Access to Mental Health Services for Foster Children Placed Out of County

Observations and Recommendations
This report was made possible by a grant to the National Center for Youth Law (NCYL) by Alameda County Health Care Services.

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Table of Contents

Introduction ........................................................................................................................................... 1

Background ............................................................................................................................................ 2
  The Unmet Mental Health Needs of Foster Children ................................................................. 2
    In General ................................................................................................................................. 2
    In California ............................................................................................................................. 3
    In Alameda County .................................................................................................................. 4

Regulatory and Statutory Framework for Provision of Mental Health Services to
Out-of-County Foster Youth in California ..................................................................................... 4
  Medicaid & Medi-Cal .................................................................................................................. 4
  California Laws, Regulations, and Policies .................................................................................... 5

Data on Alameda County’s Out-of-County Foster Youth ................................................................. 7
  Types of Data Presented ............................................................................................................. 7
  Data Sources ................................................................................................................................. 7
  The Data ......................................................................................................................................... 8
    Numbers and Percentages of Alameda Foster Children Placed Out-of-County .................... 8
    Alameda Compared with Other Large Counties & Other Bay Area Counties ................. 9
    Where Alameda Places its Out-of-County Foster Children ............................................ 11
    Foster Children Placed in Alameda by Other Counties .................................................. 14
    Provision of Mental Health Care to Out-of-County Children ........................................... 16

Discussion of the Data ...................................................................................................................... 19
  Alameda County’s Out-of-County Foster Youth ..................................................................... 19
  Disparities in Provision of Mental Health Services ................................................................. 20

Conclusion ........................................................................................................................................... 21

Recommendations ............................................................................................................................ 23
  Introduction ................................................................................................................................... 23
  Specific Recommendations ......................................................................................................... 23
    1. A Statewide Policy of Presumptive Transfer for Foster Youth Placed Out of County
      Would Likely Benefit Foster Youth and Alameda County .................................................. 23
    2. A Statewide Policy of Collectively Funding Services for Foster Youth Placed Out of
      County Would Benefit Foster Youth and Alameda County ........................................... 25
    3. Collaboration Among Youth-Serving Agencies to Reduce Out-of-County Group Home
      Placements Would Benefit Foster Youth and Alameda County .................................... 25
    4. Gathering Data and Collaborating With Other Counties That Share Common Interests
      Would Benefit Foster Youth and Alameda County ............................................................. 27

Appendices ........................................................................................................................................ 29
  Appendix A: Previous Efforts to Address the Out-of-County Mental Health Problem ........... 29
  APPENDIX B: Data Sources Explained in Detail ......................................................................... 35
Introduction

The question of how to effectively, equitably, and efficiently provide mental health services to foster youth placed across county lines (“out-of-county” foster children) is not a new one. California’s county-based system of mental health service delivery poses particular challenges for providing mental health services to this out-of-county population. The barriers faced vary from county to county depending on the unique characteristics of that county’s foster youth population, as well as the county’s placement practices, service capacity, and many other factors.

Over the past few years, the out-of-county issue has received more attention as awareness has been raised that out-of-county foster children do not seem to have equal access to mental health services. There has also been increased awareness of the substantial administrative and other barriers that currently exist. Many groups have an interest in devising and adopting a solution that will address these barriers and provide a wide range of benefits to all interested parties. One resolution under consideration by the California Child Welfare Conference is a policy of “presumptive transfer.” Under such a policy, the responsibility for providing mental health services for a foster child living out of county would fall on the county where the child actually lives.

Keeping this in mind, this report has multiple, but related, purposes:

• To provide some background on this issue as a lens through which to understand the current state of the issue in Alameda County;

• To provide a more in-depth look at the existing data on Alameda County’s out-of-county population, as well as an understanding of the children who are sent from other counties to live in Alameda, and what is known about their access to mental health services; and

• To provide analysis of how a new transfer policy would impact Alameda County, as well as other recommendations for how to improve provision of mental health care to Alameda County out-of-county foster youth.
Background

The Unmet Mental Health Needs of Foster Children

In General

Children entering foster care have a wide range of mental health needs. Many have been exposed to severe violence or neglect in their homes, which was often the cause for their placement in the child welfare system in the first place. The removal from their homes adds another level of trauma, as children are separated from their parents, and often siblings, friends, neighbors, schools, and personal belongings. Once in the child welfare system, children are often moved repeatedly, and are constantly under threat of a future move, complicating attempts to create lasting bonds in their foster homes or new schools.

Foster children\(^1\) are three to six times more likely than non-foster children to have emotional, behavioral, and developmental problems.\(^2\) One review of the literature estimated that youth in foster care exhibit problems that require a mental health assessment and/or intervention at a rate five times greater than the rate for community-based youth who are not involved in the child welfare system.\(^3\) Experts estimate that up to 85 percent of children in foster care have mental health disorders.\(^4\) Research has also shown that foster youth in certain placement types are more likely to have mental health needs than those in other placements. A study using data from the National Survey of Child and Adolescent Well-Being found that 88.6 percent of youth with completed child welfare investigations placed in group home or residential treatment settings had clinically significant emotional or behavioral problems, as compared with 47.9 percent of the population of youth with completed child welfare investigations across all placement types (and compared to the lowest percentage of 39.3 percent for youth in kinship foster care).\(^5\)

When a foster child’s mental health needs are not met, the results can be devastating: placement instability, school failure, costly institutionalization,

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\(^1\) A foster child is a child who was removed from his or her parents’ custody by a court order due to allegations of abuse or neglect, or abandonment.


delinquency, and even death.\textsuperscript{6} The mental health effects of being a foster child can last well into adulthood. One study found that foster care alumni are six times more likely to have PTSD than the general population.\textsuperscript{7}

Foster children need greater access to effective mental health treatment to help them thrive during their childhoods and throughout their lives.\textsuperscript{8}

\textit{In California}

More than 63,000 children live in foster care in California.\textsuperscript{9} As of February 2012, there were 12,817 out-of-county foster children in California, comprising 20.2 percent of California’s total foster care population.\textsuperscript{10}

“Out-of-county” foster children are defined as foster children who were residents of one county when they entered foster care (the “county of origin” \textsuperscript{11}), but were later placed in a different county (the “placement county” \textsuperscript{12}) by their county of origin. Agencies place foster children out-of-county for various reasons, and the moves are to be based on the children’s best interests.\textsuperscript{13}

Disparate access to mental health services for foster children that live inside and outside the counties in which they entered care has been a longstanding challenge created by the county-based mental health managed care system in California. Out-of-county foster children often face particular hurdles when trying to access mental health services. They may wait months, or even years, for appropriate mental health treatment or be denied treatment altogether, despite federal and state laws that entitle all foster youth to adequate care. Data suggests that children sent out-of-county have greater needs and less access to most types of mental health care.

\textsuperscript{7}25.2 percent of foster care alumni had PTSD, far higher than the four percent rate for the general population. The Foster Care Alumni Studies, \textit{Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study} (2003), available at: \url{http://www.casey.org/Resources/Publications/pdf/ImprovingFamilyFosterCare_ES.pdf}.
\textsuperscript{8}Id.
\textsuperscript{10}Id.
\textsuperscript{11}This is also called the “jurisdiction county”, and is the county in which the foster child first entered care. It is sometimes called the “county of origin,” “home county,” or “county of jurisdiction.”
\textsuperscript{12}The “placement county” is the county in which the foster child has been placed. It is sometimes called the “county of residence,” “host county,” or “county of placement.”
\textsuperscript{13}Cal. Welf. & Inst. Code §16501.1(c).
In Alameda County

As of February 2012, Alameda County had 2,006 children placed in foster care, with 946 placed out of county. Alameda County places a significantly higher percentage of its foster youth out-of-county than the state taken as a whole (47.2 percent compared to 20.2 percent). In terms of sheer numbers of children placed out-of-county, Alameda is second only to Los Angeles County. As such, Alameda County has a relatively high stake in ensuring that mental health services are provided to foster youth placed out-of-county in an effective and efficient manner.

