Foster Care Study Report

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The *Foster Care Study Report* is the culmination of the commitment, cooperation, and hard work of many people and organizations. The success and validity of this document would not have been possible without this assistance.

The California Mental Health Planning Council (CMHPC) would like to thank the members of the Children and Youth Subcommittee who devoted many hours to designing various data collection tools, collecting and reviewing data and information received, and lending their expertise to the final report.

The CMHPC would also to thank the California Alliance of Child and Family Services for reviewing, advising and assisting in administering two surveys: Foster Children and Youth Survey and the Parent, Family, Foster Parent, or Other Caregiver Survey. These surveys of mental health service recipients greatly informed the study. Of course, we are also extremely appreciative of those individual caregivers and foster youth who took their valuable time to respond to these surveys.

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Finally, we thank the Department of Mental Health (DMH) for making available valuable data about the service delivery system, and the Department of Social Services for sharing information on policy and practice changes in the child welfare services program. The CMHPC is encouraged by the progress that has been made in delivering mental health services to foster children and youth and their families. We look forward to continued collaboration and further progress.

EXECUTIVE SUMMARY

The California Mental Health Planning Council (CMHPC) is mandated in federal and state statutes to provide oversight of the public mental health system and to advocate for adults and older adults with serious mental illnesses and children and youth with serious emotional disturbances and their families. The CMHPC is further mandated by Section 5772.5(a) (1) of the Welfare and Institutions Code (WIC) (AB 376 [Chu]; Chapter 71, Statutes of 2003) to review and monitor the implementation of counties' efforts to improve the provision of quality mental health services to foster children. The CMHPC has assigned responsibility to fulfill these statutory mandates to the Children and Youth Subcommittee of the System of Care Committee. The Subcommittee fulfilled the mandate through the Foster Care Study described in this report.

The Children and Youth Subcommittee initiated the Foster Care Study in early 2004 and collected various data to accurately assess the quality of public mental health services provided to foster youth. The study involved:

- Collecting information from various public mental health and child welfare system participants using four separate tools: interviews of key informants; a county mental health Children's System of Care (CSOC) Coordinators' survey; a Foster Children and Youth Survey; and a Parent, Family, Foster Parent, or Other Caregiver survey;
- Analyzing data available from the California Department of Mental Health (DMH) on mental health services provided by local mental health programs to children and youth age 0 -20 years and to foster children using Medi-Cal program aid codes (e.g., utilization, type of services used, expenditures, etc);
- Reviewing public documents on child welfare services/foster care and mental health services to give a picture of the current environment, how these systems interface, and current challenges and opportunities in jointly serving the foster care population.

Over the past three years, the Subcommittee completed much of the necessary data collection, and in April 2007 hired a consultant to complete the analyses of these data and write the final report. The information, findings and recommendations are presented in this Foster Care Study report. Highlights of the study and findings include:

A. PHASE I – BACKGROUND INFORMATION

This part provides background information to give a picture of the current environment of mental health services being provided to foster children. Each of the separate service systems - public mental health and child welfare – are described (including recent policy and practice initiatives), how these systems interface, and current challenges and opportunities in jointly serving the foster care population. The program descriptions are followed by the findings of key informant responses to aid in further describing the current environment. Together these descriptions establish a shared understanding of the child welfare/foster care and mental health systems.

Recent policy and practice changes in California's child welfare system mirror the core values and tenets of the mental health CSOC approach. The child welfare system changes are bringing a shared statewide structure, approach, and accountability

measures to local programs that perhaps were not as strongly reflected heretofore. California's mental health CSOC and new policy and practice approaches in child welfare services are honing a shared, cross-system focus on: prevention and early intervention; family-centered practice; coordination and collaboration; and, results and accountability. These are significant and positive changes which result a shared framework within which to jointly deliver services to the same children, youth and families.

While there has been progress in better meeting the needs of foster children and their families, there is room for improvement in several areas. The review of public documents identified many of the current challenges including, but not limited to: funding restrictions and limitations in the use of available monies; human resources shortages due to insufficient numbers, types, or appropriate training; insufficient or inappropriate service availability, particularly in some areas of the state; and the need for even greater interagency collaboration and coordination.

The key informant interviews further illuminated many of the common themes found in the review of recent public documents. While the key informant data cannot be generalized, the data largely confirm system improvement themes identified through other means. For example, key themes are:

- The disruption in continuity of care, including mental health services, caused by frequent foster care placement changes;.
- The even greater disruption in care resulting from out-of-county foster care placements; not the least of which are difficulties in maintaining Medi-Cal eligibility and continuity of mental health treatment services;
- The need to build human resources (i.e., qualified staff and service providers), particularly in some areas of the state, in order to enhance the capacity of the public mental health system;
- The need for appropriate mental health screening and assessments for children entering the foster care system, including on-going care monitoring and oversight; and,
- The need to further increase access to public mental health services through removal of a language and cultural barriers.

B. PHASE II – DATA ON MENTAL HEALTH SERVICES PROVIDED

This part describes the mental health services actually provided to foster youth by county mental health programs using statistical data available from the DMH and a county mental health CSOC Coordinator's Survey. Together, these data sources provide both factual and experiential/anecdotal insights into the delivery of mental health services to children and youth in foster care.

The DMH routinely collects a wealth of data pertaining to mental health clients and the services they receive at the county level. DMH analyzes and publishes data related to utilization and expenditures for mental health services by county as well as by age,

gender, ethnicity, service type, diagnosis, funding source, etc. In general, it was found that access to public mental health services has improved greatly; particularly for children and youth age 0 - 20 years, which exceeds the rate of growth in the general population. Increased access to mental health services for children and youth is largely due to implementation of the Medi-Cal EPSDT services benefit beginning in 1995.

Within the Medi-Cal program aid groups, the number of clients served in the Foster Care aid group has increased 40.5% during the ten year period from FY 1993-94 to FY 2002-03. Moreover, the Medi-Cal Foster Care aid group has a penetration rate of 49.3%, which means that almost 50% of all eligible Medi-Cal eligible foster children received one or more mental health services in FY 2002-03 (this penetration rate is significantly higher than all other aid groups). At the same time, Medi-Cal program expenditures for the Foster Care aid group have increased significantly from FY 1993-94 to FY 2002-03, largely due to the expansion of EPSDT services. For this aid group, the average cost per eligible was $3,352 (an increase of almost 350%), and the average cost per client was $6,793 (an increase of almost 300%). These average costs are significantly higher than for all other aid groups.

These data provide an important tool in overseeing the service delivery system. It is possible to track the impact of policy decisions (such as implementation of EPSDT services) using the available data. The limitations of the data are found in the currency of the available data and the fact that it is impossible to judge the quality, availability or the manner in which services are being delivered. These limitations are overcome to some extent through periodic surveys of the system partners and stakeholders.

While, the CSOC survey had some limitations, it lends valuable information in identifying barriers and suggesting improvements to address those barriers. For example, funding restrictions and limitations can be addressed through changes in federal and state rules to allow more flexible use of monies, and, interagency collaboration may be improved through renewed commitments to coordinate care and expand partners with agencies such as education.

C. PHASE III – ANALYSIS OF SURVEYS FROM SERVICE RECIPIENTS

This part provides the findings from two mental health service recipient surveys: Children and Youth, and Parents, Families, Foster Parents, or Other Caregivers. The data collected through the surveys has some limitations and cannot be generalized to the system as a whole. However, the information does provide interesting information from the perspective of children and youth in foster care, and foster parents who are the “arrangers of care” for the children and youth in care. The information provided in the surveys provides insight into the barriers that exist in the system with respect to funding, access to services, availability of services and the need for better coordination among the system partners.

D. PHASE IV – CONCLUSIONS AND RECOMMENDATIONS

This part of the report provides summary conclusions based on the extensive data and information collected for the study, and observations and recommendations to build upon and further improve the quality of mental health services for foster children and

youth and their families. The Subcommittee, in consultation with CMHPC staff and the study consultants, identified four recommendations:

1. The CMHPC will share the Foster Care Study Report with state and local agencies involved in serving foster children and youth and their families, and call attention to several common themes which, while agency progress to date is commended, require continued focused efforts. The common themes address: the unmet needs of foster youth for public mental health services; the impact of multiple placements on continuity of care; efforts to improve interagency collaboration and coordination, particularly through involvement of educational agencies; appropriate mental health screening, assessment, service delivery and ongoing monitoring and oversight; addressing human resources shortages; and, improving access to mental health services by removing language and cultural barriers;

2. The CMHPC will work with DMH to identify and request data and reports to use as a basis for ongoing oversight and monitoring of the delivery of mental services to children and youth in foster care, including youth placed through the juvenile justice system;

3. The CMHPC will continue to monitor implementation of the Mental Health Services Act (MHSA) and its impact in addressing the themes noted in this study; and,
4. The CMHPC applauds the Legislature for their efforts to improve the lives of foster children and their families and urges continued support in providing sufficient resources to further the progress that has been made.

FOSTER CARE STUDY REPORT

I. INTRODUCTION

The California Mental Health Planning Council (CMHPC) is mandated in federal and state statutes to provide oversight of the public mental health system and to advocate for adults and older adults with serious mental illnesses and children and youth with serious emotional disturbances and their families. The CMHPC is further mandated by Section 5772.5(a) (1) of the Welfare and Institutions Code (WIC) (AB 376 [Chu]; Chapter 71, Statutes of 2003) to review and monitor the implementation of counties' efforts to improve the provision of quality mental health services to foster children. The CMHPC has assigned responsibility to fulfill these statutory mandates to the Children and Youth Subcommittee of the System of Care Committee. The Subcommittee fulfilled the mandate through the Foster Care Study described in this report.

The Children and Youth Subcommittee initiated the Foster Care Study in early 2004 by adopting an ambitious work plan and study methodology to collect data to accurately assess the quality of public mental health services provided to foster youth. The work plan and study methodology includes the following components:

- Collection of information from various public mental health and child welfare system participants using four separate tools: structured interviews of key informants; a county mental health Children's System of Care (CSOC) Coordinators' survey; a Foster Children and Youth Survey; and a Parent, Family, Foster Parent, or Other Caregiver survey;
- Solicitation of additional data as needed from the California Department of Mental Health (DMH) on mental health services provided to foster children using Medi-Cal program aid codes (e.g., utilization, type of services used, expenditures, etc);
- A review of public documents on foster care and mental health services to identify any additional information that might further inform the study; and
- A final report of findings and recommendations based upon the data collection and analysis.

During the past three years, the Subcommittee completed design of the four data collection tools, administered the questionnaire and three surveys and, with the assistance of CMHPC staff, began the analysis of some of the resulting data. However, a fairly significant workload remained in order to complete the study.

In April 2007, the CMHPC released a Request for Quotation (RFQ) to hire a consultant to complete the analyses of these data, perform background research on the current foster care and mental health operating environments, collect additional statistical data from DMH as needed, assist the Subcommittee in developing recommendations (based on the information and data collected) to improve the quality of mental health services for foster youth, and write the final report. The consultant was hired effective July 2007 and, in consultation with CMHPC staff and the Subcommittee, has completed the remaining tasks. The information, findings and recommendations are presented in this Foster Care Study report.

II. METHODOLOGY

The Foster Care Study methodology adopted by the Subcommittee involved the four phases described below.

A. PHASE I – BACKGROUND INFORMATION

This phase involved review of public documents to develop background information to provide a current picture of mental health services being provided to foster children. This task was complicated by the need to study two separate service systems - public mental health and child welfare. The resulting background section describes each program (including recent policy and practice initiatives), how these systems interface, and current challenges and opportunities in jointly serving the foster care population.

Key informant interviews were used as a tool to solicit information from experts involved in the mental health and foster care system. The purpose of the interviews was to ensure that key issues were addressed and not overlooked. This data source also augmented the public document review in describing the current foster care/mental health environment. The interview tool contained 8 open-ended questions to solicit information on the problems that children/youth face in the foster care system (including access to services), and to identify practices and strategies to improve the quality of mental health services received. Information was collected from nine key informants during March - June 2006. The information obtained reinforces many of the same findings from other sources.

Part III of the report provides this information, beginning with descriptions of California's child welfare services system and public mental health program. These descriptions are followed by highlights of important issues in the current operating environments of both programs as identified in public documents and by key informants. This information is provided to assure a shared understanding of the nature, structure, and challenges and opportunities faced by these public programs in serving foster children/youth.

B. PHASE II – DATA ON MENTAL HEALTH SERVICES PROVIDED

This phase involved the identification and analysis of data that are descriptive of the mental health services actually provided to foster youth by county mental health programs. Two methods of inquiry were used to inform this part of the study: statistical data available from the DMH; and a county mental health CSOC Coordinator's Survey.

The DMH routinely produces statistical data about services provided through locally administered public mental health programs. The DMH website provides a wealth of service and utilization data for all clients served, Medi-Cal clients only, and special target populations or services. Also provided are trend reports which allow analysis of changes in the mental health service delivery system over time. Selected information was extracted from the available data and used to inform this study.

A CSOC Coordinator's Survey was used to solicit specific information about each county mental health program's services for foster children/youth and their families. The Subcommittee developed survey had 18 questions; six (6) of which have two parts resulting in a total of 24 questions. Of the 24 questions, the possible response types

were 12 one word or "Yes/No," three Likert scale, and 9 open-ended questions requiring narrative response. The survey was administered on-line (launched December 14, 2004), although many responses were received hard copy via the mail. A total of 46 responses were received; 24 on-line and 23 hard copy/mail (one county submitting both on-line and hard copy responses was counted only once). The on-line responses were received in December 2004 and January 2005; while the hard copy responses were received June - August 2005. The survey results augment the DMH statistical data about available mental health services.

Part IV of the report provides this information, beginning with the analysis of selected data elements from the available DMH data, followed and supplemented by information obtained from the CSOC Coordinator's survey response. Together, these data sources provide both factual and experiential/anecdotal insights into the delivery of mental health services to children and youth in foster care.

C. PHASE III – ANALYSIS OF SURVEYS FROM SERVICE RECIPIENTS

This phase involved the analysis of information collected from two surveys of recipients of mental health services: Children and Youth; and Parents, Families, Foster Parents, or Other Caregivers. The Subcommittee developed both surveys, which were administered in hard copy through the offices and members of a statewide child welfare/foster care provider association.

The Children and Youth Survey consisted of 9 questions; seven "Yes/No," one Likert scale, and one multiple-choice. Two of the "Yes/No' questions provided a place to comment. The survey intent was to determine each recipient's assessment of the mental health services s/he receives. The survey was administered via transmittal from the provider association to its member agencies in January 2005. A total of 241 survey responses were received and analyzed.

The Parent, Family, Foster Parent, or Other Caregiver Survey consisted of 13 questions; six "Yes/No," three Likert scale, two multiple-choice, and two open-ended requiring a narrative response. The survey intent was to determine the provider's assessment of the mental health services received by the children and youth in their care. This survey also was administered via transmittal from the provider association to its member agencies in January 2005. A total of 220 survey responses were received and analyzed.

Part V of the report provides the findings of the two service recipient surveys. While there are data limitations, the surveys provide some interesting and useful information which augment the study findings.

D. PHASE IV – CONCLUSIONS AND RECOMMENDATIONS

This phase involved review of the wealth of data and information collected for the study in order to develop conclusions and recommendations to further improve the quality of mental health services for foster children and youth and their families. The Subcommittee, in consultation with CMHPC staff and the study consultants, identified four recommendations. Part VI of the report provides these recommendations.

III. BACKGROUND INFORMATION

This part provides background information necessary to give a picture of the current environment of mental health services being provided to foster children. This task is complicated by the need to study two separate service systems - public mental health and child welfare. The background section describes each program (including recent policy and practice initiatives), how these systems interface, and current challenges and opportunities in jointly serving the foster care population. The program descriptions are followed by the findings of key informant responses to aid in further describing the current environment. Together these descriptions are intended to assure a shared understanding of the child welfare/foster care and mental health systems. It is the interface between these two service systems to effectively serve foster children/youth and their families that is the focus of this study.

A. DESCRIPTION OF CHILD WELFARE AND MENTAL HEALTH PROGRAMS

California operates a wide range of public health, mental health and social services programs that often serve many of the same clients and families. Frequently the linkage between these public services is eligibility for California's Medi-Cal Program, which provides necessary health and mental health services to individuals with no or limited income and resources. Children and youth become eligible for the Medi-Cal program upon entry into the foster care program (some may already be eligible though other program linkages). This means that foster youth are also eligible to receive public mental health services if they meet statewide standards of medical necessity (referred to as "medical necessity criteria"). The following provides a snapshot of how the child welfare services and mental health programs operate and interface to serve foster children and youth and their families.

1. Child Welfare Services Program[1]

The Child Welfare Services (CWS) program is a federally mandated program that is operated by each state under Titles IV-B, IV-E and XX of the Social Security Act. The child welfare system is the safety net and primary intervention resource for protecting neglected and abused children, reuniting them with their families whenever possible. Whenever a family cannot be reunited, child welfare is responsible to provide an alternative placement for that child or children. In California, the program is locally operated by the 58 counties under the overall supervision and direction of DSS.

California's CWS system is a complex array of programs and services operating within a set of laws and regulations that require interaction with law enforcement, juvenile courts and community services providers. Existing law provides for child welfare services which are directed toward accomplishment of the following purposes:

- Protecting and promoting the welfare of all children, including handicapped, homeless, and dependent children;

[1] Information contained in this section was extracted from several California DSS documents: (1) CWS/Case Management System (CWS/CMS) Strategic Plan dated September 2006, pages 8, 12, & 29; (2) California's Title IV-B Child and Family Services Plan for Federal Fiscal Year 2005-2009 dated 6/30/04, pages 7-9; (3) California's CWS System: Overview dated 9/1/04; and (4) Foster Care Fundamentals: An Overview of California's Foster Care System dated 12/01.

- Preventing, remedying, or assisting in the resolution of problems that contribute to the exploitation or delinquency of children;
- Preventing unnecessary separation of children from their families where the removal of the child(ren) can be prevented by identifying family needs and assisting families in resolving those issues that lead to child abuse and neglect;
- Reunifying families whose children have been removed, whenever possible by providing necessary services to the children and their families;
- Maintaining family connections when removal cannot be prevented by identifying children for whom Tribal placement and relative placement are preferred and most appropriate; and,
- Assuring permanence for dependent children, who cannot be returned home, by promoting timely adoption, guardianship or alternative permanent placement for these children.

