JUDICIAL BENCH GUIDE

SUPPORTING THE MENTAL HEALTH OF CHILDREN & YOUTH IN FAMILY COURT

JUDICIAL COUNCIL OF CALIFORNIA

National Center for Youth Law

ACKNOWLEDGEMENTS

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Please note that this resource contains legal information, not legal advice. Readers are encouraged to consult with counsel regarding the legal topics discussed.

For questions, please contact health@youthlaw.org.

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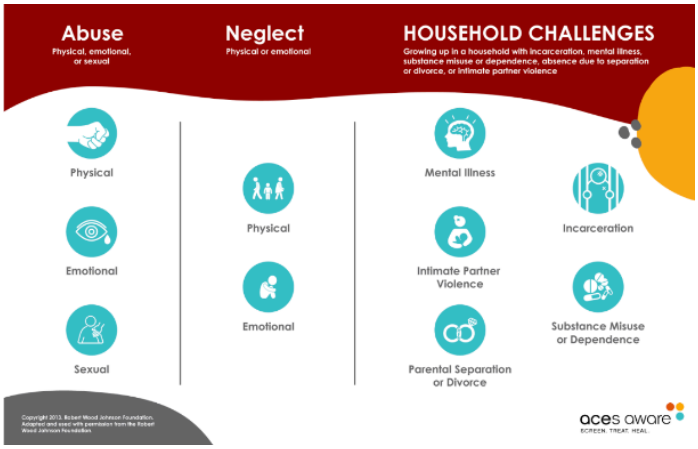
1. BACKGROUND: MENTAL HEALTH NEEDS OF CHILDREN & YOUTH

This Bench Guide focuses on the mental health of children and youth involved in family court proceedings in California. Mental health is a critical component of a person's overall health and well-being, and of healthy childhood and adolescent development. While "mental health" is often used interchangeably with terms like "mental illness" or "mental disorder," the World Health Organization conceives of mental health as a broad and multi-faceted concept: "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community."[1] In other words, mental health is not simply the absence of an illness or disorder.



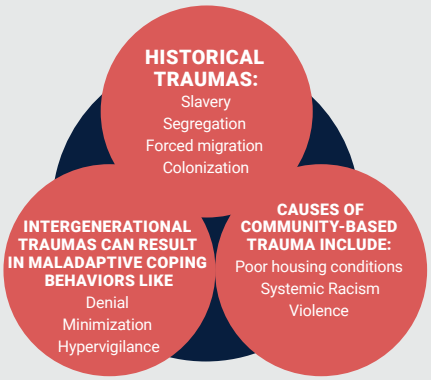
Robert Wood Johnson Foundation- Categories of Adverse Childhood Experiences

A person's mental or behavioral health is impacted, positively or negatively, by a number of factors, including biological, environmental, and socioeconomic factors. Socioeconomic factors are often referred to as **social determinants of health (SDOH):**[2] "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning and quality-of-life outcomes and risks."[3] Examples of SDOH include housing conditions, poverty, educational opportunities, literacy skills, and racism and discrimination. (For more information about the impact of race and racism on mental health issues and access to treatment, see ***Appendix A: Deeper Dive on Race, Equity, and Access to Mental Health Care.***) These factors exist at multiple levels, from individual to population levels.[4] Some conditions can operate as "risk factors" that lead to a higher likelihood of negative outcomes, while others operate as "protective factors" that reduce the risk of negative outcomes. For instance, in the domain of family, family conflict may operate as a risk factor, while positive, supportive relationships with family members are protective factors. Likewise, in the domain of school and community, exposure to community violence is a risk factor, but being surrounded by supportive mentors and positive school engagement function as protective factors.[5] Understanding risk and protective factors is critical to taking a strengths-based approach and ensuring children and families receive positive support and interventions that will mitigate risk factors and bolster protective factors to improve overall outcomes.

Many children and youth also experience **Adverse Childhood Experiences (ACEs)**, which are potentially traumatic childhood events that occur between birth and age 17 and can have negative, long-term impacts on lifelong health and well-being.[6] Examples of ACEs include the death of a parent or caregiver, abuse, neglect, family separation due to issues such as immigration or incarceration, and witnessing violence at home or in the community.[7] ACEs can contribute to **toxic stress** and are linked to increased risks for both future mental health conditions (such as depression) and physical health conditions (such as heart disease).[8] As the number of ACEs increases, risks increase.[9]

Children grow up within the ecosystem of a broader family and community dynamic, and are impacted by the well-being of those around them. Many families involved in family court proceedings have experienced what is described as **historical trauma, community-based trauma**, or **intergenerational trauma.** These refer to the understanding that an entire community can collectively experience trauma due to a threatening or harmful event with long-term impact.[10] Some children may also reside in homes in which parents or caregivers suffer from untreated mental health or substance use issues, which can impact not

only their mental health, but also that of the children in their care. Promoting access to care for the supportive adults in a child's life is part of an overall strategy of supporting the child's own mental health. When parents and caregivers receive the support and care they need, their own mental health and functioning can improve, which in turn can serve as a protective factor for children's mental health and well-being.[11]



Over the last twenty years, California children and youth have been experiencing escalating mental health concerns. For example, from 2009 through 2018, annual rates of (completed) suicides of youth between the ages of 12 and 19 increased by 15 percent, and self-harm incidents increased by a staggering 50 percent.[12] The COVID-19 pandemic turned this disturbing trend into a crisis. The pandemic exacerbated existing stressors and created new ones, as youth experienced grief, illness, housing and food instability, and school closures. One study found that global rates of youth anxiety and depression doubled during this time.[13] The pandemic also created new barriers to care, contributing to lower utilization of mental health care services.[14] (***See Appendix B: Deeper Dive on COVID-19 Impacts on Mental Health.***) But it also brought more urgency and attention to children's mental health needs, and accelerated innovations in service delivery, such as the expanded use of **telehealth** (remote delivery of health care services, through phone or internet). In 2021, the state announced a $4.4 billion, multi-year **Children and Youth Behavioral Health Initiative** (**CYBHI**), with a bold goal of transforming the mental health and well-being of Californians from birth through age 25.[15] Increased investments in access to care and sustained commitment to system reform, coupled with a tangible shift in thinking about mental health fueled by youth themselves, hold promise for improved outcomes.

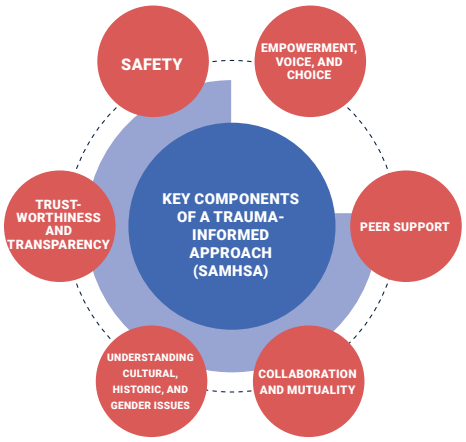
2. WHY THIS MATTERS IN FAMILY COURT PROCEEDINGS

Both family court proceedings themselves and the underlying situations that lead to them can be highly emotional and traumatic events for children and youth. Children and youth involved in these proceedings have likely experienced one or more **ACEs**, described above. Experiences like parental divorce and family separation can alter family structure, home environments, and routines, impacting youth's sense of stability and control and increasing their stress levels. Youth who have been exposed to domestic violence may also experience a mental health impact. Children also can experience stress and trauma when placed in the middle of a conflicting situation between their parents, such as a custody battle or dispute over visitation or child support payments, and may carry a tremendous emotional burden in feeling that they must "choose a side" or show loyalty to one adult at the exclusion of another. If one or both parents have unmet mental health or substance use needs themselves, this can create stress for the youth. Youth who have experienced abuse or neglect in the past may also be continuing to cope with the ongoing effects of trauma, and the family court process may lead to re-traumatization and exacerbate their underlying stress. The experience of structural racism and oppression are often a significant stressor for youth and families in family court, as well.

Unmet mental health needs and prior trauma may also impact the ways in which youth, parents, and caregivers experience, engage with, and present in family court proceedings. Mental health needs can manifest in a variety of ways in a courtroom setting.

For example, they may impact cognition and process skills, self-regulation, self-concept, and behavior control. Youth may feel overwhelmed or threatened and experience a "flight or fight" response, resulting in changes in facial expressions and body language, or protective actions such as covering their ears or closing their eyes. It is critical to understand that these are trauma responses, and to respond to them with compassion, not in a punitive way. We explore this further and provide examples in a later section of this bench guide, "***How Family Court Officers and Staff Can Promote Mental Health and Wellness***."

Understanding youth and family mental health needs can inform the choices family court judicial officers make, and the ways that court staff support the process. For example, courtrooms can proactively implement **trauma-informed practices** that can mitigate the impact of trauma, help avoid or minimize re-traumatization of children and youth, and allow the proceedings to move forward in a way that prioritizes the youth's health and well-being and leads to more successful outcomes. The key components of a trauma-informed approach are as follows: safety; trustworthiness and transparency; understanding cultural, historic, and gender issues; collaboration and mutuality; peer support; and empowerment, voice, and choice.[16]



Later in this Bench Guide, we will explore how to apply certain components of this framework to courtroom practices in concrete ways, including in approaching youth testimony. For more in-depth information regarding this framework, see SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.

Family court judicial officers and staff can also play an important role in helping parents and caregivers understand their responsibilities surrounding a child's mental health and well-being, ensuring the child's mental health needs are given sufficient attention, and promoting connections to mental health supports and services for youth, parents, and caregivers. As we will discuss below, California's children's mental health care system is a complex web of delivery systems, funding streams, and providers that can be incredibly difficult to navigate, creating barriers to children accessing the care that they need and are legally entitled to. Courts can help families by providing knowledge and guidance about local community-based resources and how to access them. In addition, by regularly thinking and talking about the importance of mental health, courts can help de-stigmatize mental health needs and normalize the decision to seek mental health care, helping contribute to a critical and long-overdue shift in how we think about and respond to childhood mental health needs.

3. YOUTH MENTAL HEALTH OVERVIEW: NEEDS, ASSESSMENTS, SERVICES, & PROVIDERS

The following section provides a brief overview of some key components of youth mental health and mental health care. It begins by discussing the mental health needs that youth often experience, including but not limited to those that rise to the level of being diagnosed as a mental health disorder. It then provides an overview of assessment and evaluation tools commonly used to identify needs, and the types of mental health services that can be provided. Finally, we provide information about the various types of providers that offer mental health services.

MENTAL HEALTH NEEDS

Children and youth experience a wide range of mental health needs. Many (if not all) children and youth will, at some point in their lives, face external stressors, such as grief, loss, or other ACEs or setbacks, that can cause distress. These situations, and the youth's normal response to them, warrant support. Sometimes mental

health issues rise to the level of a mental health disorder. Disorders are diagnosed by qualified professionals, such as psychiatrists and psychologists. The scope of disorders and their diagnostic criteria are laid out in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Once diagnosed, these disorders require specialized services. Examples of mental health diagnoses include the following.

EXAMPLES OF MENTAL HEALTH DISORDERS IN THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL HEALTH DISORDERS (DSM-V)

CATEGORY:

MOOD DISORDERS

EXAMPLES

Depression
Bipolar disorder

CHARACTERIZED BY

Persistent feelings of sadness, loss of interest that impact functioning (depression); extreme changes in mood (bipolar)

CATEGORY:

BEHAVIOR-RELATED DISORDERS

EXAMPLES

Oppositional Defiant Disorder (ODD)
Conduct Disorder (CD)

CHARACTERIZED BY

Challenges related to behavior regulation, sometimes including aggression

CATEGORY:

ANXIETY-RELATED DISORDERS

EXAMPLES

Generalized anxiety disorder (GAD)
Obsessive compulsive disorder (OCD)
Separation anxiety

CHARACTERIZED BY

Persistent fears, worries, or anxiety that disrupt play, school, or social situations

CATEGORY:

NEURODEVELOPMENTAL DISORDERS

EXAMPLES

Specific Learning Disorder/Dyslexia
Attention Deficit Disorder (ADD)
Attention Deficit Hyperactivity Disorder (ADHD)

CHARACTERIZED BY

Challenges with attention, hyperactivity, and/or learning

CATEGORY:

THOUGHT AND DISSOCIATIVE DISORDERS

EXAMPLES

Schizophrenia
Dissociative identity disorder

CHARACTERIZED BY

Disorder in perceptions and thoughts; disconnection between thoughts, memories, surroundings, actions, or identities

CATEGORY:

PERVASIVE DEVELOPMENTAL DISORDERS

EXAMPLES

Autism
Asperger's Syndrome

CHARACTERIZED BY

Delayed development of socialization and communication skills

For more information regarding various types of childhood mental health conditions, see these linked resources from the Child Mind Institute and the Mayo Clinic.

MENTAL HEALTH ASSESSMENTS AND EVALUATIONS

The road to receiving mental health services typically begins with a screening, assessment, and/or evaluation. There are different kinds of assessments. Examples include the following.[17]

SCREENING, ASSESSMENT, OR EVALUATION	DESCRIPTION
Child and Adolescent Needs and Strengths (CANS) Assessment	Assesses for general well-being and mental health needs, and is used to track outcomes and coordinate services. Informs the Child and Family Team (CFT) process for dependency-involved youth.
Neuropsychological Evaluation	Evaluates a child's thinking abilities through a series of skills tests. Helps diagnose and/or rule out conditions and informs treatment planning.
Psychoeducational Evaluation	Evaluates the mental processes underlying educational performance and helps identify learning disabilities. Used in Individualized Education Program (IEP) and 504 evaluation processes.
Psychological Evaluation	Evaluates historical and current functioning and psychological condition, through interviews, tests, and observations.
Regional Center Developmental Assessment	Assesses for developmental delays. Used to determine if a child qualifies for Regional Center support services.
Adverse Childhood Experiences (ACEs) screening	Trauma screening tool. An example is the Pediatric ACEs and Life Events Screener (PEARLS). California has an ongoing initiative to expand use of ACEs screenings.

