



# California's Children and Youths' System of Care: An Agenda to Transform Promises Into Practice

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Young Minds Advocacy  
May 2017

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## About the Organization

Young Minds Advocacy is a nonprofit organization that uses strategic communications and collaborative advocacy to help youth, their families, and communities access mental health services and supports, and improve mental health system performance and accountability. Learn more by visiting [www.ymadvocacy.org](http://www.ymadvocacy.org).

## About the Author

Patrick Gardner founded Young Minds Advocacy in 2012 in order to improve legal advocacy efforts and system outcomes for young people seeking access to quality mental health care. A public interest lawyer for 30 years, Patrick specializes in children’s mental health law and policy, and their impacts on youths involved with child welfare, juvenile justice, special education, and mental health systems. A University of Virginia Law graduate, he serves as co-counsel in statewide class actions strengthening children’s rights to mental health care, and works with legislative bodies and administrative agencies to improve access to individualized, high quality treatment. Prior to founding Young Minds, Patrick was deputy director at the National Center for Youth Law, and previously, Hawaii County managing attorney with the Legal Aid Society of Hawaii. “Decades of advocating for low-income and at-risk people has schooled me to be creative, outspoken, persistent—but never patient. Young people with serious mental health needs deserve access to quality treatment now.”

## Acknowledgements

Young Minds Advocacy gratefully acknowledges the generous support of Zellerbach Family Foundation, which made this report possible. The mission of the Zellerbach Family Foundation is to be a catalyst for constructive social change by initiating and investing in efforts that strengthen families and communities. Learn more about the Foundation by visiting [www.zff.org](http://www.zff.org).

The author wishes to acknowledge the contributions of the following people who shared their observations and insights on early drafts with the author: Ken Berrick, Reed Connell, Lyn Farr, Jesse Hahnel, Nate Israel, Laurie Kappe, Stacey Katz, Amy Price, Chris Stoner-Mertz, and Lynn Thull. The author greatly appreciates the research and editorial contributions of Nisha Ajmani, Emily Bisnett, Tara Ford, Annabelle Gardner, Margaret Mangan, Wesley Wilson Sheffield, and Aisa Villarosa. Finally, the author acknowledges the assistance provided by Annabelle Gardner in designing the report.

The views expressed in this report are solely the responsibility of the author.

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# I. Executive Summary

## California Needs a Comprehensive Children and Youths' Mental Health Policy

Mental illness is the greatest healthcare challenge facing America's children, youth, and families. Regrettably, California's current "system" of providing mental health care does not effectively meet young people's needs. While many individuals and programs make significant, positive impacts on the lives of youth with serious mental health needs, the system as a whole is not delivering on its promises to children and families.

This report provides an overview of California's publicly-funded children and youths' mental health system, examines the challenges related to access, coordination of services among child-serving agencies, quality of treatment, and leadership and accountability, and provides recommendations that stakeholders and advocates can use to ensure that all of California's young people who experience mental illness receive the care they need and deserve.

## Key System Components and Funding

Many programs, agencies, and providers, using a tangle of funding sources, make up California's children's mental health system. Understanding and accessing care is challenging due to the sheer number and scope of child-serving agencies and programs. The diversity of service domains, the variety of governing structures, and the accompanying volume of disparate rules and regulations make coordinating care a major challenge. Funding constraints add to the challenge. Restrictions commonly include categorical eligibility requirements, or limits on service type, service setting, or who may be authorized to provide care.

The main programs providing mental health services to California's young people include: Medi-Cal, the Mental Health Services Act (MHSA) programs, Educationally Related Mental Health Services (ERMHS), and several Federal programs, most notably, Substance Abuse and Mental Health Services Administration

(SAMHSA) grants. The lion's share of funding stems from Medi-Cal programs that include Early, Periodic, Screening, Diagnosis and Treatment (EPSDT), Drug Medi-Cal (DMC), pharmacy benefits, Managed Care "mild to moderate" care, and Behavioral Health Treatment for children with autism. These publicly funded programs, along with a myriad of smaller ones, account for 60 percent of national expenditures on mental health services.

## Why Change Is Needed

### *Many Children Get Access to Services, But Many More Do Not*

California serves thousands of children with mental health needs. In fiscal year 2014/15, 264,054 youth received at least one specialty mental health service from Medi-Cal. In addition, as many as 120,000 students received mental health services through an Individualized Education Plan (IEP) that year. Thousands of youth also received care under Mental Health Services Act programs.

While many youth do receive care, many more do not. More than one quarter of a million eligible California children with serious mental health needs received no Medi-Cal assistance at all. Unmet needs are even more striking in education (less than 20 percent of needy youth are likely served) and substance use (less than five percent receive treatment) programs. Also concerning are recent declines in access rates, even as funding has increased, and the highly uneven distribution of services across the state.

### *Multi-System Involved Youth Need More Coordinated Care*

Children and youth with serious mental health needs are almost invariably involved in multiple child-serving systems, most commonly: special education, juvenile justice, child welfare, and specialty mental health. It has long been recognized that these young people need a coordinated system of care. When the multiple agencies that serve youth have different ways of "doing business," with different rules, and different

goals, the result is confusion and frustration for youth and their caretakers, and significant hurdles to mental health care. And yet, recent trends in California have created new barriers to overcome. Most notable: the elimination of AB 3632, which relieved county mental health departments of responsibility for providing mental health services to special education students, shifting this obligation back to Local Education Agencies. Other promising opportunities have not materialized as expected.