California's CWS system is made up of several major components, each with a different focus but all based on the common goals of safety, permanence, and well-being for children through the provision of time-limited, objective-oriented services (Welfare and Institutions Code [WIC] Sections 16500 et seq.). The major components are:

- Prevention: service delivery and family engagement processes designed to mitigate the circumstances leading to child maltreatment before it occurs.
- Emergency Response: a response system designed to provide in-person response, 24-hours a day, to reports of abuse, neglect, or exploitation for the purpose of investigation and to determine the necessity for providing initial intake services and crisis intervention to maintain the child safely in his/her own home, or to protect the safety of the child through emergency removal and foster care placement.
- Family Maintenance: time-limited services that are designed to provide in-home protective services to prevent or remedy neglect, abuse or exploitation for the purpose of preventing the separation of children from their families.
- Family Preservation: intensive services for families whose children, without such services, would be subject to risk of out-of-home placement, would remain in existing out-of-home placements for longer periods of time, or would be placed in a more restrictive out-of-home placement.
- Family Reunification: time-limited services to children in out-of-home care to prevent or remedy neglect, abuse or exploitation when the child cannot remain safely at home and needs temporary foster care while services are provided to reunite the family.
- Foster Care: services designed to serve and protect those children who cannot remain in their homes. Current placement options include family homes (relatives or foster family homes), certified homes of foster family agencies, and group homes. Foster care *maintenance* payments are made to cover the cost of providing food, clothing, shelter, daily supervision, school supplies, a child's personal incidental and reasonable travel, including travel to the child's home for visitation.

- Permanent Placement: alternative family structures for children who, because of abuse, neglect or exploitation cannot remain safely at home, and/or who are unlikely ever to return home. These services are provided when there has been a judicial determination of a permanent plan for adoption, legal guardianship (including the Kinship Guardianship Assistance Payment Program), independent living arrangement for adolescent children, or other alternative permanent placement.

  When adoption is the permanent plan for a child, potential adoptive families are home studied, approved and children are place with them. Services include recruitment of potential adoptive parents; financial assistance to adoptive parents to assist in the support of special needs children; and direct relinquishment and independent adoption.

- Independent Living: education and services for foster youth based on an assessment of needs and designed to help youth transition successfully from foster care to living independently. Services are provided to enhance basic living skills, as well as career development skills.

More than 700,000 children come into contact with California's child welfare system each year.[2] On any given day, more than 175,000 children are in contact with the child welfare system.[3] However, the majority of children in California's CWS system are not in foster care. Instead, social workers provide services to most families while the child remains at home. Common services include parenting classes, counseling and respite care.

Foster care is a primary child welfare service and program within the various components comprising the child welfare services system. Foster care is 24-hour out-of-home care provided to children in need of substitute parenting because their own families are unable or unwilling to care for them. The purpose of foster care is to keep children safe while services are provided to reunite their family. More than 86,000 children were in foster care in 2004, a decline from the 108,000 children who were in foster care in 2000.[4]

The juvenile court has the ultimate authority over removal and reunification of children, relying on information from social workers, service providers, and others to reach decisions. According to the DSS, most children entering foster care (76%) were removed from their homes for neglect-related reasons and more than 50% are age 5 or under. Of the children in foster care about 19,000 will reunify with their parents and 8,000 will be adopted during the course of a year. About 51% of the children in foster care in California have been in foster care for over two years. As these children remain longer in care, their likelihood of being reunified decreases, thus requiring that other forms of permanency be explored (i.e., adoption, legal guardianship).[5]

[2] DDS Facts At-A-Glance dated 8-25-04 referring to unpublished data from the Center for Social Services Research, University of California at Berkeley.
[3] Ibid.
[4] Ibid.
[5] Ibid.

There are two entryways to the foster care program - the child welfare services system or the juvenile justice system. The vast majority of children (about 93%) enter foster care as *dependent children* in the CWS system, i.e., removed from their parents due to abuse or neglect.[6] These children are supervised by county CWS agencies (*"welfare supervised*"). However, some children enter foster care through the juvenile justice system as *probation wards* and are the responsibility of county probation departments ("*probation supervised*"). Foster care provides an alternative living environment for wards that could benefit from foster care and do not require a higher-level of security.

When the juvenile court determines that a child should be removed from their home due to abuse or neglect, it is the local child welfare services agency that is responsible for alternative placement of the child. In selecting a foster care provider, social workers are required to place children in the least restrictive, most home-like environment that meets the child's needs. There are two primary foster care placement options: family care and group care.

- *Family care* consists of kinship care (home of a relative), licensed foster family homes, and family homes certified by licensed foster family agencies (foster family agencies provide a treatment orientation in a family setting).
- *Group care* ranges from small, licensed group homes for six children to group homes with large numbers of children, including facilities that provide intensive therapeutic services (commonly called residential treatment centers). Community Treatment Facilities provide the most intensive care; they are licensed by DSS as a group home and certified by DMH for mental health treatment services (group home rate classification level [RCL] 13-14).

Over the last decade, the number of group home and foster family agency certified home placements have grown. At the same time, foster family home placements have decreased at a rate that is matched by an increase in use of certified family homes. In FY 2005-06, the average monthly foster care caseload was 73,679. Of this total, the type of care provided was: group homes – 11,600, foster family agency - 19,517, and foster family homes - 42,562. This means that group home care represented about 16% of all placements, foster family agency care 26%, and foster family homes (including placements with relatives) represented about 58%.[7] In recent years, about 40% of all children first entering foster care in California live in relative care placement.[8]

According to DSS, many children cycle through the foster care system more than once and experience multiple placements. Of the children who entered foster care in 2000 and remained in care for 12 months, 35% experienced three or more placements.[9]

The foster care program is supported from federal, state and local funds through an open-ended, entitlement program. For federally eligible children, the federal government

[6] DSS data on California Welfare and Probation Out-of-Home Placements for July 2002 shows that of the 97,919 youth in out-of-home placement, 93% were dependent children and 7% were probation.
[7] Legislative Analyst's Office, Children's Services and Foster Care Overview dated 11/21/05.
[8] DDS Facts At-A-Glance dated 8-25-04 referring to Child Welfare Services Reports for California.
[9] Ibid.

contributes about 50% of the costs, with the balance shared by the state (20%) and counties (30%). Most of the foster care population (about 80%) is eligible for federal foster care payments, i.e., they meet specific income/eligibility criteria linked to the federal Aid to Families with Dependent Children – Foster Care (AFDC-FC) program. Foster children who are not federally eligible are covered by the state foster care program, which is funded from state general funds (40%) and county funds (60%). The state foster care program requirements are essentially the same as the federal program except that TANF linkage is not required.

The majority of foster care costs are for foster care payments and child welfare services. Title IV-E (Foster Care and Adoption Assistance) funds foster care *maintenance payments* (the largest cost in foster care).. Title IV-B (Subpart 1 - Child Welfare Services) provides a limited (capped) allocation for child welfare services, including services to children in foster care and their families. Title IV-B covers 75% of the cost, while the state and counties share the remaining 25% (17.5% state and 7.5% county). In addition, Title IV-B (Subpart 2 - Promoting Safe and Stable Families), provides capped time-limited funds to each state for family support, family preservation, family reunification, and adoption promotion and support services.

The child welfare and foster care systems cannot serve children and families in isolation since these children and families often have a variety of needs. Several state-supervised and locally administered programs including health, mental health, substance abuse, education, public welfare, family violence, and other systems also provide a range of services that are used by foster children and their families. The role of mental health services for foster children and youth is particularly critical. National research studies have demonstrated that foster care youth are at a significantly greater risk of mental illness, while care delivery systems nationwide often do not function effectively.[10] These other service systems, particularly mental health, play essential roles in ensuring a child's safety and strengthening families.

2. Public Mental Health Programs[11]

California's public mental health system has an important role in serving the mental health needs of many foster children and youth and their families. In California, the public mental health system is administered by DMH and operated through 59 local city/county mental health programs. The nature of the public mental health system has changed dramatically during the past 15 years, largely due to changes in financing and service delivery approaches. The following describes the major changes.

California's public mental health system began in 1957 with enactment of the Short-Doyle Act. The Act organized and financed community mental health services for persons with mental illness through locally administered and controlled community mental health programs. Over the next few years the state contributed various levels of

[10] Foster Care Policy Brief, Rosenbach, 2001.

[11] The information contained in this section was extracted from two primary sources: (1) DMH AB 328 Realignment Data Report to the Legislature dated 2/03; and (2) DMH Medi-Cal Managed Mental Health Care Report dated 6/1/94. Information was also extracted from the DMH website at www.dmh.ca.gov; and documents on the Proposed Governor's Budget for FY 2007-08 prepared by the Department of Finance, Office of the Legislative Analyst, and Legislative Committee staff.

funding to the program. In 1969 the matching ratio was changed to 90% State and 10% county funds, and counties with a population over 100,000 were mandated to provide mental health services. In FY 1973-74, it became mandatory for all counties to have a mental health program to serve their residents.

During this same period (1965), the federal government enacted changes to the Social Security Act to establish the Medicare (Title XVIII) and Medicaid (Title XIX) programs. The Medicaid program provided federal matching funds to states that implemented a comprehensive health care delivery system for the poor under the administration of a single state agency. In 1966, California enacted legislation to implement the Medicaid program by establishing the California Medical Assistance Program, which now is known as the Medi-Cal program. The California Department of Health Services (DHS), operating under a different name at that time, became the single state agency.

Originally, the Medi-Cal program consisted primarily of physical health care benefits, with mental health treatment making up only a small part of the program. Mental health services for which there was federal reimbursement were limited to treatment provided by physicians (psychiatrists), psychologists, inpatient hospitals, and nursing facilities. All services were reimbursed on a fee-for-service basis, with rates set by DHS, through what is called the Fee-for-Service/Medi-Cal (FFS/MC) system. There was no separate federal funding for services provided by the county Short-Doyle mental health program.

By the early 1970's it was recognized that the Short-Doyle program was serving many individuals who were Medi-Cal beneficiaries. This recognition gave rise to the Short-Doyle/Medi-Cal (SD/MC) program, which began as a pilot project in 1971 to enable counties to obtain federal funds to match their own funding to provide certain mental health services to Medi-Cal eligible individuals. In 1972, WIC Section 14021 added for the first time Short-Doyle community mental health services into the scope of benefits of the FFS/MC program. The result was the development of the SD/MC program in addition to the FFS/MC program for mental health services.

The SD/MC program offered a broader range of mental health services than those provided by the original FFS/MC program. The SD/MC program services consisted of inpatient hospital services delivered in acute care hospitals; individual, group or family therapy delivered in outpatient or clinic settings; and various partial day or day treatment programs. The SD/MC program also included a limited range of services for treatment of substance abuse; these services are administered by the Department of Alcohol and Drug Programs. Reimbursement under the SD/MC program was largely cost-based for allowable costs, up to a statewide maximum allowance.

Consequently, prior to managed mental health care, California's Medi-Cal program consisted of two mental health delivery systems, the original FFS/MC program and the county-based SD/MC system. Access to mental health services was largely dependent upon each patient's point of entry to services, i.e., through private FFS/MC practitioners/treatment services or county community mental health programs.

In 1991, in response to an unprecedented State budget deficit, State and local responsibilities for major human services programs (including mental health) were realigned. Realignment transferred financial responsibility for most of the mental health, public health, and some social service programs from the state to local governments, and provided a dedicated revenue source (i.e., a half-cent statewide sale tax increase and a share of vehicle license fee [VLF] revenues) for counties to pay for these changes. The inclusion of mental health was intended to provide a stable fund source, enhance flexibility (i.e., reduce categorical funding and enable alternatives to inpatient programs), and establish clearly defined local performance expectations and State oversight responsibilities (see Bronzan-McCourquodale Act).

It was the *Master Plan* developed with extensive involvement of stakeholders that provided much of the philosophical and contextual framework for the population and services priorities included in realignment (Chapter 1313, Statutes of 1989 [AB 904, Farr]). Most notably, the public mental health system adopted a system of care approach to service delivery. WIC Section 5600.2 states, "To the extent resources are available, public mental health services in this State should be provided to priority target populations in systems of care that are client-centered, culturally competent, and fully accountable…."

A system of care is both a conceptual model and a service delivery system for providing mental health services to a target population, usually individuals with the most severe mental disabilities. The essential components are a single point of responsibility for the client, coordination with other involved human service agencies, and decision-making based on an evaluation of outcomes. Other components of systems of care, which are also critical to any responsive mental health system, include meaningful involvement of clients and their families (as appropriate) in treatment planning, client-centered services, cultural competence, age appropriate services, and an array of services focused on the person's mental health treatment and other supportive services needed to maintain residence in the community.[12]

Following realignment, the most significant changes in California's public mental health system have occurred as a result of changes related to the federal Medicaid program. Over the years, several services components were added to the SD/MC program to expand the array of mental health services, i.e., broaden the scope of benefits, the range of personnel who could provide services, and the location where services could be provided. Within the structure of California's public mental health system, these changes have significantly enhanced the ability of county mental health programs to serve foster youth and their families. The Medi-Cal related changes are:

- Targeted Care Management (TCM): California implemented TCM services under the Medi-Cal program in 1988; thereby allowing the state to claim federal funds for direct salaries, indirect salaries, and operating expenses related to TCM services. These services are defined as services which assist a Medicaid eligible individual in gaining

[12] Extract from DMH website publication titled, *About Systems of Care, Medicare, and Medi-Cal.*

access to needed medical, social, educational, and other services. TCM increased federal funding for public mental health services.

- Rehabilitation Option (Rehab Option): California implemented the Rehab Option in July 1993; thereby expanding the SD/MC program scope of benefits, allowing service delivery in new locations (i.e., beyond clinic-based settings), and broadening the range of personnel who can provide services. Under this option, SD/MC services include: inpatient hospital, psychiatric health facility, adult residential treatment, crisis residential treatment, crisis stabilization, intensive day treatment, day rehabilitation, linkage and brokerage, mental health services, medication support, and crisis intervention. This change enhanced the ability of county mental health agencies to provide a wider range of services with increased federal funding.
- Medi-Cal Mental Health Funding Consolidation: California consolidated the two separate Medi-Cal mental health systems (i.e., FFS/MC and SD/MC) into a single system of managed mental health care provided through county mental health programs beginning in 1995. Consolidation enabled the integration and coordination of care through county mental health programs, and adoption of consistent statewide standards for access to specialty mental health services.

  To provide a single, integrated system of mental health services, specialty mental health services were "carved out" from the rest of Medi-Cal. The "carve out" began the distinction between specialty mental health care (those services requiring the services of a specialist in mental health), and general mental health care needs (those needs which could be met by a general health care practitioner). General mental health care needs for Medi-Cal beneficiaries remained under DHS purview through their physical health managed care plans or the FFS/MC system.

  Specialty mental health services are provided through a single managed mental health care plan in each county, which in most cases is the county Mental Health Plan (MHP).[13] California obtained a federal "freedom of choice" waiver to use this single plan model. Consolidation transferred the State General Funds (SGF) anticipated as the match for FFS/MC inpatient and specialty mental health services from the DHS to the DMH budget.[14] Each MHP receives a fixed annual allocation of SGF based on what DHS would have incurred for psychiatric inpatient hospital services and psychiatrist and psychological services absent consolidation. These funds, together with realignment funds, may be used as the State Medicaid match for claiming federal matching funds.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT): California implemented the EPSDT in 1995 in response to a lawsuit that claimed the state was not fully implementing this federally mandated Medicaid benefit. The EPSDT

[13] All but two counties chose to become the local MHP; those two counties chose to partner with another county to be the MHP.

[14] Transfer of FFS/MC funding for acute psychiatric inpatient hospital services and long-term care in specialized psychiatric programs (commonly known as Inpatient Consolidation [IPC]) occurred on January 1, 1995. Consolidation of FFS/MC specialty mental health funding for outpatient specialty mental health services delivered by psychiatrists and psychologists (commonly known as Professional Services) occurred during FY 1997-98, with all counties completing the consolidation by July 1998. Some services such as medication or laboratory tests could not be clearly identified and were not included in the mental health "carve out."

program covers beneficiaries under age 21 and requires states to provide a broad range of screening, diagnosis, and medically necessary treatment services to correct or ameliorate identified conditions, regardless of whether or not such services are covered under a state's Medicaid Plan. These requirements apply to mental health as well as physical health (referred to as "EPSDT services").

EPSDT services expand specialty mental health services for children and youth with the state providing the required matching funds. Initially, county mental health plans were reimbursed the entire non-federal share of cost for EPSDT-eligible services in excess of a baseline amount (i.e., county expenditures for such services during FY 1994-95 - pre-consolidation). In 2002, a 10% match requirement was placed on counties. The EPSDT benefit allows county mental health programs to receive uncapped SGF (i.e., for costs above the baseline and a 10% match) for outpatient specialty mental health services provided to full scope Medi-Cal beneficiaries less than 21 years of age. This change is significant in expanding service to child and youth, including those in foster care.

- Therapeutic Behavioral Services (TBS): California implemented a new EPSDT supplemental specialty mental health service called TBS in 1998, also in response to a lawsuit. TBS is available for full-scope Medi-Cal beneficiaries less than 21 years of age with serious emotional disturbance. These mental health services are short-term, intensive one-on-one behavioral intervention services provided in the client's home, foster home, group home, school, day treatment program and/or other areas in the community. The goal of TBS is to reduce severe behavior problems and prevent the need for a higher level of care or enable transition to a lower level of care. Since these were new services, new SGF were provided to MHPs as match for these services. The addition of TBS is also significant in expanding services to children and youth, including those in foster care.

While many categorical funding sources were incorporated within realignment, some were maintained and new ones initiated. Virtually all of these funds are targeted toward certain populations and come with their own set of requirements. Key programs that could serve foster youth and their families include, but may not be limited to: Mental Health Services to Special Education Pupils (AB 3632); Health Families Program; and the Early Mental Health Initiative (EMHI). The new Mental Health Services Act (MHSA) will also allow enhanced services to foster children/youth and their families.

It is within this financing and service delivery structure that California's public mental health system provides services to foster children and youth and their families. The changes in the structure and financing of mental health programs have greatly and, for the most part, positively impacted to the ability of county mental health programs to provide effective mental health services to foster children and youth.

B. ISSUES AND TRENDS IN CHILD WELFARE AND MENTAL HEALTH

A review of public documents was conducted to identify current issues and trends that might influence the delivery of quality mental health services to foster youth and their families. The highlights of this review follow.

1. Child Welfare Services Program Environment[15]

Recent changes in federal and state laws and policy has resulted in philosophy and practice shifts reflected in child welfare services at both the state and national level. California's current child welfare environment reflects these practices shifts.

a. Changing Policies and Practices

According to DSS[16], over the past five years, two major initiatives of the state legislature converged to produce a new climate in which results for children are driving practice and policy changes. The two initiatives are: the Child Welfare Services Stakeholders Group and the Child Welfare System Improvement and Accountability Act. A description of these initiatives and their related policy and practice outgrowths follow.

- Child Welfare Services Stakeholders Group: the first initiative began in 2000 when a statewide stakeholders group was charged with researching best practices, and developing a consensus-based plan for redesigning California's child welfare services. Over a three-year period the 65-member group worked together to address issues facing the system and its impacts on children and families. Led by DSS, the group researched the most promising strategies being implemented in California counties and throughout the nation.

  The final report of the Stakeholder Group laid out this vision for the child welfare system in California: "Every child in California will live in a safe, stable, permanent home, nurtured by healthy families and strong communities." The group also set forth a number of objectives aimed at changing how child welfare agencies and their partners respond to children and families. This included providing better supports for struggling families, changing the system to be more responsive and less adversarial, placing greater emphasis on restoring and rebuilding families, and ensuring that youth who turn age 18 in foster care are better equipped for adulthood.