MENTAL HEALTH SERVICES AND SUPPORTS

Results from screenings, assessments, and evaluations are used to determine what services may be helpful and develop a treatment plan. Every person's mental health needs are unique, and mental health care is not "one size fits all." Young children's needs may differ from adolescent's needs, and both may differ from adults' needs. Individual children and adolescents may also have different needs from their same-aged peers depending on their own experiences, level of engagement, stressors, trauma history, family history and diagnoses. Because of this, it is crucial that providers conduct individualized assessments and develop individualized treatment plans.

Mental health care should be:

- Accessible and equitable;
- Tailored to meet a youth's individual needs;
- Provided in the **least restrictive environment (LRE)**, in home or community-based settings whenever possible;
- Provided in a trauma-informed, culturally responsive way that centers, supports, and empowers youth; and
- Reflective of and responsive to the lived experiences, expressed needs, and wisdom of youth and families.

The following are some examples of mental health services that may benefit youth.[18]

SERVICE TYPE	DESCRIPTION
Prevention and promotion	Supports to prevent mental health problems and to promote positive mental health. Examples include school-wide social emotional learning (SEL) and suicide prevention programs.
Behavioral therapy	Therapy to increase positive behaviors and decrease negative behaviors.
Parent-child psychotherapy	Therapy to help a parent and child to strengthen their relationship and interactions. An example is parent-child interaction therapy (PCIT).
Cognitive behavioral therapy (CBT)	Therapy to correct negative thought patterns.
Therapeutic behavioral services (TBS)	Short-term, intense coaching to address negative behaviors and reinforce strengths and positive behaviors.
Dialectical behavioral therapy (DBT)	Therapy to address emotional regulation and stress tolerance.
Play therapy	Supports a child's return to normal functioning and helps address trauma.
Psychopharmacology (medication)	Medications to address symptoms of a mental health disorder. Examples include mood stabilizers, antipsychotics, and anti-anxiety medications.
Crisis counseling and stabilization, mobile crisis services	Short-term, intensive interventions to address a mental health crisis.

SERVICE TYPE	DESCRIPTION
Peer support services	Guidance, mentoring, and advocacy provided by someone who has lived experience with a mental health condition.
Case management, care coordination, and "wraparound" care	Services to manage and support a child's mental health needs; "wraparound" care (or intensive care coordination) involves surrounding the child/family with a team of professionals to provide support from a strengths-based perspective.
Residential treatment	Intensive treatment for youth with severe mental health needs, in a residential group setting.
Psychiatric hospitalization (voluntary, involuntary)	Inpatient psychiatric hospitalization for evaluation and treatment in locked facilities. Initial involuntary holds are sometimes referred to as a "5150 hold" or "5585 hold," referencing Welfare & Institutions Code sections. This is a restrictive environment, legally appropriate only in extremely limited circumstances. Long-term involuntary treatment requires specialized court hearings under the Lanterman-Petris-Short Act and finding of grave disability.

For detailed information about the types of services and treatments that may be effective for children who have been exposed to domestic violence, see the National Child Traumatic Stress Network Intimate Partner Violence Interventions page.

MENTAL HEALTH PROVIDERS

There are a variety of professionals who provide mental health services, including those described above. Depending on the service need, a youth may need to see a specific type of provider. Key types of providers to be familiar with include the following.[19]

LICENSED PSYCHOLOGIST

Holds a doctoral degree in psychology, educational psychology, or education with specialization in counseling or educational psychology.

NEUROPSYCHOLOGIST

Psychologists specializing in behavior and cognitive ability as they relate to brain functioning. Holds either a PhD or a PsyD, and typically postdoctoral training in neuropsychology.

PSYCHIATRIST

MDs trained in the diagnosis of mental health conditions and providing inpatient and outpatient therapy. May prescribe medications. Child and adolescent psychiatrists have two additional years of training on disorders of childhood and adolescence.

PSYCHIATRIST NURSE PRACTITIONER

Nurse practitioners licensed to prescribe psychotropic medications generally (though Welfare & Institutions Code § 369.5 specifies that only a physician may prescribe such medications to youth in foster care).

LICENSED MARRIAGE AND FAMILY THERAPIST (LMFT)

May work as a clinician providing therapy services. Holds a master's degree in marriage and family therapy.

LICENSED CLINICAL SOCIAL WORKER (LCSW)

May work as a clinician providing therapy services. Holds a master's degree in social work.

SCHOOL-EMPLOYED MENTAL HEALTH PROFESSIONALS (COUNSELORS, PSYCHOLOGISTS, SOCIAL WORKERS, NURSES)

Professionals employed by schools include school counselors, school psychologists, and school social workers, who hold Pupil Personnel Services (PPS) credentials. Schools may also employ nurses. (In some instances, schools directly hire community providers without PPS credentials, like LCSWs or LMFTs, though there are challenges to doing so, such as ensuring appropriate supervision for their school-based work.)

COMMUNITY-BASED CASE MANAGERS, FAMILY PARTNERS, AND ADVOCATES

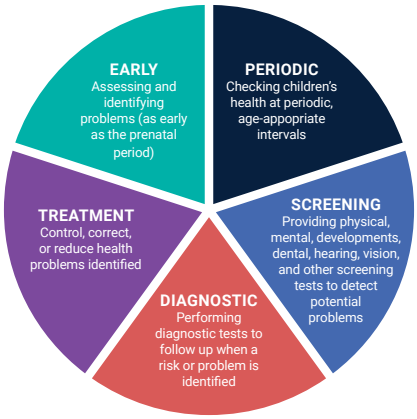
Individuals who can provide case management/ coordination services, but do not hold licenses that allow them to provide therapy.

Note that Family Court proceedings may involve mental health professionals who conduct evaluations (such as child custody evaluations, Family Court Services mediation reports, or substance abuse evaluations). These professionals may interview the child and family and include recommendations related to mental health in their reports, but they are *not* engaged in providing mental health treatment. While these court-connected processes are important to ensuring the appropriate outcome of the Family Court proceeding, they should not be viewed as a substitute for mental health treatment or support that the child otherwise needs.

4. ACCESSING MENTAL HEALTH CARE IN CALIFORNIA

The vast majority of California children and youth have health coverage that provides legal entitlements to mental health assessments, support, and services. However, through no fault of their own, only a fraction receive this care.

MEDICAID EPSDT ENTITLEMENT



Medi-Cal, California's state Medicaid program, provides health insurance for low-income and specialized populations. Roughly a third of the state's population - 13 million people, including more than 5 million children - are enrolled in Medi-Cal. A majority of Medi-Cal enrollees are **Black, Indigenous, and People of Color (BIPOC).**

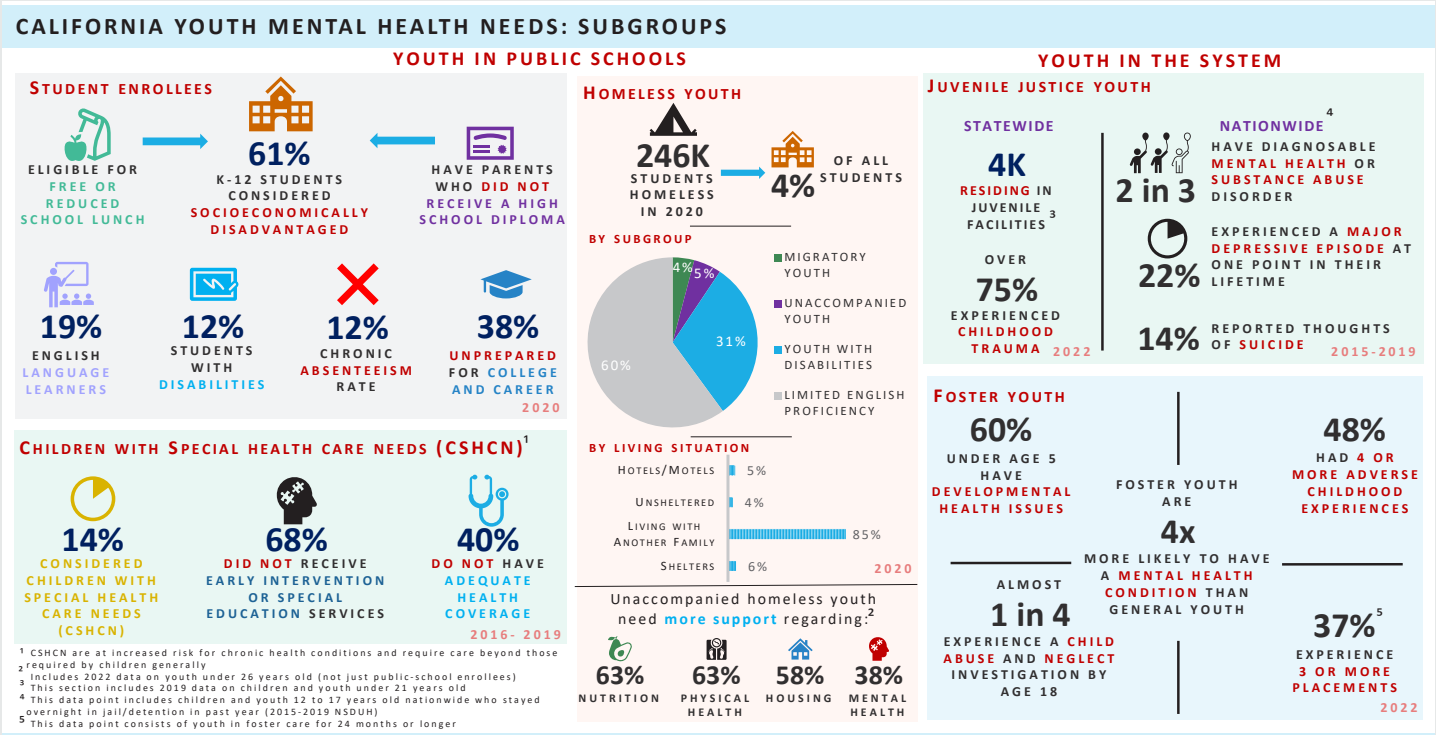
Children and youth under age 21 on Medi-Cal are entitled to the critical **Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT)** prescribed by federal law.[20] EPSDT includes mental health screening and care, services, treatment or other measures necessary to "correct or ameliorate" a defect, illness or condition discovered by the screening services, whether or not such services are covered by the State Plan. Examples include hospital and clinic services; services from a physician or other licensed professional; diagnostic, screening, prevention, and rehabilitative services; and case management services. EPSDT emphasizes prevention and early identification and treatment of needs, and is more robust than the Medicaid benefit for adults.[21]

"Medical necessity" is an individualized determination that must take into account the child's range of needs. The federal Centers for Medicare and Medicaid (CMS) explains: "The determination of whether a service is medically necessary for an individual child must be made on a *case-by-case basis,* taking into account the *particular needs* of the child. The state (or the managed care entity delegated by the state) should consider the child's *long-term needs,* not just what is required to address the immediate situation. The state should also consider all aspects of a child's needs, including *nutritional, social development, and mental health and substance use disorders."*[22] EPSDT also includes case management services to support access to medical, social, and educational services, and assistance with scheduling and transportation.

States have a proactive obligation to ensure youth and families are aware of EPSDT services and how to obtain them.[23] Despite this, and though EPSDT is a broad benefit, even after decades of implementation its promise still has not been fully realized in California. There are many factors contributing to this. One factor is the complex and difficult-to-navigate delivery system and lack of coordination within and between them, which can result in youth being funneled back and forth between providers. We provide an overview of this system below.

MEDI-CAL MENTAL HEALTH SERVICE DELIVERY SYSTEMS

Medi-Cal mental health services are delivered through two primary systems. County **Mental Health Plans (MHPs)** deliver **Specialty Mental**



Health Services (SMHS). SMHS include mental health services – assessments, plan development, therapy, rehabilitation and collateral, medication support; day treatment services and rehabilitation; crisis intervention and stabilization; Targeted Case Management (TCM); and EPSDT SMHS (for children and youth only), including I**ntensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC),** and **Therapeutic Behavioral Service (TBS)**.[24] Historically, California has implemented access to SMHS in a way that restricted access to those with specific diagnoses and other criteria. Effective January 2022, the state redefined access criteria, moving away from diagnosis as a prerequisite to services. Specific emphasis is placed on youth who have child welfare system involvement, juvenile justice system involvement, have experienced homelessness, or who otherwise are at high risk as demonstrated by a trauma screening. For details, see this Behavioral Health Information Notice describing the new access criteria as well as the "Medi-Cal Family Therapy" fact sheet. This shift is representative of a growing movement in California to embrace and value early identification and intervention to address mental health needs, and to decouple eligibility for services from specific diagnostic criteria. This approach promotes earlier access to services to prevent mental illness and to proactively promote positive mental health. It also helps avoid situations where youth must wait until they are nearing a crisis point to receive the help they need, and situations in which providers feel pressured to rush a diagnosis in order for the youth to qualify for services.

Medi-Cal Managed Care Plans (MCPs) deliver outpatient non-specialty mental health services to adults with mild to moderate impairment and to children as medically necessary under the EPSDT standard. Non-specialty mental health services (NMHS) include individual and group mental health evaluation and treatment (psychotherapy, family therapy); psychological testing when clinically indicated to evaluate a mental health condition; outpatient services for monitoring drug therapy; outpatient laboratory, medications, supplies and supplements; psychiatric consultation.[25] SMHS are "carved out" of the contracts between MCPs and the state. Some services are also delivered through **Fee-for-Service (FFS)** Medi-Cal.

