

**Child Welfare Council**  
**Out-of-County Mental Health Services Workgroup Report**  
**November 27, 2011**

**Introduction**

The Out-of-County Mental Health Services Workgroup was established by the Child Welfare Council in December 2010 after deliberations on the issue at its meetings throughout the year. The charge to the Workgroup was to engage in further analysis and discussion and to prioritize the activities necessary to facilitate equal access to medically necessary specialty mental health services for foster children and youth who are placed outside the counties which have court jurisdiction.

During the past year, the Workgroup approached its charge through the following action steps:

- Develop strategies to promote and improve foster children’s equal access to mental health treatment;
- Examine how Screening and Assessment tools can lead to improved services and outcomes for foster youth;
- Learn more from what linked child welfare and mental health services data tell us about foster children’s use of mental health services both for foster children placed within their county of jurisdiction and for foster children placed outside of their county of jurisdiction;
- Identify fiscal considerations; and
- Report back to full Child Welfare Council in December 2011 on the findings and proposed next steps.

A summary of the Workgroup’s findings and recommendations for next steps follows. Details on each area may be found in Appendices I – IV.

**Promoting Equal Access (Appendix I)**

The Out-of-County Mental Health Services Workgroup recommends that provisions similar to those described in Welfare and Institutions Code § 14093.10 (text provided in Appendix I) be used to determine the most appropriate county to provide mental health services and, when appropriate, authorize the transfer of responsibility for authorizing and providing medically necessary mental health services from the county of jurisdiction to the county of residence for children placed with relatives, with foster parents or in group homes. In addition, the Workgroup recommends that the participants in the decision-making process outlined in the statute be expanded from to include the responsible county Medi-Cal Mental Health Plan, any current or prospective mental health providers, the child (as appropriate, e.g. age 10 or older and developmentally capable), the birth parents, and/or other persons who would be involved in supporting the child’s mental health services plan. This “Collaborative Team” approach would help ensure that mental health screening, assessment and treatment plans are individualized to each child and that the role of each contributor on the team is well understood by all so that each member can hold other members of the team accountable. The Collaborative Team should also help ensure that the child’s progress is monitored and also that team meetings to review and update the mental health treatment plan are conducted as needed. The final decision-maker for the Collaborative Team would remain with the person who holds the right to make medical decisions under current law.

The Collaborative Team approach can be built into existing systems and practices currently developing plans for many children in foster care, such as Team Decision Making sessions, Wraparound Child and Family Teams, Residentially-Based Services Teams and mental health screening sessions. Over time, the capacity for all foster children to have a Collaborative Team should become established practice, and, in

the interim for those who do not have one, the presumption should be that the county of residence will provide medically necessary mental health services.

To assist the Collaborative Team in making decisions, the Workgroup recommends that the findings from the Data Mining Project be used to develop criteria that identify foster children who are at high risk for needing mental health services and therefore should be prioritized screening and assessment. An initial review of the data suggests that children who have had multiple placements, children who have been in foster care for a long period of time and children in their teens should receive priority consideration. Children who are in repeat foster care episodes, children who have serious mental health disorders, children who are placed in group homes (as opposed to family or guardian homes), and children in probation-supervised placements (as opposed to child welfare-supervised placements) should also receive priority consideration.

If the Collaborative Team determines that a foster child should receive mental health services from the county of residence (host county), the county of jurisdiction should transfer administrative responsibilities for authorization, access, planning, treatment and payment arrangements to the county of residence (host county). Under current law, the county of jurisdiction would retain responsibility for due process regarding beneficiary protection issues.

### **Screening and Assessment (Appendix II)**

Screening and assessment are two distinct steps in assessing mental health status. Screening tools should be relatively short and easily applied by non-clinicians as a way of identifying foster children who need a more in-depth evaluation of mental health needs. An example of this type of tool is the Mental Health Screening Tool (MHST) developed by the California Institute of Mental Health and used by several counties.

Assessment tools are administered by clinicians at regular intervals in order to measure progress over time. These tools inform diagnoses and treatment and identify issues that could affect placement. An example of this type of tool is the Child and Adolescent Needs and Strengths (CANS) used by several counties, community-based organizations and individual providers.