- Testing Strategies at the Local Level: eleven counties were identified in September 2003 to serve as "learning laboratories" to develop and test the implementation of key redesign strategies. These counties are testing changes in practices, measuring results and sharing lessons learned with the rest of the state. To begin, the focus has been on three specific improvement areas:

  - *Statewide Safety Assessment*: developing a standardized safety assessment process to ensure the consistent evaluation of risk from county-to-county, social worker-to-social worker, and child-to-child.

  - *Differential Response*: working with community organizations to develop a broader set of responses when child welfare agencies receive reports of possible abuse or neglect, including prevention and early intervention, engaging families to address issues of safety and risk, and improving access to a broad range of

[15] This section is largely based on extracts from: (1) Child Welfare System Improvements in California – 2003-2005: Early Implementation of Key Reforms – A Progress Report by DSS/FC/CWDA dated 12/05; (2) Improving California's Child Welfare System: Background Information by DSS/FC/CWDA dated 8/25/04; (3) Foster Care Fundamentals: An Overview of California's Foster Care System (CRB-01-008) dated 12/01; and (4) Legislative Analyst's Office Analysis of the FY 2007-08 Budget Bill for Child Welfare Services.

[16] Child Welfare System Improvements in California – 2003-2005: Early Implementation of Key Reforms – A Progress Report dated 12/05.

services for families who are formally involved in the child welfare system or who choose to participate voluntarily. Differential Response is built around three guiding principles which involve communities working together, early identification and remedy, and voluntary engagement of families.

- *Permanency and Youth Transitions*: including youth, extended family and community partners in decision-making and case planning in order to create more permanent homes and lasting relationships for foster youth and ensure their successful transition to adulthood.

- Supporting Change at the State Level: Efforts are underway to strengthen the state's capacity to support improvements in child welfare services and outcomes. These efforts have included enhancing state interagency coordination, encouraging flexible use of resources, and educating the public about ongoing improvements and challenges. Specific initiatives include:

- *State Interagency Team for Children and Youth*: formed in 2003, this team is charged with improving the coordination of policy, services and funding for children, youth and families in California. The group includes deputy directors for 10 state agencies and departments, including DMH.

- *Funding System Improvements:* created the Child Welfare Services Improvement Fund in 2004 to streamline and simplify the process of using private donations as part of the state match for federal funding. The fund has supported activities such as the Breakthrough Series Collaborative on Differential Response, the Fiscal Strategies Initiative, and the Youth Transition Action Teams.

- *Supporting System Improvements through Partnership:* solicited increased support from individual foundations for some of the initiatives highlighted in the Stakeholders' final report. Two ongoing projects include the California Family-to-Family Initiative and the Linkages Project

- *Standardized Training:* creating the Common Core Curricula (i.e., the new standardized training programs required for all new child welfare workers and supervisors) to reflect changing social work practices that are underway. The Curricula is focused on developing the capacity of the workforce to use these best practices with consistency and equity in all 58 counties. The four common themes of the Curricula are: fairness and equity; family and youth engagement; strength-based practice; and outcomes-informed practice.

- Child Welfare System Improvement and Accountability Act:[17] the second initiative established a statewide accountability system that measures progress and encourages county governments to engage the community in evaluating and improving practices. The new accountability system is known as the California Child and Family Services Review (C-CFSR). The C-CFSR is an enhancement of the federal Child and Family Services Review (CFSR) system used to evaluate each states child welfare services program performance.

[17] Established under AB 636 (Steinberg) (Chapter 678, Statutes of 2001).

The new C-CFSR shifts away from the previous process-based accountability system toward a focus on achieving results related to safety, permanence and well-being. The system is built on a continuous improvement cycle of self-assessment, planning, implementation and review. The improvement cycle uses quantitative data from the statewide child welfare database (i.e., the Child Welfare Services/Case Management System [CWS/CMS]), and qualitative data drawn from individual case reviews within each county. Key components of the new accountability system are:

- *Quarterly County Data Reports*: individual county performance on 14 data indicators to measure progress, with the data provided to each county welfare agency and published on-line.
- *County Self-Assessments:* in collaboration with community partners and stakeholders, each county identifies its strengths and challenges and conducts re-assessments every three-years.
- *Peer Quality Care Review*: each county welfare agency forms teams composed of its own social workers, staff from other counties and DSS staff to review randomly selected cases in at least one of its identified improvement areas. Teams conduct structured interviews to evaluate the cases.
- *System Improvement Plan*: based on its self-assessment, each county welfare agency collaborates with local partners to develop a plan that specifies priorities, improvement goals and action steps. The County Board of Supervisors must approve the plan.

California's child welfare services policy and practice shifts can be summarize by four overwhelming themes:

- Prevention and Early Intervention: the service approach has changed to place a greater emphasis on prevention and early intervention activities as the most effective method of protecting children and decreasing the demand for foster care.
- Family-Centered Practice: the service approach has shifted away from a "professional-driven" to a "family-centered practice." A family-centered service approach means that families share the responsibility to identify what they need and shape their own plans. The system provides support to families, building upon their existing strengths. This approach is also characterized by developing and delivering individualized services (services that are customized to the child or families' needs), and using the resources available in the family's community.[18] Wraparound and Family Decision-Making (also referred to as "family conferencing") are two examples of family-centered approaches.
- Coordination and Collaboration: there is increasing recognition of the role communities play in protecting children and supporting families. County agencies are establishing and building relationships with, and using, community agencies that serve children and families. These ties to community resources are especially important when public agency services end.

[18] Foster Care Fundamentals: An Overview of California's Foster Care System dated 12/01 (California State Library publication CRB01-008).

County social workers and probation officers are also joining forces with other public agencies that serve the same families. Many counties have foster placement committees that include social services, probation and mental health staff. Many counties have multi-disciplinary teams that bring together additional partners (such as health and alcohol/drug programs) to coordinate the separate services. Other counties are using a more collaborative approach: public and private agencies make their respective staff and funding resource available to meet a family's multiple needs more effectively.

At the same time, federal and state initiatives increasingly require agencies and groups that provide services to families and children to collaborate in order to secure funding. In addition, they require that key stakeholders be involved in planning processes: families and youth (consumers); representatives from federal, state, and local agencies; and the community. The primary goal is to reduce fragmentation and duplication.[19]

- Results and Accountability: the focus has shifted away from a process-based accountability system toward achieving results related to child safety, permanence and well-being. The emphasis is on monitoring *results*, i.e., whether programs have actually made a positive differences in the lives of children and families. The new federal CFSR system and California's C-CFSR are designed to evaluate outcomes for children and families. Moreover, these outcomes include access to effective mental health services.

b. CWS Challenges and Opportunities

According to DSS, the strategies undertaken to date appear to be having a positive impact. DSS reports, "Children today are less likely to enter the foster care system than they were five years ago. When children do enter foster care, they are more likely to exit and they tend to exit more quickly. Overall, we have seen a 20.5 percent reduction in the number of children in foster care due to abuse and neglect since 2000."[20] While the new reforms are promising, there are challenges that must be faced. Among the child welfare services challenges and opportunities most frequently noted are:

- Funding Restrictions and Incentives: the current financing structure creates a financial incentive to place and keep children in foster care. Title IV-E *maintenance* funding is open-ended. In contrast, Title IV-B funding for child welfare services is capped. This means that there are limited funds available to provide services to families to keep them at home, or return them to their parents. Moreover, funding is scarce for the types of prevention and early intervention services that communities are seeking.[21]

  Recent events provide for some optimism in this area. On March 31, 2006, the federal government approved California's request to waive certain provision of Title

[19] American Public Human Services Association (APHSA), "Child Welfare" in Crossroads: *New Directions in Social Policy* (Washington, D.C.: APHSA, 2000; and California DSS, *Child Welfare Services Stakeholders Group First Year Report* (Sacramento: the Department, 8/01).
[20] Child Welfare System Improvements in California – 2003-2005: Early Implementation of Key Reforms – A Progress Report dated 12/05.
[21] Ibid.

IV-E under an IV-E waiver demonstration project. Under the terms of the federal waiver, federal funds may be used for services that would not normally be eligible for federal reimbursement. The purpose of the waiver is to encourage and allow the use of innovative strategies or intensive services in order to prevent or limit placement in foster care.[22] The waiver presents a unique opportunity for the state use funds previously restricted to foster care maintenance payments for services to prevent and/or shorten such placements. Waiver implementation started on January 1, 2007, and ends on December 20, 2011.

- Social Worker Caseloads: county social worker caseloads remain above recommended levels on a statewide basis.[23] The state funds county social worker costs based on caseload standards that specify case-to-social worker ratios. Sufficient funding to maintain caseload standards is an ongoing concern. A major element in providing adequate services to children in foster care is the ability to fund appropriate social worker caseloads.
- Placement Resources: better recruitment, support and retention of quality foster parents, relative caregivers and adoptive parents are needed.[24] Matching a child with an appropriate placement is often challenging due to limited resources. There is an extreme shortage of foster homes, especially for children with special needs. This can lead to less than optimal placements, e.g., placement in another county, out-of-state, etc.
- Interagency Coordination: the child welfare system and foster care program cannot serve children and families in isolation. Health, mental health, substance abuse, education, public welfare, family violence, and other systems play essential roles in ensuring the child's safety and strengthening families. While interagency coordination is improving, there are often conflicting goals and timelines among systems. Multiple sources of federal and state funding come with specific allocation formulas, different matching requirements, and program-specific spending restrictions. This often creates a barrier to coordinating interagency approaches to protect children and strengthen families. Furthermore, many services are simply in short supply or lacking altogether in some locations statewide.
- Programs for Emancipating Youth: there is a shortage of programs to assist emancipating youth; existing programs are small and do not reach all that might benefit from them.[25]
- Performance Outcome Evaluation: the federal CFSR system review of California's child welfare services program in 2002 found the state failing all seven outcome measures pertaining to child safety, well-being, and permanency. One of the federal measures of well-being is that "children receive adequate services to meet their physical and mental health needs." The state must successfully implement its Performance Improvement Plan (PIP) to avoid future federal penalties.

[22] Analysis of the 2007-09 Budget Bill for Child Welfare Services prepared by the Legislative Analyst's Office.
[23] Child Welfare System Improvements in California – 2003-2005: Early Implementation of Key Reforms – A Progress Report dated 12/05.
[24] Ibid.
[25] Ibid.

2. Public Mental Health Program Environment[26]

California's public mental health system financing and service delivery approaches have changed dramatically during the past 10 to 15 years. These changes have provided counties with increased flexibility and capacity to meet local mental health needs, including those of foster children and youth and their families. Key policy and practice changes as well as challenges and opportunities are described in the following.

a. Changing Policies and Practices

With the advent of realignment, the public mental health system adopted a shared vision for mental health services based on systems of care for children and youth, adults, and older adults. For Children's System of Care (CSOC), the model was not new; experience had been gained from the Ventura County pilot that began in 1984. The pilot was based on the observation that children were receiving services from multiple agencies, yet in the absence of interagency coordination with mental health services, children's school attendance difficulties, out-of-home placement and juvenile justice system involvement remained only minimally impacted. The pilot demonstrated that by meeting mental health services needs and combining multiple agency resources, a system of care approach improved child and family outcomes and reduced the overall costs of services provided across county agencies.[27]

Since that time, the CSOC model has been adopted throughout California. The basic premise is to improve child and family functioning through interagency cooperation and collaboration in delivering planned, coordinated and effective services. At the same time, the intent is to reduce reliance on higher (institutional) levels of care thereby enabling redirection of these moneys and resources into local programs of care and support. According to DMH, implementation of the CSOC model in California has shown improvements in child and family functioning as well as significant levels of cost avoidance.[28]

In 2000, the original CSOC was revised to better support counties in their implementation efforts and DMH in supporting and monitoring counties' implementation activities (Chapter 520, Statutes of 2000 [SB 1452, Wright]). While these changes apply to counties receiving CSOC project funding (which has since been discontinued), the changes[29] are illustrative of the overall approach. The changes:

- Strengthen family partnerships by requiring counties to include family members as participants in their interagency policy and planning committees; thereby defining a specific role for family members in developing policy for CSOC at the local level.
- Expand the target population to include infant and toddlers as well as transition-aged adolescents and young adults.

[26] This section is largely based on extracts from: (1) DMH AB 328 Realignment Data Report dated 2/03; and, (2) DMH website materials including: Frequently Asked Questions "About Systems of Care, Medicare, and Medi-Cal," Children's System of Care Initiative, and Summary Findings (FY 2002-03): Children's System of Care Interagency Enrollee-Based Program dated 9/03.
[27] DMH Summary Findings (FY 2002-03): Children's System of Care – Interagency Enrollee-Based Program dated 9/03 (pg 6).
[28] DMH website for Children's System of Care (CSOC) Initiative.
[29] Ibid.

- Require greater interagency collaboration and planning by expanding the locally mandated memorandums of understanding (agreements among participating agencies) to include similar community-based child serving initiatives, e.g., juvenile justice, child welfare, substance abuse, and employment programs.
- Expand the required performance outcomes measures to include specific client and systems' improvement measures. For example, measures address reduced group home or other restrictive placements, increased school attendance, and measurable improvement in individual and family functional status.
- Strengthen DMH oversight responsibilities through annual performance contracts with counties, audits, and monitoring.

The California CSOC Model Evaluation Project conducted in 2001 found, among other things that youth served by the CSOC are: in need these services and supports; in less restrictive settings; in school and benefiting from being in school; staying out of trouble; and becoming healthier.[30] These study findings were more recently confirmed by a special outcome study of 3,198 children enrolled in CSOC based on data submitted by 54 counties.[31] According to DMH, within the last few years, the goals of the CSOC have become very clear: Children will be Safe, In Home, In School, and Out of Trouble.[32]

To a large extent, the policy and practice shifts described for the child welfare program mirror the philosophy and approach of the mental health CSOC. For example, both service systems value: child-centered and family-focused practice; community-based decision-making; prevention, early identification and intervention; interagency linkages to promote service integration and coordination; and results accountability. The policy and practice shifts in California's child welfare program reflect a CSOC approach.

b. Challenges and Opportunities

There are a number of challenges and opportunities currently facing the public mental health system, which likely impact mental health services to foster youth and their families. The challenges and opportunities most frequently noted are:

- Adequacy of Realignment Funding: while the consensus seems to be that the 1991 realignment of mental health services has been a success, it is widely believed that funding has not kept pace with anticipated returns. Specifically, the rate of growth has been less than anticipated, i.e., less than the growth in population and medical inflation. This is due to many factors including the distribution of caseload growth monies, i.e., the majority of realignment growth (over 41% through FY 2000-01) has gone to the social services program. This means that many counties may be unable to expand or maintain needed service levels. Moreover, because realignment funds are used in part as the local match for the SD/MC program, many counties are experiencing an increased draw on these funds due to increases in federal funding.

[30] Key findings from the California CSOC Model Evaluation Project conducted by DMH and the University of California, San Francisco (UCSF) in 2001.

[31] Summary of Findings (FY 2002-03) CSOC Interagency Enrollee-Based Program report prepared by DMH (with the assistance of CIMH and I.D.E.A. Consulting) dated 9/03.

[32] DMH website for Children's System of Care (CSOC) Initiative.

- Increased Federal Funding: the significant increase in federal funding has changed the nature of the public mental health system. Federal funding has increased greatly with implementation of Medicaid programs and benefits, e.g., TCM, Rehab Option, EPSDT, etc. These changes provide county mental health programs with a growing source of federal revenue and, in the case of EPSDT, an additional source of SGF revenues for outpatient service for youth under 21 years of age. However, counties must provide the state/local match for the balance of mental health Medi-Cal services.

  At the same time, these changes have resulted in a shift in individuals receiving services (i.e., more Medi-Cal clients and fewer indigent clients), increasing service demands, and growing pressure on limited non-federal sources of funding. Some local mental health programs are finding it increasingly difficult to generate sufficient revenues to keep pace with increased client and service usage, and increases in expenditures for services.

- Shortfall in EPSDT Funding: there have been multi-year deficits in the EPSDT program, with money still owing to county mental health programs to reimburse them for EPSDT services provided. This shortfall has put a significant strain on county mental health program resources. In addition, other accounting and billing issues have caused backlogs in claims processing in general, including payments to county mental health programs. Together these problems are straining county resources and disrupting the state and local partnership.

- Children's System of Care (CSOC) Funding: special state funding for CSOC was discontinued. This funding was used by county mental health programs to establish the local level infrastructure and services needed to support CSOC. While this impacts many counties, CSOC services are generally covered by the regular funding streams including realignment, SGF for managed mental health care, county general funds, and reimbursements from federal programs.[33]

- Staff Resources: there are shortages of qualified individuals to provide services to address severe mental illnesses. These shortages are in various professions, occupational categories and areas of the state. A major element in providing effective mental health services to children in foster care is the ability to hire sufficient and qualified professionals and staff.

- Implementation of Mental Health Services Act (MHSA): implementation of the MHSA is underway and is anticipated to provide significant opportunities to focus on populations that are either un-served or under-served within the current public mental health service delivery environment. While MHSA funds can be used to match federal Medicaid funding, it is expected that attention will focus on populations that are not eligible and/or services that are not covered under the Medi-Cal program.

  There is also an expectation that implementation of the MHSA will increase collaboration among various services systems both at the local and state level. This means that partnerships will be formed or enhanced to address difficult social

[33] DMH website publication titled, *About Systems of Care, Medicare, and Medi-Cal.*

problems that heretofore not have been fully addressed but have a mental health component. Some of these areas are clearly identified in the MHSA, for example, services to transition age youth ages 16 to 25 years, wraparound services for individuals and families at risk, and supportive living/housing services for individuals and families who are homeless or at-risk of homelessness. The MHSA provides the opportunity for innovation and collaboration in effectively serving the needs of vulnerable individuals and families in a holistic way.

C. KEY INFORMANT INTERVIEWS

Key informant interviews were used as a way to informally collect information from experts in mental health and child welfare services and ensure that important avenues of inquiry were not overlooked. The Subcommittee developed a tool with 8 open-ended questions for the key informant interviews.. The questions solicited information on the problems that children and youth face in the foster care system, and asked respondents to identify practices and strategies to improve the quality of mental health services received.

The Subcommittee developed a list of possible key informants to be interviewed. Information was gathered from nine individuals representing foster youth, parent or partner advocate (3/33%); county probation departments (3/33%); county child welfare agencies (2/22%); and services providers (1/11%). The key informant responses were completed during March through June 2006. The responses supplemented the information gained from other sources and supported themes that were found through other discovery methods described in other parts of the report.

1. Respondents/Organizations Role and Services Provided (Question #1)

This question asked respondents to explain your role and your organization's role with children and youth in the foster care system? What services do you provide? Given the different professions/organizations represented, the types of services provided ranged from providing care, advocacy services, to local agency administration of child welfare or probation services. This information is self-explanatory; no further analysis could be conducted.