There are some important new Medi-Cal benefits to be aware of that could be helpful to court-involved children and families. The Medi-Cal **Family Therapy Benefit**[26] provides outpatient therapy for adults and children. Families can qualify based on a child under age 21 having one or more risk factors, such as separation from a parent or guardian due to incarceration or immigration, the death of a parent or guardian, housing instability, exposure to domestic violence or other traumatic events, or the parent or

guardian having one or more risk factors. Examples of evidence-based family therapy include Child-Parent Psychotherapy (ages 0-5), the Triple P Positive Parenting Program (ages 0-16), and Parent Child Interactive Therapy (ages 2-12). The Family Therapy benefit (like the change in SMHS access criteria) is another clear example of the movement towards prioritizing early access to mental health supports. For more information, see the "New Criteria for Access to Medi-Cal Specialty Mental Health Services for Beneficiaries Under Age 21" fact sheet. Another new benefit is the Medi-Cal **Dyadic Care Benefit,** which was funded in the 2021-22 state budget, is designed to ensure that caregivers and children can access care simultaneously.[27]

PRIVATE HEALTH INSURANCE

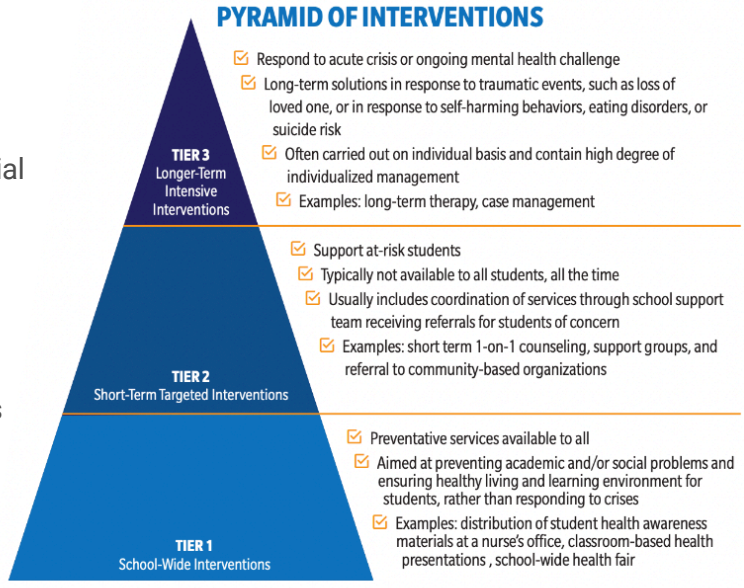
Not all California youth are enrolled in Medi-Cal; many are enrolled in private health insurance plans, for example through Covered California or through employer/group policies. Coverage for mental health care services by health plans has been expanded over the last ten years, through state and federal law. Here are some key points to know:

- Under the federal **Affordable Care Act (ACA)**, mental and behavioral health services are now considered **"essential" health benefits** that must be covered by plans.[28]
- Federal parity law also requires protections to ensure that mental and behavioral health services are covered in the same way as most medical services (deductibles, visit limitations, etc.).[29]
- As expanded by SB 855 (2020), California **mental health parity** laws now require coverage of all medically necessary treatment of mental health and substance use disorders under the same terms and conditions as medical conditions.[30]

As discussed below, despite these legal entitlements to mental health care, there are many barriers to access, even when needs are identified and appropriate referrals are made. For example, there is a severe shortage in mental health care professionals for both adult and pediatric patients. Nationwide, about 37 percent of the population lives in areas where there are too few mental health professionals, with rural areas disproportionately impacted.[31]

SCHOOL-BASED MENTAL HEALTH SERVICES

Education and mental health are inherently linked, and schools are another important access point for mental health services for many youth, particularly those who may face barriers to accessing care elsewhere in their communities. Schools often conceptualize student social and emotional support through a tiered framework called **Multi-Tier System of Support (MTSS)**. A fully-implemented MTSS includes three tiers: *universal supports (Tier 1), targeted interventions (Tier 2), and intensive individualized interventions (Tier 3).* School-based services might be delivered by school employees (such as school counselors, psychologists, social workers, and nurses) or by outside providers through various partnership structures (such as partnerships with county mental health plans or community-based organizations).



MTSS is often conceptualized as a pyramid structure, with Tier 1 representing the base of the pyramid with universal services provided to students generally, Tier 2 representing the middle level of the pyramid with services provided to a subset of students, and Tier 3 representing the top of the pyramid, with services provided to a narrower subgroup of high-needs students.

Graphic adapted with permission from the California School-Based Health Alliance (CSHA)

Here are some examples of ways that schools provide mental health services and supports:

- Under the federal **Individuals with Disabilities Education Act (IDEA),** students with disabilities (including the disability of "Emotional Disturbance") are legally entitled to a **free appropriate public education (FAPE)** in the **least restrictive environment (LRE)** and receive special education and related services to meet their needs and allow appropriate educational progress. This may include **Educationally Related Mental Health Services (ERMHS)**, such as psychological services, social work services, and counseling.
- Under **Section 504 of the federal Rehabilitation Act**, students with disabilities, including mental illness, are protected from discrimination, and schools must provide students with appropriate accommodations that meet their needs so they receive equal access to education. This may include ERMHS.
- Some schools are connected with **school-based health centers (SBHCs)** or **wellness centers** that are on or near campuses and provide mental health services, as well as physical health services, to students. There are approximately 300 SBHCs in the state. A directory by county is available this list of California School-Based Health & Wellness Centers.
- Some schools have partnerships with **community-based organizations (CBOs)** and/or **county mental health plans (MHPs),** through which outside clinicians provide services to students. To date, **Medi-Cal Managed Care Plans (MCPs)** have not had robust partnerships with schools, but the state's new Student Behavioral Health Incentive Program (SBHIP) may lead to more collaboration going forward.[32]
- **Interdisciplinary teams** of educators, mental health professionals, and others may support students. Examples are **Multidisciplinary Teams (MDTs)** that allow for information sharing to prevent child abuse or neglect; **Child and Family Teams (CFTs)** to support youth in the juvenile dependency system; and **Coordination of Services Teams (COST)** to support student learning and development.
- Other examples of school-based programs and practices to support student mental health and well-being include:
  - Suicide prevention programs;
  - Restorative justice programs;
  - Social-emotional learning (SEL) in the classroom;
  - Trauma-informed practices; and
  - Student-led/peer support groups, such as Bring Change to Mind (BC2M) and National Alliance on Mental Illness (NAMI) On Campus student clubs.

School-based mental health is funded through a variety of sources. One funding source is Medi-Cal, through the **Local Education Agency Billing Option Program (LEA-BOP)** and **School Medi-Cal Administrative Activities (SMAA)**. Another example is grants through the **Mental Health Student Services Act (MHSSA)** administered by the **Mental Health Services Oversight and Accountability Commission (MHSOAC).**[33] In addition, California recently invested significant funding in developing and expanding the **community schools** approach.[34] Community schools are those that serve as local support hubs to connect students and families to resources and services, including mental health and well-being supports.

Keep in mind that although there are many ways that schools may provide mental health services, and while federal laws like IDEA and Section 504 of the Rehabilitation Act do provide clear legal entitlements to such services for eligible students, most schools lack adequate staffing. According to a 2019 State Auditor report, no Local Education Agency (LEA) "in the State reported employing the recommended number of school counselors, school nurses, school social workers, and school psychologists; and 25 percent did not employ even one such resource.[35] There is considerable variation in access to and quality of school-based and school-linked mental health services among districts and among individual schools. Some youth and families live in "resource deserts" where both community-based and school-based mental health services may be insufficient for the population they are meant to serve, particularly given the current severe shortage in mental health providers. This can make it incredibly difficult for youth and families to access the services they need.

For a more detailed overview of school mental health services, see this "School Mental Health 101" resource guide.

OTHER PROGRAMS AND FUNDING STREAMS

Some additional mental health programs and funding streams to be aware of include the following:

- The **Mental Health Services Act (MHSA)**, which is funded through a 1% tax on personal income over $1 million annually, provides prevention, early intervention, and mental health services, along with related infrastructure support. MHSA programs are implemented at the county level.[36]
- The **Mental Health Student Services Act (MHSSA)** provides grants specifically focused on serving children and youth, including in school settings. This is a competitive grant program, and not all California counties receive MHSSA funds.[37]
- California has 21 **Regional Centers,** community-based non-profit agencies that conduct assessments and offer case management services to youth and adults with developmental disabilities.[38] Regional Centers can receive MHSA grants.[39]
- **Supplemental Security Income (SSI)** and **Social Security Disability Insurance (SSDI)** are monthly payments made to individuals, including minors, who are disabled due to a physical or mental condition and experience severe functional limitations as a result. SSI is income-dependent.[40]
- Youth who have been victims of crime or who have witnessed a violent crime can receive related mental health services funded through the **California Victims Compensation Board**, if the treatment is not covered by any other reimbursement source, such as Medi-Cal or private insurance.[41]
- Some schools are utilizing funding streams like the California Community Schools Partnership Program (CSPPS) and Expanded Learning Opportunities Program (ELOP) to expand access to social and emotional support for students.

BARRIERS, CHALLENGES, AND REALITIES

Despite the broad legal entitlement to care, there are many reasons that youth and families may face roadblocks in accessing services. Here are some examples.

- Complex delivery system
- "Wrong doors" (wrong entry points)
- Provider shortages
- Lack of culturally competent providers
- Lack of bilingual providers
- Lack of expertise in treating complex pediatric mental health issues
- Lack of transportation
- Lack of technology (devices, connectivity) needed for telehealth services
- Falling through the cracks at transition points (e.g. moves between counties, when exiting foster care)
- Health plan disputes regarding coverage / financial responsibility
- Lack of care coordination and case management between and across agencies
- Restrictive access criteria
- Failure to identify needs, or misidentification of needs
- Stigma:
  - Public stigma
  - Self-stigma
  - Institutional stigma

It is important to remain aware of these barriers to care, and to avoid making assumptions that youth or families have not attempted to access services or supports that you have referred them to. Securing mental health care can often take many attempts and persistent self-advocacy. If a family has not yet accessed desired care, it may be because they need help navigating around these barriers, not because they haven't tried.

ONGOING REFORM EFFORTS

There are several reform efforts underway intended to improve mental health care delivery in California. One is **California Advancing and Innovating Medi-Cal (CalAIM),** a state-level initiative "to improve the quality of life and health outcomes of [the state's] population by implementing broad delivery system, program and payment reform across the Medi-Cal program," including behavioral health care.[42] A complementary effort is the **Children & Youth Behavioral Health Initiative (CYBHI),** an approximately $4.4 billion multi-year investment aimed at transforming behavioral health care for youth and young adults up to age 25 through new technology, school partnerships, new services and evidence-based programs, workforce improvements and expansion, and education and awareness-raising. For more information on ongoing reform efforts, view the webinar, "California's evolving mental health care landscape: What courts need to Know". Key themes that appear across these and other state-level initiatives are increased focus on promotion of mental health and wellness, prevention of mental health problems, early identification of needs, early identification to address needs, collaboration between child-serving systems, a growing recognition of social determinants of health, and of a need to continue fighting stigma and making care more accessible to all populations.

POLICY ADVOCACY

There are many advocates working at both the state and local levels to contribute to policy reforms in this area. Here are some examples, with links to their websites to learn more:

National Health Law Program:
https://healthlaw.org

National Alliance on Mental Illness:
https://nami.org

California Children's Trust:
https://cachildrenstrust.org

The Children's Partnership:
https://www.childrenspartnership.org

Children Now:
https://www.childrennow.org

California School-Based Health Alliance:
https://www.schoolhealthcenters.org

The Trevor Project:
https://www.thetrevorproject.org

Bazelon Center for Mental Health Law:
http://www.bazelon.org

Sound the Alarm for Kids campaign:
https://www.soundthealarmforkids.org/partners

YOUTH LEADERS

There are also a number of youth organizations playing a critical role. Some examples include:

ACLU Youth Liberty Squad:
https://www.aclusocal.org/en/campaigns/youth-liberty-squad

GENUp:
https://www.generationup.net/student-mental-health-alliance

CA State Superintendent of Public Instruction Youth Advisory Council (CaliYAC):
https://www.cde.ca.gov/nr/el/le/yr21ltr0924.asp

Youth Minds Alliance:
https://youthmindsalliance.org

In addition, for examples of organizations that are working to address issues such as racial equity issues in mental health and the impact of the COVID-19 pandemic on mental health, please see Appendices A and B.

FAQS AND RESOURCES

Figuring out where to begin the process of accessing mental health support can be overwhelming for youth and families, often exacerbating their underlying stress. For a list of additional *Frequently Asked Questions - Accessing Mental Health Care,* including relevant websites and phone lines that may be helpful, see ***Appendix D***.

5. SUBSTANCE USE DISORDERS AND CO-OCCURRING NEEDS

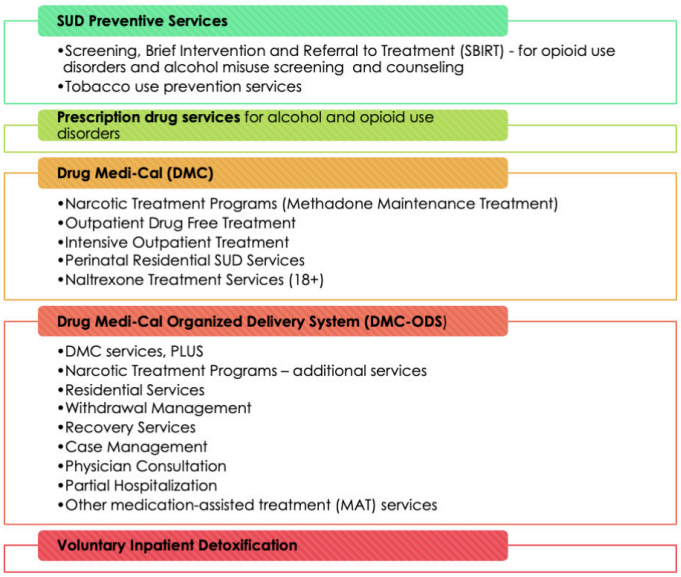
Substance use disorders (SUDs) involve the "recurrent use of alcohol and/or drugs [that] causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[43] According to a 2019 national survey, approximately 20.4 million youth aged 12 and older had a SUD (including alcohol use disorder, illicit drug use disorder, or both) within the previous year. While both adults and youth can experience addiction, alcohol and drugs can have very different effects on youth than they do on adults, and can be particularly harmful to youth, given their ongoing brain development.[44]

One ongoing example of a substance use crisis that has had devastating impacts on youth is the opioid epidemic. Opioids include illegal drugs like heroin as well as medications like hydrocodone and oxycodone that can be legally prescribed for pain, but that can be addictive and are sometimes abused.[45] In 2016, approximately four percent of adolescents ages 12 to 17 had misused opioids in the past year, and approximately seven percent of young people ages 18 to 25 did so. In 2015, of the over 4,200 youth and young adults between ages 15 and 24 nationwide who lost their lives due to drug related overdoses, half involved opioids.[46]

There are significant links between mental health issues and substance use issues, and there is a high co-occurrence between mental health and SUDs.

