UNIVERSITY OF SAN FRANCISCO

CHANGE THE WORLD FROM HERE

The Way Forward

The Katie A. Promise

by

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Abstract

A disproportional percentage of California's foster youth experience significant mental health challenges. The 2002 Katie A. v. Bonta Lawsuit sought to achieve systemic changes within our children's mental health system. It was a huge win when a settlement agreement was reached in 2011 mandating three new service arrays: Intensive Case Coordination, Intensive Home Based Services, and Therapeutic Foster Care. This research examines where we are now with Katie A. Implementation by examining Katie A. services in Santa Cruz County through a case study of a Katie A. Subclass Member. This research reveals we have a long way to go before realizing the promises of Katie A.

Acknowledgments

The culmination of my research on Katie A. Legislation presented in this paper is dedicated to my daughter, whom is a Katie A. Subclass Member. While our journey together has presented many challenges, it is an honor to watch you grow and blossom. I love you dearly. Additionally, it is with the greatest appreciation that I acknowledge Patrick Gardner, JD and Nisha Ajmani from Young Minds Advocacy for their tireless efforts and astounding dedication to improving access to mental health services for California's most vulnerable children and youth. Thank you for taking the time to speak with me over the past ten months and aid me in navigating through Katie A. Legislation. Without integrated systems that provide critical access to mental health services, California's most vulnerable populations—our children and youth—are victims of state neglect, which can have negative or even fatal consequences.

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Section 1. Introduction

In 2002, plaintiffs filed a class action lawsuit, Katie A., ET AL., V. Diana Bonta, ET AL., alleging violations of federal Medicaid laws[1], the American with Disabilities Act[2], Section 504 of the Rehabilitation Act[3] and California Government Code Section 11135[4], with the intention of improving provisions of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California.[5] Originating from the Katia A. v. Bonta Settlement Agreement, Katie A. services

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[1] EPSDT

[2] The American with Disabilities Act of 1990 is a civil rights law, which prohibits discrimination based on disability.

[3] Section 504 of the Rehabilitation Act "forbids organizations and employers from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services. It defines the rights of individuals with disabilities to participate in, and have access to, program benefits and services" (https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf).

[4] 11135(b) "With respect to discrimination on the basis of disability, programs and activities subject to subdivision (a) shall meet the protections and prohibitions contained in Section 202 of the federal Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), and the federal rules and regulations adopted in implementation thereof, except that if the laws of this state prescribe stronger protections and prohibitions, the programs and activities subject to subdivision (a) shall be subject to the stronger protections and prohibitions" (http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=11135).

[5] According to the Settlement Agreement subclass members are "(a) Are in foster care or are at imminent risk of foster care placement, and (b) Have a mental illness or condition that has been documented or, had an assessment already been conducted, would have been documented, and (c) Who need individualized mental health services, including but not limited to professionally acceptable assessments, behavioral support and case management services, family support, crisis support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition. For the purposes of this case, "imminent risk of foster care placement" means that within the last 180 days a child has been participating in voluntary family maintenance services or voluntary family reunification placements and/or has been the subject of either a telephone call to the Child Protective Services hotline or some other documented communication made to a local Child Protective Services agency regarding suspicions of abuse, neglect or abandonment" (

mandates specialty medically necessary mental health services for children and youth age 0 through 21 covered by full scope Medi-Cal in California.

This research is intended to further examine implementation of the Katie A. Settlement Agreement and Core Practice Model. While broadly examining Katie A. services across California, this research focus on Katie A. services within Santa Cruz County, California. A case study is presented to illustrate deficits in implementation. My interest in Katie A. grew out of my juxtaposition between the personal and the political. Juxtaposed between our child welfare and juvenile justice systems as a former foster and justice engaged youth, and a collision with Children's Mental Health, Child Welfare, and Juvenile Probation as the parent of a child with significant mental health challenges, I found myself in a unique position to advocate for the realization of Katie A's promise.

This reach began with one key question in mind: How might California realize the promises of the Katie A. Settlement Agreement? While there is no easy answer, given the complexity of California's mental health, child welfare, and juvenile probation systems, this research attempts to shed some light. The initial question gave rise to the following questions: What are the terms outlined in the Katie A. Settlement Agreement? What clarification has either the California Department of Social Services (CDSS) or the Department of Health Care Services (DHCS) issued via all-county letters with regards to the intentions of policymakers? What are the specific meaning of key terms, such as, Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS)? Are these

services being provided via a nonprofit partner? What are the current deficits (gaps) between mandated services and those services available? As with any research project, the assumption was made that more questions needing answers would arise and be integrated to complete the story.

This research is important for many reasons, but namely because mental health has serious implications for our societal wellbeing. "The World Economic Forum estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US $16 trillion over the next 20 years. Such an estimate marks mental health out as a highly significant concern not only for public health but also for economic development and societal welfare."[6]

The nonprofit sector plays a significant role in providing mental health services to vulnerable populations. Often through contract with County Children's Mental Health. However, the government sector does not have the capacity and infrastructure to meet the societal need for services. There is an opportunity here for the nonprofit sector to lead the conversation and develop vital programming to increase quality and access to mental health services.

This paper begins with an introduction, then moves through a policy review. In the policy review, the Katie A. v. Bonta Settlement Agreement is explored, along with

[6] (World Health Organization. ed. David Bramley., 2013)

Proposition 63, and Early Periodic Screening, Diagnostic, and Treatment federal law. Katie A's. Story is presented along with a case study of a Santa Cruz County Katie A. Subclass member. Methods and approaches to this research are articulated. Followed by and analysis of five Katie A. county quarterly reports and mental health data. Finally, implications and conclusions are drawn and a conclusion summarizing this research.

Section 2: Policy Review

Since the 1990's California has been passing legislation to provide better coordinated and more comprehensive mental health care for those living with serious mental illness. Particularly, policies aiming to improve care for underserved populations. "Under the children's provisions of the Medicaid Act, known as Early and Periodic Screening Diagnostic and Treatment (EPSDT),[7] federal law requires states to provide children and youth with a broad array of mental health services and supports, including intensive home and community-based services… Unfortunately, intensive home-based services are often not available, and until recently, the State of California did not acknowledge that Medicaid-eligible children and families were entitled to these services."[8] Children and youth in our child welfare system (foster care) and insured

[7] "EPSDT – Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need, diagnostic and treatment services are provided. EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a beneficiary under the age of 21 may receive additional medically necessary services. These additional services are known as EPSDT Supplemental Services and include mental health related diagnostic services and treatment (other than physical health care). These services are available under the Medi-Cal program only to persons under 21 years of age pursuant to Title 42, Section 1396d(r), United State Code, are services that have been determined by the State Department of Health Care Services to meet the criteria of Title 22, Section 51340(e) (3) or (f); and are not otherwise covered as specialty mental health services. EPSDT services include rehabilitative mental health services for seriously emotionally disturbed children: collateral, assessment, individual therapy, group therapy, medication services, crisis intervention, day care intensive, and day care habilitation offered in local and mental health clinics or in the community. EPSDT services include Therapeutic Behavioral Services (TBS) for children/youth with serious emotional challenges, as well as mental health evaluations and services" (www.dhcs.ca.gov).