2. Major Obstacles in Accessing Mental Health Services (Question #2)

This question asked respondents to describe major obstacles in accessing mental health services for children and youth in foster care placements? Examples of barriers were also provided, i.e., language, cultural barriers, placement changes, out-of-county placements, funding, lack of service providers, etc. The respondents each identified many barriers. The barriers grouped into nine (9) types in descending frequency are:

KEY INFORMANT INTERVIEW QUESTION #2	
MAJOR OBSTACLES IN ACCESSING MENTAL HEALTH SERVICES	# OF RESPONDENTS IDENTIFYING THIS ISSUE
1. Frequent placement changes resulting in lack of continuity of care (e.g., disrupts MH treatment, therapist relationship, and difficulties in maintaining uninterrupted coverage)	7
2. Lack of service providers or providers with appropriate training (e.g., lack of local placements or in certain areas, care providers unfamiliar with services or foster youth,	7

KEY INFORMANT INTERVIEW QUESTION #2	
MAJOR OBSTACLES IN ACCESSING MENTAL HEALTH SERVICES	# OF RESPONDENTS IDENTIFYING THIS ISSUE
inappropriate placements, etc)	
3. Lack of staff resources – types, sufficient numbers, and appropriately trained (e.g., misdiagnoses, improper treatment, unfamiliar with foster youth, poor practices not fitting to foster youth, staff shortages in some professions, high staff turnover, etc)	7
4. Lack of mental health system capacity and/or service approaches (e.g., large caseloads, waiting lists, need more early intervention/prevention services, failure to involve youth in treatment decisions, lack of non-traditional services, lack of specialized services, etc)	6
5. Out-of-county placements (e.g., nightmares in accessing Medi-Cal, finding providers to accept out-of-county minors, etc)	4
6. Language and cultural barriers (e.g., 4 mentioned language barriers and 1 cultural barriers)	4
7. Interagency coordination (e.g., 2 mentioned HIPAA regulations blocking linkage and causing delays, and 1 no collaboration – silos)	3
8. Medi-Cal eligibility and access issues (e.g., a variety of issues causing delays, loss of eligibility, etc)	3
9. Other (e.g., multiple services, providers, locations are a huge barriers for foster families, CPS overwhelmed, etc)	3

3. Major Mental Health Issues Affecting High-Risk Youth (Question #3)

This question asked respondents to identify the mental health issues affecting high-risk, underserved youth in California, particularly those in or leaving the foster care and juvenile justice systems. The question also indicated that data suggest that youth in the juvenile justice system tend to have the lowest rate of mental health services use. The respondents each identified many issues affecting these youth. The issues grouped into five (5) types in descending frequency are:

KEY INFORMANT INTERVIEW QUESTION #3	
MAJOR MENTAL HEALTH ISSUES AFFECTING HIGH-RISK UNDERSERVED YOUTH	# OF RESPONDENTS IDENTIFYING THIS ISSUE
1. Staff resources – lack of the types, sufficient numbers, and trained staff in working with youth in juvenile justice system	7
2.Lack of continuity of care and adequate care monitoring and oversight (e.g., lack of monitoring psychiatric medication usage, disruption of mental health care when moving to/from juvenile hall, lack of immediate follow-up care upon entry to community, etc)	7
3. Lack of transition assistance for youth (e.g., lack of appropriate skills training for success in the community, lack of family involvement in transition planning, etc)	3
4. Lack of services and/or inadequate staff deployment (e.g., inadequate or wrong type of mental health services provided in juvenile halls – only crisis services)	2
5. Other (e.g., juvenile justice youth are resistant to mental health treatment, lack trust)	2

4. Educational Issues Faced by Foster Children/Youth (Question #4)

This question asked respondents to identify the educational issues faced by foster children and youth. Respondents were also asked if they had any recommendation for solutions. The respondents each identified many educational issues affecting these youth. The issues grouped into six (6) types in descending frequency are:

KEY INFORMANT INTERVIEW QUESTION #4A	
EDUCATIONAL ISSUES FACED BY FOSTER CHILDREN/YOUTH	# OF RESPONDENTS IDENTIFYING THIS ISSUE
1. Frequent moves/placements result in a lack of continuity of education (e.g., loss of credits, under-educated, instability, lack of educational progress)	6
2. Lack of academic assistance or educational resources to meet special educational or other related needs (e.g., tutoring, school refusal to provide special education or assistance, lack of appropriate services and options, etc)	6
3. No academic assessment or monitoring of educational progress (e.g., no one responsible for youth's education, youth not graduating, etc)	6
4. Lack of school staff training in working with foster children/youth (e.g., lack of awareness about foster youth and educational rights, cannot deal with acting out, unfamiliar with available resources, etc)	4
5. Failure to timely transfer school records or other information	3
6. Other (e.g., lack of preparation for career and/or higher education, low educational expectations, poor education at NPAs, etc)	6

Respondent recommended solutions to the identified educational issues, grouped into five (5) types in descending frequency are:

KEY INFORMANT INTERVIEW QUESTION #4B	
RECOMMENDED SOLUTIONS TO EDUCATIONAL ISSUES FACED BY FOSTER CHILDREN/YOUTH	# OF RESPONDENTS IDENTIFYING THIS ISSUE
1. Educate social workers, school staff and foster parents/group homes on educational issues (e.g., special ed. testing, student rights, working with these youth, & educational options)	3
2. Conduct educational assessments of youth (e.g., test youth for learning problems, use assessments to enable targeted interventions)	2
3. Improve interagency collaboration (use incentives to encourage collaboration, consider use of a centralized educational database)	2
4. Education and advocacy on the educational rights of foster youth (e.g., educate foster youth on their educational rights and fund advocacy services)	2
5. Other (e.g., hire an Educational Case Worker to track children & their grades, attendance)	1

5. Proven and Promising Mental Health Practices (Question #5)

This question asked respondents to identify any proven and promising mental health practices in the community that are not being utilized in providing mental health services to foster children. Prevention and early intervention efforts were given as an example. The respondents identified several practices, which in descending frequency are:

KEY INFORMANT INTERVIEW QUESTION #5	
PROVEN AND PROMISING MENTAL HEALTH PRACTICES	# OF RESPONDENTS IDENTIFYING THIS ISSUE
1.Expand Availability of Wraparound Services, TBS, Building Blocks, etc	2
2. MTFC for infants and toddlers	1
3. Family Finding Technology	1
4. Non-traditional treatment	1
5. More group therapy (including caregivers) versus individual therapy	1
6. Parent Partners to assist families – strengths-based	1
7. Peer-To-Peer support	1
8. Independent living programs	1

6. State or Local Strategies for Appropriate Mental Health Services (Question #6)

This question asked respondents to suggest state or local strategies to ensure that foster children receive appropriate mental health services. The strategies identified by the respondents grouped into five (5) types in descending frequency are:

KEY INFORMANT INTERVIEW QUESTION #6	
STATE AND LOCAL STRATEGIES TO ENSURE FOSTER CHILDREN/ YOUTH RECEIVE APPROPRIATE MENTAL HEALTH SERVICES	# OF RESPONDENTS IDENTIFYING THIS ISSUE
1. Use screening and specialized assessments for diagnosis and treatment (e.g., use for all children entering foster care, annually thereafter)	4
2. Monitor mental health services and progress for each child/youth (e.g., create Foster Youth Ombudsperson Office for Foster Youth to monitor appropriateness of MH services, oversee use of psychotropic medications, etc)	4
3. Increase staff training for mental health providers working with foster youth	3
4. Ensure foster youth participation in treatment planning	2
5. Other (single respondent answers) (e.g., mandate MH treatment for all foster children, increase wraparound services for relative caregivers, publish materials on educational rights, provide follow-up and aftercare services, etc)	9

7. Mental Health Services for Relatives and Caregivers (Question #7)

This question asked respondents whether their county provides mental health services to relatives or caregivers. The responses are:

KEY INFORMANT INTERVIEW QUESTION #7	
PROVIDE MENTAL HEALTH SERVICES TO RELATIVES OR CAREGIVERS	# OF RESPONDENTS
1. Yes; however, 5 of these responses seemed to indicate that such services are limited or not enough (one respondent viewed this as a major barrier to family reunification or to success in placement)	7
2. No	2
3. N/A – statewide organization	1

8. Other Information (Question #8)

This question asked respondents whether they had anything else that they would like to share. The responses to this open-ended question are:

KEY INFORMANT INTERVIEW QUESTION #8	
OTHER INFORMATION AND SUGGESTIONS	# OF RESPONDENTS
1. No	3
2. Foster children need mentors that remain the constant in their lives	2
3. Need leadership and vision from the top	1
4. Need a better way to connect youth to services through the schools – they know these kids	1
5. Need to better address MH/educational issues among foster children	1
6. County Children's MH is a full partner in addressing MH needs of children in foster care/juvenile justice	1
7. Tendency to terminate services to families too soon; need longer-term commitment to support families and their success	1
8. Increase group home staff qualifications	1
9. Change CCL standards; they do not work	1
10. Placement should be viewed as short-term, high-quality intervention/prevention	1
11. Need better case management	1
12. Develop permanency plans that work	1

D. KEY FINDINGS

During the past decade, there have been significant improvements in providing mental health services to foster children/youth and their families. While the child welfare/foster care and public mental health program are two separate service systems, philosophy and practice changes are bringing these systems closer together. Recent policy and practice changes in California's child welfare system definitely reflect the core values and tenets of the mental health CSOC approach. The child welfare system changes are bringing a shared statewide structure, approach, and accountability measures to local programs that perhaps were not as strongly reflected heretofore.

California's mental health CSOC and new policy and practice approaches in child welfare services are honing the shared, cross-system focus on:

- Prevention and early intervention;
- Family-Centered Practice;
- Coordination and Collaboration; and,
- Results and Accountability.

These are significant and positive changes, which provide a shared framework within which to jointly deliver services to the same children, youth and families.

Nevertheless, despite extensive efforts of the past and new changes underway, there is room for improvement. The review of public documents identified many of the current

challenges including, but not limited to: funding restrictions and limitations in the use of available monies; human resources challenges due to insufficient numbers, types, or training; insufficient or inappropriate service availability, particularly in some areas of the state; and continuing challenges in interagency collaboration.

The key informant interviews also identified areas in which further improvement is desired. While the key informant data cannot be generalized, the data do largely confirm many system improvement themes identified through other means. For example, key themes are:

- The disruption in continuity of care, including mental health services caused by frequent foster care placement changes;
- The even greater disruption in care resulting from out-of-county foster care placements; not the least of which are difficulties in maintaining Medi-Cal eligibility and continuity of mental health treatment services;
- The need to continue efforts to improve interagency collaboration and coordination in addressing the multiple needs of foster children and their families. Of particular note, is the need to increase the involvement of schools in ensuring that foster youth receive appropriate educational assistance to enable them to achieve;
- The need to build human resources (i.e., qualified staff and service providers), particularly in some areas of the state, in order to enhance the capacity of the public mental health system;
- The need for appropriate mental health screening and assessments for children entering the foster care system, including on-going care monitoring and oversight; and,
- The need to further increase access to public mental health services through removal of language and cultural barriers.

The next step in determining the status of efforts to improve mental health services to foster children/youth and their families, is derived from reviewing actual data from the service delivery system. As will be shown in the next part of this report, available data show mental health services utilized.

IV. DATA ON MENTAL HEALTH SERVICES PROVIDED

This phase of the study involved the development and analysis of data that are descriptive of the mental health services actually provided to foster youth by county mental health programs. Two sources were used to inform this part of the study: statistical data available from DMH; and a county mental health CSOC Coordinator's Survey. Together, these sources provide both factual and experiential/anecdotal insight about the nature of mental health services provided to foster children and youth.

A. MENTAL HEALTH SERVICES DATA

The DMH collects data pertaining to mental health clients and the services they receive at the county level and presents this information on its website. The data are collected and organized by: County Mental Health Program reports for all clients (Medi-Cal and non-Medi-Cal clients); and Medi-Cal Specialty Mental Health Services reports (Medi-Cal clients only). The DMH also provides trend reports about county mental health programs. The data available are:

- County Mental Health Program Reports: These data are from the Client and Services Information (CSI) system which began in 1998 and its successor the Client Data System (CDS). The reports include service and utilization data by various demographic variable, e.g., age, gender, ethnicity. Currently available on the website are: CSI Statewide Summary Reports by fiscal year for FY 2000-01 through FY 2004-05; and data for the last eight years of the CDS, i.e., FY 1990-91 through FY 1997-98. Other CSI and CDS-based reports produced for other periods may be requested. Together, these data provide a view of county mental health services for the 14-year period from FY 1990-91 through FY 2004-05.
- Medi-Cal Specialty Mental Health Services Reports: The Medi-Cal Specialty Mental Health Services data are from the SD/MC approved claims file, the Inpatient Consolidation paid claims file, and Medi-Cal Eligibility Data System (MEDS). Additional data sources are used for San Mateo County case rate clients. These reports include data on eligibility, utilization, treatment expenditures, and indicators derived from these data. The reports also contain statewide, regional, and county data, which are presented across a number of programmatic and demographic variables including aid group, age group, gender, race/ethnicity, and type of service. Currently available on the website are Medi-Cal trend reports for two five-year periods: FY 1998-99 through FY 2002-03 and FY 1993-94 through FY 1997-98. Together these two reports provide data for the 10-year period of FY 1993-94 through FY 2002-03.

  One further note on this data: the analysis of Medi-Cal specialty mental health services is done by aid groups. Eligibility to receive Medi-Cal services is established through several programs; primarily TANF, Foster Care, and SSI/SSP. With the numerous variations within each of these programs and several other smaller programs, there are over 100 individual aid categories. The DMH reports group the aid categories based on program similarity, age, and utilization and cost of mental health services. The following five aid groupings result: Foster Care, All Other Children, Disabled, Family Adult, and Other Adult. The Foster Care aid group provides specific information on services to foster children and youth.

These data provide a wealth of information to inform this study about the nature and changes over time in mental health services provided to children/youth in foster care. The data show:

1. Large Increase in Total Number of Clients Served, Particularly Children and Youth

There has been a large increase in the number of clients served by the public mental health program in the 14-years from FY 1990-91 through FY 2004-05. This increase is particularly pronounced for youth under 21 years of age.

- Number of Clients (All Clients): The total number of clients served increased from 320,704 in FY 1990-1991 to 647,067 in FY 2004-05. This is an increase of 101.8% percent while the statewide population increased only 21.3%. At the same time, the total number of unduplicated clients age 0-20 years, increased from 77,546 in FY 1990-91 to 239,093 in FY 2004-05. This is an increase of 208.3% while the statewide population for this age range increased by only 19.6%.
- Age Groups (All Clients) - There was an increase in the number of clients for all age groups from FY 1990 through FY 2004-05. As noted, clients in the 0-20 age group experience the largest increase (208.3%), while clients aged 21-39 experienced the least group (27.2%). As a percent of total clients, the largest change was the increase in clients aged 0-20 (49.5%). Table 1 below displays these data.

TABLE 1 – CHANGE IN NUMBER/PERCENT OF CLIENTS BY AGE GROUP
STATEWIDE DATA - FY 1990-91 TO FY 2004-05

	FY 1990-91		FY 2004-05*		Change 90-91 to 04-05		% of
Age	Number	Percent	Number	Percent	Number	Percent	Change
Total	320,704	100%	647,067	100%	326,363	101.8%	100.0%
0-12	32,502	10.1%					
13-17	32,941	10.3%					
0-11			89,045	13.8%			
12-17			120,516	18.6%			
18-20	12,103	3.8%	29,532	4.6%			
Sub-Total, 0-20	77,546	24.2%	239,093	37.0%	161,547	208.3%	49.5%
21-39	139,501	43.5%	177,497	27.4%	37,996	27.2%	11.7%
40 - 59	77,593	24.2%	192,901	29.8%	115,308	148.6%	35.3%
60 - 64	8,656	2.7%	18,471	2.9%	9,815	113.2%	3.0%
65 & Up	17,035	5.3%	19,055	2.9%	2,020	118.6%	0.6%
Unknown/Not Reported	373	0.1%	50	0.0%	-323	-86.6%	-0.1%
* Note Yolo County has only reported CSI data through September 2003							

2. Large Increase in Medi-Cal Clients Served, Particularly Children and Youth

There has been a large increase in the Medi-Cal client population, particularly children and youth, in the 10-years from FY 1993-94 through FY 2002-03. This change results from the increased emphasis on managed mental health care and securing federal funding through the Medicaid program.

- Medi-Cal Eligibility: The number of persons eligible for Medi-Cal mental health services (average monthly eligibles) increased 19.9%, from 5,522,318 in FY 1993-94

to 6,621,127 in FY 2002-03. The overall increase has been steady with the exception of the late 1990's when there was a small decrease in the overall number of persons eligible largely due to welfare reform (CalWORKs). The Foster Care aid group increased 22.4%, from 74,672 to 91,379, during this period. Other aid groups (i.e., Disabled and Other Adult) had higher rates of increase. Table 2 below displays these data.

TABLE 2 - AVERAGE MONTHLY ELIGIBLES BY AID GROUP
STATEWIDE DATA - FY 1993-94 THROUGH FY 2002-03 (10 Years)

	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	Change	% Change
Total	5,522,318	5,620,035	5,682,443	5,595,331	5,303,854	5,223,271	5,277,594	5,604,584	6,106,010	6,621,127	1,098,809	19.9%
Foster Care	74,672	76,951	81,428	86,114	96,879	93,729	92,450	86,638	87,031	91,379	16,707	22.4%
All Other Children	2,712,753	2,745,851	2,769,623	2,711,101	2,523,220	2,500,276	2,384,290	2,563,782	2,754,276	2,960,365	247,612	9.1%
Disabled	715,835	742,023	788,849	805,737	811,430	828,752	848,532	867,743	899,392	956,075	240,240	33.6%
Family Adult	1,177,627	1,214,855	1,187,927	1,134,249	1,033,985	1,030,083	1,104,409	1,070,334	1,212,481	1,318,942	141,315	12.0%
Other Adult	841,483	840,430	854,650	858,155	838,374	770,484	847,936	1,016,118	1,152,882	1,294,448	452,965	53.8%

- Medi-Cal Clients: The number of clients receiving Medi-Cal specialty mental health services increased 51.1%, from 275,159 to 415,867 clients, from FY 1993-94 to FY 2002-03. The Foster Care aid group has steadily increased from 32,096 in FY 1993-94 to 45,088 in FY 2002-03, an increase of 40.5%. While other aid groups outpaced this rate of increase, the proportion of foster care clients receiving mental health services is much higher. The increase in the Foster Care aid group is largely due to implementation of EPSDT in FY 1995-96. Table 3 below displays these data.

