

Shutting Down the Trauma to Prison Pipeline

Early, Appropriate Care for Child-Welfare Involved Youth

Here is what the research shows: much antisocial and violent behavior in adulthood can be linked back to high levels of cumulative childhood stress and trauma, including physical maltreatment, exposure to violence, disrupted families, and chronic disadvantage. These children are first victims before they become actors in the cycle of violence. Early traumatic experiences form neural connections that endure... but children who receive early interventions have better outcomes.

—Drs Kenneth Dodge and Harold Koplewicz, “To prevent violence, we need to prioritize children,” 10/12/17

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Executive summary

Findings

The number of Massachusetts children removed from their homes because of allegations of abuse or neglect has increased dramatically. In 2014 Massachusetts reported the highest rate of abused children in the country, about 22.8 cases of victimization per 1,000 children, and that rate was nearly matched in 2015.^{1,2} Between 2012 and 2016, the number of Care and Protection court cases filed statewide increased by 56%.³ Some counties experienced much higher rates of child welfare cases than the state as a whole.

Since entering the foster care system increases a child's risk for eventual involvement with the juvenile justice system as well as other negative outcomes, Citizens for Juvenile Justice (CfJJ) is gravely concerned about this trend. CfJJ's 2015 report, *Missed Opportunities*, found that children who were dually involved in both DCF and DYS had early involvement with DCF and a high number of foster care placements.

The number of 6- to 11- year-old children in placement has increased 13% since 2015, with particular impact on certain Massachusetts counties. Research shows that starting at age 12 untreated symptoms of complex trauma experienced during childhood can become acute with the onset of puberty, and trauma during childhood can become aggressive and/or delinquent during adolescence and lead juvenile justice system involvement.

Children involved in the child welfare system have experienced trauma that affects brain development and can lead to behaviors as they get older that are punished in school, and eventually by law enforcement. Behavior related to trauma during childhood — particularly on the ability to regulate emotions and behavior — must be distinguished from other mental health needs and from delinquent behavior.

The children are spending more time in out-of-home placement with an associated instability in their living situations. Instability in home placements disrupts attachments essential for attachment and brain development, compounding behavioral difficulties.

Many children in Massachusetts, including those in DCF care, are unable to access culturally competent mental and behavioral health care before their behavioral health deteriorates significantly. While great strides have been made to increase access to community based mental health services for children in Massachusetts, the need is greater, particularly in certain counties and within certain communities, than the supply of clinicians who are culturally competent and trained in the area of treating children exposed to and experiencing multiple traumas.

The number of Latinx children in out of home placement has increased every year and at a higher rate than for children of other races. From 2015 to 2018, Latinx children accounted for 82% of the increase in out-of-home removals. The impact on the Latino community in Massachusetts is part of a larger picture of disproportionate numbers of Latino youth and adults in the juvenile and criminal justice system.

Recommendations

Culturally competent behavioral health services, and more non-English speaking child clinicians, should be expanded to overcome waitlists and barriers to access.

Fully incorporating behavioral health services into all schools is a model that will reach far more children and benefit all students and schools. These services should be available to children before their behavior becomes so acute that it leads to extreme interventions. Schools with the best-practice based multi-tiered system of support model — those providing three levels of behavioral support for all students — and staff trained to understand trauma-related disruptive behaviors are an excellent way to ensure early and consistent access to behavioral health care for all youth.

Invest in promising practices and program models to prevent child removal and safely promote family stabilization and focus early on building a child's resilience and positive youth development.

Early recognition of behavioral problems stemming from exposure to trauma should result in an investment in interventions that promote positive youth development, to better prevent the intensification of the problems, and the poor outcomes associated with them. Early efforts to develop a child's skills, self-esteem, and supportive investments in their futures include consistent involvement with trusted adults and with positive prosocial community activities.

Promoting stability in placements is a goal that all state employees involved in child welfare should be held accountable for.

Two placement disruptions of children in foster care should be an indication of needs and a signal for increased services, not an inevitability, and should trigger a conference of all concerned parties to ensure the next placement is stable and ready to meet the child's needs.

DCF must re-examine its newly redrafted policy increasing barriers for family members to serve as kinship placements.

Due to the racial inequities in over-policing and over-criminalization of communities of color, DCF's stricter background check policy will inequitably limit access of children of color to kinship caregivers — the most stable placement for children removed from their homes.

Data collection and analysis on children with Care and Protection and CRA cases must improve in scope and transparency.

This should include educational progress and the use, consistency, and effectiveness of mental health services. All data should be searchable by demographic features including location, age, race/ethnicity, sexual orientation and gender identity and expression.

Introduction

We start out recognizing them as victims; then fail to help them heal; and eventually punish them for expressing their pain. Most of the young people who end up committed to the Massachusetts Department of Youth Services (DYS) for delinquency had previous or current contact with our Department of Children and Families (DCF),⁴ and nearly 40% of the youth in DYS detention have current DCF involvement.⁵ National research has shown that a disproportionate number of adults in prison were in foster care.⁶ Since 2016 there has been a large increase in the number of children involved with our child welfare system. We must act now to ensure that these children do not become ensnared in the juvenile justice system.

This white paper follows up on a 2015 report by CfJJ on the same subject. We demonstrated that children removed from their homes at an early age and those who experienced multiple placements are at high risk of entering the juvenile justice system. In light of those findings, more recent data discussed in this report are particularly troubling

Most of Massachusetts' dually-involved youth were, at one point, very young and vulnerable children who had experienced a high enough level of trouble in their homes that the state child welfare agency became involved. These children had contact with multiple systems — courts, child welfare, health care, schools, social workers, families, foster families — and yet ultimately whatever services they received were not adequate to prevent juvenile justice system involvement.

We must provide support for these children and their families more effectively and earlier. To change the trajectory of these young lives, we must address behavior issues at the early warning signs, alleviate stress on caretakers, and reduce the burden on the overstretched inpatient and outpatient child mental health system. By providing more accessible mental health support earlier, behavior stemming from exposure to the trauma of abuse/neglect and disrupted caregiving can be prevented from intensifying and leading to the worst outcomes, including school exclusion, psychiatric hospitalizations, and juvenile justice system involvement.

