# HEALTH

STAR HEALTH

CHILDREN WITH DISABILITIES

PSYCHOTROPIC MEDICATION

SUBSTANCE USE DISORDERS

TRAUMA-INFORMED CARE

# HEALTH CARE FOR TEXAS CHILDREN IN FOSTER CARE: STAR HEALTH

**Please see Checklist Section for the Medical and Mental Health Care for Foster Youth Checklist.**

STAR Health is a comprehensive, managed care program designed to better coordinate and improve access to health care for:

- Children in DFPS conservatorship (under age 18);
- Youth in CPS Extended Foster Care (ages 18 through 21);
- Youth who were previously under DFPS conservatorship and who have returned to foster care through voluntary foster care agreements (ages 18 through 20); and
- Youth who aged out of foster care at age 18 and who are eligible for Medicaid services (ages 18 through 20).

Not all children are eligible for the STAR Health program. STAR Health does not cover children who are:

- In state conservatorship who are placed outside of Texas;
- From other states but placed in Texas;
- From other states who are placed in Texas Medicaid-paid facilities such as children in nursing homes, ICF-IIDs, or State-Supported Living Centers; or
- In DFPS conservatorship but adjudicated and placed in a Texas Juvenile Justice Department facility. (This population receives health care services through TJJD.)

Unless otherwise indicated, children who are ineligible for STAR Health benefits receive Medicaid through the Traditional Fee-for-Service program.

Adoption Assistance/Permanency Care Assistance (AA/PCA)

- Children in Adoption Assistance or Permanency Care Assistance will be enrolled in STAR or STAR Kids after a transition period. During the transition period they remain enrolled in STAR Health.

## A. Unique Features of STAR Health

For those children who are covered by STAR Health, STAR Health provides a full range of Medicaid-covered medical, dental, vision, prescription, and behavioral health services, including:

- A Medical Home for each child (meaning a doctor, or other Primary Care Provider (PCP), or PCP Team to oversee care);

- Immediate enrollment for immediate health care benefits;
- Licensed and degreed Managed Care Organization (MCO) staff and service coordination and service management teams who coordinate physical and behavioral healthcare and access to other non-Medicaid benefits and resources, including for complex cases;
- Access to healthcare through a network of providers (doctors, nurses, hospitals, clinics, psychiatrists, therapists, etc.) specifically recruited for their history and expertise in treating children who have been abused or neglected and who are offered ongoing trainings on such issues;
- The Health Passport, which is a web-based, secure health information tool which utilizes claims data to provide information on healthcare services including Texas Health Steps medical checkups, immunizations, lab results, prescriptions, the Family Strengths and Needs Assessments (FSNA), the Texas Child and Adolescent Needs and Strengths (CANS) 2.0 assessments, Psychotropic Medication Utilization Reviews (PMUR), and service plans to medical consenters, caseworkers, and healthcare providers;
- PMURs to determine if the prescribed medication treatment meets the guidelines of the Psychotropic Medication Utilization Parameters for Children and Youth in Texas Public Behavioral Health (6th Version) (Parameters);[95]
- STAR Health liaisons who work directly with DFPS Well-Being Specialists and DFPS Clinical Coordinators to assist with resolving any barriers to services that children in foster care might encounter;
- Transition coordinators to assist youth with activities to ensure a smooth transition to independence and adulthood, including education about their medical care and referrals to support services, as needed;
- Nursing and Behavioral Health 24/7 helplines for caregivers and caseworkers; and
- Medical advisory committees to monitor healthcare provider performance.

## B. Physical Healthcare Benefits Provided by STAR Health

Medicaid-covered physical health care benefits include but are not limited to:

- Ambulance services;
- Applied Behavior Analysis services for the treatment of autism for children through 20 years of age;
- Birthing services provided by a physician and Certified Nurse Midwife (CNM) in a licensed birthing center;
- Cancer screening, diagnostic, and treatment services;
- Chiropractic services;

- Community First Choice[96] services, which is a federal program that includes personal assistance services, habilitation, emergency response services, and support consultation;
- Dental services;
- Durable medical equipment and medical supplies;
- Early Childhood Intervention (ECI) services;
- Family planning;
- Hearing exams/hearing aids;
- Home health care services, such as private duty nursing, skilled nursing, and personal care services;
- Hospital care, including emergency and inpatient services;
- Lab tests/x-rays;
- Physical, occupational, and speech therapies;
- Podiatry;
- Prenatal care;
- Prescription drugs and biological drugs;
- Preventive care through Texas Health Steps;
- Specialty physician services;
- Telemedicine/telehealth services (applies to certain procedure codes);
- Organs and tissue transplant services; and
- Vision services.

## C. Behavioral Health Benefits Provided by STAR Health

Medicaid-covered behavioral health benefits include but are not limited to:

- Outpatient Mental Health Services to include psychotherapy (individual, group, and family), psychiatric diagnostic evaluation with and without medical services, psychological, neurobehavioral and neuropsychological testing, and pharmacological management;
- Mental Health Targeted Case Management to include intensive and routine case management services;

- Mental Health Rehabilitation Services to include crisis intervention services, medication training and support, and skills training and development (can be provided to the child/youth, Legally Authorized Representative [LAR] or primary caregiver);
- Inpatient psychiatric services that include admissions to acute care hospitals and institutions for mental disease (public or private psychiatric facility);
- Substance use disorder services to include assessment, counseling (individual and group), residential treatment, and withdrawal managements services;
    - also includes Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for persons 10 years of age and older;
- Health and Behavior Assessment and Intervention (HBAI) services;
- Collaborative Care Model services that integrate the services of behavioral health care managers (BHCMs) and psychiatric consultants with primary care provider oversight to proactively manage behavioral health conditions as chronic diseases, rather than treating acute symptoms.
- Telemedicine/telehealth services (applies to certain procedure codes); and
- Court-ordered services (outpatient and inpatient) if the person is not considered to be incarcerated.

## D. Transitioning Foster Care Youth

The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), requires states to provide Medicaid coverage to youth and young adults under age 26 who were in foster care and were receiving Medicaid when they aged out of foster care.

The Former Foster Care Children (FFCC) program provides healthcare coverage to youth who aged out of foster care at age 18, were receiving Medicaid coverage at the time they aged out, who are a U.S. citizen, and meet all other Medicaid eligibility criteria. This coverage is available through age 25 under two separate programs, based on age:

- Young adults ages 18 through 20 are automatically enrolled in the STAR Health program, but can switch to the STAR program, if they prefer; and
- Young adults ages 21 through 25 must choose a STAR or STAR+PLUS program health plan.

For foster youth who are under the age of 21 but who are not eligible for the FFCC program because the youth did not receive Medicaid at the time they aged out of care, coverage is provided by the Medicaid for Transitioning Youth (MTFCY) program in STAR Health for youth who:

- Were in DFPS conservatorship on their 18th birthday or older;
- Do not have other health coverage and meet program rules for income;

- Meet program rules for income; and
- Are a US citizen or have a qualified alien status, such as a green card.

It is not necessary for a court to extend jurisdiction beyond age 18 for this coverage to apply. For more information, see the *Extending Foster Care for Transitioning Youth* chapter of this Bench Book.

***Special Issue:*** *All Medicaid recipients, including youth formerly in foster care, must renew their Medicaid eligibility once every 12 months. To ensure continuous coverage, youth must provide their current mailing address to HHSC. If a youth changes their address without notifying HHSC, and HHSC receives returned mail and cannot locate the youth, the youth's Medicaid benefits will be denied. A youth can report an address change online through www.YourTexasBenefits.com, the Your Texas Benefits mobile app, calling 211, in person at a local Medicaid eligibility office, or by reporting in writing by mail or by fax. Youth must also respond to requests for information from HHSC and may need to verify that they are a Texas resident or their immigration status.*

## E. Child and Family Assessments

**Texas Health Steps:** All children entering DFPS conservatorship must receive a comprehensive, preventive health care checkup within 30 days of entering DFPS conservatorship known as the "Texas Health Steps" medical checkup. The checkup helps identify the child's unique healthcare needs and helps DFPS make decisions that are in the child's best interest. This checkup is repeated annually or according to the Texas Health Steps periodicity schedule.

**Medical Exam Within Three Business Days:** All children entering DFPS conservatorship receive an initial medical examination from a physician or other health care provider authorized by state law to conduct a medical examination by the end of the third business day after the child is removed from the child's home. Tex. Fam. Code § 264.1076. This is known as the "Three-Day Exam." Exceptions include the youth being in an inpatient hospital setting or requiring urgent medical treatment at the time of removal.

**Vaccinations Prohibited During Exam**: A physician or health care provider cannot administer a vaccination at this "Three-Day Exam" without parental consent except for an emergency tetanus vaccination, and only if the physician or other health care provider determines that an emergency requires a vaccination. The prohibition of vaccinations does not apply once DFPS is named the child's managing conservator. The restriction on vaccinations applies only to vaccinations (except for tetanus) administered under the medical exam required by Tex. Fam. Code § 264.1076. Thus, the prohibition is limited only to the population receiving the exam, and only restricts what can be done during the exam. This restriction is lifted once DFPS is granted conservatorship. Outside of these circumstances, the law neither expands nor restricts a parent's right to withhold consent for immunization either under Tex. Fam. Code § 32.101 or Tex. Health & Safety Code § 161.004. However, see Tex. Fam. Code § 266.002 and Tex. Fam. Code § 266.004 regarding a court's authorization to issue orders related to medical care for children in foster care. See *In re Womack*, 549 S.W.3d 760 (Tex. App.—Waco 2017) holding that to the extent Tex. Fam. Code § 266.004 and Tex. Fam. Code § 32.101(c) conflict, Tex. Fam. Code § 32.101(c) is more specific and is the controlling statute.

**Texas Child and Adolescent Needs and Strengths (CANS) 2.0 Assessment:** Children and youth ages 3 to 17 must receive a CANS 2.0 Assessment completed by an in-network STAR Health clinician within 30 days of removal. Prior to conducting the CANS, the CPS caseworker will conduct the FSNA with the family, identify targeted interventions, and work with the family to prioritize goals and tasks.

DFPS uses the results of the CANS 2.0 to evaluate each child's needs and strengths. This assessment assists in service planning, informs placement decisions, and reduces the number of assessments administered to children in DFPS conservatorship.

**Family Strength and Needs Assessment (FSNA):** DFPS administers the FSNA to assess how the family is functioning and to aid in developing a plan of service for the family. Although the FSNA and CANS will not be attached to court reports, judges may hear DFPS staff providing testimony or information regarding findings or recommendations that come from these assessments.

---

***Special Issue:*** *Many courts prefer to schedule a Status Hearing within a few days of the Adversary Hearing to jump-start services to families. However, this must be balanced with the need for both the STAR Health clinician and the CPS caseworker to have the time to utilize the CANS and FSNA tools with fidelity. The law requires that the CANS be administered within 45 days of removal, and DFPS policy sets the completion date at 30 days. The FSNA is conducted with the family within the first three weeks of removal and is used to inform the CANS. Allowing time for a thorough assessment and coordination of efforts should produce child and family service plans that set a path toward achieving permanency as quickly as possible for the child and family.*

---

**Developmental Disability Assessment:** DFPS is also required to assess whether a child has a developmental disability as soon as possible after the child is placed in DFPS conservatorship, and if the assessment indicates an intellectual disability, to ensure that a referral for a determination of such is made as soon as possible. Tex. Fam. Code § 264.1075.

## F. Medical Consent

Generally, health care providers require someone with the legal authority to consent to medical care for a child to provide informed consent for the child before the health care provider will initiate care. Texas law requires the court to specifically authorize an individual or DFPS to consent to medical care for each child in DFPS conservatorship. Tex. Fam. Code §§ 153.371-153.377 and Tex. Fam. Code § 266.004(c) provide the legal bases for DFPS' authority to make medical decisions for children and youth in DFPS conservatorship. When the court authorizes DFPS to consent to the child's medical care, the caseworker must designate a medical consenter, a backup medical consenter, and coordinate medical information. It is the responsibility of the medical consenter and backup medical consenter to become knowledgeable of the child's medical condition, known medical history, and medical needs before consenting to medical care or treatment.

### 1. Informed Consent

Medical consent means making a decision on whether to agree to or not agree to a medical test, treatment, procedure, or a prescription medication. Informed consent means the medical consenter gets complete information about the proposed medical care to provide an understanding of the

benefits and risks of the treatment before making a decision. The goal is to make sure that the "medical consenter" makes an informed decision about the child's health care.