### **Data Mining Project (Appendix III)**

The Data Mining Project was a significant undertaking in that it is the first time that the Child Welfare Services Case Management System and Medi-Cal databases had been linked. Using fiscal year 2008-09 data (the most recent year with complete information available), the project offered the opportunity analyze the characteristics of foster children who received mental health services and learn about differences among children placed in and outside of their county of jurisdiction. Key findings include:

- There was considerable variation among counties regarding the percentage of foster children receiving mental health services overall and the level of access for foster children residing in- or out-of- their county of jurisdiction; in-county foster youth received greater access to services and higher intensity of care on average than out-of-county foster youth.
- Placement in- or out-of-county was not the strongest predictor of whether or not children received mental health services, but systematic differences were observed, including apparent greater need for services as well as lower access to services and lower intensity of care.
- Significant issues were identified for sub-populations of youth who require out-of-county placements, including foster children who are older; who have been in care longer; who have had repeated placement episodes of foster care; who are placed in group homes; or who are on probation.
- The age of children in placement had the strongest correlation to receipt of mental health services. For placements with children 11-15 years of age, living in their county of jurisdiction was the best predictor of whether they received mental health services.

### **Fiscal Considerations (Appendix IV)**

As the Out-of-County Mental Health Services Workgroup is completing its charge, a new funding structure is unfolding. Under the 2011 Realignment Act (AB 118), the sharing ratios for medically necessary Medi-Cal mental health services shifted from 50% federal, 45% state and 5% county to 50% federal and 50% county, and specific revenues have been allocated to counties that reflect their increased share of costs. The statute states that it is the intention of the Legislature that new allocation formulas be developed using appropriate data and information for the 2012-13 fiscal year and each year thereafter. Further, the statute states that it is also the intent of the Legislature that sufficient protections be in place to provide ongoing funding and mandate protection for the state and local government.

This new funding structure could change the current methods by which counties reimburse each other for medically necessary mental health services provided to children and youth who do not reside in their county of jurisdiction. Counties report that there are drawbacks to all of the current options, ranging from high travel costs in some cases; lack of non-profit provider agencies in certain areas; inefficiencies that stem from having to contract with multiple providers; and need for formal accounting practices to prevent inequities. Recognizing these limitations, the stage is set to develop a treatment system that allows foster children to have equitable access to medically necessary mental health services and smoothly operating payment system that reimburses counties and providers at the established Medi-Cal rates for services to foster children regardless of their county of jurisdiction or their county of residence. As plans are underway to develop new funding structures under Realignment 2012-13 and beyond, there is an opportunity to address the limitations of the current payment structure for out-of-county placements.

The details for Realignment in 2012-13 are under development by the Department of Finance and Health and Human Services Agency and will be a focus of the Legislative session beginning in January 2012. The California Mental Health Directors Association is working with county, administration and legislative representatives to develop the financial provisions for 2011 Realignment and the transfer of the Medi-Cal Specialty Mental Health programs specified in the California state Medicaid plan and the waiver. The financial provisions will include strategies to assure that reimbursement mechanisms are in place to support statewide access to medically necessary mental health services for all Medi-Cal beneficiaries.

### **Recommendations and Next Steps**

While the longer term budget issues are being deliberated, the Workgroup recommends that the programmatic strategies described above to promote equal access to mental health services and to provide mental health screening of all foster children and mental health assessment for foster children based on the screening should move forward under the 2011 Realignment system and, if successful, continue into 2012-13.

The Workgroup further recommends that the Child Welfare Council closely follow the progress of the Realignment deliberations as they relate to removing barriers to funding medically necessary mental health services for foster children who reside outside their counties of jurisdiction. Finally, the Workgroup recommends that the Departments of Social Services and Health Care Services, in collaboration with the Child Welfare Council's Data Committee, conduct another study to determine the progress made in achieving foster children's equal access to medically necessary mental health services regardless of where they live.

