



The California Child Welfare Co-Investment Partnership is a collaboration of private and public organizations working to improve outcomes in the child welfare system. *insights* is a Partnership series of publications examining the links between data, policy, and outcomes for our state's most vulnerable children and families.

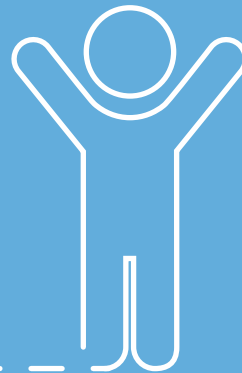
In this issue, *insights* will explore:

- Overview of Katie A.
- County Perspectives
- Moving Forward



# Improving Outcomes for Children in Foster Care

*Creating New Pathways to Mental Health Services*



“Over the last several years, California’s child welfare and mental health systems have been experiencing systemic change in incremental and meaningful ways. Several state initiatives and new federal legislation, as well as the implementation of the Katie A. v. Bonta et al. settlement agreement, have become the most recent catalysts for both systems to become more holistic and comprehensive in meeting the needs of our children, youth, and families.”<sup>i</sup>

Will Lightbourne, Director, California Department of Social Services

Toby Douglas, Director, California Department of Health Care Services

This issue of *insights* examines the current progress and promise of the Katie A. settlement implementation as a vehicle to improve the delivery of mental health services for children and youth within the child welfare system.

One study by the National Institute of Mental Health reported that nearly half (47.9 percent) of youth in foster care were found to have clinically significant emotional or behavioral problems. Likewise, researchers at Casey Family Programs estimate that over one-half of children entering foster care exhibit life-time rates of behavioral or social competency problems that warrant mental health services.<sup>ii</sup>

With a shared goal of providing better mental health outcomes for our children in foster care, California is beginning to change the way child welfare workers, mental health staff, and other service providers work with children, parents, and families who need both child welfare and mental health services and supports. The systems that serve these children and families must now work in a much more integrated way to improve outcomes.<sup>iii</sup>

**During my time in foster care, I had seen upwards of 10 different therapists and over 5 prescribing physicians. Constant changes in who was prescribing medication, rotating therapists, and none of them talking to one another or my doctor, it was impossible to find any solace, let alone address the deeper issues I was facing.**

*Anthony, San Francisco*

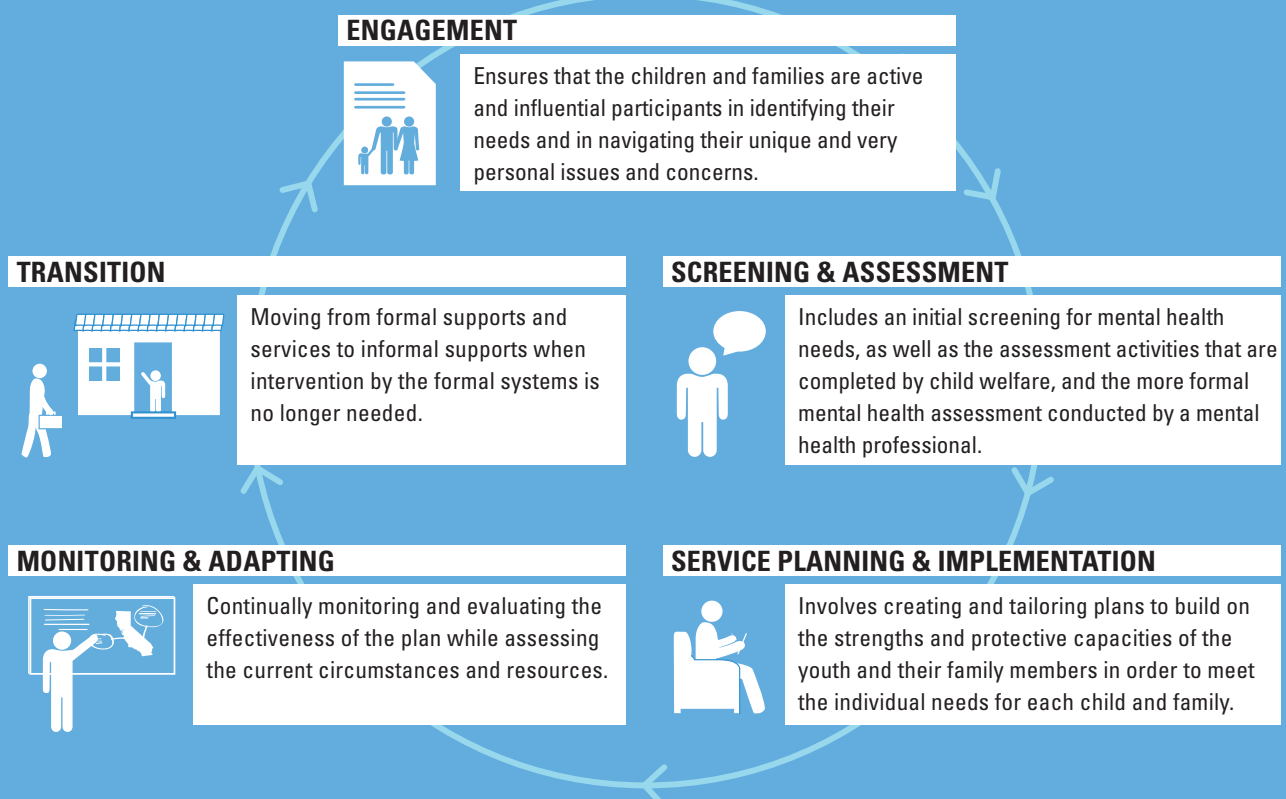
## Overview of Katie A. v. Bonta ET AL.