[8] (Young Minds Advocacy Group, n.d.)

through California's Medi-Cal program and entitled to federal Medicaid and state Medi-Cal benefits. However, children in state custody often do not receive needed appropriate mental health treatment to address their mental health needs, which is illustrated through Katie A's. Story.

> **Katie A's Story:** "When the *Katie A.** lawsuit was filed, Katie was 14 years old and had been in foster care for 10 years. She was removed from her home at the age of four due to neglect; her mother was living on the street and her father was incarcerated. By age five, Katie's assessments indicated she was a victim of trauma and in need of treatment. Despite pleas to the Department of Child and Family Services (DCFS) by her caregiver, Katie never received the mental health treatment she needed. Instead DCFS shuffled Katie from one inappropriate placement to another—37 placements in all—including psychiatric facilities and group homes."[9]

In response to Katie A's story and thousands of foster youths' who have stories like hers, attorney and mental health advocate Patrick Gardner, JD, filed the 2002, Katie A. v. Bonta lawsuit alleged "violations [by the California Department of Social Services (CDSS), the Department of Health Care Services (DHCS), and Los Angeles County] of federal Medicaid laws, the American with Disabilities Act, 504 of the Rehabilitation Act and California Government Code Section 11135..."[10]

In 2003, Los Angeles County agreed to a settlement agreement, and in 2011 state plaintiffs reached a settlement agreement. "In November 2012, the United States

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[9] (Young Minds Advocacy Group, n.d.)
[10] (State of California, 2018)

District Court approved an Implementation Plan setting forth how the California Department of Social Services (CDSS) and the Department of Health Care Services (DHCS) will fulfill the obligations in the Settlement Agreement in the Katie A. v. Bonta lawsuit (all county letter 13-73)."[11]

Nine years after the Katie A. v. Bonta lawsuit was initially filed, Federal District Court Judge A. Howard Matz, issued an order approving a proposed settlement of the case. The settlement agreement sought to achieve systemic changes within our children's mental health system by promoting, adopting, and endorsing three new service array approaches—***Intensive Care Coordination (ICC),[12] Intensive Home-Based***

[11] (Young Minds Advocacy Group, n.d.)

[12] "Intensive care coordination (ICC) is a targeted case management (TCM) service that facilitates assessment of, care planning for and coordination of services, including urgent services for members of Katie A. Subclass" (http://www.childsworld.ca.gov/res/pdf/CorePracticeModelGuide.pdf).

Services (IHBS)[13] and Therapeutic Foster Care—for existing Medicaid covered services[14] for children and youth within the class.[15]

The Settlement Agreement articulated that "[t]he California Department of Social Services and Department of Health Care Services will work together with the federal court appointed Special Master, the plaintiffs' counsel [Patrick Gardner, J.D.], and other stakeholders to develop and implement a plan to accomplish the terms of the settlement agreement."[16] As a result of the settlement agreement, the Katie A. Oversight Committee put together a "Pathways to Mental Health Services - Core Practice Model (CPM) Guide,"[17] which describes how child welfare and mental health can work together to ensure best practices in supporting children, youth and their families in accessing *mental health services.* Young Minds Advocacy Staff Attorney & Policy Advocate, Nisha Ajmani, wrote in a blog titled "Katie" Turns 15: How the Katie A. Lawsuit Has Reduced Youth Institutionalization and Expanded Opportunities for

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[13] "Intensive home-based mental health services (IHBS) are mental health rehabilitation services provided to members of the Katie A. Subclass. IHBS are individualized, strength-based interventions designed An effective practice model encompasses an array of services that generally includes culturally responsive and trauma-informed or trauma-responsive, evidence-based practices, promising practices, innovative practices, and culturally specific healing practices and traditions. 28 to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family ability to help the child/youth successfully function in the home and community" (http://www.childsworld.ca.gov/res/pdf/CorePracticeModelGuide.pdf).

[14] Under the children's provisions of the Medicaid Act, known as Early and Periodic Screening Diagnostic and Treatment (EPSDT), federal law requires states to provide children and youth with a broad array of mental health services and supports, including intensive home and community-based services.

[15] (State of California, 2018)

[16] (State of California, 2018)

[17] (California Department of Social Services C. D., n.d.)

Thousands of Young People in CA with Mental Health Needs, posted on December 20, 2017 that,

> "The Settlement Agreement was an important milestone because it required that the state develop three types of previously unavailable community-based mental health services ("*Katie A*. services") for child welfare-involved youth. Additionally, California agreed that foster youth and children at risk of out-of-home placement – who are Medi-Cal-eligible and need intensive home or community-based care – would be entitled by law to *Katie A*. services. As a result, tens of thousands of youth became eligible for services that are intended to reduce institutionalization and criminalization of abused and neglected young people."[18]
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> Nisha Ajmani, Staff Attorney and Policy Advocate at Young Minds Advocacy

Katie A. is not the first proposed legislation aimed at transforming California's mental health system. Proposition 63, The Mental Health Service Act, was voted into law on November 2004 imposing an additional 1% tax on individuals' taxable income in excess of one million dollars. The law was designed with the intention of expanding and transforming California's county mental health services system. Its successes, as supporters argue, were the development of innovative and integrated Full-Service Partnerships aimed at providing youth and their families who have complex needs and are involved with multiple service providers well-coordinated delivery of care that addresses the underlying causes for the youth's behaviors. However, proponents of

[18] (Ajmni, 2017)

MHSA, highlight that without overcoming implementation challenges, MHSA will not rise to its advertised potential.