### ***Overall Quality of Care Is An Unknown***

Notwithstanding a growing patchwork of data collection efforts, mental health program managers cannot accurately or regularly report even the most rudimentary systemic information about our billion dollar programs: We do not know, with confidence, what we buy; we generally do not know who gets services and who does not; and we can only rarely say what impact the services provided have had on the children and families who received them.

Moreover, the data we do have suggest serious challenges exist in the overall quality of care provided to youth in California. A partial picture that emerges shows wide disparities in access and intensity of services, minimal adoption of evidence-based practices, accelerating use of hospitalization, under-utilization of home and community-based care, and limited reliable improvement across and within key programs.

## **Recommendations**

The great strength of the children and youths' stakeholder community is its members' knowledge, training, experience, dedication, and compassion. But these strengths alone have not been sufficient to ensure that our system of care collaboratively treats all children and youth in need, or systematically achieves improved outcomes for the young people and families served. To do this, the community of stakeholders needs to come together to set goals, establish priorities, and put into motion concerted action that will promote, and ultimately ensure, access, collaboration, quality, and accountability for California's Children and Youths' System of Care.

The following recommendations were developed to provide a framework for identifying specific activities that can be combined into a proactive stakeholder

agenda for achieving better outcomes for thousands of California's children and youth with unmet mental health needs.

### ***A. Provide Children and Youth Full and Equal Access to Mental Health Care***

#### **1. Fulfill Our Promises**

California's existing laws and policy commitments promise most children adequate mental health care and support. Simply fulfilling our promises would dramatically improve access to care and improve outcomes for families and youth.

#### **2. Identify Needs**

The first imperative for any children's mental health system is to identify and assess children with unmet mental health needs. Greater effort to identify youth early would reduce harm and save money.

#### **3. Allocate Funds Equitably to Ensure Equal Access to Care**

California needs to allocate public mental health funding to cities, counties, and regions so as to ensure that all children and youth have equal access to care.

#### **4. Close Gaps in Coverage**

Recent research has concluded that more than 96 percent of California's children have or are eligible for health insurance. It's time to close the insurance coverage gap altogether and guarantee all children and youth in California full access to quality mental health care.

### ***B. Coordinate Services and Resources***

#### **1. One Child, One Plan**

One joint plan is needed to coordinate services and eliminate the multitude of confusing and alienating interventions and goals confronting youth with serious mental health needs and their families. It's time for the system designers and managers to coordinate policies and programs, rather than making clinicians, families, and youth do it.

#### **2. Funds and Resources Must Follow the Child**

Resources must be tied to an individual youth's strengths and needs, not those of the agencies intended to serve them.

### 3. Use a Shared Wraparound Practice Model for All Multi-System Involved Youth

The State needs to use a common wraparound and teaming practice model for all child-serving agencies or systems with consistent performance and quality standards and the formal authority needed to combine, or “braid,” funding sources.

4. Develop a Collaborative, Culturally Competent Workforce That Practices Cross-System Teaming  
Development of the skills needed to effectively serve multi-system youth will require changes in workforce training and supervision, reconciling practice models and attitudes that differ across service domains, and redoubling our efforts to develop and provide culturally appropriate care for individuals and groups.

### *C. Provide Effective, Quality Care*

#### 1. Close the Science-Practice Gap for Children’s Mental Health Treatment

Key challenges include: poor fit between services and clients; inadequate client engagement and transitions to the community; and using interventions without demonstrated effectiveness. Closing the gap could double reliable improvement system-wide.

#### 2. Measure, Assess, Report, Improve. Repeat!

Solving quality challenges will require: (i) Consistent and reliable measuring and reporting—in real time—what we are doing so we understand what is happening at the clinical, program, and system level; and (ii) Providing an information feedback loop at every level of the service system, so that we can inform and improve practice.

#### 3. The State Needs to Fund the Core Functionality of California’s Performance and Quality Improvement System

By funding the basic quality and performance infrastructure, the State would improve its leverage in pursuing system integration, increase standardization, accuracy, transparency, and efficiency, and lower system costs.

#### 4. Quality Improvement Must Become Embedded in Routine Practice and Decision-Making

Performance and quality information must be made understandable and accessible. Information has to become the daily companion of clinicians, supervi-

sors, program managers, decision-makers—and just as importantly—families and youth.

### *D. Develop Leadership, Support Engagement, and Increase Accountability*

#### 1. Community Members Need to Build a Sustainable Stakeholder Coalition

The children and youth stakeholder community must build and sustain a collaborative network of activists to promote information sharing and goal-setting, identify and provide the resources needed to improve advocacy capabilities, and provide leadership that can balance listening to many voices and speaking with one.

#### 2. Broaden the Focus and Reach of Children and Youths’ Mental Health Policy

Educating others about the costs and benefits of both mental illness and mental health offers the opportunity to broaden the base of the children and youth stakeholder coalition, and reduce competition among child-serving (and possibly adult) domains, agencies, and resources.