Massachusetts child welfare trends: 2015–2018

Since 2014, Massachusetts has had a surge in filings of Care and Protection cases — cases filed in juvenile court alleging that a child’s caregiver abused or neglected the child — and an increase in the number of children in DCF placement.⁷ In 2014, Massachusetts reported the highest rate of abused children in the country, about 22.8 cases of victimization per 1,000 children, and that rate was nearly matched in 2015.^{8,9} Between 2012 and 2016, the number of Care and Protection cases filed statewide increased by 56%.¹⁰ Some counties (Essex, Plymouth, Suffolk) experienced a 70% increase (Figure 1).^{11,12} The majority of the Care and Protection filings were for allegations of neglect.¹³ In FY2018 (2nd Quarter), 47,417 children had open cases with DCF, with 80% remaining at home, and more infant to 5-years-old children on the caseload than any other age group (Figure 2).¹⁴

In FY2018, 9,458 under age 18 were in out-of-home placement, representing a 5% increase from FY2015. While the statewide increase of care and protection case filings impacted

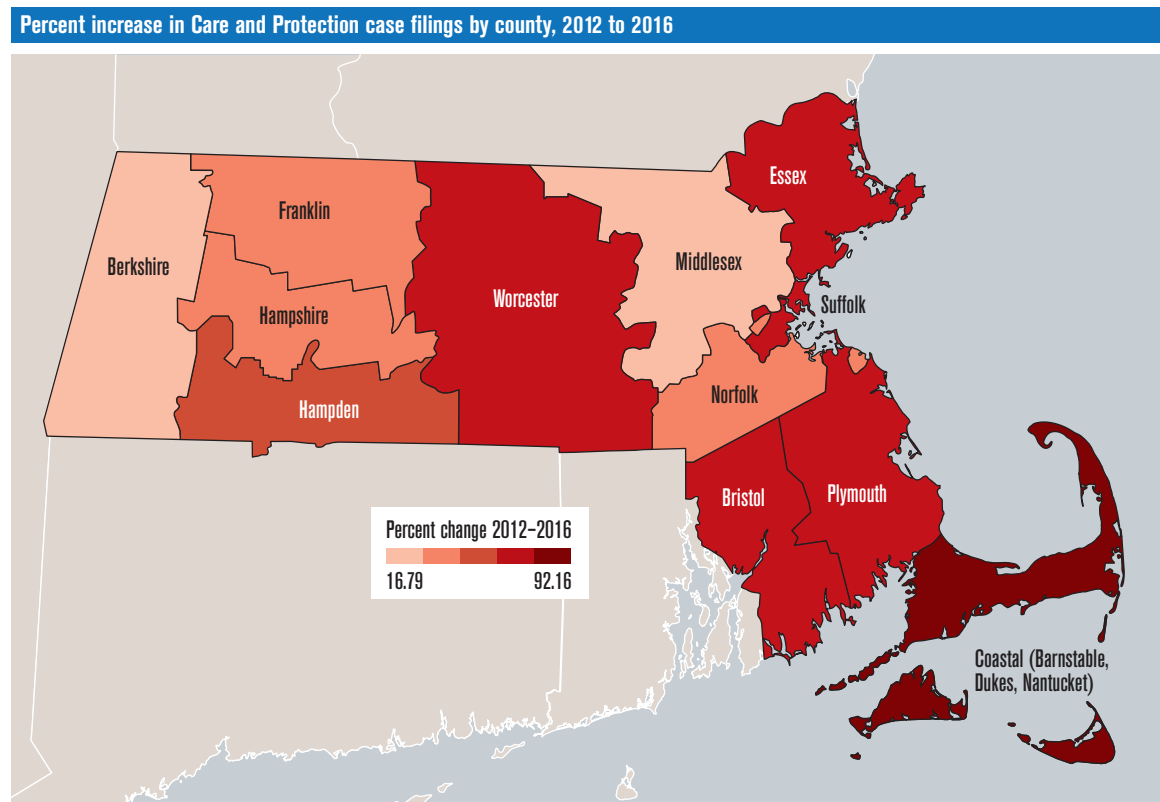


Figure 1. Counties' increased rate of Care & Protection case filings, 2012-2016

Children under 18 in DCF caseload, 2018

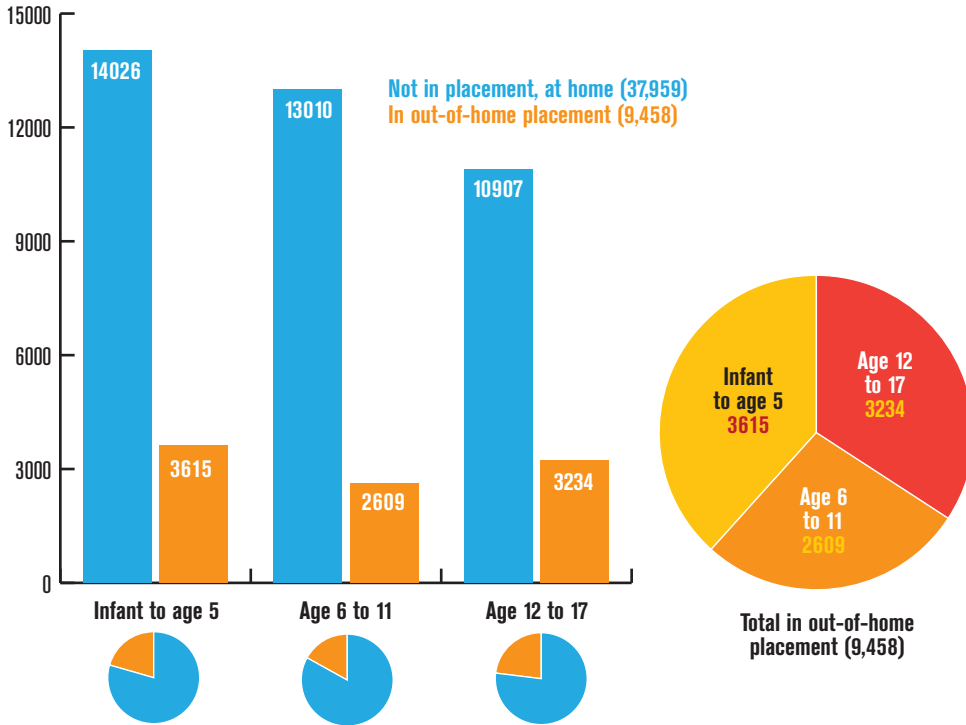


Figure 2. Statewide placement by age, FY2018 Q2

DCF placement by race (fiscal year 2018, second quarter)