Since the inauguration of the Katie A. Settlement Agreement, entitlements under Katie A. have legislatively been made available to a broadened population. Justice engaged youth became incorporated in 2015, and in 2016, *ALL* of California's children and youth covered by full scope Medi-Cal who meet the medical necessity criteria were declared entitled to receive specialty mental health services. However, while tens of thousands of children and youth are eligible for specialty mental health services, California is struggling to realize the promises made in the Katie A. Settlement Agreement. Just as MHSA offered grand promises to transform the way county mental health delivers services to youth and their families, individual counties responsible for implementing legislative mandates, are struggling with implementation. There is an array of reasons highlighted by individual counties in their Katie A. quarterly reports submitted to the oversight committee, including funding deficits and lack of current infrastructure.

In an interview with Patrick Gardner, JD, Principle Attorney in the Katie A. Lawsuit and Founder and CEO of the watch dog nonprofit, Young Minds Advocacy (YMA) Group based in San Francisco California, he explained that *even the best intended legislation has minimal impact without effective oversight and enforcement that holds*

stakeholders accountable.[19] YMA was established in 2012 "to address the number one health issue facing young people and their families—unmet mental health needs."[20] YMA uses a blend of policy research and advocacy, impact litigation, and strategic communications to change attitudes towards mental illness and break down barriers to quality mental healthcare for young people and their families.[21] Mr. Gardner went on to explain that while the Katie A. Settlement Agreement established an oversight committee, which requires all fifty-eight California Counties' to submit quarterly reports, the committee has limited capacity to provide necessary oversight for ensuring compliance with meeting the requirements of the Settlement Agreement and implementation of the Core Practice Model. Additionally, the oversight committee will eventually sunset. Mr. Gardner explains, through an analogy drawn from traffic law to illustrate the imperative of oversight in ensure access to mental health services. Traffic laws are established, and fines imposed, which are enforced by police officers. The financial cost of violating traffic regulations acts as a deterrent for citizens because of the strength of the enforcement vehicle, i.e. police presence and likelihood of being cited for not adhering to speed limits, signaling, and so on. County mental health however, does not have such a deterrent to comply with legislation. Few county mental health clients are aware of the regulations that mediate the services they are entitled to

[19] (Gardner, Founder and CEO, 2018)
[20] (Young Minds Advocacy Group, n.d.)
[21] (Young Minds Advocacy Group, n.d.)

and even those that are aware of mental health legislation get bogged down in bureaucratic processes that hinder access to necessary services in a timely manner.

> Furthermore, *legislation is costly and time consuming.*[22]*The Katie A. Lawsuit lasted 9 years before a settlement agreement was reached. Watch dog groups like Young Minds Advocacy are needed to provide oversight of government to ensure accountability. Yet, oversight costs money and funding can be challenging to secure because nonprofit foundations are more inclined to give grants to direct service agencies rather than to those providing oversight. Currently, oversight occurs on a case by case bases. We hear about stories like yours, and where we can gather evidence of a direct policy violation, we can take actions to ensure remedies.*[23]
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> Patrick Gardner, JD, Founder and CEO Young Minds Advocacy

County administrators often lack critical understanding of the legislation. This is in part because legislation is written broadly to allow individual counties to develop programs within the confines of their unique position—resources and demographic needs—and this leaves room for interpretation of the law. Individual county's need clarity from the legislators regarding the intentions of the law.

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[22] (Gardner, Founder and CEO, 2018)
[23] (Gardner, Founder and CEO, 2018)

Through interviewing Santa Cruz County CMH and DFCS staff, there was great variance in knowledge of Katie A. In interviews, questions posed were, "Have you heard of Katie A. Legislation and have you participated in Katie A. services trainings?"[24] While interviewees had heard of Katie A., their knowledge of the legislation was restricted to broad understanding of Katie A. in relationship to foster youth. All were under the impression that a child or youth had to have an open child welfare dependency case—meaning a dependent under Welfare and Institutions Code § 300 (in foster care)—to be eligible for entitlements. There was a general lack of awareness of the broadened entitlements of Katie A. to all children and youth age 0 – 21 receiving full-scope Medi-Cal with a serious mental health condition. In response to inquiry about participation in training, few said they had attended some type of Katie A. services training. While CMH staff possessed more general knowledge of Katie A., through having participated in Child Family Team (CFT)[25] meetings, DFCS staff generally possessed less awareness of the entitlements under Katie A. One of the requirements articulated in the Katie A. Settlement Agreement is cross-training across CMH and DFCS and partnerships established through Memorandums of Understandings (MOU's). In interviews with Santa Cruz County Juvenile Probation Officers, responses indicate a

[24] (CMH, 2018)

[25] "The CFT is a team of people—it is comprised of the youth and family and all of the ancillary individuals who are working with them toward their mental health goals and their successful transition out of the child welfare system" (http://www.childsworld.ca.gov/res/pdf/CorePracticeModelGuide.pdf).

general lack of awareness of Katie A. and no participation in Katie A. services trainings. When interviewees across all three systems were asked, if there was a protocol for identifying youth for Katie A. Subclass Membership, they had no response. In an interview with Patrick Gardner, JD, Founder and CEO of Young Minds Advocacy Group, he expressed that similar breakdowns in awareness and training are persistent across California's counties. While the Settlement Agreement highlights the imperative of cross-training among CMH, DFCS, and Juvenile Probation for effective delivery of services, how counties achieve this is left for individual county administrators to determine. In Santa Cruz County, CMH is the lead agency to provide specialty mental health services. Both DFCS and Juvenile Probation refer foster youth to CMH for mental health care. CMH contacts with Encompass Community Services (a local mental health serving nonprofit) through Request for Proposal (RFP) for delivery of a Therapeutic Support Program (TBS), which provides short term intensive home and community based behavioral intervention supports. However, Encompass is new to providing TBS, winning the contract bidding in early 2018. The contract was previously held by Unity Care Group, Inc. For a short time, DFCS partnered with Encompass to offer the Fuente II Program, which offered a teaming approach between DFCS social worker, Encompass therapeutic service providers, and children or youth and their families or caregivers to provide intensive services. However, the Fuente II Program, ceased to be funded by DFCS in earlier 2018. Juvenile Probation currently contracts with Encompass to offer the

Fuente I Program, which swaps out the social worker for a probation officer. Though, this is a three-year pilot program set to sunset at the end of 2018 and has the limited capacity of only serving fifteen youth at one time. Juvenile Probation also operates a WRAP Around[26] program internally, however, this program is scheduled to be phased out, and the Fuente I model adopted.