TABLE 3 - UNDUPLICATED CLIENTS BY AID GROUP
STATEWIDE DATA – FY 1993-94 THROUGH FY 2002-03 (10 Years)

Aid Group	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	Change	% Change
Total	275,159	280,129	303,272	320,265	329,455	310,561	334,533	352,493	385,617	415,867	140,708	51.1%
Foster Care	32,096	32,210	35,359	40,213	45,225	34,881	39,218	41,418	43,293	45,088	12,992	40.5%
All Other Children	54,387	56,818	63,151	72,568	70,574	67,596	79,585	83,824	100,730	108,023	53,636	98.6%
Disabled	131,647	136,028	149,150	158,319	163,703	165,196	174,611	183,928	195,912	207,648	76,001	57.7%
Family Adult	55,358	53,144	53,772	51,156	49,475	46,077	47,731	47,727	54,284	59,075	3,717	6.7%
Other Adult	8,630	8,889	10,212	10,583	12,007	8,669	9,368	10,462	12,152	13,301	4,671	54.1%

3. Increased Access to Mental Health Services - Total Clients Served Exceeds Population Growth, Particularly for Children and Youth (Penetration Rate)

The total number of individuals receiving mental health services out of the general population has increased (this measure is referred to as the penetration rate). The total penetration rate increased from 1.07% to 1.19% from FY 1990-91 to 1997-98, an overall increase in the penetration rate of 11.2%. During this same period, the percent change in clients is 21.8%, while the percent change for the general population is 10.1%.

With implementation of EPSDT in FY 1994-95 the penetration rate for the children and youth age groups increased more than for the other age groups. The penetration rate of children/youth aged 0-20 years was 0.83% in FY 1990-91 and 1.13% in FY 1997-98,

an increase in the rate of 36.2%. This rate of increase is much higher than for other age groups. Table 4 below display these data.

TABLE 4 – NUMBER OF UNDUPLICATED CLIENTS, POPULATION COUNT, PENETRATION RATE & PERCENT CHANGE BY AGE GROUP - STATEWIDE DATA – FY 1990-91 TO 1997-98

Age	1990-1991			1997-1998			Percent Change 90-91 to 97-98 Penetration Rate
	Clients	Population	Penetration Rate	Clients	Population	Penetration Rate	
Total[1]	320,704	29,942,397	1.07	390,695	32,956,588	1.19	11.2%
0-4	2,783	2,492,268	0.11	4,057	2,795,429	0.15	36.4%
5-9	15,847	2,225,554	0.71	26,465	2,781,335	0.95	33.8%
10-12	13,872	1,217,890	1.14	21,886	1,429,127	1.53	34.2%
13-17	32,941	1,933,420	1.70	52,260	2,245,149	2.33	37.1%
18-20	12,103	1,439,074	0.84	14,516	1,271,618	1.14	35.7%
Sub-Total, 0-20	77,546	9,308,206	0.83	119,184	10,522,658	1.13	36.2%
21-39	139,501	10,242,839	1.36	129,142	9,873,391	1.31	-3.7%
40-59	77,593	6,159,258	1.26	112,950	7,919,631	1.43	13.5%
60-64	8,656	1,103,864	0.78	9,780	1,100,514	0.89	14.1%
65+	17,035	3,128,230	0.54	16,691	3,540,394	0.47	-13.0%
Unknown	373	n/a	n/a	2,948	n/a	n/a	

[1]Total includes Other/Unknown Race/Ethnicity Group and Unknown Age Group

[2] Note: Population Count source: Department of Finance (DOF) P-3 July 1, 1990 and July 1, 1997 Reports

4. Increased Access to Mental Health Services – More Medi-Cal Eligibles Receive Mental Health Services, Particularly Foster Youth (Penetration Rate)

The number of persons eligible for Medi-Cal services who actually received one or more mental health service increased during the 10-year period from FY 1993-94 to FY 2002-03. Across all aid groups, the percent of eligibles who received specialty mental health services increased by 26.1%, from 4.98% in FY 1993-94 to 6.28% in FY 2002-03. The aid group with the highest penetration rate in FY 2002-03 is Foster Care at 49.34%, an increased of almost 15% over the 10-year period. Table 5 below displays these data.

TABLE 5 - PERCENT OF ELIGIBLES RECEIVING MENTAL HEALTH SERVICES BY AID GROUP STATEWIDE DATA - FY 1993-94 THROUGH 2002-03 (10 Years)

	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	% Change
Total	4.98%	4.98%	5.34%	5.72%	6.21%	5.95%	6.34%	6.29%	6.32%	6.28%	26.10%
Foster Care	42.98%	41.86%	43.42%	46.70%	46.68%	37.21%	42.42%	47.81%	49.74%	49.34%	14.80%
All Other Children	2.01%	2.07%	2.28%	2.68%	2.80%	2.70%	3.34%	3.27%	3.66%	3.65%	81.59%
Disabled	18.39%	18.33%	18.91%	19.65%	20.18%	19.93%	20.58%	21.20%	21.78%	21.72%	18.11%
Family Adult	4.70%	4.38%	4.53%	4.51%	4.79%	4.47%	4.32%	4.46%	4.48%	4.48%	-4.68%
Other Adult	1.03%	1.06%	1.20%	1.23%	1.43%	1.13%	1.10%	1.03%	1.05%	1.03%	0.00%

5. EPSDT Services Utilization has Increased Dramatically

During the nine year period from FY 1994-95 through FY 2002-03, the utilization of EPSDT services for children and youth under 21 years of age has increased dramatically. Total SD/MC approved dollars (FFP and match) for EPSDT services have increased 660.6%, from $107.3 million in FY 1994-95 to $709 million in FY 2002-03. The number of clients served and the overall penetration rate have also increased

dramatically. In addition, the number of clients receiving TBS has increased 6.8% from FY 2001-02 to FY 2002-03, from 2,636 to 2,814 clients respectively. Table 6 below provides an extract of SD/MC EPSDT data.

TABLE 6 - SHORT-DOYLE MENTAL HEALTH EPSDT TREND DATA
STATEWIDE DATA - FY 1994-95 through FY 2002-03

Data Elements	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2003-04	Change	
										#	%
SD/MC EPSDT Clients	61,411	67,074	76,408	96,945	123,287	131,759	141,619	158,618	173,117	111,706	182%
M/C Avg. Monthly EPSDT Eligibles	2,948,125	2,985,317	2,941,866	2,771,394	2,767,204	2,748,384	2,795,578	3,000,632	3,227,282	279,157	10%
SD/MC Cost Per EPSDT Client	$1,747.91	$2,010.44	$2,379.80	$2,436.72	$2,475.29	$3,044.26	$3,673.67	$4,388.47	$4,715.78	$2,967.87	170%
SD/MC Avg. Monthly Cost Per EPSDT Eligible	$36.41	$45.17	$61.81	$85.24	$110.28	$145.94	$186.10	$231.98	$252.96	$216.55	595%
SD/MC EPSDT Penetration Rate	2.08%	2.25%	2.60%	3.50%	4.46%	4.79%	5.07%	5.29%	5.36%	n/a	158%

6. Increased Service Usage and Intensity

One measure of program access is service utilization. There has been a rapid increase in the number of clients served and the volume of services (number of service units) being provided to clients. The clients served data is shown above. The number of statewide service units has also increased between FY 1990-91 and FY 2004-05, with the increase attributed to Medi-Cal clients and a decrease for non-Medi-Cal units.

7. More Males Receive Services in the 0-20 Age Group

The number of clients (all clients) both male and female clients increased during the period FY 1990-91 to FY 2004-05. During this period, female clients continued to be about the same percent of total clients (about 48%), while the percent of male clients declined to 51% in FY 2004-05. The decline may be partly due to the increased number of clients with an unknown or missing gender code.

Males have a higher percent of clients in the 0-20 age group than females. In FY 1997-98, males comprised 60% and females 38% of the 0-20 aged group (gender unknown makes up the difference). There were also slightly more males (52%) in the 21-39 age group in FY 1997-98. Females had a higher percent of clients in all other age groups (40-65+) than the males in FY 1997-98. Table 7 below displays these data. It should be noted that detailed information on age was not available for FY 2004-05.

TABLE 7 - NUMBER/PERCENT OF UNDUPLICATED CLIENTS BY AGE GROUP & GENDER
STATEWIDE DATA – FY 1990-91 TO FY 2004-05

AGE GROUP	MALES						FEMALES					
	1990-91		1997-98		2004-05*		1990-91		1997-98		2004-05*	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Total	170,330	100%	201,164	100%	332,571	100%	149,900	100%	182,741	100%	312,237	100%
0-4	1,570	1%	2,307	1%			1,210	1%	1,694	1%		
5-9	10,279	6%	17,206	9%			5,561	4%	8,929	5%		
10-12	9,232	5%	14,457	7%			4,634	3%	7,117	4%		
13-17	18,906	11%	30,089	15%			14,021	9%	21,387	12%		

TABLE 7 - NUMBER/PERCENT OF UNDUPLICATED CLIENTS BY AGE GROUP & GENDER STATEWIDE DATA – FY 1990-91 TO FY 2004-05												
AGE GROUP	MALES						FEMALES					
	1990-91		1997-98		2004-05*		1990-91		1997-98		2004-05*	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
18-20	7,061	4%	8,333	4%			5,034	3%	6,026	3%		
Sub-Total, 0-20	47,048	28%	72,392	36%			30,460	20%	45,153	25%		
21-39	78,888	46%	67,458	34%			60,468	40%	60,511	33%		
40-59	35,536	21%	52,224	26%			41,933	28%	59,837	33%		
60-64	3,057	2%	3,551	2%			5,586	4%	6,159	3%		
65+	5,657	3%	5,492	3%			11,338	8%	11,020	6%		
UNKNOWN	144	0%	47	0%			115	0%	61	0%		
* Note Yolo County has only reported CSI data through September 2003												
Gender-Unknown	474		6,790		2,259							

8. Increased Diversity in Race/Ethnicity, Particularly Children and Youth

The absolute number of clients in all race/ethnicity groups increased over the period from FY 1990-91 to FY 2004-05 (all clients). The percent increase in number of clients who were White was 101.8% percent, Hispanic 180.9%, Black 121%, and Asian/Pacific Islander 122.3%. The Other category declined by 18%.

The White race/ethnicity group as a percent of the total clients declined (from 56.1% to 38.7%), while the Hispanic, Black and Asian/Pacific Islander groups increased during the same time period. The number of unknown/not reported also increased significantly during this period. Table 8 below displays these data.

TABLE 8 – CHANGE IN NUMBER/PERCENT OF UNDUPLICATED CLIENTS BY RACE/ETHNICITY STATEWIDE DATA – FY 1990-91 TO FY 2004-05						
	1990-91		2004-05		Change 90-91 to 04-05	
	Number	Percent	Number	Percent	Number	Percent
Total	320,704	100.0%	647,067	100.0%	326,363	101.8%
WHITE	179,979	56.1%	250,236	38.7%	70,257	39.1%
HISPANIC	56,837	17.7%	159,648	24.7%	102,811	180.9%
BLACK	50,122	15.6%	110,746	17.1%	60,624	121.0%
ASIAN/PACIFIC ISLANDER	15,453	4.8%	34,358	5.3%	18,905	122.3%
OTHER	18,313	5.7%	15,017	2.3%	(3,296)	-18.0%
UNKNOWN/NOT REPORTED			77,062	11.9%	77,062	100.0%

As shown on Table 9, there are significant differences in race/ethnicity by age group. The 0-20 age group is much more diverse than any of the other age group. In FY 1997-98, the 0-20 age group was White – 44%, Hispanic – 28%, Black – 17%, Asian/Pacific Islander – 4%, and Other – 6%. All other age groups are more than 50% White, with a comparable and much narrower distribution of clients between the other race/ethnic groups.

TABLE 9 – CHANGE IN NUMBER/PERCENT OF UNDUPLICATED CLIENTS BY AGE GROUP & RACE/ETHNICITY STATEWIDE DATA – FY 1997-98												
Age	White		Hispanic		Black		Asian/Pacific		Other		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Total	202,900	51.9%	76,273	19.5%	61,195	15.7%	22,225	5.7%	28,102	7.2%	390,695	100%
0-4	1,616		1,230		766		171		274		4,057	
5-9	11,186		7,441		5,393		749		1,696		26,465	
10-12	9,742		5,908		4,347		597		1,292		21,886	
13-17	23,183		15,594		7,927		2,345		3,211		52,260	
18-20	6,847		3,644		2,207		795		1,023		14,516	
Sub-Total, 0-20	52,574	44.1%	33,817	28.4%	20,640	17.3%	4,657	3.9%	7,496	6.3%	119,184	30.5%
21-39	70,060	54.3%	23,599	18.3%	19,621	15.2%	7,255	5.6%	8,607	6.7%	129,142	33.1%
40-59	64,175	56.8%	15,166	13.4%	18,156	16.1%	8,202	7.3%	7,251	6.4%	112,950	28.9%
60-64	5,307	54.3%	1,534	15.7%	1,137	11.6%	964	9.9%	838	8.6%	9,780	2.5%
65+	10,736	64.3%	2,143	12.8%	1,631	9.8%	1,139	6.8%	1,042	6.3%	16,691	4.3%
Unknown	48	1.6%	14	0.5%	10	0.3%	8	0.3%	2,868	97.3%	2,948	0.8%

9. Shift in Service Delivery Strategies; More Clients Served in Community-Based Programs

There has been a shift in service delivery strategies, moving away from reliance on inpatient services to more clients served in community-based programs. There are many reasons for this shift including, but may not be limited to: realignment which gave counties the flexibility to create and use less costly and less restrictive outpatient alternatives; expansion of Adult Systems of Care funding; new and better medications; and, service practices that assist clients in remaining in the community.

For the period FY 2000-01 to FY 2004-05, there is an increase in the number of persons served in outpatient services, little change in persons served in day services, and a decline in persons served in inpatient services. When viewed by age group, the 0-20 age group experienced a greater increase in outpatient service, and a decline in day treatment services as well as inpatient services. Table 10 below displays these data.

TABLE 10 – CHANGE IN NUMBER/PERCENT OF UNDUPLICATED CLIENTS BY AGE GROUP & TYPE OF SERVICES STATEWIDE DATA – FY 2000-01 TO FY 2004-05												
Age	Inpatient Services				Day Services				Outpatient Services			
	00-01	04-05*	Change		00-01	04-05*	Change		00-01	04-05*	Change	
			#	%			#	%			#	%
Total	46,839	42,918	(3,921)	(8.4)	74,593	73,606	(987)	(1.3)	547,174	618,193	71,019	13.0
0-11	562	418			3,659	2,885			75,672	88,591		
12-17	2,613	2,656			11,809	10,845			90,270	118,083		
18-20	2,730	2,470			4,452	4,610			22,479	27,402		
Sub-Total, 0-20	5,905	5,544	(361)	(6.1)	19,920	18,340	(1,580)	(7.9)	188,421	234,076	45,655	24.2
21-39	21,000	18,315			28,138	28,112			162,936	165,032		
40 - 59	17,648	16,908			23,048	23,975			162,639	183,186		
60 - 64	1,048	1,157			1,364	1,506			14,655	17,827		
65 & Up	1,238	991			2,123	1,649			18,099	18,045		
Unknown/Not Reported	0	3			0	24			424	27		

10. Diagnostic Groups Confirm Expected Patterns for Children and Youth

For the period FY 1990-91 to FY 1997-98, the number of clients (all clients) in all diagnostic groups increased with the exception of adjustment disorders which had a 21.5% decrease. The seven diagnostic groups and distributions of clients are shown in Table 11 below.

TABLE 11 - NUMBER/PERCENT OF UNDUPLICATED CLIENTS BY DIAGNOSIS
STATEWIDE DATA – FY 1990-91 TO 1997-98

DIAGNOSIS	1990-91		1997-98		Change	
	Number	Percent	Number	Percent	Number	Percent
Total	320,704	100.0%	390,695	100.0%	69,991	21.8%
1. ADHD & Other Conduct Disorders	26,809	8.4%	43,538	11.2%	18,729	70.0%
2. Schizophrenia & Other Psychotic Disorders	84,679	26.4%	93,173	23.9%	11,494	13.6%
3. Depressive Disorders	72,491	22.6%	105,761	27.1%	33,270	46.0%
4. Bipolar Disorders	19,186	6.0%	26,032	6.7%	6,846	35.7%
5. Anxiety Disorders	18,525	5.8%	21,078	5.4%	2,553	13.8%
6. Adjustment Disorder	43,917	13.7%	34,457	8.8%	-9,460	-21.5%
7. Other MH Disorders	40,882	12.8%	45,251	11.6%	4,369	10.7%
8. Deferred/Missing	14,215	4.4%	21,405	5.5%	7,190	50.6%

Though not shown in the table above, sorting diagnosis by age group provides further illumination. The majority of individuals diagnosed with ADHD and conduct disorders are between ages 0-20 years, as would be expected. The 0-20 age group represents 97.6% of the clients with these diagnoses in FY 1997-98. In FY 1997-98, Individuals between ages 0-20 years are mostly frequently diagnosed with: ADHD and Other Conduct Disorders (35.8%); Depressive Disorders (21.3%); Adjustment Disorder (14.2%); Other Mental Health Disorders (9.2%); Anxiety Disorders (7.2%); Schizophrenia and Other Psychotic Disorders (4%); Bipolar Disorders (1.6%). Data is deferred or missing for almost 7% of clients in this age group.

11. Increased Expenditures for All Services

There has been a large increase in total expenditures for all services. County mental health programs report that the cost of services has been affected by many factors including inflation and increased service usage and service intensity in the Medi-Cal population. Data for the Medi-Cal program only, shows:

- Expenditures: From FY 1993-94 through FY 2002-03, the total expenditures for Medi-Cal specialty mental health services increased 161.2%, from $648,774,995 to $1,045,598,283. The largest percentage increase was for the Foster Care aid group, which increased 450.2%, from $55.7 million to $306.3 million. This increase, along with the 242.1% increase in expenditures for All Other Children (other than those in the Foster Care aid group), is largely due to implementation of the EPSDT program in FY 1995-96. Table 12 below displays these data.

TABLE 12 – EXPENDITURES BY AID GROUP STATEWIDE DATA – FY 1993-94 TO FY 2002-03 (10 YEARS)											
	Expenditures Shown in Millions										%
Aid Group	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	Change
Total	$648.8	$630.3	$662.9	$758.2	$834.1	$902.1	$1,038.7	$1,222.4	$1,500.3	$1,694.4	161.2%
Foster Care	$55.7	$53.9	$60.3	$76.5	$102.4	$107.9	$146.4	$205.2	$255.5	$306.3	450.2%
All Other Children	$112.0	$98.2	$103.8	$128.2	$147.5	$159.5	$199.2	$251.7	$338.6	$383.1	242.1%
Disabled	$412.8	$411.9	$435.6	$488.2	$514.7	$564.2	$616.5	$678.1	$795.8	$881.1	113.4%
Family Adult	$50.9	$49.1	$45.2	$46.0	$49.4	$54.1	$57.6	$65.0	$81.2	$89.3	75.4%
Other Adult	$17.4	$17.2	$17.9	$19.3	$20.2	$16.4	$18.9	$22.4	$29.2	$34.6	98.8%

- Expenditures per Medi-Cal Eligible – The expenditures per average monthly eligible has increased across all aid groups. During the 10-year period from FY 1993-94 through FY 2002-03, expenditures per average monthly eligible increased 117.8%, from $117.48 to $255.90. The Foster Care aid group had the highest expenditures per eligible and the biggest increase over the 10-year period, from $745.42 in FY 1993-94 to $3,351.60 in FY 2002-03, an increase of 349.6%.

