NATIONAL CONFERENCE of STATE LEGISLATURES

The Social and Emotional Well-Being of Children in Foster Care

By Nina Williams-Mbengue

A. Introduction

Just over 415,000 children and youth in the U.S. currently reside in foster care. While this number is high, it represents a significant decline in foster care placements over the past decade, with the number of children in foster care decreasing by almost a quarter between 2002 and 2013.[1]

A federal and state-level focus on the safety and permanency of children in care has been an important factor contributing to the decline in caseloads. Despite such progress, state child welfare systems continue to struggle with the social and emotional well-being of children in care, particularly for children with complex behavioral and mental health disorders.[2]

Definition of Child Well-Being. Child well-being is described by the federal Administration for Children, Youth and Families in its April 2012 Information Memorandum (ACYF-CB-IM-12-04) as,

> "…children's behavioral, emotional and social functioning—those skills, capacities and characteristics that enable young people to understand and navigate their world in healthy, positive ways." [3]

The administration has further identified four primary domains for measuring well-being: cognitive functioning, physical health and development, behavioral/emotional function and social functioning.

Child well-being is an important focus for states because of its lifelong impact on children and their success as productive adults. State policymakers now understand that children and youth in foster care face long-term risks from their exposure to violence, child maltreatment and other adverse childhood experiences and are anxious to identify and implement strategies that will minimize the long term consequences for children and the costs to state budgets. Fortunately, there is also an increasing body of evidence-based programs that state child welfare systems can develop to significantly improve children's well-being.

This extended edition newsletter focuses on the social and emotional well-being of children and youth in foster care. The newsletter will provide information on the social and emotional characteristics and needs of children in care, discuss the impact of child maltreatment and trauma on children's development and examine state and local policies and practices to address the well-being of children in foster care. Additionally, the legislative role in improving child well-being will be considered.

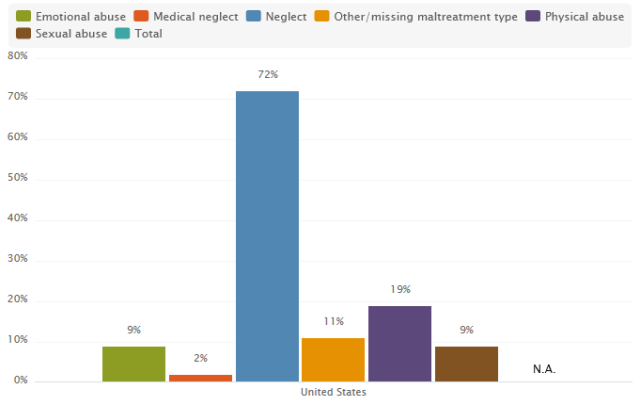
B. Why is the Social and Emotional Well-Being of Children in Foster Care at Risk?

The social and emotional well-being of children in foster care is jeopardized by the conditions that lead to their

removal from home, as well as their experiences once in care. While the number of children in placement has been reduced in the last decade from more than 511,000 in 2005 to 415,000 in 2014, little data exists about the well-being of children in care.[4] Additionally, effective indicators of well-being have not been identified or measured routinely.

The Well-Being of Children Who Enter Foster Care

Children who are placed in foster care for their protection have experienced many conditions that may threaten their safety and well-being. As the table below indicates, the majority of children who are confirmed for child maltreatment are victims of neglect.



CHILDREN WHO ARE CONFIRMED BY CHILD PROTECTIVE SERVICES AS VICTIMS OF MALTREATMENT BY MALTREATMENT TYPE: ALL (PERCENT) - 2012

National KIDS COUNT
KIDS COUNT Data Center, datacenter.kidscount.org
A project of the Annie E. Casey Foundation

Though defined differently from state to state, neglect is often a complex combination of conditions that may include: [5]

- Physical neglect, such as abandonment or failure to provide for a child's nutritional or other physical needs.
- Inadequate supervision, such as exposure to hazards or lack of appropriate caregivers;
- Medical neglect through denial or delay of health care.
- Emotional neglect, such as inadequate nurturing or affection, social isolation, chronic or extreme spouse abuse.
- Neglect of a child's educational needs.
- Newborns addicted or exposed to drugs.

After child neglect, the most common reason for removal is parental substance abuse. Other removal reasons include caretaker inability to cope, child behavior, physical abuse, and other conditions that make a child vulnerable and that may impact the child's well-being.

In addition to abuse and neglect, children who enter foster care may have been exposed to parental substance abuse, domestic and community violence and poverty.

The Impact of a Child's Experiences While in Foster Care

The removal from home can be devastating and confusing for children. Once in foster care, children may experience prolonged stays in care. According to 2014 AFCARS data, of the 238,230 children who exited foster care in Fiscal Year 2014, 53 percent had been in care 12 months or more.[6]

Children's Length of Stay in Foster Care in Fiscal Year 2014		
Number of Children	**Percent in Care**	**Length of Stay in Care**
94,358	23%	1 - 5 Months
83,978	20%	6 – 11 Months
62,447	15%	12 – 17 Months
39,620	10%	18 – 23 Months
29,401	7%	24 – 29 Months
18,833	5%	30 – 35 Months
36,292	9%	3 – 4 Years
28,058	7%	5 Years or More

The longer a child is in placement, the greater the chance that he or she will move from one foster placement to another, placing the child at further risk of negative social and emotional outcomes. [7],[8] Frequent moves mean that the child faces continuing disruption of relationships with friends, siblings and other relatives, coaches, teachers, classmates, religious leaders and others. Children may move from their original schools multiple times during the school year. Frequent changes in caseworkers, judges and legal representation also interfere with child well-being and achievement of a permanent home. [9]