#### 3. Government Leadership at the State and County Level Is Needed to Support a Collaborative System of Care

State and county leaders need to articulate and embrace an operational vision for the whole system of care. They also need to create a transparent mechanism to co-manage information, funding, policies, and programs, and agree on their respective roles in this shared responsibility model.

#### 4. Leaders and Managers Must Set Clear, Accountable, Data-Driven Short and Long Term Goals

Providing relevant and timely information, establishing a clear agenda, and setting and meeting an aggressive timetable for achieving it are essential management capabilities for building and sustaining California’s children and youths’ System of Care.

### **Conclusion**

The Great Recession and recent policy changes have battered California’s children’s mental health system. The result has been declining access to treatment, inadequate overall quality of care, uncoordinated care among child-serving agencies, and minimal account-

ability for the intended outcomes of better health and stronger families. Turning this around will require setting clear goals; better-informed and more responsive leadership; more effective engagement by stakeholders; and the roll-out of essential infrastructure to measure and report performance and outcomes. Accomplishing these goals will be necessary to improve quality of care and to hold the State, counties, and healthcare providers accountable to the children and families they serve, and the public.



## II. Introduction

This report makes the case for why California needs a comprehensive children and youths' mental health care policy by presenting an overview of the public system and its performance, and outlining the resulting challenges in terms of access to care, coordination among agencies and programs, quality of care, and leadership and accountability. The report offers a series of recommendations as a roadmap for improving outcomes for young people and their families to policy-makers, stakeholders, and advocates.

### Why Is Children's Mental Health Important?

Mental illness is America's number one health challenge for young people between the ages of 12 and 24, and by a wide margin. More than one child in five in the U.S. will have a diagnosable mental health disorder that causes some impairment by the time they reach age 18. That means more than 17 million American youth meet or have met diagnostic criteria in 2015.<sup>1</sup> While research shows that children are generally quite healthy, they face higher risks of mental health problems than other age groups.<sup>2</sup>

Mental illness among youth is often co-occurring with other conditions. Young people may have related Substance Use Disorders (SUDs), physical ailments, or developmental, learning, or other disabilities. The interrelated nature of these conditions means that youth often have complex needs that require coordinated care from multiple public agencies or service providers. Although millions of young Americans and their families are dealing with mental health challenges daily, fewer than 20 percent receive *any* treatment.<sup>3</sup>

The consequences of unmet mental health needs are often severe and include failure in school, family disintegration, delinquency, homelessness, and suicide. Mental illness is also a contributing factor in the institutionalization of thousands of young people and the leading cause of hospitalization among minors.

Treating mental illness is the Nation's most expensive

youth healthcare cost. In 2011, expenditures on mental health services totaled \$13.8 billion,<sup>4</sup> with a mean expenditure per child of \$2,465, the highest average among all childhood conditions.<sup>5</sup> Taking into account broader system and social costs, the expense of mental illness is a staggering \$247 billion annually for young Americans under age 24.<sup>6</sup>

Many children with unmet mental health needs end up in restrictive care that includes group homes, juvenile detention, and psychiatric hospitals. Studies suggest that more than 700,000 children with diagnosable mental health needs are institutionalized each year by child welfare, juvenile justice, and mental health authorities.<sup>7</sup> Institutional care is necessary for the most severely ill youth, but for others, it may aggravate their condition. Isolating youth with serious mental health needs from their networks of support and caring adults threatens the links that are critical for successful development. As youth become institutionalized, they become less capable of transitioning back to the families and communities they need for support.

Poor outcomes, however, are not preordained. Evidence is growing that intervening earlier in the trajectory of mental illness can reduce its severity or avoid long-term problems altogether.<sup>8</sup> A better understanding of mental health, and a more informed view of how mental disorders affect families and institutions, would provide useful tools for effecting change and securing improved outcomes.

### Why Is a Distinct Children's Mental Health Policy Needed?

The mental health of young people depends on families. Young people, especially those under age 18, are dependent on others—physically, emotionally, socially, and legally. Moreover, children's mental health challenges occur within a psycho-social developmental arc that makes assessment, diagnosis, and treatment more complicated and much more time-sensitive than adult treatment.

For too long, conversations about mental health and illness have focused primarily on adult mental health, and in particular, serious mental illness *among adults*. This focus often translates into a “me-too” approach to children’s needs, where children are thought of simply as little adults, and services and programs that aid adults are assumed to satisfy children’s needs. Moreover, the adult population’s needs are often prioritized over young people’s, and adult programs and funding may be given higher priority. Even more troubling, many interventions and therapies for children and youth are derived from adult services that have not been proven effective, or even safe, for children.

address young people’s needs and strengths directly—while simultaneously being mindful of the family and community context within which they live.

The sheer number and variety of child-serving agencies that may interact with a young person in need adds to the differences. For example, a young person with serious emotional or behavioral disturbance may be involved with agencies ranging from special education, child welfare, probation, family court, substance use disorder, specialty mental health, managed health-care, developmental disabilities, youth development, and more. Each agency has its own mission, language, culture, and rules, and the approach or intervention undertaken by one is rarely coordinated with efforts by others.