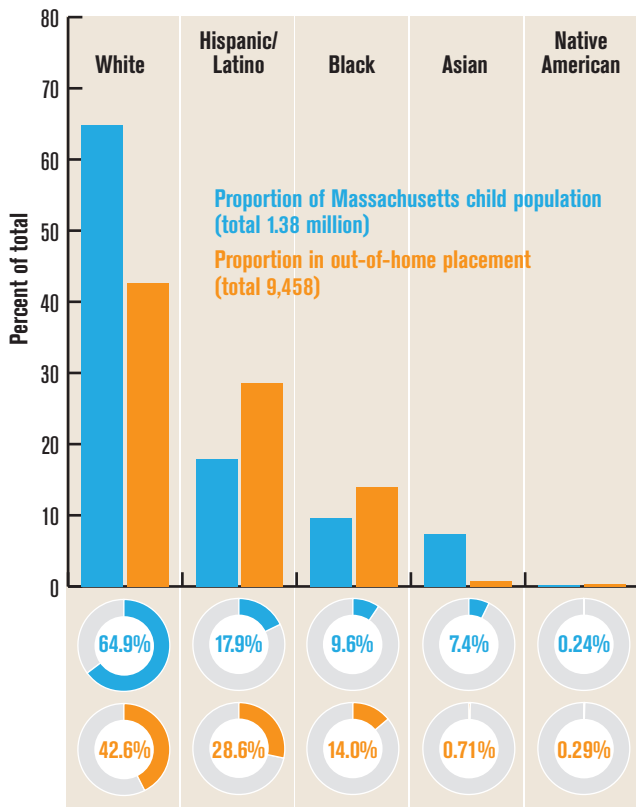


Figure 3. Child Population (most recent census 2016) and DCF Out-Of-Home Placements, by Race (FY2018, Q2)

A Look at Racial and Ethnic Disparities

- Massachusetts has the worst inequality between white and Latino residents of any state in terms of income, housing, poverty, unemployment, incarceration, and educational attainment
- Massachusetts has the highest disparity of imprisonment of Latinos in the country: 4.3/1

Johnston, Katie. "Invisible in Any Language: Mass. Latinos Face Intense Inequality." *Boston Globe*, March 9, 2018. <https://www.bostonglobe.com/business/2018/03/08/invisible-any-language-mass-latinos-face-intense-inequality/Wp7mUPBWFLNXMtpAUNEYGL/story.html>.

- Highest disparities of juvenile arrest are black youth at a rate almost 3x higher than white youth
- Highest disparities for juveniles in probation, detention, commitment are Latinx youth

Massachusetts Juvenile Detention Alternatives Initiative, Decision-Specific Relative Rate Index (RRI) Dashboard, <https://public.tableau.com/profile/jdaimassachusetts#!/vizhome/RRIDRAFT10132016/RRIDashboard>

Placement Per Capita: Children Placed Out of the Home Per 10,000 Youth in the Population

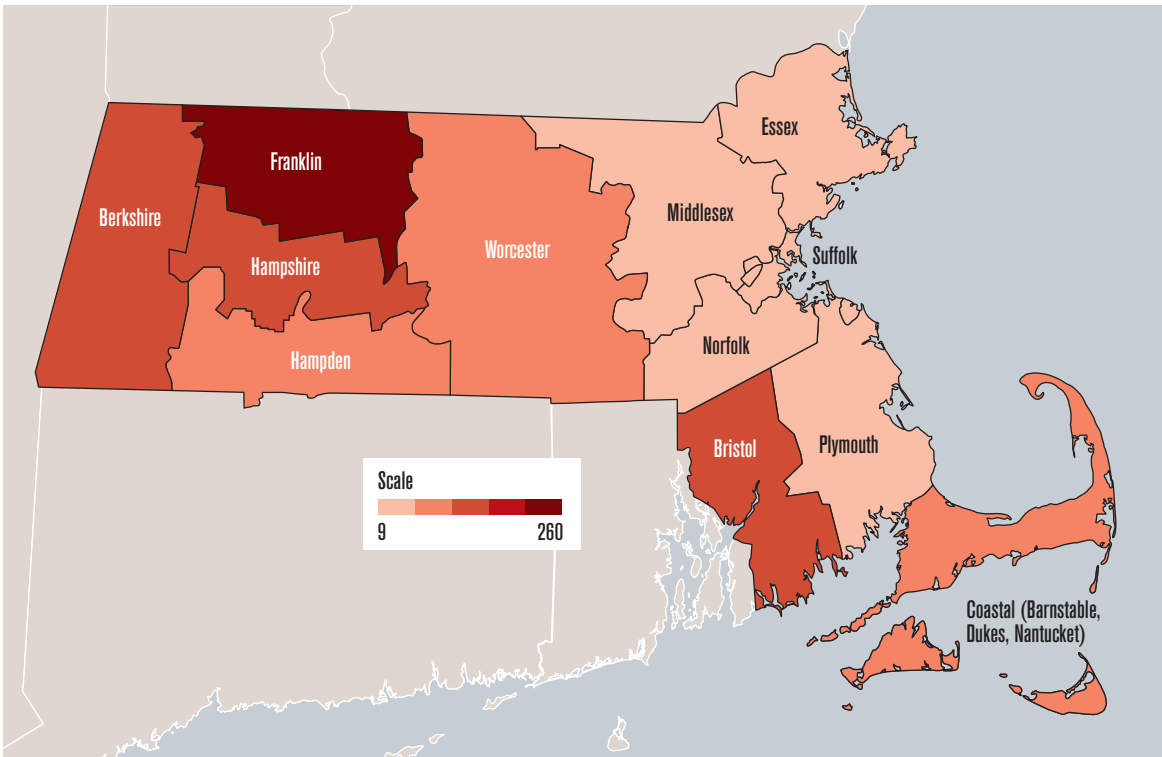


Figure 4. Massachusetts Department of Children and Families, Quarterly Report, FY2017 Q4

youth of all races, families involved with DCF (“consumers”) are disproportionately families of color, and youth of color are overrepresented in out-of-home removals (Figure 3). Certain Massachusetts counties have particularly high rates of children in out-of-home placement relative to their under 18 child population. Worcester has the highest number of children in out-of-home placement. Franklin, Hampshire and Berkshire counties — and in turn their school districts — have the highest per youth under 18 per capita rates of children in DCF placement (Figure 4).

From 2015 to 2018, the number of youth in foster care increased for all races, but the highest rate of increase was of Latinx youth. During this time

