



## Psychotropic Medications and Foster Youth

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The California Mental Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. Our majority consumer and family member Council is also statutorily required to advise the Legislature on mental health issues, policies and priorities in California. The Council has long recognized the disparity in mental health access, culturally-relevant treatment and need to include physical health. The Council has advocated for mental health services that will address the issues of access and effective treatment with the attention and intensity they deserve for the recovery, resiliency and wellness of Californians living with severe mental illness.

# Psychotropic Medications and Foster Youth

## A New Definition of “Drug Abuse”

### Introduction:

The California Mental Health Planning Council (CMHPC) is mandated by both federal and state law to provide monitoring of the adequacy and efficacy of California’s mental health services across the life span. Its focus is on care and services that are culturally appropriate, inclusive, and based on rehabilitation rather than medical management. Children and youth have been one of the key areas of focus for the CMHPC. In over 20 years of research and publications for this demographic, successful practices as well as current and potential areas of concern in youth mental health care have been presented. The intent of these publications has always been to provide information and context in order to influence policy discussions and best practice decisions, particularly from the perspective of the diagnosed individual experiencing symptoms or their caregivers and providers. The steadfast and increasing use/misuse of psychotropic medications as a behavioral intervention for our foster youth has gained the attention of the CMHPC especially considering the dramatic side effects and the long-term effects of such medications on children. The CMHPC is mandated to review, monitor and advise in order to ensure implementation of appropriate solutions at the state level to address this rampant concern among foster youth.

### Background:

In September 1999, SB 543 (Bowen) was enrolled, amending Welfare and Institutions Code Section 16010 and adding Section 369.5 to enact that:

*“...only a juvenile court judicial officer shall have authority to make orders regarding the administration of psychotropic medications for that child. The juvenile court may issue a specific order delegating this authority to a parent upon making findings on the record that the parent poses no danger to the child and has the capacity to authorize psychotropic medications. Court authorization for the administration of psychotropic medication shall be based on a request from a physician, indicating the reasons for the request, a description of the child’s diagnosis and behavior, the expected results of the medication, and a description of any side effects of the medication. On or before July 1, 2000, the Judicial Council shall adopt rules of court and develop appropriate forms for implementation of this section.”*

SB 543 was authorized largely in response to a 1997 Los Angeles Times investigative series and Los Angeles County Grand Jury report that focused on wide-ranging abuses within the foster care system, particularly in group homes, and most particularly in the prescription and monitoring of psychotropic drugs to the foster children. Two findings of the Grand Jury’s Juvenile Services Committee quoted by the Los Angeles Times were that:<sup>1</sup>

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<sup>1</sup> *Grand Jury Cites Abuses in Group Foster Homes*: April 09, 1997 | James Rainey | Los Angeles Times [http://articles.latimes.com/1997-04-09/news/mn-46959\\_1\\_county-grand-jury/2](http://articles.latimes.com/1997-04-09/news/mn-46959_1_county-grand-jury/2)

*“Children were given a variety of medications without the proper consent of a guardian or judge in nearly half of 158 audited cases. In another instance, a group home withheld drugs in hopes that a child would be ruled severely emotionally disturbed--thus drawing a higher rate of government payments.”*

(and)

*“Inadequate psychotherapy for children. Sometimes sessions of as little as five minutes were held, although therapists billed for a full 40 - or 50-minute session. One therapist reportedly made the same boilerplate reports, month after month, to describe every child in a six-member group home. In other cases, therapists would complete copious reports, only to have their recommendations ignored.”*

The report also observed that foster family placements would be therapeutically superior as well as more cost effective, citing the difference between a monthly foster family stipend ranging from \$315 to \$1,515 per child and group home rate of \$5,000 per child. It shall also be noted that lack of funding for group homes was not the issue despite the generous annual distribution of \$238 million. Also cited from the Los Angeles County Grand Jury Report: <sup>1</sup>

*“Children are suffering additional harm at the hands of their purported protectors--being bounced repeatedly from home to home, sometimes physically abused, often medicated without proper court authorization and offered little positive reinforcement for improving their lot in life.”*

The investigation and Grand Jury report resulted in changing the centralized Los Angeles County foster care system to one that was community-based, keeping foster children in their neighborhoods. Caregivers and foster families were actively recruited in the community of origin rather than distant group homes, and encouraged family involvement and regular social worker visits. <sup>2</sup>