Research shows that establishing CFT's are an essential vehicle in driving ICC and IHBS services and helps prevent costly – and frequently ineffective – residential placements. The instability and lack of adequate treatment had devastating impacts on Katie A. and profound implications for California's children and youth. It is unfortunate that Katie's story is not so unusual. Children placed outside of the home disproportionately suffer mental health disorders. "Up to 80% of children in foster care have significant mental health issues, compared to approximately 18-22% of the general population."[27] Adolescents living with foster parents or in group homes have about four times the rate of serious mental health needs than those living with their own families. Institutional or group care may be necessary for some youth with extremely high-level needs, but for others it is unnecessary—even harmful. According to the Surgeon General, although three out of every five children in out-of-home care have moderate to

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[26] "Wraparound is an intensive, individualized care planning and services management process. The Wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that results in plans and services that are effective and relevant to the child and family" (http://www.childsworld.ca.gov/res/pdf/CorePracticeModelGuide.pdf).
[27] (National Conference of State Legislatures, 2018)

severe mental health problems, fewer than one in three receive *any* mental health treatment."[28] While the majority of youth are placed in foster care due to immediate risk of abuse or neglect by a biological parent, Adolescents may be placed by court order because of their own behavioral and emotional issues or because of minor criminal involvement (juvenile delinquency or person in need of supervision).[29] It is critical for these young people to receive mental health assessments and timely interventions. "…A disproportionate number of children placed in foster care come from families with the fewest psychosocial and financial resources and the most complex needs."[30]

"The article by Dorsey provides a specific example of how one treatment approach, Trauma-focused Cognitive Behavioral Therapy can be effective to remediate mental health problems for youth in foster care and how foster parents [caregivers, and parents] can be engaged in the treatment process. Even when effective treatments exist, the evidence supporting psychological care is meaningless without access to treatment."[31] It is perplexing that given the amassed data showing significantly poorer outcomes for foster youth then those in the general population, that California has not invested in the building of the necessary infrastructure to ensure expanding access to

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[28] (Young Minds Advocacy Group, n.d.)
[29] (Szilagyi, 2015)
[30] (Szilagyi, 2015)
[31] (Jackson, 2012)

specialty mental health services. Indeed, separating children from their homes and families may add to their distress. This is certainly the case as illustrated in my own story, which I present below as a case study.

Case Study:

In early 2016, my thirteen-year-old daughter's mental health quickly began deteriorating. While she had been receiving mental health services since the age of four, included individual therapy, family therapy, psychiatric care, medication management, and Therapeutic Behavioral Support (TBS) Services[32], her mental health symptoms continued to evolve and escalate over the years, which was accompanied by addition of new diagnoses. With the onset puberty in early adolescence her symptoms became critical. She began experiencing suicidal ideations that resulted in visits to our local hospital and crisis stabilization unit, and a ten-day hospitalization at a pediatric behavioral health unit. Additionally, she began engaging in increasingly aggressive

[32] "EMILY Q., ET AL.V. BELSHE, ET AL: The California Department of Health Services Director, Diana Bonta, was the named defendant for the State in 1998. During the course of this litigation, the defendant was changed to the California Health and Human Services Secretary (currently Kim Belshe) who has statutory and administrative authority over both the recently (2007) renamed Department of Health Care Services, and the Department of Mental Health. DMH is significantly involved in this litigation since DHCS has delegated to DMH the responsibility of administering the Medi-Cal reimbursed mental health services program, and DMH contracts with the Mental Health Plans (County governments) regarding the provision of EPSDT services. In 1999, it was determined that Therapeutic Behavioral Services (TBS) eligibility is determined by the following criteria: All current and future beneficiaries of the Medicaid program below the age of 21 in California who: 1. are placed in a Rate Classification Level (RCL) facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs; 2. are being considered for placement in these facilities; or 3. have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months" (http://www.dhcs.ca.gov/services/MH/Documents/EQ_Webpage_DRAFTLanguage_Nov2008.pdf).

behaviors at home and school. In response to the escalating negative behavioral challenges, I sought increased supports from Santa Cruz County Children's Mental Health and through our local the School District. A Student Study Team (SST) meeting was held at my request, and school-based therapy was added to her existing Individualize Education Plan (IEP). Additionally, we added a new therapist to work one-on-one with me, in addition to the current therapist providing one-on-one support to my daughter. Additionally, we were recertified for Therapeutic Behavior Support Services and had a TBS Coach in our home three times per week to assist with positive behavioral interventions and life skills development. However, even with the array of services being received, my daughter's mental health continued to decline. She began engaging in increasingly high-risk behaviors, and in late 2016 collided with our juvenile justice system.

After multiple arrests, including possession of a controlled substance and distribution on a school's grounds and multiple battery charges, and several juvenile detentions, my daughter was placed on a Welfare and Institutions Code (WIC) § 300 hold by delinquency court judge Heather Morse and made releasable to Santa Cruz County Children Protective Services (CPS) for placement in out of home care. The argument made was that because I was unable to *control* my child and prevent her from engaging in high risk behaviors, she was at risk of neglect. I was flabbergasted by what I viewed as an incompetence in the system to effectively address my daughter's mental

health needs. I had been pleading with juvenile probation for months to provide WRAP Around Services, which had been denied because my daughter didn't evaluate as a high enough risk based on juvenile probations standardized risk assessment tool.

Overwhelmed and frustrated by the added involvement of CPS because of the WIC § 300 hold, I reached out to Hadée Cuza the Executive Director of California Youth Connection (CYC). CYC is the largest youth-lead nonprofit advocacy organization promoting individual and collective wellness for foster youth in California. Following an emotional conversation with Hadée, who compassionately listened to me share the challenges I had been experiencing over the subsequent months and even years throughout my attempts to accesses appropriate mental health services for my daughter. Upon finishing my story, Hadée asked if I had ever heard of Katie A. Legislation. I paused, attempting to recall if I have ever head of Katie A. I responded by saying NO! What is Katie A.? Hadée shared a high-level overview of Katie A. Legislation and offered to follow up with Patrick Gardner, JD, to see if he could aid me in anyway. After the call ended, I began scouring the internet to find out more about Katie A. Services. The more I read, the greater disillusioned I became. Given Katie A. Subclass membership criteria my daughter was eligible for subclass membership, including Child Family Teaming, Intensive Care Coordination, and Intensive Home Based Services.