The Katie A. settlement agreement has been a catalyst for changing the way California's child welfare and mental health departments work together, and has created the opportunity to reimagine the departments' service delivery model, integrate management oversight, and create data-driven decision-making systems that improve outcomes for children and their families.

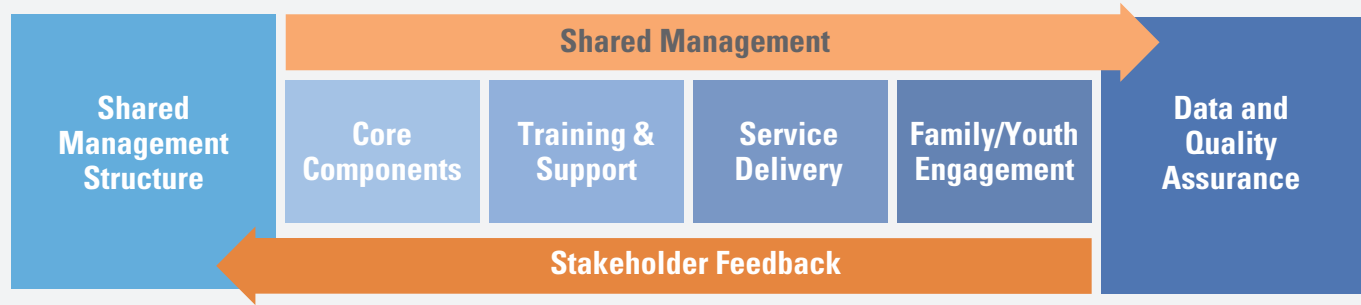
Katie A. v. Bonta is a federal class action lawsuit filed on behalf of California foster youth and children at risk of out-of-home placement. Although Katie's case may be extreme, her story highlighted the need for significant reform of the systems assessing and delivering mental health services to foster youth. At the time the lawsuit was filed, Katie was a 14-year old who suffered from significant mental health issues and had been in foster care for 10 years. Katie had 37 total placements throughout her time in foster care, with 30 of those taking place between the ages of 11 and 14.

Initially filed in July 2002, the lawsuit sought to improve access to intensive home and community-based mental health services offered through Medi-Cal, California's Medicaid program. While Los Angeles County settled its portion of the case in 2003, the state reached agreement in the landmark settlement in September 2011, after several years of litigation and negotiation.