Children are often entitled by law to mental health-care, whereas adults may not be. A host of state and federal laws mandate that children must be provided care, including extraordinary broad and deep coverage under Medicaid, or Medi-Cal in California, which far exceeds the coverage provided adults. Additional entitlements include: IDEA (special education), the Lanterman Act (developmental disabilities), minor consent services (confidential mental health care for minors not requiring parental consent), the 14<sup>th</sup> Amendment (children in custody), Supplemental Security Income (SSI), and Temporary Assistance to Needy Families (TANF) (public assistance), to name the most prevalent sources.

The mental health policy implications stemming from the differences between youth and adults are significant. That does not mean youths’ needs must be pitted against adults’. It does not mean that adult mental health concerns are less vital, or that reduction in services and supports for adults is in any way desirable.<sup>9</sup> The point is simply that children’s needs are sufficiently distinct and weighty that public policy-makers must

# III. A Brief Overview of California's Publicly-Funded Children and Youths' Mental Health Service System

The children and youths' mental health system is a disaggregated array of programs and services offered by many agencies (directly and indirectly), for many purposes, and is funded from widely varying sources by every level of government. What follows is an overview of the most significant components of the system and how they are funded and provided in preparation for taking a closer look at the system's overall impact on California's children, youth, and families.

## Key Programs That Make Up the Children and Youths' Mental Health System

### *Medi-Cal*

The core of California's children and youths' mental health system is Medi-Cal. Medi-Cal is the state's largest publicly-administered health program in terms of annual expenditures and caseload,<sup>10</sup> serving just over half of California's children, and enrolling over 5.5 million youth under age 21.<sup>11</sup> Medi-Cal is essentially a health insurance program for low-income and disabled Californians. Program benefits are provided by public and private healthcare providers who are reimbursed for allowed medical expenses by the state and federal government.

Federal law requires California to offer certain services as part of the Medi-Cal program, including Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) services.<sup>12</sup> EPSDT services include screening for all Medi-Cal eligible youth under age 21 for health and behavioral health conditions, as well as diagnosis and treatment services necessary to help improve or correct identified illness or disorders.

Medi-Cal mental health services are provided to young people through a county-based managed care arrangement. Authorized by a section 1915(b) waiver of the Medicaid freedom of choice provision, California's counties (and two cities) operate 58 children and youth mental health managed care organizations called Mental Health Plans (MHPs). Program oper-

ations are governed by federal Medicaid and state Medi-Cal rules and regulations, and operationalized with contracts between each MHP and the Department of Health Care Services (DHCS). Private healthcare agencies and Fee-for-Service (FFS) clinicians provide 80 percent of services statewide, with county employees providing the balance of care.

California's Drug Medi-Cal Treatment Program (DMC) is responsible for ensuring that substance use disorder (SUD) services are provided to Medi-Cal eligible youth who meet medical necessity. DHCS estimates that it spends approximately \$7.3 million each year to fund counties to provide adolescent SUD treatment and intervention services.<sup>13</sup> A variety of substance use services may be offered to youth through a fee-for-service structure, including outpatient community programs, residential treatment, transition services for youth after discharge from an institutional facility, and programming onsite at schools. In 2015, California received a section 1115 waiver to create a pilot program, which enables counties to provide a fuller continuum of care to DMC beneficiaries.

In addition to DMC and EPSDT specialty mental health services, Medi-Cal programs and providers offer youth screening (Child Health and Disability Prevention program), medication (supplied by formulary), primary care (offered through FFS and managed care plans), and recently, California expanded its Medi-Cal managed primary care program to include lower-level, or "mild to moderate," mental health services, and more.

### *Education Related Mental Health Services*

Every child with a disability, including mental illness, is entitled to a free public education.<sup>14</sup> School-based services provided under the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973, are designed to assist children with disabilities to succeed in school and receive an appropriate education. Enacted by Congress in 1975,

IDEA provides states with federal monies and requires schools to provide “specially defined instruction, and related services, at no cost to parents, to meet the unique needs of a child with a disability.” Students eligible<sup>15</sup> for services under IDEA are entitled to special instruction as well as developmental, corrective, and other supportive services needed in order to benefit from their education. Similarly, Section 504 prohibits discrimination against students with disabilities. Children whose mental health needs substantially limit one or more life activity, including the ability to learn, are entitled to the specialized instruction and/or services they need to be able to participate in public education. Both laws require schools to identify students with disabilities and to provide them with the individualized services they need to access a free appropriate public education, or FAPE.

Special education programs are required to provide a broad variety of mental health services, including counseling, psychological services, rehabilitative counseling, case planning, case management, social work services, parent counseling and training, and residential care, among others.<sup>16</sup> During California’s 2011/2012 school year, more than 100,000 students received education related mental health services (ERMHS).<sup>17</sup> With the passage of AB 114 in 2011, Local Education Agencies became solely responsible for ensuring that children and youth are identified and served as required by the IDEA and Section 504.