In roughly just three-months' time my daughter lived in four foster placements and had attended two different schools. She was first placed at Bill Wilson Center in Santa Clara County; a nonprofit homeless shelter for youth. She experienced verbal threats of violence from other youth in the shelter while there and was restricted from having contact with family members. She was moved to Chamberland's aggregated Care facility in Hollister, where she has sense shared complaints of staff locking her bedroom closet to restrict access to personal belongs as a consequence. Such a consequence would be conceived of as punitive if occurring in a home and found as a justification to substantiate an allegation of abuse in our dependency court system if done by a parent. After complaining about the method of consequences used at Chamberland's. Still pending disposition[33] in dependency court, family visits had yet to occur over this two-month period. Over this same period, I met several times with social workers from Family and Children Services who stated they had no intentions of filing in dependency court. This is a common complaint made by parents, who are deceived by social workers for the purpose of the social worker to gain entry into the family's home. The department informed me that they had received reports from juvenile probation that there were concerns regarding my level of involvement in my daughter's

[33] "Disposition and Jurisdiction Hearings are often held together; however, they have separate functions. Jurisdiction Hearings determine whether or not abuse and neglect allegations are true and if intervention is warranted under W&IC 300. At a Disposition Hearing, the court determines a child's placement and establishes a service plan" (http://www.childsworld.ca.gov/res/pdf/CorePracticeModelGuide.pdf).

therapeutic care. I scoffed at such a notion, it was outrageous, and I was outraged. I engaged exhaustively engaged in my daughter's treatment over the previous ten years. At the onset of the escalating declining of her mental health I had even took Intermittent Family Medical Leave under the Family Medical Leave Act (FMLA) from my career in a foster youth serving agency in Santa Clara County and decreased the number of hours I was working to increase my level of engagement; and was participating three times per week in TBS Services in my home, weekly with my daughters therapist, monthly psychiatric appointments, and engaged weekly with my own therapist to ensure my own mental wellness. I actively pleaded with Santa Cruz Juvenile Probation Department to provide my daughter with WRAP Around Services, which they repeatedly denied. Following one court hearing, Jennifer a Juvenile Probation Officer informed me that if I contacted law enforcement to assist in mitigating my daughter's violent outbursts, they would make a CPS report alleging abuse and/or neglect. Juvenile Probation offered the Fuente I program, and I quickly agreed to participate. After initial intake with the Fuente I therapist, it became clear that services under the program would be short lived. The therapist expressed concerns that given my daughters lack of interest of engagement and escalated behaviors of domestic violence, her needs were greater than the program could support.

After a great deal of advocacy, my daughter became a certified Katie A. Subclass Member on August 29th, 2017; disposition was still pending in dependency court. In

early September 2017, even though no allegations of abuse and/or neglect were ever substantiated by CPS, by daughter became a dependent of our child welfare system under WIC § 300 and remined in out of home aggregated care. I was informed by the social worker assigned to oversee my daughters case that given her level of need for care she would not be able to be placed into a home like environment. My daughters appointed attorney advocated that my daughter be moved to a less restrictive placement and in response he was moved again to Haven of Hope Group Home, and placed in their Watsonville, California house. After a few weeks of being at Haven of Hope, the group home director and social worker made the decision to move my daughter yet again, and she was placed at Haven of Hopes Aptos, California house. Once settled into Haven of Hope Aptos house, she began exhibiting violent behaviors. She made threats to harm her roommate unless she was permitted to move into another bedroom in the house and threated to harm a staff when the staff refused to transport her to school. My daughter began running away from the group home. On one occasion, traveling with an adult male and another minor from the group home to Salinas California. From SNAP Chat video's taken by my daughter and posted, the male was under the influence of alcohol and marijuana, which he also provided to my daughter. On many more occasions however, my daughter would leave school and show up at home. Each time, I was forced to contact the group home and social worker and make arrangements for her to return to school or the group home. The social worker wrote

these incidents up as me having unapproved visits with my daughter, which were provided to the court. On one occasion however, in early November, my daughter left school and showed up at home. She was upset and crying. We engaged in a lengthy conversation where she informed me that under no circumstances was she going to return to the group home. She wanted to be home. She pleaded with me, saying *If you make me go back to the group home I will just runaway again*.[34] Following protocol, I contact Haven of Hope group home staff and made arrangements for a staff member to come to my home to pick her up. The staff member arrived and attempted to convince her to return to the group home. She contested, repeatedly saying, *I'm not going back, I hate it there, I want to be home, I want to sleep in my own bed.*[35] I was juxtaposed between my daughter's emotional needs and the systems requirements. I felt powerless. I know first-hand what it is like to live in a group home as a former foster and justice engaged youth, and I in disbelief that child was now placed in one. While the staff member continued to try to reason with my daughter, I stepped away and called the social worker and the social workers supervisor. Upon being set to both their voicemails and leaving messages, I called the main county number. I explained the situation to the receptionist and said, I need to speak with a supervisor. I was transferred and found myself listening to yet another voicemail recording. After nearly

[34] (Minor, 2017)
[35] (Minor, 2017)

three house of run arounds, I called the main county number again and this time demanded to speak to a live person. Hours had passed since the staff had arrived at my house and I could see their growing annoyance. She had expressed that Haven of Hope protocol was to contact law enforcement to aid in the situation. I know what meant. My daughter would be detained and taken up to Juvenile Hall. I negotiated with the staff to given me just a little more time to get in touch with someone at Family and Children Services. This time when I called, the receptionist answered, I explained again that I needed to speak with a supervisor immediately. She began giving me the run around again, saying she could transfer me. I interrupted her and said *NO, I need to talk to a supervisor NOW*. *Please go find one*.[36] She began protesting. I cut her off again, stating, *so you are telling me that a government agency like Family and Children Services doesn't have a social worker supervisor available at all time?*[37] She acknowledged, and responded, *I will walk around and go find one for you*.[38] I said, *Thank you*.[39] I was placed on hold and when I heard the receptionist voice again, she said, *I'm going to transfer you to a supervisor now.*[40] I said, *thank you.*[41] After several conversations over the next hour and the development of a safety plan, I received approval for my daughter to remain with me in our home. The next day, my daughter was placed on an extended

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[36] (Wright, 2017)
[37] (Wright, 2017)
[38] (DFCS, 2017)
[39] (Wright, 2017)
[40] (DFCS, 2017)
[41] (Wright, 2017)

home visit until our next court hearing, which was scheduled for later in the month. At the hearing, my daughters' case was switched to Family Maintenance (FM).