The Behavioral and Mental Health Needs of Children in Foster Care

Recent research from the National Survey of Child and Adolescent Well-Being finds that children and youth in foster care have high levels of mental health needs and that those needs are not being met. Children and youth in foster care with mental health disorders stay in foster

care longer, rely more on expensive residential treatment placement, experience more moves in care, have higher involvement with the criminal justice system and have poorer educational outcomes.[10]

- Eighty percent of youth involved with the child welfare system require mental health intervention and services due to developmental, behavioral or emotional issues.[11]

- Children in foster care utilize mental health services at five to eight times the rate of other Medicaid-eligible children.[12]

- Children and youth in residential treatment centers (the majority of whom come from the child welfare system) have higher rates of mental and behavioral health disorders than children in the general population.[13]

- Children in foster care are more likely to use multiple psychotropic medications than children that are not in the child welfare system.[14]
- Compared to other Medicaid-eligible youth, children in foster care have two to eight times the rates of various psychiatric medication prescribing.[15]

Impact of Trauma

It is estimated that 90 percent of children in foster care have been exposed to trauma.[16] A comprehensive review of children entering foster care in one state revealed that one in four exhibited trauma symptoms requiring treatment.[17] The term "complex trauma" describes children's exposure to multiple or prolonged traumatic events, which are often invasive and interpersonal in nature. Complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse. Trauma can be compounded by the removal of children from their families, loved ones, and communities and by adverse experiences in foster care. A growing body of research reveals negative long-term consequences of traumatic stress, especially repeated exposure to trauma such as might be experienced by children who have been abused or neglected, on physical, cognitive, social and emotional functioning. [18] Children's relationships and attachments to caretakers can be affected, further exacerbating difficulties they may experience in foster care. Into adulthood, children and youth who have undergone traumatic experiences may have problems ranging from depression and addiction to cancer, diabetes and heart disease.[19]

C. The Costs of Poor Social and Emotional Well-Being

The social and emotional well-being of children who enter foster care has tremendous consequences— both on the course of their lives and on the long term costs to taxpayers.

- The total annual cost of child abuse and neglect in the U.S. in 2012 has been estimated to be $80.2 billion.

- The Pew Center on the States estimates the costs to society to pay for medical and mental health services annually is more than $30,000 for each abused child.[20] For children in foster care, mental health expenditures are 8 to 11.5 times greater than the expenditures for other Medicaid eligible children.[21]

- In addition to Medicaid costs for direct health services of children in foster care, such as in-patient treatment or dental services, states spend more than $1 billion in Medicaid for child welfare services. Of the 39 states that responded to a recent survey of FY2010 state child welfare expenditures, 27 reported that the number one use of Medicaid dollars by child welfare systems was for rehabilitative services such as residential and behavioral modification treatment, followed by targeted case management and therapeutic foster care. [22]

Recent research also shows that multiple, negative events in childhood, such as those experienced by many children in foster care, have costly health consequences that can impact state budgets for many years. The Adverse Childhood Experiences Study (ACES) is a longitudinal examination of health outcomes for adults who experienced a variety of multiple, negative events in childhood such as child maltreatment, exposure to domestic violence, living with substance abusing parents, growing up with a growing up with a mentally ill or incarcerated parent or parental abandonment through divorce or death. The study indicates significant effects well into adulthood, including:[23]

Child Maltreatment Impacts: Brain Function and Structure

Neuroscience teaches us that the early experiences of young children have a tremendous influence on their developing brains. Healthy emotional and cognitive development is shaped by responsive, dependable interaction with adults, while chronic or extreme adversity, such as extreme poverty, caregiver substance abuse or mental illness, exposure to violence or family hardship without appropriate adult support, can cause excessive amounts of the cortisol hormone to be produced resulting in toxic stress, which disrupts developing brain circuits. This kind of prolonged activation of the stress response systems can not only disrupt the development of brain architecture and other organ systems, but can also increase the risk for stress-related disease and cognitive impairment well into the adult years.[24]

Despite the potential for significant harm to young children's health development, studies show that providing supportive, responsive relationships as early in life as possible can prevent or reverse the damaging effects of toxic stress.[25] In addition, emerging science has deepened the understanding of adolescent capabilities and behaviors and the ability to impact brain development through adolescence. Neuroscience has made clear that the brain is not "done" by age 6 as was previously believed.[26]

Instead, the adolescent brain continues to develop, providing a window of opportunity similar to that which is open in early childhood. Young people can build and practice resiliency and develop knowledge and skills that will positively serve them throughout adulthood. View NCSL's Extending Foster Care Policy Toolkit for more.

- Alcoholism and drug abuse.
- Heart disease.
- Cancer.
- Lung disease.
- Depression and suicide.
- Obesity.
- Fetal death.
- Health-related quality of life.
- Unintended pregnancies and adolescent pregnancy.
- Early initiation of smoking.