Before consenting to any health care, the medical consenter must make sure he or she understands:

- The child's symptoms and medical diagnosis;
- How the treatment will help the condition;
- What happens if the treatment is not applied; and
- The side effects and risks associated with the treatment. Tex. Fam. Code § 266.004(h); CPS Policy Handbook § 11130.

---

***Special Issue:*** *A person otherwise authorized to consent to the immunization of a child may not consent for the child if the person has actual knowledge that a parent, managing conservator, guardian, or other person who under the law of another state or a court order may consent for the child and has expressly refused to give consent to the immunization, has been told not to consent for the child, or has withdrawn a prior written authorization for the person to consent. Tex. Fam. Code § 32.101(c).*

---

### 2. Choosing a Medical Consenter

When a judge gives DFPS the authority to consent to medical care for a child in conservatorship, the agency designates up to four primary and backup medical consenters to make health care decisions for the child. The two primary medical consenters are usually the child's caregivers or a caseworker and another CPS staff. The goal of designating multiple consenters is to ensure that a consenter can be present in person when the child receives treatment. This is particularly important when the child is being prescribed psychotropic medications.

DFPS may choose medical consenters and backup medical consenters who are:

- Professional employees of emergency shelters;
- Foster parents;
- Relatives;
- CPS caseworkers, supervisors, or other CPS staff;
- Parents whose rights have not been terminated, if in child's best interest.

Medical consenters and backup medical consenters must be individuals, not a facility or a facility's shift staff. DFPS may not choose medical consenters and backup medical consenters who are employees of staffed facilities such as Residential Treatment Centers (RTCs) or intermediate care facilities for individuals with developmental disabilities. CPS caseworkers are usually designated in these cases.

Once the caseworker designates a medical consenter, and the medical consenter meets training requirements, the caseworker must issue Form 2085-B Designation of Medical Consenter (which provides authorization to consent to medical care) to the medical consenter and backup medical consenter, all of whom must sign the form. The CPS caseworker must consent to medical care until a medical consenter and backup medical consenter have been designated and have signed the form.

When the court names an individual as medical consenter, that person is ultimately responsible for the medical decisions for that child and reports directly to the court.

In some cases, the court allows a youth 16 or 17 years old to be their own medical consenter, if other requirements are met. Tex. Fam. Code § 266.010.

Attorneys ad litem and DFPS staff are required to inform 16 and 17 year-olds in foster care of their right to ask the court whether they can consent to their own medical care. Tex. Fam. Code § 107.003(b)(3) and Tex. Fam. Code § 264.121.

DFPS requires both designated primary medical consenters (including youth designated by the court as their own medical consenter) and backup medical consenters to complete the following two department-approved trainings before being allowed to make medical or health care decisions:

- DFPS Medical Consent Training for Caregivers; and
- DFPS Psychotropic Medication Training.

### 3. Informed Consent for Psychotropic Medications

Texas law requires the medical consenter to attend all appointments with the health care provider when a child may be prescribed psychotropic medication. The medical consenter must always have a complete discussion with the child's healthcare provider in order to consider options for the child or youth that do not involve medication before or at the same time as using psychotropic medication. According to Texas law, consent to giving a psychotropic medication is valid only if:

- It is given voluntarily and without undue influence, and
- The consenter receives information (given verbally or in writing) describing:
    - the specific condition to be treated;
    - the beneficial effects on that condition expected from the medication;
    - the probable health and mental health consequences of not consenting to the medication;
    - the probable clinically significant side effects and risks associated with the medication;
    - the generally accepted alternative medications and non-pharmacological interventions to the medication, if any; and
    - the reasons for the proposed course of treatment. Tex. Fam. Code § 266.0042.

Texas law requires medical consenters to assure that the child prescribed a psychotropic drug has an office visit with the prescribing healthcare provider at least once every 90 days to allow the practitioner to:

- Appropriately monitor for side effects of the medicine;
- Decide whether the medicine is helping the child; and
- Decide whether continuing the medicine is recommended for the child. Tex. Fam. Code § 266.011.

The medical consenter must attend these medical appointments with the child and provide documentation of the medical appointment to the caseworker by the next business day.

**4. Guidance for Youth Who are Their Own Medical Consenter**

If a court determines that a youth is capable of consenting to their own medical care, the caseworker must:

- Educate the youth about their medical care and the process for making informed decisions on an ongoing basis;
- Ensure the youth completes the DFPS Medical Consent Training for Caregivers;
- Ensure a youth who has been prescribed psychotropic medication, or is considering taking psychotropic medication, completes the DFPS Psychotropic Medication Training; and
- Offer ongoing support and guidance to the youth.

Before a youth reaches age 16, DFPS must advise the youth of the right to request a hearing to determine whether he or she may be authorized to consent to their own medical care. DPFS provides the youth with training on informed consent and the provision of medical care as part of the Preparation for Adult Living (PAL) program. Tex. Fam. Code § 266.010(l).

Youth in DFPS conservatorship who are not authorized by the court to be their own medical consenters at age 16 or 17 will become their own medical consenters when they turn 18. Conservatorship caseworkers must ensure that 17-year-old youth complete the *DFPS Medical Consent Training* for *Caregivers* and *DFPS Psychotropic Medication Training* if the youth has prescription psychotropic mediations, no later than 90 days before becoming 18 years of age.

Tex. Fam. Code § 264.121(g) requires DFPS to ensure that the youth's transition plan includes provisions to assist the youth in managing the use of any medication and in managing the child's long-term physical and mental health needs after leaving foster care, including provisions that inform the youth about:

- The use of the medication;
- The resources that are available to assist the youth in managing the use of the medication;
- Informed consent; and

- The youth’s right to request to be their own medical consenter. Tex. Fam. Code § 264.121(g)(1).

For youth 17 or older taking medication, DFPS must ensure the youth’s transition plan includes a program supervised by a health care professional to assist the youth with independently managing their medication. Tex. Fam. Code § 264.121(g)(2).

The youth's caseworker and caregivers should help the youth get information about any medical condition(s), tests, treatment, and medications, and support them in making informed decisions.

If a youth's healthcare decision puts the youth at risk of harm, the court can overrule a youth's decision to refuse medical care even after authorizing the youth to make medical decisions. To do so, the court must find by clear and convincing evidence that the medical care is in the best interest of the youth and also find one of the following:

- The youth lacks the capacity to make the decision;
- Not getting the care will result in observable and material impairment of growth, development, or functioning of the youth; or
- The youth is at risk of causing substantial bodily harm to self or others. Tex. Fam. Code § 266.010(g)(1)-(3).

In these situations, DFPS may file a motion asking the court to order a specific medical treatment or to allow DFPS to consent to medical care for the youth. The motion must include the youth's reasons for refusing medical care and a statement signed by the physician explaining why medical care is necessary. Tex. Fam. Code § 266.010(d)-(e).

## G. Admission of a Child in DFPS Custody to an Inpatient Mental Health Facility

DFPS may not admit a child in DFPS conservatorship to an inpatient mental health facility based on the child’s consent to be admitted. The Department may request admission only if a physician states that the child has a mental illness or demonstrates symptoms of a serious emotional disorder and presents a serious risk of harm to themselves or others. Tex. Health & Safety Code 572.001.

The admission is considered a significant event for purposes of Tex. Fam. Code § 264.018 and requires notice to all parties entitled to notice and to the court of continuing jurisdiction within three days of admission. DPFS must continue to review the need for continued placement and if DFPS determines there is no longer a need for inpatient treatment, DFPS must notify the facility administrator that the child may no longer be detained without an application for court-ordered mental health services.

## H. Monitoring Psychotropic Medications

In February 2005, DFPS, the Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC) released a "best practices" guide to ensure the proper use of psychotropic medications for the children in foster care.

The Psychotropic Medication Utilization Parameters for Children and Youth in Texas Public Behavioral Health (6th Version) (Parameters)[97] is the most recent version of these guidelines. It serves as a resource for physicians and clinicians who care for children diagnosed with mental health disorders. The guide provides recommendations for the appropriate use of psychotropic medications for children served by the public behavioral health system in Texas, including those in foster care, and includes nine criteria indicating the need for review of the child's clinical status.

Since April 2008, STAR Health has conducted PMURs on the children whose medication treatment fall outside of the expectations of the Parameters.

PMUR Process for STAR Health Members FAQ and Stakeholder Manual explains this process and how to request a review.[98] Please also see the *Psychotropic Medication* chapter of this Bench Book.

## I. End of Life Medical Decisions

If a child in DFPS conservatorship has been diagnosed with an "irreversible condition" or a "terminal condition" and medical professionals suggest withholding or withdrawing life-sustaining treatment, the regular process for medical consent does not apply and the caseworker and supervisor must follow the procedures outlined below. However, any party may seek court intervention at any time if all parties do not agree on a course of action or if any party is concerned about the child's rights. CPS Policy Handbook § 11720.

If parental rights have not been terminated and the child's attending physician recommends end-of-life care, the parents have the authority to make the end-of-life decisions even if DFPS is the temporary managing conservator (TMC) or permanent managing conservator (PMC) of the child. DFPS staff or other medical consenters do not have the legal authority to consent in these circumstances. CPS Policy Handbook § 11721.

If parental rights have been terminated as to both parents, or the parents are deceased and the attending physician recommends end-of-life care, the caseworker and supervisor must:

- Obtain a written statement from the attending physician certifying that the child has a terminal or irreversible condition, and that the physician recommends withholding or withdrawing life-sustaining treatment;
- Request a second opinion or a review by a hospital medical or ethics review board if there are any concerns regarding the recommendation of the attending physician;
- Confirm that there is no relative, fictive kin, or other individual with possessory or custodial rights of the child. If one of these individuals is available, that person must be consulted for end-of-life decisions, if possible;
- Notify and discuss the recommendation with the program director, regional director, regional attorney, attorney representing DFPS, the child's attorney ad litem, guardian ad litem, CASA (if applicable), and any other legal party to the case; and
- Notify and consult with the court of continuing jurisdiction. CPS Policy Handbook § 11722.

## J. Health Passport

The Health Passport is a web-based, secure health information tool which utilizes claims data to provide information on healthcare services for every child, youth, or young adult enrolled in the STAR Health program. The Health Passport is not a full medical record. It contains the following information:

- A record of healthcare visits and services with any network provider;
- Immunizations, lab results, and prescriptions received;
- Healthcare forms such as psychotropic reviews, service plans, Texas Health Steps forms, CANS 2.0 results, and the FSNA;
- Allergies, vital signs, height, weight, and record of future scheduled appointments if entered by network providers; and
- A two-year history from prior to entering foster care if the child received Medicaid or Children's Health Insurance Program (CHIP) coverage in the past.

Medical consenters, caseworkers, network providers, some CASA staff, and some residential provider staff are able to view Health Passport records. STAR Health Network providers are able to enter data into Health Passport.

Only a DFPS staff member may give a printed copy of the Health Passport or sections of the Health Passport to other persons or entities, including judges.

## K. Court Orders for Medical Services

If a health care professional has been consulted regarding a health care service, procedure, or treatment for a child in DFPS conservatorship, a court must make findings in the record supporting its decision if the court declines to follow the recommendation of the health care professional. Tex. Fam. Code § 266.005.

---

***Special Issue**: If the child needs a service not covered by Medicaid, the judge may order that a physician assess the need for the service, if that has not already been done. Also, the judge may order the service and DFPS will seek that service through a private pay contract. When entering orders for services that are not covered by Medicaid, a judge might consider drafting an order that provides DFPS the maximum flexibility in contracting because a particular provider may not be in the position to fulfill the contract as dictated by the court order. Also, a copy of the signed order should be sent via fax to Superior HealthPlan at 1-866-702-4837 or the court order can be escalated through the DFPS Well-being Specialist who works directly with the STAR Health Liaison.*

---

STAR Health is required to pay for Medicaid covered services ordered by a court pursuant to the statutory citations listed below. STAR Health cannot deny, reduce, or controvert the court's orders for Medicaid inpatient mental health covered services for members from birth through age 20, when such inpatient mental health services are provided pursuant to:

- A court order; or
- As a condition of probation.

STAR Health cannot deny, reduce, or controvert the court orders for Medicaid inpatient mental health covered services for members of any age if the court-ordered services are delivered in an acute care hospital.

