



July 11, 2013

Dear State Director,

We deeply appreciate the work you do to help vulnerable children, youth and families. At the federal level, we strive to collaborate and provide resources to support you and your colleagues in that critical work. This guidance letter is intended to encourage the integrated use of trauma-focused screening, functional assessments and evidence-based practices (EBPs) in child-serving settings for the purpose of improving child well-being. The Department of Health and Human Services' (HHS) Administration for Children and Families (ACF), Centers for Medicare & Medicaid Services (CMS) and Substance Abuse and Mental Health Services Administration (SAMHSA) are engaged in an ongoing partnership to address complex, interpersonal trauma and improve social-emotional health among children known to child welfare systems. We look to state and tribal governments to further this important work.

I. Background

Complex trauma is a common yet serious concern for children, especially those referred to child welfare services. Rates of trauma exposure are approximately 90 percent among children in foster care.¹ These high rates of trauma have far-reaching consequences. 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. In addition to these traumatic events, a child's experience of these events can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, emotional or spiritual well-being. These adverse effects can include a child's physiological responses; emotional responses; ability to think, learn, and concentrate; impulse control; self-image; and relationships with others. Across the life span, complex trauma is linked to a wide range of problems, including addiction, chronic

¹ Stein, B., Zima, B., Elliott, M., Burnam, M., Shahinfar, A., Fox, N., et al. (2001). Violence exposure among school-age children in foster care: Relationship to distress symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(5), 588–594.

physical conditions, depression and anxiety, self-harming behaviors and other psychiatric disorders.²

A focus on complex trauma has important implications for how screening, functional assessment and effective treatments are essential to improve child outcomes. Medicaid is an important source of reimbursement for services and support to children and youth who have experienced complex trauma and have behavioral health needs requiring treatment.³ The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid's comprehensive preventive child health service designed to make health care services available and accessible and to assist eligible children and their families in effectively using their health care resources. The preventive thrust of EPSDT helps to ensure that health problems, including behavioral health issues, are identified and treated early, before problems become more complex and their treatment more costly. EPSDT benefit requirements apply to Medicaid-eligible children under age 21, and include Medicaid reimbursement for covered services.⁴

Complex trauma affects a child's sense of safety, ability to regulate emotions and capacity to relate well to others. Since complex trauma often occurs in the context of the child's relationship with a caregiver, it interferes with the child's ability to form a secure attachment. Consequently, an important aim of service delivery is to help children and youth develop positive social-emotional functioning, restore appropriate developmental functioning and reestablish healthy relationships. New legislation, the *Child and Family Services Improvement and Innovation Act of 2011*, requires states to include details of how trauma associated with maltreatment and removal from home will be monitored and treated in their Child and Family Services Plans.

The landmark Adverse Childhood Experiences (ACE) Study demonstrated long-term consequences in adulthood of multiple adverse experiences that occur in childhood,⁵ including increased likelihood of stroke, diabetes, cardiovascular disease, cancer, and early death, as well as lower job performance and employment.⁶ ACEs are quite common. In this study, half of the over 17,000 participants had been exposed to at least one adverse childhood experience. However, when multiple ACEs were experienced, the results are compounded. Adults who experienced six or more ACEs were likely to die 20 years sooner than those with no ACEs.⁷ These consequences represent unfulfilled human potential and significant costs to public systems.

² National Child Traumatic Stress Network. (n.d.). Types of traumatic stress. Retrieved from <http://www.nctsn.org/trauma-types#q2>

³ Teich, J.L., Buck, J.A., Graver, L. and Zheng, D. (2003). Utilization of public mental health services by children with serious emotional disturbances. *Administration and Policy in Mental Health* 30(6): 523-534.

⁴ [Section 1905\(a\)\(4\)\(b\) of the Social Security Act. http://www.ssa.gov/OP_Home/ssact/title19/1905.htm](http://www.ssa.gov/OP_Home/ssact/title19/1905.htm)

⁵ Ten ACEs were identified: emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, witnessing mother being treated violently, growing up with someone in the household abusing alcohol or drugs, growing up with a mentally ill person in the household, losing a parent due to separation or divorce, and growing up with a household member in prison.

⁶ Anda, R.F., Fleisher, V.I., Felitti, V.J., Edwards, V.J., Whitfield, C.L., Dube, S.R., and Williamson, D.F. (2004). Childhood abuse, household dysfunction, and indicators of impaired adult worker performance. *The Permanente Journal*, 8(1):30.