In addition to the long term costs associated with treating and responding to many of these consequences, repeated, negative childhood experiences contribute to reduced economic productivity. Dr. Robert Anda, co-principal investigator of the ACES Study, reported that annual workforce costs due to adverse childhood experiences included $28 billion for chronic back pain, $40 to $44 billion for medical costs, reduced productivity, and absenteeism due to depression and $246 billion for substance abuse.[27]

D. What State Legislators Can Do to Promote the Social and Emotional Well-Being of Children in Child Welfare Systems

- To combat the damaging effects of child maltreatment, trauma and adversity, child welfare leaders at federal, state and local levels are developing policies and financing strategies to address social and emotional well-being. State lawmakers can partner with them to focus on: Prevention of maltreatment and other adverse childhood experiences that contribute to traumatic stress and long term negative outcomes.
- Improving experiences of children who must be placed in temporary foster care, by reducing length of stay, multiple moves from one placement to another, overuse or inappropriate use of psychotropic medications, high turnover of caseworkers, and other harmful practices, while maintaining and strengthening connections with kin.
- Increasing access to comprehensive early and periodic assessments that include social/emotional functioning.
- Ensuring effective treatment of trauma and of behavioral/mental health problems for children in foster care, including authorization of evidence-based and evidence-informed services and training for in-home service providers, foster parents, courts, and others.
- Leveraging existing resources and funding opportunities, and reinvesting in effective practices and strategies that contribute to positive well-being.

NCSL reviewed recent state policy and legislative initiatives from 2008-2015 to identify areas in which state legislatures have been active, including convening child and family system leaders, promoting the coordination of mental health, health and child welfare, encouraging comprehensive screening and assessment; implementing evidence-based services and encouraging the use of Medicaid to improve the social and emotional well-being of children in foster care.

Convening Child and Family Services System Leaders

Legislators are uniquely positioned to convene key decision makers from other branches of government, as well as leaders of multiple state agencies, to address the social/emotional well-being of children. As state and local leaders, legislators have the ability to increase awareness of child well-being and to bring together stakeholders who can impact outcomes. These stakeholders include the courts, which have a critical role in considering the social and emotional functioning of each child in their decisions and ensuring that the court experience itself is not traumatic, as well as state agencies which have a role in Medicaid, child mental health, health care systems, substance abuse, education, early childhood and juvenile justice programs, as well as the child welfare system. At the local level, the array of resources that contribute to well-being include schools, community service providers, foster parents, and many others.[28] Together these stakeholders can identify:

- Shared outcomes and common measures for child well-being, as well as strategies for sharing information to support effective treatment for children in foster care.
- Strengths, resources, and connections across agencies that can be maximized to improve well-being, such as existing assessments and effective services.
- Needs and gaps in the service array and access across programs and agencies, as well as unnecessary duplication.
- Policy barriers and solutions.
- Funding opportunities and limitations.
- Concrete action steps to improve the well-being of the state's young people.

Following are several examples of this type of legislative leadership.

Three Branch Institute. In 2013-2014, seven states—Connecticut, Illinois, Kansas, New Mexico, Virginia, West Virginia and Wisconsin—participated in the Three Branch Institute on the Social and Emotional Well-Being of Children in Foster Care, a two-year initiative facilitated by a strategic partnership between NCSL, the National Governors Association Center for Best Practices, Casey Family Programs, the National Center for State Courts and the National Council for Juvenile and Family Court Judges. Teams from each participating state consisted of representatives from the legislative, executive and judicial branches of government (and tribal officials in some states) working together to develop and implement coordinated, comprehensive strategic plans addressing well-being. The executive branch team members included both child welfare and Medicaid leaders.

States were selected through a competitive RFP process. In July 2013, teams participated in a two-and-a-half day convening where they interacted with national experts, foster youth, state administrators and their colleagues in other states to develop plans, exchange ideas, and discuss barriers and potential solutions. States received ongoing technical assistance from national experts, participated in educational webinars, attended a second national convening and received other assistance in 2014.

Legislators played an active role in the three-branch partnerships, sponsoring legislation, sharing ideas, meeting with legislators in other states and developing relationships with child welfare administrators, judicial leaders and other important stakeholders.

Examples of state strategies developed as part of the institute included New Mexico's goal to strengthen collaboration between child welfare and Medicaid systems to ensure that all children in foster care receive trauma assessments and appropriate Medicaid-covered services. Wisconsin's team worked to expand a community-level pilot project to integrate childhood

trauma-informed practices and policies throughout the state's systems that serve children, and to provide trauma-informed training for professionals such as frontline staff, family court judges, and others. Virginia focused on improving behavioral and mental health services, especially strategies to ensure that psychiatric drugs are effectively used for children in foster care. Virginia's child welfare and Medicaid agencies collaborated to transition children in foster care from fee-for-service to managed care.

Several states that participated in the Three Branch Institute have continued the partnership to further their work on well-being or to tackle other important issues. For more information see *Governing* magazine's November 2013 article, Coordinating Foster Care Across the Three Branches of Government or to learn about work in Connecticut, see Connecticut Three Branch Institute.

State lawmakers may also want to partner with or learn about the work of state-level and local partnerships and collaborative efforts to provide services for children and families with behavioral health needs. Some examples of such initiatives include the following.