FIGURE 1 Focus on Youth and Families – Integrated Service Delivery Model



**FIGURE 2** Framework for State and County Implementation of Katie A.



The vision for the **Shared Management Structure** is to create a framework whereby the California Department of Social Services (DSS) and the California Department of Health Care Services (DHCS) jointly make decisions concerning policy and program direction, provide clear and consistent guidance to program managers and stakeholders, develop outcomes and accountability measures, and perform other activities consistent with the CPM and the mental health needs of Katie A. class members.

Furthermore, decisions are consistently informed by **Quality Data** and **Stakeholder Feedback**, thereby holding the system accountable, promoting transparency and demonstrating leadership for delivering mental health services to children in and at risk of foster care placement.

The **Shared Management Structure** supports the development and quality delivery of:

- **Core Components** – Development and approval of guidelines for ICC, IHBS and TFC, delivered within the Core Practice Model.
- **Training and Support** – Supporting the integration and coordination of how child welfare and mental health workforces can deliver consistent and quality services.
- **Service Delivery** – Implementation of ICC, IHBS and TFC, facilitated by a process to identify subclass members and link them to services.
- **Family and Youth Engagement** – Ensuring family culture, strengths and vision are incorporated at every step of the service delivery process.

The State settlement delineated the objectives of the services to be provided:<sup>iv</sup> **1.** Facilitate the provision of an array of services delivered in a coordinated, comprehensive, and community-based manner that allows for service access, planning, delivery, and transition, into a coherent, all-inclusive approach; **2.** Support the development and delivery of a service structure involving standards and methods to achieve quality oversight, and training and education that support the practice and fiscal models; and, **3.** Address the need for certain children in and at imminent risk of foster care, and with more intensive needs, to receive medically necessary mental health services in their own home, a family setting, or the most home-like setting appropriate to their needs, in order to facilitate reunification, and to meet their needs for safety, permanence, and well-being.

Beyond simply designing a new program, the Katie A. settlement agreement provides the opportunity to transform the system that delivers mental health services to children and families in foster care. At the heart of sustainable systems change are two key components:

**Integrated Service Delivery** – Implemented through the Core Practice Model (CPM), which puts youth and families at the center to help ensure improved outcomes for the individuals served. The first priority is to ensure that youth within the subclass, i.e., youth in greatest need of mental health services, receive Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS), and after 2014, Therapeutic Foster Care (TFC), delivered within the CPM approach. The overarching goal is to use the CPM in delivering services to all children and families in foster care who need mental health support. (Figure 1)

**Shared management and decision-making, informed by data, at the state and county levels** – Designed at the state level, with supported rollout at the county level, the goal is a framework whereby the DSS and the DHCS jointly make decisions concerning policy and program direction. (Figure 2)

## County Perspectives on Implementation

Even before the Katie A. settlement, foundational work was underway in a number of counties to apply new integrated delivery practices to a fragmented system of mental health and child welfare services that did not have the capacity to support some of our most vulnerable children and families. Much can be learned and applied from these pioneers as most counties continue to work towards a more integrated mental health and child welfare system.

### Fresno County Department of Social Services

#### System of Care for Child Welfare Families for Mental Health

##### Approach

For counties struggling to develop an integrated system of mental health delivery and shared management structure, Fresno County is an excellent example of the winding evolutionary path of change. Nearly a decade ago, child welfare and mental health was an integrated human services system under the same department, known as YouthLink. The integrated agencies had the ability to assess all children for mental health needs, and placed a special emphasis on children in foster care. Although there was a shared oversight structure, culture issues between the two agencies disrupted seamless mental health service delivery. Family and youth suffered from the disjointed delivery approach.

Ultimately, the formula for success started with Fresno's work with the California Institute of Mental Health. A deeper understanding of evidenced-based practices continued to expose the weakness of child welfare and mental health agencies that were not on the same page concerning service delivery. Armed with significant knowledge of what does and doesn't work, Fresno was selected as an early implementation county for the federally funded [California Partners for Permanency \(CAPP\)](#)<sup>v</sup> program. CAPP provided the model and discipline needed to transform delivery systems into a truly integrated approach. It also enabled the county to outsource components of service delivery which ended up addressing some of the culture differences. With CAPP work underway, Katie A. became a facilitator to force the difficult conversations and accelerate the transformation.