## **Foster Children's Equal Access to Mental Health Services Regardless of County of Jurisdiction and Residence**

The Child Welfare Council has been reviewing the issue of equal access to mental health services for foster children<sup>1</sup> placed outside their county of jurisdiction. At its December 9, 2010, meeting the Child Welfare Council unanimously recommended a policy of equal access to medically necessary mental health services for all foster youth. To operationalize this goal, the Council endorsed shifting responsibility for providing services between sending and receiving counties, as well as elements two through five of an Action Plan developed by the County Mental Health Directors Association and the County Welfare Directors Association. The Council also stipulated that additional operational details and funding implications would be addressed separately in a Workplan developed by stakeholders and Council members. Specifics to be fleshed out in the Workplan included: (1) a detailed fiscal analysis; (2) detailed recommendations around screening and assessment; and (3) presumptive transfer—need for more detail around objective standards and criteria.

The Council formed an Out-of-County Mental Health Services Workgroup to develop the three elements of the Workplan with the goal of establishing clear and consistent practice recommendations for consideration by the Council and ultimately for use by counties in order to ensure that foster children gain equal access to medically necessary mental health services.

The specifics of presumptive transfer and exemptions were sequenced ahead of the other two areas on the belief that decisions regarding transfers would likely drive the fiscal analysis and screening and assessment recommendations. The Workplan recommendations include framing presumptive transfer as individualized decision-making by a Collaborative Team whenever possible, based on existing state statutes that apply to former and current foster youth. At this juncture, no recommendation has been agreed upon regarding where ultimate authority for decision-making would reside. The approaches for these two populations and the relevant statutes that apply to each are described in Sections I and II below.

The next steps are to:

- Apply the findings from the data mining project (draft currently under review) so that policy makers, case managers and practitioners can develop strategies to improve equal access to medically necessary mental health services for foster children;
- Determine how mental health screening and assessment tools and tools reviewed by a separate subgroup should be integrated into best practices for serving foster children;
- Conduct a detailed fiscal analysis, including how risk pools and joint powers may support the payment processes;
- Identify and prioritize any additional issues that need to be addressed including capacity building; and
- Prepare a final report that incorporates the results of the above steps into one document for presentation to the Child Welfare Council on December 14, 2011.

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<sup>1</sup> Foster children are dependents of the court under Welfare and Institutions Code Section 300 or wards of the court under Welfare and Institutions Code Section 601 or 602 who are placed by juvenile court order in out-of-home care.

## **SECTION I – KinGAP and Aid to Adoptive Parents Recipients**

Current law addresses transfer of responsibility for providing mental health services for former foster children who now have permanency through non-relative legal guardianship, KinGAP or who now have permanency through adoption and receive Aid to Adoptive Parents funding. The relevant codes are:

### **Welfare and Institutions Code § 11376**

A foster child who has become the subject of a legal guardianship, who is receiving assistance under the Kin-Gap Program, including Medi-Cal, and whose foster care court supervision has been terminated, shall be provided medically necessary specialty mental health services by the local mental health plan in the county of residence of his or her legal guardian, pursuant to all of the following:

- (a) The host county mental health plan shall be responsible for submitting the treatment authorization request (TAR) to the mental health plan in the county of origin.
- (b) The requesting public or private service provider shall prepare the TAR.
- (c) The county of origin shall retain responsibility for authorization and reauthorization of services utilizing an expedited TAR process.

### **Welfare and Institutions Code § 16125**

A foster child whose adoption has become final, who is receiving or is eligible to receive Adoption Assistance Program assistance, including Medi-Cal, and whose foster care court supervision has been terminated, shall be provided medically necessary specialty mental health services by the local mental health plan in the county of residence of his or her adoptive parents, pursuant to all of the following:

- (a) The host county mental health plan shall be responsible for submitting the treatment authorization request (TAR) to the mental health plan in the county of origin.
- (b) The requesting public or private service provider shall prepare the TAR.
- (c) The county of origin shall retain responsibility for authorization and reauthorization of services utilizing an expedited TAR.