Massachusetts Children's Behavioral Health Initiative. This interagency initiative consists of a comprehensive, wraparound, community-based system of services for families and children with significant behavioral, emotional and mental health needs. The services provide support for families and enable them to better maintain their family at home and not in facilities or extended out-of-home placements. The Office of Medicaid, the Department of Children and Families, the Department of Mental Health, juvenile justice and other state agencies collaborated to design the new system. The state legislature mandated the creation of a Children's Behavioral Health Advisory Council to advise the governor, the general court and the secretary of health and human services on behavioral health issues and to make recommendations on best and promising practices and on the implementation of the statewide behavioral health initiative. [29]

Both Michigan and New Jersey developed similar statewide behavioral health efforts that include high level collaboration between the child welfare agency, Medicaid, behavioral health and other state agencies.[30] While there had been collaboration between the child welfare and behavioral health systems in Michigan, a consent decree provided the impetus to use a Medicaid Section 115(c) Home and Community Based Services (HCBS) Waiver which allows states to provide long-term care services in home and community-based settings rather than in institutions. The waiver focused on children with serious emotional disturbances. The Michigan effort includes an interagency operational team of directors from child welfare, behavioral health Medicaid and other agencies to oversee implementation of the partnership.

New Jersey's Children's Interagency Coordinating Councils engage in cross-system planning at the local level for children and families with behavioral health issues. Child-serving agencies partner with parents and youth to offer an integrated system of care for serving these families. The councils also identify resource gaps and priorities for resource development.

All of these efforts would likely benefit from legislative participation and feedback, as well as legislative ability to convene stakeholder groups for ongoing collaboration and planning across state agencies on behalf children and families with behavioral health needs.

Promoting the Coordination of Health, Mental Health and Child Welfare

Recent Federal Legislation and Initiatives. Federal policies require coordinated approaches to health and mental health care for children in foster care.

- Fostering Connections to Success and Increasing Adoptions Act of 2008: requires that states develop plans for the oversight and coordination of health care services for children in foster care, including dental and mental health, in coordination with State Medicaid agencies.
- The Child and Family Services Improvement and Innovations Act of 2011: specifies that state plans must outline protocols for the appropriate use and monitoring of psychotropic medications.
- The Affordable Care Act: requires information about health care be included in the youth's transition plans and extends Medicaid coverage for former foster youth to age 26. The act also promotes medical homes for children which would involve contact with a single health provider.

- In July of 2013, the U.S. Department of Health and Human Services disseminated a Federal Guidance Letter to state child welfare directors to encourage states to use trauma-focused screening, assessments and evidence-based practices in child welfare to improve child well-being.

Recent State Legislative Enactments. Legislators in a number of states have enacted laws related to the oversight and coordination of health and mental health care, across state agencies, for children in foster care. Following are recent examples related to oversight and coordination, health passports, psychotropic medication oversight and delivery of health care services. See NCSL's Mental Health and Foster Care web page for more.

Oversight and Coordination. In 2009, California required a plan for the oversight and coordination of health care services for foster children with specific assurances that a child's mental health needs are to be identified.[31] Public health nurses are stationed in child welfare county offices and are responsible for medical case management to ensure that children and youth in care receive services, including behavioral health. The nurses provide training for health, child welfare and probation and juvenile court staff related to children's behavioral and health needs. The nurses follow each child in care and coordinate with caseworkers, probation officers and caregivers to ensure that the child's health, mental health and developmental needs are identified and addressed.[32]

Other states that have enacted legislation mandating a coordinated approach to address children's health and behavioral health include Arizona, Connecticut, Texas and Washington.[33] In 2013, Arizona legislators required the development of a plan to deliver comprehensive medical, dental and behavioral health for children in foster care. Also in 2013, Connecticut lawmakers enacted legislation that required the Department of Children and Families (which includes child welfare, child mental health services, and juvenile justice and youth services) to develop a comprehensive implementation plan for meeting the emotional and behavioral health needs of all children in the state. The plan, must: (1) strengthen families through home visitation and parenting education programs; (2) increase mental, emotional, or behavioral health issue awareness within elementary and secondary schools; (3) improve the current system of addressing such issues in youths and (4) provide public and private reimbursement for some mental, emotional, or behavioral health services. In 2015, Texas lawmakers directed the establishment of an integrated managed health and behavioral health plan for foster children enrolled in Medicaid.

Health Passports. In efforts to better coordinate delivery of important health-related services and sharing of information on such services to children in foster care, at least 32 states have developed some form of health passport system to contain information, accessible to specified entities such as child welfare, Medicaid, and foster parents. [34] A recent example is Oklahoma's 2009 legislation which created a "Passport Program" to include educational, medical and behavioral health information for all children in care. The passport must accompany each child to wherever the child lives while in care.

Psychotropic Medications Oversight. Concerns about the overuse of psychotropic medications and new federal requirements for states to develop protocols for the use of such medications have prompted states to examine the use and oversight of psychotropic medications for children in foster care. California, Colorado, Connecticut, Florida, Illinois, Nevada, New Mexico, Oregon, Texas and Washington all have addressed the issue in statute. In 2011, Illinois created the Administration of Psychotropic Medications to Children Act.[35] The law required the Department of Children and Family Services to promulgate rules establishing and maintaining standards and procedures to govern the administration of psychotropic medications to children and youth in state care. Such rules include administration to youth in correctional facilities, residential facilities, group homes and psychiatric hospitals.

In 2015, California legislation provided specified rights for children who are prescribed psychotropic medications; required a foster care public health nurse to monitor and oversee a foster child's use of psychotropic medications, provided training for the nurses; and, allowed group foster homes to use psychotropic medications under certain conditions. The department is also required to collect data related to psychotropic medication use by children and youth in care and to identify group homes that have high levels of use, through confidential discussions with former group home residents and medical personnel.[36]

Delivery of Health Care Services. In 2014, lawmakers in California required the State Department of Social Services to convene a stakeholder group to identify barriers to, and make recommendations about, the provision of mental health services by mental health professionals with specialized clinical training in adoption or permanency issues to children receiving those medically necessary specialty mental health services.[37] Also in 2014, Delaware legislators mandated the establishment of a task force to analyze the health and delivery and receipt of health services of children in custody of the state.[38]

North Dakota created a task force on substance-exposed newborns and required a report to the legislature.[39] The task force is charged with researching the impact of substance abuse and neonatal withdrawal syndrome; collecting data on costs associated with treating expectant mothers and newborns suffering from withdrawal substance abuse; and, identifying and evaluating programs for mothers and newborns suffering from addiction.