⁷ Brown, D.W. et al. (2009). Adverse childhood experiences and the risk of premature mortality. *American Journal of Preventive Medicine*. 37(5):389-396

Without regard to foster care status, children with disabilities comprise approximately one-third of maltreated children between the ages of birth to nine years, almost one-fourth in the middle school years, and around one-sixth in the high school years. Furthermore, studies indicate that children with communication or sensory impairments and learning disabilities are at increased risk for abuse.⁸ These studies underscore the need for a collaborative response to identify and meet the treatment needs of all children who have experienced trauma.

Many of these children will demonstrate complex symptoms and/or behaviors that may not map directly to the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). For example, there is currently no DSM diagnosis that adequately captures the range of child trauma effects.⁹ Many children who have experienced complex trauma will not meet the criteria for a diagnosis of Post-Traumatic Stress Disorder (PTSD). Yet, trauma-related symptoms are identifiable, can be clinically significant and can be addressed with appropriate interventions. For these children, appropriate screening, assessment and referral to evidence-based practices are clearly indicated. To this end, ACF released an Information Memorandum (ACYF-CB-IM-12-04 <http://www.acf.hhs.gov/programs/cb/resource/im1204>) to encourage child welfare agencies to focus on improving the behavioral and social-emotional outcomes for children who have experienced abuse and/or neglect.

II. The Interplay between Child Trauma and Psychotropic Medications: HHS Response

The focus on improving child well-being through screening, assessment and evidence-based practices cannot be achieved without a discussion of the use of psychotropic medications with this population. Children and youth in foster care are far more likely than their peers to receive psychotropic medications, including atypical antipsychotic medications, which carry a high risk of side effects.¹⁰ There is reason to believe that such widespread and at times problematic use of these drugs is a reaction to the clinical complexity of symptoms among children exposed to complex trauma and the lack of appropriate screening, assessment and treatment.¹¹

There has been increasing concern at HHS and among stakeholders, families and youth about the safe, appropriate and effective use of psychotropic medications among children in foster care. Multiple divisions within HHS, including ACF, CMS, Food and Drug Administration (FDA), and SAMHSA, have been working together for nearly two years to strengthen oversight and monitoring of psychotropic medications with this population.

⁸ Stalker, K., & McArthur, K. (2012). Child abuse, child protection and disabled children: A review of recent research. *Child Abuse Review*, 21(1), 24-40.

⁹ Griffin, G. (2010). Illinois Childhood Trauma Coalition White Paper: Child Trauma as a Lens for the Public Sector. Chicago, IL: ICTC.

¹⁰ Medicaid Medical Directors Learning Network and Rutgers Center for Education and Research on Mental Health Therapeutics. Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study. MMDLN/Rutgers CERTs Publication #1. July 2010. Distributed by Rutgers CERTs at <http://rci.rutgers.edu/~cseap/MMDLNAPKIDS.html>.

¹¹ Raghavan, R., Inoue, M., Ettner, S.L., Hamilton, B.H. and Landsverk, J. (2010). A preliminary analysis of the receipt of mental health services consistent with national standards among children in the child welfare system. *American Journal of Public Health*. 100(4): 742

A Dear State Director letter to directors of state child welfare, Medicaid and mental health authorities (November 2011) and an ACF Information Memorandum¹² were released concerning the safe, appropriate and effective use of these medications among children in foster care. In August 2012, a two day state summit, “*Because Minds Matter: Collaborating to Strengthen Psychotropic Medication Management for Children and Youth in Foster Care*,” brought together child welfare, mental health and Medicaid leaders from across the country to address the issue. Additionally, child welfare agencies are now required to submit information on how psychotropic medications will be overseen and monitored as part of their Child and Family Services Plan (CFSP) and provide updates in the Annual Progress and Services Report (ASPR).¹³

The Center for Medicaid and CHIP Services (CMCS) in CMS issued an Informational Bulletin (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-08-24-12.pdf>) encouraging states to use “drug utilization review” to address the use of psychotropic medications in vulnerable populations. The technical assistance resources provided states with additional tools to promote the appropriate use and enhanced oversight of psychotropic medications for children in foster care.

This letter describes the importance of making research-based, psychosocial interventions readily available to meet the needs of children who have experienced complex trauma.