##### Progress to Date

- Children and families have greater involvement throughout the process and help to shape the treatment plan.
- Job sharing and role changes have helped to build a strong partnership between child welfare and mental health.
- Newly added role of Intensive Care Coordinators (ICCs) assists in facilitating conversations and collaboration between child welfare workers and mental health providers.
- An integrated charge-back billing system helps to improve service delivery and minimize delays.

##### Challenges

- Change is slow. It took over a year for people to begin to understand the value of an integrated model.
- Lack of consensus across the system on what the continuum of care should include deepens the gap between service providers.
- Child welfare workers and mental health professionals need ongoing support in working together, and in more deeply understanding each other's work.
- Applying Katie A. mandates to an integrated system that is working, especially around billing.

## Los Angeles County Department of Mental Health

### Child Welfare Division

#### Approach

Los Angeles County started developing an integrated service delivery system in 2003 as part of the county settlement of Katie A., which was separate from the state settlement agreement. At that time, the county had no systematic way of identifying children who needed mental health care or of connecting them to the appropriate services. They estimated that 20% of children in the child welfare system were receiving services but knew the need was likely much greater. As a first step, the Department of Mental Health (DMH) and the Department of Child and Family Services (DCFS) agreed upon the use of a mental health screening tool to be completed by DCFS child welfare workers for each open case. Children who have a positive screen are immediately referred to mental health staff, co-located in each of the DCFS regional offices. These staff members then refer the cases to the appropriate community based mental health provider for assessment and treatment. Increasingly, treatment includes intensive care coordination, evidence-based practices and individualized home-based services.

#### Progress to Date

- 100% of children entering the child welfare system are screened for mental health services.
- Approximately 85% of the children screened are referred for further assessment and treatment.
- Approximately 70% of children with open DCFS cases are receiving mental health services (up from approximately 28% less than 10 years ago).
- The DCFS population includes a substantial number of pre-school-aged children and DMH has significantly expanded service for this population.
- Substantial work has been done around data sharing, so the county can easily identify those in the child welfare system who are receiving mental health services.
- Development of the [Quality Service Review \(QSR\)](#)<sup>vi</sup> process is promoting improved practice consistent with the shared Core Practice Model in areas such as child and family engagement; needs and strengths based assessments; teaming across traditional service boundaries; and the development of individualized services and supports to promote safety, permanency, and well-being.

#### Challenges

- Systems reform and practice change are frequently challenged by traditional work practices and competing priorities.
- LA County has done a fair amount of training within both the child welfare and mental health departments, but the training is not sufficient to move the practice forward to where it needs to be. Ongoing coaching services are necessary for the departments to fully integrate their work.
- The need is greater than expected. The estimate was that 50% of children coming into the system would need mental health services, and the reality is closer to 70%.
- The intensity of mental health services is still not at the level it needs to be, especially for the children that fall into the Katie A. subclass, i.e. those with the greatest need for mental health treatment. More professionals will need to be added to the workforce to meet this capacity need.

Many counties already had shared management structures that were working very well. Katie A. was a driver to make the change statewide, with all counties working towards improving their processes, collaboration and communication between child welfare and mental health agencies. And at the State level, Katie A. has intensified DHCS' and CDSS' focus on shared management structures.

**Dina Kokkos-Gonzales**, Chief of Program, Policy & Quality Assurance Branch, Mental Health Division, The California Department of Health Care Services

Nearly two decades ago, San Francisco County's departments of Child Welfare and Mental Health created a collaborative and co-funded system to improve mental health delivery for children in foster care. Katie A. is a great vehicle for us to sit down and talk about how to continue improving upon that work.

**Ken Epstein**, Director, San Francisco County, Children, Youth and Families System of Care

Collaboration is the **ONLY** way to make this work, and it is the key to targeting the right kids and making sure they receive the services they need in a way that works for them.

**Twylla Abrahamson, Ph.D.**, Placer County, Assistant Director, Children's System of Care, Managed Care Unit Manager

System delivery is the key! An integrated approach must happen. You will get a few people in social services who get it, and a few people in mental health who get it, but it can be tough to move the rest of the system.