Rhode Island mandated a transition plan for all older children under the family court's jurisdiction and who are developmentally delayed or seriously emotionally disturbed, which addresses housing, support services, health insurance and education.[40] In 2015, Washington legislators directed the Health Care Authority to establish an integrated managed health and behavioral health plan for foster children and Montana lawmakers created a pilot project to improve outcomes for the children's mental health system and an interim study of evidence- based outcomes.[41]

Promoting Comprehensive Screening and Assessment

State lawmakers are recognizing the importance of the comprehensive screening and assessment for children in care to better identify and address children's mental and behavioral health needs. Many states are now requiring an immediate assessment of a child's needs upon entry into foster care. States can use the EPDST (Early and Periodic Screening, Diagnostic, and Treatment) benefit which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

Trauma Assessment and Crisis Intervention. In 2010, West Virginia legislators established a pilot program (to be known as Jacob's Law) for children ages 4 to 10 in foster care to provide children in crisis with early intervention, assistance with emotional needs, medical evaluations, independent advocates and foster family training and education.[42] The law also required immediate evaluation of the child for emotional and physical trauma following removal from a home.

Screening and Assessment of Mental Health Treatment Needs. Lawmakers in several states have addressed the issue of appropriate screening and assessment of children in public child welfare systems. In 2011, Michigan lawmakers enacted a bill that required the Department of Human Services to use a standardized assessment tool to ensure greater cooperation between Human Services and the Department of Community Health and to measure the mental health treatment needs of every child in care.[43] Also in 2011, Minnesota required that county boards must arrange for or provide mental health screening for children in care.[44] In 2010, lawmakers stipulated that all children referred for treatment of severe emotional disturbance in a treatment foster care setting or residential treatment facility undergo an assessment to determine the appropriate level of care prior to admission.[45]

Implementing Evidence-Based Services that Can Improve Social/Emotional Well-Being

To ensure that scarce resources are used effectively, state legislators are authorizing and investing in evidence-based and evidence-informed services and addressing adverse childhood experiences to improve social and emotional well-being.

Investing in Evidence-Based Services. Washington enacted legislation in 2012 that aimed to increase the proportion of contracted services that have a sound scientific evidence base.[46] The law required agencies that deliver prevention and intervention services to meet graduated requirements for increasing the percentage of funds expended on evidence-based programs. In 2015, Montana legislators created a pilot project to improve outcomes for youth in the children's mental health system, required an interim study of evidence-based outcomes, and provided for public

participation in development of evidence-based outcomes models.[47]

What works?

Here are a few examples of evidence-based practice that can have an impact on children's social and emotional well-being. Source: California Clearinghouse on Evidenced Based Programs in Child Welfare.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a practice that addresses children's behavior as a result of traumatic experiences, including post-traumatic stress syndrome, anxiety and depression. TF-CBT aims to improve children's behavior as well as parenting and caretaker skills and parent- and caretaker-child communication. Key components include cognitive therapy, behavioral therapy and family therapy. The approach also helps non-offending parents develop skills to address their children's behavioral problems. TF-CBT, aimed at children ages 3 to 18 and their families and caretakers, is deemed "Well Supported by Research evidence" by the California Clearinghouse on Evidence Based Services for Child Welfare.[48]

Multi-Systemic Therapy for Child Abuse and Neglect (MST) is for families who have come to the attention of child protective services due to serious physical abuse or neglect. The program, deemed "Well Supported by Research Evidence" by the California Clearinghouse on Evidence Based Services for Child Welfare aims to reduce out of home placement, improve parent and youth mental health function and increase social support.[49] The program is aimed at families with children between ages 6 and 17, who are either in foster care or in the home.

Parent Child Interaction Therapy (PCIT) is an intervention designed to decrease 2- to 7-year-old children's behavioral problems, such as defiance and aggression, increase children's social skills and improve the relationship between the parent or caretaker and the child.[50] The intervention is for use with parents, foster parents and other caretakers who are coached by a therapist. PCIT has been shown to be effective with foster parents, improving the relationship between foster parent and child and teaching foster parents appropriate behavior management skills. PCIT is designated "Well Supported by Research evidence" by the California Clearinghouse on Evidence Based Services for Child Welfare.[51]

For more, search evidence-based programs described in the California Clearinghouse on Evidence-Based Programs in Child Welfare, the SAMHSA's National Registry of Evidence-Based Programs and Practices, and the Results First Clearinghouse Database.

Addressing Adverse Childhood Experiences. In 2011, Washington House Bill 1965 was enacted to identify the primary causes of adverse childhood experiences and mobilize public and private support to prevent harm to young children and reduce the accumulated harm of adverse experiences throughout childhood. The law required the Secretaries of the Department of Social and Health Services and the Department of Early Learning to convene and participate in a planning group to develop a nongovernmental, private-public initiative and to identify and promote the use of innovative strategies based on evidence-based approaches. Iowa and Wisconsin are among states that have also examined ACES in their states and developed initiatives and recommendations based on findings from their use of CDC-developed state and U.S. territory behavioral risk factor surveys. Legislators can determine if their state has participated in these surveys and partner with other stakeholders to develop policy around the findings.