STAR Health may not limit substance use disorder treatment or outpatient mental health services for members of any age provided pursuant to:

- A court order; or
- A condition of probation.

STAR Health cannot apply its own utilization management criteria through prior authorizations, concurrent reviews, or retrospective reviews for such services. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A member who has been ordered to receive treatment pursuant to a court order can only appeal the court order through the court system. STAR Health is required to have a mechanism to receive court order documents from providers at the time of an authorization request.

STAR Health must provide all Medicaid inpatient psychiatric covered services to members and outpatient covered services to members of any age who have been ordered to receive the services by:

- A court of competent jurisdiction including services ordered pursuant to the Tex. Health & Safety Code Chapters 573, Subchapters B and C, Tex. Health and Safety Code Chapter 574, Subchapters A-G, Tex. Fam. Code 55, Subchapter D; or
- As a condition of probation.

These requirements are not applicable when the member is to be considered incarcerated.

For STAR Health members ages 21 or older, STAR Health may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting as allowed by 42 C.F.R. §438.6(e).

STAR Health must provide Medicaid-covered substance use disorder treatment services, including substance use disorder residential treatment, required as a court order consistent with Tex. Health and Safety Code Chapter 462, Subchapter D, or as a condition of probation.

These requirements are not applicable when the member is considered to be incarcerated.

## L. References

**Key STAR Health Phone Numbers**

| Organization | Phone Number |
| --- | --- |
| Superior HealthPlan Network Member Services Hotline | 1-866-912-6283 |
| HHSC Managed Care Ombudsman | 1-866-566-8989 |

#### Nonemergency Medical Transportation Services

Nonemergency Medical Transportation[99] (NEMT) services provide medical transportation services for youth who do not have a way to get to covered health care services. NEMT services allow the youth to arrange a ride to a doctor's office, dentist's office, hospital, drug store, or any place that provides covered health care services. Types of rides and related covered expenses include:

- Public transportation (for example, the city bus);
- A taxi or van service;
- Commercial transit, like a bus or plane, to go to another city for an appointment;
- Money for gas;
- Meals and lodging for children and youth 20 and younger staying overnight to get covered health care services; and
- Payment for some out-of-state travel.

If STAR Health youth need medical transportation services, it is recommended to contact the SafeRide Appointments/Call Center at 1-855-932-2318; TTY: 7-1-1. If there is a complaint about services, it is recommended to contact the phone number on the back of the member ID card.

## M. Who to Contact with Health Care Questions

DFPS developed a STAR Health mailbox which is staffed by the DFPS medical services team and is checked each business day. The email address is: DFPSStarHealth3In30@dfps.texas.gov.

Superior STAR Health staff are also available to serve as a liaison to help court teams navigate through the STAR Health program and avoid gaps in care and services to children and youth. Superior STAR Health can help court teams:

- Facilitate interactions between Superior STAR Health, caseworkers and Child Placing Agencies to provide a single point of contact.
- Access to Superior STAR Health Liaisons who conduct education and provide Court Teams and caregivers with customized information packets.
- Enhance communication with Court Teams and Superior STAR Health pertaining to referrals and follow-up for improved accountability, collaborative efforts and streamlined resolutions.
- Collaborate with Court Teams to achieve better outcomes for members and foster parents.
- Offer Superior STAR Health benefits education including, but not limited to, the 24/7 Nurse Advice Line and transportation options through the Superior STAR Health training team.
- Assistance from Superior Member Advocates with Medicaid-related needs and barriers Court Teams identify by calling 1-866-912-6283.

- Address pending needs and resources during the staffing that occurs outside of court proceedings.
- Follow identified cases until referrals are completed and members are linked with appropriate services.
- Enroll Superior STAR Health members into Service Management/Service Coordination (as needed).

To set up a court meeting and training, provide the following information by email to Superior STAR Health at SH_JudicialMailbox@superiorhealthplan.com:

- Your name
- Your contact number
- Your email address; and
- What Superior STAR Health can assist you with.

Additional Links / Resources:

Texas DFPS Star Health webpage[100]

Superior HealthPlan STAR Health website[101]

# CHILDREN WITH DISABILITIES

## A. What Laws and Policies Protect Individuals with Disabilities?

A number of federal laws protect individuals with disabilities from discrimination in public and private settings. Some of these laws include:

- The Americans with Disabilities Act (ADA) 42 U.S. Code § 12101 et seq., which prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications;
- The Rehabilitation Act of 1973, which prohibits discrimination by any entity that receives federal funds;
- The Individuals with Disabilities Education Act (IDEA) 20 U.S.C. § 1400, et. seq., which requires states to provide students with disabilities special education and related services;
- The Fair Housing Act 42 U.S.C. § 3601 et seq. which addresses discrimination in housing;
- And others. See: https://www.ada.gov/cguide.htm for a summary of federal laws.

## B. Children with Disabilities in DFPS care

Children with disabilities in DFPS conservatorship must be provided with a placement and services to meet their needs. Relevant DFPS handbook policies include:

- 4117 Specific Placement Considerations for Children or Youth Who Have Primary Medical Needs
- 4118 Additional Actions for Placing Children with Intellectual or Developmental Disabilities
- 4131.1 Durable Medical Equipment
- 6237 Permanency Planning for Children with Intellectual or Developmental Disabilities in Institutional Settings
- 10340 Preparation for Long-Term Care or Support in Adulthood for Youth with Disabilities

For additional information, please see DFPS Mental Health Resource Guide.

DFPS Developmental Disability Specialists are the main point of contact for information about serving children with disabilities in the child welfare system. Responsibilities for the Developmental Disability Specialist are outlined in the CPS Policy Handbook § 6411.31 and 6411.4.

## C. Parents and Other Adult Caregivers with Disabilities and Child Welfare

Federal law prohibits governmental agencies, including child welfare and court systems, from discriminating against people with disabilities in their services, programs, and activities. Agencies in

the child welfare system must provide accommodations to ensure persons with disabilities have equal opportunity to access services to ensure safety, permanency, and well-being for the children and families DFPS serves

See the DFPS Resource Guide - Working with Persons with Disabilities for information on working with persons with disabilities in the child welfare system, including specific suggestions for reasonable accommodations for a parent with a disability when child safety is involved.

## D. What Resources are Available for Children and Adults with Disabilities?

- Disability Rights Texas (DRTX) provides legal representation and advocacy for individuals with disabilities.[102] DRTX can help caregivers and caseworkers advocate for services for a child with disabilities in the school system or appeal denials of Medicaid services, may be appointed as a child's ad litem or "surrogate parent," or may advocate on behalf of parents or foster parents with disabilities.

- EveryChild Inc. provides assistance and support for children with disabilities to reside in a family setting.[103]

- Texas Health and Human Services Disability webpage includes disability-related resources and information.[104]

- Home and Community-Based Services (HCS) is a Medicaid waiver program that provides services and support for individuals with intellectual disabilities.[105]

- The Judicial Commission on Mental Health Texas Mental Health and Intellectual and Developmental Disabilities Law Bench Book is a procedural guide for Texas judges hearing cases regarding persons with mental illness and/or intellectual and developmental disabilities (IDD).[106]

- Local Intellectual and Developmental Disability Authorities (LIDDA) and Mental Health Authorities (MHA) support children and adults in crisis. Local LIDDA and MHA contacts are available on the Texas Health and Human Services webpage at Contact HHS webpage.[107]

- Navigate Life Texas is a website developed by HHS to explain resources for families with children who have disabilities and special health care needs.[108]

# PSYCHOTROPIC MEDICATION

Psychotropic medications are substances that affect the mind and alter mental processes such as perception, mood, and behavior. Psychotropic drugs include stimulants, antidepressants, antipsychotics, and mood stabilizers. Some children need to use psychotropic medications long-term to treat mental health disorders that they inherited or developed, such as attention deficit hyperactivity disorder, major depressive disorder, or psychosis. Other children need to use psychotropic medications on a more temporary basis to help relieve severe emotional stress and help them function in school, at home, and in the community.

The use of psychotropic medication in children in foster care can be a controversial issue. Psychiatric medication may be life-saving and relieve challenging and sometimes severe symptoms of mental health disorders. Children and youth in foster care may benefit from medication to address mental illness exacerbated by the effects of trauma brought on from exposure to abuse or neglect. However, studies have shown that psychotropic medications can have serious side effects on adults using them, and relatively little research has been conducted to understand the effects of long-term use in children and adolescents. Many psychotropic medications do not have Food and Drug Administration (FDA) approved labeling for use in children.[109] Therefore, it is imperative that a comprehensive evaluation be performed before beginning treatment with psychotropic medication for a mental, emotional, or behavioral disorder. Except in the case of an emergency, a child should receive a thorough health history, biopsychosocial assessment, mental status exam, and physical exam before being prescribed a psychotropic medication.[110]

Under Tex. Fam. Code § 266.001, a “psychotropic medication” means a medication that is prescribed for the treatment of symptoms or psychosis or another mental, emotional, or behavioral disorder and that is used to exercise an effect on the central nervous system to influence or modify behavior, cognition, or affective state. The term includes the following categories when used as described by Tex. Fam. Code § 266.001(7):

- Psychomotor stimulants;
- Antidepressants;
- Antipsychotics or neuroleptics;
- Agents for control of mania or depression;
- Anti-anxiety agents; and
- Sedatives, hypnotics, or other sleep-promoting medications. Tex. Fam. Code § 266.001(7).

Texas led the nation in creating oversight protocols in 2005 when the 79th Texas Legislature enacted Senate Bill 6. This sweeping legislation proposed reforms for DFPS, including a plan to place all children and youth in foster care under a single comprehensive managed care system. Texas was the first state to develop a "best practices" guide for oversight of psychotropic medications for children in foster care. Released in 2005 and most recently updated in June 2019, DFPS, the Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC) developed

the Psychotropic Medication Utilization Parameters for Children and Youth in Texas Public Behavioral Health (6th Version) (Parameters).[111] The Parameters are updated periodically and serve as a resource for physicians and clinicians who care for children diagnosed with mental health disorders.

Additionally, DFPS' Behavioral Health Services Division includes a Behavioral Health Services Division Administrator, a Trauma-Informed Care Manager, six regional Trauma-Informed Care Program Specialist positions, a Behavioral Health Program Specialist Lead position, three Substance Use Program Specialists, two Child and Adolescent Needs and Strengths (CANS) Program Specialists, and a Mental Health Program Specialist. Please also see more about this division under the Bench Book chapter entitled *Substance Use Disorders*.

The Texas Legislature also enacted Tex. Fam. Code Chapter 266 which governs medical care and education services for children in foster care primarily through three processes:

- Medical Consenter;
- Agency Oversight; and
- Judicial Review.

## A. Medical Consenter

Tex. Fam. Code § 266.004(h) requires medical consenter training, which must include training related to informed consent for the administration of psychotropic medication and the appropriate use of psychosocial therapies, behavior strategies, and other non-pharmacological interventions that should be considered before or concurrently with the administration of psychotropic medications. Tex. Fam. Code § 266.004(h-1).

Each person required to complete a training program under Tex. Fam. Code § 266.004(h) must acknowledge in writing that the person:

- Has received the training described by Tex. Fam. Code § 266.004(h-1);
- Understands the principles of informed consent for the administration of psychotropic medication; and
- Understands that non-pharmacological interventions should be considered and discussed with the prescribing physician, physician assistant, or advanced practice nurse before consent to the use of a psychotropic medication. Tex. Fam. Code § 266.004(h-2).

The DFPS Medical Consent Training for Caregivers is available online and typically takes an estimated two and half hours to complete.[112]

DFPS also has a two-hour online Psychotropic Medication Training for DFPS staff, foster parents and residential providers, relative caregivers, and youth medical consenters.[113]

### 1. Informed Consent

Although the term "informed consent" as it relates to medical care for a child in foster care is not defined in Tex. Fam. Code Chapter 266, the Texas Legislature has defined consent for psychotropic medication. Consent to the administration of a psychotropic medication is valid only if:

- The consent is given voluntarily and without undue influence;
- The person authorized by law to consent for the foster child receives verbally or in writing information that provides:
    - the specific condition to be treated;
    - the beneficial effects on that condition expected from the medication;
    - the probable health and mental health consequences of not consenting to the medication;
    - the probable clinically significant side effects and risks associated with the medication; and
    - the generally accepted alternative medications and non-pharmacological interventions to the medication, if any, and the reasons for the proposed course of treatment. Tex. Fam. Code § 266.0042.