Number of Children Out-of-Home Placements by Race/Ethnicity

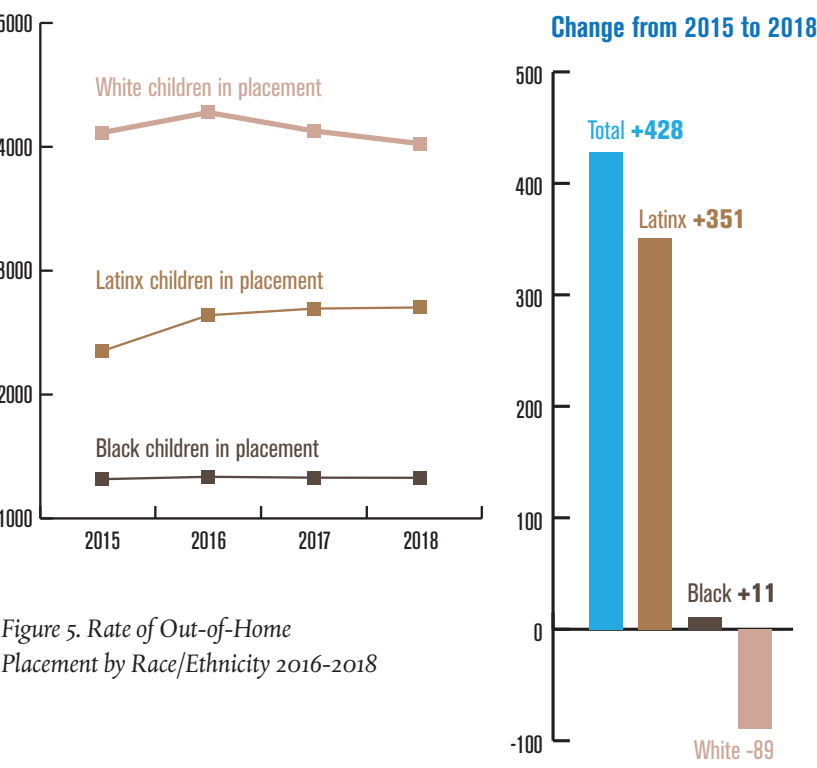


Figure 5. Rate of Out-of-Home Placement by Race/Ethnicity 2016-2018

period, there were 428 more children in out-of-home placement and Latinx children account for 82% of this increase (Figure 5).

Massachusetts' child welfare outcomes data from 2014-2016 also showed that children ages 10 through 13 had the lowest rates of exiting foster care.¹⁵ Age 1 was by far the highest rate of entry into foster care: 16-17% of children entering foster care were 1-year-old during 2014-2016, followed by age 16 at around 8%.¹⁶ This points to a very young population of children in foster care at times of rapid brain development and periods of critical attachment needs.

Additionally, the amount of time youth are spending in placement has been steadily going up. The timeframes for continuous time in placement of between 2 to 4 years, and for more than four years, (Figure 6) have been increasing over the past several years. It is important to note that continuous time in placement does not mean the same placement.¹⁷ The longer children remain in placement, the more likely they are to experience placement instability (Figure 7). Two-thirds of children who have been in out-of-home placement for more than two years experience placement instability.¹⁸

There was an increase in each of the youngest age groups in placement in 2016 indicating a large number of children removed from their homes that year. The 6-11 age group had the largest percent increase over the course of 2015-2018 (Figure 8). The large number of young children in placement each

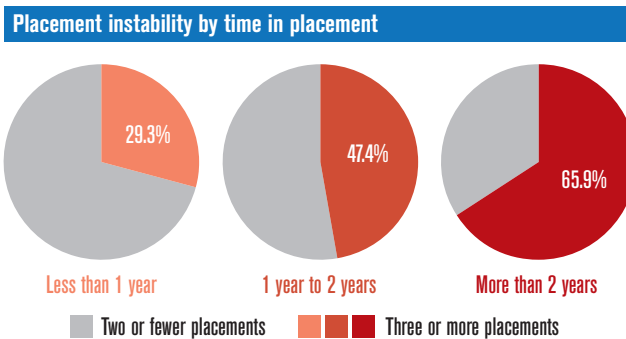


Figure 7. Placement instability (three or more placements) as defined by Administration for Children and Families, Child Welfare Outcomes, Massachusetts 2016¹⁹

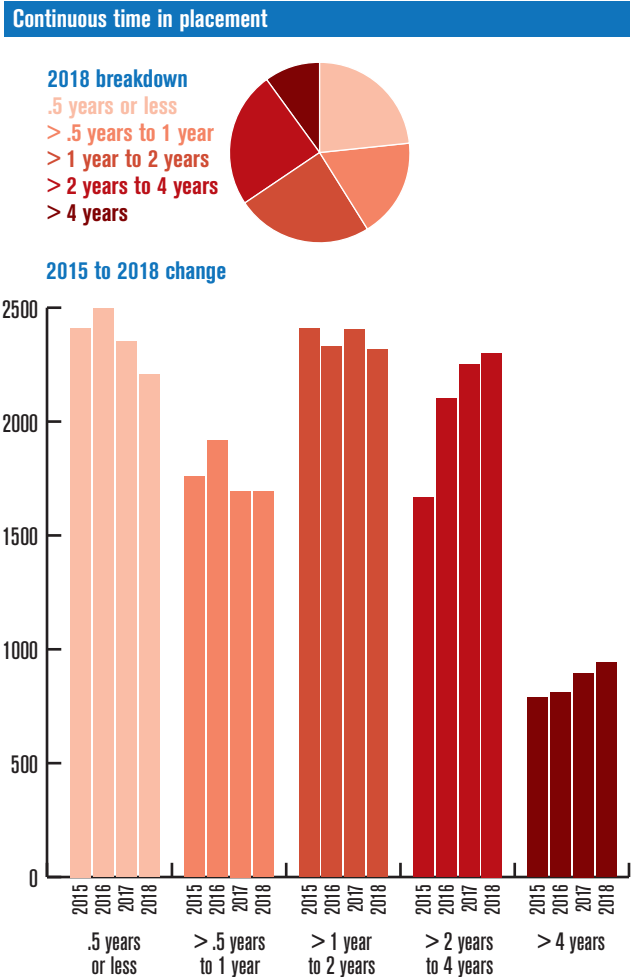


Figure 6. Figure 6. DCF Quarterly Reports, FY2015 Q4, FY2016 Q4, FY2017 Q4, FY2018 Q2.

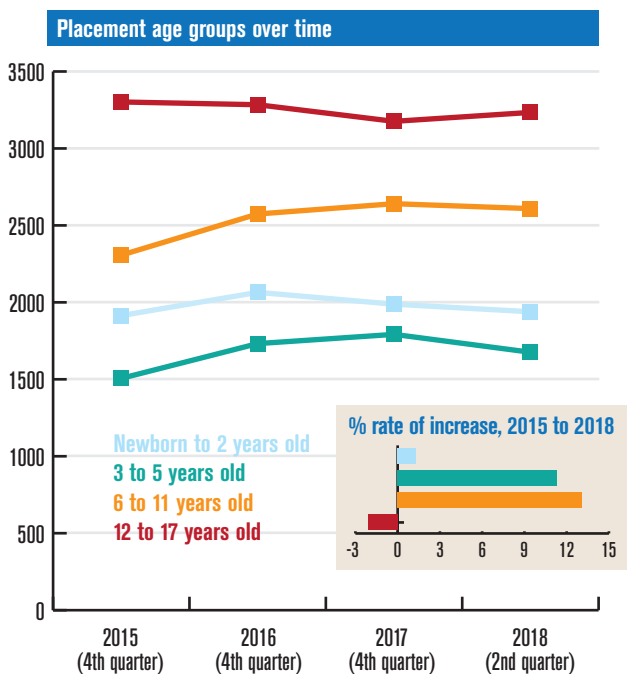


Figure 8. Age of children in placement.

year (most under age 5) during very vulnerable stages of brain and emotional development, and within the context of children spending longer time in placement (2-4 or more than four years), raises the important issue that Massachusetts currently has a large number of young children who have been removed from their homes, and many are spending longer time in out-of-home placement.