III. Components of a Cross-system Approach for Promoting Child Well-being: Integrating Screening, Assessment, Referrals, and Interventions

Achieving well-being among children and youth who have experienced complex trauma requires tools and practices to identify service needs, an array of effective interventions to meet those needs, and periodic data on outcomes to track whether interventions are effective in helping young people. This section describes the essential components of an approach for promoting the health and well-being of children served by child-welfare systems, mental-health systems and Medicaid. These components include functional assessment, trauma screening, mental-health assessment, evidence-based practices and individual outcome measurement:

- *Functional assessment* involves periodic evaluation of a child’s well-being using standardized, valid and reliable measurement tools. These tools are not diagnostic; rather, they provide individual-level data on child strengths and needs to inform case planning. Functional assessment is used to determine outcomes for children regardless of the specific referrals or treatments they receive. These assessments allow for standardized monitoring by child welfare personnel and the treatment team of child outcomes over time and across service experiences. Functional assessment tools can be administered by a range of professionals, depending on the requirements of the particular

¹² Dear State Director letter:

<https://www.childwelfare.gov/systemwide/mentalhealth/effectiveness/jointlettermeds.pdf> and ACF Information Memorandum ACYF-CB-IM-12-03: <http://www.acf.hhs.gov/programs/cb/resource/im1203>

¹³ ACF Information Memorandum ACYF-CB-IM-11-06 - The Child and Family Services Improvement and Innovation Act (Public Law (Pub. L.) 112-34: <http://www.acf.hhs.gov/programs/cb/resource/im1106>

tool, and they can involve child, caregiver and/or professional reporters. Functional assessment data can inform broader outcomes monitoring and system-level decisions about service array planning and contracts. Examples of functional assessment tools for young children and adolescents can be found at the following ACF links:

<http://www.acf.hhs.gov/programs/cb/resource/well-being-instruments-early-childhood>
and

<http://www.acf.hhs.gov/programs/cb/resource/well-being-instruments-adolescence>.

- *Trauma screening* involves brief evaluation of potential trauma symptoms and/or history. Such screening can indicate a potential need for further assessment and treatment. Trauma screening instruments can be administered quickly by a range of professionals and can be conducted independently or as part of a broader screening and/or assessment process. Information on trauma screening tools can be found at SAMHSA's National Child Traumatic Stress Network's Measures Review Database: <http://www.nctsn.org/resources/online-research/measures-review>.
- *Mental health assessment* involves an in-depth clinical evaluation of an individual's mental health status. These more intensive assessments may include a diagnostic interview in combination with standardized mental emotional and behavioral assessment tools. Mental health assessments allow for evaluation of symptoms and the possible determination of a mental diagnosis or condition. A mental health assessment may also take into consideration experiences of traumatic events, previous and current risk factors, and emotional strengths and needs. A mental health assessment includes an evaluation of symptoms and is the basis for treatment planning. Mental health assessments can more deeply inform the use of evidence-based practices (EBPs) for trauma-related needs and mental, emotional, or behavioral disorders or conditions. The ACF Information Memorandum (ACYF-CB-IM-12-04 <http://www.acf.hhs.gov/programs/cb/resource/im1204>) on social-emotional well-being identifies a number of EBP's, including Trauma-Focused Cognitive Behavioral Therapy, Multi-Systemic Therapy and Parent-Child Interaction Therapy, among others. Many of the EBPs designed to address child trauma include parents as part of the treatment in order to provide parenting strategies and supports that improve outcomes for their children. More information on trauma-related EBPs can be found through SAMHSA's National Child Traumatic Stress Network (www.nctsn.org) and the National Registry of Evidence-based Programs and Practices (<http://www.nrepp.samhsa.gov/>) websites.
- *Outcome Measurement and Progress Monitoring*: Measuring success by tracking child-level well-being outcomes allows systems to ensure that services are achieving desired improvements in children's health and functioning. Using data from screening and assessments, systems can gauge the effectiveness of interventions with both individual children and the population served. At the child level, these data allow for the matching of specific characteristics and needs of individual children with appropriate, responsive interventions. At the system level, an iterative process of reviewing aggregated data can be used to tailor and refine an array of services to address the needs of the population.

One cross-systems example that includes the core components described above is the Comprehensive Community Mental Health Services for Children and Their Families Program (Children's Mental Health Initiative, or CMHI) administered by SAMHSA. CMHI is based on the System of Care (SOC) approach, which is an organizing philosophy and framework designed

to create a coordinated array of effective community-based services and supports. The SOC approach builds meaningful partnerships between families and youth who have or are at risk of serious mental health conditions and community-based providers and supports. Developing an individualized treatment plan and a “wraparound approach,” the SOC approach uses evidence-based practices to help children, youth, and families function better at home, in school, and in the community. This work is highlighted in SAMHSA’s 2012 Short Report “Promoting Recovery and Resilience for Children and Youth Involved in Juvenile Justice and Child Welfare Systems” (http://www.samhsa.gov/children/SAMHSA_ShortReport_2012.pdf).

IV. Financial Resources for Addressing Child Trauma

Children who have experienced complex trauma are served by numerous systems through a number of funding sources. A trauma-informed approach also recognizes that children are best served when services meet individual needs, gaps and duplication are eliminated, and funders communicate effectively to coordinate and reimburse providers for the right services and treatments. The following describes how comprehensive approaches for serving children who have experienced trauma can be funded or reimbursed by three federal sources: Child Welfare, Mental Health and Medicaid.