Title IV-E Waivers

The federal Child Welfare and Family Services Innovation Act of 2011 authorized the U.S. Department of Health and Human Services to issue up to 10 Title IV-E waiver demonstration projects per year in 2012, 2013 and in 2014. The waivers allow states to use money usually reserved for specific foster care expenses to test new ways of providing and financing child welfare services. Plans were to aim to safely shorten children's stays in care, increase children's safety and well-being, prevent child abuse or keep children from going back into care. Priority was given to projects that will improve the lives of children who have experienced trauma, contribute to the body of evidence about what works and include other programs, such as mental and behavioral health services. Nine states were awarded

waivers in 2012, eight in 2013, and nine states and one tribe were approved in 2014.

Several states with waivers approved in 2012, 2013 and 2014 are focusing their efforts on innovations that specifically address trauma. Colorado's demonstration project involves identifying and treating the effects of trauma in abused children. Illinois is targeting babies and toddlers in Cook County to reduce the effects of trauma, find permanent homes sooner and lower the rates of repeat foster care due to abuse. Utah intends to improve trauma assessment. Hawai'i, New York, Idaho, Rhode Island, and Tennessee are implementing new functional screening tools to better identify the needs of children and families. Idaho, Maryland and New York are taking a trauma-informed approach to providing services. The Port S'kallum tribe's waiver addresses historical trauma. Oklahoma's waiver links families to trauma focused cognitive behavioral therapy. One of the Kentucky waivers' key outcomes will be decreased trauma by children. See NCSL's Title IV-E Child Welfare Demonstration Waivers website for more information on states' initiatives.

Encouraging or Requiring the Use of Medicaid Services to Improve Social and Emotional Well-Being of Children in Foster Care

Virtually all children in foster care are eligible for Medicaid which offers a variety of opportunities to leverage federal funds for services to meet the mental health needs of children and to identify and treat trauma, including some opportunities for which enhanced Federal Financial Participation (FFP) is available. Examples of Medicaid funding strategies that states can use for children in foster care include:

1915(i) State Plan Amendment allows states to amend their state Medicaid plans to offer intensive home and community-based behavioral health services such as intensive care coordination, respite and family/youth peer support partners to serve children and youth with significant mental health conditions. The Affordable Care Act provides greater flexibility to direct such services to a specific population such as children with serious emotional disturbance or children in foster care.

1905(a) authority for targeted case management (TCM) and rehabilitative services has been used by Massachusetts, Connecticut, New Mexico and Hawaii to finance services for children with significant mental health conditions.

States have used Medicaid waivers, including 1915(c) and 1915(b) waivers, to deliver children's mental health services.[52]

Other steps that legislators can take to encourage or require the use of Medicaid include:

- Requiring the Medicaid agency to consider or to implement specific changes to the state Medicaid plan or waiver to improve the social and emotional well-being of children in foster care.
- Allowing use of state funds as Medicaid match, thereby enabling the state to draw down additional federal Medicaid dollars and maximizing the resources available for services.
- Authorizing incentives for providers of mental health services to children in foster care.

Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). As a required benefit for Medicaid-eligible children, the EPSDT program provides early detection and treatment of behavioral health issues through initial and periodic, follow-up screenings. Events that may trigger a periodic screening include entry into the foster care system, a change in living circumstance (like a foster care placement move), or a change or presentation of acute behavioral health needs (such as a school suspension due to behavior or referral to residential psychiatric care). In addition, states must provide other necessary health care, diagnostic services, and treatment to "correct or ameliorate" any physical and mental illnesses or conditions discovered by the screenings, even if those services are not covered under the state Medicaid plan.

Increasing Access to Home- and Community-Based Services for Children in Foster Care. Arizona, Massachusetts, Michigan and New Jersey are among the states that have expanded their state Medicaid plans or used a Medicaid Home and Community-Based Services Waiver to fund a broad array of services and supports beyond traditional medical treatment. For

example, Medicaid-funded services include intensive in-home services, intensive care management, wraparound service planning, family and youth peer support, mobile crisis services, respite care, family training, therapeutic mentoring, therapeutic foster care, supported housing, and supported education and employment. [53]

Legislatures Address What Works

Washington State Institute for Public Policy (WSIPP)
State lawmakers created WSIPP in 1983 to conduct non-partisan research on a wide range of state policies and programs—including child welfare, mental health and substance abuse—at the direction of legislators and legislative and state agency staff. Legislation in 2012 directed WSIPP to publish an annual inventory of prevention and intervention services that are evidence-based, research-based, and designated as promising practices and services in the areas of child welfare, mental health and juvenile justice. WSIPP conducts a meta-analysis of all rigorous evaluations of policies to improve public outcomes, computes the benefits and costs of programs using a specific framework, and measures program risk to determine the likelihood that a program or policy will break even or provide cost benefits to the people of Washington. View WSIPP's child welfare policy reports for more information and to see the latest Inventory of evidence-based programs.