According to one estimate, approximately 60 to 75% of adolescents with SUDs have a co-occurring mental illness.[47] Stress, negative emotions, and negative experiences can lead adolescents to seek out drugs and alcohol, and substances exacerbate mental health issues, for example by increasing the risk of impulse-based suicidal behavior.[48]

Ensuring youth experiencing SUDs have access to services and support is critical. Recall that for children and youth, Medicaid includes the EPSDT entitlement, which includes medically necessary services to correct or ameliorate a condition, including a SUD condition. Medi-Cal provides a variety of SUD services. While there is overlap between mental health conditions and SUDs, they involve different services, systems, and providers.



Medi-Cal SUD Services

Caregivers may also suffer from substance use issues. Medi-Cal coverage for adult SUD services was significantly expanded through the ACA's "essential benefits" provision in 2014, which required all state Medicaid programs to include SUD benefits. Parity requirements also apply to SUD services, as well as mental health services.

Substance use is undoubtedly a serious issue and youth should receive all necessary treatment and support. Note, however, that experimentation with substance use during adolescence is common and does not itself constitute a SUD; it may be something to monitor, rather than a reason to impose a significant intervention. For example, requiring daily attendance at Narcotics Anonymous meetings would likely not be an appropriate intervention for a youth who has admitted to smoking marijuana twice with friends, but who does not show any indication of an ongoing substance use problem.

For a detailed guide to co-occurring mental health and substance use disorders, see this helpful Complete Guide to Substance Use + Mental Health resource from the Child Mind Institute.

6. HOW FAMILY COURT OFFICERS AND STAFF CAN PROMOTE MENTAL HEALTH AND WELLNESS

Courts have a specific but enormously impactul role to play in the lives of court-involved children and families. The unique role of Family Courts, specifically, is described in California Rule of Court (CRC) 5.30(f) (emphasis added):

> *Under the direction of the presiding judge of the superior court, the family court, to the extent that it does not interfere with the adjudication process or violate any ethical constraints, is encouraged to:*
>
> 1. *Provide active leadership within the community in **determining the needs of, and obtaining and developing resources and services for children and families** who participate in the family law court*

system;

2. *Investigate and determine the availability of specific **prevention, intervention, and treatment services in the community** for families who come before the family courts;*
3. *Take an active role in helping the court develop rules and procedures that will result in the ordering of **appropriate treatment and services for children and families;***
4. *Exercise a leadership role in the development and maintenance of services for self-represented and financially disadvantaged litigants;*
5. *Take an active part in the formation of a community-wide network to promote and coordinate private- and public-sector efforts to focus attention and resources on the needs of family law litigants;*
6. *Educate the community and its institutions, including the media, concerning the role of the family court in meeting the complex needs of families;*
7. *Encourage the **development of community services and resources** to assist families and children in the family court system, including self-help information; supervised visitation; **substance abuse and drug prevention, intervention, and treatment; services for families with domestic violence issues; counseling; parenting education**; vocational training; mediation; alternative dispute resolution options; and other resources to support families;*
8. *Manage cases more efficiently and effectively to avoid conflicting orders;*
9. *Take an active role in promoting completion of cases in a timely manner;*
10. *Appoint counsel for children in appropriate family law custody cases; and*
11. *Ensure that the best interest of children is served throughout the family court process.*

Family Court judicial officers and staff come into contact with families at what are often times of significant transition, when children may be experiencing unmet needs and may benefit from mental health support. There are a variety of ways in which courts can support positive mental health, ensure children have access to services, and more broadly contribute to a positive evolution in how we think and talk about childhood mental health and well-being.

ENSURE ACCESS TO APPROPRIATE MENTAL HEALTH SERVICES.

Family Courts have the authority to order participation in outpatient counseling with a licensed mental health professional or through other community programs and services that provide appropriate counseling on mental health and/or substance abuse issues, in the best interest of the child. See Cal. Family Code § 3190(a). This counseling is for the limited purposes of facilitating communication between parties regarding the child's best interest, reducing conflict associated with custody and visitation issues, and improving parenting skills. See Cal. Family Code. § 3191. Note that while these court-ordered services can be important and effective, they are unlikely to be sufficient, on their own, to address any trauma or mental health issues that children and youth themselves may be experiencing.

One of the most powerful ways that judicial officers in family court proceedings can promote the mental health and well-being of youth is through educating, empowering, and supporting the guardian, as there are limitations in what the judicial officers can do through orders or other actions. Throughout the court process, judicial officers and court staff can also signal the importance of childhood mental health and well-being, and overall family mental health and well-being. This may include providing resources and information to the guardian on how and where to access mental health support for the youth. As discussed above, California's children's mental health care delivery system includes a complex web of systems that may feel overwhelming and difficult to navigate, and guardians may not know where to begin the process. Help families become aware of the existing resources available to them, and the range of legal entitlements for children's mental health care, whether through Medi-

Cal, private insurance coverage, or IDEA/Section 504. See ***Medi-Cal Mental Health Delivery Systems***. If possible, provide resources and support - such as a family navigator or a services navigator - for helping connect youth and families with appropriate mental health services and overcoming common barriers to accessing care. This list of ***Frequently Asked Questions (FAQ)*** may also be helpful as a quick reference tool.

In speaking with families about mental health, be sure to keep in mind the importance of individualized, culturally responsive services that are tailored to the youth's unique age and developmental health. A "one size fits all" approach is not appropriate, and a treatment plan should be developed by an experienced mental health provider.

Be aware that California law also provides that minors ages 12 and older may consent to their own outpatient mental health treatment and counseling under certain circumstances. See Cal. Family Code § 6924 and Cal. Health & Safety Code § 124260 (but note that the latter section is not applicable to Medi-Cal). Minors ages 12 and older may also consent to certain substance use treatment services. See Cal. Family Code § 6929.

ENSURE THAT COURT-APPROVED PARENTING PLANS PROMOTE YOUTH MENTAL HEALTH AND MINIMIZE TRAUMATIC IMPACT ON YOUTH.

Court-approved parenting plans are required to describe "how parents or other appropriate parties will share and divide their decision making and caretaking responsibilities to protect the health, safety, welfare, and best interest of each child who is a subject of the proceedings." See CRC 5.210. In reviewing parenting plans, take the time to ensure that plans:

- Reflect the child's age, developmental level, psychological development, past trauma history, and associated needs.
- Consider the impact of the plan on the youth's schooling, extracurriculars, friendships, and other important relationships, all of which can impact their mental health.
- Consider the impact on access to ongoing services, including mental health services, that the child is receiving.
- Minimize opportunities for conflict and tension between parents that may negatively impact the child's mental health.

Keep in mind that mental health information is sensitive, and any information sharing must honor applicable confidentiality and privilege laws. See the section below, *Confidentiality and Information Sharing Considerations*, for more detail on this topic.

ENSURE DECISIONS REGARDING YOUTH PARTICIPATION IN FAMILY COURT AND COURT-CONNECTED PROCESSES ARE INDIVIDUALIZED, TRAUMA-INFORMED, AND CONSIDER THE IMPACT ON THE YOUTH'S MENTAL HEALTH.

In some cases, parents will be able to reach agreements, perhaps through strategies like co-parenting counseling, that successfully prioritize their children's best interests without the child's direct involvement in the court process. In other cases, children may play a larger role. Direct involvement in court processes can be a traumatic or empowering experience for a youth, depending on their individual age and developmental level, the circumstances of their case, and the amount of agency they experience during the process. It is important to carefully consider and make individualized, trauma-informed decisions regarding a youth's potential participation in court and court-connected processes. This should include consideration of how each factor might impact the youth's mental health.

The California Rules of Court and California Family Code provide some guidance on considerations around

meeting with and interviewing minor children during court-connected processes along these lines.

- Child custody evaluators are required to "minimize the potential for psychological trauma to children during the evaluation process." See CRC 5.220(d)(2).
- Mediators may interview minor children "when the mediator considers this interview appropriate or necessary" (Family Code § 3180(a)), and this is determined "at the mediator's discretion" (CRC 5.210(e)(3)). Interviews and observation must be "age-appropriate" and should not be done if "contraindicated to protect the best interest of the child." See CRC 5.220(e)(2)(D).

The California Rules of Court and Family Code also provide a framework for making decisions regarding ***youth testimony or other forms of direct participation in court proceedings***. See CRC 5.250; Family Code § 3042. Decisions about participation are made on a "case-by-case basis," as there is no statute or rule that universally requires (or prohibits) children from participating. When a child does want to participate, courts balance protecting the child, their statutory duty to consider the child's input, and the probative value of that input. CRC 5.250(a).

- If a child is "of sufficient age and capacity to reason so as to form an intelligent preference" regarding custody or visitation, the court is required to consider the child's wishes. The court may not require the child to express a preference, however. Fam. Code § 3042.
- If a youth is *age 14 or older* and would like to address the court, they must be permitted to do so unless the court determines that it is not in the youth's best interest and states the reasons why. The best interest determination should include considering factors such as the child's age and capacity "to reason to form an intelligent preference" on custody or visitation questions; the child's age and capacity to "understand the nature of testimony"; whether the child would benefit from addressing the court or "be at risk emotionally" if allowed or not allowed to do so; and whether the input would be substantively relevant to the issues before the court. CRC 5.250(c). The court may also allow a child under age 14 to address the court, if in the child's best interest. Fam. Code § 3042.
- A minor's counsel, an evaluator, an investigator, or a child custody recommending counselor are to inform the judge if the child would like to address the court. A party or party's attorney may also do so. Or, the judge can proactively inquire about whether the child wishes to do so. If a child informs minor's counsel, an evaluator, an investigator, or a child custody recommended counselor that they have changed their mind about addressing the court , that person must notify the judge, the parties or their attorneys, and other involved professionals of this change. Fam. Code § 3042 (as amended by Stats. 2021, Ch. 768, Sec. 2. (SB 654) Effective January 1, 2022.).
- If a child will be providing testimony, it is important to consider the courtroom environment and whether the presence of parents and counsel will impact the child's ability to be "open and honest." CRC 5.250(d)(3). Potential adjustments to the process include taking the testimony in a private setting, such as a closed courtroom or in chambers; limiting whether adults (other than the judicial officer and court officer) may be present during the testimony; having a judicial officer, child advocate, or child development advocate pose the questions to the child (rather than the parties' attorneys themselves); and using listening devices such that testimony taken in chambers can be heard by parents and counsel who are not physically present in chambers. CRC 5.250(d)(3). The Court may not permit a child to address the court regarding custody or visitation in the presence of the parties, unless it determines that doing so is in the child's best interests and describes this finding, and reasons for the finding, on the record. This determination includes considering potential detrimental effects on the child. The Court must provide an alternative means of obtaining input from the child, without the child having to address the court in front of the parties. Fam. Code § 3042 (as amended by Stats. 2021, Ch. 768, Sec. 2. (SB 654) Effective January 1, 2022.).
- Moreover, when a child testifies, courts must "take special care to protect the child from harassment or embarrassment," to prevent repetitive questioning, to ensure questions are appropriate for age and cognitive level, CRC 5.250(d)(4). If the child does not have an attorney, the court is also responsible for explaining to the

child that information provided will be "on the record" and subject to confidentiality limitations. CRC 5.250(d)(4).

- Children who testify must be *permitted, but not required*, to express their preference(s) regarding custody or visitation. The court should inform the child how this decision will ultimately be made. CRC 5.250(d)(4).
- If the child will be testifying, the court should consider appointing a minor's counsel. The minor's counsel responsibilities are to include providing age-appropriate information to the child, explaining the court's decision-making process, and orienting the child to the courtroom, among other duties. CRC 5.250(d)(5). The role and responsibilities of minor's counsel and considerations for appointment are described in CRC 5.240, CRC 5.242, and Fam. Code § 3150-51 and *FL-323, Order Appointing Counsel for a Child*, is available here. Appointment of minor's counsel can help ensure that the child feels heard, understood, and supported during the court process, thereby minimizing the child's stress level. In fact, one of the considerations for appointment described in CRC 5.240 is whether "[t]he child is subjected to stress as a result of the dispute that might be alleviated by the intervention of counsel representing the child."
- If the court determines that the child will not be called as a witness, it must provide an alternative way to obtain the child's input. Fam. Code § 3042 (as amended by Stats. 2021, Ch. 768, Sec. 2. (SB 654) Effective January 1, 2022.). Possibilities include participation in child custody mediation; involvement of a child custody evaluator, investigator, or child custody recommending counselor (CCRC); information provided by parents, parties, or witnesses; or information gained by a child interview center or professional. CRC 5.250(d)(1). If one of these methods is used, the child's views should be documented in writing, among other requirements. CRC 5.250(d)(2).