Comparison to earlier findings

Our 2015 report, *Missed Opportunities*, matched DCF-DYS data from 2014 and showed clear racial and ethnic disparities in dual-status involvement, as well as a clear connection between those in DYS having previous involvement with DCF. We found that:

- **Most children committed to the custody of DYS had current or former child welfare involvement:** 72% of the overall committed population had prior DCF involvement — 85% of girls and 70% of boys.²⁰
- **Most dually involved youth had their first DCF intake before age 5.**
- **Most dually involved foster youth experienced “placement instability”:** In 2014, 88% of the dually involved youth had been in DCF “placement,” with most having three or more placements in their lives; 77% of dually involved girls and 64% of boys had three or more DCF placements.

The current data suggest that the issues we uncovered three years ago continue to threaten the futures of abused and neglected Massachusetts children. According to DCF as of the last public reporting on number of placements, the median number for all foster children was three.²¹ As of 2017, children in state custody in Massachusetts are still moving an average of two or more foster homes before final placement.²²

Placement instability: A key factor in delinquency and mental health harm

Children who are placed in foster care are three times more likely than similarly situated children who remained with their families to be juvenile justice-involved.²³ National research and Massachusetts data show that placement instability — when a child is moved through multiple out-of-home placements — is a key risk factor for later juvenile justice system involvement.²⁴

National research further indicates that placement instability significantly harms children’s neurological and emotional development. Children exposed to multiple changes in environments at younger ages engaged in more aggressive and delinquent behaviors in adolescence.²⁵ Multiple placements disrupt attachments and can affect executive functioning and can lead to an increase of internalizing and externalizing behavior issues.²⁶ Massachusetts has a particularly high rate of placement instability. According to federal standards, placement stability is defined as two or fewer placements per time in care, yet Massachusetts

averages three placements per child in its custody. An additional factor in placement instability is failed reunification efforts. In FY17 16.8% of children were returned to DCF custody within 12 months of returning home.²⁷ A survey of the sources of Post Traumatic Stress Disorder among foster care alumni revealed that many of the alumni identified the initial home removal itself as a trauma and also considered being returned home as an additional “placement” as it involved having to re-create relationships.²⁸

Double jeopardy: Child welfare involvement and trauma

Children in the child welfare system have been exposed to multiple traumas, toxic stress, and unstable caretaking during a time when their brains are developing at a phenomenal rate. From birth through their teenage years, children’s brains are building skills that are critical for life success. When exposed to trauma, the part of the brain that is developing at that particular age is affected, limiting the child’s development. The term “Complex Trauma” was developed by clinicians in an effort to cover a broader exposure to trauma. Complex trauma encompasses the exposure of a child to multiple traumatic events and/or exposure

Child Welfare-Involved Children are Doubly Trauma-Exposed

Abused and neglected children experience exposure to multiple traumas during a time of maximum brain development:

“Numerous studies of traumatized children find problems with unmodulated aggression and impulse control, attentional and dissociative problems, and difficulty negotiating relationships with caregivers, peers and, subsequently intimate partners.”

– van der Kolk, Bessel A., *Developmental trauma Disorder: Towards a rational diagnosis for children with complex trauma histories.*

Children involved in the child welfare system also experience “Complex Trauma”:

“The term complex trauma describes both children’s exposure to multiple traumatic events, often of an invasive and interpersonal nature, and the wide-ranging, long-term impact of this exposure. These events are severe and pervasive, such as abuse or profound neglect. They usually begin in early life and can disrupt many aspects of the child’s development, including the formation of a self. Since these adversities frequently occur in the context of the child’s relationship with a caregiver, they can interfere with the child’s ability to form a secure attachment bond. Many aspects of a child’s healthy physical and mental development rely on this primary source of safety and stability.”

– National Child Traumatic Stress Network: *Complex Trauma in Juvenile Justice System Involved Youth*, March 2017

to continued and profound stress, often within the context of the child's relationship with their caregivers.²⁹ As a child approaches adolescence, exposure to multiple traumas can increase the risk of aggression toward self or others. National research shows that over two-thirds of young people in the juvenile justice system have histories of complex/developmental trauma, including abuse and neglect, family and community violence, and disrupted relationships with their primary caretakers.³⁰

The effects of early exposure to trauma can manifest in different ways as children get older and are more able to express themselves verbally and physically. Recognizing this is an important step in understanding the large percentage of children who end up in the juvenile justice system having previously been involved in the child welfare system. A child who has experienced abuse and neglect and a disrupted home environment has experienced enough trauma to already have behavioral health needs. This behavior can manifest and be interpreted as disruptive, depressive, anxious, or aggressive behavior. Children first and immediately need a stable and nurturing caretaker and environment, and they will also need emotional and behavioral regulation modeling and training, from consistent caregivers in developmentally appropriate ways. Providing a seamless implementation of support that fulfill the child's need to feel safe and also addresses dysregulated behaviors directly and consistently as they show up can begin the process of re-wiring the traumatized child's brain early and go a long way toward preventing an increase in disruptive, anti-social, and aggressive behaviors that can lead to school exclusions, hospitalizations, or arrest.

Behavioral problems were six times more likely among children who spent time in foster care. Foster youth have a three times greater risk for ADHD diagnosis, and are twice as likely to have learning disabilities and developmental delays than children not in foster care.³¹

Children who have experienced exposure to multiple and ongoing traumas such as abuse/neglect, homelessness, domestic violence, community violence, lack of safe and consistent

Girls

Research on girls has shown that there are gender-specific reactions to previous traumatic events including higher prevalence of PTSD, depression, and internalizing behaviors. Girls in a juvenile justice facility reported higher exposure to traumatic events, victimization within interpersonal relationships, PTSD, and other mental health problems and had significantly higher rates of suicidal ideation, depression/anxiety, and traumatic experience history.

- Grande, Todd L., Hallman, Janelle M., Underwood, Lee A., Warren, Kellie M., Reh fuss, Mark. *Treating Detained Juveniles: Measuring Mental Health and Gender Differences, Review of European Studies, Vol.4, No.5. (2012)*
- NCTSN *Complex Trauma In Juvenile Justice System Involved Youth 2016*

Girls may receive more serious sanctions for status offenses than their male counterparts; girls are more often detained due to problems at home. LGBTQ girls are more likely to be sexually abused within the family by more than one person for a longer period of time than non-LGBTQ girls. They are also more likely to be detained than non-LGBTQ boys and girls.