### ***The Mental Health Services Act (MHSA)***

Proposition 63--more formally known as the Mental Health Services Act--passed in 2004, imposing a one percent income tax on millionaires to fund expansion of California’s community-based mental health services. MHSA provides the State’s second largest public funding stream for mental health services, after Medi-Cal, accounting for 25 cents out of every dollar budgeted in California’s public mental health system.<sup>18</sup> MHSA programs and services are intended to enhance, rather than replace, existing programs, providing community services and supports that would otherwise be inadequate or unavailable altogether.<sup>19</sup> MHSA programs also include prevention and early intervention services for children and adults. Other innovations include significant consumer involvement, as well as funding for stakeholder advocacy.

The Mental Health Services Act sought to build upon

the policy goals of the Children’s Mental Health Act and similar adult goals. The MHSA specifies that “services provided . . . to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and his or her family.”<sup>20</sup> The vast majority of MHSA programming is dedicated to direct services for clients, with an emphasis on Full Service Partnerships (FSPs). FSPs are special programs designed to deliver a full spectrum of coordinated services and supports to clients and their families, taking a “whatever it takes” approach to service delivery by providing any mental health and non-mental health services necessary to meet the clients’ needs.<sup>21</sup>

Management of MHSA programs is shared among the counties, DHCS, the Office of Statewide Health Planning and Development (OSHPD), and the Oversight and Accountability Commission (OAC), a quasi-independent oversight body created by the Act.

### ***Children Placed Out-of-Home***

In addition to the above core mental health services programs, many other agencies and programs serve children and youth with mental health needs. Of particular importance are the systems that treat children and youth placed out of the home.

### ***Dependents and Wards***

In 2014, more than 62,000 children were dependents in California’s foster care system.<sup>22</sup> That same year, of the 40,000 young people in the state’s juvenile justice system, over 15,000 youth were detained in county and state facilities.<sup>23</sup> It is estimated that as many as 70 percent of foster youth have a diagnosable mental illness, and juvenile justice-involved youth have similarly high incidences of mental health challenges, including substance use needs.<sup>24</sup>

A person in government custody has a constitutional right to safety, and the government has the duty to protect that person from harm. This duty applies to youth in foster care, and it includes protection from mental and emotional harm. Detained youth have similar rights, including access to treatment for mental illnesses.<sup>25</sup> Because virtually all foster youth are eligible for Medi-Cal, county MHPs are responsible for providing them with mental health care. However, when a youth is detained in juvenile hall or a Division

of Juvenile Justice facility, federal Medicaid funding is often unavailable, and, instead, the local government is responsible for medical care, including mental health treatment.<sup>26</sup>

### ***Other Programs***

The California Department of Developmental Services (DDS) provides services and supports to people with developmental disabilities. Services are provided both through contracts with regional centers, and via state-operated developmental centers and community facilities. DDS receives Mental Health Services Act funds for regional centers to develop or oversee innovative projects for their clients, with a focus on treatment for those with mental health disorders. In fiscal year 2014, DDS data shows that regional centers served 155,758 youths up to age 21 – at an estimated cost of over \$1.1 billion.<sup>27</sup>

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) oversees several programs supporting mental health, including the Community Mental Health Block Grant program and the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances project. These programs serve children with serious emotional disorders, and they provide technical assistance and grants to support evidence-based programs and collaborative systems of care for youth. Other federal programs, such as the Child Abuse Prevention and Treatment Act grant program, provide funding to states to improve child protective services systems, including addressing the mental health needs of children in the system. The federal Office of Juvenile Justice and Delinquency Prevention administers several grants, among them the Reduction and Prevention of Children’s Exposure to Violence program, which funds studies on the impact of violence on children and the expansion of community partnerships to build a comprehensive service delivery system.<sup>28</sup>

California has many additional programs, too numerous to include here, that provide services to promote or support mental health, or ameliorate mental illness. Of particular note are broad-based programs such as First Five and Head Start, which positively contribute to children’s emotional and physical well-being, but are not considered mental health programs or services.

Understanding and accessing care is challenging due

to the sheer number and scope of child-serving agencies and programs. The diversity of service domains, the variety of governing structures, and the accompanying volume of disparate rules and regulations make coordinating care a major challenge.

### **Funding the Children’s Mental Health “System”**

The many programs and services that make up California’s public mental health system of care for young people are funded using a complex mix of federal, state, local, and private sources. The complexity of the system derives from the large number of programs, agencies, and recipients involved, and from the myriad controls that are placed on the public funds that pay for, and the public and private organizations that provide, mental health-related services and supports.

### ***There is No Free Lunch***

Public funding invariably comes with strings attached that fundamentally impact the characteristics of the services provided to children and youth. These strings, or controls, may take the form of categorical eligibility requirements (e.g., age, income, diagnosis or disability), or limits on service type (e.g., psychotherapy, education supports, medication), service setting (e.g., hospital, detention center, school, home), or on who may be authorized to provide care (e.g., M.D., certified masters-level clinician, education specialist). Substantial record-keeping and reporting requirements also attach to most public disbursements.

Funding sources also have structural characteristics governing the discretion that managers have over program administration. Cooperative federalism, where the federal government cost shares expenses with the state and, in return, may set anything from broad goals to highly prescriptive procedural rules, is by far the most important program structure for mental health-related programs. The trade-off between amount of costs shared and degree of program control varies widely. At one end of the spectrum are entitlement programs, where federal funding is made contingent on providing services to every person who meets prescribed eligibility criteria and applies for benefits. Medi-Cal is the largest federal entitlement program providing mental health services to California’s youth. Most Medi-Cal services are cost-shared from 50 to 100 percent by the

federal government.