If a decision is made for a youth to be directly involved in the court process, every effort should be made to honor the youth's voice, without exacerbating the youth's emotional burden and stress or causing retraumatization. See below for some specific strategies.

ENSURING CHILDREN INVOLVED IN FAMILY COURT PROCEEDINGS RECEIVE APPROPRIATE SUPPORT DURING THE PROCESS.

Involvement in a court proceeding can be an overwhelming experience for a youth. Courts are full of unfamiliar terminology, people, and situations that are difficult to process, which can lead to confusion and a sense of loss of agency and control. Providing youth with information and guiding them through the situation in a way that is appropriate for their age and developmental level is critical.

California Rule of Court 5.250(f) describes methods of providing information to parents and supporting children during the Family Court process:

> *Courts should provide information to parties and parents and support for children when children want to participate or testify or are otherwise involved in family law proceedings. Such methods may include but are not limited to:*
>
> 1. Having court-connected professionals meet jointly or separately with the parents or parties to discuss alternatives to having a child provide direct testimony;
> 2. Providing an orientation for a child about the court process and the role of the judicial officer in making decisions, how the courtroom or chambers will be set up, and what participating or testifying will entail;
> 3. Providing information to parents or parties before and after a child participates or testifies so

that they can consider the possible effect on their child of participating or not participating in a given case;
4. Including information in child custody mediation orientation presentations and publications about a child's participation in family law proceedings;
5. Providing a children's waiting room; and
6. Providing an interpreter for the child, if needed.

As noted above, appointment of minor's counsel can also help support the child during the court process. Minor's counsel can ensure the child understands the process, has their questions answered, and feels their perspective has been communicated and heard, all of which can make the experience less stressful for the child. For a list of factors to consider in determining whether minor's counsel should be appointed, see CRC 5.240(a). See also CRC 5.242; Fam. Code § 3150-51; and *FL-323, Order Appointing Counsel for a Child*.

Keep in mind that some youth may have had previous exposure to court systems in other contexts, which may impact their understanding of the situation and their emotions about being in family court. For example, for a youth with an incarcerated family member, being in a courtroom or seeing a judge may trigger negative feelings and associations about loss or fears of punishment. In such a case, it is especially crucial to orient the youth to the specific role and purpose of family court proceedings, and to make clear that this is not criminal court, and being there does not mean they or their family members have been accused of doing something wrong or are "in trouble."

You can also let youth and families know that there is a set of resources available called *Families Change: Guide to Separation and Divorce*, that provides guidance to help parents, teens, and children ages 6-12 navigate their experience.

HELP DISPEL MYTHS REGARDING MENTAL HEALTH AND NORMALIZE SEEKING SUPPORT.

Help normalize mental health for families by explaining that many youth undergoing major life transitions, including changes in family structure, benefit from proactive emotional support. Needing support does not indicate that there is "something wrong" with the child, or that the family has failed or is doing something wrong. Rather, when the child needs help and the caregiver helps them access the relevant support, the caregiver is fulfilling their legal responsibilities and setting the child up for a healthy and successful future - much like they do when they ensure the child undergoes annual pediatrician check-ups and regular dental cleanings. This re-framing may be helpful given the stigma that continues to surround mental health issues across many communities and cultures.

BE AWARE THAT THE COURT PROCESS MAY BE TRIGGERING OR RE-TRAUMATIZING FOR YOUTH, AND BE READY TO RECOGNIZE THE SIGNS.

Below is a list of some of the ways that anxiety, depression, and other mental health issues may manifest for youth in a courtroom. Understand how this may differ for children, adolescents, and adults. Be ready to recognize these cues. Avoid making negative assumptions, and prepare yourself to respond in supportive and understanding ways.

Examples: Understanding Youth Behaviors From a Trauma Perspective

THESE BEHAVIORS…	MAY INDICATE…
Anger, irritability, defiance, opposition to authority	> Emotional/mood dysregulation > Hyperarousal > Survival strategies > Strategies to get needs met
Lying, distrust of authority	> Negative beliefs based on traumatic experience
Running away, fleeing situation	> Survival ("flight or fight") > Hypervigilance > Hyperarousal
High-risk behavior (e.g., self-harm, substance use)	> Attempts to numb pain > Attempts to increase sense of power, control, or self-worth
Impulsivity	> Impact on brain development > Hyperarousal
Distractibility, lack of concentration	> Challenges in regulating attention and cognition > Hyperarousal > Re-experiencing > Dissociation
Denying or avoiding discussing trauma history	> Primary symptom of trauma > Strategy for management of overwhelming emotions
Avoidance and isolation	> Anxiety > Depression > Poor self-concept

Source: Chart adapted from National Child Traumatic Stress Network resource, available at https://www.nctsn.org/sites/default/files/resources//testifying_the_court_hearing.pdf

IMPLEMENT COURTROOM PRACTICES THAT PROMOTE POSITIVE MENTAL HEALTH.

- Look for and reduce any environmental stressors in the courtroom.
- Use trauma-informed communication strategies, such as person-first, non-stigmatizing language to discuss mental health, whether you are referring to the mental health of a youth or a parent/caregiver.
- Be aware of your body language, the tone of voice you are using, and the messages you may be inadvertently conveying. Make eye contact, listen carefully, and speak in a welcoming manner.
- Ensure your language is at an accessible level and pace, and avoid using unnecessarily complicated terminology.
- In considerations regarding testimony, consider whether there are alternatives to oral testimony that would feel safer or more comfortable for the youth.
- Allow the youth to hold a "grounding object" or "transitional object" (a small item of their choice that brings them comfort) in the courtroom or during court-connected processes. Sometimes these are objects with a smooth or soft surface.
- Encourage the youth to ask questions about anything they do not understand or would like more information regarding.
- Let the youth know they may take a break if they are feeling emotionally or physically dysregulated.
- Acknowledge and thank the youth for participating in the process and for sharing their voice and perspective.

"By the time the youth is in the courtroom, it is likely that the youth has been exposed to a significant life changing event, divorce, removal from parents' care, incarceration. Now you may not know the extent of previous traumatic exposure, but we ask that you please ask yourself, 'I wonder if this is the first traumatic event this youth has experienced?'"

- **Amy Sanchez**
Regional Executive Director – Los Angeles
Pacific Clinics

AT ALL STAGES, CENTER YOUTH AND FAMILIES.

- Understand that each youth and each family enters the courtroom with unique strengths, needs, and experiences, which may include a trauma history.
- Be aware that there is no single, one-size-fits-all approach to meeting the needs of youth and families experiencing mental health issues.
- Recognize the resilience of youth and families. Center their strengths, and recognize and support their needs. Avoid falling into an approach that focuses on the child's perceived deficits, instead of strengths.
- Take the time to pause and consider the courtroom experience from the perspective of the youth and families involved. As a judicial officer or court staff member, the courtroom is your everyday environment. But for youth and families, a courtroom may feel like a strange, unfamiliar, or intimidating place, or perhaps it brings back difficult memories of prior court-involved experiences. Consider how youth might experience the proceeding, what emotions it may trigger, and how those emotions may manifest in the courtroom.
- Keep in mind that while it is your courtroom, it is the youth's life that you are discussing and making decisions regarding. Ensure that it is the youth's needs and best interest that is driving the process.

7. CONFIDENTIALITY AND INFORMATION SHARING CONSIDERATIONS

Individuals responsible for the children, including caregivers, court investigators and the judicial officer, may desire access to information in youths' mental health records to ensure appropriate care is provided and make informed decisions on the children's behalf. Yet, these mental health records also contain sensitive information. Privacy is a central legal and ethical tenet of mental health care, helping ensure patients feel safe seeking care and receive appropriate diagnoses and treatment. Mental health information is often protected by both confidentiality and privilege laws.

Individually identifiable health information generated by a health care provider during a mental health assessment, evaluation or services may be protected by one or a combination of federal and state confidentiality laws, including the **Health Insurance Portability and Accountability Act of 1996 Privacy Rule (HIPAA)**, the **California Confidentiality of Medical Information Act (CMIA)**, the **Lanterman Petris Short Act (LPS)**, or the **Family Educational Rights and Privacy Act (FERPA).** All of these laws shape what a health provider may disclose to third parties. All allow appropriate disclosure of otherwise protected health information pursuant to a signed and valid authorization to release information. They all also include exceptions that allow disclosure of protected health information absent a release, in some circumstances. In general, a legal guardian is allowed to access a youth's health information protected by confidentiality laws; however, there are situations in which a health provider may have the right, or obligation, to restrict or limit guardian access under these laws, especially related to patients ages 12 and older. See *Sharing Mental Health Information for Children in Foster Care and Sharing Education Information for Children in Foster Care*[49] for more information on the confidentiality laws described here.

When health information may enter into a court setting, evidentiary privilege laws also become relevant. Psychotherapist-patient privilege gives patients the assurance that what is communicated in a therapeutic setting generally will not be admissible in court without their permission. Evidence Code § 1015 requires psychotherapists who made or received a communication subject to privilege to claim the privilege on behalf of their client if they receive a request to disclose confidential communications. While there are exceptions to privilege, in most cases, disclosures in court or for use as evidence in a court proceeding require a waiver of privilege by the privilege holder.

Obtaining the knowing and informed authorization of the youth and/or authorized representative to share information or waive privilege ensures compliance with state and federal law, encourages and promotes transparent communication, allows for informed decision making and case planning, and contributes to creating a safe and trauma-informed courtroom setting.

Another source of relevant information may be the files of other agencies or courts. In many cases, these files are subject to their own confidentiality laws, and disclosures and information sharing practices must comply with both those laws as well as any applicable health confidentiality laws. For example, the juvenile court and/or a child welfare agency may have a juvenile case file that includes information about a youth who is now part of a family court proceeding. Access to information in a juvenile case file is controlled by Welfare and Institutions Code § 827. Pursuant to WIC 827, "a judge, commissioner, or other hearing officer assigned to a family law case with issues concerning custody or visitation, or both, involving the minor" may inspect a juvenile case file as well as "the following persons, if actively participating in the family law case: a family court mediator assigned to a case involving the minor pursuant to Article 1 (commencing with Section 3160) of Chapter 11 of Part 2 of Division 8 of the Family Code, a court-appointed evaluator or a person conducting a court-connected child custody evaluation, investigation, or assessment pursuant to 3111 or 3118 Section of the Family Code, and counsel appointed for the minor in the family law case pursuant to Section 3150 of the Family Code." However, prior to allowing counsel appointed for the minor in the family law case to inspect the file, the court clerk may require counsel to provide a certified copy of the court order appointing the minor's counsel." See WIC § 827(a)(1)(L). A child welfare agency is also permitted to provide copies of files and records relating to a minor who is the subject of either a family law or a probate guardianship case involving custody or visitation issues, or both, to the above individuals. WIC § 827.10.

There are limitations on access and use of this information. These individuals may not further disseminate the information other than to persons authorized to receive it pursuant to WIC § 827; they may not access information in the file that is privileged or confidential pursuant to others laws, unless they are entitled to access under the other state law or federal law or regulation; and information obtained must be maintained in the "confidential portion" of the family law file. See WIC §§ 827(a)(3)(A), (4), (5); 827(b),(d). Any access or use beyond these limitations requires petitioning the juvenile court for a court order. See WIC § 827(a)(1)(Q).

8. YOUTH STORIES

Below are some hypothetical scenarios to work through. Consider how you might apply the information in this bench guide in these situations.

MAYA'S STORY

Maya is 14 years old and in ninth grade. Her favorite subject in school is history and she loves to act and has a lead role in the school play. About a year ago, Maya's parents separated, and they are in the process of legally dissolving their marriage. There has been significant conflict between Maya's mothers regarding custody of Maya and her two younger siblings, Emmy (age 5) and Caleb (age 7), and communication between them has deteriorated to the point where anything contentious is now discussed through their respective attorneys. During the separation, the children have been back and forth between two homes, about an hour apart, sometimes multiple times per week. This has been difficult, both logistically and emotionally. Maya is often late to school and has missed several play rehearsals. She is frustrated about the conflict between her parents, and the effect it is having on her and her siblings, especially Caleb, whose teacher has complained about him being aggressive towards other kids during recess. Maya has spoken up about her opinions during court-connected processes and is adamant that she wants to speak directly to the court.

Discussion Questions:

How might Maya's experiences be impacting her mental health and well-being?

How might this manifest during the family court process?

What are at least three specific steps you can take to support Maya's mental health and well-being?

What resources might you direct Maya's family to?

How would you approach the possibility of Maya addressing the court in a trauma-informed way?

How might this situation be impacting Maya's younger siblings, and what steps would you take to promote their mental health and well-being?

DOMINIC'S STORY

Dominic is 16 years old and a high school junior. He lives with his mother and grandmother in the Los Angeles area. After struggling in middle school, he is now thriving academically and is on the varsity baseball team, hoping to get an athletic scholarship to college. Dominic is also active in, and connected with, the Mexican-American community in downtown LA, where he's involved in a folklórico group and frequently volunteers with a Chicano community organization. Dominic's parents are divorced, and his mother has full custody of Dominic and his 12-year-old sister, Sophie; his father has been in and out of his life over the years. Dominic was recently featured in the local newspaper as "student athlete of the week." His father, also a former athlete, saw this and attempted to get back in contact with Dominic through his mother, who refused. Dominic's father eventually approached Dominic outside his school, and said he wanted to be back in his life, but asked him to keep it a secret from his mother and sister for now. This has been weighing on Dominic. Dominic's father is now seeking a modification of the family's existing custody and visitation order. Dominic's mother, who suffers from anxiety, is feeling blindsided and distressed. Because of a past experience where she was discriminated against in a medical setting, Dominic's mother is reluctant to seek mental health services. Sophie is unsure what to make of the situation and is looking to her older brother for direction.

Discussion Questions:

What experiences has Dominic had that may be impacting his mental health and well-being?

How might this manifest during the family court process?

What are three specific steps you can take to support Dominic's mental health and well-being?

