party health insurance in addition to public behavioral health revenue. Funding streams to be leveraged include:

- Mental Health Services Act (MHSA) Funds
- Medi-Cal EPSDT, Specialty Mental Health Services
- Private Insurance
- California Health Facilities Financing Authority (CHFFA) Investment in Mental Health Wellness Grant Program (Capital Funds)
- County General Funds

Partial Hospitalization Programs

Goal: To serve a small number of youth (e.g., up to ten at a time) who are transitioning from inpatient facilities, as well as those who are participating in other outpatient programs yet remain at significant risk of psychiatric hospitalization.

Services and Supports: PHPs engage youth on a short-term basis (typically ten days) and operate during daytime hours on weekdays, typically 8:30 AM to 2:30 PM, Monday through Friday. During this time, a multidisciplinary team delivers highly-individualized interventions within a structured milieu designed to increase coping, interpersonal, and life skills so that youth can more safely and effectively respond to any challenges they encounter at home, in school, or in the community. The team works collaboratively with the youth and family to support their stabilization and connection to needed resources that ensure their long-term recovery, well-being, and safety.

The ratio of youth to staff may range from 1:1 to 3:1 and is based on the acuity of clients at any given time, as well as the interaction between clients within the milieu. The daily structure of the program is based on cognitive-behavioral interventions that are flexible and responsive to the needs of youth while meeting treatment standards. Treatment includes group therapies to address the developmental desires of each child/adolescent to relate to their peers, as well as a variety of interventions to support each youth to trace the elements of their crisis and develop alternative response patterns. PHP groups include but are not limited to DBT skills, drama therapy, healthy living skills, family timeline, community group, journaling, and art therapy. A school group is designed to address stressful issues in school and provide clients with helpful responses to bullying, academic failure, non-attendance, and social anxiety.

Linkage to Other Continuum Components: PHPs should be utilized as a step-down from more intensive crisis programs, such as PHFs, CCRPs, or crisis-focused STRTPs. Youth can either be residing in a crisis program or in the community while enrolled in the PHP. In situations where the youth is also enrolled in a CCRP or STRTP, youth would seamlessly transition into the PHP for their day programming, then return to the crisis residential portion of the program for evening and weekend treatment activities. Youth typically step down from PHPs to ongoing outpatient treatment, with Wraparound and/or mobile response available for stabilization as needed.

Fiscal Structure: PHPs rely on behavioral health funding but can achieve cost efficiencies by (1) utilizing regional collaboration to maintain consistent census and (2) serving privately-insured youth to leverage third-party health insurance in addition to public behavioral health revenue. Funding sources to be leveraged include:

- Mental Health Services Act (MHSA) Funds
- Medi-Cal/EPSDT, Specialty Mental Health Services
- Private Insurance
- County General Funds

Children’s Crisis Residential Programs

Goal: To provide a residential and therapeutic alternative to hospitalization for youth for a period of 10 to 15 days. The intended outcome of a crisis residential program is to decrease the utilization of locked inpatient care for young people, including PHFs or hospitalization.

Services and Supports: Crisis residential programs for children and youth can be provided using a Children’s Crisis Residential Program (CCRP) or Psychiatric Residential Treatment Facility (PRTF) license, Community Treatment Facility (CTF) license, or a Short-Term Residential Treatment Program (STRTP) license. Regardless of license type, this service option is designed to provide 10- to 15-day, short-term crisis residential care for a small number of youth at a time (ideally up to four clients, to allow for highly- individualized care and treatment).

This program employs a multidisciplinary team to work collaboratively with the youth, their caregiver(s), and community supports to create a sustainable plan for the young person to safely return home. Structured treatment includes psychiatric care, case management, family finding and engagement, and individual and family therapy. For youth who are disconnected from family or remain in need of mental health support, staff will assist the youth in permanency planning or transitioning to their next type of home-based care.

Linkage to Other Continuum Components: This tier of service is designed to serve youth who are stepping down from a CSU and do not require hospitalization in a PHF but who do need additional support prior to transitioning home with the support of MRT or Wraparound services.

Fiscal Structure: Crisis residential programs can be funded by behavioral health revenue utilizing either a CCRP or STRTP license. Any court-dependent youth served by an STRTP may also draw down the social services placement rate for that program type. Funding streams for crisis residential services include:

- Medi-Cal EPSDT, Specialty Mental Health Services
- Private Insurance
- Mental Health Services Act (MHSA) Funds
- CHFFA Investment in Mental Health Wellness Grant Program (Capital Funds)
- Social Services Placement Rate (STRTP) for child welfare-involved youth
- County General Funds

Psychiatric Health Facilities

Goal: To provide hospital-level stabilization services for youth in a therapeutic and developmentally appropriate setting for up to 14 days.

Services and Supports: The treatment provided by a PHF will include hospital-level stabilization and integrated assessment and planning services for children and adolescents in serious distress for a period of up to 14 days. PHFs offer a secure treatment setting, staffed according to state and federal regulations, with the capacity to admit two to four youth at a time, recognizing their profound need for individualized care and

attention during the period of crisis. Intakes for PHFs must be accepted 24/7, with four hours of advanced notice prior to a youth's placement. PHF-enrolled youth and families receive individualized treatment, psychiatric services, and linkages to community-based supports to support ongoing care and treatment for a successful discharge.

Linkage to Other Continuum Components: PHFs are most effective when co-located with other crisis programs to support step-up and step-down as a young person's behavioral health needs stabilize. For example, a PHF co-located with a CSU as well as a CCRP or STRTP can ensure that youth do not overstay in settings that are more restrictive than their level of need dictates.

Fiscal Structure: PHFs rely on behavioral health funding but can achieve cost efficiencies by (1) co-locating with a CSU and/or CCRP, (2) utilizing regional collaboration to maintain consistent census, and (3) serving privately insured youth to leverage third-party health insurance in addition to public behavioral health revenue. Funding sources for PHFs include:

- Medi-Cal/EPSDT, Specialty Mental Health Services
- Mental Health Services Act (MHSA) Funds
- Private Insurance
- County General Funds