Child Welfare

National child welfare policy focuses on three general outcomes for children: safety, permanency and well-being. Although significant progress has been made on advancing the safety and permanency of children known to child-welfare systems, their well-being outcomes lag behind.¹⁴ Through legislative actions by Congress and through recent HHS actions described below, the federal government has increased its efforts to better integrate safety, permanency and well-being, including more of a focus on the impact of trauma on children who have been maltreated and strategies to improve social-emotional well-being outcomes.

Child Welfare IV-B and IV-E Legislative Authority and Financing

Title IV-B and title IV-E of the Social Security Act (SSA) are the primary sources of federal child welfare funding. For the purposes of this letter, the distinction between titles IV-B and IV-E relates to how the funds may be used in the provision of services.

Title IV-B funds may be used for family or individual counseling, and, to this end, states can use these funds to provide counseling that delivers evidence-based interventions to meet the trauma-related needs of its population. Title IV-B funds are primarily distributed via two formula grant programs, the Stephanie Tubbs Jones Child Welfare Services (CWS) program and the Promoting Safe and Stable Families (PSSF) program. The CWS and PSSF programs have overlapping purposes and can be used to fund similar types of services, including scaling up EBPs for children with complex trauma. However, each program has its own set of federal requirements. Through the CWS funds, states may provide services to support, preserve, and/or reunite

¹⁴ Children’s Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. (2011). Child and Family Services Reviews: Aggregate Report: Findings for Round 2 Fiscal Years 2007-2010. Washington, DC: Author

children and their families. States, territories, and tribes may provide training, professional development, and support to ensure a well-qualified child-welfare workforce. The approach encouraged in this letter is consistent with the requirement that states must describe, in their CFSPs, their efforts to provide child-welfare services on a statewide basis, to expand and strengthen the range of services available, and to develop and implement services that improve child outcomes (SSA section 422(b)(4)(A)) in order to receive title IV-B funding.

Through the PSSF program, states are required to spend 90 percent or more of the funding they receive on four specified categories of services: community-based family support, family preservation, time-limited reunification and adoption promotion and support. These services prevent maltreatment among at-risk families, address problems in a timely manner with families whose children have been placed in foster care so reunification can occur and support adoptive families to enable them to make a lifetime commitment to children.

Title IV-E funding use is limited to certain costs of providing for the care of children whom the title IV-E agency determines to be eligible. Funds are available for monthly maintenance payments for the daily care and supervision of eligible children and administrative costs to manage the program, such as recruiting foster parents and costs related to designing, implementing, and operating a statewide data collection system.

Under the title IV-E Foster Care and Adoption and Guardianship Assistance Programs, title IV-E agencies can also use title IV-E funding to support targeted child welfare training activities. Relevant allowable training topics can include referral to services, placement of the child, development of the case plan, case reviews and case management and supervision. Title IV-E agencies may offer training on the nature and consequences of child trauma, the use of screening and assessment tools and practices, and the array of EBPs to address trauma, including when they might best be applied.

Although these funds can be used to provide training to title IV-E child welfare staff, foster/adoptive parents, employees of private child placing and child care agencies, and other individuals listed in section 474(a)(3)(B) of the SSA, these dollars cannot be used to train individuals to treat child or family problems or behaviors. That type of training would support the delivery of social services rather than the administration of the title IV-E plan. More details on opportunities and limitations for using this authority to support training needs are provided in the Child Welfare Policy Manual (http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=116#2541).

New Child Welfare Legislative Authority

New child welfare legislative authority was provided through the *Child and Family Services Improvement and Innovation Act* (P.L. 112-34), which allows HHS to approve up to ten waiver demonstration projects in each of federal fiscal years (FFYs) 2012, 2013 and 2014. These demonstration projects, while providing no additional funding, allow child welfare agencies greater flexibility in using titles IV-E and IV-B funding to implement services that are likely to improve outcomes for children and families involved in the child welfare system.

States can choose to use this flexibility to build capacity related to training, screening, assessment and EBPs to improve the well-being of children who have experienced complex

trauma. The development and implementation of these demonstration projects can be strengthened through partnerships with state Medicaid programs and by leveraging other federal, state, and local resources in order to effectively and efficiently serve children. In its guidance inviting proposals under the renewed waiver authority, ACF encouraged child welfare agencies to explore partnerships with state mental health authorities and Medicaid to improve outcomes for children and families. Read ACF's Information Memorandum (ACYF-CB-IM-12-05 <http://www.acf.hhs.gov/programs/cb/resource/im1205>) that announces the child welfare waiver demonstration projects for FFYs 2012 – 2014 and includes information about applying.