Regulatory and Statutory Framework for Provision of Mental Health Services to Out-of-County Foster Youth in California

Medicaid & Medi-Cal

Foster youth – including out-of-county foster children – have an enforceable right to mental health services under Medicaid, a joint federal and state program that provides medical assistance to low-income individuals and families.

Under Medi-Cal, California’s version of Medicaid, foster youth under 21 are eligible for a full range of services, including “early and periodic screening, diagnostic and treatment services” (EPSDT). EPSDT services, which are more expansive than those covered under Medicaid for adults, are required as long as they are “necessary… to correct or ameliorate defects of physical and mental illnesses and conditions discovered by the screening services.” EPSDT imposes a broad obligation on states to provide medically necessary care and has been

18 Cal. Welf. & Inst. Code § 14007.4; 42 C.F.R § 435.115(e)(2).
20 See 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). For more information about EPSDT, see Jane Perkins, National Health Law Program (NHeLP), Fact Sheet: Early Periodic, Screening, Diagnosis and Treatment (March 1999), available at www.healthlaw.org.
21 42 U.S.C § 1396d(r)(5).
described as a “comprehensive child health program of prevention and treatment.” Social workers must provide for the overall health and well-being of foster children, including monitoring the child’s emotional condition and taking action to safeguard the child’s growth and development while in placement.

Not only must states provide EPSDT and other medical services to all foster youth under age 21, but they must do so without delay. The Medicaid Act provides that the state agency providing Medicaid services is required to furnish Medicaid promptly to recipients, without delay caused by any of the agency’s administrative processes.

**California Laws, Regulations, and Policies**

Federal laws make no distinction between in-county and out-of-county foster children – virtually all foster children in California are Medi-Cal eligible and thereby entitled to mental health services. Nevertheless, California’s county-based system creates various barriers that make it difficult at times for out-of-county foster children to access mental health services.

In California, counties administer child welfare services and are primarily responsible for the key decisions affecting foster children’s lives. Although the state agency California Department of Social Services (DSS) supervises county welfare agencies and is empowered to set child welfare policies, county welfare agencies and departments have tremendous influence. Staff providing child welfare services, including caseworkers, are county employees.

The California Department of Health Care Services (DHCS) is responsible for ensuring that Medi-Cal beneficiaries – including foster children – within each county’s jurisdiction receive mental health services consistent with state and federal requirements. To that end, DHCS contracts with county mental health departments, called Mental Health Plans (MHPs). Each California county has its own MHP, and each MHP may employ mental health practitioners and/or contract

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22 *Katie A. v Bonta*, 481 F.3d 1150, 1154 (9th Cir. 2007).
25 California has delegated responsibility for providing care under Medi-Cal to each of its 58 individual counties. However, the state agencies, DHCS and DMH, remain under a legal obligation to provide Medicaid services promptly, regardless of the fact that responsibility is dispersed throughout 58 different entities.
30 CMHPC report, at 117.
31 All but two counties have their own, and those two share an MHP.
with private mental health providers to serve Medi-Cal beneficiaries. DHCS is charged with providing oversight to MHPs to ensure quality, access, and cost efficiency. 32 Each MHP must submit to the DHCS a detailed implementation plan specifying the procedures it will use to serve its beneficiaries.33

Under the current state of law and regulations, when a child is placed out-of-county, her foster care case remains with the county of origin. Responsibility to provide or arrange for mental health care of the child also remains with the county of origin. The county of origin is responsible for the cost of an out-of-county child’s mental health care unless there is a written contract in which the placement county accepts responsibility for payment.34 The mental health agency (MHP) of the county of origin remains responsible for ensuring that the child receives necessary mental health treatment. 35

There have been various efforts to improve access to care for out-of-county youth in California. While three mechanisms – Value Options, Senate Bill (SB) 745, and SB 785 – have begun to address the out-of-county access problem, they fall short of providing a comprehensive solution. Appendix A provides significantly more detail on these past efforts. Continuing widespread complaints and new research demonstrate that equal access to mental health services for foster child placed out of county has not yet been achieved.

In the last few years, the Child Welfare Council (CWC) has taken on this issue. The Out-of-County Mental Health Services Workgroup was established in December 2010 after deliberations on the issue at CWC meetings throughout the year. The charge of the Workgroup was to engage in further analysis and discussion and prioritize the activities necessary to facilitate equal access to medically necessary specialty mental health services for foster children placed out of county. The issuance of the Data Mining Report in October 2011 was an outgrowth of this effort, and contributes significantly to the available data and analysis of the disparities in access to mental health care for in-county and out-of-county foster children.36 The Workgroup also issued a number of findings and recommendations in November 2011,37 including a preliminary proposal to “presumptively” transfer responsibility for mental health services to the residence county, subject to appropriate conditions.38

34 MPP 31-505.1 - .123(e).
35 See MPP 31-505.1 - .123(e).
36 For further discussion of the Data Mining Report, see Disparities in Provision of Mental Health Services, infra, at 24.
38 “Presumptive transfer” means that responsibility for providing or arranging for mental health services for youth transferred out-of-county is presumed to be the responsibility of the county of residence. The presumption may be overcome in instances where the child may be better served by
Data on Alameda County’s Out-of-County Foster Youth

Types of Data Presented

This report provides a range of information about foster youth placed out-of-county by Alameda and their access to mental health services:

- How many foster youth Alameda places out of county and their percentage of the total foster care population;
- How Alameda compares to the eight other large counties (with a foster care population of over 2,000) and other Bay Area counties in terms of total numbers and percentage of youth placed out-of-county;
- The counties and types of placements where Alameda out-of-county foster children are most commonly placed;
- How many foster youth are placed by other counties in Alameda, where they come from, and where they are placed;
- Alameda’s provision of mental health services in general and level of intensity of services provided for in-county and out-of-county youth.

Data Sources

This report uses three data sources:

1. Monthly extracts from the Child Welfare Services/Case Management System (CWS/CMS);\(^{39}\)
2. University of California, Berkeley/CDSS Child Welfare Performance Indicators Project;\(^{40}\) and


\(^{40}\) California Department of Social Services and University of California at Berkeley Performance Indicators Project, Placement Grids (July 1, 2009), available at: http://cssr.berkeley.edu/CWSCMSreports/Pointintime/fostercare/childwel/grids/data/grid_sXr_jul2009_0.html.
Appendix B provides a fuller description of these data sources, including important differences in the methods used to count numbers of foster children. One key difference bears noting here – the data from CWS/CMS includes all foster children, including those placed in foster care by probation or other agencies. The data from the Performance Indicators Project at UC Berkeley that provides detailed information about out-of-county placements (“Point in Time Placement Grids”) includes only those foster children placed in foster care by child welfare. Thus, the total population of “foster children” from the Berkeley data source is always smaller, even for similar time periods. This report provides cites to data sources throughout the following section, but for readability uses the term “foster children” to refer to both sets of data.