New Mexico Results First
New Mexico's Legislative Finance Committee (LFC) is responsible for developing budget recommendations and program evaluations. The LFC also issues "report cards" on state programs to assess whether or not those programs are delivering desired outcomes. The LFC recently began a partnership with the Pew-MacArthur "Results First" initiative to support evidence-based policy making and budgeting. "Results First" provides a national database on effective programs. States add their own information on each of the programs they wish to examine based on their populations, costs and goals. The Results First model calculates long-term costs and benefits for each program. The model then ranks the programs. Policymakers can then use this information in their budgeting process. See New Mexico's recent Results First reports.

Conclusion

State policymakers have an unprecedented opportunity to improve child welfare systems so that children and youth in care have the necessary tools to overcome the trauma of maltreatment and removal from their families. Science has revealed important insight into the effects on the development of young children exposed to violence and trauma. We are also developing an excellent knowledge base about what programs are effective and what kinds of outcomes we can expect in these children's lives.

The Title IV-E waiver demonstration program will provide the nation with five years of experience from up to 30 states who are experimenting with new and more effective ways to impact the lives of children in foster care or at risk of entering or re-entering care. The waivers also offer states the opportunity to flexibly use funding to meet well-being and other goals for children in foster care.

Local, state and federal agencies, courts, and other state systems are examining their services and strategies to determine whether or not they incorporate the impact of trauma on child development. They are also investing in trauma-informed training for foster, kin and adoptive families who are at the forefront in the battle to protect millions of vulnerable children and families.

State lawmakers, in their oversight capacity, can convene key stakeholders to analyze state data, determine outcomes and set measures for the social and emotional well-being of child welfare involved children and families. Legislators can further lead these cross-agency collaborative efforts to identify policy barriers and solutions, identify best practice and develop effective strategies to fund and deliver behavioral health services.

NOTES

[1] Children's Bureau. *Preliminary Estimates for FY 2014 as of July 2015. AFCARS Report #22.* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families. Washington, D.C., July 2015. *Accessible at:* http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf

[2] McCarthy, J. *Meeting the Health Care Needs of Children in the Foster Care System*. Washington, D.C.: Georgetown University Child Development Center, 2002.

[3] Children's Bureau. *Information Memorandum (ACYF-CB-IM-12-04).* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families. Washington, D.C., April 2012.

[4] Children's Bureau. *Trends in Foster Care and Adoption: FY 2005-FY 2014.* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families. Washington, D.C., July 2015. Accessible at: http://www.acf.hhs.gov/sites/default/files/cb/trends_fostercare_adoption2014.pdf

[5] DePanfilis, Diane. *Child Neglect: A Guide for Prevention, Assessment and Intervention.* Office on Child Abuse and Neglect, Children's Bureau. Washington, D.C., 2006. Accessible at: https://www.childwelfare.gov/pubPDFs/neglect.pdf#page=11&view=Chapter 2 Definition and Scope of Neglect

[6] Children's Bureau. *Preliminary Estimates for FY 2014 as of July 2015. AFCARS Report #22.* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families. Washington, D.C., July 2015. *Accessible at:* http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf

[7] National Resource Center for Permanency and Family Connections. *Placement Stability Information Packet.* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families. Washington, D.C., December, 2009. *Accessible at:* http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/Placement_Stability_Info_Pack.htm

[8] Dolan, M., Casanueva, C., Smith, K., & Ringeisen, H. *NSCAW Child Well-Being Spotlight, OPRE Report #2013-05.* Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, D.C., 2013.

[9] National Resource Center for Permanency and Family Connections. *Placement Stability Information Packet.* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families. Washington, D.C., December, 2009. *Accessible at:* http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/Placement_Stability_Info_Pack.htm

[10] Ibid.

[11] Horwitz, SM, Hurlburt MS, Heneghan A, Zhang J, RollsReutz J, Fisher E, Landsverk J, Stein REK. "*Mental health problems in young children investigated by U.S. child welfare agencies."* Journal of the American Academy of Child and Adolescent Psychiatry. (2012); Pecora PJ, Jensen PS, Hunter Romanelli L, Jackson LJ & Ortiz A. "*Mental health services for children placed in foster care; an overview of current challenges."* Child Welfare 51:572-581 (2009): 88: 5-26.

[12] Terry Lee, MD, George Fouras, MD, Rachel Brown, MBBS, MPhil, and the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). "*Practice Parameter for the Assessment and Treatment of Youth Involved with the Child Welfare System."* American Academy of Child and Adolescent Psychiatry. Washington, D.C.: 2012

[13] Ibid.

[14] Ibid

[15] Ibid

16 The Centers for Medicare and Medicaid Services (CMS). *Tri-Agency Letter on Trauma Informed Treatment, Guidance Letter to State Medicaid Directors.* Administration for Children and Families, Centers for Medicare and Medicaid Services, Substance Abuse and Mental Health Services Administration. Washington, D.C.: July 13, 2011. Accessible at: http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

[17] Children's Bureau. *Information Memorandum (ACYF-CB-IM-12-04).* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families. Washington, D.C.: April 2012.

[18] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication No. (SMA) 14-4884. Substance Abuse and Mental Health Services Administration, Rockville, MD: 2014.