Proposals and summaries of projects that were approved in FFY 2012, along with technical assistance documents can be found at: <http://www.acf.hhs.gov/programs/cb/programs/child-welfare-waivers>.

Additionally, the *Child and Family Services Improvement and Innovation Act* includes new requirements concerning the social-emotional and mental health of children who have experienced maltreatment. State CFSP, five-year strategic plans setting forth goals to strengthen each state's child welfare system, must now include details about how the agency will monitor and treat emotional trauma associated with a child's maltreatment and removal, as well as a description of how the use of psychotropic medications will be monitored. Read ACF's recent Information Memorandum (ACYF-CB-IM-11-06 <http://www.acf.hhs.gov/programs/cb/resource/im1106>) on the new law.

Discretionary Funding Awards

ACF is aligning its discretionary grant making to advance the guidance in this letter: building capacity to deliver screening, assessment, and EBPs related to trauma and social-emotional well-being. Examples of grants made in 2011 include five new discretionary awards for projects to integrate trauma-informed practice in child protective service delivery with a focus on strengthening capacity to deliver EBPs.

In 2012, ACF announced nine new discretionary awards to improve children's access to an evidence-based service array to meet behavioral health needs identified through screening and assessment. In addition, ACF released new funding opportunity announcements in the late spring and early summer, which can be accessed through the HHS Grants Forecast.

Links to resources:

Summary of FFY 2011 discretionary grants related to trauma-informed practice:
Integrating Trauma-Informed and Trauma-Focused Practice in Child Protective Services
(<http://www.acf.hhs.gov/grants/open/foa/view/HHS-2011-ACF-ACYF-CO-0169>)

Summary of all FFY 2012 grants:
Integrating Safety, Permanency and Well-being for Children and Families in Foster Care: A
Summary of Administration on Children, Youth and Families Projects in FY 2012
(https://www.acf.hhs.gov/sites/default/files/cb/acyf_fy2012_projects_summary.pdf)

New funding opportunities:
HHS Grants Forecast

<http://www.acf.hhs.gov/hhsgrantsforecast/index.cfm>).

Mental Health and Substance Abuse

In 2011, SAMHSA designated trauma as one of its key strategic initiatives, recognizing the central role that traumatic experiences play in mental health, physical health, and substance use disorders. During the past decade, SAMHSA has made significant investments in understanding different types of trauma across the life span, developing trauma-specific therapeutic interventions, and developing and implementing the concept of trauma-informed care in care-giving organizations. SAMHSA is continuing to develop and refine its working concept of trauma and guidance for a trauma-informed approach, which will be the foundation for establishing measures for population surveillance, clinical encounters, quality measures and a standardized approach to training on trauma.

Since 2001, SAMHSA has funded the National Child Traumatic Stress Initiative (NCTSI) to develop, disseminate, implement, and evaluate screening, assessment, and treatments for children, adolescents, and families experiencing a wide range of traumas. These include child physical and sexual abuse, community violence, homelessness, disaster, and medical and war-time and refugee related traumas. The NCTSI has brought improved access and availability of trauma screening, assessment and treatment interventions across the child age range for states and local communities and to children in multiple service sectors, including mental health, child welfare, juvenile justice, education, primary care and homeless/runaway settings.

SAMHSA's National Center for Trauma Informed Care (NCTIC) has promoted the implementation of a trauma-informed approach to care that prevents the re-traumatizing of individuals who enter treatment systems and recognizes the pervasiveness of trauma in lives of individuals in care-giving systems, whether health, human services, criminal justice, or primary care.

While SAMHSA does not have specific authorities or funding mechanisms focusing on children in the child-welfare system, it has significant funding efforts that focus on children with mental health needs that are inclusive of children who may be child-welfare connected. Children who have experienced trauma often have complex clinical presentations and thus qualify for mental health-funded programs and practices. Relevant SAMHSA funds are described below in the categories of State Block Grants funds and Discretionary Funding Awards.

SAMHSA Block Grants

SAMHSA awards formula-driven Mental Health Block Grants and Substance Abuse Block Grants to states and territories. The parameters for funding are established by law. However, there has been significant flexibility for states to determine how these funds are used. States use the Block Grant funding for treatment, recovery supports, prevention and other services that are not covered by Medicaid, Medicare or private insurance, or for services for individuals who are not insured. Specifically, the Block Grant funds priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time; and, priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery.

The revised Mental Health SAMHSA Block Grant Application (<http://www.samhsa.gov/grants/blockgrant/>) for 2014-2015 prioritizes trauma, children, and expanded SOC approaches for children and youth with mental health and substance use disorders. Through the Block Grant applications, SAMHSA encourages states to leverage mental health funds to develop and identify strategies that will build state and provider capacity to provide evidence-based trauma-specific interventions in the context of a trauma-informed delivery system.