Over the next several months, I have continued to advocate across Children's Mental Health, Family and Children Services, and Juvenile Probation for appropriate mental health services. In the weeks and months following my daughters return home, we saw a dramatic decline in services. This was both in part because of my daughter's refusal to engage with services providers and a decline in service availability. Santa Cruz Children's Mental Health ended the contract with Unity Care Group, Inc. for the TBS Program in mid-2017 and had issues an RFP, but no alternative service provider had been identified. In fact, it took more then six months of asking for TBS during CFT meetings, one-on-one meetings with my daughter's therapist, and email and phone conversations with Paul Vitali, LMFT, Supervising Mental Health Client Specialist at Children's Mental Health and Jennifer Canu, LMFT, Child Family Team Coordinator, before it was implemented; and ten months later, we are still waiting for IHBS to be implemented. It has been a rocky road with the journey towards recovery having no end in in sight. With the lack of integrated systems across Children's Mental Health, Child Welfare, and Juvenile Probation youth like my daughter stand no chance in receiving necessary and appropriate access to mental health services. No matter how well intended legislators and individual service providers are, if the infrastructure to fully implement policies hasn't been established, promised mental health services simply are

not available. This leaves families with the brunt of the burden to navigate complete mental health challenges without the necessary supports to aid in alleviating the youths' suffering and sets the youth up for long term negative impacts.

Section 3: Methods and Approaches

This capstone project used a mixed method approach, relying on archival data available via online sources including principle documents, such as the Katie A. Settlement Agreement and Katie A. Quarterly Reports; Expert interviews with professionals from Family and Children Services, Children's Mental Health, Encompass Community Services, and Young Minds Advocacy Group. Interviewees' were principle persons involved in the Katie A., v. Bonta lawsuit, principle persons at the California Department of Social Services and the Department of Health Care Services, and county mental health and child welfare administrators and service providers involved with implementing and administering Katie A. services. In addition, this project relied heavily on personal account of navigating across multiple systems, attendance at a Katie A. Oversight Committee Meeting, and participation in the 2018 CMHACY Conference, held in Monterey California, as a parent advocate.

Additionally, fundamental to this project was its applicability to generate systems changes. This project included surveying nonprofit and government websites across California to assess for accuracy of information regarding Katie A. entitlements. Nonprofits and government agencies sharing incorrect information were sent standardized email communications asking for corrections to be made to their web published content. Nonprofits and government agencies were selected randomly and represent both Northern and Southern California counties'.

Furthermore, Santa Cruz County was presented via a case study composed from an individual Katie A. Subclass members account. The Katie A. Settlement Agreement requires counties to complete quarterly reports, which are submit to the Katie A. Oversight Committee for review. These reports were an essential data source for understanding the phase each county is at with regards to implementation. Additionally, they were helpful in gathering broad data, such as the total number of foster youth per county and the total number of Katie A., Class and Subclass members living in each county.

Section 4. Data Analysis

Mental Health, Suicide, and the State

"In California, over 3,000 people die by suicide each year. The three strongest risk factors for suicide are prior suicide attempts, **mental disorders**, and substance use/abuse."[42] According to the Centers for Disease Control and Prevention (CDC) suicide is the third-leading cause of death for youth between the ages of 15 through 24 in the United States and is frequently contributed to mental illness. "One half of all chronic mental illness begins by the age of 14: three-quarters by the age of 24."[43] "Adolescents who had been in foster care were nearly two and a half times more likely to seriously consider suicide than other youth [and] [a]dolescents who had been in foster care were nearly four times more likely to have attempted suicide than other youth."[44] This highlights the need for necessary and appropriate mental health services to be readily available to these most vulnerable youth.

Furthermore, 97% of children are covered by or can be covered by health insurance,[45] and most of these children and their families are insured through California's Medi-Cal program. County Mental health is the primary provider as the

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[42] (Eberhart)
[43] (National Alliance on Mental Illness, n.d)
[44] (Ramaglia, 2013)
[45] (Gardner, Founder and CEO Young Minds Advocacy, 2018)

states agent for providing mental health services to this population. Both federal and state laws guarantee certain entitlements to an array of services to address mental illness. As illustrated through the statistics above, untreated mental illness can have serious or even fatal implications for young peoples' wellness. Especially foster youth, who have often lost the supports of their families as a core asset, to assist with managing the complex challenges that accompany living with mental illness.

Furthermore, "[m]ental, emotional, and behavioral disorders are highly prevalent"[46] and "[t]hese disorders result in high economic costs to society and exact a heavy personal and family toll on those who experience them."[47]

Mental Health and Katie A.

In review of Katie A. data provided to the Katie A. Oversight Committee through county reports, **Table 1** presents data compiled for five counties, regarding the total number of foster youth by county; the total number of Katie A. Subclass Members by county; percent of subclass members to total number of foster youth by county; total approved reimbursements for delivered Katie A. services. The counties selected were chosen by subtracting and adding 25+/- from the total number of foster youth in Santa Cruz County.

[46] (Eberhart)
[47] (Eberhart)

Table 1: Katie A. Data, by County

County	Total No. of Foster Youth, by County	Total No. of Katie A. Subclass Members, by County	Percent of Subclass Members to Total No. of Foster Youth, by County	Total Approved Reimbursed for Katie A. Services	IHBS	ICC
Tehama County	245	57	23%	$15,775.00	$0.00	$15,775.00
Mendocino County	271	132	49%	$466,990.00	$197,925.00	$269,065.00
Santa Cruz County	272	73	27%	$821,381.00	$656,675.00	$164,707.00
Yolo County	281	71	25%	$292,601.00	$117,013.00	$51,355.00
Madera County	296	175	59%	$441,381.00	$0.00	$56,906.00

Data modified from "Katie A. Specialty Mental Health Services Report - Fiscal Year 2015/2016, Report run on 11/20/2017," by Katie A. Oversight Committee, Nov. 2017, p. 12.

