COMPLEX CARE
AND TRIBAL ADVOCACY

Complex care refers to circumstances in which youth have a variety of needs that have been unmet by behavioral health, child welfare, probation, education and other systems. As a result, these youth need high intensity, individualized treatment options to better resolve challenges and address their needs.

COMPLEX CARE AND INDIAN CHILDREN

With California Native children being more than four times as likely to be placed in foster care than white children, issues related to foster care and complex care are of priority concern to tribal providers. Advocacy in the area of complex care is a critical exercise of ICWA and tribal oversight.

ICWA ELIGIBLE YOUTH LIVING IN **GROUP HOMES**

CCWIP, 2023

10%

The number of tribal foster children living in congregate care in California has steadily decreased in the past decade by 38%, matching national foster care trends. (CCWIP, 2023) This marks a systemwide understanding of the negative impacts of congregate care, though disparities remain. Youth are at greater risk for further physical abuse when they are placed in group homes, compared with their peers placed in families. (Ryan et al, 2008) State, county and local systems have a responsibility to better serve tribal youth with complex care needs.

AB 153

Assembly Bill 153 allocated $61.3 million to counties and IV-E Agreement Tribes to provide additional services and develop programs to serve children with complex or co-occurring needs. Counties should consult with any Tribe that has children under the county's jurisdiction regarding the availability of this funding and how it can best serve tribal children in their care. (ACIN I-18-22)

$61.5 MILLION FOR COMPLEX CARE NEEDS

BOARDING SCHOOL HISTORY AND CONTEMPORARY IMPLICATIONS

Separating tribal children from their communities by way of congregate care harkens back to Indian Boarding School Era practices of forcibly removing tribal children from their communities. This history and its implications are generally well-known in tribal communities, but may not be known to county providers working with tribal children and families. For example, research indicates that having a parent or grandparent who attended boarding school is associated with a near doubling the likelihood of suicidality. (Bombay et al, 2014) It is critical for providers to understand this historical context when making treatment and placement decisions for tribal children. See Resources below for more information.

COMPLEX CARE

AND TRIBAL ADVOCACY

COMPLEX CARE WITHIN THE COMMUNITY

When considering how to meet the multiple needs of a youth in care within the community, there are a number of opportunities to consider. County child welfare agencies should be exploring and exhausting these opportunities with the tribal social worker prior to considering congregate care.

WRAPAROUND

A family-driven model designed to resource community based services to coordinate care across life domains.

IN HOME BEHAVIORAL SERVICES AND KATIE A. SUBCLASS SERVICES

Intensive in-home and in-community mental health services available via county behavioral health and contracted providers.

INTENSIVE SERVICES FOSTER CARE

ISFC can support a rate up to the STRTP rate for a parent to provide a child's placement in a family setting.

SCHOOL SUPPORTS VIA INDIVIDUALIZED EDUCATION PLANS (IEPs) and 504 PLANS

Children eligible for an IEP or 504 have the right to an educational program designed to meet their individual needs. Supports included in the plan can include one on one behavioral support.

DEVELOPMENTAL REGIONAL CENTER SERVICES

Children eligible for regional center services are entitled to supports that meet their developmental needs, which can include intensive in-home and in-community support.

SERVICES SHOULD ALLEVIATE, NOT ADD TO FAMILY STRESSORS

The intention of intensive services delivery is to alleviate existing stressors to the family system to preserve the child's placement within community. However, tribal providers throughout the state have shared that is not always the case. Poor service provision can be culturally inappropriate, task the family with additional "homework" rather than alleviate the multiple stressors across life domains they may be experiencing, and/or be of insufficient duration, frequency or inaccessible due to barriers of distance and transportation. Tribal providers are strongly encouraged to address poor service delivery and/or care coordination early on by notifying agency leadership, contacting the ombudsman, and documenting the grievance.

INSTITUTIONS ARE NOT AN ALTERNATIVE TO COMMUNITY CARE

Tribal providers can advocate by reminding county service providers of their responsibility to offer adequate care within the tribal child's community, regardless of the remote or rural location of placement.

