Kevin S.

Resource Materials

- INTRODUCTION TO *KEVIN S.*
- TRAUMA
- CAT/CANS
- EPSDT
- COMMUNITY-BASED SERVICES

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Kevin S. Settlement and Implementation

The *Kevin S.* settlement is a groundbreaking agreement that brings together foster youth, child advocates, nationally recognized experts, and New Mexico's Children, Youth and Families Department (CYFD) and Human Services Department (HSD) to transform the State's child welfare system

The settlement agreement sets forth a unique process that aims to unite advocates for children and youth with state agencies and nationally-recognized experts. It sets a number of specific and ambitious targets that CYFD and HSD agree to achieve in the coming years. Three experts on child welfare reform (the "Co-Neutrals") will help reach the targets and will evaluate performance using data and input from the community. Each target will be evaluated until it has been met for at least 24 months.

The Co-Neutrals—Kevin Ryan, Pam Hyde, and Judy Meltzer—were selected by the *Kevin S.* litigation team and the state agencies for their expertise in the issues raised by the agreement as well as the process of turning around complex systems. The Co-Neutrals and the state agencies will produce public reports on settlement activities and progress toward achieving the targets in the settlement.

An implementation team made up of lawyers from Disability Rights New Mexico, Pegasus Legal Services, and Public Counsel will monitor the implementation of the settlement. Along with the Co-Neutrals, the implementation team will receive and analyze data from both state agencies and will seek input from community stakeholders as the implementation proceeds throughout the settlement implementation.

The targets are detailed in four appendices. They include:

A Trauma-Responsive System of Care

- Screenings, including a functional trauma assessment, to identify which children need intensive home-based services
- A cross-departmental training and coaching plan that will help staff understand the impacts of trauma and what they can do to support children who have been affected by trauma
- Access to trauma-responsive services, supports, and treatment for every child for whom the services are medically necessary
- Individualized planning meetings for each child—a process informed by Child and Family Teaming (CFT), collaborative decision-making, and High Fidelity Wraparound models
- A Quality Assurance, Improvement, and Evaluation plan to ensure capacity to meet children's needs

Least Restrictive and Appropriate Placements

- A plan to increase recruitment and retention of culturally reflective, community-based placements, and to support children and caregivers

- A commitment not to place any children in hotels, motels, offices, or out-of-state providers absent extraordinary circumstances and an approval/notification process
- Joint clinical reviews of out-of-state placements and congregate care placements on a monthly basis
- A workforce development plan that will ensure that the system's staff has the necessary qualifications, expertise, skills, and personnel
- Published guidance to prohibit retaliation against any person, including resource families, who raises concerns related to unmet needs of children in state custody or their caregivers

Indian Child Welfare Act

- A State ICWA law that mirrors and expands upon the federal version and that will be drafted with New Mexico Tribes and Pueblos and other stakeholders
- Processes and procedures to promote traditional interventions as first-line interventions and services, developed with the input of New Mexico's Tribes and Pueblos
- Maximizing federal funding for traditional and culturally responsive treatments, interventions, and supports, including non-medicalized intervention as appropriate and in consultation with New Mexico Tribes and Pueblo
- A plan to increase recruitment and retention of Native resource families
- A policy to provide or ensure provision of direct assistance for traditional ceremonies, including arranging for all preparation and providing payment if needed, if Native children want to participate

Behavioral Health Services

- A Behavioral Health Care Workforce Development Review to expand provider capacity to provide community-based mental and behavioral health services with reasonable promptness throughout the State, and particularly in rural areas
- Regulations governing medication protocols to ensure that children in state custody are not overmedicated, and a clinical review process for all children prescribed psychotropic medication
- Incentives for providers to be trained in evidence-based, well-supported, and promising trauma-responsive services
- A joint process for offering services and supports include screening, assessing, referring, treating and providing transition services to children in state custody, including those who are not removed from their homes
- Notice to caregivers, legal representatives, and legal custodians whenever a service recommended by an Individualized Planning Meeting Team is reduced, modified, delayed, or denied, or if the service or is not approved within 10 days