At the other end of the spectrum are discretionary grants and appropriations. Examples include SAMHSA's block<sup>29</sup> and competitive<sup>30</sup> grant programs, and child welfare prevention grants under Title IV-B of the Social Security Act. Money is appropriated each year, and services are limited by the appropriated amount. Treatment or care is first come, first served, and assistance ends when funds run out. The level of funding may vary substantially from year to year due to changing legislative priorities and budget limitations. Education related mental health services funding under IDEA lies somewhere in the middle of the cooperative federalism spectrum. Services are mandated by federal law, but funding is not directly tied to service expenditures as it is under Medicaid. As a result, the federal share of cost is not fixed or guaranteed.

### ***County-State Relationships***

Cooperative Federalism has its corollary in program administration at the state-county level. Cooperative approaches may range from pilot programs in which the State offers financial incentives to counties to voluntarily provide services, to mandatory obligations wherein the State requires counties to administer local programs in exchange for fixed payments or cost reimbursement from the State. In many cases, the state county relationship overlays the federal-state cooperative structure. County Mental Health Plans, for instance, administer EPSDT programs under contract with DHCS, which is governed by the Medicaid State Plan that must be approved by the federal Center for Medicare and Medicaid Services (CMS).

Cost-sharing among the State and counties is as varied in approach as is cost-sharing between California and the federal government, with the added complexity that funding must be allocated among 58 counties. It's also a dynamic relationship: Realignment 2011 and the state constitutional amendment limiting county obligations for un-funded mandates, Proposition 30 (2012), recently altered the landscape by placing more fiscal control and program responsibility with county governments.

One critical mental health program that does not require a local share-of-cost is the Mental Health Services Act. It comes with its own set of challenges, however. Chief among these are the requirement

that overall spending must remain above a minimum threshold amount (maintenance of effort), and the prohibition on shifting existing mental health resources to other uses (non-supplantation). These requirements are meant to ensure that MHSA dollars are used to expand the system's capacity to meet mental health needs, not replace or supplant existing funding or resources. Also, MHSA revenues come from income taxes which are driven by the state's economic performance and not by the need for services. This may have a positive impact in that funding is not dependent on the annual fluctuations of State General Fund appropriations. This smoother process, however, may be accompanied by a serious structural problem. That's because the business cycle is well-known for its ups and downs, and when hard times arrive, demand for human services go up as tax revenues fall.

In addition to funding controls and structural issues, the payment mechanisms used to compensate service providers can have a substantial impact on the availability of mental health services and supports. For example, up front funding tends to reduce provider financial risk, thereby increasing access to care. After-the-fact reimbursement of expenditures tends to have the opposite result: provider financial risk increases, and access to care is suppressed. Furthermore, reimbursement rules that penalize providers who overspend their funding allocations, or do not reward them for cutting costs, can make the difference between a viable program and no program at all. Arbitrary contract limits on how many youth may be served by individual providers or organizations also impede access to care by forcing agencies, at times, to limit service intensity or program intake irrespective of individual client needs or overall service demand.

### ***Follow the Money***

The complex web of funding for mental health services for youth in California creates multiple challenges for managers, decision-makers and the public.

The most basic form of government accountability involves knowing how public funds are spent. And yet, accounting for the roughly \$4 to \$5 billion California spends annually to provide mental health services and supports to young people is elusive. Using available public records and reports, it's not possible to pinpoint how much is spent, on whom, and for what purposes. Part of the challenge is simply accounting: There are

so many programs, agencies, and levels of government, with diverse accounting conventions and reporting requirements, that teasing out mental health-related dollars for young people from existing data is exceedingly difficult. In addition, pertinent data often simply don't exist.

Periodically, comprehensive studies have sought to present a snapshot of overall mental health spending for children,<sup>31</sup> adults,<sup>32</sup> or both.<sup>33</sup> Although these efforts are infrequent and limited in time and scope, they do provide valuable information about aspects of the children and youths' system of care.

Using these sources and annual budget data, some big picture aspects of the system of care can be brought into focus. Key findings include:

1. Government is the largest payer for mental health services, *see* Figure 1a.
2. Medi-Cal contributes the largest share; second is MHSA, *see* Figure 1b.
3. Although billions are spent, children and youths' mental health care payments are a small share of larger programs, *see* Figure 1c.
4. Allocation of funding is strongly influenced by his-

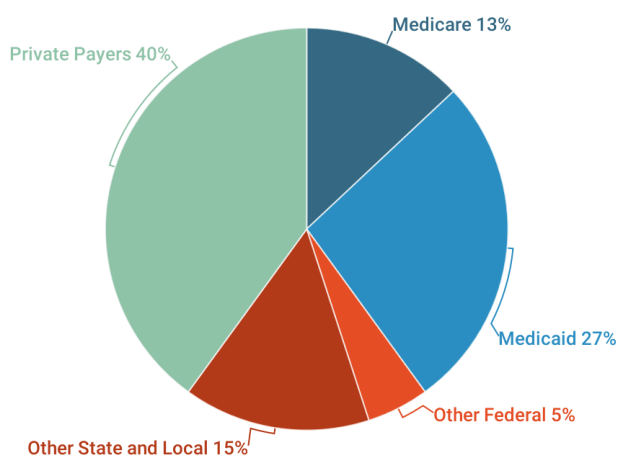
toric spending patterns, and varies widely across the state, *see* Figures 3 and 4.