The Data

**Numbers and Percentages of Alameda Foster Children Placed Out-of-County**

The number of Alameda foster children placed out of county has dropped over the past five years, along with the total population of children in foster care. In 2008, the total number of Alameda foster children was 3,029, and the number placed out of county was 1,478. By 2012, the total number of foster children was down to 2,006, and the number placed out of county was down to 946. As such, even with the significant decline in the foster care population, the percentage of Alameda foster youth placed out of county has remained quite stable, ranging from a high of 48.8 percent in 2008 to a low of 44.7 percent in 2011. As of February 2012, 47.2 percent of Alameda foster youth were placed out of county.41

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Alameda County is one of nine counties with a foster care population of over 2,000 children. Collectively, the nine largest counties place almost three-quarters (73 percent) of the out-of-county foster youth in California. Of these counties, Alameda is the smallest, with a population of 2,006, but sends the second largest total number of foster children out-of-county, and by far the highest percentage of its foster care population out of county. (See Charts 2 & 4.)

![Chart 2: Total number of foster children and number of foster children sent out of county for the nine largest counties](http://www.dss.ca.gov/research/res/pdf/CWS/2012/CWS1/cws1Feb12.htm)

Alameda County also exchanges out-of-county foster youth with a number of other Bay Area Counties. Eight counties constitute the top five counties to which Alameda sends foster children and from which Alameda receives foster children: Contra Costa, San Joaquin, Solano, Stanislaus, Sacramento, San Francisco, San Mateo, and Santa Clara (Contra Costa and Sacramento are in the top five for both sending and receiving). The following data on Bay Area counties refers to these eight counties.

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43 These counties are not all considered “Bay Area” counties by other sources. For example, the Association of Bay Area Governments does not include San Joaquin, Stanislaus, or Sacramento, and includes Marin, Napa, and Sonoma. This report uses this specialized list of “Bay Area” counties due to the fact that Alameda sends and receives foster children to these counties most frequently, and as such a comparison to these counties should be most helpful to Alameda.
When represented by percentages of total foster care population sent out of county, it becomes apparent that Alameda County is an outlier among the nine largest counties – with a percentage over twice as high as the next highest county.

Interestingly, among Bay Area counties, Alameda is not as much of an outlier in terms of the percentage of its total foster care population it places out of county. In fact, San Francisco places an even higher percentage of its foster care population out of county, and three other counties (San Mateo, Contra Costa, and Solano) place more than one-quarter of their foster care population out-of-county.
Where Alameda Places its Out-of-County Foster Children

The percentage of Alameda foster children placed out-of-county varies greatly by placement type. Alameda also has very different patterns from the state as a whole. For all placement types, Alameda places a higher percentage of its children out-of-county than all counties taken together, but for some, the difference is negligible (e.g., foster placements), while for others the difference is dramatic (FFA and group home placements). In terms of sheer numbers, of the 946 youth placed out of county by Alameda, 398 (or 42 percent) are in either a FFA or group home placement.44 For this reason, it is worthwhile to pay closer attention to these two types of placements.

Looking More Closely at Group Home Data

This section focuses extra attention on the data for group homes because of the research suggesting that youth in group homes have a higher incidence of mental health needs.45 The data on Alameda County also suggests that out-of-county group home placements are increasing. This suggests that Alameda County might have a greater impact on reducing inequities in treatment of in-county and out-of-county foster youth by focusing on youth placed in group homes. The first step is getting a fuller picture of Alameda’s group home youth, where they are placed, and trends in recent years.46

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46 See more in Recommendations section, infra.
The data show that the percentage of group home youth placed out of county is much higher than the percentage of Alameda foster youth placed out-of-county for all placement types (61.4 percent versus 41.1 percent).\(^{47}\)

Looking at past trends for group home placements, Alameda County has been placing a high percentage of its group home youth out-of-county for at least the past five years. The percentage has also gone up in the last five years, from 51.5 percent in 2008 to 61.4 percent in 2012, while the overall percentage of youth sent out-of-county in the past five years has remained relatively stable.

While the percentage of Alameda group home youth placed out of county has gone up somewhat in the past five years, the sheer number of group home youth placed out of county has gone down significantly (along with the total foster care population). In 2008, Alameda County had 331 foster youth in group home placements, with 167 placed out-of-county. Just five years later, those numbers have decreased by more than half. As of January 2012, Alameda had just 134 foster youth placed in group homes, with 81 placed in other counties. Of those placed out of county, over half were in one of two counties: Contra Costa (33 children) and Sacramento (10 children).\(^{48}\)

**Looking More Closely at Foster Family Agency (FFA) Data**

This section focuses on children placed in foster family agencies (FFAs) because of the very high percentage of Alameda foster youth in these placements who are sent out of county, and the stark contrast to the rate for the rest of the state (69.5 percent

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\(^{47}\) Note that the percentage of youth placed out of county in this chart is different from another chart showing percentage of youth placed out of county. This difference is attributable to the different data sources used for each chart. See more in Appendix A: Data Sources.

for Alameda as compared to 21.1 percent for all counties). Despite this large difference, Alameda County is not out of the ordinary in placing many children in FFAs. In 2008, of the children entering the foster care system for the first time in California, the most common initial placement was an FFA.\(^4^9\) In California as a whole, FFA placements seem to be on the rise. Between 2000 and 2009, the number of youths initially placed with foster families or with group homes shrank, but the proportion placed with an FFA grew by 88 percent.\(^5^0\)

One of the possible reasons for this increase in FFAs in general is a shortage of an adequate supply of licensed foster family homes, which may at least in part be a result of reimbursement rates not keeping up with inflation.\(^5^1\) Another potential reason is that social workers with high caseloads may be incentivized to send children to FFAs because FFAs employ social workers who can offer additional oversight.\(^5^2\) These incentives may not be as high in Alameda because they recently added 43 new staff members to the child welfare agency with Title IV-E Waiver funds, but it bears consideration.\(^5^3\) Lastly, despite the lack of data on the matter, it is possible that counties have found FFAs have better outcomes (in providing care for children with greater needs, etc.), in which case they may be a more cost-effective placement than they appear.\(^5^4\) However, these general explanations do not provide insight into why Alameda places a higher percentage of its FFA youth out of county than does the rest of the state.

The data shows that the percentage of FFA youth placed out of county is much higher than the percentage of Alameda foster youth placed out-of-county for all placement types (69.5 percent versus 41.1 percent).\(^5^5\) This is an even bigger difference than the difference between rate of placement out of county for group home youth.

Looking at past trends, Alameda County has been placing a high percentage of its FFA youth out-of-county for at least the past five years, never placing less than 60.9 percent of its FFA youth out of county (in 2009). The percentage has gone up somewhat since 2008 (from 65.5 percent to 69.5 percent), but has not been on a consistent upward trajectory. During this same time period, the overall percentage of youth sent out-of-county in the past five years has remained relatively stable. (See Chart 8).

\(^4^9\) Caroline Danielson & Helen Lee, Public Policy Institute of California, Foster Care in California, Achievements and Challenges (2010), at 12.
\(^5^0\) Id. at 13.
\(^5^1\) Id.
\(^5^2\) Id.
\(^5^3\) Casey Family Programs, Ensuring Safe, Nurturing and Permanent Families for Children, The Need to Reauthorize and Expand Title IV-E Waivers (May 2010), at 4.
\(^5^4\) Danielson & Lee, supra, at 14.
\(^5^5\) Note that the percentage of youth placed out of county in this chart is different from another chart showing percentage of youth placed out of county. This difference is attributable to the different data sources used for each chart. See more in Appendix A: Data Sources.
While the percentage of Alameda FFA youth placed out of county has gone up somewhat in the past five years, the sheer number of FFA youth placed out of county has still gone down significantly (along with the total foster care population). In 2008, Alameda County had 586 foster youth in FFAs, with 384 placed out-of-county. Five years later, those numbers have decreased, though not as much as the numbers placed in group homes. As of January 2012, Alameda had 380 foster youth placed in FFAs, with 264 placed in other counties. Of those placed out of county, over half were in one of two counties: Contra Costa (92 children) and San Joaquin (78 children).\(^{56}\)

**Foster Children Placed in Alameda by Other Counties**

As of January 2012, 271 foster youth were placed by other counties in Alameda County, and Alameda County placed 628 foster youth in other counties.\(^ {57} \) Both of these numbers have declined over the past five years as the total foster care population has declined, but the percentage of its total foster care population that Alameda County places out-of-county each year (about a quarter of the total population) has remained remarkably stable. (See Chart 9.)