TRIBAL SERVICE DELIVERY AND FFPSA

Tribes and tribal agencies continue to grow their social and behavioral service menu, and can be contracted with to deliver culturally driven services that meet the holistic needs of the tribal child and family. As California counties develop their Family First Prevention Services Act (FFPSA) plans, tribes are critical partners in meeting the unique and varied needs within their respective tribal communities. Tribal agencies are encouraged to engage in discussion related to contracting with their respective counties and advocate for reimbursement when service delivery is provided. These services may make the difference needed to keep a tribal child within their community.

COMPLEX CARE

AND TRIBAL ADVOCACY

CONGREGATE CARE

Congregate care is an umbrella term that refers to out of home care in institutions or group home like settings. These are typically the most restrictive placement settings available, however may be necessary to meet the Indian child's individualized treatment needs.

"GOOD CAUSE"

California Law sets out a list of factors that may constitute good cause not to follow ICWA placement preferences, to include:

1. The request of the biological parents or the child when the child is of sufficient age;
2. The extraordinary physical or emotional needs of the child as established by testimony of qualified expert witnesses; or
3. The unavailability of suitable homes that meet the preference criteria after a diligent search and "whether a placement is unavailable shall conform to the prevailing social and cultural standards of the Indian community." (WIC 361.31(j)(5))

A placement shall not depart from the preferences based solely on ordinary bonding or attachment that flowed from time spent in a nonpreferred placement made in violation of ICWA. (WIC 361.31(l))

SHORT TERM RESIDENTIAL THERAPEUTIC PROGRAMS (STRTP)

STRTPs were established in 2017 by Continuum of Care Reform with the intent to reduce the time children live in congregate care. STRTPS vary widely, but must provide 24-hour care as well as some Medi-Cal specialty mental health services. You may also hear the term Qualified Residential Treatment Programs (QRTP), which is the federal term established by FFPSA. Currently, there are over 340 licensed STRTPs in California. Additionally, there are lower level group home settings available that may or may not be appropriate based on complexity of needs. (See CCL Facility Search Lookup.)

WHAT YOU NEED TO KNOW

A county seeking to place a child in congregate care via an STRTP or out of state placement must obtain an assessment from a Qualified Individual (QI) who determines the setting which will provide the child with the most effective and appropriate level of care in the least restrictive environment, consistent with the short- and long-term goals for the child, as specified in the permanency plan. (BCIN 21-060)

QUALIFIED INDIVIDUALS (QI)

QI Assessments are typically conducted by county behavioral health clinicians. An individual may also be designated by the child's tribe as the QI. In the absence of that designation, the QI must have specialized knowledge of, training about, or experience with, tribes and ICWA. (BCIN 21-060)

WHAT TO LOOK FOR IN THE QI ASSESSMENT

1. The QI must confer with the child's tribe as part of the assessment. Did the QI contact the tribal designee and conduct a thorough interview?
2. Is the tribe's position accurately reflected in the QI assessment?
3. Was the QI Assessment process discussed through Child and Family Teaming?

QI ASSESSMENT TIMELINES

Unless an emergency placement, the QI must conduct the assessment prior to placement, and has **30 days from time of referral** to complete the assessment.

Emergency Placements: The placing agency caseworker shall notify and engage CFT members **within 1 business day of placement**, and submit a QI referral within 2 business days of placement.

CCL FACILITY SEARCH LOOKUP

Community Care Licensing maintains a transparency facility search lookup website, where you can find details about specific licensed STRTPs and other residential settings, to include recent citations, inspections, complaints and reports conducted by CCL.

COMPLEX CARE

AND TRIBAL ADVOCACY

ATTENDING TO ACTIVE SUICIDALITY

Tribal youth experience suicide at higher rates than any other demographic (CDC, 2023), and attending to youth suicidality in tribal communities can be among the most complex work for tribal providers. When youth are actively suicidal or have just attempted suicide, a timely response is critical and may warrant an involuntary hold.