A much more specific analysis of California's mental health spending on children and youth is not practicable. We cannot say, for example, how many youth are currently served by MHSA programs, or how much of the several billions of dollars that California spends on developmental disabilities pays for youth mental health services. Data showing how many children were provided SMHS in each county, and at what cost, lag by two years or more. Overall, the lack of adequate and useful information suggests that managers and decision-makers simply do not know, or cannot agree on, what information must be collected and disseminated to effectively account for and manage children and youths' mental health programs.

### Service Delivery Model

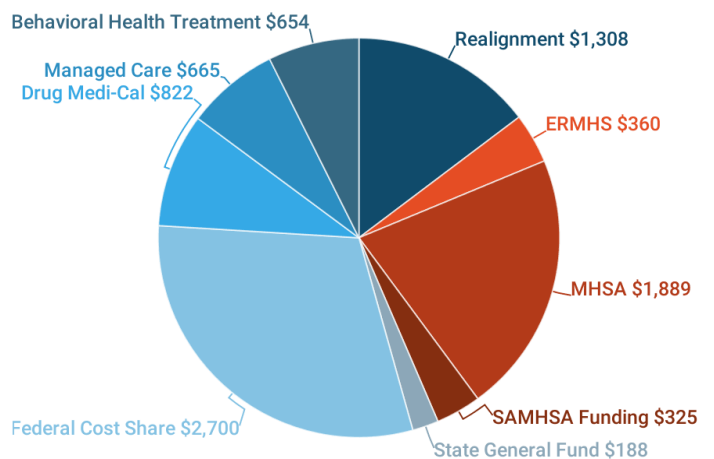
Because the lion's share of children and youths' mental health services are paid by Medicaid, the predominant service approach is the traditional medical model. Patterned after somatic healthcare methods, the medical model generally relies on trained "specialty"

## 2009 Sources of U.S. Spending on Treatment by Payer: \$147 Billion



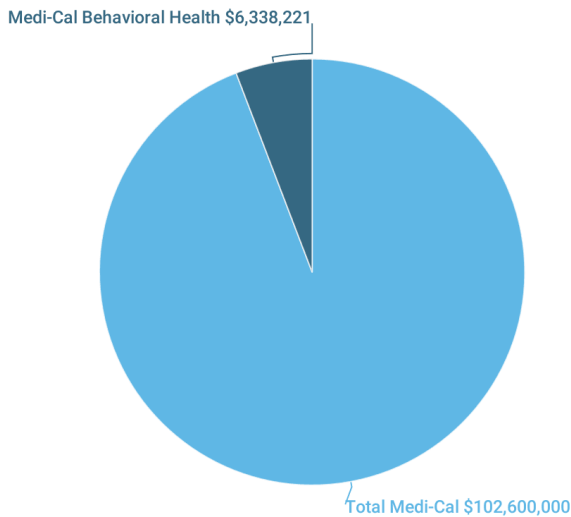
[FIG 1a] Source: SAMHSA, National Expenditures for Mental Health Services & Substance Abuse Treatment, 1986-2009.

## CA Behavioral Health Proposed Spending Major Programs FY 2017/18



[FIG 1b] Sums are in millions. Sources: Governor's proposed FY 2017/18 budget, President's proposed 2017 budget. Does not include Medi-Cal pharmacy budget.

## Behavioral Health Is Small Part of Total Medi-Cal Spending



[FIG 1c] Sources: DHCS Budget Book; President's Federal Budget. Sums are x \$1,000.

clinicians in an office setting, individually treating an illness that has been formally diagnosed based on a child's mental health challenges and pathology. What is more, eligibility for care turns on the clinician's individual professional judgment regarding what services and supports are medically necessary. The vast majority of specialty mental health services provided are assessment, in-office therapy, medication, medication management, case management, residential care, and hospitalization.

The medical model developed hand-in-hand with fee-for-service funding, thereby relying on the professional judgement of clinicians to manage both treatment and spending decisions. As managed care models have grown more predominant, however, administrative or "utilization" controls over the professional judgment of individual clinicians have become pervasive. Utilization controls include activities such as administrative pre-approvals for treatment, preset limits on units of service or use of multiple services or workers, and restrictions on time and place of services, as well as who is authorized to perform them, to name just a few.

The medical model has acknowledged drawbacks for treating children and youth with mental health needs. Most notable is the concern that the medical model is often applied in a "fail-first" approach to care. That is,

lower levels of care are tried first, and more intensive treatment is afforded only if initial efforts fail. This trial by error can happen repeatedly to a child because mental illness fluctuates in severity over time. The medical model also restricts care to the patient, for the most part, making the treatment or involvement of a sibling or family member, to say nothing of multiple agencies, much more challenging. Finally, the medical model conditions care on a deficits-based diagnosis. That is, a youth must meet diagnostic criteria for a listed illness and experience functional limitations in order to receive treatment. That makes sense for a broken arm or pneumonia; but in the case of psycho-social interventions, ignoring children's strengths, and labeling them as mentally ill, limits their potential for improvement and aggravates the stigma associated with seeking care.