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\(^{56}\) Data source: Center for Social Services Research, University of California at Berkeley, January 1, 2008 & January 1, 2012, Supervising County and Placement County, Child Welfare Supervised, FFA, available at: [http://cssr.berkeley.edu/CWSCMSreports/Pointintime/fostercare/childwel/grids/data/grid_sXrFFA_jan2008_0.html](http://cssr.berkeley.edu/CWSCMSreports/Pointintime/fostercare/childwel/grids/data/grid_sXrFFA_jan2008_0.html).

\(^{57}\) Data source: Center for Social Services Research, University of California at Berkeley, January 1, 2012, Supervising County and Placement County, available at: [http://cssr.berkeley.edu/CWSCMSreports/Pointintime/fostercare/childwel/grids/data/grid_sXr_jan2012_0.html](http://cssr.berkeley.edu/CWSCMSreports/Pointintime/fostercare/childwel/grids/data/grid_sXr_jan2012_0.html).
Looking at the data for where Alameda is sending its foster children as compared to where it is receiving children from, the trends are quite consistent over the past five years. The top five counties to which Alameda sends its foster children and the top five counties from which Alameda receives foster children have remained the same over the last five years, without exception. However, only two counties appear on both lists – Contra Costa and Sacramento.

**Top Five Counties Where Alameda Sends its Foster Children**
1. **Contra Costa**
2. San Joaquin
3. Solano
4. Stanislaus
5. **Sacramento**

**Top Five Counties from which Alameda Receives Foster Children**
1. **San Francisco**
2. **Contra Costa**
3. Santa Clara
4. San Mateo
5. **Sacramento**
Charts 10 and 11 show the distribution of foster children among the top five counties where Alameda sends foster youth, and the top five counties from which it receives foster youth.  

![Chart 10: Counties Where Alameda Sends its Foster Children, by % Share of Total Population of Foster Youth Alameda Sends Out of County](chart10.png)

![Chart 11: Counties from which Alameda Receives Foster Children, by % Share of Total Population of Foster Children Received from Other Counties](chart11.png)

__Provision of Mental Health Care to Out-of-County Children__

The Data Mining Report issued in October 2011 by the Child Welfare Council provided data on provision of mental health services to foster youth placed in and out of county by linking the statewide DSS and DMH databases for the first time. The data gathered was from FY 2008-2009.

This report provided some interesting information about Alameda’s current level of performance in comparison to other counties, as well as disparities between Alameda youth placed in and out of county.

Alameda County was in the top quintile of counties for provision of mental health services to foster children overall – meaning that Alameda County provided mental health services to a high percentage (56.6 percent) of foster children relative to other counties (34.7 percent for all counties taken together). Looking only at foster

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58 Data source: Center for Social Services Research, University of California at Berkeley, January 1, 2012, Supervising County and Placement County, available at: http://cssr.berkeley.edu/CWSCMSreports/Pointintime/fostercare/childwel/grids/data/grid_sXr_jan2012_0.html

59 See Appendix A for a fuller description of this data source.
youth placed out-of-county, only one county had a higher percentage served than Alameda County.\textsuperscript{60} However, as was the pattern for all counties taken together, there was some disparity between children placed in and out of county, with a higher percentage of Alameda children placed in-county receiving services than those children placed out-of-county. (See Table 1.) This was similar to the statewide trend, with children placed out-of-county about 10 percent less likely than children placed in county to receive at least one mental health service.\textsuperscript{61}

Table 1: Percent of Alameda County foster youth served with mental health services by Alameda County (compared to all counties)

<table>
<thead>
<tr>
<th>County Name</th>
<th>Total Placements</th>
<th>Total Placements Sent OOC</th>
<th>% Served (All)</th>
<th>% Served (In County)</th>
<th>% Served (Out of County)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>5,264</td>
<td>2,418</td>
<td>56.6</td>
<td>59.2</td>
<td>55.6</td>
</tr>
<tr>
<td>All Counties</td>
<td>173,965</td>
<td>31,969</td>
<td>34.7</td>
<td>36.1</td>
<td>32.4</td>
</tr>
</tbody>
</table>

The Data Mining Report also analyzed data on level of intensity of mental health services provided to foster youth, as measured by average monthly days of mental health outpatient or day services (MHODS).\textsuperscript{62} Alameda County was in the top quintile of counties for average days of MHODS for children overall (4.7 average days for Alameda County, compared to 2.8 average days for all counties taken together). Further, looking solely at average days of MHODS for children placed out-of-county (4.1 for Alameda), only two counties were at the same or a higher level of service intensity.\textsuperscript{63} However, again there was a disparity between children placed in and out of county: children placed out of county received fewer average days of MHODS per month than children placed in county (4.1 versus 5.3 average days). (See Table 2.)

\textsuperscript{60} Monterey, at 59.6 percent, with 946 youth placed out of county. Data Mining Report, Appendix C, at 43.

\textsuperscript{61} Data Mining Report at v.

\textsuperscript{62} See Data Mining Report at 6 for in-depth explanation of how this variable was measured.

\textsuperscript{63} Sonoma, at 4.1 average days with 134 youth placed out-of-county, and Ventura, at 5.9 average days with 105 youth placed out-of-county. Data Mining Report, Appendix C, at 44.
Table 2: Average days of MHODS per month for Alameda County foster youth (compared to all counties).

<table>
<thead>
<tr>
<th>County Name</th>
<th>Total Placements for Kids in CMH</th>
<th>Total Placements Sent OOC</th>
<th>Average Days of MHODS Per Month (All)</th>
<th>Average Days of MHODS Per Month (Placed In-County)</th>
<th>Average Days of MHODS Per Month (Placed Out-of-County)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>3,980</td>
<td>1,904</td>
<td>4.7</td>
<td>5.3</td>
<td>4.1</td>
</tr>
<tr>
<td>All Counties</td>
<td>100,826</td>
<td>19,198</td>
<td>2.8</td>
<td>2.9</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Overall, Alameda showed similar patterns to the state as a whole, with foster children placed out of county less likely to receive mental health services at all, and receiving fewer days of service for those services they do receive.
Discussion of the Data

*Alameda County’s Out-of-County Foster Youth*

The data presented above shows that Alameda County is unique in a number of ways as compared to all counties viewed together, but generally follows the same patterns as the state. In certain areas, Alameda is simply a more extreme example of a trend that exists statewide.

Alameda is the ninth largest county in the state, but has the second highest number of foster youth placed out-of-county. The number of foster youth overall has been declining over the past five years for all counties, including Alameda. Interestingly, as the number of foster youth has declined, the percentage of youth Alameda places in out-of-county has remained quite stable, and is close to half of Alameda’s foster care population. In contrast, all counties as a whole place less than a quarter of the foster care population out-of-county. Thus, in terms of both numbers and percentages, Alameda has a significant interest in addressing the issue of how out-of-county foster children receive mental health services. Some other Bay Area counties place a similarly high percentage of their foster care population out-of-county, but none places as many out-of-county as Alameda.