**Howard Himes**, Director, Fresno County Department of Social Services

The Katie A. settlement agreement really was a catalyst in helping to reform the relationship between child welfare and mental health and moving our practice on behalf of dependent children to a higher level. While the settlement lit the fire, this work has taken on a life of its own that will last well beyond court oversight.

**Greg Lecklitner**, District Chief, Los Angeles County Department of Mental Health, Child Welfare Division



## Placer County

### Children's System of Care

#### Approach

Placer County began formalizing a structurally and functionally integrated child welfare-mental health delivery approach more than 20 years ago. At the core of their model is the Systems Management, Advocacy and Resource Team (SMART) which comprises senior County representatives from both the Probation Department and the Department of Health and Human Services, as well as the presiding Juvenile Court Officer, and the Superintendent of the County Office of Education. The mission of SMART is to ensure that all public programs for children and families provide services in an integrated, comprehensive, culturally responsive, evidence-based manner, regardless of the agency door by which the child enters.

#### Progress to Date

- A child can enter the system through any department and he/she will be served by an integrated system of care.
- While many dependent children received mental health services in the past, 100% of children are now being screened as a result of Katie A. mandates and support. This has enabled Placer's already integrated system to produce better outcomes by identifying more children in need and identifying those needs earlier in the care process.
- A formal job rotation program has enabled deeper collaboration across social services, probation and mental health.
- The intensity of service delivery has created even greater collaboration between child welfare workers and mental health providers. Specifically, Team Decision Making meetings are now jointly conducted with members of both departments.
- Integrated service delivery has enabled the county to effectively claim Medi-Cal dollars before using Child Welfare funds.

#### Challenges

- Issues were arising due to the mandated mental health screening at the initial investigation and intake stage. Workers realized that it was too much for children and families to participate in the screening during such an emotional and chaotic time. The county was able to move the screening to correspond with the first court hearing, while still complying with state mandates.
- Redundancy in reporting. The reports mandated by Katie A. have data requirements that overlap with several other required reports, e.g., annual external quality review, system reviews, etc. The time necessary to deliver reports that are redundant is distracting from the focus on actually delivering services to children and families. No one seems to be looking at solutions to this problem.
- Managing care for children placed out-of-county remains a challenge. Fortunately, Placer has a very small percentage of youth in distant care locales.

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## San Francisco County

### Children, Youth and Families System of Care

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#### Approach

San Francisco County created the Foster Care Mental Health system nearly 20 years ago to better assess, triage and deliver the right mental health services to children in foster care. Taking the work a step further, San Francisco created the Interagency Services Collaboration (iASC), which sets goals beyond what Katie A. requires, and formally replaces the name 'Katie A.' iASC expands the collaboration beyond child welfare and mental health, to include probation, juvenile justice, and First 5. The goal of iASC is to design an attachment and trauma focused system with a shared framework that is information driven, integrated, and innovative. The system will support the health, safety, permanency and well-being of children, youth and families that have been involved with or are at risk of involvement with foster care, probation, or special education, and/or are struggling with complications of behavioral health issues.