The Parameters describe what is meant by "informed consent" by stating that consent to medical treatment in non-emergency situations must be obtained from appropriate parties with the child or adolescent assenting before beginning psychotropic medication, which includes discussing the following with the prescribing provider before consenting:

- A DSM-5 (or current edition of the American Psychiatric Association's [APA] Diagnostic and Statistical Manual of Mental Disorders) psychiatric diagnosis for which the medication is being prescribed;
- Target symptoms;
- Expected benefits of treatment;
- Risks of treatment, including common side effects, laboratory finding, and uncommon but potentially severe adverse events;
- Risks of no treatment; and
- Alternative treatments available and/or attempted treatments.[114]

Included in the idea of informed consent is the consideration of alternative treatments and trauma-informed care. The concept of trauma-informed care is a paradigm shift for the entire system and acts as a lens through which children, youth, and families experiencing the child welfare system are viewed. The Introduction and General Principles Section of the Parameters promote a trauma-informed child and family-serving system where all parties involved recognize and respond to the varying impact of traumatic stress on those who have contact with the system, including youth, caregivers, and service providers. A robust trauma-informed system should not only screen for

trauma exposure and related symptoms, but also use culturally and linguistically appropriate, evidence-based assessments and treatment.

In 2015, the 84th Texas Legislature added Tex. Fam. Code § 266.012 regarding comprehensive assessments. Described in detail in the Health Care chapter herein, the comprehensive assessment for children and youth in state conservatorship is called CANS 2.0 and is administered in a developmentally appropriate way not later than the 45th day after the date a child enters the conservatorship of DFPS. This statute was updated in 2017 to require that any Single Source Continuum Contractor (SSCC) providing therapeutic foster care services to a child ensure that the child receives a comprehensive assessment at least once every 90 days. Tex. Fam. Code § 266.012(c). The assessment must include:

- A screening for trauma; and
- Interviews with individuals who have knowledge of the child's needs. Tex. Fam. Code § 266.012(a).

DFPS requires that children and youth placed in substitute care ages 3 to 17 years old receive a CANS 2.0 assessment within 30 days of removal. The CANS 2.0 is used to gather information about the strengths and needs of the child and family and is used in Service Planning to assist the child and family in reaching their goals.[115] DFPS may consent to health care services ordered or prescribed by a health care provider authorized to order or prescribe health care services regardless of whether services are provided under the medical assistance program under Tex. Hum. Res. Code Chapter 32, if DFPS otherwise has the authority under Tex. Fam. Code § 266.004 to consent to health care services. Tex. Fam. Code § 266.004(k).

### 2. Monitoring Use of Psychotropic Drugs

The medical consenter shall ensure that the child has been evaluated by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days to allow the physician, physician assistant, or advanced practice nurse to:

- Appropriately monitor the side effects of the medication; and
- Determine whether:
  - the medication is helping the child achieve the treatment goals; and
  - continued use of the medication is appropriate. Tex. Fam. Code § 266.011.

## B. Agency Oversight

The Parameters provide recommendations for the appropriate use of psychotropic medications for children served in the public behavioral health system, including children in foster care. They include criteria indicating the need for review of the child's clinical status. Medical consenters, caregivers, judges, attorneys, and advocates also use the Parameters as they fulfill their duties of advocacy and oversight.

### 1. Medication Review

The STAR Health Managed Care Organization (MCO) oversees automated reviews of pharmacy claims data for all children in foster care receiving psychotropic medications to identify medication treatments which appear to be outside the Parameters. Additionally, STAR Health MCO clinical staff routinely conduct telephonic health screenings when children newly enter DFPS conservatorship or change placements.

The telephonic health screening includes screening of the child's psychotropic medications treatment. The screening process includes criteria such as:

- Does the child have a documented mental health diagnosis?
- What is the child's age? (Prescriptions might need further review if the child is under age 3 or 4, depending on the class of medication.)
- Is the child taking two or more medications from the same drug class? (Two mood stabilizers and long and short acting stimulants from the same "family" are allowed, but two or more medications from the same class call for further review.)
- Is the child prescribed four or more psychotropic medications regardless of the class?

### 2. Psychotropic Medication Utilization Review [116]

The Psychotropic Medication Utilization Review (PMUR) process is designed to determine whether a child's psychotropic medication treatment is outside of the Parameters and, if so, whether a consultation call from a STAR Health child psychiatrist to the prescribing physician is indicated. A PMUR can be initiated by the STAR Health MCO if indicated by a health screening or pharmacy claim review. A PMUR may also be triggered by a request from any judge, attorney, caseworker, advocate, foster parent, medical consenter, or other concerned person working with the child. The PMUR examines child-specific clinical information about a child's diagnoses, medication dosage, and whether the medication treatment is in compliance with the Parameters. The STAR Health MCO has committed to prioritize responses to inquiries from judges concerning children under their supervision. PMUR findings are usually sent to the child's caseworker or can be faxed or emailed directly to the court, if requested.

All PMUR requests are reviewed by one of two STAR Health Licensed Behavior Health Clinicians who gather medical records and screen children's psychotropic medication treatment for compliance with the Parameters. If the treatment is outside the Parameters, the clinician refers the case to a STAR Health child psychiatrist to conduct a PMUR. The child psychiatrist outreaches to the treating physician, works with the treating physician to reduce polypharmacy if indicated, and prepares a PMUR report. The PMUR report will contain a formal determination about the foster child's medication treatment. The possible determinations are as follows:

- Medication treatment within Parameters;
- Medication treatment outside Parameters. Medication treatment reviewed and found to be within the standard of care;
- Medication treatment is outside Parameters and there is opportunity to reduce polypharmacy; or

- Medication treatment is outside Parameters and there is risk for or evidence of significant side effects.

The STAR Health MCO is in a good position to intervene and educate the prescribing physician because it holds a contract with these providers to participate in STAR Health. Physicians and other clinicians who appear to consistently prescribe outside the Parameters despite risk for or evidence of significant side effects, or when there is an opportunity to reduce polypharmacy, are referred to the Quality of Care (QOC) review process. Additional records are examined for pervasive patterns of over-prescribing or dangerous prescribing. Qualifying cases may be referred to the Peer Review Committee for further investigation and action. The Peer Review Committee is established by the MCO and consists of network providers to review PMUR concerns for STAR Health Members that exceed the QOC thresholds. Superior HealthPlan also utilizes consultant physicians as needed to review specific specialist issues if a need is identified. The results of Quality Improvement and Peer Review Committee investigations and actions are confidential and may not be released to or discussed with the public. All QOC issues are tracked and trended. Any practitioner showing a pattern or trend may be placed on corrective action and/or face disciplinary action up to and including termination of contract, if warranted.

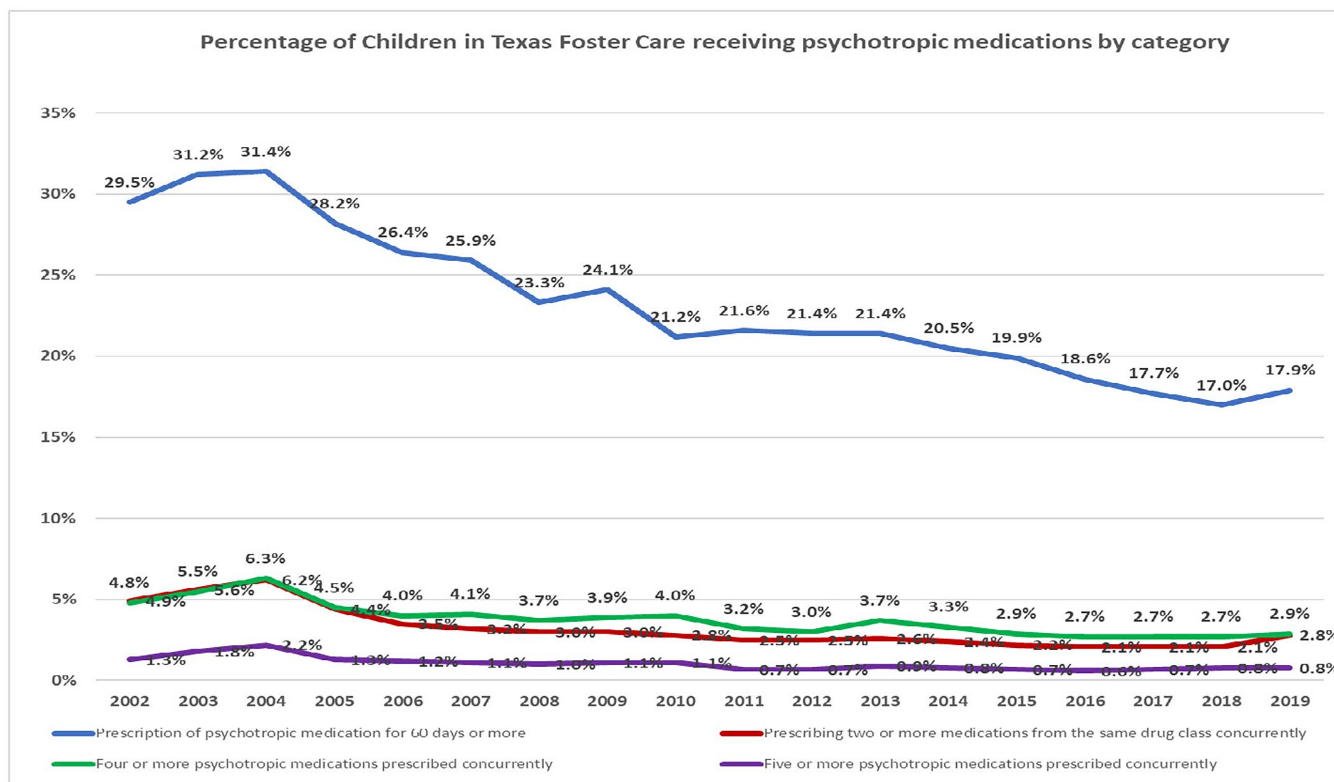
A PMUR cannot address whether other medications might be effective, and this process is not the appropriate avenue to address immediate concerns about new medications or medication side effects. Instead, the informed consent process is considered the appropriate avenue to inquire about new medications and side effects. In these situations, the STAR Health MCO recommends that the Medical Consenter contact the prescribing physician directly. DFPS also employs CPS Nurse Consultants in each administrative region to assist CPS staff with children's health issues, including questions about psychotropic medications.

Please see the PMUR Process for STAR Health Members FAQ and Stakeholder Manual for more information on the process.[117]

### 3. Effect of Texas' Oversight Process

As a result of the various improvements to Texas' oversight process, including hiring a Medical Director at DFPS, implementing the Parameters as a statewide monitoring system, and launching managed care and clinical consultation by the STAR Health programs, the prescription patterns of psychotropic medications for Texas children experiencing foster care have improved significantly. Since implementation of the Parameters in 2005, the use of psychotropic medications in Texas foster care has decreased substantially from a high of 31.4% in 2004 to under 18% in 2019 for children prescribed psychotropic medications for 60 days or more (a roughly 42% decrease).[118] It should be noted in 2020, HHSC revisited the foster care prescription data from State Fiscal Years 2002 to 2019 using the new psychotropic drug list and other methodological changes to provide a single consistent historical timeline. Previous versions of the cited report incorporated changes as they occurred. Due to programming code changes, additional data becoming available, and additional medications being added to the list of psychotropic medications, the data have changed from previous versions of the report.[119]

**Table 2: Percentage of Children in Texas Foster Care receiving psychotropic medications by measure**




## C. Parental Notification of Certain Medical Conditions

DFPS must provide notice of significant events regarding a child in foster care to the child's biological parents and others under Tex. Fam. Code § 264.018 in a manner that would provide actual notice to a person entitled to the notice, including the use of electronic notice whenever possible. Tex. Fam. Code § 264.018(c).

Not later than 24 hours after an event described by Tex. Fam. Code § 264.018(d), DFPS shall make a reasonable effort to notify a parent of a child in the managing conservatorship of the DFPS of:

- A significant change in medical condition of the child, as defined by Tex. Fam. Code § 264.018(a)(4);
- The enrollment or participation of the child in a drug research program under Tex. Fam. Code § 266.0041; and
- An initial prescription of a psychotropic medication, as defined by Tex. Fam. Code § 266.001. Tex. Fam. Code § 264.018(d).