Alameda County also places a disproportionality high percentage of its FFA and group home youth out-of-county (60-70 percent as compared to about 20 percent statewide). It is not clear from the data why Alameda places so many youth in out-of-county group homes and FFAs.

Alameda also receives a number of youth from other counties, but Alameda places more youth out of county than it receives – the number has declined over the past five years as the foster care population has declined, but the overall percentage difference (youth sent out of county minus youth received from other counties) has remained quite stable, right around 25 percent. Alameda and Contra Costa exchange a fair number of foster youth, but Alameda sends far more to Contra Costa than it receives. The situation with San Francisco is the opposite: Alameda receives a large percentage (44 percent), but sends very few.

These patterns raise important questions. For instance, assuming placements close to home are preferred, all other things being equal, why have in-county placements not increased proportionately in the last several years as overall foster care placements have substantially declined? Also, it is often assumed that out-of-county placements are driven, in part, by the high cost of urban housing. Why then would San Francisco send so many youth to Alameda County — a high-cost urban county, and a net “exporter” of foster youth? We cannot answer these questions with our data. Answering these questions requires examination of state and local DSS policies and procedures, a task that is beyond the scope of this report. However, it seems evident that understanding access to mental health care for out-of-county
foster youth necessitates a close look at mental health and social services policies and practices for children served by both systems.

Disparities in Provision of Mental Health Services

Children in out-of-county placements overall receive both less care and less intensive treatment, on average, than what is provided to foster youth placed in-county. The Data Mining report provided this information broken down by county, and this pattern held true for Alameda County.64

The Data Mining Report was able to look at many child welfare and mental health characteristics for the state as a whole and identify certain differences between in and out-of-county children. Unfortunately, the report does not provide analysis at the county level, but some of the findings for the state as a whole may apply to Alameda County and at the very least provide some interesting insights.65

Although this analysis at the county level was not available to the authors of this report, it suggests that Alameda’s large percentage of out-of-county youth placed in group homes may be a key factor in the observed disparities in the amount and intensity of services provided to Alameda’s in and out-of-county children.

Furthermore, statewide data show that out-of-county children have even higher mental health needs than in-county children.66 This finding is consistent with national data showing that group home children tend to have the highest incidence of mental health needs.67 These findings rule out the possibility that lower access to services for out-of-county children is simply due to a lower need for services. These data are especially important for Alameda because the County sends a higher percentage of its group home youth out-of-county than for all placement types taken together.68 Assuming that Alameda County foster youth follow the statewide and national norms, then Alameda’s out-of-county foster children have greater mental health needs than those placed in-county and yet, are getting less services and supports.

64 See Chart 12, supra.
65 Data Mining Report, p. 36.
66 Data Mining Report at 36.
67 One study found that 88.6 percent of youth with completed child welfare investigations placed in group home or residential treatment settings had clinically significant emotional or behavioral problems, as compared with 47.9 percent of the population of youth with completed child welfare investigations across all placement types. John A. Landsverk, et al, Mental Health Care for Children and Adolescents in Foster Care: Review of Research Literature, prepared for Casey Family Programs, February 2006, at 14. See more in Introduction section, supra.
68 See Chart 7, supra.
Conclusion

As has been recognized for some time now, foster children placed out of county receive fewer and less intense mental health services than children placed in county. At the same time, foster children placed out of county tend to have greater mental health needs. The available data on Alameda County show that these patterns hold true for Alameda County.
The data show that Alameda has a particular interest in addressing access to mental health services to out-of-county youth. Alameda places more and a higher percentage of foster children out-of-county than almost all other counties, and a higher percentage of its group home and FFA children are placed in other counties than children in other types of placements.

The data also show that Alameda foster children placed out-of-county overall receive both less care and less intensive treatment, on average, than what is provided in in-county placements. Alameda also receives a significant number of foster children from out-of-county, although it receives about 25 percent fewer youth than it sends out-of-county.

The fact that Alameda has a disproportionately large number of foster children placed out-of-county compared to the state as a whole and to most other Bay Area counties, and that Alameda County foster children placed out-of-county tend to receive fewer and less intense mental health services despite having higher needs, suggests that it is worth considering whether Alameda County can do more to ensure that all of its children, no matter where they are placed, receive the mental health services they need.
Recommendations

Introduction

This report presents compelling evidence that foster youth placed outside of their county of jurisdiction have greater mental health needs and receive less mental health care than their counterparts who remain within their jurisdiction counties. It also details how Alameda County sends more than 50 percent of all its foster youth (the second highest rate among California’s 58 counties), and more than 60 percent of its youth placed in group-homes out-of-county (almost twice the state average). Together, these findings suggest that Alameda County may have good reason to explore ways to improve access to care for Alameda County foster youth who are placed out-of-county.

In order to tackle this challenge, a key question is whether state policy will continue on its present course, or will take positive steps to shift responsibility for providing care to the mental health networks where foster children actually reside. If there is no change in the status quo, Alameda County decision-makers will need to assess whether to focus on taking steps to improve access to services in the far-flung counties where foster youth are placed, on reducing out-of-county placements, or some combination of the two. If a policy of presumptive transfer is adopted and Alameda becomes responsible for providing or arranging for out-of-county services primarily to youth from other counties residing in Alameda, the focus is likely to shift to identifying the children from other counties, assessing their needs, and taking steps to integrate them into Alameda County’s existing system of care. Clearly, these are two very different pathways.

Specific Recommendations

1. A Statewide Policy of Presumptive Transfer for Foster Youth Placed Out of County Would Likely Benefit Foster Youth and Alameda County

Issue to Address: Access to mental health services by foster youth placed out-of-county is limited by the structure of California’s public mental health system, which is comprised of 56 independent Mental Health Plans (MHPs). Children who move between counties present all of the usual challenges of providing out of network care to beneficiaries. Presumptive transfer eliminates this problem simply by transferring responsibility for serving youths from their distant home networks of

69 Challenges include lack of contracting clinicians, individualized licensing, certifying and contracting, lack of economies of scale, differential service arrays, inadequate or non-existent referral mechanisms, and much more.
services and providers to the local network. Shifting these responsibilities, a policy endorsed unanimously by the California Child Welfare Council, should also reduce the per-person costs of treatment.\(^70\)

**Recommendation:** Alameda County should consider supporting a policy of ‘presumptive transfer,’ subject to continuity of care, and other appropriate access and treatment considerations.\(^71\)

**Impact on Alameda County:** If a policy of “presumptive transfer” is adopted, Alameda would be responsible for providing or arranging for mental health services for all foster children\(^72\) placed in Alameda by other counties. As of January 2012, 271 foster youth were residing in Alameda County, placed there by other counties. For children placed out-of-county by Alameda (620 as of January 2012), the receiving counties would become responsible for providing or arranging for their mental health services (subject to limited exceptions).\(^73\) The likely short-term impacts from presumptive transfer would be:

- Alameda County’s MHP would be responsible for providing mental health services to fewer foster youth;
- Alameda County’s MHP would no longer be required to provide or arrange for mental health services for more than 300 foster youth living in other counties;
- Alameda County foster youth who reside in other counties would continue to be eligible for the full array of medically necessary EPSDT services from their county of residence;
- Alameda County’s MHP would likely need to expand its service capacity to accommodate a greater number of foster youth needing to be served within Alameda County;
- Foster youth from other counties who reside in Alameda would have full and prompt access to behavioral health care services; and
- The net costs of providing Alameda County’s foster youth with behavioral health care services would go down because fewer youth would be served and the expenses related to serving distant beneficiaries would be minimized.