TRAUMA AND CHILDREN IN STATE CUSTODY

Developing and supporting a trauma responsive system of care is the first principle of the *Kevin S Agreement*. Every child in state custody is by definition a trauma victim, not only because of the circumstances that led to their custody, but also because of the separation from their caretakers (often worsened by a series of subsequent separations from substitute caregivers). Despite the possible physical and sexual trauma that a child may have experienced, attachment trauma is itself the most significant trauma that a child can experience. A child's early development is completely dependent upon the presence and devotion of a consistent caretaker, which is why the second pillar of the *Kevin S Agreement* is adequate, homelike and stable placements. A secure placement is the most critical and immediate aid for a child in custody.

Childhood trauma has been extremely well researched and described. Early brain development is fundamentally devoted to the establishment of regulatory neural pathways. The neurological development of the first five years constitutes the essential hardware that will be subsequently necessary to establish healthy peer relationships, to manage moods and anxiety, to attend successfully to schoolwork, to tolerate frustration, and to solve conflicts without resorting to aggression. All this early development requires the presence and attention of a consistent attachment figure.

In the absence of this regulatory neurological framework, a child will have lifetime problems with the management of mood, anxiety, attention and behavior, which is why children who have been in custody oftentimes have such a rocky course in school and in life. Moreover, since a person with trauma always seeks relief from what may be chronic hyperarousal, substance use poses a very high risk. Drug and alcohol use, for example, in severely traumatized individuals is found to be more than 40 times that of the general population, and suicide is more than 10 times as high. These are the findings and the basis of the ACE study, which found that as childhood trauma increased so do subsequent life problems over a vast range of physical and emotional disorders.

In addition to the requirements for improved placements and community-based supports, the Kevin S Agreement requires that every child in custody be assessed by the Child and Adolescent Needs and Strengths (CANS) screen. The results of the screen will be used to pull together a support team and to direct subsequent treatment. Finally, while medication and traditional therapies may be supportive for the traumatized child, evidence-based trauma therapies are recommended. Therefore, the Kevin S Agreement requires that a number of specific trauma therapies be developed and reimbursed by Medicaid. These include:

Eye Movement Desensitization and Reprocessing (EMDR)

Trauma Informed Cognitive Behavioral Therapy (TICBT)

Dialectical Behavior Therapy (DBT)

Multisystemic Therapy (MST)

Functional Family Therapy (FFT)

Mobile Crisis Response Services

All of these system improvements, including screening, placement enhancements and trauma therapies have timelines for implementation.

CANS / CAT

CHILD AND ADOLESCENT NEEDS AND STRENGTHS / CRISIS ASSESSMENT TOOL

Description

The CANS and the CAT are screening tools that have been developed by CYFD in collaboration with the Praed Foundation to meet the requirements of the Kevin S Agreement. These instruments were specifically developed to identify areas of need for children in state custody and to inform decision making and service planning, support quality improvement initiatives and monitor progress and outcomes. The instruments are not intended as diagnostic tools, but instead assess the areas of need for support and treatment across a wide range of functional domains for children entering state custody. They are intended to identify deficits that impede a child's placement and recuperation regardless of the cause, and will sometimes require additional clinical assessment to determine diagnoses and appropriate therapies.

Components

The CANS is the more comprehensive of the two screens and identifies areas of need within a prescribed number of functional domains, which are then incorporated into a treatment plan. There are domains that address how the child or youth functions in everyday life, specific emotional or behavioral concerns, trauma history and trauma responses, risk behaviors, strengths and skills needed to grow and develop. The CAT is a shorter version composed of a subset of questions taken directly from the CANS and is used for a rapid estimate of the most immediate needs of a child recently taken into custody. Both tests are scored using a 4-level rating scale that indicates some degree of recommended attention ranging from no problem at all to the need for immediate intervention. By the use of specific individualized modules the CANS and CAT are able to be applied to children of different ages and specific symptom clusters such as sexually reactive or aggressive behaviors. In summary:

- ★ Basic core items – grouped by domain – are rated for all individuals.
- ★ A rating of 1, 2 or 3 on key core questions triggers extension modules.
- ★ Individual assessment module questions provide additional information in a specific area.