Figure 1: Foster Youth & Katie A. Subclass Members, by County

Blue: No. of Foster Youth, by County & Orange: No. of Katie A. Subclass Members

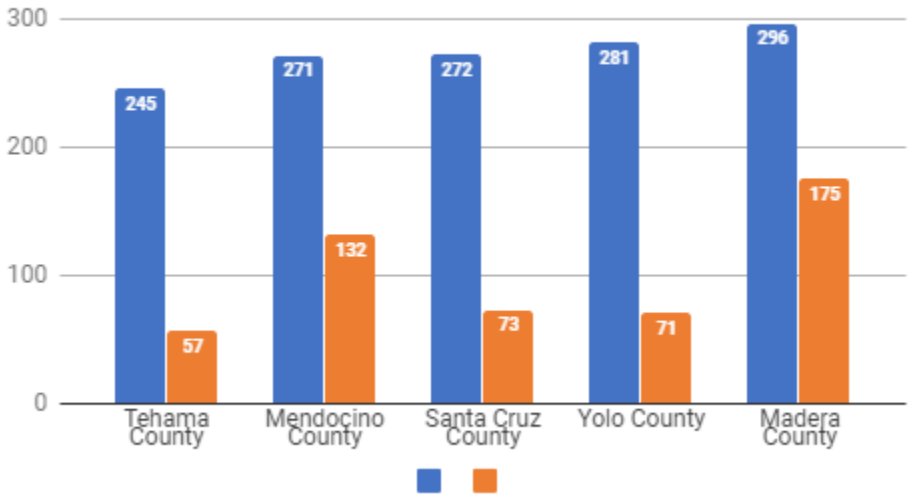
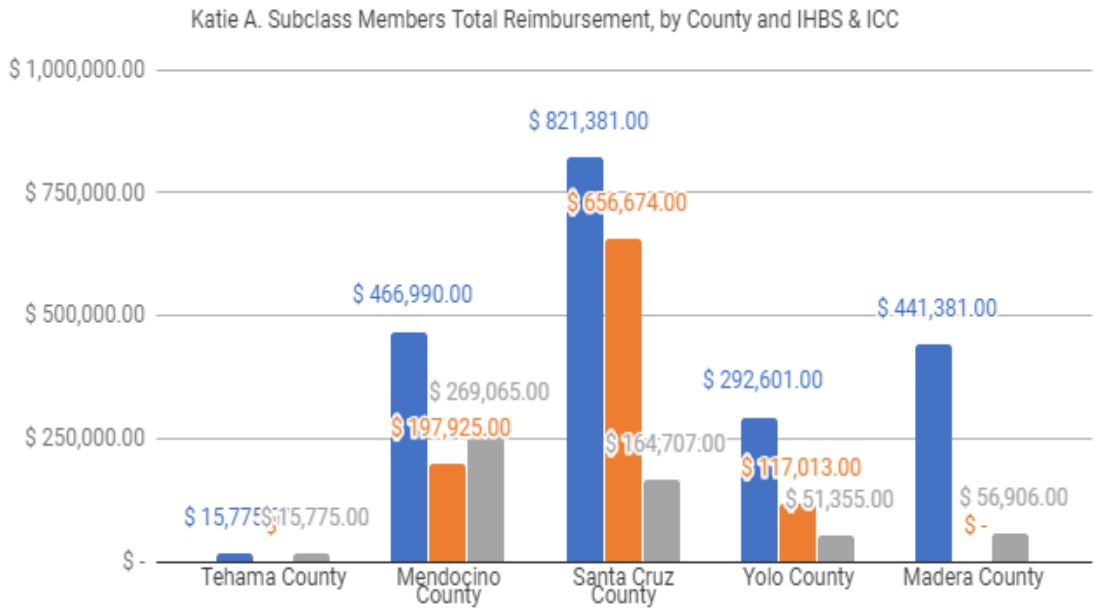


Figure 2: Katie A. - Total Approved Reimbursement, by County and IHBS & ICC

Blue: Total Approved Reimbursement for Katie A. Services, Orange: Reimbursement for IHBS, & Gray: Reimbursement for ICC



While up to 80% of foster youth have significant mental health challenges, on average only 32% of the counties' foster youth are certified as a Katie A. Subclass member. There are two exceptions: 49% of Mendocino Counties foster youth are subclass members; and in Madera County, 59% of the counties foster youth are subclass members. However, Madera County has received zero dollars in reimbursements for IHBS, while they have received total of $441,381 in reimbursements. The assumption drawn from this data is that Madera County has not implemented an IHBS program. When I conducted a google search using the key term, "Madera County IHBS," google results returned a link to the Madera County Department of Behavioral Health Services

Mental Health Plan Medi-Cal Provider List.[48] In review of this document, IHBS was folded into TBS. This is a consistent trend across California. County administrators frequently express that IHBS and TBS are one in the same. Mr. Gardner confirmed that in his experience this may be an intentional oversight. According to the Core Practice Model IHBS and TBS are two distinct services. This was consistent in Santa Cruz County. Personal experience and interviews with CMH staff revealed that Santa Cruz County Children's Mental Health has not implemented an IHBS program.

In review of Santa Cruz County (SCC) Quarterly Katie A. Reports, SCC has been reimbursed through Medi-Cal billing in the about of $ 656,674.00 (10/2017) for IHBS rendered. However, Santa Cruz County does not have an IHBS program. This discrepancy in service availability and billing is highly concerning. In comparison to two other counties with similar size foster youth populations (272 +/- 25), Santa Cruz County is claiming spending for IHBS at roughly $ 500,000.00 more than the other two counties. This begs the questions, without an IHBS program, what is SCC claiming as IHBS; and our other counties engaging in similar practices?

[48] (Madera County Department of Behavioral Health Services, 2018)

Section 5: Implications and Recommendations

Implications:

- Katie A. Services have not been implemented across California's Counties.
- Katie A. Subclass Membership certification is not representative of the population experiencing significant mental health challenges.
- Counties lack understanding of the differences between TBS and IHBS, assuming they are one in the same. While both are entitlements under State and Federal Law.
- Santa Cruz County does not have an IHBS program and yet is billing Medi-Cal for IHBS reimbursements.
- Government lacks appropriate infrastructure
- Nonprofits have a role to play

Recommendations:

First: "Legislation Requires Enforcement"

The best intended legislation has minimal impact without effective oversight and enforcement that holds stakeholders accountable.

Patrick Gardner, JD, Founder and CEO Young Minds Advocacy Group

While the Katie A. Settlement Agreement established an oversight committee and requires counties to submit quarterly reports, given limited capacity of government, this committee cannot provide the much-needed oversight of all fifty-eight counties in

California. For California to realize the promise of Katie A., an oversight vehicle is necessary for ensuring compliance with the Settlement Agreement and comprehensive implementation of the Core Practice Model. Furthermore, caregivers of Katie A. Subclass Members need a forum where they can connect with other caregivers in their local area and across the state to enable collective caregiver advocacy.

Second: "Oversight Cost Money"

Litigation and advocacy are both expensive and time consuming.

Patrick Gardner, JD, Founder and CEO Young Minds Advocacy Group

Nonprofit foundations prioritize funding direct service organizations; however, this creates funding challenges for advocacy organizations. For California to realize the promise of Katie A., nonprofit foundations prioritizing child/youth mental illness need to understand the need for watch dog groups like, Young Minds Advocacy, to function as an oversight vehicle to ensure accountability. While litigation may be necessary to hold the state and individual counties accountable, exhaustive efforts should be taken to remedy deficits prior to litigation. When litigation does become necessary, funding support is needed to provide access to free legal counsel for caregivers.