## **SECTION II – Current foster children**

Current statute addresses how decisions regarding which county will provide needed health services (which could include needed mental health services) when a foster child who is enrolled in a county organized health system is placed out-of-county. The required process involves the county child welfare agency or probation department with responsibility for the care and placement of the child to determine, in consultation with the child's foster caregiver, whether the child should remain enrolled in that county organized health system. The determination is made no later than one working day after the out-of-county placement begins. If it is determined, when the foster child is first placed out-of-county or at any later date, that a foster child should be disenrolled from a county organized health system due to an out-of-county placement, the county child welfare agency or probation department with responsibility for the care and placement of the child shall request that the child be disenrolled from the county organized health system. The request shall be made to the entity designated by the State Department of Health Care Services to receive requests for disenrollment or to the department, if the department has no designee, no later than one working day after the out-of-county placement begins or any subsequent decision to designate the county of residence (host county) as the health provider (again, could include mental health). The relevant code is:

### **Welfare and Institutions Code § 14093.10**

(a) Whenever a foster child enrolled in a county organized health system, established pursuant to Article 2.8 (commencing with Section 14087.5), is placed in an out-of-county placement, the county child welfare agency or probation department with responsibility for the care and placement of the child shall determine, in consultation with the child's foster caregiver, whether the child should remain enrolled in

that county organized health system. The determination shall be made no later than one working day after the out-of-county placement begins.

(b) If it is determined, pursuant to subdivision (a) or at any later date, that a foster child should be disenrolled from a county organized health system due to an out-of-county placement, the county child welfare agency or probation department with responsibility for the care and placement of the child shall request that the child be disenrolled from the county organized health system. The request shall be made to the entity designated by the State Department of Health Care Services to receive requests for disenrollment or to the department, if the department has no designee, no later than one working day after either of the following occurs:

(1) The out-of-county placement begins.

(2) It is determined that a child who initially remained enrolled in the county organized health system following the out-of-county placement, pursuant to subdivision (a), should subsequently be disenrolled.

(c) The State Department of Health Care Services shall, in consultation with other agencies and organizations interested in health care access for foster children, establish for county organized health systems urgent disenrollment procedures that provide for disenrollment of foster children in out-of-county placements within two working days of receipt by the department's designee or by the department, if the department has no designee, of a request for disenrollment made by the county child welfare services agency, the county probation department, the foster caregiver, or any other person authorized to make medical decisions on behalf of the foster child.

(d) The department shall issue all-county letters or similar instructions to implement subdivision (c) no later than January 1, 2009, and thereafter shall adopt any necessary implementing regulations.

### **SECTION III -Recommendations**

The Out-of-County Mental Health Services Workgroup recommends that provisions similar to those described in Welfare and Institutions Code § 14093.10 be used to determine the most appropriate county to provide mental health services and, when appropriate, transfer the responsibility for the authorizing and providing medically necessary mental health services from the county of jurisdiction (origin county) to the county of residence (host county) for children placed with relatives, with foster parents or in group homes.

In addition, the Workgroup recommends expanding the participants to the individualized decision-making process outlined above to include the county of jurisdiction (as the responsible county Medi-Cal Mental Health Plan), any current or prospective mental health providers, the child (as appropriate, e.g. age 10 or older and developmentally capable), the birth parents, and/or other persons who would be involved in supporting the child's mental health services plan. This "Collaborative Team" approach would help ensure that mental health screening, assessment and treatment plans are individualized to each child and that the role of each contributor on the team is well understood by all so that each member can hold other members of the team accountable. The Collaborative Team should also help to ensure that the child's progress will be monitored and also that team meetings to review and update the mental health treatment plan are conducted as needed. The final decision-maker for the Collaborative Team would remain with the person who holds the right to make medical decisions under current law.

The Collaborative Team approach can be built into existing systems and practices that develop plans for foster children such as Team Decision Making sessions, Wraparound Child and Family Teams, Residentially-Based Services Teams and mental health screening sessions.

To assist the Collaborative Team in making decisions, the Workgroup recommends that the findings from the Data Mining Project be used to develop criteria that identify foster children who are at high risk for needing mental health services and therefore should be prioritized screening and assessment.

An initial review of the data suggests that children who have had multiple placements, children who have been in foster care for a long period of time and children in their teens should receive priority consideration. Children who are in repeat foster care episodes, children who have serious mental health disorders, children who are placed in group homes (as opposed to family or guardian homes), and children in probation-supervised placements (as opposed to child welfare-supervised placements) should also receive priority consideration.

If the Collaborative Team determines that a foster child should receive mental health services from the county of residence (host county), the county of jurisdiction should transfer administrative responsibilities for authorization, access, planning, treatment and payment arrangements to the county of residence (host county). Under current law, the county of jurisdiction would retain responsibility for due process regarding beneficiary protection issues.