Usage

According to the terms of the Kevin S Agreement, the Crisis Assessment Tool is required to be administered between the time a child is first taken into custody and when the Ten Day Hearing occurs, and must be filed with the court 24 hours prior to that hearing. The CANS is required to be administered with the first 45 days of custody. The screens are most accurate when the child or youth is able to provide direct responses in addition to document review. Both of the screens are intended to be the shared informational basis of the treatment plan which is to follow. The CANS describes itself as a communication tool designed to gather multiple supports for the child into a single service plan. Therefore, given the appropriate consents, both screens will be shared with providers, the children's court, GALs, and Managed Care Treatment Coordinators.

EPSDT in New Mexico: What You Need to Know About this Critical Medicaid Benefit and Behavioral Health

Medicaid is a federal program that provides health care coverage to low-income adults, children, pregnant women, elders, and people with disabilities. States that participate in the Medicaid program, like New Mexico, must with comply with federal program requirements including EPSDT.

What is EPSDT?

By state and federal law[1], **New Mexico's Medicaid program must pay for all medically necessary health services for Medicaid-eligible children under the age of 21 through the EPSDT program**. This includes preventative health services, maintenance health services to prevent a condition from worsening, and treatment of medical conditions. It also includes a complete range of behavioral health services, including treatment for alcohol and substance abuse.

EPSDT stands for "Early and Periodic Screening, Diagnostic and Treatment," and EPSDT services encompass:

- **Early:** assessing health care early in life so that potential disease and disabilities can be prevented or detected in their preliminary stages, when they are most effectively treated;
- **Periodic:** assessing a child's health at regular recommended intervals in the child's life to assure continued healthy development;
- **Screening:** the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention;
- **Diagnostic:** the determination of the nature or cause of conditions identified by the screening; and
- **Treatment:** the provision of services needed to control, correct or lessen health problems.[2]

Well Child Check and Screenings

In New Mexico, the screening component of EPSDT is called the "Well Child Check" (or sometimes the "Tot to Teen Health Check"). The Well Child Check is performed by a Doctor, Nurse Practitioner, or Physician's Assistant at regular intervals throughout childhood and adolescence, and should include a full assessment of both physical and behavioral/developmental health.[3]

Additional medical screens are also available under EPSDT. Behavioral health screens should be performed at "reasonable" regular intervals, or when medically necessary for the diagnosis or treatment of a behavioral health condition.[4]

Diagnostic/Treatment Services Under EPSDT

When there is need for further evaluation or treatment based on a screen or other information, a child must receive the appropriate referrals without delay.

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[1] *See* 42 CFR 441.50 Subpart B; *see also* **8.320.2.9 NMAC**
[2] NMAC **8.320.2.9 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES:**
[3] NMAC **8.320.2.15 TOT TO TEEN HEALTHCHECK**
[4] NMAC **8.320.2.15(b)(4) TOT TO TEEN HEALTHCHECK**

EPSDT provides that children are entitled to receive any Medicaid-coverable service, regardless of whether it is otherwise offered under the New Mexico Medicaid State Plan, when it is medically necessary to "correct or ameliorate any defects and chronic conditions discovered," including both physical and mental illnesses or conditions.[5] **So if the service is necessary to prevent, diagnose or treat a condition or to help a child attain, maintain or regain functional capacity, the child is entitled to receive the service.** [6]

Available mental health services are a comprehensive suite that include case management, outpatient mental health counseling, psychiatric and medication support services, day treatment, crisis stabilization, therapeutic behavioral services, speech/physical/occupational services, early intervention for delays, and more. By regulation, New Mexico also includes comprehensive community support services, crisis services, family support services, behavior management, multi-systemic therapy and treatment foster care.[7]