[19] Child Welfare Information Gateway. *Developing a trauma-informed child welfare system.* U.S. Department of Health and Human Services, Children's Bureau. Washington, D.C: 2015

[20] The Pew Center on the States. *"Paying Later: The High Costs of Failing to Invest in Young Children*." Issue Brief. Partnership for America's Economic Success, Washington, D.C.: January 2011

[21] Terry Lee, MD, George Fouras, MD, Rachel Brown, MBBS, MPhil, and the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). "*Practice Parameter for the Assessment and Treatment of Youth Involved with the Child Welfare System."* American Academy of Child and Adolescent Psychiatry. Washington, D.C.: 2012

[22] DeVooght, Kerry; Megan Fletcher; Brigitte Vaughn; and Hope Cooper. *Federal, State, and Local Spending to Address Child Abuse and Neglect in SFYS 2008 and 2010.* Washington, D.C.: Child Trends, June 2012

[23] Centers for Disease Control and Prevention. *Adverse Childhood Experiences (ACE) Major Findings*, National Center for Injury Prevention and Control. Division of Violence Prevention. Atlanta, GA: 2013. Accessible at: http://www.cdc.gov/violenceprevention/acestudy/

[24] Harvard University Center on the Developing Child. "In Brief: The Impact of Early Adversity on Children's Development." Center on the Developing Child. Cambridge, MA: 2007. http://developingchild.harvard.edu/wp-content/uploads/2015/05/inbrief-adversity-1.pdf

[25] Harvard University Center on the Developing Child. "In Brief: The Impact of Early Adversity on Children's Development." Center on the Developing Child. Cambridge, MA: 2007. http://developingchild.harvard.edu/wp-content/uploads/2015/05/inbrief-adversity-1.pdf

[26] Jim Casey Youth Opportunities Initiative. *The Adolescent Brain: New Research and Its Implications for Young People Transitioning From Foster Care.* Jim Casey Youth Opportunities Initiative. St. Louis, MO: 2011. Accessible at: http://www.jimcaseyyouth.org/sites/default/files/documents/The%20Adolescent%20Brain_prepress_proof%5B1%5D.pdf

[27] Anda, Robert, MD, MS. *The Health and Social Impact of Growing Up with Adverse Childhood Experiences: The Human and Economic Costs of the Status Quo*. The Adverse Childhood Experiences Study. 2007. Accessible at: http://acestudy.org/files/Review_of_ACE_Study_with_references_summary_table_2_.pdf

[28] Pires, Sheila A. Pires, MPA, and Beth A. Stroul, Med. *Making Medicaid Work for Children in Child Welfare: Examples from the Field*. Hamilton, N.J.: Center for Health Care Strategies, June 2013. Accessible at: http://www.chcs.org/media/Making_Medicaid_Work.pdf

[29] Ibid.

[30] Ibid.

[31] 2009 Cal. Stats., Chap. 339 (Senate Bill 597)

[32] California Department of Social Services 2015-2019 Child and Family Services Plan

[33] 2013 Ariz. Sess. Laws, Chap. 220 (Senate Bill 1375); 2013 Conn. Acts, P.A. 178 (Senate Bill 972); 2015 Tex. Gen. Laws, Chap. HB19, Act No 324 (House Bill 19); 2015 Wash. Laws, Chap. 283 (House Bill 1979)

[34] Woolverton, Maria. *Meeting the Health Care Needs of Children in the Foster Care System: Implementation Strategies.* Washington, D.C.: Georgetown University Child Development Center, September 2002. Accessible at: http://gucchd.georgetown.edu/products/FCStrategies.pdf

[35] 2011 Ill. Laws, P.A. 97-245, Illinois Administration of Psychotropic Medications to Children Act

[36] 2015 Cal. Stats., Chap. 534 (Senate Bill 238); 2015 Cal. Stats., Chap. 535 (Senate Bill 319)

[37] 2014 Calif. Stats., Chap. 766

[38] 2014 Vol. 79 Del. Laws. Chap. 293 (Senate Bill 266)

[39] 2015 N.D. Sess. Laws, Chap. 332 (Senate Bill 2367)

[40] 2015 R.I. Pub. Laws, Chap. 2015-118 (Senate Bill 572)

[41] 2015 Wash. Laws, Chap. 28 (House Bill 1879); 2015 Mont. Laws, Chap. 265 (House Bill 422)

[42] 2010 W.Va. Acts, Chap. 20 (House Bill 4164)

[43] 2011 Mich. Pub. Acts, Act 63 (House Bill 4526)

[44] 2011 Minn. Laws, Chap. 86

[45] 2010 Minn. Laws, Chap. 303

[46] 2012 Wash. Laws, Chap. 232 (House Bill 2536)

[47] 2015 Mont. Laws, Chap. 265 (House Bill 422)

[48] California Evidence Based Clearinghouse for Child Welfare, accessible at: http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed

[49] California Evidence Based Clearinghouse for Child Welfare, accessible at: http://www.cebc4cw.org/program/multisystemic-therapy/

[50] Child Welfare Information Gateway. *Parent-child interaction therapy with at-risk families.* Washington, DC: U.S. Department of Health and Human Services, 2013.

[51] California Evidence Based Clearinghouse for Child Welfare, accessible at: http://www.cebc4cw.org/program/parent-child-interaction-therapy/

[52] Simmons, Dayana. *Medicaid Financing for Family and Youth Peer Support: A Scan of State Programs*. Presentation at National Federation of Families for Children's Mental Health Annual Conference. Washington, D.C.: November 2012. Accessible at: http://www.chcs.org/media/20121117-D.-Simons-NFFCMH-FYPS-Medicaid-Financing1.pdf

[53] Pires, Sheila A. Pires, MPA, and Beth A. Stroul, Med. *Making Medicaid Work for Children in Child Welfare: Examples from the Field*. Hamilton, N.J.: Center for Health Care Strategies, June 2013. Accessible at: http://www.chcs.org/media/Making_Medicaid_Work.pdf