## **Mental Health Services for Children in Foster Care Screening and Assessment**

### **BACKGROUND**

The California Child Welfare Council has been concerned about the extent to which foster children living outside their county of jurisdiction receive medically needed mental health services. At its December 9, 2010 meeting the CWC unanimously endorsed the following four elements of an Action Plan developed by the County Mental Health Directors Association and the County Welfare Directors Association as a viable framework: Identification, Screening and Communication; Authorization and Payment; Provision of Services and Capacity; and Outcomes and Accountability.

The Council also stipulated that transfer of responsibility for authorizing and providing mental health services from the county of jurisdiction to the county of residence was appropriate subject to further operational details and funding implications to be addressed separately in a Work Plan to be developed by a designated workgroup. Specific details to be fleshed out in the Work Plan should include: (1) a fiscal analysis; (2) recommendations around screening and assessment; and (3) criteria for when a child placed out-of-county would receive needed mental health services from the county of residence (host county) and also criteria for receiving needed mental health services from the county of jurisdiction (county of origin).

The CWC formed an Out-of-County Mental Health Services Workgroup to develop the three elements of the Work Plan with the goal of establishing clear and consistent practices for counties to follow so that foster children gain equal access to medically necessary mental health services.

The task of developing criteria to determine which county would provide needed mental health services was sequenced ahead of the other two elements because this decision was expected to drive the fiscal analysis and screening and assessment recommendations. The Workgroup has developed a proposal recommending that decisions as to who will provide foster children with needed mental health services should be made by a "Collaborative Team" on a child-by-child basis whenever possible. "Collaborative Team" members may include a mix of the following: a social worker, probation officer, mental health social worker, caregiver(s), birthparent(s) and others who would be involved in supporting implementation of a mental health services plan.

To aid the Workgroup in its analysis of the problem, members of the Council's Data Linkage and Information Sharing Committee with access to child welfare data collaborated with a Department of Mental Health analyst with access to mental health data to provide an analysis. The Out-of-County Data Mining Project resulted in a report containing a substantial level of detail regarding both who has access to what services and also the extent to which being placed out-of-county disadvantages foster children who need mental health services. In summary, data from the Report indicate the following: many children received mental health services, although there was considerable variability across counties; in-county foster youth received greater access to services and higher intensity of care on average than out-of-county foster youth; placement in- or out-of-county was not the strongest predictor of whether or not children received mental health services, but systematic differences were observed; and factors such as type of placement, age, and county of origin have a strong impact on access to and delivery of mental health services for in- and out-of-county foster placements.

Additionally, the Report highlights characteristics of youth placed out-of-county that warrant careful consideration from a policy and system design perspective, including the need to engage juvenile probation in the development and implementation of improvements to the current system. Specifically,



children and placements characterized by the following should receive priority consideration: children who are older, children who are in care longer, children who are in repeat in-care episodes, children who have serious mental health disorders, children who are in their second or greater placement, children who are placed in group homes, and children who are in probation-supervised placements.

#### **GOALS OF THE SCREENING AND ASSESSMENT SUBGROUP**

The goals of the Screening and Assessment Subgroup were: (1) to learn about members experiences with screening and assessment tools and also identify tools that support best practices; (2) to describe collaboration and integration strategies necessary for effective work with foster children and families; (3) to note barriers and issues to be addressed in implementing the tools and collaborating across agencies; and (4) to report on promising strategies to move forward to serve foster children with a medical necessity for mental health treatment regardless of where they live.

#### **SCREENING AND ASSESSMENT TOOLS**

The Subgroup reviewed screening and assessment tools currently in use in Alameda, Humboldt, San Bernardino and San Francisco Counties. They also reviewed a matrix of screening tools compiled by Frances Page Glascoe, Ph.D., professor of Pediatrics at Vanderbilt University and distributed to all County Welfare Directors and Chief Probation Officers via All County Letter 06-54, dated December 6, 2006; Child Health and Disability Prevention Assessment Guidelines distributed to Program Providers and Medi-Cal Managed Care Plans via Provider Information Notice 09-14, dated December 9, 2009; Mental Health Practice Guidelines for Child Welfare developed by the Reach Institute, Casey Family Programs and The Annie E. Casey Foundation; and Manuals for using the Child and Adolescent Needs and Strengths (CANS) assessment tool.