What community-based resources might you direct the family to?

TALIA'S STORY

Talia is 7 years old, and in second grade. She is an only child and a talented artist who loves to draw and paint. Until recently, Talia lived with her mother and father, who never married, but have been together for about 10 years. About three months ago, Talia's parents had a major argument. Talia doesn't know what the argument was about and was upstairs in her room, but she could hear them yelling at each other and was scared. The argument escalated to the point where Talia's mother threatened to call the police. Talia's father left the home and did not come back. Since then, Talia has only seen her father for a couple of short visits at a park near where she and her mother live. Following the separation, Talia's mother has been struggling financially and is now seeking child support from Talia's father. Talia's father is upset about his limited access to his daughter and is seeking a formal custody and visitation plan. Talia has accompanied her mother to some meetings related to the court process, but doesn't understand what is happening. Talia misses her father, and she worries about her mother, who has been crying a lot, but she tries her best to be cheerful at home. At a recent school pick-up, Talia's teacher mentioned to her mother that she'd like to set up a parent-teacher conference, because Talia recently made some drawings of her family that she is concerned about.

Discussion Questions:

What experiences has Talia had that may be impacting her mental health and well-being?

How might this manifest during the family court process?

What are at least three specific steps you can take to support Talia's mental health and well-being?

What resources might you direct Talia and her family to?

ANTHONY & ADRIAN'S STORY

Jose and Lucy have been married for 8 years and have two children, Anthony and Adrian. Anthony is 7 years old and in second grade, and Adrian is 5 years old and in kindergarten. Both boys are outgoing, active on sports teams, and get along well with their peers, with no known history of behavioral or mental health issues.

Jose works the night shift as a hospital custodian; Lucy stopped working as a preschool teacher when she had their first child. She has stayed home since at Jose's insistence, although she was agreeable due to the high cost of childcare relative to the salary she was earning.

Lucy recently filed for divorce requesting sole legal and physical custody of the children with monitored visits for Jose. She described in her declaration that the parties have a history of heated arguments, some of which have taken place in front of the children. Lucy has tried to remove herself and the children during arguments, but Jose will follow her to continue yelling at her. The most recent incident resulted in Jose breaking down the door when Lucy locked herself and the children in the bedroom. Jose gives Lucy a monthly allowance for the household and fights often revolve around finances when Lucy asks for additional spending money for groceries and children's needs. There is no history of police or social service involvement.

In recent weeks, Anthony has become increasingly quiet, and even somewhat withdrawn, passing up opportunities to play sports or spend time with friends. Adrian's teacher has reported to Lucy that he frequently becomes upset and emotional at school, and frequently asks to see his mother during the school day.

Discussion Questions:

What experiences have Anthony and Adrian had that may be impacting their mental health and well-being?

How might their needs and emotions be manifesting at school and elsewhere?

What are at least three specific steps you can take to support (a) Anthony and Adrian's well-being, and (b) Lucy's well-being and capacity to help address the children's emotional needs?

What resources might you direct the family to?

APPENDICES

APPENDIX A: DEEPER DIVE: RACE, EQUITY, AND ACCESS TO MENTAL HEALTH CARE

There are existing disparities in the access and utility of mental health care among different racial and ethnic groups, with individuals from racial/ethnic minorities being less likely to receive mental healthcare. As such, BIPOC are more likely to have unmet mental health care needs, which can result in poorer mental health outcomes. There are various factors why people from racial/ethnic minority communities are less likely to receive mental health care, including:[50]

- Lack of insurance or underinsurance;
- Mental illness stigma;
- Lack of diversity among mental healthcare providers and culturally competent providers;
- Lack of availability of mental health services and providers;
- Racism, bias, and discrimination in treatment settings;
- Language barriers, including an insufficient number of providers who speak languages other than English; and
- Distrust of the healthcare system.

Lack of insurance or underinsurance:

Many **Black, Indigenous, and people of color** (BIPOC) groups experience higher rates of uninsurance or underinsurance. Hispanic, American Indian and Alaskan Native (AIAN), Black, and Native Hawaiian or Pacific Islander (NHOPI) people are more likely to be uninsured than their White counterparts.[51] Higher rates of uninsurance or underinsurance within these communities prevent them from accessing mental health care that would be typically covered through health insurance. Medicaid can help bridge this gap in coverage for some communities, but does not completely close the gap. Additionally, uninsured Black, Hispanic, and Asian people are less likely to be eligible for Medicaid or marketplace coverage through the Affordable Care Act than their white counterparts due to ineligibility due to immigration status, income, or geographic location, as some states chose not to expand Medicaid eligibility.[52] Additionally, COVID-19 job losses disproportionately affected BIPOC and may cause further disparities in health coverage.

Lack of diversity among mental healthcare providers and lack of culturally competent providers:

Despite the growing diversity in the United States population as a whole, the majority of psychologists and other mental health providers in the country's workforce are white. According to the 2021 data on Labor Force Statistics from the United States Bureau of Labor Statistics, 90% of school psychologists and 84.6% of other psychologists were white.[53] Additionally, 70% of substance abuse and behavioral disorder counselors and 76% of mental health counselors were white.[54] This distribution of white mental health providers does not reflect the diversity of the United States and can result in a decreased understanding about the specific mental health needs among minority groups, cultural differences in mental health, and a lack of understanding about the impact of lived experiences on mental health. Studies have found that when there is racial/ethnic concordance, or when a patient and their provider have a shared racial/ethnic identity, patients were more likely to rate their experience more positively, making the issue of diversifying the mental health workforce a critical step in promoting mental health care access and utility among BIPOC.[55]

Given the mismatch in the lack of diversity among mental health care providers and the diversity of the United States, there is an even greater need for cultural competence in mental health care. Cultural competence allows health professionals to develop an understanding of their patients from different backgrounds as culture impacts how individuals perceive, understand, and experience mental health conditions. Training in cultural competence can encourage providers to be culturally-informed, increase awareness of cultural norms, promote integration of culturally-sensitive practices and increase incorporation of cultural strengths in their practice when serving patients from different racial/ethnic backgrounds. Lack of cultural competency among providers remains one of the main reasons for underutilization of mental health services among racial/ethnic minority communities[56] and increased cultural competence has been linked with improved mental health outcomes.[57]

Language barriers, including an insufficient number of providers who speak languages other than English:

Limited English proficiency is a significant barrier in accessing healthcare services, including mental health care. Language discordance, or when a patient and provider do not have a shared preferred language, interferes with a patient's and provider's ability to develop trust and communicate effectively about stigma, lived experiences, and cultural attitudes.[58] As such, language discordance can also hinder a provider's ability to properly determine psychiatric diagnoses and can result in misdiagnosis. Providing language assistance for individuals with limited English proficiency has been shown to lead to increased utilization of mental health services.[59]

Lack of availability of mental health services and providers:

Beyond the availability of diverse, culturally competent, and linguistically accessible providers, there is also the issue of availability of mental health providers generally. Geographic areas where there are larger Black and Hispanic communities often have fewer behavioral health professionals in proximity than communities with larger white populations.[60] Additionally, rural and low-income areas, as well as other areas with a high proportion of racial/ethnic minorities, experience little or no access to outpatient mental services[61]. Inadequate availability of mental health services and providers within proximity further inhibits the capacity of BIPOC communities to obtain mental health care.

Mental illness stigma:

Mental illness stigma, or negative attitudes that people have toward mental illness, exists in all communities. However, racial and ethnic minority groups often experience higher levels of mental illness stigma.The California Well-Being Survey found that Asian Americans and Latinos reported higher levels of self-stigma, or feeling inferior in comparison to those without a mental illness, compared to their white counterparts.[62] In this same survey, almost 90% of Latinos surveyed indicated they would conceal a mental health problem from their peers. Stigma toward mental illness can result from various factors, including lack of knowledge about mental health, fear of judgment or discrimination, or cultural beliefs on well-being and health.[63] Stigma within racial and ethnic minority groups is also compounded by historical traumas experienced by racial and ethnic minorities, including medical exploitation and experimentation that criminalized mental illnesses in racial/ethnic minorities.[64]

Racism, bias, and discrimination in treatment settings:

There is a long and well documented history of forced experimentation and acts of violence committed against BIPOC in US history. There is also a long history of racism and discrimination in health care, and the history of mental health care is no exception. Additionally, ideas of "inferiority" of certain racial and ethnic groups were abundant in the healthcare space, and often used to justify aforementioned experimentation and acts of violence.[65] While racism and discrimination in the contemporary health care context may not be as overt, these ideas and historical contexts still have a pervasive impact on health care spaces, including in the training of healthcare professionals, which leads to real repercussions for BIPOC. Certain racial and ethnic groups, such as Black and Latinx[66] communities, are overdiagnosed with mental health disorders like schizophrenia, but underdiagnosed for other disorders like posttraumatic stress disorder and mood disorders, such as depression.[67] Additionally, these biases result in experiences of discrimination felt by BIPOC. In California, Black and Latinx people were significantly more likely to report being treated unfairly when getting medical care, and in 2020[68], 7 out of 10 Black Americans reported being treated unfairly by the health care system. Historical and contemporary racism and discrimination in the healthcare setting and training of healthcare providers leads to implicit biases, or assumptions that the provider has regarding their patient based on demographic information, on the behalf of the provider, which in turn leads to medical mistrust and perceived discrimination on the behalf of the patient, which is a significant barrier in accessing care.

Distrust of the healthcare system:

Because of the extensive history of abuses conducted by the United States healthcare system on BIPOC, communities of color experience higher rates of medical distrust than their white counterparts.[69] In 2020, a poll conducted by the Kaiser Family Foundation found 55% of Black Americans reported distrusting the health care system.[70] Findings from the Survey of California Adults on Serious Illness and End-of-life found that Hispanic and Black respondents were 49% and 79% more likely to distrust health professionals, than their white counterparts, respectively.[71] Medical distrust has many repercussions, including dissuading individuals from obtaining needed and routine health care, including mental health care. This could lead to aggravated levels of illness and worsening outcomes, and an increased reliance on urgent or emergency care.

These disparities in access and utilization of mental health care among BIPOC can result in negative mental health outcomes, including a disproportionately high burden of disability resulting from forgone treatment, more persistent mental illness, increased interaction with the justice system, and higher rates of mental illness overall.[72] These factors not only persist, they often intersect, making it difficult for BIPOC communities to access and effectively utilize mental health care services. As such, increasing access and utilization of mental health care for BIPOC communities requires a multi-faceted approach to address the often intersecting causes of health access disparities.

However, there are already many organizations leading such work, including CPEHN ,Active Minds ,NAMI ,Commonwealthfund.org Community Health Councils, and the California Health Care Foundation

APPENDIX B: DEEPER DIVE: COVID-19 IMPACT ON MENTAL HEALTH NEEDS

Even before COVID-19, children's mental health needs were already on the rise. The Centers for Disease Control and Prevention found that 1 in 5 children had a mental disorder and of those children, only 20% had received care from a provider.[73] In 2018 and 2019, 8% of children aged 3-17 had an anxiety disorder and 4% had a depressive disorder.[74] Since the pandemic, mental illness and mental health needs have reached unprecedented levels. A national survey of high school students found that almost 30% of students felt more unhappy and depressed than usual, while mental health-related emergency department visits increased by more than 20% for children ages 5-17.[75] COVID-19 has further exacerbated existing mental health needs throughout all communities, but especially among vulnerable communities including women, racial/ethnic minorities, people with preexisting conditions, older persons, and children.[76] COVID-19 impacts in the areas of employment, income loss, social cohesion, housing, and food security, in addition to sickness and loss brought on by the pandemic, are stressors that impact mental health.[77] To understand the impact of COVID-19 on mental health needs of children, it is crucial to examine the impacts of COVID-19 on each of these areas and how they have affected the well-being of vulnerable communities and families in which young people belong.

Sickness/Loss of life:

The COVID-19 pandemic has caused almost a million deaths and has caused more than 80 million people to be sick in the United States alone. COVID-19 cases and deaths have disproportionately burdened BIPOC communities. In particular, CDC data has shown persistent disparities in COVID-19 cases among Hispanic people and deaths for Black people.[78] Additionally, Black and Hispanic people faced higher risks of hospitalization compared to their white counterparts.[79] Part of this increased risk of developing COVID-19 results from the overrepresentation of Black and Hispanic communities in "essential" jobs that increases their exposure to others and requires them to work in person. In 2018, a report by the Urban Institute found that 31% of Hispanic workers and 33% of Black workers were employed in essential work, as compared to 26% of White workers. The higher risk of contracting, getting hospitalized, and dying from COVID-19 has multiple implications on the mental health needs of these communities.

Not only has COVID-19 itself been linked to mental disorders, such as depression, anxiety, and dementia, there are also indirect impacts such as heightened fear and anxiety surrounding getting sick or grief associated with losing a loved one to COVID-19 that also aggravates mental health needs.[80] Black children in particular have been disproportionately affected by parental loss; 20% of those who lost a parent to COVID-19 are Black children, despite only accounting for 14% of children in the United States.[81] Because of the disproportionate burden of COVID-19 as an illness on BIPOC communities, it is unsurprising that young people in these communities are facing higher rates of mental health issues. Parental loss is considered an Adverse Childhood Experience (ACE), and ACEs are linked to numerous physical and mental health outcomes, including increased risk of developing chronic illnesses, depressive disorder, and substance use disorder.[82] Outside of the mental health outcomes associated with parental or caregiver loss, children in all communities also experienced increased fear surrounding getting sick overall, which has implications for developing anxiety and posttraumatic stress disorder.[83]

Employment/Income Loss:

Though job and income loss affected all communities during the pandemic, BIPOC communities bore a disproportionate burden. And, despite the disproportionate number of Black and Hispanic adults employed in essential jobs, during the pandemic, 32% of Black adults and 41% of Latinx adults experienced job loss compared to only 24% of white adults. Unemployment rates among Asian Americans rose to 11% compared to 3% in 2019.[84] Parental job loss has been shown to be linked to poorer child physical and mental variables, even prior to the pandemic.[85] Job loss and income loss increases financial strain on families, creating conditions that have been linked to anxiety and depression among parents and caregivers, and to increased parent-child conflicts which poses negative consequences on youth emotional well-being.[86] Another potential mechanism for job loss impacting mental health is that job losses lead to loss of insurance, which is not only another source of stress, but also decreases the ability of affected communities to seek health care, including mental health care.