Discretionary Funding Awards

SAMHSA has multiple funding opportunities well positioned to address the trauma and mental health needs of children in the child welfare system. SAMHSA's Children's Mental Health Initiative (<http://www.samhsa.gov/children/>) supports states, jurisdictions, the District of Columbia, territories, tribes and tribal organizations, in developing integrated home and community-based services and supports for children and youth with serious emotional disturbances and their families by encouraging the development and expansion of effective and enduring SOC. In 2012, in addition to the ongoing CMHI grants, SAMHSA developed the System of Care Expansion Grants aimed at state recipients with the intent to take the SOC approach statewide. A subset of these state grantees were then awarded SOC Implementation Grants to implement state plans developed in the SOC-Expansion grants. Information regarding System of Care Expansion Implementation Cooperative Agreements grants can be found at: http://www.samhsa.gov/grants/2012/sm_12_003.aspx. These grant programs focus on developing and implementing cross-systems infrastructure and services and providing support to states for EBPs for children and youth, including programs focused on trauma. The SOC framework inherently involves cross-sector collaboration, of which child welfare is a critical and consistently named partner by many of the state grantees.

As described earlier, the NCTSI is a significant part of SAMHSA's effort to address and treat trauma experienced by children and adolescents and to further a public health approach to trauma that strengthens surveillance, prevention, screening and treatment and supports trauma-informed systems. The initiative is designed to address child trauma by supporting a national network of grantees, the National Child Traumatic Stress Network (NCTSN), which works collaboratively to develop and disseminate effective community-based practices for children and adolescents exposed to a wide array of traumatic events. Grantees provide an extensive array of trauma-specific interventions in community-based provider settings and a comprehensive series of trainings in trauma and trauma treatments to build the provider capacity in states and communities. Historically, many of these grantees have focused on youth in the child-welfare system.

The 2012 NCTSI funding awards continue to address the trauma-related needs of children and youth involved with child welfare and juvenile justice systems. These new grantees support increased capacity to address the complex trauma issues of youth in these systems. The list of 2012 NCTSI awardees is available online at: <http://www.samhsa.gov/grants/2012/index.aspx>.

Future SAMHSA grant announcements will be posted on the HHS Grants Forecast online (<http://www.acf.hhs.gov/hhsgrantsforecast/index.cfm>).

Medicaid

CMS is committed to working in partnership with states to ensure coverage of needed benefits and establish effective service delivery options for children and youth who have experienced complex trauma. CMS is prepared to offer technical assistance to states pursuing the opportunities described below and throughout this letter.

Under the EPSDT benefit, eligible individuals are entitled to periodic screening services (well-child exams) as defined by the statute. One required element of such screening services under section 1905(r) of the Social Security Act (the Act) is “a comprehensive health and developmental history (including assessment of both physical and mental health development).” CMS expects that part of this assessment should include an age-appropriate behavioral health screening. Early detection and treatment of behavioral health issues, including mental illness and substance use disorders, is important in the overall health of a child and may reduce or eliminate the effects of a condition when identified and treated early. Additionally, as the statute specifies, other necessary health care, diagnostic services, treatment and other measures coverable under section 1905(a) of the Act must be made available to “correct or ameliorate” any physical and mental illnesses or conditions discovered by the screening services, whether or not the services are covered under the state plan.

In addition to the required periodic screenings, Medicaid-eligible children are entitled to inter-periodic screenings in order to identify a suspected illness or condition not present or discovered during the periodic exam.¹⁵ An inter-periodic screening may also trigger the need for further diagnostic or treatment services, including services related to behavioral health issues. A change in living circumstance (like a foster care placement move), a change or presentation of acute behavioral health needs (like a school suspension due to behavior, an inpatient psychiatric admission, or a referral to residential psychiatric care), and entry into the foster care system are all events that may elicit the need for an inter-periodic screening.

We describe below a variety of authorities and service-delivery approaches. Under some of these authorities, enhanced Federal Financial Participation (FFP) is available.

State Plan Services Described in Section 1905(a) of the Act

Services to meet children’s behavioral health needs may be covered under several service categories described under section 1905(a) of the Act. For example, certain behavioral health services may be covered under rehabilitative services at 42 CFR 440.130(d), including interventions such as cognitive behavioral therapy, crisis management services, peer supports, or family therapy. Other service categories support reimbursement for targeted case management or services provided by licensed practitioners such as psychiatrists, psychologists, or clinical social workers.