The enrollment of SB 543 granted authority to the Juvenile Court to approve medication requests for minor dependents of the courts, and required the child protective agency to ensure that education, health, dental, and mental health records, including medication dosage and history, be up-to-date and provided to foster parents within 30 days of initial placement, and within 48 hours to any subsequent placement sites. Additionally, the Child Welfare System Improvement and Accountability Act, established under AB 636 (Steinberg) in 2001, shifted processes towards results-based accountability that measured success in terms of safety, permanence, and well-being. It also called for Peer Quality Care Reviews that objectively measured performance, and for continuous systems improvement plans developed with county welfare and community partners to establish priorities and goals for improvement.

The legislation and foster care system overhaul merged with several other key mental health program and policy landmarks that included a statewide shift to a Children System of Care

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<sup>2</sup> Foster Care System Begins Overhaul: November 10, 1998 | James Rainey | Los Angeles Times  
<http://articles.latimes.com/1998/nov/10/news/mn-41278>

model for mental health services. An example of this approach was the expansion of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program to include Therapeutic Behavioral Services (TBS), enacted in 1998. This inclusion ensured mental health services for minors, up to the age of 21; and regardless of insurance status, particularly significant for children in foster care. This would soon be followed by the passage and implementation of the Mental Health Services Act, funded by a 1% tax on incomes over \$1 million which included a strong component on improving and expanding the services for children and transition age youth. All of these events benchmarked the necessity for a rehabilitation model from a strictly medication-based model.

In October of 2007, the Children and Youth Subcommittee of the California Mental Health Planning Council (CMHPC), released the *“Foster Care Study Report,”* which listed several positive advancements made in the reshaped mental health system for children and youth. However, it also highlighted concerns such as financing that seemed to favor foster care over reunification, lack of coordination between agencies, and lack of oversight and monitoring of treatment plans and medications. In addition to literature research, interviews were conducted with a small group of key informants representing foster youth, parent or partner advocates, county probation departments, county child welfare agencies, and services providers. When asked 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 second most frequently cited issues (after adequate staffing) included *“lack of continuity of care and adequate care monitoring and oversight (e.g., lack of monitoring psychiatric medication usage,....”*<sup>3</sup>

In August 2014, the Mercury News began a series of reports - *“Drugging Our Kids”*<sup>4</sup> which detailed an over-reliance on medications for foster youth and the questionable justifications for those prescriptions. More specifically, the series made the point that those excessive prescriptions were not only unmentioned and unquestioned by the State of California Department of Social Services (CDSS), which had ultimate responsibility for overseeing the quality and safety of care and services, but also unmonitored and unaccounted for by the Department of Health Care Services (DHCS), which is charged with accounting for the quality of the health care provided to foster youths. As the newspaper series progressed, it became clear that both departments had difficulty obtaining and sharing data on the number of medications, dosages, and the frequency of reauthorization that was specific to each child in the foster care system when psychotropic medication was prescribed and administered.

At the time the investigative series began, the *known* rate of psychotropic medications prescribed between 2004 and 2014 for adolescent foster youth in California was at 22%, even

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<sup>3</sup> CHILDREN AND YOUTH SUBCOMMITTEE FOSTER CARE STUDY REPORT | California Mental Health Planning Council | 10/15/2007 | <http://www.dhcs.ca.gov/services/MH/Documents/FinalReportFosterCareStudy101507.pdf>

<sup>4</sup> DRUGGING OUR KIDS: Children in California’s foster care system are prescribed unproven, risky medications at alarming rates: August 24, 2014 | Karen De Sa, The Bay Area News Group | The Mercury News | : <http://extras.mercurynews.com/druggedkids/>

though only 1 to 2% of children are conclusively diagnosed as psychotic. Despite the low percentage of psychosis diagnoses, of the total Medi-Cal expenditures for children in foster care, between the ages of 12-18, 72% are on psychotropic medications. This compares to a national rate of 6% of the general adolescent population receiving prescriptions. Additionally, the number of prescriptions per child frequently exceeded the state guidelines for their age group, the dosages prescribed were frequently higher than recommended, and often the medications prescribed were inappropriate to the diagnosis. Stated by Will Lightbourne Director of CDSS in the article “Drugging Our Kids.”<sup>4</sup>

*“Clearly there are some situations in which psychotropic prescriptions may be appropriate, we have to know that something is being done because it’s absolutely necessary, not because it’s convenient — that it’s not simply behavior management.”*

The Mercury News clarified that the medication figures were extrapolated because the data provided by DHCS contained only aggregate data from pharmacy benefit claims, and not individual health records. It was also noted that this data did not include information from children insured under managed health care plans, so the total numbers are not fully known and could be significantly higher.