Children's Code Requirements

New Mexico's Children's Mental Health Code also evinces an intent to "provide children with access to appropriate assessments, services, and treatment" for the purpose of "identification, prevention, and intervention for developmental and mental health needs."[8]

The law provides that "**a child receiving mental health or habilitation services shall have the right to prompt treatment and habilitation pursuant to an individualized treatment plan and consistent with the least restrictive means principle"**.[9] This means a child's treatment must be no more intrusive than necessary to accomplish the treatment objectives. Residential care should only be used when required for effective treatment or to protect from physical injury to the child or others.[10]

EPSDT is a Child's Right

EPSDT is not optional: it is a state and federal requirement that eligible children receive all medically necessary Medicaid-coverable services, and that requirement stands regardless of the child's geographic area or particular needs. Therefore, **providers should recommend whatever services are medically necessary**, even if that service is perceived to be unavailable. **Parents and guardians and foster parents should familiarize themselves with EPSDT requirements, and work with their MCO Care Coordinator, advocate, or attorney** if help is needed to obtain a necessary service.

For More Information or Help:

New Mexico Human Services Department's Keeping Kids Healthy website:
https://www.hsd.state.nm.us/lookingforinformation/keeping-kids-healthy/

Pegasus Legal Services for Children: https://pegasuslaw.org

Disability Rights New Mexico: https://www.drnm.org

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[5] 42 C.F.R. § 440.40(b)
[6] NMSA § 32A-6A-4(T)
[7] NMAC Title 8, Chapter 308, Part 9
[8] NMSA § 32A-6A-2
[9] NMSA § 32A-6A-7
[10] NMSA § 32A-6A-4(M)

Home/Community Based Behavioral Health Services in New Mexico: Centennial Care Covered Services[11]

Applied Behavior Analysis (ABA) Therapy: May be provided in coordination with other medically necessary services. Entails a three-part comprehensive approach.

> *Stage 1*: Screening for Autism Spectrum Disorder (ASD), diagnostic evaluation, development of Integrated Service Plan (ISP), referral to Stage 2 services.
>
> *Stage 2*: Behavior or functional analytic assessment, ABA service model determined, treatment plan developed.
>
> *Stage 3*: Clinical management of treatment. If recipient's needs exceed expertise of clinical supervision, ABA Specialty Care Services are available (requires prior authorization). Patients in Treatment Foster Care (TFC) are eligible for ABA Therapy outside of the TFC agency.

Assertive Community Treatment Services: Generally for adults, but may also be provided to eligible individuals ages 15-30 years-old who are within two years of their first episode of psychosis. Voluntary medical, comprehensive case management and psychosocial intervention program.

Behavioral Health Professional Services for Screenings, Evaluations, Assessments, and Therapy: Screenings for high-risk conditions to provide early treatment or interventions. Covers psychological, counseling, and social work services that are diagnostic or active treatments. Services also include assessments. Services must be thought to "reasonably improve an eligible recipient's physical, social, emotional, and behavioral health or substance abuse condition," and the services can be expected to improve the individual's condition or level of functioning.

Behavioral Health Respite Care: Managed Care Organization (MCO) only. For individuals under age 21 with a diagnosis of Severe Emotional Disturbance (SED) who live with their primary caregivers or for youth in protective custody whose placement may be at risk whether or not they have a diagnosis of SED. Short-term direct care and supervision of the individual so as to afford caregivers/parents opportunity for rest/respite. Usually planned, but can also be used in an emergency or on an unplanned basis.

Behavior Management Skills (BMS) Development Services: Used to assist in reducing or preventing inpatient hospitalizations or residential placements. Not a stand-alone service, but delivered as part of an integrated service plan for individuals under the age of 21 years-old to help them acquire, enhance, or maintain life, social, behavioral skills needed to function in their community.