If, in the future, Alameda County were to decrease the number of youth it places out-of-county, or other counties were to increase the number of foster youth placed in Alameda County, the analysis would necessarily change. Also, factors such as

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\(^70\) Accountability—Proposal Discussion 20120601 FINAL, on file with the authors.

\(^71\) May 24, 2012 Issues letter to Under Secretary of CHHS, M. Wilkening, on file with the authors.

\(^72\) Subject to exceptions based on continuity of care, etc.

\(^73\) Data source: Center for Social Services Research, University of California at Berkeley, January 1, 2012, Supervising County and Placement County, available at: http://cssr.berkeley.edu/CWSCMSreports/Pointintime/fostercare/childwel/ grids/data/grid_sXr_jan2012_0.html
placement type and age of the population could have a substantial impact on the analysis. For example, if Alameda sends mostly young children out of county, but is receiving mostly older children, the County could conceivably experience increased demand for mental health services (because 11-15 year olds require more mental health services than other age groups), even though it is serving fewer youth.

2. A Statewide Policy of Collectively Funding Services for Foster Youth Placed Out of County Would Benefit Foster Youth and Alameda County

**Issue to Address:** All counties, including Alameda, must allocate funds for foster youth who transfer among counties. Historically, the county of jurisdiction bore the responsibility of paying for mental health services for foster youth placed out-of-county. Under presumptive transfer, it is unclear who will bear the costs of providing or arranging for mental health services for out-of-county foster youth.

**Recommendation:** All counties would benefit from the establishment of a statewide pool to fund the non-federal match for EPSDT mental health services provided by a county of residence to foster youths placed outside their county of jurisdiction. Presumably, this pool would be funded using the Realignment Behavioral Health subaccount. Funding from the subaccount would be used to reimburse counties for their actual expenditures on the non-federal share of services provided to out-of-county foster youth.

**Impact on Alameda County:** The principle benefit to Alameda County (and others) of pooled funding for out-of-county foster youth would be avoidance of costs that the county has no control over, i.e., mental health services for foster youth placed by other counties in Alameda. There may be a risk that shifting the cost of providing out-of-county mental health services from individual counties to the counties as a whole may encourage counties to “export” their most challenging youth. On the other hand, it may also incentivize some counties to invest in high-end services they might otherwise not be able to afford. Foster youth are likely to benefit from pooled funding because the county of residence will have no financial incentive to limit their access to covered mental health services.

3. Collaboration Among Youth-Serving Agencies to Reduce Out-of-County Group Home Placements Would Benefit Foster Youth and Alameda County

**Issue to Address:** Alameda County places a far higher percentage of out-of-county foster youth in group homes and FFA placements (60-70 percent) than the state as a whole. The data also show that the Probation Department is a major contributor to out-of-county foster care placements. The often-heard rationale for this pattern (similar to San Francisco’s) is the high cost of housing in the Bay Area. However,

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74 Data Mining Report at vi.
research shows that placements in expensive group homes or residential treatment centers may not be the most effective mental health treatment for many foster youth. Intensive home and community-based treatments are often more effective and less expensive.\textsuperscript{75} As such, it is possible that increased access to home and community-based services could reduce Alameda County’s reliance on high cost out-of-county congregate care placements. This could have a direct or indirect effect on Alameda’s out-of-county placements.

\textbf{Recommendation:} Alameda County mental health policies and practices relating to foster youth clearly intersect with the policies and practices of other youth-serving agencies, particularly social services and probation. Child welfare and probation policies or practices that rely on out-of-county placements will have both clinical and financial impacts on Behavioral Health Care’s clients and programs. Logically, the three agencies should collaborate on policies and practices that impact children who are served by multiple agencies. More particularly, the Interagency Children’s Policy Council (ICPC) should closely examine the circumstances and characteristics of group home youth with mental health needs who are placed out of county, and assess whether alternatives exist that would allow more children to remain at home, or in more home-like settings in their own communities. Of particular interest is why the out-of-county group home population has grown proportionately as the overall foster care population has substantially declined.

\textbf{Impact on Alameda County:} Increasing access to home and community based services and decreasing the need for more expensive out-of-county group home placements would be a win-win for Alameda County. Research indicates that not only would costs decline, child and family outcomes would improve.\textsuperscript{76} Moreover, as a IV-E waiver county, there should be sufficient flexibility to reprogram child welfare board and care savings into behavioral health care services. Additionally, \textit{Katie A. v. Bonta}\textsuperscript{77} should provide added resources to increase the use of home and community based mental health services. Foster youth would also benefit from improved collaboration among child-serving agencies that results in fewer out-of-county group home placements and greater access to intensive home and community-based services.

\textsuperscript{75} John A. Landsverk, et al, \textit{Mental Health Care for Children and Adolescents in Foster Care: Review of Research Literature}, prepared for Casey Family Programs (February 2006), at 3.
Gathering Data and Collaborating With Other Counties That Share Common Interests Would Benefit Foster Youth and Alameda County

**Issue to Address:** One of the goals of presumptive transfer is to increase access to care statewide by ensuring that mental health treatment is equally available to all foster youth. The policy is intended to reduce administrative barriers and thereby increase access to services. If successful, one would assume that the amount of services overall would likely increase. However, it is unclear where the additional demand for services may occur, and what the impact would be on the distribution of mental health services infrastructure and capacity statewide. As one of nine large counties with more than 2,000 foster youth in care, Alameda has a substantial stake in learning the answers to these questions.

**Recommendation:** Alameda County should collaborate with other counties and the state to gather better information on existing and anticipated mental health services demand, infrastructure, and capacity. In addition, Alameda County would be well served by further developing information sharing relationships among the child-serving agencies of counties that send foster youth to, and receive foster youth from, Alameda County.

**Impact on Alameda County:** Change is likely coming that involves greater sharing among counties of the statewide demand for and supply of mental health services for foster youth. A quarter of all foster youth in California reside out-of-county. While many of these children likely do not need mental health services, those that do tend to have greater needs that require larger expenditures than their in-county counterparts. Additionally, lower administrative barriers to care for out-of-county foster youth are likely to increase demand for mental health services for this population. Because the out-of-county foster youth population’s mental health needs are substantial and growing, and are not confined to any one county, developing a regional understanding of the resources and means available to serve these needs will benefit all of the counties in the Bay Area region, including Alameda.

Also, while administrative barriers to mental health care would decrease under presumptive transfer, the administrative challenges of supervising foster youth at a distance will not. Indeed, new relationships will need to be established and sustained among social workers in jurisdiction counties, and mental health clinicians in residence counties. Improved information sharing among county agencies will help to cultivate these relationships to the benefit of sending and receiving counties, including Alameda, and foster youth.

Exchange of information and collaborative mental health care strategies among Bay Area counties should increase Alameda County’s leadership impact on regional and statewide child welfare and mental health policies and practice. Of the large counties, Alameda is particularly well situated to address the question of how to maintain a high quality service base. Sharing its knowledge with
other large counties could benefit thousands of foster youth. Also, as a high performing county that sends many of its foster youth out-of-county, Alameda has an interest in ensuring that counties that receive Alameda foster youth provide high quality mental health care. Gathering information about the amount and intensity of treatment provided and improving information sharing will assist the county in determining quality and sufficiency of care, identifying future challenges, and building relationships necessary to solve inter-county challenges.