The final article of the Mercury News series in August 2016 coincided with the California State Auditor’s report *“California’s Foster Care System: The State and Counties Have Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care.”* By this time, several legislative hearings had been held and several bills, aimed at ameliorating the most egregious of the findings, were passed. Among them:

## **RELATED LEGISLATION**

Bill #	Author	Enrolled	Intent/Requirement
SB 484	Beall	10/5/2015	Primarily specific to Group Homes - Requires enhanced record keeping on psychotropic medications administered to youths by the group home; requires DSS to: gather and post information on psychotropic medications dispensed by each facility; review homes that exceed normal levels of psychotropic medications dispensation and monitor any required corrective plans that are triggered; share information with courts, placement agencies, the Medical Board, dependency counsel, and other advocates and relevant parties; and develop performance standards and outcome measures leading to alternative programs in order to promote continuous system improvement plans.
SB 238	Mitchell	10/6/2015	Ensures that child and/or advocate has input on prescribed medications and requires periodic oversight of their administration; requires DSS to share data on Medi-Cal funded psychotropic medications authorized for child with all agencies involved in child's care and services. Requires additional training on psychotropic medications usage, risks, benefits, and interactions be provided to caregivers, administrators, legal and court entities, and related public entities directly involved in child's care.
SB 319	Beall	11/6/2015	Authorizes a foster care public health nurse, as part of required participation in medical care planning and coordination, to monitor and oversee the child's use of psychotropic medications and to assist a non-minor dependent to make informed decisions about his or her health care.
SB 1174	McGuire	9/29/2016	Requires DHCS and DSS, pursuant to a specified data-sharing agreement, to provide the Medical Board of California with information regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services for specified children and minors placed in foster care. It also requires the board to prioritize investigations that involve repeated acts of excessive prescribing, furnishing, or administering psychotropic medications to a minor, as specified, and to report annually to the Legislature, DHCS, and DSS on the results of the data review.



Bill #	Author	Enrolled	Intent/Requirement
SB 1291	Beall	9/29/2016	Requires annual mental health plan reviews to be conducted by an external quality review organization (EQRO) and to include specific <i>disaggregated</i> data for Medi-Cal eligible minor and non-minor dependents in foster care, including the number served each year. Requires that DHCS share data that informs the development of county mental health service plans and performance outcome system data and metrics with county board of supervisors and to post any corrective actions plans resulting from EQRO review and data on the DHCS website.

### These Might Be the Answers, But Were the Right Questions Asked?

*“Psychotropic medication does not change a child’s past life experiences and the impact of these experiences on his or her view of the world. A young survivor of maltreatment who is angry and guarded does not become trusting simply as a result of medication use.”<sup>5</sup>*

To date, the majority of the investigations and legislation to address psychotropic medication has centered on the types, frequency, dosage levels, lack of oversight and accountability, and who may prescribe, but there has been very little discussion as to whether medication is prescribed for the *right reasons*. The enacted legislation addresses very important safeguards for medication protocols, but does not address the underlying issue - that medications are being prescribed as behavior modifiers rather temporary therapeutic tools to develop coping mechanisms to promote healing. Ultimately the aim should be for cessation of the medication when appropriate, and if applicable to the individual.

There can be no denying that children placed in foster care experience multiple and persistent traumas, starting with the events that lead to initial removal from the home and placement in the child welfare system. Frequently, these events include separating from siblings, experiencing reduced contact with other significant family members and family support, starting a new school mid-semester, and fitting into a new home environment with strangers - all of which are potentially new sources of trauma. Medication may address some of the reactions to those stressors, but it cannot mitigate the causes.