Comprehensive Community Support Services (CCSS): Culturally sensitive coordination of services and resources to promote recovery, rehabilitation, and resiliency in the individual. Must be under the age of 21 years-old and meet criteria for SED and/or neurobiological/behavioral disorders. Exceptions for individuals over 21 years-old, those with severe substance abuse disorder, or those with dual diagnoses with a primary diagnosis of mental illness.

[11] For a complete list of approved services, see *Specialized Behavioral Health Services* (NMAC 8.321.2)

Crisis Intervention Services: For individuals experiencing breakdown of normal strategies/resources who are exhibiting acute problems, disturbed thoughts, behaviors, or moods that could threaten the safety of self or others. Four types of Crisis Intervention Services: (1) Telephone services, (2) Face-to-Face services in a clinic setting, (3) Mobile services, and (4) Outpatient Stabilization services.

Crisis Triage Center: Available for individuals 14 years-old and older. Voluntary stabilization of behavioral health crises including emergency mental health evaluation and treatment. Screening and evaluation available 24-hours a day, seven days a week. Discharge available seven days a week.

Day Treatment: EPSDT benefit for individuals under the age of 21 years-old. Must be identified in EPSDT health check or in another diagnostic evaluation to access services. Focus on the amelioration of functional and behavioral deficits.

Family Support Services: MCO reimbursed only. Community-based, face-to-face interactions with MCO member and their family. Enhance the family's strengths/capacities/resources to reach behavioral goals prioritized by the individual and their family. For MCO members who have parents, family members, legal guardians, or other primary caregivers who live or are closely linked with them. Available for MCO members with a diagnosis of SED or SMI.

Intensive Outpatient Program (IOP) for Mental Health Conditions: Available for individuals 11-17 years-old diagnosed with SED or adults diagnosed with SMI. Targets specific behaviors with individualized interventions. Before individual services can be accessed, the individual must have a treatment file with: (1) one diagnostic evaluation with a diagnosis of SED or SMI for which IOP is approved, and (2) one individualized service plan that includes IOP as an intervention.

Multi-Systemic Therapy (MST): Available for individuals ages 10-18 years-old who meet the criteria of SED, involved in or at serious risk of involvement with juvenile justice; OR has antisocial, aggressive, violent, and substance abuse behaviors; OR is at risk for out-of-home placement; OR is returning from an out-of-home placement where the aforementioned behaviors were the focus of treatment. Must be identified in EPSDT health check or other diagnostic evaluation.

Partial Hospitalization Services: Available for individuals 5 years-old and older. Requires the individual be diagnosed with SMI, SED, or moderate/severe SUD. Individuals must be able to be safely managed in the community with high-intensity therapeutic interventions that are more intensive than outpatient services, but who risk inpatient care without such community-based services. Can be used to address deteriorating conditions or as a step-down strategy.

Screening, Brief Intervention & Referral to Treatment: For individuals 11-13 years-old (with parent consent), 14-18 years-old, or adults. Used to identify and reduce problematic substance use or abuse and co-occurring mental health disorders. Relies on early identification in a medical setting and aims to integrate behavioral health and medical care. Warm hand-offs for positive screening results.

Treatment Foster Care I (TFC I): TFC I services must be identified in the individual's EPSDT health check or other diagnostic evaluation(s). TFC I provides for therapeutic services to an individual experiencing emotional or psychological trauma. Individual must: (1) be at risk for placement in a higher level of care or is returning from a higher level of care; OR (2) have complex and difficult psychological, neurobiological, behavioral, psychosocial problems; AND (3) requires (and would optimally benefit from) the services and supervision of a treatment foster home.

Treatment Foster Care II (TFC II): TFC II services must be identified in the individual's EPSDT health check or other diagnostic evaluation(s). Provides therapeutic family living experiences as the centerpiece to treatment services. Other individualized services can be added. Individual must: (1) have successfully completed TFC I (as indicated by treatment team); OR (2) require the initiation or continuity of treatment and support of the treatment foster family; OR (3) require this treatment modality as an appropriate entry level service from which the individual will optimally benefit.