Dial 988

The preferred national response to suicidality, 988 crisis line staff can support tribal providers navigate complex situations over the phone and help determine whether a call to 911 is warranted.

INVOLUNTARY HOLDS

5150-HOLD

Up to a 72-hour involuntary hold for adults.

5585-HOLD

Up to a 72-hour involuntary hold for minors.

5250-HOLD

Up to a 14-day involuntary hold for BOTH adults and minors. These, as well as any extensions requested by the holding facility, must be reviewed by the court.

WHO CAN PLACE A HOLD

Only Peace Officers and designated county personnel can place a hold, though these individuals should be conferring with the parent/guardian, **tribe** and other providers when making determinations about whether to place the hold.

HOLD CRITERIA

In order to place an involuntary hold, the youth must meet one of the following criteria:

1. Danger to self
2. Danger to others
3. Gravely disabled (unable to provide for their own food, clothing, shelter) even though provided to minor by others (WIC 5585.25)

ADVOCATING FOR A HOLD

Designated personnel may be resistant to placing a hold if they are unable to verify the youth meets criteria. While this should not be a consideration, severe shortages in availability of bed space in suitable facilities also impacts decision-making. Youth may also be more transparent with trusted providers and withhold information from designated personnel. Tribal providers can advocate for a hold in these situations. Examples follow.

USE A TOOL TO IDENTIFY HIGH RISK

A universally recognized screening tool such as the Columbia Suicide Severity Rating Scale offers a measurable way to identify risk with a corresponding recommended response. Providing these results to the designated personnel documents the measured need for intervention.

VIEW THE CRISIS AS A MENTAL HEALTH EMERGENCY

Responders may arrive at the scene and mis-identify a youth experiencing a mental health crisis as a criminal matter. Advocate for the crisis to be viewed as a mental health emergency. You can do this as early as when speaking with dispatch by requesting an ambulance or crisis clinician in lieu of law enforcement to respond.

RESOURCE THE CLINICAL TEAM

Clinical providers familiar with the youth can assist in communicating the youth's typical presentation and highlighting the differences in current behaviors that present the danger.

WHAT HAPPENS NEXT

Once a hold is placed, youth may be transported by ambulance or law enforcement to a Crisis Stabilization Unit or ER. From there, youth must be discharged with an aftercare plan as soon as they no longer meet criteria. (WIC 5585.57) If, after 72-hours, the youth is unable to be discharged, a 5250-hold will be submitted to the court for review and, pending approval, the youth will either remain at the hospital/CSU or else be transported to a Psychiatric Health Facility. (WIC 5250)

COMPLEX CARE
AND TRIBAL ADVOCACY

TREATMENT VERSUS PLACEMENT

A youth in crisis may simultaneously risk a loss of placement during that time. This could be due to a variety of factors, to include caregiver fatigue and a belief that access to treatment can only be facilitated by giving up placement. Parents and guardians may also sustain a belief that refusing to take their child back is a necessary step in accessing treatment for their child, and misinformed providers may reinforce this belief. Tribal providers who encounter these beliefs can support the family with understanding their child's complex needs as a need for treatment, which may necessarily include short and long-term residential treatment options. Treatment should be understood as a necessary rehabilitative step to support the child's return home, and not confused with placement. Accessing these treatment options can be accomplished by a variety of avenues, which may include a Voluntary Placement Agreement (VPA) and may or may not require formal child welfare intervention. (Alliance for Children's Rights, 2021) Especially for Indian children living at home and in tribally preferred placements, every effort should be made to preserve and support family and relative placement.

GROUP HOMES ARE NOT IN-PATIENT TREATMENT

While STRTPs offer a treatment component in their service array, services and scope vary widely and may not meet the child's complex needs. (CDSS STRTP Interim Licensing Standards, 2023) Lower level group homes and transitional housing may offer a variety of case management and outpatient mental health services, but these should not be confused with the higher level of care offered by in-patient treatment options. Be wary when providers seeking placement options revert to placement options that do not meet the child's complex treatment needs.