  During the same period, the All Other Children aid group increased 213.5%, from $41 to $129.42 per eligible. Again, the increases in the Foster Care and All Other Children aid group expenditures are largely due to the implementation of the EPSDT program. Table 13 below displays these data.

TABLE 13 - EXPENDITURES PER AVERAGE MONTHLY ELIGIBLE BY AID GROUP STATEWIDE DATA - FY 1993-94 TO 2002-03 (10 Years)												
Aid Group	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	Change	% Change
Total	$117.48	$112.15	$116.65	$135.51	$157.27	$172.71	$196.81	$218.11	$245.70	$255.90	$138.42	117.83%
Foster Care	745.42	700.26	740.99	888.42	1,056.62	1,150.86	1,584.04	2,367.94	2,936.28	3,351.60	2,606.18	349.63%
All Other Children	41.29	35.77	37.47	47.29	58.47	63.79	83.56	98.19	122.92	129.42	88.13	213.45%
Disabled	576.71	555.13	552.17	605.92	634.30	680.83	726.50	781.43	884.80	921.61	344.90	59.81%
Family Adult	43.22	40.40	38.08	40.54	47.77	52.53	52.19	60.71	66.99	67.70	24.48	56.64%
Other Adult	20.66	20.45	21.00	22.49	24.07	21.30	22.31	22.08	25.30	26.70	6.04	29.24%

- Expenditures per Client – Expenditures per client across all aid groups increased 72.8%, from $2,358 per client in FY 1993-94 to $4,074 per client in FY 2002-03. The largest increase over the 10 years was for the Foster Care aid group, which increased 291.7%, from $1,734 per client to $6,793 per client. Table 14 below displays these data.

TABLE 14 - EXPENDITURES PER UNDUPLICATED CLIENT BY AID GROUP STATEWIDE DATA - FY 1993-94 TO 2002-03 (10 Years)												
Aid Group	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	Change	% Change
Total	$2,357.82	$2,249.97	$2,185.71	$2,367.43	$2,531.91	$2,904.82	$3,104.88	$3,467.86	$3,890.57	$4,074.32	$1,716.50	72.8%
Foster Care	$1,734.24	$1,672.95	$1,706.41	$1,902.50	$2,263.45	3,092.48	3,734.11	4,953.25	5,902.75	6,792.63	5,058.39	291.7%
All Other Children	$2,059.34	$1,728.43	$1,643.17	$1,766.70	$2,090.47	2,359.43	2,503.26	3,003.29	3,361.03	3,546.76	1,487.42	72.2%
Disabled	$3,135.89	$3,028.22	$2,920.41	$3,083.71	$3,144.02	3,415.57	3,530.46	3,686.65	4,061.92	4,243.39	1,107.50	35.3%
Family Adult	$919.45	$923.59	$841.16	$898.89	$998.29	1,174.44	1,207.54	1,361.51	1,496.24	1,511.43	591.98	64.4%
Other Adult	$2,014.19	$1,933.37	$1,757.58	$1,823.69	$1,680.32	1,893.31	2,019.81	2,144.35	2,399.88	2,598.01	583.82	29.0%

B. COUNTY CHILDREN'S SYSTEM OF CARE COORDINATOR'S SURVEY

The CMHPC Children and Youth Subcommittee conducted a statewide survey of all 59 county CSOC Coordinators. The 59 county mental health programs include all 58 counties (two of which jointly administer a single MHP [Sutter-Yuba] and two city programs [City of Berkeley and Tri-City]). The Sub-committee designed survey instrument consists of 18 questions; six (6) of which have two parts resulting in a total of 24 questions. Of the 24 questions, the possible responses types are: 12 one word or yes/no; 3 Likert-scale rating (respondents specified their opinion using a scale); and 9 open-ended requiring a narrative response. Together, the questions and responses are intended to provide information about the nature and type of county mental health program services available to foster children/youth and their families or other caregivers.

The survey was administered on-line (launched December 14, 2004), although many responses were received in hard copy via mail. A total of 46 county/city mental health programs responded to the survey; this represents 78% of the possible universe of 59 respondents. Of the total responses received, 24 were received on-line and 23 hard copy/mail. One county responded twice (via paper and electronically), but only one response is included in the respondent total. Interestingly, the county that responded twice provided the same or consistent answers to most questions, but not in all cases. The differences and resolutions are identified in the analysis. Thirteen (13) or 22% of county/city mental health programs did not respond to the survey.

The electronic submissions were received through a proprietary system called Zoomerang. This system enables respondent survey completion and submission electronically and also enables electronic tabulation of responses. The system accumulates one word and Likert-scale responses by number of respondents and percentage of the total and provides a "results overview" in graphical form. On the other hand, narrative responses to open-ended questions can only be assembled by question and provided for manual analysis by the user (the Subcommittee).

There were minor differences between the electronic and hard copy survey forms, which required adjustment during the analysis. Specifically, the Zoomerang-administered survey form contained four choices (poor, fair, good and excellent) in the three Likert-scale questions (questions #7, #11, and #16); whereas the hard copy form contained five choices (Poor 1 – 2 - 3 - 4 - 5 Excellent). In many cases, the responses themselves helped to clarify the respondents' intent and resulted in the decision to eliminate "1" and equate the numbers as follows: 2 = poor, 3 = fair, 4 = good, and 5 = excellent. Moreover, most responses were at the high-end of the scale, i.e., 4 and 5.

All responses were received during the period from December 2004 through August 2005. The Zoomerang survey responses were received in December 2004 and January 2005. The hard copy survey was distributed by the CMHPC in mid-June 2005 and mailed responses were received mostly in June and July 2005 (one response was received in August 2005). Therefore, it is assumed that the survey response data address the nature of county mental health services as of or prior to FY 2004-05.

While the survey was analyzed by CMHPC staff, it was not written-up. Therefore, due to the difficulties in re-constructing the original analysis, a new analysis was completed. The following provides highlights of the data analysis.

1. Plan for Mental Health Services for Foster Care Youth (In-County and Out-of-County) (Questions #2 & #3)

These questions asked if there is a plan for mental health services for children and youth in foster home/group home care placed in-county and out-of-county – Yes or No? The responses to both questions were the same. There were a total of 46 responses, with 41 responding "yes" and 5 responding "no."

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #2		
HAVE A PLAN FOR MENTAL HEALTH SERVICE FOR CHILDREN/YOUTH PLACED IN FOSTER CARE IN-COUNTY		
Response	Number Respondents	Percent Respondents
Yes	41	89% of respondents
No	5	11% of respondents
Total	46	100% of respondents

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #3		
HAVE A PLAN FOR MENTAL HEALTH SERVICE FOR CHILDREN/YOUTH PLACED IN FOSTER CARE OUT-OF COUNTY		
Response	Number Respondents	Percent Respondents
Yes	41	89% of respondents
No	5	11% of respondents
Total	46	100% of respondents

Four counties responded "No" to both questions and did not have a plan for placements in-county or out-of-county. Two other counties had differing responses: one county had an in-county but no out-of-county placement plan, and the other county did not have an in-county but had an out-of-county placement plan.

2. Early Intervention Plan to Avoid Placement (Question #4)

This question asked if the county has an early intervention plan for alternatives to placement and/or at point of placement – Yes or No? Respondents were further requested to describe the plan. There were a total of 45 responses (1 additional county did not respond to this particular question), with 40 (89%) responding "yes" and 5 (11%) responding "no."

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #4		
HAVE AN EARLY INTERVENTION PLAN FOR ALTERNATIVES TO PLACEMENT IN FOSTER CARE		
Response	Number Respondents	Percent Respondents
Yes	40	89% of respondents
No	5	11% of respondents
Total	45	100% of respondents

The descriptions of the early intervention plan to avoid placement ranged from: processes used prior to placement and/or after-placement, a single service type, and/or

an array of services or service types. The responses grouped into six (6) types in descending frequency are:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #4		
DESCRIPTION OF EARLY INTERVENTION PLAN		
RESPONSE	# OF RESPONDENTS	% OF TOTAL RESPONDENTS
1. Interagency Placement Committee, collaboration, and/or team decision-making	21	47%
2. Local mental health services	14	31%
3. SB 163 Wraparound (including associated services)	14	31%
4. CSOC	7	16%
5. Other services	6	13%
6. TBS	4	9%

In general, the responses seem to demonstrate recognition of the importance of early intervention services to avoid placement. However, a survey format provides only a snapshot response, i.e., it likely does not give a full description of processes or services. Therefore, a respondent's failure to mention a particular process or service does not mean that it is unavailable.

3. Alternatives to Foster Care (Question #5)

This question asked what alternatives to foster care are offered. There were a total of 45 responses; three responses indicated either that the question was "N/A" or "none" (1 additional county did not respond to this particular question). The 42 responses that described alternatives mostly identified specific services, with most respondents listing or describing more than one service. In general, the responses seem to demonstrate recognition of the importance of offering alternatives to foster care placement. However, as noted above for the prior question, a survey format provides only a snapshot response and likely does not give a full description of services available. The services mentioned grouped into nine (9) types in descending frequency are:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #5		
ALTERNATIVES TO FOSTER CARE		
RESPONSE	# OF RESPONDENTS	% OF TOTAL RESPONDENTS
1. Local mental health services	19	42%
2. SB 163 Wraparound	14	31%
3. Family preservation	12	27%
4. TBS	11	25%
5. In-home services	7	16%
6. CSOC	4	9%
7. Multi-Dimensional Treatment Foster Care (MTFC)	3	7%
8. Intensive mental health case management	3	7%
9. N/A or none	3	7%

4. Foster Youth Access to Specialty Mental Health Services (Question #6)

This question asked if children/youth in foster home/group home care in your county have access to specialty mental health services, e.g., TBS, SB 163 Wraparound, Day Treatment, Multi-Dimensional Treatment Foster Care (MTFC), and Transitional Housing – Yes or No. If yes, indicate which services. There were a total of 46 responses, all of which responded "Yes." The responses grouped into seven (7) types in descending frequency are:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #6		
ACCESS TO SPECIALTY MENTAL HEALTH SERVICES		
RESPONSE	# OF RESPONDENTS	% OF TOTAL RESPONDENTS
1. TBS	43	94%
2. Day treatment	25	54%
3. SB 163 Wraparound	23	50%
4. Local MH services (therapy, crisis intervention, medication support, etc)	23	50%
5. Transitional Housing	12	26%
6. MTFC	9	20%
7. Other (educational-related services, etc)	3	7%

While some respondents selected only from the five services listed in the question, others expanded upon the listing. The listing may have artificially limited respondent answers, i.e., in most cases, respondents appear to have chosen only from the list.

5. Opinion on Quality of Services Received by Foster Youth (Question #7)

This question asked respondents for their opinion regarding the quality of services received by foster youth using a rating scale of poor, fair, good or excellent. As previously noted, differences in the rating scale between the electronic and hard copy survey forms were adjusted during the analysis. The Zoomerang survey used a 4-point rating scale & the hard copy survey used a 5-point rating scale. The analysis used a 4-point rating scale by dropping "1". It is noted that respondents often gave other indications of their intended rating, e.g., circled the word "excellent" or added verbiage. There were a total of 45 responses (1 additional county did not respond to this particular question), as follows:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #7		
QUALITY OF MENTAL HEALTH SERVICES RECEIVED BY FOSTER CHILDREN/YOUTH		
RESPONSE	# OF RESPONDENTS	% OF TOTAL RESPONDENTS
Excellent	11	25%
Good	29	65%
Fair	4	9%
Poor	1	2%

6. Children/Youth Participation in Service Delivery (Question #8)

This question asked respondents if children/youth are given voice, choice and preference in the type of mental health services they receive – Yes or No. If yes, respondents were further asked how this happens. There were a total of 46 responses, with 39 (85%) of respondents answering "yes" and 7 (15%) answering "no." Most of the respondents answering "yes" described a single approach to how children/youth are given voice, choice and preference in the types of mental health services they receive. The responses grouped into five (5) types in descending frequency are:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #8		
MANNER IN WHICH CHILDREN/YOUTH IN FOSTER CARE ARE GIVEN CHOICE, VOICE AND PREFERENCE IN SERVICES		
RESPONSE	# OF RESPONDENTS	% OF TOTAL RESPONDENTS
1. Involvement in treatment planning process	26	57%
2. Requesting and considering child/youth preferences in services and providers	7	15%
3. Involvement of children/youth in policy, program and practice (e.g., Youth Advocates programs, Youth Council, etc)	4	9%
4. Staffing approach or interview process	2	4%
5. Answer not directly responsive to question	2	4%

7. Reunification Plans (Question #9)

This question asked if the county had a reunification plan for foster children/youth and their families – Yes or No. There were 44 responses (2 additional counties did not respond to this particular question), with 36 (82%) of respondents answering "yes" and 8 (18%) answering "no."

8. Services and Assistance to Families and Caregivers (Question #10)

This question asked what services or assistance do counties/cities offer to parents, family members, foster parents and/or other caregivers. There were 46 responses to this question; all counties that participated in the survey offered a response. The responses mostly identified specific services that are provided to parents and caregivers, with most respondents listing or describing more than one service. The services grouped into eight (8) types in descending frequency are:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #10		
SERVICE/ASSISTANCE OFFERED TO PARENTS, FAMILY MEMBERS, FOSTER PARENTS, AND/OR OTHER CAREGIVERS		
RESPONSE	#	% TOTAL
1. Individual and family therapy	19	43%
2. Parent Partner, support groups and advocacy	18	41%
3. Interagency/community support (e.g., respite, community linkages, information and referral, transportation, drug/alcohol treatment, etc)	15	34%
4. Specialty MH services	14	32%
5. Case management	6	14%
6. Parent training	3	7%
7. Medication services	2	5%
8. Not specific	2	5%

Some respondents also mentioned parent/caregiver inclusion in the treatment process, e.g., being equal partners of the team, participation in family team meetings and team decision-making. Parent and caregiver participation is addressed in the question below.

9. Opinion on Quality of Services Received by Families/Caregivers (Question #11)
This question asked respondents for their opinion regarding the quality of services received by parents, family members, foster parents and/or other caregivers using a rating scale of poor, fair, good or excellent. There were a total of 45 responses (1 additional county did not respond to this particular question), as follows:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #11		
QUALITY OF MH SERVICES RECEIVED BY PARENTS, FAMILY MEMBERS, FOSTER PARENTS & OTHER CAREGIVERS		
RESPONSE	# OF RESPONDENTS	% OF TOTAL RESPONDENTS
Excellent	13	29%
Good	23	51%
Fair	8	18%
Poor	1	2%
Note: see Question #5 above – the same qualification re: rating scales applies.		

10. Family/Caregiver Participation in Service Delivery (Question #12)
This question asked if parents, family members, foster parents and/or other caregivers are given voice, choice and preference in the type of mental health services they receive – Yes or No. If yes, respondents were further asked how this happens. There were 45 responses (I additional county did not respond to this particular question), with 43 (96%) of respondents answering "yes" and 2 (4%) saying "no."

The responses to this question seemed to identify a primary approach used to involve families and caregivers in their mental health service planning and delivery, although many respondents described more than one approach. The approaches grouped into seven (7) types in descending frequency are:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #12		
MANNER IN WHICH PARENTS, FAMILY MEMBERS, FOSTER PARENTS AND OTHER CAREGIVERS ARE GIVEN CHOICE, VOICE AND PREFERENCE IN SERVICES		
RESPONSE	# OF RESPONDENTS	% OF TOTAL RESPONDENTS
1. Involvement in treatment planning	25	56%
2. Offered choice of services and providers	13	29%
3. Involvement and/or input to mental health policy, program and practice (e.g., satisfaction surveys, focus groups, advisory groups, etc)	8	18%
4. Informing materials made available (e.g., client's rights, complaint process, freedom of choice, etc)	3	7%
5. Staff approach	1	2%
6. Interview process	1	2%
7. Non-specific	1	2%

11. Cultural Competence (Questions #13 & #14)

There were two questions that addressed the topic of cultural competency. Respondents were asked if their county's cultural competency plan includes a component relating to youth in foster/group home placement – Yes or No. If yes, respondents were asked to describe the contents of that plan component. Respondents were also asked if treatment services are provided in the primary language of the client and/or family.

There were 45 responses (1 additional county did not respond to this particular question) regarding the cultural competency plan component, with 16 (36%) of respondents answering "yes," 28 (62%) answering "no," and 1 (2%) saying "not sure." It is also noted that 4 of the counties responding "yes" (1) or "no" (3), also expressed lack of certainty about their answer. Furthermore, the 1 county that responded both by Zoomerang and hard copy gave contrary answers (i.e., yes and no); the "yes" answer was recorded in the tally because it gave added information about the plan and the "no" answer expressed doubt about what question meant.

Fourteen (14) of the 16 respondents answering "yes" to having a cultural competency plan component for foster youth provided further information; however, for the most part, the answers did not describe the cultural competence plan component. Instead, the answers mostly addressed general cultural competence topics. The 14 answers grouped by topic(in descending frequency are:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #13		
COMPONENT IN CULTURAL COMPETENCY PLAN THAT ADDRESSES CHILDREN/YOUTH IN FOSTER./GROUP PLACEMENT		
RESPONSE	#	% TOTAL
1. Non-responsive and/or non-specific response about cultural competence plan	10	63%
2. General description of importance and/or approaches to achieve cultural competence, (e.g., staff recruitment, service provider recruitment, interpreters, committee oversight, etc.)	2	13%
3. Interpretation of what is required (e.g., address cultural issues in assessment, treatment planning, etc.)	2	13%

In response to the question relating to the provision of services in the primary language of the client or family member, there were 45 respondents (the last page of the survey for one additional county was missing), with 43 (96%) of respondents saying "yes" and 2 (5%) of respondents saying "no."

12. TBS Services (Question #15)

This question asked if transition-aged youth (age 18-21 years) are receiving TBS services – Yes or No. If yes, respondents were further asked how many youth are receiving services. There were 45 responses (1 additional county did not respond - last page of survey missing), with 27 (60%) of respondents saying "yes" and 18 (40%) of respondents saying "no." The respondents answering "yes" were further asked to indicate how many youth were receiving TBS services. The answers given were:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #15		
YOUTH BETWEEN THE AGES OF 18 AND 21 RECEIVING TBS SERVICES		
# YOUTH RECEIVING TBS SERVICES	# OF RESPONDENTS	% OF YES RESPONDENTS
5	1	4%
2-3	2	7%
1	2	7%
0	10	37%
No # or # Unknown	12	45%

This question appears to have been highly prone to differing interpretation. Some respondents seem to answer "no" if no youth are currently receiving TBS services, even though the service is available. At least 7 "no" respondents appear to answer in this way. In the same situation, other respondents answered "yes" TBS services are available, but no youth are currently eligible/receiving service. Changing the answer of these 7 respondents would increase the "yes" responses to 75%, up from 60%.