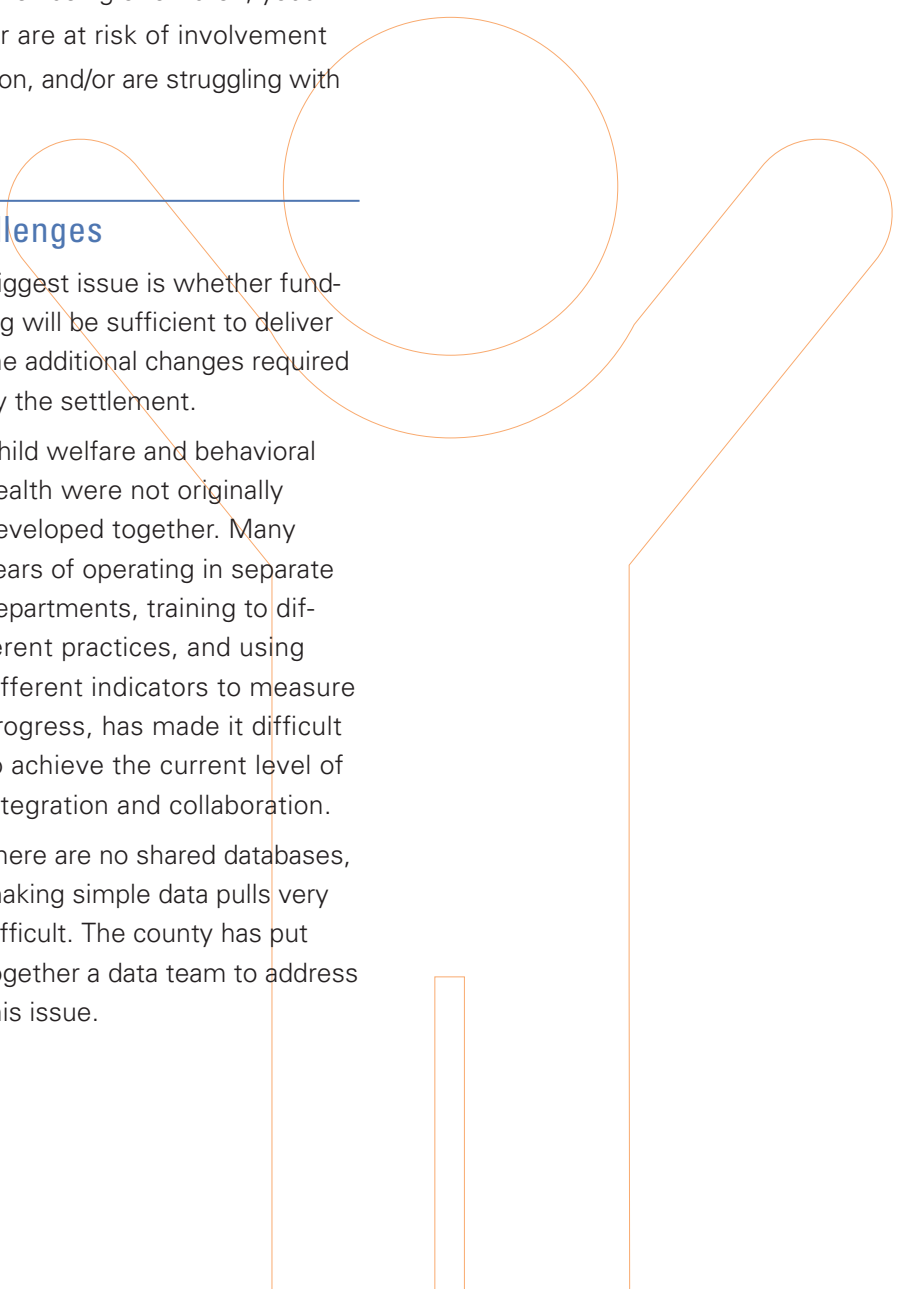
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#### Progress to Date

- As a result of the collaborative Foster Care Mental Health model that San Francisco implemented nearly 20 years ago, 60% of foster youth currently receive a mental health assessment.
- The majority (approximately 85%) of children assessed with a need for mental health services receive the appropriate treatment, at the right time and in a manner that minimizes the number of service providers interacting with each child.
- The focus on collaboration has enabled the County to develop a fairly robust wraparound network to support children receiving services.

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#### Challenges

- Biggest issue is whether funding will be sufficient to deliver the additional changes required by the settlement.
  - Child welfare and behavioral health were not originally developed together. Many years of operating in separate departments, training to different practices, and using different indicators to measure progress, has made it difficult to achieve the current level of integration and collaboration.
  - There are no shared databases, making simple data pulls very difficult. The county has put together a data team to address this issue.
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## Moving Forward – Building Sustainable Pathways to Mental Health Services

Two years into the implementation of the Katie A. settlement, progress is evident. However, major systems change on this scale will take time. A preliminary review of the first semi-annual reports submitted by 53 counties in October reflects the following activity between May 15, 2013 – August 31, 2013.\*

- 16** counties provided and billed for ICC and IHBS.
- 500** children and youth received ICC.
- 312** children and youth received IHBS.
- 4,911** children and youth are projected to receive ICC and IHBS by April 2014. Projections take into account that many counties are still learning how to identify and report the required data and may be providing similar services but using other claim codes. For example, as of December 2013, data show that 29 (instead of 16) counties are providing ICC/IHBS to Katie A. subclass members.