Subgroup members agreed that screening and assessment are two distinct steps in assessing mental health status. Screening tools should be relatively short and easily applied by non-clinicians as a way of identifying foster children who need a more in-depth evaluation of mental health needs. An example of this type of tool is the Mental Health Screening Tool (MHST) developed by the California Institute of Mental Health and used by several counties.

Assessment tools are administered by clinicians at regular intervals in order to measure progress over time. These tools inform diagnoses and treatment and identify issues that could affect placement. An example of this type of tool is the Child and Adolescent Needs and Strengths (CANS) used by several counties, community-based organizations and individual providers.

#### **COLLABORATION AND INTEGRATION OF SYSTEMS**

Elements of the proposed Katie A. model, as outlined in the Katie A. class action suit settlement agreement that was developed over a two year period by experienced professionals, can serve as guidelines for achieving a system that promotes collaboration among state agencies, county agencies, nonprofit providers, individual providers and families and children. The specific objectives as described in the agreement include:

- (a) Facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery and transition into a coherent and all-inclusive “core practices” approach;
- (b) Support the development and delivery of a service structure and a fiscal system that supports a core practices model, as described in (a);
- (c) Support an effective and sustainable solution that will involve standards and methods to achieve quality-based oversight, along with training and education that support the practice and fiscal models;

- (d) Address the need for certain class members with more intensive needs ... to receive medically necessary mental health services in their own home, a family setting or the most homelike setting appropriate to their needs, in order to facilitate reunification, needs for safety permanence and well being.<sup>2</sup>

#### **BARRIERS AND CHALLENGES**

Subgroup members identified the following barriers and challenges to an effective mental health delivery system that provides equitable access and treatment for foster children who have a medical necessity for mental health services:

- Shortage of mental health practitioners, especially in areas with few, or no, providers;
- Inadequate budget for funding and effective implementation of realignment of fiscal responsibility to counties;
- Prioritization of scarce resources, including criteria to determine who has the greatest need;
- Uncertain funding for education-related mental health services over the long term that could put additional pressures on Medi-Cal funding;
- Overlapping and conflicting criteria in the child and adult program requirements for the age 18 – 21 population who may qualify for services under foster care, corrections or health care.

#### **PROMISING STRATEGIES**

Subgroup members identified the following promising strategies that support an effective mental health delivery system that provides equitable access and treatment for foster children who have a medical necessity for mental health services:

- Emerging best practices for effective screening and assessment tools that are available at low or no cost to counties;
- Technical assistance and training available through a joint project of the California Social Work Education Center and Zellerbach Foundation;
- Possibility of adding a mental health screen as part of the Child Health and Disability Prevention exam at a minimal cost and thereby meet timeframes for minimum mental health screening within 30 days of placement and once per year thereafter.

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<sup>2</sup> “Special Master’s Report Pursuant to Agreement that Would Lead to Resolution of the Katie A. Case,” filed in United States District Court for the Central District of California on July 22, 2011.

**OUT-OF-COUNTY MENTAL HEALTH SERVICES  
DATA MINING PROJECT FINAL REPORT  
OCTOBER 25, 2011**

**PROJECT DATES**

Date Project Started	May 26, 2011
Date of Data Exchange from DSS to DMH	July 14, 2011
Date of Data Return/Destroy from DMH to DSS	July 25, 2011
Date of Transfer of all Project Files from DMH to DSS	August 3, 2001
Date of Draft Report for Discussion	August 2, 2011
Date of Draft Report for Discussion	October 3, 2011
Date of Final Report	October 25, 2011

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**NOTE: THE FULL REPORT MAY BE FOUND AT:**

<http://www.chhs.ca.gov/initiatives/CACChildWelfareCouncil/>

**EXECUTIVE SUMMARY**

At the request of the California Child Welfare Council (CWC), a workgroup was created to examine the extent to which foster children living outside their county of jurisdiction received medically needed mental health services. This workgroup – the Out-of-County Mental Health Services Workgroup – collaborated with members of the CWC’s Data Linkage and Information Sharing Committee and created the Out-of-County Data Mining Project. This report features an analysis of linked child welfare and mental health data. The analysis examines characteristics of foster children who received mental health services and details differences among children placed in and outside of their county of jurisdiction. This undertaking was significant in that it is the first time that the two databases have been linked. Furthermore, such linking represents a milestone toward achieving the Data Committee’s goal of sharing and linking data related to children in the Child Welfare System.