Beginning in 2013, enhanced FFP is authorized under section 1905(b) of the Act, as amended by section 4106 of the Affordable Care Act, if states elect to provide coverage of preventive

¹⁵ Section 5140(B), *State Medicaid Manual*.

services that are assigned a grade of A or B by the U.S. Preventive Services Task Force (USPSTF). Coverage includes adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Cost sharing for such services must not be imposed on beneficiaries. Included among clinical preventive health care services are a broad variety of mental health services and supports.
(<http://www.uspreventiveservicestaskforce.org/3rduspstf/behavior/behsum1.htm>).

Alternative Benefit Plans

Section 1937 of the Act provides states with significant flexibility to design Medicaid Alternative Benefit Plans (ABP) to provide specially designed benefit packages. ABPs must include coverage of EPSDT and must comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act of 2008 in the same manner as group health plans.¹⁶ Beginning January 1, 2014, ABPs must also include essential health benefits, including mental health and substance use disorder benefits. States can design ABPs that are based on certain public employee or commercially available health care coverage plans, or are based on the standard Medicaid package, supplemented as necessary to provide coverage of essential health benefits and EPSDT. States can add services to meet the needs of certain populations or residents of certain geographic areas. While there are some populations who may not be required to enroll in an ABP, they can still be enrolled in an ABP on a voluntary basis. For example, children in foster care or children who have serious emotional disturbances as a result of trauma may participate in ABPs designed to comprehensively meet their unique needs. This link provides a description of a state serving children in foster care through section 1937 authority: <http://www.dhs.wisconsin.gov/mareform/foster/FosterCareMedicalHome.pdf>.

Home and Community-Based Services

In addition to the EPSDT benefit covered under section 1905(a) of the Act, other Medicaid authorities provide states with opportunities to further meet individuals' behavioral health needs. Section 1915(i) of the Act, State Plan Home and Community-Based Services, permits states to provide a full array of home and community-based services to individuals whether or not they qualify for an institutional level of care, as long as they have significant need. This can include individuals with mental health or substance use disorders. This link provides a description of a state's program for serving children in foster care through section 1915(i) authority: <http://www.dphhs.mt.gov/mentalhealth/children/i-home/PolicyManual.pdf>

A state can also use section 1915(c) home and community-based services waiver programs to cover similar services and serve individuals with significant needs who meet institutional level of care criteria. Examples of services and supports beyond those covered under EPSDT may include psychosocial rehabilitation, respite care, transition services and social skill development.

¹⁶ State Health Official/State Medicaid Director Letter describing the application of the Mental Health Parity and Addiction Equity Act of 2008 to Alternative Benefit Plans, <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>.

Health Homes

Section 2703 of the Affordable Care Act provides states with the option to cover health home services for beneficiaries. Health homes provide comprehensive care management; care coordination; health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up care; individual and family support; referral to community and support services; and the use of health information technology to link services. States can target health home models to specific populations based on specified chronic conditions, including serious or persistent mental health conditions. While age is not an allowable targeting criteria for health home participation, CMS recognizes that the available providers and the treatment modalities and protocols may involve different approaches for children as compared to adults for key health home activities such as coordinating, managing, and monitoring services; therefore, states may develop different qualifications and protocols for health home providers that serve different age groups based on distinctions between the health home needs of the population.

To assist states in the development of health homes, health home services receive enhanced FFP of 90 percent for the first eight quarters following establishment of a specific health home model. States have significant flexibility in the design of health home models, including in the development of payment methodologies. For example, states may structure a tiered payment methodology that accounts for the severity of each individual's chronic conditions and the capabilities of the designated providers. States may submit alternative models that are designed to improve service delivery, provide for quality health outcomes for participants and help document evaluative measures.

In collaboration with SAMHSA, CMS has developed a guiding document (http://www.samhsa.gov/healthreform/docs/Guidance_Doc_Health_Homes_Consultation_Process.pdf) to assist states to prepare for implementing health homes for individuals with behavioral health needs.

Links to states with health homes include the following: <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html>.

Managed Care

States may deliver Medicaid-covered services through managed care plans. States must continue to assure access to the full set of state plan services, including EPSDT. In addition, managed care plans may be required by contract to provide care management and coordination activities. States receive approval from CMS to operate a managed care delivery system through a variety of authorities, including under a state plan option, section 1915 waivers, and section 1115 demonstration projects. While 42 CFR Part 438 provides that children in foster care out-of-home placements and children receiving foster care adoption assistance cannot be mandated into managed care under the state plan option, some states have used waiver authority to mandate enrollment for this population. Currently, states are using three managed care models to serve children in foster care: plans that serve the general Medicaid population; plans with special

networks qualified to meet the behavioral health needs of children; and plans that serve only individuals with special needs.