The State departments will continue to monitor Katie A. implementation through the required submittal of semi-annual progress reports from the counties, due April 1st and October 1st of each year. In addition, a critical element of the Katie A. settlement agreement to fully serve this population is the implementation of TFC services. TFC continues to be a work in progress with expected statewide implementation and roll out now slated for August 1, 2014. Implementation of TFC as well as the Joint Management Structure at the State and local levels, will over time help ensure that youth in foster care receive the right mental health services resulting in improved outcomes for children and families.

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**The true promise of Katie A. will happen when we no longer think of it as a “program,” but rather as an ongoing approach to delivering mental health services to all children who need it and in particular to those in child welfare.**

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**Rick Saletta,**  
Katie A. Special Master

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\*Note: The state is conducting its analysis of these data, and final findings will be posted in February 2014.

The most significant progress to date has been made in the area of service delivery, including subclass access to ICC and IHBS through an integrated delivery model; guidelines and ongoing trainings and technical assistance to sustain the integrated approach; and launch of a county peer-to-peer Learning Collaborative to share

best practices. The greatest amount of work remaining for the final 12 months of settlement agreement implementation is in developing a shared management and data reporting structure that will support and sustain the service delivery transformation.

Six Core Areas of State Implementation	Progress Highlights	Implementation Needs*
<b>Shared Management Structure</b>	<ul style="list-style-type: none"> <li>» CPM Fiscal Task Force Recommendations completed and sent to DSS and DHCS to be evaluated for adoption.</li> </ul>	<ul style="list-style-type: none"> <li>» Continue to develop the Shared Governance and Accountability, Communication and Oversight (ACO) Structure.</li> <li>» Determination of structures needed to enable counties to share governance at the local level.</li> </ul>
<b>Core Components</b>	<ul style="list-style-type: none"> <li>» Completed and posted on DSS and DHCS web sites: Core Practice Model Guide; Medi-Cal Manual for ICC and IHBS; FAQs</li> <li>» Statewide implementation and access for subclass to ICC and IHBS</li> </ul>	<ul style="list-style-type: none"> <li>» Federal approval of Therapeutic Foster Care (TFC).</li> </ul>
<b>Family and Youth Involvement</b>	<ul style="list-style-type: none"> <li>» DSS Parent Leadership team to be attached to State Learning Collaborative first quarter of 2014.</li> </ul>	<ul style="list-style-type: none"> <li>» Creation of organizational policies that reflect families' decision-making power.</li> <li>» Offering of peer support networks for children, youth, and caregivers.</li> </ul>
<b>Service Delivery Rollout</b>	<ul style="list-style-type: none"> <li>» ICC and IHBS are being delivered to subclass members.</li> <li>» CPM implementation launched.</li> </ul>	<ul style="list-style-type: none"> <li>» Closing the gap between subclass members identified and those receiving ICC and IHBS services.</li> <li>» Resources to support coaching and mentoring for statewide CPM implementation.</li> </ul>
<b>Training and Technical Assistance</b>	<ul style="list-style-type: none"> <li>» Weekly technical assistance calls opened to all counties and other stakeholders.</li> <li>» State-County Learning Collaborative established, and first meeting convened.</li> </ul>	<ul style="list-style-type: none"> <li>» Increase state guidance on CPM implementation at the county level.</li> <li>» Opportunities for joint training to staff and families.</li> </ul>
<b>Data and Quality Assurance</b>	<ul style="list-style-type: none"> <li>» Joint Management Taskforce (JMT) issued specific instructions and expectations on information required in County Semi-Annual Progress Reports.</li> <li>» State analysis nearly complete for county and statewide data on subclass members receiving ICC and IHBS.</li> </ul>	<ul style="list-style-type: none"> <li>» Ability to accurately count the subclass, track services delivered, and quantify the gaps between child welfare and mental health reported numbers.</li> <li>» Finalize JMT/ACO recommendations and present to DHCS/DSS</li> </ul>

\* Includes high and moderate needs as reported by the counties through the State's Readiness Assessment and Service Delivery Rollout analysis.