As soon as possible but not later than the 10th day after the date DFPS becomes aware of a significant event affecting a child in the conservatorship of DFPS, DFPS shall provide notice of the significant event to the child's parent. Tex. Fam. Code § 264.018(f).

Under Tex. Fam. Code § 264.018(5), a significant event includes:

- A placement change, including failure by DFPS to locate an appropriate placement for at least one night;
- A significant change in medical condition, as defined by Tex. Fam. Code § 264.018(a)(4);
- An initial prescription of a psychotropic medication or a change in dosage of a psychotropic medication, as defined by Tex. Fam. Code § 266.001;
- A major change in school performance or a serious disciplinary event at school;
- A placement in a qualified residential treatment program, as that term is defined by 42 U.S.C. Section 672(k)(4); or
- Any event determined to be significant under DFPS rule.

For purposes of Tex. Fam. Code § 264.018(f), if a hearing for the child is conducted during the 10-day notice period described by Tex. Fam. Code § 264.018(f), DFPS shall provide notice of the significant event at the hearing. Tex. Fam. Code § 264.018(g).

DFPS is not required to provide notice under Tex. Fam. Code § 264.018 to a parent of a child in the managing conservatorship of DFPS if:

- DFPS cannot locate the parent;
- A court has restricted the parent's access to the information;
- The child is in the permanent managing conservatorship of DFPS and the parent has not participated in the child's case for at least six months despite DFPS' efforts to involve the parent;
- The parent's rights have been terminated; or
- DFPS has documented in the child's case file that it is not in the best interest of the child to involve the parent in case planning. Tex. Fam. Code § 264.018(h).

A person entitled to notice from DFPS under Tex. Fam. Code § 264.018 shall provide current contact information pursuant to Tex. Fam. Code § 264.018(j).

## D. Judicial Review

The judiciary is charged with oversight of the safety, permanency, and well-being of the children in their courts. Tex. Fam. Code § 266.007 requires that the judge overseeing the case review a summary of the medical care being provided to the child at each hearing held pursuant to Tex. Fam. Code Chapter 263, specifically the Permanency Hearings Before and After Final Order.

### 1. Court Shall Review Medical Summary

Tex. Fam. Code Chapter 266 requires the summary of medical care to include:

- The nature of any emergency medical care provided to the child and the circumstances necessitating emergency medical care, including any injury or acute illness suffered by the child;
- All medical and mental health treatment that the child is receiving and the child's progress with the treatments;
- Any medication prescribed for the child and the condition, diagnosis, and symptoms for which the medication was prescribed and the child's progress with the medication;
- The degree to which the child or foster care provider has complied or failed to comply with any plan of medical treatment for the child;
- Any adverse reaction to or side effects of any medical treatment provided to the child;
- Any specific medical condition of the child that has been diagnosed or for which tests are being conducted to make a diagnosis; and
- Any activity that the child should avoid or should engage in that might affect the effectiveness of the treatment, including physical activities, other medications, and diet. Tex. Fam. Code § 266.007.

Additional information may be required to effectively oversee that informed consent has been given. Tex. Fam. Code Chapter 266 requires that judges review the medical care at each hearing conducted under Tex. Fam. Code Chapter 263.

The court must determine whether the child has been provided the opportunity, in a developmentally appropriate manner, to express opinion about medical care. Tex. Fam. Code § 263.306(a-1)(5)(D). For a child receiving psychotropic medication, the court must determine whether the child has:

- Been provided appropriate psychosocial therapies, behavior strategies, and non-pharmacological interventions; and
- Seen their prescribing physician at least every 90 days for review. Tex. Fam. Code § 263.306(a-1)(5)(F).

### 2. Youth in Foster Care Must Be Heard at Each Hearing Held Under Tex. Fam. Code Chapter 263

The Family Code provides that sixteen and seventeen-year-olds can serve as their own medical consenter with a judicial determination that the youth is capable of the role. Tex. Fam. Code § 266.010. If the youth is not the medical consenter, Tex. Fam. Code § 266.007(c) requires that he or she be provided the opportunity to express to the court their views on the medical care being provided. Further, Tex. Fam. Code § 263.302 requires that the youth attend Permanency Hearings Before and After Final Order.

***Special Issue**: Although it may be difficult to routinely include youth in their hearings, supporting youth attendance and participation in hearings is very important. This is especially impactful for older youth, as they are more likely than younger foster youth to be prescribed psychotropic medications.*

The regular use of videoconferencing has now made it easier for youth to attend hearings and judges should consider the mental health benefits of doing so for a youth when given the opportunity for youth to advocate for themselves. For more ideas on involving youth in the court process, please see the Bench Book chapter entitled *Child and Youth Voice*.

### 3. Judicial Psychotropic Medication Information Line

Judges can contact the Judicial Medication Information Email Box which allows judges to submit a request for general medication information to SH_JudicialMailbox@superiorhealthplan.com. Judges should expect a response to general questions within 5 business days. Additionally, Superior HealthPlan now has a Manager of Service Coordination dedicated to their judicial program. Veronica Anaya can be reached at Veronica.Anaya@superiorhealthplan.com or by cell at 210-262-2769.

Emails are reviewed by a STAR Health Behavioral Health Service Manager, who has support from the STAR Health Behavioral Health Team, including a Medical Director (child psychiatrist), a Clinical Pharmacist, and Clinical Managers. (An example of an appropriate type of question for the email box is: "What are the side effects of a medication or combination of medications on a 12-year-old girl who weighs 100 pounds?")

The STAR Health MCO also maintains a 24/7 Behavioral Health hotline with access to behavioral health professionals when urgent needs arise. The hotline can be reached at 1-866-912-6283. For more details on this program see the Bench Book chapter entitled *Health Care for Texas Children in Foster Care: STAR Health*.

### 4. Some Courts Use Standardized Court Report

A standardized court report may help provide a summary of medical information that directly follows Tex. Fam. Code § 266.007. A standardized report may include the child's age and weight as well as information about medication and dosage, condition and diagnosis, symptom(s) being treated, last medication review, and the prescribing physician.

### 5. Some Courts Use Specific Forms and Practices

Some Texas child welfare judges have adopted a practice of ordering that in non-urgent situations, medical consenters must appear in court before giving consent to medication treatments that fall outside the Parameters. Also, to augment the information-sharing process, some judges ask the medical consenters to complete a checklist of questions before appearing in court to ensure that the consenter considered the many steps to informed consent (as defined by the Parameters).

# SUBSTANCE USE DISORDERS

## A. Statewide Overview of Substance Use

Substance use by parents in DFPS cases is very common. In 2019, 66% of children removed from their homes and placed in out-of-home care had parental alcohol or other drug abuse as an identified condition for removal[120].

***Special Issue:*** *The term "abuse" is highly associated with negative judgments and punishments. The preferred terms are substance "use" when referencing illicit drugs and "misuse" for prescription medications used other than prescribed.* [121]

Methamphetamine continues to be perceived as the primary drug threat by the three DEA Field Divisions covering Texas. Cocaine indicators continue to decrease. However, heroin and fentanyl indicators have been increasing, as fentanyl is specifically used to "cut" heroin. The number of seizures of fentanyl items identified by law enforcement has risen from 23 in 2006 to 841 in 2020.[122]

Death rates associated with heroin have increased steadily since 1999 with the highest number of deaths occurring in the 24-34 age group. There has been a decrease in heroin-related poison center calls, even while a rising number of toxicology reports, deaths, and seizures are being identified; however, Texas has not suffered the epidemic of overdoses seen in the northeast United States.[123]

### 1. Useful Definitions from the Health and Human Services Commission (HHSC)

- Substance Use: use of a substance.
- Substance Misuse: using a substance in a way that is not consistent with medical or legal guidelines (e.g., using two pills rather than one as prescribed to assist with sleep).
- Risky Use: refers to using a substance in ways that threaten the health and safety of the user or others (e.g., drunk driving).
- Substance Use Disorder (SUD): a condition marked by a cluster of cognitive, behavioral, and physiological symptoms in which the use of a substance leads to clinically significant impairment or distress in a person's life. Substance use disorders range can range widely in severity (mild, moderate, or severe), with severe substance use disorders typically including clinical criteria of tolerance and withdrawal.
- Recovery: a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks. Because setbacks are a natural part of substance use,[124] resilience becomes a key component of recovery.[125]

## B. Substance Use Among Women

Substance use in women tends to be multifaceted and can be related to family or partner use or co-morbid mental health conditions such as depression, anxiety, and eating disorders. Additionally, substance use disorders in women are strongly correlated with childhood personal violence and histories of trauma. Consequences of substance use for women include physical complications, the risk of losing custody of children under their care, and exposure to partner violence. Women develop physiological complications from substance use, especially alcohol use, in a shorter time and at lower rates of consumption than men. Additionally, reproductive consequences for pregnant women may include fetal alcohol spectrum disorders, long-term cognitive deficits, low birth weight, or miscarriage.[126]

A gender-responsive approach to the treatment process and recovery for women includes the importance of relationships and family, the prevalence and history of trauma and violence, common patterns of co-occurring disorders, and, when applicable, particular recognition of caregiver responsibilities.[127]

According to a 2009 Substance Abuse and Mental Health Services Administration (SAMHSA) publication, pregnant women may be reluctant to seek prenatal care due to fear of losing custody of the infant or other children. Most mothers who are in substance use disorder treatment feel a strong connection with their children and want to be good mothers. Most of these mothers want to maintain or regain custody of their children and become "caring and competent parents." Women who believe they have not cared for their children adequately or who believe that they are perceived as having neglected their children carry enormous guilt. Therefore, for many women, maintaining caring relationships with their children is sufficient motivation to keep them in treatment. Unfortunately, they often have inadequate role models in their own lives or lack the information, skills, or economic resources that could make motherhood less difficult.[128]

## C. Pregnant Women and Relapse Prevention and Safety Plans

### 1. Pregnant Women and Substance Use

Since 1994, SAMHSA has designated pregnant women as a federal priority population in substance use disorder treatment services. In Texas, a pregnant woman who is financially eligible and clinically appropriate must be admitted to HHSC-funded treatment services within 48 hours of the woman's request for service. Additionally, SAMHSA requires states to spend five percent of the states' overall budget on specialized female programs for pregnant and parenting women.

Neonatal abstinence syndrome (NAS) is a treatable condition that newborns may experience as a result of prenatal exposure to certain substances, most often opioids. Neonatal Opioid Withdrawal Syndrome (NOWS) is a related term that refers to the symptoms that infants may experience as a result of exposure to opioids specifically.[129] Pregnant women using opioids should not discontinue opioid use due to the risk of maternal return to use, overdose, withdrawals, and fetal demise. The American College of Obstetricians and Gynecologists (ACOG) and Substance Abuse and Mental Health Services Administration (SAMHSA) recommend Medication Assisted Treatment (MAT) as a best practice in managing an opioid use disorder in pregnancy.[130] Tapering of MAT dosing during pregnancy is also associated with more frequent return to use. Prior to birth, engaging pregnant women with opioid and other substance use disorders in substance use treatment and other services

as a component of prenatal care can also mitigate or prevent negative birth outcomes associated with NAS and NOWS.[131]

Every health region in Texas has an Outreach, Screening, Assessment and Referral (OSAR) Center which can assist any Texas resident with finding appropriate treatment and community resources. To find local resources and additional assistance, please visit the HHSC OSAR webpage.[132] Individuals can also locate substance use services in their area by visiting the substance use service locator map.[133]

***Special Issue:*** *"Return to use" is the recommended term to avoid shame and stigma associated with the term "relapse," however "relapse" and "relapse prevention" are still commonly used terms.*

### 2. Relapse Prevention

Parents in DFPS cases who have difficulty with substance use may relapse or return to use. However, with the right support and appropriate level of intervention, it is possible to achieve successful reunification with a parent who has addressed or is addressing their substance use. At this time, there are no standardized resources statewide. DFPS uses state funded and community resources that use individualized treatment approaches to meet the needs of parents and families. DFPS policy states the following in relevant part regarding relapse prevention planning:

- Relapse is a return to a pattern of substance use after a period of non-use.
- In the relapse safety plan, the client, along with a trusted support system, plans to ensure the safety of the child or children, in case relapse becomes an issue.
- Court orders supersede any actions that the client requests in the relapse safety plan.
- A relapse safety plan can be developed at any stage of service.