13. Opinion on Quality of Mental Health Services for Foster Youth (Question #16)

This question asked respondents to rate the overall quality of mental health services for children/youth in foster home/group home care in your county using the rating scale of poor, fair, good or excellent. There were 44 responses (2 additional counties did not respond -1 due to last page of survey missing) as follows:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #16		
OVERALL QUALITY OF MENTAL HEALTH SERVICES FOR CHILDREN/YOUTH IN FOSTER HOME/GROUP HOME CARE		
RESPONSE	# OF RESPONDENTS	% OF TOTAL RESPONDENTS
Excellent	10	23%
Good	22	50%
Fair	10	23%
Poor	2	5%
Note: see Question #5 above – the same qualification re: rating scales applies.		

14. Barrier to Providing Services (Question #17)

This question asked respondents to identify the barriers to providing mental health services to children/youth in foster home/group home care. There were 43 (3 additional counties did not respond, i.e., 2 indicated "N/A" and 1 - last page of survey missing). The responses identified a variety of barriers, with most respondents identifying more than one. The barriers grouped into ten (10) types in descending frequency are:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #17		
BARRIERS TO PROVIDING MENTAL HEALTH SERVICES TO CHILDREN/YOUTH IN FOSTER HOME/GROUP HOME CARE		
RESPONSE	# OF RESPONDENTS	% OF TOTAL RESPONDENTS
1. Funding issues	14	33%
2. Interagency collaboration issues (e.g., difficulty working with CPS, courts, Value Options, others)	13	30%

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #17		
BARRIERS TO PROVIDING MENTAL HEALTH SERVICES TO CHILDREN/YOUTH IN FOSTER HOME/GROUP HOME CARE		
RESPONSE	# OF RESPONDENTS	% OF TOTAL RESPONDENTS
3. Out-of-county placements issues	12	28%
4. Human resources (e.g., shortage of MH professionals, insufficient number of staff, caseload ratios, etc)	9	21%
5. Lack of foster/group home care providers (in-county)	6	14%
6. Transportation	6	14%
7. Lack of continuity of care and/or frequent placement changes	5	12%
8. No CSOC	3	7%
9. Establishing constructive relationship with parents, families, caregivers	3	7%
10. Miscellaneous other barriers (e.g., geographic distances, rural vs. city location, lack of appropriate languages, etc)	10	23%

15. Suggestions for Improvement (Question #18)

This question asked for suggestions for improvement in the quality of mental health services provided to children/youth in foster home/group home care in your county. There were 43 responses (3 additional counties did not respond -1 no response, 1 indicated "N/A" and 1 - last page of survey missing). The responses identified a number of suggestions, with most respondents offering more than one suggestion. The suggestions grouped into nine (9) types in descending frequency are:

COUNTY SYSTEM OF CARE COORDINATOR STUDY – QUESTION #18		
SUGGESTION TO IMPROVE MENTAL HEALTH SERVICES FOR CHILDREN/YOUTH IN FOSTER HOME/GROUP HOME CARE		
RESPONSE	# OF RESPONDENTS	% OF TOTAL RESPONDENTS
1. More resources (i.e., funding, flexible funding & services, including service expansions & reinstatement of CSOC)	22	51%
2. Improve interagency collaboration	11	26%
3. Prevention, early detection and screening of mental illness	10	23%
4. Recruit and retain MH staff (includes increasing number of staff & bilingual staff)	7	16%
5. Continuous training for staff, foster care staff and MH professionals	6	14%
6. More placement options, including more foster homes	5	12%
7. More support to caregivers	5	12%
8. More transportation	3	7%
9. Miscellaneous other	7	16%

C. KEY FINDINGS

This phase of the study provides significant information about the nature of mental health services provided to foster children and youth and their families. Two sources of data were used: statistical data available from DMH; and a county mental health CSOC Coordinator's Survey. Together, these sources provide both factual and

experiential/anecdotal insight about the nature of mental health services provided to foster children and youth.

The DMH routinely collects a wealth of data pertaining to mental health clients and the services they receive at the county level. DMH analyzes and publishes large quantities of data related to utilization and expenditures for mental health services. The data are maintained by county as well as by age, gender, ethnicity, service type, diagnosis, funding source, etc. The data show that there has been:

- A large increase in the total number of clients served in the public mental health system, particularly children and youth, which exceeds the rate of growth in the general population;
- Within the Medi-Cal program aid groups, the number of clients served in the Foster Care aid group has increased 40.5%;
- Moreover, the Medi-Cal Foster Care aid group has a penetration rate of 49.3%, which means that almost 50% of all eligible Medi-Cal eligible foster children received one or more mental health services in FY 2002-03 (this penetration rate is significantly higher than all other aid groups);
- Medi-Cal program expenditures for the Foster Care aid group have increased significantly from FY 1993-94 to FY 2002-03, largely due to the expansion of EPSDT services. For this aid group, the average cost per eligible was $3,352 (an increase of almost 350%), and the average cost per client was $6,793 (an increase of almost 300%). These average costs are significantly higher than for all other aid groups.

These data provide an important tool for public oversight of the service delivery system. It is possible to track the impact of policy decisions using the available data. The limitations of the data are found in the currency of the available data and the fact that it is impossible to judge the quality, availability or the manner in which services are being delivered. These limitations are overcome to some extent through periodic surveys of the system partners and stakeholders.

While, the CSOC survey had some limitations with respect to the manner in which the data were collected and in the survey instrument, it lends valuable information in identifying barriers and suggesting improvements to address those barriers. The identified barriers to services and the suggested solutions tend to be opposites; they include:

- Funding restrictions and limitations;
- Interagency collaboration;
- Out-of-county placements;
- Human resources shortages; and,
- Availability of quality services.

Together, the information provides a good sense of the services currently provided to foster children/youth and the areas of focus in future monitoring and oversight activities.

V. ANALYSIS OF SURVEYS FROM SERVICE RECIPIENTS

Part V of this report discusses the analysis of information collected from two surveys of recipients of mental health services: Children and Youth; and Parents, Families, Foster Parents, or Other Caregivers. The Subcommittee developed both surveys, which were administered in hard copy through the offices and members of a statewide child welfare/foster care provider association. The children and youth surveyed were the direct recipients of mental health services. The caregivers are the "arrangers of care" for the children and youth.

A. PARENT, FAMILY, FOSTER PARENT, OR OTHER CAREGIVER SURVEY

The CMHPC Children and Youth Subcommittee designed a survey instrument for distribution to parents, families, foster parents or other caregivers of children and youth in foster care with mental health needs. The purpose of the survey was to identify the availability and quality of mental health services to children and youth in foster care. The survey consists of 13 questions. One question had two parts and another question had three parts resulting in a total of 16 questions. Of the 16 questions, the possible responses types were: 2 multiple choice; 8 "yes" or "no"; 3 Likert-scale type (respondents specified their opinion using a scale); and 3 open-ended requiring a narrative response. Together, the questions and responses were intended to inform the Subcommittee about the accessibility, availability, type and quality of county mental health program services available to foster children/youth.

The survey, along with the survey for Children/Youth that is discussed in the next section, was distributed through the California Alliance of Child and Family Services to its member Foster Family Agencies (FFA). The surveys were transmitted to the FFAs with a cover memo from the Executive Director of the Alliance. The memo instructed the FFA to "Reproduce the surveys and distribute the appropriate surveys to at least two foster parents and two children/youth for each social worker/caseworker in your FFA." The memo indicted that the surveys could be distributed in meetings, when FFA staff visited the foster homes, "or in any other way you think will be manageable for your staff, foster parents and children and youth." The memo indicted that the participants should be informed that the surveys were anonymous. Finally, the memo instructed that distribution of the surveys be limited to "those who can understand and complete the questions; however, it is fine to help respondents understand the questions and write their responses." The instructions requested that completed surveys be mailed by January 26, 2006 to the CMHPC. Surveys were received between January and March 2006.

It is unknown how many surveys were distributed. There were a total of 220 surveys returned from 26 FFA located in 26 counties. The number of surveys received from the agencies ranged from one to 22. Most (71%) of the 220 respondents were foster parents or other caregivers. Sixty (60) responses were un-coded as to respondent. Each survey response represented a child or youth in the FFA. The survey asked for identification of the residence county and, where different, the placement county. Thirty-five counties were listed as either the county of residence or placement. Twenty-three (23) counties were neither the placement nor the residence county. San Diego is

the largest county among the 23. The data entry and analysis of the survey required two adjustments.

1. Open ended questions were reviewed and categorized as to type. Since a foster parent may have filled out more than one survey, the comments with respect to what could be done to improve the system were identical. When frequency counts were maintained, the identical comments were counted as one response.
2. There was more than one version of the survey. In some cases there was an additional option under the type of mental health service received by the foster child or youth and under the unmet needs. The additional options were coded consistently to conform to an option in the survey used by most of the respondents.

The data collected through the Parent, Family, Foster Care or Other Caregiver Survey cannot be generalized to the system as a whole. However, the information does provide useful information from the perspective of the foster parents who are the "arrangers of care" for the children and youth in foster care. A summary of the survey responses follows.

1. Types of Mental Health Services Received by Children and Youth (Question #1)
The survey asked respondents to indicate the mental health services the child or youth was receiving. There were seven (7) options listed and the instructions indicated that an X be placed by each service the child or youth was receiving. There were a total of 313 service options listed on the surveys. This is an average of 1.5 services per survey (excluding the no service option). The table that follows shows the number and percentage of the 220 surveys for each option. The most frequently provided service was in an office with a therapist/counselor (62%) followed by meeting a therapist/counselor in an individual or group setting (42%). Twenty-seven (11%) of the surveys indicated that the child or youth currently received no mental health service. Seventeen of the 27 indicated that the child or youth did not have unmet mental health needs.

PARENT, FAMILY, FOSTER CARE OR OTHER CAREGIVER SURVEY QUESTION #1		
TYPE OF MENTAL HEALTH SERVICES RECEIVED BY CHILDREN AND YOUTH		
SERVICE OPTIONS	#	% 220
Meet in an office with a therapist/counselor	136	62%
Meet with a therapist/counselor in an individual or group setting	92	42%
Get help in the classroom from a therapist /counselor	22	10%
Go to a counseling program at least two hours a day at school or outside of school (Day Treatment)	3	1%
Get help from a therapist/counselor who goes places with me	20	9%
Live in a place where there is special help available	13	6%
None	27	11%
Total	313	
Average Number of Services Per Survey Excluding No Service Option	1.5	

2. Medication for Moods (Question #2)

The survey asked whether the child/youth receiving mental health services was getting medication for his/her moods. Sixty-nine (31%) of the children/ youths was reported as receiving medication. Six (9%) of the 69 children or youths were not receiving any service at the time the survey was completed.

3. Opinion on Ease in Acquiring Services (Question #3)

Respondents were asked to rate their experience in obtaining the mental health services described above for children/youths receiving mental health services. The ratings choices were: Very Difficult (1); Somewhat Difficult (2); Somewhat Easy (3); and Very Easy (4). The table below shows the ratings from the 191 surveys that responded to the question. The overall average rating for the surveys that specified a rating was 3.2. The ratings may not be an entirely accurate picture of the ease in obtaining mental health services since it was not clear that the services in question were provided through county mental health or some other provider. Also, in some cases it appears that the same person filled out multiple surveys.

PARENT, FAMILY, FOSTER CARE OR OTHER CAREGIVER SURVEY QUESTION #3						
EASE IN OBTAINING SERVICES						
TOTAL SURVEYS RESPONDING	% TOTAL SURVEYS	SATISFACTION RATINGS				
		1 VERY DIFFICULT	2 SOMEWHAT DIFFICULT	3 SOMEWHAT EASY	4 VERY EASY	AVERAGE RATING
191	86.8%	17	19	59	96	3.2

4. Unmet Mental Health Service Needs (Question #4)

Respondents were asked to list the unmet mental health service needs of the children or youth described in the surveys. The same options for services were listed as those listed for the first question above. Most (69%) of the surveys listed no unmet service needs. Sixty-four (31%) of the surveys listed one or more unmet mental health service need. These are shown in the table below. The average number of unmet service needs reported on the 64 surveys was 1.4.

PARENT, FAMILY, FOSTER CARE OR OTHER CAREGIVER SURVEY QUESTION #4		
UNMET MENTAL HEALTH SERVICE NEEDS		
SERVICE OPTIONS	# RESPONSES	% 64 SURVEYS
Meet in an office with a therapist/counselor	27	42%
Meet with a therapist/counselor in an individual or group setting	21	33%
Get help in the classroom from a therapist /counselor	17	27%
Go to a counseling program at least two hours a day a school or outside of school (Day Treatment)	6	9%
Get help from a therapist/counselor who goes places with me	12	19%
Live in a place where there is special help available	4	6%
Average number of unmet needs	1.4	

5. Opinion on Overall Quality of Mental Health Services (Question #5)

Respondents were asked to rate the overall quality of the mental health services received by the children/youths. The ratings were: Poor (1); Fair (2); Good (3); and Excellent (4). There were ratings on 182 of the 220 surveys. A summary of the ratings is shown on the following table. The overall average for these 182 surveys was 3.1. As with Question #2 on ease of obtaining these services, these ratings may not be an accurate picture of what is happening.

PARENT, FAMILY, FOSTER CARE OR OTHER CAREGIVER SURVEY QUESTION #5						
OPINIONS ABOUT OVERALL RATING OF MENTAL HEALTH SERVICES						
TOTAL SURVEYS RESPONDING	% TOTAL SURVEYS	RATINGS OF OVERALL QUALITY				
		1 POOR	2 FAIR	3 GOOD	4 EXCELLENT	AVERAGE RATING
192	82.7%	13	20	77	72	3.1

6. Choice in the Type of Mental Health Services (Questions #6 and 7)

The next questions in the survey have to do with choice and respect. Question #6 asks whether the child or youth was given a choice and had his/her preferences respected in the type of mental health service s/he receives. This question was answered affirmatively on 138 (63%) of the surveys. Forty-eight (22%) responses indicated that the child had not had a choice and 34 surveys did not answer the question.

Question #7 is a two part question. The first part of the question asks whether the respondent was given a choice in the type of mental health services received by the child/youth. There were 137 (63%) surveys that indicated that the respondent did have a choice in services. Of the remaining surveys, 49 (22%) respondents indicated that they did not have a choice and 34 did not answer the question. This is the same proportions as the responses to Question #6.

The second part of Question #7 asked how the choices and preferences had been acknowledged. Forty-nine (36%) of the 137 surveys provided an example of how their preferences had been acknowledged. The following table shows the response to the second part of Question #7 on the 137 surveys that indicated that the respondent had a choice in services.

PARENT, FAMILY, FOSTER CARE OR OTHER CAREGIVER SURVEY QUESTION #7		
ACKNOWLEDGEMENT OF CHOICE OR PREFERENCE		
HOW CHOICE OR PREFERENCE IS ACKNOWLEDGED	# SURVEYS	% TOTAL
No comment or explanation	56	41%
"Yes"	28	20%
Implemented in treatment plan and discussed	9	7%
Receives requested/needed service	7	5%
Choice of type, time and/or location of therapy	7	5%
Communication with professionals	6	4%
"N/A"	4	3%
Complied with request	3	2%
Choice of therapist	3	2%

PARENT, FAMILY, FOSTER CARE OR OTHER CAREGIVER SURVEY QUESTION #7		
ACKNOWLEDGEMENT OF CHOICE OR PREFERENCE		
HOW CHOICE OR PREFERENCE IS ACKNOWLEDGED	# SURVEYS	% TOTAL
Quarterly/annual review	3	2%
Participate in therapy	2	1%
Choice and preference acknowledged	2	1%
Offered through FFA	2	1%
Sometimes/so far	2	1%
Counselor doesn't seek information from Foster Parent	1	1%
Respected only after assertiveness	1	1%
Child understands not her fault	1	1%
Total	137	100%

7. Cultural Sensitivity in Service Delivery (Questions #8 and 9)

Question # 8 has two parts. The first part asks whether the mental health services were provided in a culturally sensitive manner. The response option is a "yes" or "no". The second part provides a space for comments or amplification on the response.

- The majority (72%) of the responses to Question #8 were affirmative. Six of the 158 affirmative responses had comments explaining how the services were culturally sensitive, e.g., bilingual therapists.
- Twenty-eight (13%) surveys did not answer the question. Four of the 28 were incomplete surveys in which only the first page was transmitted.
- Eighteen (8%) surveys indicated "not applicable". There were no comments.
- The respondents answered "no" in 13 (6%) surveys. There was one comment indicating that translators were not always available.
- Two surveys indicated that no services were provided. One survey answered "unknown".

Question #9 asked if the services were provided in the child's/youth's primary language. The response option is a "yes" or "no". Most (175) of the responses were "yes". There were six "no" responses and four "not applicable" responses. Twenty-six surveys left the answer blank.

8. Substance Abuse Services (Question #10)

Question #10 asked if the child or youth had problems with substance abuse and, if so, did the mental health service delivery system provide substance abuse services. Finally, the survey asks respondents to rate the substance abuse services as Harmful (1), Not at All Useful (2), Somewhat Useful (3), or Very Useful (4). Eight surveys reported that the child or youth had substance abuse problems. Four of the eight individuals received substance abuse services. Two of the four services were rated. One was rated as Somewhat Useful (3) and the other was rated as Very Useful (4).

9. One-on-One Counseling Services for Youth between Ages of 18 and 20 (Question #11)

The question on one-on-one counseling services for youth between the ages of 18 and 20 has two parts. The first part asks if the subject of the survey is between 18 and 20.

If the answer is yes, respondents are asked whether the individual is receiving one-on-one counseling several hours a week in the home or community. There are three possible responses: "yes", "no" or "don't know". Eight individuals were between 18 and 20 years old. Five of the eight were receiving one-on-one counseling services.

10. Suggestions and Other Comments (Questions #12 and 13)

Question #12 asked respondents to make suggestions for the improvement in the quality of mental health services provided to children/youth in foster home/group home care in their county or in the county where the child/youth has been placed. There were 94 suggestions for improvements. Many of the suggestions were general and did not seem to relate to a specific county. The suggestions were reviewed as to content and grouped under general topics. The result of the review is shown on the following table.