The State has several 2014 activities in place to address the implementation gaps, including county submission of semi-annual progress reports in April, hosting of the Pathways to Well-Being Institute (formerly the California Wraparound Institute) in June, and ongoing technical support calls and Learning Collaborative county and regional meetings. December 2014 marks the end of federal court jurisdiction, and oversight will then be absorbed by the state.

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**(I was) headed down the wrong path. (Connecting through my probation officer) I was able to get the kinds of supports my family was unable to provide me, including help with getting into college, finding an affordable place to live, paying my utilities and finding health benefits. I was connected with a (mental health) counselor and other adults that left me feeling that I am cared for.**

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**Robert, Placer County**

Creating new pathways to integrated child welfare and mental health service delivery is a complicated and slow process, and ensuring the change is sustainable will take many years beyond the settlement period. The progress to date is a strong indication that Katie A.'s story will not be repeated.

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## Quick Links: Katie A. Implementation Resources

- Katie A. FAQ  
<http://bit.ly/1jmZwuH>
- Sept. 2013 MHSD Information Notice / All County Letter on implementation expectations  
<http://bit.ly/1c2OMzk>
- Core Practice Model guide  
<http://bit.ly/188yrMu>
- Medi-Cal Manual for implementation  
<http://bit.ly/1fVMUec>
- Readiness Assessment Tool  
<http://bit.ly/1howtrM>
- Service Delivery Plan  
<http://bit.ly/1dhQj9G>

More Katie A. resources can be found at:

- CDSS web site  
<http://bit.ly/HZleYF>
- DHCS web site  
<http://bit.ly/VRqdQU>
- For questions email for both departments  
[KatieA@dss.ca.gov](mailto:KatieA@dss.ca.gov) or  
[KatieA@dhcs.ca.gov](mailto:KatieA@dhcs.ca.gov)

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i. [www.dhcs.ca.gov/Documents/KACorePracticeModelGuideFINAL3-1-13.pdf](http://www.dhcs.ca.gov/Documents/KACorePracticeModelGuideFINAL3-1-13.pdf)  
 ii. [www.casey.org/Resources/Publications/pdf/MentalHealthEthnicitySexuality\\_FR.pdf](http://www.casey.org/Resources/Publications/pdf/MentalHealthEthnicitySexuality_FR.pdf)  
 iii. [www.dhcs.ca.gov/Documents/KACorePracticeModelGuideFINAL3-1-13.pdf](http://www.dhcs.ca.gov/Documents/KACorePracticeModelGuideFINAL3-1-13.pdf)  
 iv. [www.csuchico.edu/swrk//mh/docs/Katie\\_A\\_Overview.docx](http://www.csuchico.edu/swrk//mh/docs/Katie_A_Overview.docx)  
 v. [cfpic.org/capp/](http://cfpic.org/capp/)  
 vi. [dcfs.co.la.ca.us/katieA/docs/QSRprotLAdt1.pdf](http://dcfs.co.la.ca.us/katieA/docs/QSRprotLAdt1.pdf)



California Child Welfare  
**Co-Investment Partnership**

## About the California Child Welfare Co-Investment Partnership

The California Child Welfare Co-Investment Partnership comprises five philanthropic organizations (Casey Family Programs, Conrad N. Hilton Foundation, Stuart Foundation, Walter S. Johnson Foundation, and Zellerbach Family Foundation) and the California Department of Social Services, Administrative Office of the Courts, and County Welfare Directors Association. The partners meet regularly to share perspectives on federal, state and local policy, and to coordinate investments needed to improve the child welfare outcomes of safety, permanency, and well-being. Download previous editions of insights and find out more about the Partnership at [co-invest.org](http://co-invest.org).