MEDI-CAL COVERED IN-PATIENT

The following treatment options are covered by Medi-Cal insurance.

CRISIS STABILIZATION UNITS (CSUs)

Licensed by DHCS, CSUs provide short-term, 24-hour inpatient care and are designed to address immediate behavioral health crises, though scope of services vary widely. DHCS maintains an active list of CSUs by county.

PSYCHIATRIC HEALTH FACILITIES (PHF)

Licensed by DHCS, PHFs provide 24-hour inpatient care for mentally disordered, incompetent, or other persons as described in WIC. Care includes: psychiatry, clinical psychology, and psychiatric nursing beyond what can be offered in residential (i.e. STRTP) settings. Currently there are just four PHFs that accept youth in the state. DHCS maintains a current Dataset of licensed PHFs.

IHS COVERED IN-PATIENT

The following treatment options are covered by Indian Health Services (IHS) via direct or Purchase Referred Care (PRC).

IHS YOUTH RESIDENTIAL TREATMENT CENTERS

Currently, Indian Health Service maintains two Youth Residential Treatment Centers in California and several more throughout the country. These centers are designed to treat co-occurring substance use disorders in youth ages 12-17 and may not be appropriate for youth who are actively suicidal.

PURCHASE REFERRED CARE

IHS may determine a private pay or private insurance facility to be the only suitable treatment option for a youth's complex needs and support payment for this treatment. However, children with active child welfare cases should first be served by the responsible county agency.

COMPLEX CARE
AND TRIBAL ADVOCACY

PRIVATE INSURANCE OPTIONS

There are a variety of Residential Treatment Centers accepting private pay or private insurance throughout the state serving a range of specialty diagnoses. While the services provided may be best suited to support a youth's treatment, often they are financially prohibitive. In these cases where most appropriate treatment is identified, tribal providers are encouraged to advocate with the county child welfare agency involved to resource the Complex Care funding counties receive to ensure tribal children receive appropriate, individualized treatment that allows them to safely return to their communities. Psychology Today maintains a list of Teen and Adolescent Residential Treatment Centers in California.

WHAT IF THE FACILITY WANTS TO DISCHARGE PREMATURELY?

Due to the widely known lack of treatment options available, tribal providers may find that facilities want to discharge a youth without an adequate or safety plan in place for discharge. Concerns may include:

- Youth remains actively suicidal, continuing to voice intent and/or plan;
- Inadequate services are in place to maintain the child's safety upon discharge, the family is voicing they cannot attend to safety.
- Facility is giving notice or voicing the child needs a higher level of care

Planning for discharge should occur as soon as admission, however discharge of a youth who remains in crisis should only occur to an appropriate level of care. If you believe premature or inadequate discharge planning is occurring with a tribal youth, you can act by notifying agency leadership, contacting the ombudsman, documenting the grievance and presenting your concerns in court.

STEP DOWN PLANS AND RETURNING TO COMMUNITY

Planning for discharge should occur as soon as admission to ensure adequate supports are in place when the youth is ready to return home safely. Once a youth achieves treatment goals and is ready to return to community, discharge planning should include intensive home-based and community services that can support the transition from 24-hour therapeutic care to less frequent services. Greater than weekly frequency and duration is recommended to transition from 24-hour care to community living. See Page 3, Complex Care within the Community, for examples of intensive, community based services the child and family team can explore implementing prior to discharge.

RESOURCES

1. Voluntary Placement Agreement Self-Advocacy Guide Alliance for Children's Rights, 2021
2. Notional Directory of Crisis Services for Indigenous People
3. CDSS Complex Care Resource Guide
4. Stanford Child & Adolescent Mental Health ECHO Program
5. Congregate Care in the Age of Family First, ACF 2020
6. Away From Home: Youth Experiences of Institutional Placements in Foster Care, Think of Us, 2021
7. Group Placement Impacts, Casey Family Programs, 2022