- Davis, A. *Fighting for Hope: The criminalization of Trauma in Justice Involved Girls' Lives and Stories from Resilience from a Juvenile Prison (2017).*

caregivers, etc. have disrupted brain development which can prevent them from reaching milestones critical for behavior regulation as they get older. The impact on a child with complex trauma can show up in behavior that becomes increasingly difficult for adults and peers to manage or tolerate. The lack of emotional and/or physical safety, and/or ability to attach to a consistent caregiver, impacts children's ability to cope well with stress and causes them to become hypersensitive to even tone of voice or changes in facial expressions.³² A brain focused on survival above all becomes most adept at perceiving threat everywhere and eventually becomes unable to distinguish a real threat from a perceived threat.³³

Ages of transition: Educational and mental health implications

Research shows that child welfare-involved children who are removed from home between the ages of 12 and 15, children with multiple placements, and children supervised by probation had a higher risk of incarceration for a serious or violent offense during adolescence.³⁴

More than a third of children in placement in Massachusetts are ages 12-17. When a child reaches age 12, the typical age for a large amount of new social stressors including onset of puberty and transitions to middle school, research and data indicate an increased risk of behaviors that lead to school exclusions, hospitalizations, and arrest. It can also be increasingly difficult to find stable placements for children in this age range.

The Missed Opportunities data set revealed that the number of dually involved boys quintupled between age 12 and 13, and then almost doubled between 14 and 15, and after that it increased by around 100 children per year up until age 17. For girls, while the overall numbers were lower, dual-involvement tripled between age 12 and 13, and then almost tripled again between 13 and 14. For both boys and girls, the biggest jump in numbers of dually involved youth is between 12 and 13 years of age. This also correlates with the data showing that this is the age of a child's first DCF home removal and correlates with a spike in suspension/exclusion in Massachusetts.

Research has found that minority children (African American, Latino, Asian American) use mental health services significantly less than white children, due in theory to access, stigma, and insurance barriers.³⁵ Studies have also indicated that English language proficiency is a determinant of mental health care utilization.³⁶ A survey of Massachusetts residents and providers by Health Care For All confirmed the reporting on the long waitlists for available child mental health clinicians, particularly MassHealth members (most children involved with DCF are covered by MassHealth) stating that there are very long waits, which is particularly impactful when a child is in need of behavioral/psychiatric help. These waits were even more pronounced for non-English speaking youth or for families who are non-citizens.³⁷ In many areas there are anecdotal reports of a six-month wait for Spanish-speaking child mental health clinicians. Other barriers include a high mental illness stigma in all communities including minority communities, parent disapproval in using mental health care, lack of citizenship of family members, and shortage of mental health providers in the area.³⁸

While most psychiatric and behavior problems show up in youth before the age of 15, the majority go untreated or are not treated until youth are incarcerated. This is particularly true of youth of color whose rates of receiving treatment for all types of outpatient mental health services can be as low as half of those of non-Hispanic white youth. But when it comes to inpatient and emergency department use black and white children rates were similar.

For children in foster care, additional barriers to timely and appropriate access to behavioral health care include placement disruptions, lack of coordination or continuity of care across agencies and providers, and shortages of children’s mental health providers trained in child trauma.³⁹

A national study suggested that for minority youth psychiatric and behavioral health problems more often result in punishment at school or within the justice system, but not in pre-acute intervention mental health care.⁴⁰ Black and Latinx child-welfare children disproportionately end up in the justice system. National research indicates that this disproportionality is explained by the differential treatment by the child welfare and juvenile justice systems: “African-American youth have a greater likelihood than Caucasian children of being diagnosed with disruptive behavioral problems, despite no indication of racial/ethnic differences according to parent and clinician ratings of behavior. The risk of over-diagnosing disruptive behavioral problems is that instead of youth being referred to mental health services when warranted, they may be referred to the juvenile justice system resulting in a lack of mental health services that are needed... Given the protective nature of mental health services in reducing delinquent behavior and the well-documented disparities in mental health service use for children of color in the child welfare system, it is imperative that we strengthen systems processes and capacity to ensure that all children receive the mental health services that they need.”⁴¹

Profile of children in court: a snapshot from the Mental Health Advocacy Program for Kids⁴²

By the time the 156 children served by MHAP reached court on a delinquency or CRA matter:

- 83% diagnosed with one or more mental illness (average of 3.5 mental health related conditions)
- 89% experienced a barrier to mental health treatment 63% had accessed crisis or emergency mental health care systems in the past year
- 44% had been hospitalized for psychiatric care in the past year
- 37% had been admitted to a residential mental health facility in the past year
- 28% did not attend school or missed almost every day in the prior three months
- 61% missed school more than one day per week in the past three months

Emergency psychiatric hospitalization

The high rate of emergency psychiatric “boarding” is another symptom of the lack of access to outpatient clinicians and other services in place to manage kids whose mental health needs intensify before they get treatment. In recent years Massachusetts children have been increasingly sent to emergency departments for psychiatric care and end up “boarding” there due to lack of beds. “Boarding” means spending 12 or more hours in the Emergency Department from the time of arrival to time of departure.⁴³ Young people, especially 12- to 17-year-olds, are more than twice as likely as adults to experience emergency department boarding. They are more likely to be boarded during the academic year — peaking during the fall and ebbing in the summer. Teens are also more likely to have more than one behavioral health boarding episode, with a quarter boarding two or more times.⁴⁴

According to the Massachusetts Health Policy Commission, the increase in boarding for behavioral health needs was likely a consequence of inadequate outpatient and inpatient behavioral health services.⁴⁵ Long waits for child mental health clinicians, particularly those who take insurance, has been a consistent concern for several years from all sectors — parents, foster parents, providers, nonprofit groups, DCF caseworkers, doctors, probation officers, attorneys, etc. A study by Harvard researchers in the International Study of Health Services found long waits and inaccurate information on online provider availability directories for pediatric psychiatric services. That study⁴⁶ also found that Massachusetts had an overall “high” level of provider shortage, which was considered “severe” in certain areas of the state including Hampden County and the North and South Shores regions, which are experiencing among the highest increase in abuse and neglect court filings.

Schools: Untapped support for children’s mental health

Schools are often the first source of a mental health referral for children. Teachers are with children for more than thirty hours a week, and for children who are experiencing disrupted home placement, the school, their friends, and teachers can form their most stable relationships. Children separated from siblings in foster care may be able to stay connected to siblings or family in the school setting. School is also where many behavioral health issues show up. Disrupting the school-to-prison pipeline, particularly for children of color, and addressing the need for improved social emotional learning and mental health in schools remain priorities in Massachusetts and nationwide. As we consider ways to improve all outcomes for child welfare-involved youth, fulfilling the call for all schools to incorporate emotional health and well-being as part of the academic mandate provides a model that can reach and support a much larger group of traumatized children.