Data Mining Project members framed the following two questions for the study:

**Question 1:** What are the characteristics of the placements for children in which any community Mental Health or Outpatient Day Service (MHODS) was received during placement? Did the proportion with services differ by in- or out-of-county placement?

**Question 2:** For children who did receive community MHODS service in the year prior or the year during the analysis period, how did the level of service during placement differ based on placement/child characteristics? Did the level of service differ by in- or out-of-county placement?

The report examined placements, or portions of placements, that occurred in fiscal year 2008/09 (FY2008/2009).

### **Key Findings**

*1. Many children placed in foster care in California do receive mental health services, although there was considerable variability across counties.*

- Among the 105,483 unique foster children examined in this analysis, 56,339 children (53.4%) were linked to mental health services data in fiscal years 2007/08 and 2008/09.
- Among the 173,965 foster placements examined in the Question 1 analysis, 34.7% included at least one mental health service during the analysis period. (Note: Mental health case management and medication support were not counted as services.)
- Among the 100,826 placements included in the Question 2 analysis, 59.8% included at least one mental health service during the analysis period. The average days per month in which mental health services were provided was 2.8 days.

*2. In-County foster youth received greater access to services and higher intensity of care on average than out-of-county foster youth.*

- Overall, for the Question 1 population, out-of-county foster placements statewide were about 10% less likely to receive at least one mental health service than in-county placements (36.1% in-county vs. 32.4% out-of-county).
- There was considerable variation among counties both in terms of percentages of foster children receiving mental health services overall and in percentages of foster children receiving these services in- or out-of-county.
- For the Question 2 population, out-of-county placements were about 15% less likely on average to include any mental health service (63.1% in-county vs. 53.9% out-of-county).
- If access to services had been equally provided for in- and out-of-county placements, between 1,183 (Question 1 pop.) and 1,756 (Question 2 pop.) additional out-of-county placements would have received at least one mental health service during the analysis period.

- For the Question 2 population, in-county placements received approximately 26% more days of service per month on average than out-of-county placements (2.9 days in-county vs. 2.3 days out-of county).

*3. Placement in- or out-of-county was not the strongest predictor of whether or not children received mental health services, but systematic differences were observed.*

- Differences included apparent greater need for services (“demand” for services), as well as lower access to services and lower intensity of care (“supply” of services).
- Discrepancies in access to mental health services were identified that need to be addressed for children placed out-of-county.
- In addition, significant issues were identified that further refine the problem statement in terms of sub-populations of youth who require focused attention, including probation youth and youth in congregate care, and the wide differences among counties in providing mental health services to foster youth.

*4. This study highlights characteristics of youth placed out-of-county that warrant careful consideration from a policy and system design perspective, including the need to engage juvenile probation in the development and implementation of improvements to the current system.*

- Regarding demand for services, out-of-county placements (as compared to in-county placements):
  - Were for older youth
  - Were more likely for youth who were in care longer
  - Were more likely to be a repeat in-care episodes
  - Were more likely to be the second or greater placement
  - Were far less likely to be foster family homes or guardian homes
  - Were more likely to be group homes
  - Had much greater likelihood to be probation supervised than child welfare
  - Were more likely to have youth diagnosed with a serious mental health disorder in nine of eleven reported categories
- Regarding supply of services, out-of-county placements both received less care and less intensive treatment, on average, than in-county placements. More specifically, out-of-county placements:
  - Were less likely to be placements that served children at any age, and received lower intensity services at all ages except 1 to 2 years; the disparity in access to services increased with age, from age 11 on.
  - Were 34% percent more likely to be a group home, but 21% percent less likely to receive any care there; and for those placements receiving care, there were 38% percent fewer days of service per month.
  - Were over 2.5 times as likely to be probation placements but half as likely to receive any mental health service; when served, such placements received 54% of the days of service in-county placements received.
  - Received 10% to 30% fewer days of service in every category of mental health disorder reported.