Better planning and information sharing among counties that serve out-of-county foster youth should benefit foster youth through increased access to mental health services and more coordinated foster care. Concerns have been raised, however, that sending youth from high performing to low performing counties may adversely impact out-of-county foster youth who are obliged to become beneficiaries of the lower performing county. The presumptive transfer policy, properly implemented, should avoid this outcome because the child or his or her healthcare decision-maker is empowered to request a waiver of the automatic transfer for reasons including continuity of care, among others. Thus, a child could retain his or her membership in the county of jurisdiction’s MHP in instances where the child’s needs are being well met by the county of jurisdiction.
Appendices

Appendix A: Previous Efforts to Address the Out-of-County Mental Health Problem

While three mechanisms – Value Options, Senate Bill (SB) 745, and SB 785 – addressed the out-of-county access problem, they fell short of providing a comprehensive solution. The narrow scope of the Value Options approach limits its usefulness, while adding another layer of administration to an already complex system. SB 745, while helpful in creating a framework for further regulations, did not go far enough to create lasting changes for out-of-county children. And although SB 785 has the potential to significantly improve mental health access for Kin-Gap and AAP children, its value for children currently in foster care is limited because it did not address the fundamental problem of initial access: outright denial of services when an out-of-county child calls the mental health hotline (“Access”) in the placement county.

Value Options, SB 745, and SB 785 – and their limitations – are explored below.

Value Options

Value Options is a private company that was selected by the California Mental Health Director’s Association (CMHDA) to oversee inter-county administration of mental health services throughout California. CMHDA also gave Value Options the authority to credential mental health providers, authorize outpatient services, and streamline billing and payment for mental health services for foster youth placed outside their jurisdiction county.\(^{78}\) Though the company provides various services in different states, in California Value Options provides certain specialty mental health services to out-of-county foster children.\(^{79}\) It has had contracts with as many as 30 counties but maintains a provider network in all 58 counties, allowing its client counties to send their beneficiaries to any county in the state.\(^{80}\)

Limited Scope of Value Options

Value Options lacks the capacity to significantly improve mental health access for foster children placed outside their jurisdiction county, while adding an additional layer of administration. First, the company only provides a limited set of services; it does not offer the full array of services for which out-of-county children are eligible

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\(^{78}\) Value Options calls itself the country’s “largest independent behavioral health care and wellness company,” specializing in “management for all behavioral health issues, and mental health and chemical dependency diagnoses.” [http://www.valueoptions.com/company/Company.htm](http://www.valueoptions.com/company/Company.htm).

\(^{79}\) Information regarding Value Options’s contract to serve foster children in California was obtained from a two-part interview with a Value Options California representative. The interview was conducted by NCYL in July 2010.

\(^{80}\) For general information about Value Options, See [http://www.valueoptions.com](http://www.valueoptions.com).
under Medi-Cal. Value Options does not treat children with dual diagnoses or autism, nor does it provide inpatient services or more specialized services that are often necessary for foster youth with mental health problems. For example, Value Options does not cover wraparound services – individualized, collaborative care that has been shown to help youth with serious emotional and behavioral problems stay in their homes and communities.

If a child requires a mental health service not covered by Value Options, she must request that service from the jurisdiction county. These children therefore have to deal with an added layer of administrative complexity: in addition to the barriers they already face due to their out-of-county status, they may now have to seek mental health services from three entities: the jurisdiction county, the placement county, and Value Options. This is because it is likely that out-of-county children with intensive mental health needs will be clients of Value Options for some services but will also require other mental health services directly from the jurisdiction county.

Providers that routinely contract with Value Options are likely to only request services they know Value Options will cover. Children who need more services than are provided through Value Options may not be informed of other available services because they may only have diagnoses from Value Options providers. These providers are likely to only request services they know Value Options will cover.

For services that Value Options does offer, the company only provides a fixed number of units for each. For example, if a child is authorized for therapy, she will only receive a fixed number of sessions of therapy, regardless of her needs. If she needs additional therapy, Value Options must obtain special authorization from the jurisdiction county to continue treatment.

The Value Options system also may cause payment delays, which could limit the number of providers willing to treat out-of-county foster children. Many providers are wary of treating children from counties that have a reputation for delaying payment. The company operates on a fee-for-service basis and according to the terms of its contract with counties, it cannot pay providers until it has received full payment from the jurisdiction county. As a result, the time lag between a Value Options provider treating a child and getting reimbursed is often long.

**SB 745**

SB 745 was the first legislative enactment in California dealing specifically with out-of-county foster children’s mental health needs. It went into effect in 2000, adding section 5777.6 to the Welfare and Institutions Code. Overall, the provisions of SB

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81 The provider in the placement county performs the service and bills Value Options, which then bills the jurisdiction county. After that, the jurisdiction county pays Value Options, which in turn pays the provider.
745 are helpful for setting up a framework to improve access to mental health care. However, because they are either not mandatory or insufficiently detailed, SB 745 has not significantly improved foster children's access to mental health services.

SB 745 requires each local MHP to “establish a procedure to ensure access to outpatient mental health services, as required by the EPSDT standards, for any child in foster care who has been placed outside his or her county of adjudication.”\(^{82}\) MHPs may use one or all of three methods to fulfill the above requirement: the establishment of a statewide procedure, an arrangement between local MHPs for reimbursement of services provided by an MHP other than the jurisdiction county's, or an arrangement between the jurisdiction county MHP and placement county providers for authorization and reimbursement of services provided to out-of-county children.\(^{83}\) Since none of these alternatives is binding on MHPs, the only mandate in 5777.6 (a) is that MHPs must put procedures in place to ensure access to mental health services for out-of-county foster children.

The statute also required DMH (now DHCS) to “collect and keep statistics that will enable the department to compare access to outpatient specialty mental health services by foster children placed in their county of adjudication with access to outpatient specialty mental health services by foster children placed outside their county of adjudication.”\(^{84}\)

In August 2008, new regulatory provisions pursuant to SB 745 went into effect.\(^{85}\) One aim of these regulatory changes was to stipulate timeframes absent from existing law governing authorization and reimbursement of out-of-county mental health services. Among the more significant developments was that Title 9 CCR §1830.220 (b)(4)(A) was amended to require that the:

- Jurisdiction county must authorize services for an out-of-county youth and notify the placement county and requesting provider of its authorization decision within three working days (maximum of fourteen calendar days if the county requires additional information) following the date of request for services;
- Jurisdiction county MHP must arrange for reimbursement for the services provided to a child through the placement county or provider within 30 calendar days of the date of authorization of the services; and
- Jurisdiction county and placement county MHPs must resolve any disagreements...

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\(^{82}\) Welf. & Inst. Code § 5777.6.
\(^{83}\) Welf. & Inst. Code § 5777.6(b)(1)-(3)
\(^{84}\) WIC § 5777.6(c).
\(^{85}\) DMH Information Notice 08-24. In August 2008, additional provisions went into effect. Title 9 CCR §1810.207.5 was adopted to define “county of origin” for the purposes of out-of-plan (including out-of-county) mental health services, as the county where legal jurisdiction has been established and/or that has financial responsibility for the child. Furthermore, Title 9 CCR §1810.220.5 was adopted to define “host county” as it relates to the Foster Care, Adoption Assistance and Kin-GAP programs for mental health services.
through an arbitration process.\textsuperscript{86}

These regulatory changes were useful in terms of setting timelines for providing services to out-of-county foster children. Nevertheless, further legislation and/or regulations within the framework it lays out will be necessary to achieve equal access to care for in- and out-of-county foster youth.