It is well established that children of all ages who have been exposed to multiple traumas have a difficult time paying attention and learning. The current prevailing mechanism for providing mental health services in schools without a full-time school psychologist or

social worker is either an individual case management model, based on insurance reimbursements, or referral to a community-based mental health clinician, if one is available. Common in more affluent communities, full-time school-based mental and behavioral health support provides social and emotional learning tools that benefit all children while creating support for children who need more help.⁴⁷ Furthermore, educational outcomes for foster youth can be significantly improved if interventions for emotional and behavioral problems are implemented at younger ages.⁴⁸ Access to pre-acute mental health services where the child goes every day, the school, is an important method of preventing behavior related to past trauma from leading to school removal, involvement of law enforcement, or hospitalizations.

As Massachusetts moves forward with implementation of the “school of origin” element of the Every Student Succeeds Act⁴⁹, which aims to improve stability and academic outcomes for foster youth, school-based models of behavioral health support that benefit all children within a school are a clear model for better outcomes. School-based, full-time behavioral health supports that are integrated into the school culture have shown tremendous success in reducing exclusions, improving academic success and teacher satisfaction, and addressing behavioral health issues at early warning signs.⁵⁰ While foster children are 2.5 – 3.5 times more likely than other students to receive special education,⁵¹ and about 35% of traumatized students develop learning disabilities,⁵² special education is not the best means for addressing the learning set-backs and difficulties caused by changes in home placement or schools, or behavior related to traumatic experiences.

These school-based behavioral health models of support also overcome the many barriers to access to mental health care that youth in foster care experience, such as long waitlists for clinicians, burden on caretakers and social workers to transport children to appointments during the day, placement and provider disruption, cultural and mental illness stigma, and opposition to receiving behavioral health services.⁵³ The daily and longer continuous access to the services also allows children to receive support more frequently. School-based models that create a full behavioral health multi-tiered model of service also address the issue of overwhelmed school guidance/adjustment counselors or social workers, many of whom are part-time yet try to serve hundreds of children, thereby reducing their services to crisis interventions.⁵⁴ Many schools and teachers⁵⁵ are now requesting this kind of model as they recognize that kids suffering from the short or long term effects of PTSD, depression, trauma, and/or the stress of multiple adverse life experiences overwhelm teachers and classrooms, leading to an overuse of suspensions/expulsions, school based arrests, or calls for emergency psychiatric removals.

There are models of school-based behavioral health supports in Massachusetts and across the country that have shown excellent results in addressing behavioral health issues among students. Examples include the Multi-Tiered System of Supports (MTSS) which has been implemented through several pilot programs in Massachusetts as well as elsewhere across the country. This three-tiered, evidence-based model for administering supports and services within the school context has shown significant success with enhancing coping and

emotional regulation skills, ability to focus and learn, helping teachers understand how to manage behavior issues, and improving overall skills.⁵⁶ Often these are public/private partnerships that come together and save money in the long term, while greatly improving outcomes. Models that have proven excellent results, and help to address so many issues of access and behavior and learning, provide a clear path forward as we work to put support traumatized children and prevent behaviors from becoming acute, entrenched, and disruptive.

Recommendations

1. Culturally competent behavioral health services should be available to every child and not cause hardship for caretakers to access. Availability in schools is an excellent way to ensure early and consistent access. Diversifying the children's mental health workforce should be a priority of all state bodies concerned with the wellbeing of children. We must continue to work to overcome location, transportation, cultural and stigma-based barriers to access to behavioral health. Innovations should be guided by surveys of parents, foster parents, social workers, clinicians, teachers, and school personnel. All stakeholders should be encouraged to be creative in our response to overcoming those barriers to access.
2. Invest in promising practices and program models to prevent child removal and safely promote family stabilization and focus early on building a child's resilience and positive youth development. DCF's services budget under invests in in-home and reunification services. The Federal Family First Act presents an opportunity for additional funding to safely prevent out-of-home removals. Additionally, recent research found that opioid-dependent newborns who remain with their moms have fewer hospital stays (4-5 days compared to 22-23 days) and fewer infants received needed medication assisted withdrawal treatment (14% compared to 98%). Yet, parent's service plans may conflict with this promising clinical treatment.⁵⁷ Additionally, early recognition of behavioral problems stemming from exposure to trauma should result in an investment in interventions that promote positive youth development, to better prevent the intensification of the problems and the poor outcomes associated with them. Early efforts to develop a child's skills, self-esteem, and positive investments in their futures include consistent involvement with positive trusted adults and with positive prosocial community activities.
3. All state employees involved in child welfare cases should be accountable for promoting stability in placements. Attorneys, social workers, and judges must flag a child's case after the second placement disruption as a call for more services and have the parties come together to address the causes of the disruption. They should be ready to ask and answer the important questions about why a placement disrupted and what can be done to ensure the next placement is stable, as well as address all issues of school discipline and academic/special education representation, and access to pre-emergency mental health services. Furthermore, as children are spending longer in out-of-home placement and their time in care drags on, we must track the number of continuances of their court cases that can add months and years to a child's time in care and increase the risk for disrupted attachments and placement and school instability.

4. The Department of Children and Families (DCF) should continue its work to increase the use of kinship care by removing barriers that prevent minority families' participation. DCF must re-examine its newly redrafted background check policy increasing barriers for family members to serve as kinship placements. Due to the racial inequities in over-policing and over-criminalization of communities of color, DCF's stricter background check policy will inequitably limit children of color's access to kinship caregivers — the most stable placement for children removed from their homes.
5. Additional data must be collected and shared by DCF and the courts, and tracked by gender, race, ethnicity — including country of origin, age, sexual orientation, gender identity and expression, and by geography:
 - There is no public, aggregated data source on the educational well-being of DCF-involved children. DCF should track the educational status and outcomes of foster children, including attendance, special education status specific by disability, disciplinary records, school stability and graduation rates.
 - We have no information on what mental health services are used or their effectiveness. Mental health needs of DCF-involved youth must be tracked in order to better identify and address the behavioral health needs of these children. In order to attend to the critical need for a larger workforce of clinicians who are capable of serving the specific mental/behavioral health needs that are required, including cultural and linguistic competence, this information must be also be tracked by language, diagnosis and presenting behaviors.
 - Child Requiring Assistance (CRA) data must be disaggregated by gender, race, ethnicity, country of origin, age, sexual orientation, gender identity and expression, and by geography. CRA trends over time can help us identify needs for services by location/age/cultural competence.
 - Publish the newly gathered data on sexual orientation and gender identity and explore its implications for DCF service delivery as recommended by the Commission on LGBTQ Youth Annual Policy Recommendations of FY 2019.⁵⁸
 - We must track and make public the number of placements a child experiences, again, broken down by gender, race, ethnicity, country of origin, age, sexual orientation, gender identity and expression, and by geography. Starting in late 2017 and the beginning of 2018 DCF began incorporating questions that would collect data on LGBTQ youth involved with DCF. DCF's Quarterly reports of 2018 include an "Intersex" category for Youth in Placement after Male and Female. The reported number of Intersex Youth in Placement Statewide in 2018 Quarter 2 was two.⁵⁹ As of yet there is no public facing dataset on DCF-involved youth who identify as LGBTQ. This is important information for the state to track and have, as research indicates that LGBTQ youth are significantly overrepresented among foster youth. Transgender youth are also found to be overrepresented in the foster care system at over double the average in the general population.⁶⁰ Family rejection may cause an increase in abuse/neglect and/or CRA filings. Studies have indicated that LGBTQ youth also experience higher numbers of placements when in foster care (on average six placements compared to the average of three)⁶¹.