Third: "Consistency"

While the Katie A. Core Practice Model provides guidelines for implementation of ICC, IHBS, and Therapeutic Foster Care, individual counties are responsible for interpretation and delivery. For California to realize the promise of Katie A., there is an urgent need for the Katie A. Oversight Committee to address caregiver concerns and

issue timely *All County Letters* that further clarify counties' responsibilities to provide intensive mental health services. Additionally, with the great variance between counties programming, there is a great need for the development of a comprehensive standardized base line of services that comply with best practices in mental health treatments.

Fourth: "Infrastructure and the role of the Nonprofit Sector"

In most counties, county mental health lacks the infrastructure and resources to provide all the direct services necessary to meet the mental health needs of its communities' child, youth, families, and individuals. They routinely outsource via contract with nonprofits who deliver a broad array of mental health services.

For California to realize the promise of Katie A. nonprofits have a role to play. There is an urgent need for the Katie A. nonprofit to lead the conversations and guide the formation of public-private partnerships necessary for increasing accessibility of mental health services. Nonprofits can also play a role by optimizing current programming (such as TBS) and to develop new programs (such as IHBS). Furthermore, after surveying dozens of mental-health serving nonprofits across California, their website communications do not accurately articulate what Katie A. services are and who are entitled to them. Nonprofit websites target foster youth as their services beneficiary, which restricts access to specialty mental health services to only a segment of the eligible population; children and youth with open dependency court cases within

our child welfare system. Leaving children and youth living with their biological families without access to vital services necessary to mitigate significant mental health challenges. Nonprofits need to engage in critical advocacy by ensuring their websites are up to date with accurate information.

Section 6: Conclusions

Katie A. was groundbreaking legislation that secures the right to mental health services for vulnerable child and youth who are experiencing severe mental health conditions and whose families are of low socioeconomic status by mandating specialty medically necessary mental health services for children and youth age 0 through 21 covered by full scope Medi-Cal in California. However, counties across the state of California are struggling to implement Katie A.

This began with one key question; how might California realize the promises of the Katie A. Settlement Agreement? The approach to answering this question was to first frame the problem. Why is California not living up to the Promise of Katie A. or other important landmark mental health legislation? The interview with Mr. Gardner reviled that there is not the necessary oversight or enforcement to incentivize counties to comply with the legislation. Informal Interviews with Children's Mental reviled that SCC has insufficient knowledge and understanding of Katie A. Mr. Gardner explained that this is in partly intentional, because providing services cost money.

Additionally, counties often contract out delivery of services. There is not sufficient oversight to ensure that the programs contracted out to nonprofit service providers are developed to meet the full scope of the legal requirement; nor do counties have necessary oversight from the state, which cannot be stressed enough. This paves way for a unique opportunity for the nonprofit sector to step up to the table

and play a significant role in guiding the conversation and push for the development of public-private partnerships necessary for increasing accessibility of mental health services. There is a potential for nonprofits to leverage government funding to finance development and optimization of services.

The Katie A. v. Bonta Lawsuit sought to achieve systemic changes within our children's mental health system. The settlement agreement was a win. Though we have not reached our goal. Without integrated systems that provide critical access to mental health services, California's most vulnerable populations—our children and youth—are victims of state neglect, which have can negative or even fatal consequences.

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Author's Bio

Native to the San Francisco Bay Area, Brandy Wright has spent her career working for foster youth serving agencies in the Silicon Valley. Most recently, Brandy worked as a Development Associate for the Silicon Valley Children's Fund (SVCF), an organization whose sole mission is to improve educational, career and life outcomes for foster youth. Brandy assisted with composing and implementing SVCF's development strategy, which included customizing a CRM system. Additionally, Brandy worked on several special projects, including participating on the planning committee of the 2016 Silicon Valley Hack Foster Care Summit, which brought together corporate, government, and nonprofits to engage in design thinking to revolutionize the child welfare system through technology innovation.

Prior to her role as an Associate of Development, Brandy served as the RISE. (Relationships Inspiring Scholar Excellence) Coach as a co-located staff member at De Anza College. She supported 56 federal and state foster youth through intensive case management. Additionally, Brandy co-presented with Mayra E. Cruz, M.A, Early Childhood Education Transfer Degree Faculty Advisor, to faculty and staff at De Anza College on trauma informed teaching practices relating to foster youth.

Brandy has completed Western Michigan University's Fostering Success Coach Training, Mission Be's Intensive Mindful Educator Training, Cornell Model Therapeutic Crisis Intervention, Motivational Interviewing, Child Abuse Mandated Reporter Training, and HIPAA Compliance Requirements Training.

Previously, Brandy worked for Family and Children Services as the Special Projects Coordinator for the Independent Living Skills Program, which provided services to support transitional age foster youth.

Brandy received an award from the city and county of San Francisco for her outstanding contributions in service of improving positive outcomes for foster youth. Concurrently with her undergraduate studies, Brandy worked for the Smith Renaissance Society (SRS), a friends of UCSC group, which supports current and former foster and justice engaged youth, as the Project Coordinator for Foster Youth Initiative (FYI), an innovative program targeting middle school foster youth girls in Santa Cruz to increase their exposure to post-secondary education through social activities. Additionally, she served as the Secretary for the Program Committee of the SRS Board.

Brandy earned her BA in Feminist Studies with an emphasis in Law, Politics and Social Change at the University of California Santa Cruz. She graduated with honors in her major and the Oaks College Highest Community Services Award for her volunteerism as a Court Appointed Special Advocate (CASA). UCSC awarded Brandy the Humanities Undergraduate Research Award for her independent senior thesis, "Reproducing the

Slave-Master Paradigm in Child Welfare "Law's," which is being used by Bettina Aptheker as a course reading for Feminism and Social Justice. Currently, Brandy is attending the University of San Francisco School of Management and is a candidate for a Masters in Nonprofit Administration. She also earned two associates degrees from West Valley College in Liberal Arts and Women's Studies. Brandy aspires to leverage the skills gained through her Masters of Nonprofit Administration to advance successful outcomes for current and former foster youth. She has a passion for working with federal "refugee" foster youth and advocating for appropriate policy advancements to create systematic changes within our child welfare, juvenile justice, and mental health systems.