Please see *Developing a Safety Plan in Case a Client Relapses* (CPS Policy Handbook § 1982.2) for more information.

## D. DFPS Response to Substance Use Disorders

The Child Abuse Prevention and Treatment Act (CAPTA, P.L. 93-247) was originally enacted in 1974, was last reauthorized in 2010, and amended most recently in 2019; additionally, certain provisions were amended by the Comprehensive Addiction and Recovery Act (CARA) of 2016 and the Victims of Child Abuse Act Reauthorization Act of 2018 (P.L. 115-424).[134]

Under these federal laws, states are required to have plans of safe care for infants born and identified as being affected by substance use or withdrawal symptoms of both legal and illegal substances. The plans of safe care are required to "ensure the safety and well-being of such infant following [the infant's] release from the care of health care providers" to be achieved through "addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver." 42 U.S.C.S. § 5106a(b)(1)-(2).

To avoid confusion, DFPS does not utilize the unique federal term "plan of safe care" as set forth in CARA, as there are a number of DFPS tools and policies that reference "plans." Statewide Intake protocols, safety and risk assessment tools, and the service planning process used in different stages of service, collectively mean that the state meets the requirements under the CARA plans of safe care.

Examples of types of plans that do not include removal include: use of Parental Child Safety Placements (PCSP) to assure safety as the parent initiates or becomes engaged in services; use of residential substance use disorder treatment programs that allow a mother (or father in a few programs) to live in a treatment setting with the child, when appropriate; use of Medication-Assisted Treatment in combination with behavioral therapies; and the guidance of specialized drug courts in some areas. While access to treatment can be challenging, families referred by DFPS are considered a state priority population for state-funded substance use intervention and treatment services. In Texas, a client who is not pregnant and is referred to an HHSC-funded substance use intervention or treatment service by DFPS must be admitted to services within 72 hours or 3 business days, depending on the program or services.

Doctors and nurses are required by mandatory reporting laws to report suspected child abuse and neglect if they have reasonable cause to believe the child has been abused as defined by statute. Tex. Fam. Code § 261.101(b). Definitions of child abuse in Texas law include the current use of controlled substances by an adult in a manner or to the extent that the use results in physical, mental, or emotional injury to a child. Tex. Fam. Code § 261.001(1)(I).

DFPS Statewide Intake advances any reports of substance-exposed infants to the field for an investigation. During the investigation, multiple steps occur including: a child assessment, parental assessment, holistic family assessment, safety planning, and the development of initial services. In some cases, the parent has sufficient support and is protective and/or engaged in treatment services, thereby eliminating the need for further DFPS involvement beyond investigation. Other parents may be assisted in development of a plan and access to services during the investigation stage of services, or a Family-Based Safety Services (FBSS) stage may be opened to provide ongoing services without removal. Where safety cannot be assured, DFPS will seek removal of the infant.

***Special Issue**: The birth of a substance-exposed infant does not result in an automatic removal of that child, nor even an automatic disposition of child abuse or neglect. Each family's specific circumstance is assessed. DFPS works closely with Health and Human Services agency partners who provide substance use intervention or treatment services to strengthen the State's response to parents who engage in substance use or misuse.*

### 1. Behavioral Health Division at DFPS

In Fiscal Year 2019, DFPS formed the Behavioral Health Services Division within CPS. The division now includes a Behavioral Health Services Division Administrator, a Trauma-Informed Care Manager, six new regional Trauma-Informed Care Program Specialists, a Behavioral Health Services Program Specialist Lead, three Substance Use Program Specialists, two CANS Program Specialists, and a Mental Health Program Specialist. The Medical Services Division covers medical and dental issues for CPS with Nurse Consultants and Well-Being Specialists. The Behavioral Health Services Division

Administrator and the Trauma Informed Care Program Manager are based at the State Office in Austin. The Behavioral Health Services Program Specialist is located in Houston, one CANS Program Specialist operates in San Antonio, and a second CANS Program Specialist is in Houston. The Trauma Informed Care Program Specialist positions are based in San Antonio, Dallas, Houston, Corpus, Midland, and Paris. The division includes three Substance Use Program Specialists located in San Antonio, Dallas, and Houston. These positions complement two additional Substance Use Program Specialists and two Mental Health Program Specialists who are based in Austin and report to Child Protective Investigations. These staff work together to provide support, resources, and technical assistance to direct delivery staff in their work with families experiencing substance use disorders through every stage of service.

## E. Resources

Children and Family Futures[135]

American Addiction Centers' Information on Addiction Signs, Symptoms, Effects, and Treatment[136] and Addiction Cravings: Symptoms, Treatment and Relapse Prevention[137]

National Institute on Drug Abuse[138]

National Center on Substance Abuse and Child Welfare (NCSACW)[139]

National Council of Juvenile and Family Court Judges (NCJFCJ)[140]

NCSACW Information on Family Treatment Drug Court[141]

Substance Abuse and Mental Health Services Administration (SAMHSA)[142]

Texas Health and Human Services Mental Health and Substance Use[143]

# TRAUMA-INFORMED CARE

## A. Trauma

The concept of trauma and the accompanying research have shifted the paradigm about the way in which systems, organizations, professionals, and caregivers approach and serve children, youth, young adults, and families who experience the child welfare system. The field of trauma and trauma-informed care is constantly evolving and expanding. The information in this chapter is intended to give judges a basic understanding of these topics to help them manage child welfare cases in a trauma-informed manner.

40 Tex. Admin. Code § 702.701(a) defines trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening with lasting adverse effects on the individual's functioning or the individual's mental, physical, social, emotional, or spiritual well-being."[144]

**Some examples of traumatic experiences include:[145]**

- Physical, sexual, or psychological abuse and neglect (including trafficking);
- Family or community violence (both experiencing and witnessing);
- Loss of loved ones or traumatic grief;
- Witnessing violence;
- Natural and technological disasters or terrorism;
- Serious accidents;
- Historical trauma;[146]
- Medical trauma; and/or
- Military family-related stressors (e.g., deployment, parental loss, or injury)

## B. Trauma Impacts a Child's Development and Health

The groundbreaking 1998 study on Adverse Childhood Experiences (ACEs) and the replicated studies which followed demonstrate that childhood stress is linked to poor health outcomes, including obesity, diabetes, depression, heart disease, cancer, and stroke as well as alcohol and drug abuse, low graduation rates, and poor employment outcomes.[147] The presence of ACEs does not mean that a child is guaranteed to experience poor life outcomes. Positive experiences and protective factors can prevent children from experiencing adversity and protect against many negative health and life outcomes.[148]

Undoubtedly, children and youth who experience abuse or neglect, are removed from their families, or interact with the child welfare system are vulnerable to experiencing trauma. Further, many parents and caregivers may have their own experiences with trauma and systems must respond to the needs

of children and families through a trauma-informed lens. This requires judges, attorneys, court staff, and other stakeholders to understand how traumatic responses manifest in the children and families in front of the court and subsequently change courtroom practices and the courtroom environment to help families feel supported and build resilience. In doing so, serving children and families can move beyond responding to behaviors to promoting healing.

It is important to note that no age is immune to the effects of traumatic experiences, including infants and toddlers. Traumatic stress will manifest differently from child to child and will depend on the child's age and developmental level.[149]

Children who are not experiencing consistent safety, comfort, and protection may develop ways of coping that allow them to survive and function day-to-day. These learned adaptations make sense when a physical and/or emotional threat is pervasive but are not helpful once a person is no longer under such threats.[150] Additionally, unaddressed trauma can lead to long-term effects into adulthood.

Some potential effects of trauma are:[151]

- Difficulties with emotional regulation, focus, and self-control (when in fight or flight mode, the brain loses executive functions that do not serve fight or flight, such as higher learning and problem-solving which contribute substantially to school success);
- Anxious and avoidant behaviors;
- Difficulty developing strong, healthy attachment to caregivers and others;
- Distrust of people in authority, who are seen as threats;
- Over-responding or under-responding to sensory stimuli;
- Misinterpreting motives, facial expressions, body language in others;
- Difficulties belonging and playing well with others;
- Difficulty with problem solving and decision-making;
- Chronic or recurrent physical complaints;
- Potential impacts to self-efficacy; and/or
- More likely to engage in high-risk behaviors.

## C. Trauma-Informed Child Welfare System

40 Tex. Admin. Code § 702.701(b) defines Trauma-Informed as:

An individual, program, organization, or system that is trauma-informed fully integrates knowledge about trauma into policies, procedures, and practices by:

- Realizing the widespread impact of trauma, understanding potential paths for recovery, and acknowledging the compounding impact of structural inequities related to culture, history, race, gender, identity, locale, and language;

- Recognizing the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- Maximizing physical and psychological safety and responding to the impact of structural inequities on individuals and communities;
- Building healthy, trusting relationships that create mutuality among children, families, caregivers, and professionals at an individual and organizational level; and
- Striving to avoid re-traumatization.

The document "Building a Trauma-Informed Child Welfare System: A Blueprint" lays out nine Guiding Principles for child welfare stakeholders to use to continue transforming the system to one that is trauma-informed and trauma-responsive. The nine Guiding Principles as well as suggested trauma-informed practices to be implemented in the courtroom are provided below.

1. **CULTURE:** Texas will create a culture of trauma-informed care for all individuals and organizations that touch the lives of children, youth, young adults, and families while they are involved in the child welfare system.

   - Acknowledge the children, youth, young adults, and family members in court have likely experienced trauma and may continue to experience trauma throughout the case.
   - Review current courtroom practices and environment with a trauma-informed lens and integrate improvements.
   - Base communications between court professionals and participants in trauma-informed principles.
   - Create an environment of safety, respect, honesty, and humility to nurture healing, rehabilitation, and resiliency. Modify the environment, such as seating, lighting, and signage to be trauma-informed.
   - Develop a shared understanding of the role that trauma has played in shaping the survivor's life. Connect trauma concerns with the rest of the child's problems and goals, and understand that experiences of physical, sexual, and emotional abuse can shape fundamental patterns of perceiving the world, other people, and oneself.
   - Identify current circumstances that may trigger trauma responses, e.g., unexpected touching, threats, loud arguments, violations of privacy or confidentiality, being in confined spaces with strangers, or sexual situations. Be watchful for other less obvious triggers that become evident as you know the family better and as family members recognize and can express their individual stress responses more accurately.
   - Promote and support efforts to reduce the use of seclusion and restraint practices.
   - Create service plans and court orders that are individualized to address the trauma-related needs of the child and family to promote healing and minimize re-traumatization.
   - Address trauma-related needs during transition periods.

2. **COLLABORATION:** A trauma-informed child welfare system requires collaboration within and across systems, organizations, and individuals.

   - Create an environment of open collaboration between all stakeholders to enhance services to families.

   - Increase accessible and effective trauma services through education and collaboration among the many stakeholders (mental health providers, caseworkers, foster parents, caregivers at kinship placements and residential treatment centers, judges, attorneys, CASAs, medical community, law enforcement)

3. **EQUITY:** A trauma-informed child welfare system is culturally competent and equitable.

   - Consider a child and family's identity and cultural background when addressing participants and making decisions.

   - Seek out equity training for court staff. See the Chapter on Disproportionality for additional resources.

   - Review disaggregated data and address disproportionalities and disparities in collaboration with community partners. See the Bench Book chapter *Disproportionality and Equity* for more information.

4. **YOUTH & FAMILY VOICE:** A trauma-informed child welfare system includes and respects youth and family voice and cultivates resilience.

   - Gather the child's perspective on their case through the appropriate avenue for each individual child (in-person, video conference, letter, etc.).

   - Engage children, youth, parents, and family members in identifying the best approach for achieving reunification or other permanency options when reunification is not possible.

   - Minimize the trauma from removal and attachment disruption by increasing visitation with parents, siblings, and other close family (especially in children ages zero to three) to provide meaningful and consistent connections with appropriate family members.

   - Help children and youth identify strategies helpful in the past in dealing with overwhelming emotions. Place priority on child's preferences regarding self-protection and self-soothing needs by using de-escalation preference surveys.

   - Facilitate healthy relationship building with a trusted adult (e.g., CASA; community member; family member)

   - Support and encourage normalcy activities as defined by the individual child. See the Bench Book chapter *Child and Youth Voice* for more information.