Opportunities to move forward

Several major shifts in policy and funding provide great opportunities for Massachusetts to incorporate accessible support services early in children's lives and prevent involvement with the juvenile justice system and other negative outcomes.

1. With the full implementation of the Every Student Succeeds Act (ESSA), youth in placement will have the benefit of school stability. This is a tremendous opportunity for the state and school districts to invest in the social and emotional support of foster youth early to benefit them and their entire schools. The state can use the geographic information provided under DCF reports to support school districts with large numbers of children in DCF custody so that schools may implement models of behavioral health support that will address the complex emotional needs of children who have experienced abuse/neglect and home disruptions.
2. Massachusetts has no less than five legislatively-mandated commissions aimed at addressing child mental health and trauma. The Safe and Supportive Schools Commission, The Child Mental Health Access Commission, The Promote Prevent Commission, The Children's Behavioral Health Advisory Council, The Childhood Trauma Taskforce newly formed under the recent Criminal Justice Reform Act, as well as the Chapter 321 Committee. The efforts of these committees should be coordinated and include prioritization of children involved with child welfare system and their cultural/geographical needs.
3. Laws in Massachusetts pertaining to the overuse of school exclusions (Chapter 222), requiring data on school-based calls for law enforcement, raising the lower age of arrest, and addressing racial and ethnic disparities in our criminal justice system all provide added information and incentive for the Commonwealth to be creative and forward-thinking in how we address pathways to court. This includes looking toward more fully supporting young children in the child welfare system and not waiting for them to reach adolescence with increasingly acute needs and behaviors.
4. The Families First Act will provide an influx of money for family preservation. By fundamentally shifting federal funding away from incentivizing the removal of children to addressing their needs and supporting their families, there are tremendous opportunities to keeping children safe and supported while reducing the reliance on out-of-home placement. Though states have an option to delay implementation, Massachusetts should pursue these federal funds immediately.

Massachusetts has been at the forefront of providing and improving services and systems for children involved with our juvenile courts. Implementation of criminal justice reform and a statewide focus on addressing access to mental health services and childhood trauma have made us standard bearers in the nation for working to understand and implement best practices for children. We have moved when other states have hesitated or continued with failed policies that cause additional disruption and poor outcomes for traumatized children. Just as we have pushed forward with action before, we must continue to apply our energies and resources to identifying and addressing the gaps and flaws in care for vulnerable and suffering children. The united efforts already underway to protect and treat children impacted by neglect, violence, racism, and poverty are strong foundations on which to do this. National and state research and data show us the way forward to making sure all the children of the Commonwealth traumatized at a young age get the support and services they need.

Methodology

For this white paper CfJJ relied on data from DCF Quarterly reports to better understand children involved with the child welfare system for the past several years through the first two quarters of 2018. We conducted interviews with over 40 child mental health clinicians, teachers, school-based clinicians, youth trauma specialists, DCF workers, foster parents, parents, parole officers, child mental health experts, attorneys, and others involved with the juvenile and child welfare system. Additionally we reviewed research, data, and studies on the trauma and behaviors stemming from child welfare involvement, outcomes for foster youth, school-based behavioral health, access and barriers to mental health services for children in Massachusetts, predictors of delinquency, disruptive and delinquent behavior in traumatized and child welfare involved children, and models for early intervention and care. In everything it does, CfJJ aims to use data to understand systems and the needs of individuals impacted by those systems. Additionally, specific data is the only way we can identify particular trends, gaps, needs, or breakdowns within our systems that we can work to address. In this paper, there are areas that we are not able to cover due to limitations in the data as they are collected and/or shared.

Limitations of this report: Data gaps

The overarching goal of our research was to identify interventions and support to prevent the arrest of child welfare-involved youth. Yet there were two gaps in the data: the child's educational outcomes (attendance, behavior, and academic achievement); and mental and behavioral health referrals and access.

- **Education:** Within the 2014 dual-status dataset there was no information on education level for 55% of the youth. Of the girls with an education level given: 29% were one year off; 32% were two years below grade level as estimated by birth year; 26% three years below. For boys: 28% were one year below grade level; 31% were two years below, 23% were three years below. In total, 84% of dually-involved youth were below grade level as estimated by age.
- **Mental/Behavioral Health Services:** Massachusetts Behavioral Health Partnership data, which at the time managed the behavioral health benefit for the majority, but not all, youth in the care and custody of DCF, did not have data available on the mental/behavioral health services used by the dual-status youth only. MBHP data available showed that in FY 2014, 27,314 DCF-involved youth were enrolled in MBHP for at least one month during that year.⁶² Of that number, 39.45% received behavioral health services paid for by MBHP, and more than 99% used non-24 hour care such as counseling (individual/family/group), medication management, or mobile crisis intervention. Approximately one in eight received services in a 24-hour facility (hospital, Community-Based Acute Treatment Unit (CBAT), or detox program.⁶³

Terminology

We use the term “foster care” to refer to out-of-home placement by the Department of Children and Families. Such placement may include other forms of out-of-home placement including congregate and residential care. The data terminology used is often from the data source. Cfj acknowledges that the data collection language can be limiting in terms of the impact on collection and also does not always reflect the way communities would self-refer. Umbrella terms like “Latino,” “Latinx,” and “Hispanic” do not capture the many country identifications or multi-racial identifications of those who are captured within those large terms, nor do the terms “LGBTQ” or “intersex” adequately capture the range of people who identify within those categories. In this report we used these terms as they were used in the datasets and research we analyzed.

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