Too often the discussion can become clouded when we ask “Why would we prescribe psychotropic medications to children?” In a January 2016 presentation to the CMHPC

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<sup>5</sup> *Appropriate Psychotropic Medication Use for Children and Adolescents: Safety and Quality in Mental Health Treatment*/American Academy of Child Adolescent Psychiatry: 2015/  
[https://www.aacap.org/App\\_Themes/AACAP/docs/clinical\\_practice\\_center/systems\\_of\\_care/AACAP\\_Psychotropic\\_Medication\\_Recommendations\\_2015\\_FINAL.pdf](https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf)

Healthcare Integration Committee, Laura Vleugels, MD,<sup>6</sup> stated that the more useful question might be framed “Why would a child *need* such medications? The very general answer would be “When the symptoms interfere with the effectiveness of treatment.” When the symptoms include issues of aggression, tantrums, sleep difficulties, and impulsivity and children can hurt themselves, others, and cause trouble through their behavior, those symptoms become problems. Most importantly, when those problems are pervasive, feel permanent and personal to the child, and the child feels that those symptoms won’t go away, medication can be an essential component of *developing* a treatment plan.

Medications, when prescribed *appropriately*, can diminish a person’s symptoms sufficiently enough to be able to address the sources, promote self-awareness, and learn coping mechanisms that build a strong foundation for survival and resilience. Unfortunately, the practice of prescribing psychotropic medications has evolved into a behavioral modification tool rather than a supportive means of facilitating a treatment plan, and has become the norm rather than the exception. Worse, using medication as means to control and suppress undesirable behaviors does not work indefinitely; medication use leads to a level of tolerance causing the dosage to be increased over time. Compliance is often tacitly coerced because the child understands that noncompliance could mean yet another placement in yet another unknown environment, which can be terrifying. At the heart of their situations, what these children crave most is consistency and security, and they believe compliance will help them attain it.

Sometimes the medication is prescribed in the sincere belief that a compliant, chemically subdued child will fare better due to the increased likelihood that the child will remain in a foster home and not be institutionalized. As Carol Brown, a public health nurse interviewed for the Mercury Times series explained it:

*“Very often, there’s pressure on the doctors from the foster parents and the group homes to provide medication to deal with the behaviors that the foster youth are exhibiting,” Brown said. “The foster parents won’t take the kids with the behaviors, and it’s the behaviors they want treated.”<sup>7</sup>*

However, the same article goes on to detail the encouragement and incentives provided to physicians by pharmaceutical representatives:

*“An investigation by this newspaper has found that drug-makers, anxious to expand the market for some of their most profitable products, spent more than \$14 million from 2010 to 2013 to woo the California doctors who treat this captive and fragile audience of patients at taxpayers’ expense.*

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<sup>6</sup> Supervising Child and Adolescent Psychiatrist for Children, Youth and Families at the Dept. of Behavioral Health Services for the County of San Diego Health & Human Services Agency

<sup>7</sup> DRUGGING OUR KIDS: Children in California’s foster care system are prescribed unproven, risky medications at alarming rates: August 24, 2014 | Karen De Sa, The Bay Area News Group | The Mercury News | <http://extras.mercurynews.com/druggedkids/>

*Drug-makers distribute their cash to all manner of doctors, but the investigation found that they paid the state's foster care prescribers on average more than double what they gave to the typical California physician.”<sup>8</sup>*

Despite the California guidelines that limit the number of permissible prescriptions for youths by age; i.e., 0 – 5 years of age - one prescription; 6 to 11 years of age - two prescriptions; 12 to 17 years old - three prescriptions, these limits are often exceeded as the tolerance builds and more medications, frequently off-label, are added to the mix. The Federal Food and Drug Administration has authorized the use of antipsychotic medications for children for only three diagnoses: Schizophrenia, Bipolar Disorder and severe Autism. These conditions affect only 1 to 2 percent of the child population, but in 2009 nearly 1/2 of the antipsychotic medications prescribed for children covered by Medi-Cal were for off-label diagnoses, and approximately 1/3 were for behavioral issues such as Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, or Oppositional Defiance Disorder. Under Medi-Cal, the antipsychotic prescription rates for foster children exceeded the rates for Medi-Cal covered children *not* in foster care by 18-fold.

While the federal government has instituted several measures of oversight, studies, and legal actions to monitor the use of medications, California's lack of monitoring and oversight – has brought us to this serious situation and has been exacerbated by record-keeping that relied on aggregated counts with little or no focus on recipients. State and local governments were not the only elements in this equation.