The following is a link to a state using managed care authority for children in foster care:
<http://www.dhs.wisconsin.gov/badgercareplus/faq.htm>

Integrated Care Models

Integrated care models (ICMs) can be adopted to promote coordinated, person-centered and comprehensive care. Section 1905(a)(25) and, by reference, 1905(t)(1) of the Act allow states to provide coverage and payment for case management services that coordinate, locate and monitor health care services. Payment methods include fee-for-service; per-member per-month rates; incentive payments for meeting certain goals; and shared savings based on the total cost of care measured against performance periods. ICM providers include individual practitioners, physicians, nurse practitioners, certified nurse-midwives, or physician assistants. Providers may also include physician group practices, or entities employing or having arrangements with physicians to provide such services.

State Medicaid Directors Letters on Integrated Care Models can be found at
<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf> and
<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf>.

Section 1115 Research and Demonstration Programs

States seeking to implement an experimental Medicaid pilot or demonstration project may use the authority of section 1115(a) of the SSA. To promote the purpose of the Medicaid program, certain sections of Medicaid statute may be waived or federal financial participation may be made available for costs not otherwise within the scope of the Medicaid program. Through section 1115 demonstrations, many states have been approved to implement innovative, budget-neutral concepts for expanding who may be served, covering new services or other approaches for improving their Medicaid programs.

A State Health Official Letter concerning the section 1115 application process can be found at the following link: <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-12-001.pdf>.

Moving forward, CMS is releasing a series of Informational Bulletins to provide additional information regarding services and supports to meet the health, behavioral health, and long-term services and support needs of individuals with mental health or substance use disorders. Of particular note are the recently released bulletins regarding services and good practices for individuals with behavioral and mental health disorders: Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, (http://content.govdelivery.com/attachments/USCMS/2012/12/03/file_attachments/178580/CIB-12-03-2012.pdf) and Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions (<http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>).

CMS also recently released the Center for Medicaid and CHIP Services CMCS Informational Bulletin on Prevention and Early Identification of Mental Health and Substance Use Conditions, which addresses prevention of and early intervention for mental health conditions in children, youth, and adults; see (<http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf>). This bulletin includes information regarding screens that can be used to identify the early onset of mental illness (encompassing conditions related to trauma and suicide), or substance use, including strategies for enhancing states' efforts to comply with EPSDT requirements.

V. Quality Impact of Addressing Child Trauma

For children and youth exposed to adverse events and involved with the child welfare system, integrated use of trauma-focused screening, functional assessments, and EBPs in child-serving settings will likely result in improved social, emotional and health outcomes. When care coordination is optimal, mechanisms for seamless information sharing and assessment-driven treatment planning create a system in which youth are regularly screened and assessed for needs and receive high-quality, efficacious interventions that improve social and emotional well-being.

Key to success is measuring outcomes and using on-going progress monitoring to determine the extent to which the approach taken is making a difference. Quality improvements may include:

- Reduction in the number of children with a clinical level of need receiving no services;
- Increase in the number of children receiving evidence-based screening, assessment and treatment;
- Reduction in the use of “deep-end” services, including emergency department visits for acute crisis stabilization and residential treatment for extended periods;
- Reduction in the use of psychotropic medication prescribing practices that do not conform with the American Academy of Child and Adolescent Psychiatrists Practice Parameters;
- Reduction in the number of psychotropic medications prescribed and a reduction in the total number of youth with prescriptions for psychotropic medications;
- Reduction in the use of foster home placements to include re-entries into care;
- Net increase of Medicaid-participating EBP-trained clinicians; and
- Improvements in child functioning across well-being domains and reductions in trauma symptoms.

Integrated approaches in the area of child behavioral health have had success in reducing costs while improving care. The following link describes a state's cost-effective innovations based on collaboration among agencies serving children in foster care who have experienced complex trauma: <http://www.wsipp.wa.gov/rptfiles/12-04-1201.pdf>.

VI. Conclusion

The impact of complex trauma for children who have experienced maltreatment can be profound, derailing them from healthy development, impairing social and emotional functioning, and compromising health. These effects can be addressed, however, and children can heal and recover. CMS, SAMHSA, and ACF are committed to improving the life outcomes for children

who have experienced the complex trauma associated with child abuse and neglect and exposure to violence and are prepared to offer technical assistance as needed.

We are encouraged by the growing interest and action in states, territories, and tribes to implement effective approaches to address the specific needs of this vulnerable group of children and their families. This letter has been provided in an effort to help further that work, and we hope the information is both helpful in your current efforts and spurs new thinking, new partnerships, and increased capacity to deliver the screening, assessment, and evidence-based practices that can help children and youth get back on track developmentally.

Sincerely,

/s/

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/s/

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/s/

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