*5. The data indicate that factors such as type of placement, age, and county of origin have a strong impact on access to and delivery of mental health services for in- and out-of-county foster placements.*

- The age of children in placement had the strongest correlation to receipt to mental health services in the model. For placements with children 11-15 years of age, county of origin was the best predictor of mental health service receipt. The variation across counties was larger than any other factor considered.
- Controlling for other factors, placement type was the strongest predictor of the level of mental health services children would receive. Average monthly days of service ranged from 1.1 days for children in pre-adoptive homes to 5.5 days for children placed in congregate care. Children placed in kinship foster care received a monthly average of 1.6 days of service.

There are a number of limitations to this report:

- While the foster care data extracted for the study period are generally assumed to be reasonably accurate, the mental health data used relies on monthly reporting from counties, and a review of the data suggests that there may be reporting issues in some counties.
- Children who appear to receive no services or minimal mental health services in the database used for this report may be receiving services other than those reported here.

Appendices A and B contain Question 1 and 2 results by factors included in the model.  
Appendices C and D contain Question 1 and 2 results by county.

## **Out-of-County Mental Health Services for Foster Children Fiscal Considerations**

As the Out-of-County Mental Health Services Workgroup is completing its charge, a new funding structure is unfolding. Under the 2011 Realignment Act (AB 118), the sharing ratios for medically necessary mental health services shifted from 50% federal, 45% state and 5% county to 50% federal and 50% county, and specific revenues have been allocated to counties that reflect their increased share of costs. The statute states that it is the intention of the Legislature that new allocation formulas be developed using appropriate data and information for the 2012-13 fiscal year and each year thereafter. Further, the statute states that it is also the intent of the Legislature that sufficient protections be in place to provide ongoing funding and mandate protection for the state and local government.

This new funding structure could change the current methods by which counties reimburse each other for medically necessary mental health services provided to children and youth who do not reside in their county of jurisdiction. Prior to the 2011 Realignment, the counties with jurisdiction used several methodologies for reimbursing other counties for mental health services provided to children who resided in a different county including:

- Passing on the federal and state shares of cost (95%) to the county of residence that provided the services and writing off the remaining five percent;
- Authorizing county mental health staff to travel outside the county of jurisdiction to serve youth residing in other counties;
- Contracting with non-profit mental health providers to serve youth where they live;
- Contracting with ValueOptions® Inc., an administrative services organization that operates under contract with counties and then subcontracts with mental health clinicians to serve youth residing outside the county of jurisdiction; or
- Informally “trading” services with another county, e.g., one county serves five youth from another county and that county serves five youth from the first county.

Under Realignment, the option of writing off the county share may not be realistic, although the other options in theory could continue without compromising the funding for the services. At the same time, counties report that there are drawbacks to all of the listed options, ranging from high travel costs in some cases; lack of non-profit provider agencies in certain areas; inefficiencies that would stem from having to contract with multiple providers; and need for formal accounting practices to prevent inequities. Recognizing these limitations, the stage is set to develop a treatment system that allows foster children to have equitable access to medically necessary mental health services and a smoothly operating payment system that reimburses counties and providers at the established Medi-Cal rates for services to foster children regardless of their county of jurisdiction or their county of residence.

The details for Realignment in 2012-13 and beyond are under development by the Department of Finance and Health and Human Services Agency and will be a focus of the Legislative session beginning in January 2012. The California Mental Health Directors Association is working with county, administration and legislative representatives to develop the financial provisions of 2011 Realignment and the transfer to the counties of the obligations for the Medi-Cal Specialty Mental Health Programs specified in the California state Medicaid Plan and the waiver. The financial provisions will include strategies to assure statewide access to medically necessary mental health services for all Medi-Cal beneficiaries.

The Workgroup recommends that the Child Welfare Council closely follow the progress of the Realignment deliberations as they relate to removing barriers to funding medically necessary mental health services for foster children who reside outside their counties of jurisdiction. In the meanwhile, the Workgroup is presenting programmatic strategies that could move forward under the 2011 Realignment system and, if successful, continue into 2012-13.