Educational instability and social isolation:

Social connection is crucial in the mental well-being of young people. And for many children and youth, school serves as a vital linkage to connect with peers and thus, a crucial source of socialization. For many students, schools also serve as an integral part of their daily routine and their overall development. School closures, as a preventive measure during the pandemic, must be examined in their impact to child and adolescent mental health. School closures and social lockdowns during COVID-19 have been associated with negative mental health symptoms, such as distress, anxiety, and depressive symptoms.[87] Even before the pandemic, social isolation and resulting loneliness had been associated with elevated depressive and anxiety symptoms among young people as well as being potentially linked to posttraumatic stress.[88] Though most students are now back in school in-person, increases in crying, disruptive behavior, and bullying appear to be lasting impacts from the social disruption that young people experienced during the pandemic.[89] Additionally, families in low-income communities of color have had to contend with another impact of school and daycare closures: older siblings having to be caretakers for their younger siblings and helping them navigate online learning while navigating their own needs while their parents continue to report to essential jobs.[90] This added pressure further disproportionately strains the mental well-being of young people in communities of color. Furthermore, school is one potential source of mental health services for young people, and with many schools closed during the pandemic, adolescents did not have access to such services, potentially leaving many with unmet mental health needs.[91]

Housing and food insecurity:

Job and income loss during the pandemic put further strain on other financial aspects of everyday life, increasing food insecurity and exacerbating housing insecurity and instability. Even before the pandemic, housing insecurity disproportionately burdened communities of color due to historic and current discriminatory housing policies, higher rates of eviction, gentrification, increased housing costs, and housing that does not meet the needs of multigenerational families of color.[92] Due to the increased job and income losses experienced during the pandemic, housing instability increased and overall confidence in being able to pay rent decreased for renters of color. As of 2021, 5.2 million households with children were behind on rent and 4.5 million of those households were behind on mortgage payments, and of those behind on rent, 46% said they would likely have to move within the next 2 months.[93] Housing insecurity can lead to homelessness, which can lead to emotional, behavioral, and development issues.[94] Evictions resulting from inability to pay rent result in disruptions and instability in children's lives, disrupting their daily routines. Job and income loss also put further strain on families' abilities to buy food. Food insecurity has been associated with a 357% higher risk of anxiety and a 253% higher risk of depression among adults.[95] Among adolescents, food insecurity can lead to poor health and developmental outcomes and

has been linked with increased substance use, higher dropout potential, and increased conduct problems.[96]

These are just some areas that have been impacted by the COVID-19 pandemic and have repercussions on child and adolescent mental health. Though these impacts may not always be directly felt by young people, they do impact the families and households in which children and adolescents belong, creating at minimum indirect effects. Many studies have indicated that parental stress has implications for the mental health outcomes of children in the household.[97] Children who had a parent who reported poor mental health were more likely to experience a mental, emotional, or developmental disability and to be exposed to ACEs.[98] The social and economic impacts, in addition to the physical health impacts of COVID-19, further strained parents, caregivers, and families. To mediate the impact of COVID-19 on the mental health of children and youth, coordinated efforts must address these different arenas simultaneously.

To learn more about the work organizations are doing to mitigate and address these impacts on communities color, visit
United Ways CA
Legal Aid At Work
California Association of Food Banks

APPENDIX C: MENTAL HEALTH TERMS

TERM	ACRONYM	DEFINITION
Adverse Childhood Experiences	ACEs	Potentially traumatic events that occur during childhood (0-17 years) and involve aspects of the child's environment that affect their sense of safety, stability, and bonding. Examples include witnessing violence and being exposed to substance use problems. https://www.cdc.gov/violenceprevention/aces/fastfact.html
Affordable Care Act	ACA	The ACA is a comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or "Obamacare") that was intended to make affordable health insurance available to more people through subsidies and lower costs, expand the Medicaid program to cover all adults with income below 138% of the Federal Poverty Level (FPL), and support innovative medical care delivery methods to lower the costs of healthcare. https://www.healthcare.gov/glossary/affordable-care-act/
Black, Indigenous, and people of color	BIPOC	BIPOC stands for Black, Indigenous, and people of color and is intended to center the experiences of Black and Indigenous groups and demonstrate solidarity between communities of color. https://www.ywcaworks.org/blogs/ywca/wed-04062022-0913/why-we-use-bipoc#
California Advancing and Innovating Medi-Cal	CalAIM	California Advancing and Innovating Medi-Cal initiative — known as CalAIM — is a multi-year plan to innovate California's Medi-Cal program and integrate it more seamlessly with other social services. The goal of CalAIM is to improve outcomes for the millions of Californians covered by Medi-Cal, especially those with the most complex needs. https://www.chcf.org/publication/calaim-explained-five-year-plan-transform-medi-cal/

California Victims Compensation Board	CalVCB	The California Victim Compensation Board (CalVCB) and its network of providers throughout California helps victims of violent crimes recover financially through assistance with paying expenses resulting from crimes that are not covered by insurance or other resources. https://www.cdcr.ca.gov/victim-services/restitution-vcgcb/
Child and Family Teams	CFTs	A Child and Family Team (CFT) is a family-centered team that supports the needs of a dependency-involved child or youth. It includes the youth, family, medical and mental health providers, educators, and other supportive adults. https://www.cdss.ca.gov/inforesources/foster-care/child-and-family-teams
Child and Youth Behavioral Health Initiative	CYBHI	The Child and Youth Behavioral Health Initiative program was announced in 2021 to enhance, expand, and redesign California's behavioral health systems for children and youth. The goal of this $4.5 billion investment is to promote well-being and prevent behavioral health challenges. https://www.chhs.ca.gov/home/children-and-youth-behavioral-health-initiative/
Community schools		A community school is both a place and a set of partnerships between the school and other community resources that integrate academics, services, supports and opportunities. https://www.csba.org/en/GovernanceAndPolicyResources/ConditionsOfChildren/ParentFamComEngageandCollab/CommunitySchools
Community- based trauma		An aggregate of trauma experienced by a community or an event that only directly affects a few people but has wide-reaching structural and socially traumatic consequences. https://icjia.illinois.gov/researchhub/articles/individual-and-community-trauma-individual-experiences-in-collective-environments

Community-based organizations	CBOs	Community-Based Organizations (CBOs) are public or private not-for-profit organizations that provide specific services to a community or for a targeted population within a community. https://www.phe.gov/Preparedness/planning/abc/Pages/engaging-CBO.aspx
Coordination of Service Teams	COST	A Coordination of Services Team (COST) is a strategy for managing and integrating various learning supports for students. COST teams identify and address student needs holistically and ensure that the overall system of supports work together. https://cpehn.org/assets/uploads/archive/149_cost_toolkit_single_pdf.pdf
County Mental Health Plans	MHPs	County Mental Health Plans are responsible for providing or arranging provision of Specialty Mental Health Services (SMHS) to Medi-Cal enrollees (adults and children) in each county. https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx
Dyadic Care Benefit		The Dyadic Care benefit was funded in the 2021-2022 budget and is a benefit that covers a form of therapy that treats both the young child and caregiver holistically. https://cssp.org/2021/03/californias-medicaid-breakthrough-an-opportunity-to-advance-childrens-social-and-emotional-health/
Early and Periodic Screening, Diagnostic, and Treatment benefit	EPSDT	The Early and Periodic Screening, Diagnostic, and Treatment benefit provides comprehensive and preventive health care services for children under age 21 enrolled in Medicaid. States are required to provide such services and provide all Medicaid coverable, appropriate, and medically necessary services to correct and ameliorate health conditions, including mental health. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

Educationally Related Mental Health Services	ERMHS	Educationally Related Mental Health Services (ERMHS) are mental health services for students who qualify for special education that are intended to support student's social-emotional and mental health needs, and can also help to improve the student's academics, behavior, and overall well-being. https://www.disabilityrightsca.org/publications/educationally-related-mental-health-services-ermhs-0
Essential health benefits		Essential health benefits are a set of 10 categories of services that health insurance plans must cover, as defined by the Affordable Care Act (ACA). Examples include doctors' services, inpatient and outpatient hospital services, prescription drug coverage, pregnancy and childbirth, and mental health. https://www.healthcare.gov/glossary/essential-health-benefits/
Family therapy benefit		In 2020, a new policy made Family Therapy a covered Medi-Cal benefit for children and their families. A child's mental health diagnosis is not a prerequisite for this service; a family may qualify based on the child having one or more risk factors, for example. https://first5center.org/blog/new-medi-cal-policy-expands-access-to-family-therapy-for-young-children
Fee-for-Service Medi-Cal	FFS Medi-Cal	FFS providers provide services and then submit claims for payment that are adjudicated, processed, and paid by Medi-Cal program's fiscal intermediary. https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal_Fee-for-Service_Expenditures.aspx#
Free Appropriate Public Education	FAPE	Under the IDEA and Section 504 of the Rehabilitation Act of 1973, students with disabilities are entitled to a "free appropriate public education" (FAPE). https://www2.ed.gov/about/offices/list/ocr/docs/edlite-FAPE504.html

Historical trauma		Multigenerational trauma experienced by a specific community related to major oppressive events. Examples include slavery, the Holocaust, and the violent colonization of Native Americans. https://www.acf.hhs.gov/trauma-toolkit/trauma-concept#
Individuals with Disabilities Education Act	IDEA	The Individuals with Disabilities Education Act (IDEA) is a law that entitles all children with disabilities to a free, appropriate public education (FAPE) that meets their unique needs to prepare them for further education, employment, and independent living. https://www.apa.org/advocacy/education/idea
Intensive Care Coordination	ICC	Intensive Care Coordination is a targeted case management service that facilitates assessment of, care planning for, and the coordination of services for Medi-Cal beneficiaries under 21 eligible for full scope services and who meet the "medically necessary" criteria. It is a Specialty Mental Health Service that is specific to children and youth. https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx#:
Intensive Home-Based Services	IHBS	Intensive Home-Based Services are individualized, strength-based interventions that are intended to correct or ameliorate mental health conditions that interfere with the functioning of a child or youth. The interventions are designed to build skills for successful functioning for the individual and to help the family's ability to promote the child or youth's functioning. It is a Specialty Mental Health Service that is specific to children and youth. https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx#
Interdisciplinary teams		Generally speaking, an interdisciplinary team is a group of professionals from different fields or specialties (e.g., education and mental health) that come together to support a child. Specific examples are Multidisciplinary Teams (MDTs), Child and Family Teams (CFTs), and Coordination of Services Teams (COSTs).

Intergenerational trauma		The transmission of the traumatic effects of historical events. Intergenerational trauma can result in unhealthy coping mechanisms, including denial and minimization. https://oie.duke.edu/inter-generational-trauma-6-ways-it-affects-families
Least restrictive environment	LRE	Least restrictive environment is a federal and state law requirement that students with disabilities receive their education with nondisabled peers, to the maximum extent appropriate. It is also a guiding principle in the mental health context, indicating that care should be provided in the last restrictive setting possible (e.g., home or community-based setting, rather than inpatient hospitalization). https://serr.disabilityrightsca.org/serr-manual/chapter-1-information-on-basic-rights/1-52-what-does-least-restrictive-environment-lre-mean/
Local Education Agency Billing Option Program	LEA-BOP	The Local Educational Agency (LEA) Medi-Cal Billing Option Program reimburses LEAs (school districts, county offices of education, charter schools, community college districts, California State Universities and University of California campuses) the federal share of the maximum allowable rate for approved health-related services provided by qualified health service practitioners to Medi-Cal eligible students. This is a mechanism through which school districts can be direct billers of mental health services provided to students. https://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx
Medi-Cal Managed Care Plans	MCPs	Medi-Cal Managed Care Plans are contracts for health care services through networks of organized systems of care that emphasize primary and preventive care. Most children and youth on Medi-Cal are enrolled in an MCP. MCPs are responsible for providing them with all medically necessary mental health services except for Specialty Mental Health Services (SMHS), which are “carved out” of MCP contracts and delivered through county Mental Health Plans (MHPs). https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx

Mental health parity		The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that prevents health plans and health insurance issuers that provide mental health or substance use disorder benefits from providing less favorable limitations on those benefits compared to medical/surgical benefits. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet
Mental Health Services Act	MHSA	The MHSA was passed by California voters in 2004 to expand and transform California's behavioral health system to better serve individuals with, and at risk of, serious mental health issues, and their families to address a broad set of service needs and the necessary infrastructure, technology, and training elements that effectively support the public behavioral health system. https://www.dhcs.ca.gov/services/MH/Pages/MH_Prop63.aspx
Mental Health Services Oversight and Accountability Commission	MHSOAC	The primary role of the Mental Health Services Oversight and Accountability Commission (MHSOAC) is to oversee the implementation of the Mental Health Services Act (MHSA) and to develop strategies to improve the mental health of Californians. https://mhsoac.ca.gov/
Mental Health Student Services Act	MHSSA	Mental Health Student Services Act (MHSSA) provides ongoing funding for establishing additional mental health partnerships between county behavioral health departments and school districts, charter schools, and county offices of education. https://mhsoac.ca.gov/sites/default/files/MHSSA%20Listening%20Session%20%233%20Brief%20Final.pdf
Multi-Tier System of Support	MTSS	In California, MTSS is an integrated, comprehensive framework that focuses on Common Core State Standards, core instruction, differentiated learning, student-centered learning, individualized student needs, and the alignment of systems necessary for all students' academic, behavioral, and social success. https://www.cde.ca.gov/ci/cr/ri/mtsscomprti2.asp