*“In recent years, each of the manufacturers of the top five antipsychotic medications billed to Medi-Cal - Abilify, Risperdal, Geodon, Seroquel and Zyprexa - have been prosecuted by the U.S. Justice Department for illegal marketing to children and seniors. Eli Lilly, Johnson & Johnson, Pfizer, Bristol-Myers Squibb and AstraZeneca have collectively paid \$4.6 billion in fines, in some cases the largest health care fraud settlements in U.S. history.”*

*“From 2004 to 2013, sales of the five antipsychotic drugs most often prescribed to children on Medi-Cal skyrocketed 128 percent. Last year, Bristol-Myers Squibb's Abilify was the top-selling drug in the United States, with more than \$6.8 billion in sales.”<sup>9</sup>*

Ultimately, the poly-pharmaceutical approach creates far more problems than it has solved. The most obvious problem is rapid weight gain, which tends to display within weeks of starting psychotropic medication. The side effects of the medications include a strong potential for liver damage, high cholesterol, high blood sugar, diabetes, and high blood pressure. These are all well-known warnings for adult consumers of this classification of medications, yet they have been prescribed to children on an ongoing basis before their systems have fully matured. Many

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<sup>8</sup> Ibid (Part 3 of 7)

<sup>9</sup> Ibid (Part 3 of 7)

of the former foster youth interviewed for the Mercury News also cited long term effects of their extended medications usage such as rapid onset obesity and a potentially irreversible condition known as “tardive dyskinesia,” which can cause uncontrollable movements.

Less well known perhaps are the results of a recent study cited by the Mercury News series demonstrating that prolonged use of antipsychotics caused smaller brain tissue volumes in 211 adults living with schizophrenia based on MRI images. This departs from conventional thinking that assumes that decreased brain tissue volume is caused *by* schizophrenia, and the effect of these medications on children’s brains can only be extrapolated because no similar research has been conducted.

It has also been established that early childhood trauma and toxic, chronic stress creates its own source of decreased size or connectivity in several key regions of the brain such as the hippocampus, cerebellum, prefrontal cortex, etc.<sup>10</sup> The initial trauma of being removed from the home compounded by potentially multiple placements in different foster care settings, combined with a pharmaceutical protocol that creates additional diminishment of brain tissue is a wholly devastating effect experienced by an extremely vulnerable population.

## **Current Foster Care Reform Process**

In 2013 - one year before the investigative series in the Mercury News ran - the California Department of Social Services (CDSS) was legislatively mandated to develop overall reforms in the foster care system, known as the Continuum of Care Reform project, requiring it to be planned and implemented by January 1, 2017. The recommended actions, known as the Core Practice Model, are guided by a vision that placements in group care be minimal and short-term, that foster homes are nurturing and lead to permanent placement if reunification is not an option, provides a stronger focus on emancipation skills, and a stronger and more structured coordination between the agencies.

The more major reforms eradicate Rate Classification Levels, and standardize caregiver requirements so that relative caregivers received the same training and review as licensed homes and facilities. The reforms also require psychosocial assessments as part of the provider certification process, which also streamlines any potential adoptions requests. Group foster homes will be phased out and replaced with Short-Term Residential Therapeutic Centers (STRTCs). Also, CDSS developed a Core Practice Model that ensures the same services are available to families as those that are available for STRTCs, and all Foster Family Agencies (FFAs) must now be accredited by a nationally recognized agency.

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<sup>10</sup> Child Welfare Information Gateway. (2015). Understanding the effects of maltreatment on brain development. Washington, DC: U.S. Department of Health and Human Services, Children’s Bureau

In a presentation to the CMHPC in June of 2016, Lori Fuller, Chief of the Permanency Policy Branch at CDSS presented on the activities of the Quality Improvement Project (QIP), which specifically addresses mandated reforms in the area of medications for foster youth. The QIP workgroups addressed several different components of the recently enacted legislation (SB 238, SB 484, SB 319) impacting psychotropic medications, that includes increased monitoring, reducing inappropriate concurrent use, creating educational materials for youths, care providers, social workers, and using data to oversee and analyze the use. Significantly, it also institutes a three-way Agency Data Sharing agreement between CDSS, DHCS, and the county government agencies, and provides a process to identify and document the data that is exchanged. Also noteworthy is the development of data measures that specifically target the prescription rates, types, and whether concurrent use with other medications is present, whether corresponding psychosocial care is offered, and close monitoring of youths' physical health while on medications.