**SB 785**

SB 785, which went into effect on January 1, 2008, added three sections to the California Welfare & Institutions Code, each pertaining to a distinct category of out-of-county children: children currently in foster care,\textsuperscript{87} children who are currently receiving Kin-Gap and have transitioned from foster care into legal guardianships,\textsuperscript{88} and children who have been adopted out of the foster care system and are receiving AAP payments.\textsuperscript{89} SB 785 was enacted “to facilitate the receipt of medically necessary specialty mental health services by a foster child who is placed outside of his or her county of original jurisdiction.”\textsuperscript{90}

While SB 785 has the potential to significantly improve access to mental health services for out-of-county Kin-GAP and AAP children, its benefits for out-of-county children who are still in foster care are limited, because it does not address many of the fundamental problems they face in accessing mental health services.

**SB 785 and Children Currently in Foster Care**

SB 785 may address one major problem that out-of-county foster children have faced: providers attempting to serve these children in the placement county have confronted administrative hurdles when trying to get authorization and payment from jurisdiction counties. The statute standardizes the contracting process between placement county providers and jurisdiction counties, so placement county providers are no longer forced to deal with each jurisdiction county’s unique credentialing, certification, authorization, contracting, documentation, and payment standards.\textsuperscript{91} The statute’s standardization of documents and authorization procedures could help reduce the administrative burden, and with it, the reluctance of providers to serve out-of-county children.\textsuperscript{92}

\textsuperscript{86} See Title 9 CCR §1850.405.
\textsuperscript{87} WIC § 5777.7.
\textsuperscript{88} WIC § 11376.
\textsuperscript{89} WIC § 16125.
\textsuperscript{90} WIC § 5777.7(a).
\textsuperscript{91} Children & Family Policy Institute of California, “Mental Health Services for Foster Care Children Placed Outside of Their County of Jurisdiction.” (January 14, 2008) (unpublished Powerpoint Presentation) (on file with author).
\textsuperscript{92} SB 785 mandates that for both in- and out-of-county foster youth, DMH must create standardized contracts to purchase medically necessary services from providers, standard authorization procedures, and standard documentation and forms. They also must provide informational materials both foster care agencies and individual foster care providers describing how to arrange for mental
Nevertheless, the standardization requirements of SB 785 are not broad enough. The requirement to use standardized documents and a restriction on demanding certification of an already certified provider only apply to organizational, not individual, providers. Moreover, MHPs subject to an externally placed requirement such as a federal integrity agreement are exempt from the restriction on requiring information or documents in addition to the standard documents. This exemption allows counties to erect additional administrative barriers and creates a disincentive for providers to serve children from these counties.

Furthermore, the standardization requirements are triggered only once the child has secured a placement county provider willing to contract with the jurisdiction county to serve the child. Many out-of-county children never reach this stage.

The most fundamental shortcoming of SB 785 for out-of-county foster children is that the jurisdiction county remains solely responsible for providing, authorizing, and paying for services for these children. This is a challenge for many jurisdiction counties, especially when children are placed far away. Also, absent any legal obligation, placement counties may continue to disclaim responsibility for children who entered foster care in another county and are therefore not considered their ‘own.’

Lastly, it appears that even under SB 785, it is often not clear which county is supposed to move the authorization process along. Despite SB 785 there is confusion among counties as to which county is responsible for initiating authorization. Given that many foster children do not have adult advocates with the time, expertise, and patience necessary to doggedly push for authorization, such confusion can derail attempts to secure services for out-of-county children.

SB 785 and Kin-GAP95 and AAP96 Children

SB 785 does benefit children receiving services under Kin-GAP and AAP. For those children, the placement county MHP is responsible for submitting a Treatment Authorization Request (TAR)98 for medically necessary specialty mental health services to the jurisdiction county MHP, the requesting service provider is

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93 Welf. & Inst. Code § 5777.7(c)(2).
94 Interview by Deanne Katz with case worker, in Oakland, Cal. (July 7, 2010).
95 A Kin-GAP child is a foster child who is now in a legal guardianship, receives Medi-Cal, and whose court supervision has been terminated.
96 An AAP child is a former foster child who has been legally adopted and receives Medi-Cal, and whose court supervision has been terminated.
97 WIC §11376.
98 Also known as Service Authorization Request (SAR).
responsible for preparing the TAR, and the jurisdiction county remains responsible for authorizing and reauthorizing services using an expedited TAR process.

SB 785 shifts responsibility for providing services from the child’s jurisdiction county to the county where the legal guardian or adoptive parent resides, while leaving control over authorization with the jurisdiction county. In most instances, the child will reside with her legal guardians or adoptive parents, whose county of residence will thus be the same as the child’s placement county. Therefore, SB 785 makes the placement county responsible for providing services to out-of-county Kin-GAP and AAP children.

The provider typically prepares a TAR and sends it to the placement county, which then forwards it to the jurisdiction county.99 Responsibility for initiating contact with the jurisdiction county therefore now lies with the placement county. Once the jurisdiction county receives the TAR, the timelines in CCR 1830.225 are triggered – the jurisdiction county must decide the TAR and notify the placement county and requesting provider within 3 - 14 days.

DHCS has not established specific timelines within which the placement county must initiate contact with the jurisdiction county, which can create barriers to access for out-of-county children. DMH Information Notice 09-06 simply requires that the placement county “must complete the authorization process (including authorization by the MHP in the county of origin) within the MHP’s established authorization timelines for in-county beneficiaries.” However, this does not take into account that for out-of-county children, there is the additional step of forwarding the TAR to the jurisdiction county and waiting for its decision. Since this step does not apply to in-county children, requiring placement counties to complete the authorization process in the time it takes for in-county beneficiaries is an unclear directive. The absence of a specific timeframe between a child (or anyone on her behalf) first requesting services from the placement county MHP or provider, and the placement county MHP or provider forwarding the TAR to the jurisdiction county will lead to yet another gray area for out-of-county children, and their requests for services will continue to get delayed responses. Without specific timelines, it will also be difficult to enforce the placement county MHP’s obligation to forward the TAR to the jurisdiction county MHP.

There is ample precedent for DHCS to set timelines through regulations where none are specified statutorily. In the out-of-county context, Section 1830.225, which imposes a 3 - 14 day timeline for TAR authorization by the jurisdiction county, was added to the CCR after the enactment of SB 745.100 The current situation is analogous – given the absence of specific timeframes in SB 785 for the placement county to forward the TAR to the jurisdiction county, DHCS could impose timelines by regulation.

100 See DMH Information Notice 08-24.
APPENDIX B: Data Sources Explained in Detail

1. The CWS/CMS data is publicly available on the CDSS website and is updated monthly. It provides the state's total foster population, as well as the foster population of each county, breaking the data down by in-county and out-of-county status. The data we used for our analysis includes children placed in foster care by both child welfare and probation. The data is monthly.

The main website is: http://www.dss.cahwnet.gov/research/PG317.htm.

2. The UC Berkeley data provides detailed information on California's foster care population. We used the 'point-in-time placement grids,' which provide each county’s total foster care population, broken down by in-county and out-of-county children. The grids further break down the out-of-county population by placement county. Thus, we can identify the placement counties to which each jurisdiction county sent its foster children, as well as the number of children sent to each of these placement counties. This data is a point-in-time snapshot of the foster care population on a particular day.

The main website is: http://cssr.berkeley.edu/ucb_childwelfare.

3. The full title for the “Data Mining Report” is the “Out-of-County Data Mining Project Report.” It was released in October 2011 by the Child Welfare Council, Out-of-County Mental Health Services Work Group, Data Linkage and Information Sharing Committee. The report used data from two separate data systems (DSS and DMH) for children in foster care for state fiscal year 2008/09. Members of the CWC’s Data Linkage and Information Sharing Committee with access to child welfare data collaborated with a DMH analyst with access to mental health data to provide an analysis.

The report is available here: www.chhs.ca.gov/.../CWC00CDataMining20111025.pdf.