Multidisciplinary Teams	MDTs	Cross-agency teams that allow for the sharing of information to prevent child abuse or neglect, that can include medical providers, law enforcement, child welfare agency staff, and school staff. MDTs may also be formed to support specific subgroups of youth. https://www.courts.ca.gov/documents/BTB24-3H-5.pdf
Regional Centers		Regional centers provide assessments, determine eligibility, and provide case management services and also develop, purchase, and coordinate the services in each person's Individual Program Plan. https://www.dds.ca.gov/rc/
School Medi-Cal Administrative Activities	SMAA	The MAA Program offers a way for Local Governmental Agencies (LGAs) and Local Educational Consortia (LECs) to obtain federal reimbursement for the cost of certain administrative activities necessary for the proper and efficient administration of the Medi-Cal program. https://www.dhcs.ca.gov/provgovpart/Pages/SMAADescription.aspx
School-based health centers/ wellness centers	SBHCs	School-based health centers are health centers based at or near schools which provide age-appropriate health care, including primary medical care; mental/behavioral health care; dental/oral health care; substance abuse counseling. https://www.hrsa.gov/our-stories/school-health-centers/index.html https://www.schoolhealthcenters.org/school-based-health/programs/
Section 504 of the federal Rehabilitation Act	504	Section 504 of the Rehabilitation Act of 1973 is a federal law that protects qualified individuals from discrimination based on their disability, including students. https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf

Social Determinants of Health	SDOH	Socioeconomic and environmental conditions in which people are born, live, learn, work, and play that affect health and quality of life outcomes. Examples include economic stability, educational access, built environment, and health care access. https://health.gov/healthypeople/priority-areas/social-determinants-health
Social Security Disability Insurance	SSDI	The SSDI program pays benefits to individuals with disabilities and certain family members if they have worked long and recently enough and paid Social Security taxes on their earnings. https://www.ssa.gov/benefits/disability/
Specialty Mental Health Services	SMHS	Specialty Mental Health Services are provided to Medi-Cal beneficiaries through a county Mental Health Program and can include Rehabilitative Mental Health Services, Psychiatric Inpatient Hospital Services, and Psychiatric Nursing Facility Services. Services are only provided if they are medically necessary. https://www.disabilityrightsca.org/publications/specialty-mental-health-services-through-a-county-mental-health-plan-mhp Criteria for accessing SMHS were recently updated and are available here: https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf
Substance Use Disorders	SUDs	A substance use disorder (SUD) is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications that can range from moderate to severe, with addiction being the most severe form of SUDs. https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health#
Supplemental Security Income	SSI	Supplemental Security Income (SSI) is a federal income supplement program designed to help aged, blind, and disabled people, who have little or no income and provides cash to meet basic needs. https://www.ssa.gov/ssi/

Telehealth		Telehealth or telemedicine allows patients to connect with their doctors without an in-person office visit via online visits through a computer, tablet, or smartphone. https://telehealth.hhs.gov/patients/understanding-telehealth/#what-does-telehealth-mean
Therapeutic Behavioral Services	TBS	Therapeutic behavioral services are an intensive, individualized, one-to-one behavioral mental health service available to full-scope Medi-Cal covered young people under 21 years with serious emotional challenges and their families. It is a Specialty Mental Health Service that is specific to children and youth. https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx#
Therapeutic Foster Care	TFC	Therapeutic Foster Care is a short-term, trauma-informed, individualized, highly coordinated Specialty Mental Health Service (SMHS) provided by a specially trained and intensely supported TFC parent. It is a Specialty Mental Health Service that is specific to children and youth. https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx#
Toxic stress		The body's response to sustained and serious stress. The body becomes unable to turn off the stress response normally and can harm the body and brain, causing lifelong health problems. https://www.acesaware.org/wp-content/uploads/2019/12/2-What-is-Toxic-Stress-English.pdf
Trauma-informed practices		Trauma-informed practices are procedures and practices that acknowledge and integrate an understanding of the impact of trauma and its signs and symptoms, and actively avoid re-traumatization. https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

APPENDIX D: FREQUENTLY ASKED QUESTIONS - ACCESSING MENTAL HEALTH CARE

This is a quick reference sheet for judges on questions that may come up from parents / caregivers regarding access to mental health care for a child in their care.

I DON'T HAVE HEALTH INSURANCE FOR MYSELF OR FOR THE CHILD IN MY CARE. HOW DO I APPLY?

- How to Apply for Medi-Cal: https://www.dhcs.ca.gov/services/medi-cal/Pages/ApplyforMedi-Cal.aspx
- How to Apply for individual/family coverage through Covered California: https://www.coveredca.com/apply/
- If you are employed, ask your employer about health care coverage options through your job ("group policies")
- More information about finding individual/family coverage is available here: http://www.insurance.ca.gov/01-consumers/110-health/20-look/shop-ind-fam.cfm

I HAVE HEALTH INSURANCE BUT I DON'T KNOW WHERE TO START THE PROCESS OF FINDING MENTAL HEALTH SERVICES FOR MYSELF OR A CHILD IN MY CARE.

- Call your county's Medi-Cal mental health services access line (multilingual), which you can find here: https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx
- If you or the child in your care has a primary care provider (PCP) or pediatrician, ask them for a referral to a mental health provider, or a phone number to schedule an appointment with a mental health provider
- Call the number on your health plan membership card and ask for help connecting to a mental health provider
- Call the Medi-Cal Mental Health Care Ombudsman: 1-800-896-4042
- If you are interested in school-based mental health services and supports:
  - If you think your child may be eligible for special education, request an assessment and ask for educationally related mental health services (ERMHS).
  - Reach out to a school counselor, social worker, teacher, or administrator to find out what supports are available on campus or through school referrals.
  - Check if your school has a school-based health center (SBHC), using this directory: https://www.schoolhealthcenters.org/school-based-health/sbhcs-by-county/
- If the child in your care has a developmental disability, contact your local Regional Center for connections to mental health services: https://www.dds.ca.gov/rc/

I HAVE TRIED TO GET MENTAL HEALTH SERVICES BUT AM RUNNING UP AGAINST PROBLEMS. WHAT ARE MY OPTIONS FOR GETTING HELP?

- Call your health plan member services line (look for this on your health plan membership card) for assistance. If the issue is not resolved, consider filing a complaint / seeking Independent Medical Review of your situation.
- Look for legal help, using this Legal Aid directory searchable by county and issue area: http://www.lawhelpca.org/
- Call the Health Consumer Alliance Help Line: https://healthconsumer.org/

I NEED TO SPEAK TO SOMEONE FOR EMOTIONAL SUPPORT AS SOON AS POSSIBLE. IS THERE SOMEONE I CAN CALL OR TEXT?

- National Suicide Prevention Hotline: Call 800-273-8255 or text 838225, or simply dial 9-8-8
- SAMHSA National Helpline: Call 800-662-HELP (information and referrals)
- Crisis Text Line: Text HOME to 741741 for crisis support
- Directory of county-specific crisis services phone lines: https://files.covid19.ca.gov/pdf/wp/county_crisis_services_and_suicide_prev-_hotlines_4-08-2020.pdf
- CalHOPE Peer-Run Warm Line: Call 833-317-HOPE (4673) (non-emergency support regarding COVID stressors)

Youth-Specific

- California Youth Crisis Line: Call or text 800-843-5200 (youth ages 12-24)
- Teen Line**:** Text TEEN to 839863 (6-9 pm) or call 800-852-8336 (6-10 pm)(talk to another teen)

IS THERE A WAY TO SEARCH FOR SERVICE PROVIDERS BASED ON WHERE I LIVE?

- You can try searching for providers through this interactive map from the Catalyst Center: https://www.catalyst-center.org/resources

Note on terminology: Generally, "hotlines" are appropriate for immediate crisis situations, while "warmlines" aim to provide support prior to escalation to a crisis situation.

APPENDIX E: WHERE TO LEARN MORE

ACEs Aware Initiative
https://www.acesaware.org/

CalAIM Initiative
https://www.dhcs.ca.gov/CalAIM

DHCS, *Medi-Cal's Strategy to Support Health and Opportunity for Children and Families*, March 2022
https://www.dhcs.ca.gov/Documents/DHCS-Medi-Cal%27s-Strategy-to-Support-Health-and-Opportunity-for-Children-and-Families.pdf

California Children's Trust, *Practical Guide for Financing Social, Emotional, and Mental Health in Schools*
https://cachildrenstrust.org/wp-content/uploads/2020/08/practicalguide.pdf

California Department of Education, *Mental Health Resources*
https://www.cde.ca.gov/ls/cg/mh/mhresources.asp

California State Auditor, *Report 2019-125, Youth Suicide Prevention: Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm*, Sept. 2020
https://auditor.ca.gov/pdfs/reports/2019-125.pdf

NCYL, NHeLP, CCT on EPSDT Mental Health Implementation in California:
https://youthlaw.org/sites/default/files/attachments/2022-03/Meeting-the-Moment_FINAL.pdf

CMS Guidance on EPSDT:
https://www.hhs.gov/guidance/document/epsdt-guide-states-coverage-medicaid-benefit-children-and-adolescents

Judicial Council Keeping Kids in School (KKIS) Juvenile Court Bench Guides:
https://www.courts.ca.gov/documents/kkis-mentalhealth-juvcourt.pdf

Judicial Council Mental Health 2021-22 Webinar Series:
Webinar 1: https://www.youtube.com/watch?v=V-WS4-KfUMU
Webinar 2: https://www.youtube.com/watch?v=xcOi8aiI7lQ
Webinar 3: https://www.youtube.com/watch?v=viSfVXpncnk

Mental Health Services Oversight & Accountability Commission, *Every Young Heart and Mind: Schools as Centers of Wellness,* 2020
https://mhsoac.ca.gov/sites/ default/files/schools_as_centers_of_wellness_final.pdf

School Mental Health 101: A Primer for Medi-Cal Managed Care Plans:
https://cachildrenstrust.org/wp-content/uploads/2021/11/SchoolMentalHealth101_final.pdf

The Children's Partnership, First 5 Center for Children's Policy, *Addressing Infant and Early Childhood Mental Health Needs: Opportunities for Community Solutions*, 2021
https://childrenspartnership.org/wp-content/uploads/2021/10/IECMH-Report-FINAL.pdf

National Child Traumatic Stress Network, Trauma-Informed Judicial Practices
https://www.nctsn.org/resources/nctsn-bench-cards-trauma-informed-judge

Child Welfare Information Gateway, *Impact of Domestic Violence*,
https://www.childwelfare.gov/topics/systemwide/domviolence/impact

U.S. Department of Health and Human Services, Office of Women's Health,
Effects of domestic violence on children,
https://www.womenshealth.gov/relationships-and-safety/domestic-violence/effects-domestic-violence-children

ENDNOTES

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[2] Note: Bolded terms will be included in Appendix C.

[3] U.S. Dep't. Health & Hum. Servcs., *Social Determinants of Health*, Health.gov (undated), https://health.gov/healthypeople/objectives-and-data/social-determinants-health.

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[11] Mental Health America, *Parenting with a Mental Health Condition, MHA National* (2022), https://www.mhanational.org/parenting-mental-health-condition (citing Joanne Nicholson, Elaine Sweeny, and Jeffrey Geller.,Mothers With Mental Illness: I. The Competing Demands of Parenting and Living With Mental Illness. Psychiatric Services. May 1998. Vol. 49. No. 5.); Krystal Jagoo, *Parental stress is key contributor to development of Children's mental illness*, Verywell Mind (2022), https://www.verywellmind.com/parental-stress-is-key-contributor-to-development-of-children-s-mental-illness-5212787

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(stating that from 2009 through 2018, the annual number of suicides of youth between the ages of 12 and 19 increased by 15 percent, and incidence of self-harm increased by 50 percent). "Self-harm" refers to purposeful, self-inflicted injury as a way of attempting to cope with distress. Examples are cutting or burning oneself.

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[18] This chart is adapted from information provided in: Solchany, "*Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges*" (Oct. 2011)
Practice & Policy Brief (ABA Center on Children and the Law), p. 7. (as cited in App. IV (Common Treatments) of Judicial Council of California, *Keeping Kids in School and Out of Court Initiative, Supporting the Mental Health of Youth in Juvenile Court Resource Guide*, https://www.courts.ca.gov/documents/kkis-mentalhealth-juvcourt.pdf); Substance Abuse and Mental Health Services Administration, *Peer Support Workers for Those in Recovery* (Sept. 2022), https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers; and Center for Health Care Strategies, *Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles* (July 2014), https://www.chcs.org/resource/intensive-care-coordination-using-high-quality-wraparound-children-serious-behavioral-health-needs-state-community-profiles.

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[23] See 42 U.S.C. § 1396a(43)(A)-(C). Courts have also affirmed this active, not passive, obligation. See e.g. *Tinsley v. Faust* (411 F. Supp. 3d 462, 474 (D. Ariz. 2019) ("Arizona may not simply shrug indifferently when children do not request help, but instead must affirmatively determine what obstacles lie between the children and the 'help that is available,' and then mitigate those obstacles.").

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[34] *Senate Bill (SB) 130* (Education Finance: Education omnibus budget trailer bill), https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB130; Cal. Dep't of Finance, California State Budget 2021-22 (Budget Summary), 47 (2022), https://www.ebudget.ca.gov/budget/2022-23/#/BudgetSummary
[35] See Elaine M. Howle, *Youth Suicide Prevention*, *Report 2019-125* , Auditor.ca.gov (Sept. 2020), https://www.auditor.ca.gov/reports/2019-125/summary.html.
[36] Cal. Welf. & Inst. Code 5850 et al; DHCS, Mental Health Services Act (2022), https://www.dhcs.ca.gov/services/MH/Pages/MH_Prop63.aspx.
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