5. **SECONDARY TRAUMA:** A trauma-informed child welfare system recognizes and addresses secondary trauma.

- Assess courtroom practices to evaluate the work environment and its impact on court staff and professional wellness as it relates to secondary trauma.[152]

- Encourage court staff and professionals to complete periodic self-assessments for personal reflection.[153]

- Provide trainings and resources that support self-care and minimize the impact of secondary trauma.

6. **TRAINING:** A trauma-informed child welfare system recognizes that ongoing, quality training is fundamental.

   - Train court staff and professionals on the basic concepts of brain science, trauma, and trauma-related behaviors. Collaborate with stakeholders and community partners to leverage existing training and technical assistance resources. (The Judicial Trauma Institute replay and materials are available on the Children's Commission's website.)[154]

   - Provide ongoing, regular training to court staff and professionals to sustain trauma-informed changes and provide opportunities to implement what they learn.

7. **INFORMATION SHARING:** A trauma-informed child welfare system has information sharing capabilities that are accessible, manageable, innovative, and user-friendly.

   - Enhance collaboration pathways within and outside the courtroom to enhance information sharing processes.

   - Encourage the creation of a learning collaborative in the community to increase opportunities for sharing resources and knowledge and building relationships.

8. **DATA:** A trauma-informed child welfare system is informed by data and committed to continuous quality improvement.

   - Collaborate with stakeholders to ensure quality data collection practices.

   - Evaluate data and institute necessary changes with a trauma-informed lens.

9. **FUNDING & SUSTAINABILITY:** A trauma-informed child welfare system is adequately funded and sustainable.

   - Partner with community stakeholders to develop strategies for sustaining a trauma-informed courtroom.

## D. Statutory Requirements for Trauma-Informed Care Training

### 1. Training for Attorney Ad Litems

As of September 1, 2021, an attorney who is on the list maintained by the court as being qualified for appointment as an attorney ad litem for a child in a child welfare case must provide proof that the attorney has completed a training program regarding trauma-informed care and the effect of trauma on children in DFPS conservatorship. Attorneys should complete the training as soon as practicable

once placed on the appointment list. Thereafter, an attorney must provide proof each year of compliance with the statute. Tex. Fam. Code § 107.004(b)-(b-3).

An attorney ad litem is responsible for periodically reviewing the child client's safety and well-being, including effects of trauma to the child. Tex. Fam. Code § 107.004 (d-3). Attorney ad litem training must now include information regarding:

- The symptoms of trauma and the impact that trauma has on a child, including how trauma may affect a child's development, emotions, memories, behavior, and decision-making;
- Attachment and how a lack of attachment may affect a child;
- The role that trauma-informed care and services can have in a child's ability to build connections, feel safe, and regulate the child's emotions to help the child build resiliency and overcome the effects of trauma and adverse childhood experiences;
- The importance of screening children for trauma and the risk of mislabeling and inappropriate treatment of children without proper screening, including the risks and benefits associated with the use of psychotropic medication;
- The potential for re-traumatization of children in the conservatorship of the Department of Family and Protective Services; and
- The availability of:
    - research-supported, trauma-informed, non-pharmacological interventions; and
    - trauma-informed advocacy to increase a child's access, while the child is in the conservatorship of the Department of Family and Protective Services, to:
        - trauma-informed care; and
        - trauma-informed mental and behavioral health services. Tex. Fam. Code § 107.004 (b-4).

**2. DFPS Training**

In 2011, the Texas Family Code was amended to require DFPS to include training in trauma-informed programs and services in any training which DFPS provides to foster parents, adoptive parents, kinship caregivers, department caseworkers, and department supervisors. Tex. Fam. Code § 264.015.

DFPS caseworkers are required to complete an initial, in-person training on trauma-informed care during their basic skills development training and an annual refresher course online. Supervisors and mentors are also required to complete a secondary trauma training. DFPS internal learning management system offers several optional trainings on trauma-related topics.

**3. Residential Child Care Contract (RCCC) Requirements**

As of September 1, 2015, DFPS required all caregivers and employees who are subject to RCCC for direct care to complete:

- At least eight hours of trauma-informed care training prior to being the only caregiver responsible for children; and
- At least two hours of trauma-informed care annually, and contractors may select their own curriculum/model for the annual refresher training.

Since 2015, DFPS is required to institute a comprehensive psychosocial assessment tool to assess all children who enter the foster care system within 45 days. The tool must include a trauma assessment and an interview with at least one individual who knows the child. DFPS utilizes the CANS 2.0 to assess children and youth placed in substitute care ages 3 to 17 years within 30 days. Tex. Fam. Code § 266.012.

### 4. Related Fields

Since 2013, the Texas Human Resources Code requires trauma-informed care training for certain staff of county and state juvenile facilities, including probation officers, supervision officers, correctional officers, parole officers and court-supervised community-based program personnel. Tex. Hum. Res. Code § 221.002(c-1) and Tex. Hum. Res. Code § 221.0061.

## E. Emergency Behavior Interventions

Many trauma-informed care trainings promote specific strategies including self-care approaches, peer-provided services, arts programs, and comfort rooms to enhance healing and as to provide a means to avoid the use of restraint and seclusion. In Texas, the Administrative Code offers the following guidelines on utilizing Emergency Behavior Interventions, such as restraints and seclusion, on children in General Residential Operations and Residential Treatment Centers. These guidelines are summarized in the chart which follows.

### 1. Restraint/Seclusion May Only Be Used:

- As last resort

  26 Tex. Admin. Code § 748.2455(a)(1) and (2); 26 Tex. Admin. Code § 749.2055(a)(1) and (2); 26 Tex. Admin. Code § 748.2551(a); and 26 Tex. Admin. Code § 749.2151

- After less restrictive and more positive measures have been tried and failed

  26 Tex. Admin. Code § 748.2455(a)(1) and (2); 26 Tex. Admin. Code § 749.2055(a)(1) and (2); 26 Tex. Admin. Code § 748.2551(a); and 26 Tex. Admin. Code § 749.2151(a)

- Only in an emergency situation or to administer intra-muscular medication or other physician prescribed medication

  26 Tex. Admin. Code § 748.2455(a)(2); 26 Tex. Admin. Code § 749.2055(a)(2); 26 Tex. Admin Code § 748.43(22); and 26 Tex. Admin. Code § 749.43(25) (Definition of emergency situation)

- When immediately necessary

26 Tex. Admin. Code § 748.43(20); 26 Tex. Admin. Code § 749.43(23) (Definition of Emergency Behavioral Intervention (EBI); 26 Tex. Admin Code § 748.43(22); and 26 Tex. Admin. Code § 749.43(25) (Definition of emergency situation)

- To prevent imminent probable death or substantial physical injury

  26 Tex. Admin. Code § 748.43(20); 26 Tex. Admin. Code § 749.43(23) (Definition of EBI); 26 Tex. Admin. Code § 748.43(22); 40 Tex. Admin. Code § 749.43(25) (Definition of emergency situation); 26 Tex. Admin. Code § 748.43(68); and 26 Tex. Admin. Code § 749.43(72) (Definition of substantial physical injury)

- Never as punishment, retaliation, means of compliance, convenience, or treatment

  26 Tex. Admin. Code § 748.2463 and 26 Tex. Admin. Code § 749.2063

**2. Types of Restraints That May Be Administered with Restrictions:**

- Short personal restraint and personal restraint

  26 Tex. Admin. Code § 748.2451(a)(1) and (2); 26 Tex. Admin. Code § 749.2051(a)(1) and (2); 26 Tex. Admin. Code § 748.43(51) and (65); and 26 Tex. Admin. Code § 749.43(52) and (69) (Definition of personal restraint and short personal restraint)

- Emergency medication

  26 Tex. Admin. Code § 748.2451(a)(3); 26 Tex. Admin. Code § 749.2051(a)(3); 26 Tex. Admin. Code § 748.2753 (simultaneous use with another EBI); 26 Tex. Admin. Code § 749.2233 (simultaneous use with personal restraint); 26 Tex. Admin. Code § 748.43(21); and 26 Tex. Admin. Code § 749.43(24) (Definition of emergency medication)

- Seclusion

  26 Tex. Admin. Code § 748.2451(a)(4); 26 Tex. Admin. Code § 748.2651; 26 Tex. Admin. Code § 748.43(63); 26 Tex. Admin. Code § 749.43(67) (Definition of seclusion); and 26 Tex. Admin. Code § 749.2051(b)

- Mechanical restraint

  26 Tex. Admin. Code § 748.2451(a)(5) (only in Residential Treatment Centers); 26 Tex. Admin. Code § 748.2701; 26 Tex. Admin. Code § 748.2703; 26 Tex. Admin. Code § 748.2755 (simultaneous use with emergency medication); 26 Tex. Admin. Code § 748.43(39); 26 Tex. Admin. Code § 749.43(40) (Definition of mechanical restraint); and 26 Tex. Admin. Code § 749.2051(b)

**3. Restraint/Seclusion May Only Be Administered by:**

- A caregiver qualified in emergency behavior interventions

  26 Tex. Admin. Code § 748.2453; 26 Tex. Admin. Code § 749.2053; (Requirements); 26 Tex. Admin. Code § 748.947; 26 Tex. Admin. Code § 749.947 (Annual training

requirements)26 Tex. Admin. Code § 748.863(a); 26 Tex. Admin. Code § 749.863(a) (Pre-service training requirements); 26 Tex. Admin. Code § 748.930; and 26 Tex. Admin. Code § 749.930 (Training hours).

- Whose duties include the direct care, supervision, guidance, and protection of child

  26 Tex. Admin. Code § 748.43(5) and 26 Tex. Admin. Code § 749.43(9)

4. **A Child Must Be Released from a Restraint/Seclusion**:

- Immediately if an emergency health situation arises

  26 Tex. Admin. Code § 748.2553(1)(A), (2)(A), (4)(A), and (5)(A); 26 Tex. Admin. Code § 749.2153(1)(A) and (2)(A); 26 Tex. Admin. Code § 748.2603; and 26 Tex. Admin. Code § 749.2203

- Immediately once the danger is over

  26 Tex. Admin. Code § 748.2553(2)(C) and 26 Tex. Admin. Code § 749.2153(2)(C)

- Once maximum time allowed is reached

  26 Tex. Admin. Code § 748.2553(2)(E); 26 Tex. Admin. Code § 749.2153(2)(E); and 26 Tex. Admin. Code § 748.2553(2)(E) and (4)(D)

**Figure: 26 Tex. Admin. Code § 748.2553**

| **Type of Emergency Behavior Intervention** | **The caregiver must release the child if any of the following apply:** |
|---|---|
| (1) Short personal restraint | (A) Immediately when an emergency health situation occurs during the restraint and the caregiver must obtain treatment immediately; or<br>(B) Within one minute, or sooner if the danger is over or the emergency situation no longer exists. |
| (2) Personal restraint | (A) Immediately when an emergency health situation occurs during the restraint. The caregiver must obtain treatment [for the child] immediately;<br>(B) Within one minute of the implementation of a prone or supine transitional hold;<br>(C) As soon as the child's behavior is no longer a danger to himself or others;<br>(D) As soon as the medication is administered; or<br>(E) When the maximum time allowed for personal restraint is reached. |
| (3) Emergency medication | Not applicable. |

| Figure: 26 Tex. Admin. Code § 748.2553 | |
|---|---|
| **Type of Emergency Behavior Intervention** | **The caregiver must release the child if any of the following apply:** |
| (4) Seclusion | (A) Immediately when an emergency health situation occurs during the seclusion and the caregiver must obtain treatment immediately;<br>(B) As soon as the child's behavior is no longer a danger to himself or others;<br>(C) No later than five minutes after the child begins exhibiting the required behaviors;<br>(D) When the maximum time allowed for seclusion is reached;<br>(E) If the child falls asleep in seclusion, the caregiver must:<br>(i) Unlock the door;<br>(ii) Continuously observe the child until he awakens; and<br>(iii) Evaluate his overall well-being; or<br>(F) If the child is receiving emergency care services:<br>(i) As soon as the child is no longer a danger to himself or others;<br>(ii) Upon the arrival of a medical professional; or<br>(iii) Upon assistance from law enforcement or the fire department. |
| (5) Mechanical restraint | (A) Immediately when an emergency health situation occurs during the restraint and the caregiver must obtain treatment immediately;<br>(B) As soon as the child's behavior is no longer a danger to himself or others;<br>(C) No later than five minutes after the child begins exhibiting the required behaviors;<br>(D) When the maximum time allowed for mechanical restraint is reached; or<br>(E) If the child falls asleep in the mechanical restraint. In this situation, the caregiver must release the child from the restraint and continuously observe the child until he awakens and evaluate him. |

| Figure: 26 Tex. Admin. Code § 748.2801 | |
|---|---|
| **Types of Emergency Behavior Intervention** | **The maximum length of time is:** |
| (1) Short personal restraint | One minute. |
| (2) Personal restraint | (A) For a child of any age, 30 minutes;<br>(B) A prone or supine personal restraint transitional hold may not exceed one minute. |
| (3) Emergency medication | Not applicable. |
| (4) Seclusion | (A) For a child under nine years old, one hour.<br>(B) For a child nine years old or older, two hours. |
| (5) Mechanical restraint | (A) For a child under nine years old, 30 minutes.<br>(B) For a child nine years old or older, one hour. |