PARENT, FAMILY, FOSTER CARE OR OTHER CAREGIVER SURVEY QUESTION #12	
SUGGESTIONS TO IMPROVE MENTAL HEALTH SYSTEM FOR CHILDREN/YOUTH IN FOSTER CARE	
Resources	
Availability of group in local area	1
Better availability to psychiatrist	2
Better funding for services	1
Counselors for children under 18 in San Joaquin County who accept Value Options	1
Easier to find resources	1
Have more Christian therapy available	1
Health care should be available statewide, not dependent on county policy/payment	2
Hours of services (after school and weekends) need to be expanded	1
More choices of therapists in Fort Bragg area	1
More social opportunities in the community	4
Need youth facility in San Luis Obispo County	1
Providers with knowledge of and experience with bilingual children	3
Schools should have on-site social worker	1
Therapist nearer the youth's home	1
Access to Services	
Get response quickly - too many steps to get to the first session	2
Make services available through mental health at no cost	1
More accessible services are needed during crises	1
More timely access	3
Requested services are not offered	1
System awareness of difficulty in accessing services	1
Takes too long to get medications	1
Waiting lists are too long	2
Coordination Among the Partners	
Better coordination between medical and mental health	1
Better funding of services	1
Counties use different payment methods which makes it difficult to find a counselor	4
Counseling before the child is removed from family	1
Difficult to get neuro-psych evaluation because county is slow to pay	1
Difficulty in finding therapists that would accept the San Francisco Medicare	1
Earlier screening (before placement) and more complete information about the child's/youth's needs	3

PARENT, FAMILY, FOSTER CARE OR OTHER CAREGIVER SURVEY QUESTION #12	
SUGGESTIONS TO IMPROVE MENTAL HEALTH SYSTEM FOR CHILDREN/YOUTH IN FOSTER CARE	
Foster parents and psychiatrist should work more closely with regard to medications	1
Medi-Cal needs to be easier to obtain	1
Meeting with all people involved with child	1
More communication from the clinic/therapist	2
More communication with parents	1
Schools do not provide enough at school	1
Sheriff hard to get in an emergency	1
Therapist working with foster parents to implement treatment plan	2
Therapy	
Additional time and more in-depth sessions with the child	4
Age appropriate therapy	1
Better training for children on the benefits of therapy	2
Continued therapy	2
Get children out of unneeded counseling	1
Have group therapy available to foster and adopted youth	1
Have more sit-downs with biological parents and foster parents with therapists	1
If siblings had different therapists, they could have the same appointment times	1
In home treatment	1
Include biological parents and close relatives	2
Increase the frequency of therapy	3
Individual counseling is more helpful than group therapy	2
Less reliance on medication	1
Make it family therapy not drop off and pick up after 50 minutes	1
Meet outside foster home and deal with issues outside of foster home environment	1
More exposure to community treatment programs that show effects of drugs	1
More frequent and have other teens participate in group therapy	1
More rapid results	1
Suggestion to retain a specific therapist	3
Support the child to complete the program	1
Therapist of same gender as child/youth	1
Foster Parent Specific	
More training for foster parents on counseling arrangements and process	1
More involvement in therapy session	1
Understanding of foster parent tradition/culture and communication	1
View the foster parent as an expert on the child or youth	4
Total	94

Question #13 provided an opportunity for the respondents to add thoughts and comments. There were 38 comments. Sixteen of the comments expanded upon suggestions for improvements in the service delivery system shown on the table above. Thirteen comments expressed support for the services and/or agency. Five comments were related to the child or youth. Four comments were general in nature.

B. SURVEY FOR COUNSELING SERVICES FOR CHILDREN/YOUTH IN FOSTER HOME PLACEMENT BY CHILD WELFARE AND/OR PROBATION DEPARTMENT

The CMHPC Children and Youth Subcommittee also designed a survey instrument for distribution to children and youth in foster home placement receiving mental health services. The purpose of the survey was to obtain information on the manner in which services were delivered from the perspective of the "user" (child or youth). The survey consists of 9 questions. Three of the question had two parts resulting in a total of 11 questions. Of the 11 questions, the possible responses types are: 1 multiple choice; 8 "yes" or "no"; 1 Likert-scale type (respondents specified their opinion using a scale); and 2 open-ended. Together, the questions and responses were intended to inform the Subcommittee about the experience of children and youth who were receiving mental health services.

The survey, along with the survey for Parents, Families, Foster Parents, or Other Caregivers that is discussed in the previous section, was distributed through the California Alliance of Child and Family Services to its member Foster Family Agencies (FFA). The surveys were transmitted to the FFAs with a cover memo from the Executive Director of the Alliance. The memo instructed the FFA to "Reproduce the surveys and distribute the appropriate surveys to at least two foster parents and two children/youth for each social worker/caseworker in your FFA." The memo instructed that distribution of the memos be limited to "those who can understand and complete the questions; however, it is fine to help respondents understand the questions and write their responses." The instructions requested that completed surveys be mailed by January 26, 2006 to the CMHPC. Surveys were received between January and March 2006.

It is unknown how many surveys were distributed. There were a total of 247 surveys returned from 24 FFA residences located in 28 counties. The number of surveys received from the agencies ranged from one to 30. The respondents' ages ranged from 2 years to 20 years. The median age of the respondents was 13 years. Thirty-four counties were listed as the child's/youth's county of residence or placement. Twenty-four (24) counties were neither the placement nor the residence county. San Diego is the largest county among the 24.

The data collected through the Survey for Counseling Services for Children/Youth in Foster Home Placement by Child Welfare and/or Probation Department cannot be generalized to the system as a whole. However, the information does provide useful information from the perspective of the children and youth who are the "users" of the mental health services.

1. Types of Mental Health Services Received (Question #1)

The survey asked respondents to indicate the mental health services they were receiving. There were seven (7) options listed. There were a total of 308 service options selected. This is an average of 1.3 services per survey (excluding the no service option). The table that follows shows the number and percentage of the 247 surveys for each option. The most frequently provided service was in an office with a therapist/counselor (55%) followed by meeting a therapist/counselor in an individual or

group setting (34%). Thirty-nine (16%) of the surveys indicated that the child or youth currently received no mental health service.

CHILD/YOUTH IN FOSTER HOME PLACEMENT SURVEY QUESTION #1		
TYPE OF MENTAL HEALTH SERVICES RECEIVED		
SERVICE OPTIONS	# Responses	% 247 Surveys
Meet in an office with a therapist/counselor	137	55%
Meet with a therapist/counselor in an individual or group setting	85	34%
Get help in the classroom from a therapist /counselor	14	6%
Go to a counseling program at least two hours a day at school or outside of school	1	0%
Get help from a therapist/counselor who goes places with me	17	7%
Live in a place where there is special help available	15	6%
None	37	15%
Total	306	
Average Number of Services Per Survey Excluding No Service Option	1.3	

2. Opinion about How Helpful the Services Were (Question #2)

The respondents were asked to rate the helpfulness of the counseling services. The instructions indicated that the rating was to be applied to past and present services. The services were to be rated as Harmful (1), Not at all Helpful (2), Somewhat Helpful (3), or Very Helpful (4). The overall average rating for the 230 surveys that included a rating was 3.4.

CHILD/YOUTH IN FOSTER HOME PLACEMENT SURVEY QUESTION #2 OVERALL RATINGS OF HELPFULNESS OF SERVICES						
TOTAL SURVEYS RESPONDING	% TOTAL SURVEYS	1 HARMFUL	2 NOT AT ALL HELPFUL	3 SOMEWHAT HELPFUL	4 VERY HELPFUL	AVERAGE RATING
230	92.1%	1	23	87	119	3.4

The next table for Question #2 arrays the ratings by service delivery option and shows respondent opinions regarding usefulness of the services. There is some variation in the ratings by service option. The lowest average rating (2.0) was associated with Day Treatment. The highest average rating (3.5) was given to two services: meetings in an office and living in a place where there is special help.

CHILD/YOUTH IN FOSTER HOME PLACEMENT SURVEY QUESTION #2 RATINGS OF HELPFULNESS OF SERVICES BY SERVICES RECEIVED					
SERVICE OPTIONS	1 HARMFUL	2 NOT AT ALL HELPFUL	3 SOMEWHAT HELPFUL	4 VERY HELPFUL	AVERAGE RATING
Meet in an office with a therapist/counselor	0	10	45	80	3.5
Meet with a therapist/counselor in an individual or group setting	0	7	39	37	3.4

CHILD/YOUTH IN FOSTER HOME PLACEMENT SURVEY QUESTION #2					
RATINGS OF HELPFULNESS OF SERVICES BY SERVICES RECEIVED					
SERVICE OPTIONS	1 HARMFUL	2 NOT AT ALL HELPFUL	3 SOMEWHAT HELPFUL	4 VERY HELPFUL	AVERAGE RATING
Get help in the classroom from a therapist /counselor	0	2	7	5	3.2
Go to a counseling program at least two hours a day at school or outside of school (Day Treatment)	0	1	0	0	2.0
Get help from a therapist/counselor who goes places with me	0	1	7	8	3.4
Live in a place where there is special help available	0	2	3	10	3.5
Indicated that they were not receiving services in Question #1	1	8	9	7	2.7
Overall Ratings for 230 Surveys	1	23	87	119	3.4

3. Choice in Type of Services (Question #3)
Respondents were asked whether they had choice in the type of counseling services that they received currently or in the past. The response options were "yes" or "no". A little over half (125) of the respondents indicated that they got a choice in the type of service they received.

4. Involvement of Important People in the Child's/Youth's Treatment (Question #4)
Question #4 asked respondents whether important people in their lives were involved in their treatment. The response options were "yes" or "no". A greater number (160) and proportion (65%) of the respondents indicated that important people in their lives were included in their treatment than was indicated in the choice question. The survey did not ask the respondents to identify their relationship to the important people.

5. Services in the Child's/Youth's Primary Language (Question #5)
Respondents were asked if the people providing services spoke the same language as the respondent. The response options were "yes" or "no". Of the 247 responses, 228 (92%) indicated that service providers spoke their primary language. However, it should be noted that this response is likely influenced by the instructions given to respondents, i.e., share with individuals able to respond to the survey which was provided in English only.

6. Respect (Question #6)
This question has two parts. The first part asks the respondent whether they felt respected by the people offering them services. The response options were "yes" or "no". The second part of the question provided an opportunity to amplify on the response. Of the 247 surveys, 221 (89%) indicated that they felt respected. There were 16 comments that were quite general in nature and did not add information.

7. Services for Individuals between the Ages of 18 and 20 Years (Question #7)
This is a two part question. The first part asks if the respondent is between the ages of 18 and 20 years. The response options were "yes" or "no". The second part asks those

respondents who meet the age requirement whether they are receiving one-on-one counseling several hours a week in the home or community. The response options were "yes", "no" or "don't know". There were eight individuals between the ages of 18 and 20 years. Two of the eight were receiving one-on-one counseling services.

8. Medication for Moods (Question #8)

This question asked whether the individual was receiving medication for moods. The response options were "yes" or "no". Sixty (24%) individuals indicated that they were receiving medication.

9 Suggestions for Changes in Services (Question #9)

This is a two part question. The first part asks if the respondent would change anything about the services s/he receives. The response options were "yes" or "no". The second part asks the respondent to specify the changes. Thirty-three (13%) respondents indicated that they would like changes. There were 32 suggestions. The suggestions were reviewed and grouped under several themes. The groupings and suggestions are shown on the table below. The most frequent suggestion was a desire to discontinue therapy.

CHILD/YOUTH IN FOSTER HOME PLACEMENT SURVEY QUESTION #9	
SUGGESTIONS FOR CHANGES IN SERVICES	
SUGGESTIONS	NUMBER
General	
Everything	1
Discontinue therapy	9
Increase Control	
Be more involved in decision making	1
Not to be controlled by people or meds	1
Choose to go to therapy and not be ordered by court	1
More control over who the therapist is	1
Phone privileges	1
Alter Setting	
Meet in different location (not at home)	1
Food or outing incorporated in treatment setting	1
Don't want to miss class	1
Frequency of Service	
Weekly meetings and wider choices of therapy	1
More frequent services	1
Obtaining services in a more timely manner	2
Access	
Closer therapist	2
Have Value Options accepted	2
Therapy Content	
Talk about my biological mother and brother	1
Therapy with birth mother and brother	2
Don't like talking about feelings to strangers	1
Work with bother and parents	1

CHILD/YOUTH IN FOSTER HOME PLACEMENT SURVEY QUESTION #9	
SUGGESTIONS FOR CHANGES IN SERVICES	
SUGGESTIONS	NUMBER
To talk about my biological mother and problems	1
Total Suggestions	32

C. KEY FINDINGS OF SURVEYS

The data collected through the Parent, Family, Foster Care or Other Caregiver Survey and the Child/Youth in Foster Care cannot be generalized to the system as a whole. However, the information does provide interesting information from the perspective of children and youth in foster care, and foster parents who are the "arrangers of care" for the children and youth in care. The information provided in the surveys provides insight into the barriers that exist in the system with respect to funding, access to services, availability of services and the need for better coordination among the system partners.

The suggestions for changes from foster children and youth focused in the areas of: increased control; altering the setting for mental health services; changing the frequency of services; improving access to services; and changing the content of therapy. The suggestions for changes from parents and other caregivers focused in areas of: increasing resources; improving access to services; improving coordination among partners; and changing the way in which therapy is conducted.

VI. CONCLUSIONS AND RECOMMENDATIONS

The Foster Care Study conducted by the CMHPC Children and Youth Subcommittee provides additional insight into the nature of mental health services provided to foster children and youth and their families. Both quantitative and qualitative data were collected and analyzed to determine the current environment in which mental health services are provided. While the study did not identify new findings, it did reaffirm the themes of prior studies and reports that cite the challenges in effectively addressing the mental health needs of foster children and youth and their families.

The study found that while there has been progress in many areas, continued vigilance to improve service delivery in several areas is encouraged. For example, this study found that survey respondents continue to cite frequent foster care placement changes as a major concern because of the negative impact on continuity of care including mental health services. Similarly, out-of-county foster care placements were cited as causing even greater disruption in the continuity of care largely due to the added difficulties in maintaining eligibility for and/or continuing necessary services under the Medi-Cal program. Some of the Medi-Cal problems cited were county-tied Medi-Cal eligibility, difficulties in accessing eligibility information, and complicated reimbursement systems.

Respondents also frequently cited the need to further improve interagency collaboration and coordination in bringing together the resources of several service systems to focus in a comprehensive way on the needs of foster children and families. Related to this issue was what respondents' described as the need for appropriate mental health screening, assessment and service planning/delivery for all children entering the foster care system. This is often referred to as an interagency "trauma response" capability which screens all foster children for various needs, including mental health, health, educational, etc. There was also an identified need for continued and on-going monitoring and oversight of the mental health needs of children and youth in foster care as well as the services provided.

A final theme frequently noted by respondents was human resources; there are insufficient numbers and types of qualified staff, particularly in some areas of the state. This is an issue of needing more staff in many professional categories and geographic locations as well as staff who can meet the language and cultural backgrounds of the state's diverse population.

Despite these continuing themes, the study found that there has been progress in meeting the needs of foster children and youth and their families. Access to public mental health services has improved for children and youth, including those in foster care. This improvement is primarily due to implementation of the Medi-Cal EPSDT services benefit beginning in 1995. Prior to EPSDT mental health services for children was under-funded. By FY 2002-03 almost 50% of foster children were receiving at least one mental health service; however, most respondents believe that many more foster children could benefit from mental health services. There is a documented high need for mental health services among foster children, but 50% of these children/youth are not receiving any public mental health services.

There also have been recent philosophy and practice shifts in California's child welfare services system that more closely mirror the core values and tenets of the public mental health system's CSOC. California's CWS system is placing greater emphasis on prevention and early intervention as the most effective method of protecting children and decreasing the demand for foster care. The system is embracing family-centered practice in working *with* families as partners to identify needs and strengths and develop customized services. And, the system is connecting families with community supports and resources that will remain after formal services end. Central to this approach is the commitment to interagency coordination to meet the multiple needs of children and families. The CWS system is also shifting its focus to looking at outcomes – the effects of services on children and families – instead of monitoring programs based on compliance with procedures and process. These changes are entirely consistent and supportive of the philosophy and values of the public mental health system CSOC. The state DSS and county CWS agencies are commended for this shared vision and commitment to join forces with sister agencies to meet the needs of foster children and families.

Finally, the study found that DMH already collects a wealth of data from county mental health programs about the mental health services they provide, which are extremely helpful in monitoring the mental health services provided to foster children. These data provide an important tool for ongoing public oversight of services provided to foster children and their families and a way to track the impact of policy decisions. While the availability of these data is commendable, there are limitations in the currency of available data and in the fact that it is impossible to judge the quality, availability or the manner in which services are being delivered. These limitations are overcome to some extent through periodic surveys of the system partners and stakeholders such as those undertaken in this study.

B. RECOMMENDATIONS

Based on the information and data collected through this study, the Subcommittee makes the following observations and recommendations:

1. The CMHPC will share the Foster Care Study Report with state and local agencies involved in serving foster children and youth and their families. State level agencies include, but may not be limited to, the Departments of Mental Health, Social Services, Health Care Services, Alcohol and Drug Program and Education. Local level agencies include child welfare services and local juvenile probation departments, county mental health programs and other deemed appropriate. In sharing the reports, attention will be called to several common themes which, while agency progress to date is commended, require continued focused efforts. These themes are:

- Continue efforts to increase mental health services to foster children and youth; approximately 50% of children/youth in foster care received no public mental health services in FY 2002-03.
- Continue efforts to mitigate the need for foster placement whenever appropriate and possible; however, when placement is necessary, continue to reduce the frequency

of foster care placement changes. Frequent placement changes disrupt the continuity of care, including health and mental health services, as well as educational achievement.

- Continue efforts to reduce out-of-county foster care placements unless such placement is an objective in the child's plan of care. Out-of-county placements often compound the difficulties faced in achieving continuity of care. Moreover, out-of-county placements face significant difficulty with regard to the Medi-Cal program, e.g., maintaining Medi-Cal eligibility, difficulties in accessing eligibility information, and complicated reimbursement systems.
- Continue efforts to improve interagency collaboration and coordination in bringing together the resources of service systems to meet the multiple needs of foster children and families. While many counties are effectively collaborating at the local level to meet the needs of foster children, the importance of local educational agency involvement is critically important. The recovery model for children and youth is dependent upon educational participation and achievement.
- Ensure that all children entering the foster care system receive appropriate mental health screening, assessment, and service planning and delivery. An interagency "trauma response" capability which screens all foster children for various needs, including mental health, health, educational, etc, is encouraged. The mental health needs of foster children should also be monitored on a routine basis to ensure that identified and emerging mental health needs are appropriately addressed.
- Continue efforts to address human resource shortages in California's public mental health system, i.e., the lack qualified staff and service providers. The capacity of the mental health service system is hindered, particularly in some areas of the state, as a result of sufficient numbers, types, and qualified staff.
- Continue efforts to ensure access to mental health services for California's diverse population by removing language and cultural barriers. The CMHPC Mental Health Master Plan provides specific recommendations to address these barriers to treatment and make services more accessible to ethnic communities.

2. The CMHPC will work with DMH to identify and request data and reports to use as the basis for ongoing oversight and monitoring of the delivery of mental health services to children and youth in foster care, including youth placed through the juvenile justice system.

3. The CMHPC will continue to monitor implementation of the Mental Health Services Act (MHSA) and its impact in addressing the themes noted in this study.

4. The CMHPC applauds the Legislature for their efforts to improve the lives of foster children and their families and urges continued support in providing sufficient resources to further the progress that has been made.