### How Placements Have Shifted Over Nearly 30 years

Although the number of foster care placements has steadily declined, the proportional distribution of the population has remained fairly constant for group home placements while foster home and kin-relative placements have actually decreased. Please see the footnotes below the table for definitions of placement types, explanation of count totals, and what groups are included in the "Total Other – Aggregate."

California	Number of Placements						
	Type of Placement	1998		2007		2015	
		Number	Percent	Number	Percent	Number	Percent
Court-Specified Home	1,993	2%	294	0.4%	235	0.4%	
Foster Home	19,087	18%	7,543	10%	5,504	8%	
Foster Family Agency Home	17,138	16%	19,490	26%	15,679	25%	
Group Home	6,554	6%	5,588	8%	3,664	6%	
Kin-Relatives	46,286	43%	26,373	35%	21,739	35%	
Total Other - Aggregate	10,110	9%	6,168	8%	5,392	7%	
<b>Total Children in Foster Care</b>	<b>108,000</b>	<b>94%</b>	<b>74,806</b>	<b>87.4 %</b>	<b>62,035</b>	<b>81.4%</b>	

<http://www.kidsdata.org/topic>

#### Definition, Source & Notes

**Definition:** Number of children/youth under age 21 in foster care on July 1 of each year, by type of out-of-home placement (e.g., 21,739 of California children in foster care on July 1, 2015 were placed with kin-relatives).

- **Data Source:** Webster, D., et al. [Child Welfare Services Reports for California](#), U.C. Berkeley Center for Social Services Research (Jun. 2016).
- Data represent a point-in-time, unduplicated count of children under the supervision of county welfare departments and exclude cases under the supervision of county probation departments, out-of-state agencies, state adoptions district offices, and Indian child welfare departments. A 'Foster Family Agency Home' is overseen by licensed non-profit agencies, whereas 'Foster Homes' are licensed directly by a county. (For more on Foster Family Agencies, see <http://www.childsworld.ca.gov/PG1346.htm>.) A 'Court-Specified Home' can be of any type, but is mandated by the court. 'Guardian' includes children placed with guardians who are designated wards of the court and children placed with guardians who do not fall under the legal authority of the dependency system. 'Runaway' includes foster children who left care voluntarily and cannot be accounted for by the agency responsible for their care and placement. 'Other' includes children in transitional housing and children with an open placement episode but no out-of-home placement record. The caseload may be inflated by children who are no longer in care but are still being counted in the 'Trial Home Visit' and 'Other' categories. **Totals for all groups may not sum to the total number of children in foster care due to missing values.**
- The category "Total Other - Aggregate" is expanded to aggregate Pre-Adopt, Runaway, Shelter, Trial Home visit, and "Other" categories described in Footnote 1, who are included in the Kidsdata.org totals.

## Conclusion

It is too soon to predict whether the enacted legislation and reforms will result in lower rates of psychotropic medications being prescribed to foster youth. All of the new strategies developed, if implemented, would certainly combine to create a more holistic, informed, and effective means of addressing the trauma and symptoms experienced by children in foster care. The objective and purpose for the CMHPC is to monitor and report on this opportunity for the best possible outcome for these children. These are optimistic and obtainable goals, and should be encouraged as standard regulation. However, it should be acknowledged that past efforts to reform the foster care system, and the increased options for behavioral health care actualized by EPSDT, TBS, and alternatives offered through MHSA funded programs, have not yet smoothly coalesced into a comprehensive coordinated system of care that is accessible and fully effective. It is imperative that advocacy groups and watchdog groups continue to hold the government accountable to ensure that these measures are fully implemented, adhered to, monitored, and reported on so that improvements can be celebrated and our foster youth protected.

To conclude, the purpose for all these measures to be put in place is to set a new precedent in how foster youths' emotional and behavioral health issues are acknowledged and addressed and consequently pave better opportunities for this population for their long-term success and overall well-being. The CMHPC will continue to monitor and report on the impact of the enacted legislation and reforms as well as outcomes for foster youth in the state of California.