**When restraining/secluding, a written order is required:**

- By a licensed physician when administering emergency medications

  26 Tex. Admin. Code § 748.2501(3) and 26 Tex. Admin. Code § 749.2101(3)

- By a licensed psychiatrist when administering mechanical restraints

  26 Tex. Admin. Code § 748.2501(5)

- By a licensed psychiatrist, physician, or psychologist when administering successive restraints

  26 Tex. Admin. Code § 748.2501(2); 26 Tex. Admin. Code § 749.2101(2)(A); 26 Tex. Admin. Code § 748.2751(3); and 26 Tex. Admin. Code § 749.2231(a)

- When using restraints simultaneously

  26 Tex. Admin. Code § 748.2501(2); 26 Tex. Admin. Code § 749.2101(2)(A); 26 Tex. Admin. Code § 748.2753(a)(3) and (b); 26 Tex. Admin. Code § 749.2233(a) (Emergency medications with personal restraint); and 26 Tex. Admin. Code § 748.2755(a)(3) and (b) (Mechanical restraints with emergency medications)

- When maximum length of time allowed is exceeded

  26 Tex. Admin. Code § 748.2805; however under 26 Tex. Admin. Code § 749.2283, time extension prohibited.

- Also see: 26 Tex. Admin. Code § 748.2505; 26 Tex. Admin. Code § 749.2105 (Content of written orders); 26 Tex. Admin. Code § 748.2507; 26 Tex. Admin. Code § 749.2107 (PRN orders); and 26 Tex. Admin. Code § 748.2807 (verbal orders to exceed maximum time allowed)

| Figure: 26 Tex. Admin. Code § 748.2501 | | |
|---|---|---|
| **Type of Emergency Behavior Intervention** | **Are written orders required to administer the intervention for a specific child?** | **Who can write orders for the use of the intervention for a specific child?** |
| (1) Short personal restraint | NO. | Not applicable. |
| (2) Personal restraint | NO. However, successive restraints, a restraint simultaneous with emergency medication, and/or a restraint that exceeds the maximum time limit all require orders as specified in this subchapter. PRN orders are also permitted under 26 Tex. Admin. Code §748.2507 of this title (relating to "Under what conditions are PRN orders permitted for a specific child?"). | Not applicable. |
| (3) Emergency medication | YES. | A licensed physician. |
| (4) Seclusion | YES, except written orders are not required when [professionals] provide emergency care services to the child placed in seclusion. | A licensed psychiatrist, psychologist, or physician. |
| (5) Mechanical restraint | YES. | A licensed psychiatrist. |

**A review is triggered when:**

- Personally restrained four times in a seven-day period or more than 12 times in 30-day period or same child personally restrained more often than order allows.

  26 Tex. Admin. Code § 748.2901(a)(2) and 26 Tex. Admin. Code § 749.2331(a)(2)

- Emergency medications used three times in a thirty-day period

  26 Tex. Admin. Code § 748.2901(3) and 26 Tex. Admin. Code § 749.2331(3)

- Secluded more than twelve hours or three times in a seven-day period

26 Tex. Admin. Code § 748.2901(a)(4) (Note that this is not applicable to foster care placements.)

- Mechanically restrained more than three hours or three times in a seven-day period

  26 Tex. Admin. Code § 748.2901(a)(5) (Note that this is not applicable to foster care placements.)

**Restraint/Seclusion that is NOT allowed:**

- Mechanical restraint may not be simultaneously used with seclusion or pursuant to PRN order

- 26 Tex. Admin. Code § 748.2757 and 26 Tex. Admin. Code § 748.2507(5)

- No chemical restraints

  26 Tex. Admin. Code § 748.1119(1); 26 Tex. Admin. Code § 749.1021(1); 26 Tex. Admin. Code § 748.2451(b); 26 Tex. Admin. Code § 749.2051(b); 26 Tex. Admin. Code § 748.43(7); and 26 Tex. Admin. Code § 749.43(12) (Definition)

- Prone or supine restraints except for a transitional hold for 1 minute or less or as a last resort

  26 Tex. Admin. Code § 748.2605(b); 26 Tex. Admin. Code § 749.2205(b) and (c); 26 Tex. Admin. Code § 748.2461(b)(1); 26 Tex. Admin. Code § 749.2061(b)(1); 26 Tex. Admin. Code § 748.2553(2)(B); 26 Tex. Admin. Code § 749.2153(2)(B); 26 Tex. Admin. Code § 748.2801(2)(B); and 26 Tex. Admin. Code § 749.2281(2)(B)

- Foster care placements may never administer chemical restraints, mechanical restraints, or seclusion.

Also see other relevant provisions:

- 26 Tex. Admin. Code § 748.1119 and 26 Tex. Admin. Code § 749.2051 (Techniques prohibited)

- 26 Tex. Admin. Code § 748.2303 and 26 Tex. Admin. Code § 749.1953 (May not use or threaten corporal punishment)

- 26 Tex. Admin. Code § 748.2307 and 26 Tex. Admin. Code § 749.1957 (Methods of punishment prohibited)

- 26 Tex. Admin. Code § 748.2605 and 26 Tex. Admin. Code § 749.2205 (Prohibited physical restraint techniques)

- 26 Tex. Admin. Code § 748.2705 (Types of mechanical & other restraint devices prohibited)

## F. Trauma Work in Texas

### 1. Reports

Building a Trauma-Informed Child Welfare System: A Blueprint[155]

Trauma-Informed Care Final Report, The Meadows Mental Health Policy Institute for Texas[156]

### 2. Statewide Initiatives

- **The Statewide Collaborative on Trauma-Informed Care**

In July 2017, the Children's Commission launched the Statewide Collaborative on Trauma-Informed Care (SCTIC), which aims to elevate trauma-informed policy in the Texas child welfare system by creating a statewide strategy to support system reform, organizational leadership, cross-systems collaboration, and community-led efforts with data-informed initiatives to develop champions, consensus, and funding. The SCTIC began with a planning group with the Children's Commission, Meadows Mental Health Policy Institute (MMHPI), Texas CASA, and the Department of Family and Protective Services and created workgroups to carry out its mission. Since its inception, the SCTIC assisted in the release of resource documents and training events which can be found on www.TraumaInformedTexas.com.

- **Behavioral Health Division at DFPS**

In Fiscal Year 2019, DFPS formed the Behavioral Health Services Division within CPS. The division now includes a Behavioral Health Services Division Administrator, a Trauma-Informed Care Manager, six new regional Trauma-Informed Care Program Specialists, a Behavioral Health Services Program Specialist, three Substance Use Program Specialists, two CANS Program Specialists, and a Mental Health Program Specialist. The Medical Services Division covers medical and dental issues for CPS with Nurse Consultants and Well-Being Specialists. The Behavioral Health Services Division Administrator and the Trauma Informed Care Program Manager are based at the State Office in Austin. The Behavioral Health Services Program Specialist is located in Houston, one CANS Program Specialist operates in San Antonio and a second CANS Program Specialist is in Houston. The Trauma Informed Care Program Specialist positions are based in San Antonio, Dallas, Houston, Corpus, Midland, and Paris or surrounding areas. The division includes three Substance Use Program Specialists located in San Antonio, Dallas, and Houston. These positions complement a two additional Substance Use Program Specialists and two Mental Health Program Specialists who are based in Austin and report to Child Protective Investigations. These staff work together to provide support, resources, and technical assistance to direct delivery staff in their work with families experiencing substance use disorders through every stage of service.

- **Cross-Systems Trauma-Informed Care initiative**

The Texas Health and Human Services Commission (HHSC) Office of Mental Health Coordination leads a Cross Systems Trauma-informed Care (CSTIC) initiative. The vision of the CSTIC is a coordinated behavioral health system, as envisioned by the Behavioral Health Strategic Plan, which is healing-centered and trauma-informed in its foundation and unified in its implementation of a person-centered and family-focused approach across Texas. The CSTIC initiative involves working with state agencies across Texas to advance trauma-informed organizations, culture, and services. The collaboration includes representatives from state agencies who receive state funding for

behavioral health training or services. As part of the CSTIC initiative, HHSC leads an internal Trauma Transformation Team with representatives from different divisions and departments within the agency who facilitate trauma-informed change within HHSC.

- **Children's Advocacy Centers (CAC) Practice Model**

In 2013, the Texas Legislature raised the standard for mental health services in CACs, requiring that all mental health services be trauma-focused and evidence-based. Additionally, mental health services must be provided by professionals who have a master's degree and are licensed, or who are students in an accredited graduate program and supervised by a licensed mental health professional.

- **Trauma-Informed Care Specialty Network**

Created by STAR Health, the Trauma-Informed Care Specialty Network allows its providers to list the training on trauma that they have pursued and helps identify providers who have been trained in trauma-informed care in the STAR Health network for caseworkers, caregivers, and others in the child welfare community. STAR Health also offers TIC trainings to CPA, kinship families, RTC staff, and Emergency Shelter staff.

### 3. Examples of Community-Level Initiatives

- Region 3 Foster Care Consortium

Established in 2015 to promote collaboration and information sharing among the many stakeholders committed to the well-being of children in the child welfare system. the Consortium facilitates productive partnerships and sponsors informative programming, drawing on the resources of integrated health care and other service providers, child advocates, policy groups, child placing agencies, education liaisons, foster parents, court personnel, single source continuum contractors, and DFPS leadership.

- The Travis County Collaborative for Children (TCCC)

Led by Texas Christian University's (TCU) Karyn Purvis Institute of Child Development (KPICD), the TCCC implemented system-wide changes to the way children in Travis County are cared for during and after their time in state custody. TCCC's goal is to accelerate healing and speed to permanency for children in foster care utilizing KPICD's research-based Trust-Based Relational Intervention (TBRI®) principles and practices.

- The Trauma-Informed Care Consortium of Central Texas (TICC)

Established in 2013 by St. David's Foundation and Austin Child Guidance Center, the TICC brings together professional organizations quarterly to network, share information, and coordinate trainings for mental health clinicians, school personnel, medical/nursing professionals, law enforcement, and juvenile justice professionals.

- The South Texas Trauma-Informed Care Consortium

The South Texas Trauma Informed Care Consortium is a collaboration between The Children's Shelter, Voices for Children, and City of San Antonio Metro Health Department that brings together community participants who are committed to addressing the impact of trauma.

## G. National Resources

NCJFCJ, Ten Things Every Juvenile Court Judge Should Know about Trauma and Delinquency[157]

NCJFCJ, Assessing Trauma for Juvenile and Family Courts[158]

NCSC, Study of Virtual Child Welfare Hearings Facilitating Trauma-Responsive Virtual Hearings for Dependency Cases[159]

National Child Traumatic Stress Network (NCTSN), Bench Cards for the Trauma-Informed Judge[160]

NCTSN, LGBTQ Issues and Child Trauma[161]

Mental Health America (MHA) and the National Association of State Mental Health Program Directors (NASMHPD), Position Statement on Seclusion and Restraint[162]

## H. Training Resources

Children's Commission's Judicial Trauma Institute[163]

Trauma Informed Texas www.TraumaInformedTexas.com[164]

DFPS Trauma-Informed Care Training[165]

NCTSN Learning Center[166]

Superior HealthPlan, the STAR Health Managed Care Organization (MCO), offers online webinars through their parent organization, Centene Foster Care[167]