### Core Values of a System of Care Philosophy

specify that services and supports should be: family driven and youth guided, community-based, culturally and linguistically competent, and evidence informed. Guiding principles to implement these values in both policy and practice specify that services provided to children, youth, and families should:

- » Be comprehensive, incorporating a broad array of services and supports;
- » Be individualized and flexible based on the strengths and needs of the child and family and guided by an individualized service plan;
- » Be provided in the least restrictive, appropriate settings;
- » Involve families as full partners in all decisions;
- » Be coordinated at both the administrative and service delivery levels across service systems;
- » Be integrated as well as linked and coordinated through care management;
- » Emphasize early identification and intervention; and
- » Be accountable, demonstrating positive outcomes.

Source: Pires, S.A. (2002) *Building Systems of Care: A Primer*.



## System Transformation

Service As Usual	CSOC
Focus on child	Focus on family
Emphasize child deficits and pathology	Emphasize child and family strengths
View parents as clients	View parents as partners
See parents as cause of problem	See parents as part of solution
Color and culture blind	Culturally competent
Offer office-based services	Offer office, in-home, and community-based services
Provide placement for child	Try to prevent placement of child
Individual clinicians working with individual clients	Service team concept
Focus on conditional treatment	Focus on long-term commitment, unconditional care, no eject/no reject policy
Focus on interventions	Outcome driven
Categorical funding	Flexible funding
Fragmented services	Collaborative integrated service development and delivery
Advocacy	Voice, ownership, access, quality, and accountability
Isolation	Community

[FIG 2] Source: K. Kendziora, et.al, Promising Practices in Children's Mental Health Systems of Care – 2001 Series, Vol. I, Wraparound Stories from the Field, 22.

Implementation of the rehabilitation option under Medicaid has loosened some restrictions associated with the medical model. First implemented in California in the mid-nineties, this alternative service approach is intended to achieve “the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.”<sup>34</sup> As a result, a great many children and youth are now served in the community by a broader range of professionals using a wider array of services than before. Essential rehabilitation services for children and youth include Therapeutic Behavioral Services (TBS), Intensive Care Coordination (ICC), and Intensive Home and Community-Based Services (IHCBS), among others.

In contrast to the medical model, a Children’s System of Care (CSOC) approach is grounded in “a broad array of effective services and supports for children and adolescents with behavioral health disorders and their families that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery, management, and policy

levels.”<sup>35</sup>

CSOC emphasizes teaming with a child and family’s community to bring both formal and informal services and supports to bear. Specialty Mental Health Services (SMHS) may well form the core of the CSOC treatment plan, but those services are provided in the home to the greatest extent possible and are supplemented with assistance from other youth-serving agencies, including informal sources such as the family’s church, a boy’s and girl’s club, or the extended family.

The Mental Health Services Act (MHSA) sought to build upon the CSOC approach rather than replicate the traditional medical model. The MHSA specifies that “services provided . . . to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and his or her family.”<sup>36</sup>

Similarly, litigation in *Katie A. v. Bonta*<sup>37</sup> established a Medi-Cal funded wraparound-based practice model for all foster youth with serious mental health needs.

Recently expanded to include all Medi-Cal youth with serious mental health needs, the *Katie A.* practice model emphasizes child and family teaming, home and community-based care, and a strengths and needs approach, with individualized engagement and interventions in the wraparound mode. The system transformation envisioned for moving from the traditional medical model to CSOC and wraparound is depicted in Figure 2.



In addition, access to services is highly uneven across the state. Add intensity of mental health services, as measured by spending per child, and the inequities increase. Children in Fresno County, for example, are about two-fifths as likely to get *any* services, and the services they do get amount to less than half the value of services, as compared to youth in Alameda County. Not only is underserving large parts of the state harmful to thousands of youth, it contravenes the Medicaid requirement that services must be equally available statewide.

Not all the news is bad. For instance, coverage under the Affordable Care Act and full-scope Medi-Cal for children regardless of immigration status (SB 75) have expanded Medi-Cal eligibility and increased enrollments. In addition, juvenile justice-involved youth have greater access to Medi-Cal because of efforts to suspend rather than terminate eligibility while in custody, and because access to intensive home and community-based services provided pursuant to the *Katie A. v. Bonta* settlement agreement has been extended

to all Medi-Cal youth, not just child welfare-involved youth. Foster and former foster youth have greater access to care as well, due to extended foster care and extended Medi-Cal to age 26.

Providing access to mental health services and supports is the first order of business for a system of care, and notwithstanding some positive developments, California is falling short on this essential metric. Improvements are needed in access to basic and intensive services across child-serving domains, and geographic disparities must be resolved. Especially concerning are the recent reductions in services even as funding has significantly increased.

### Multi-System Involved Youth Need More Coordinated Care

As previously noted, children and youth with serious mental health needs are almost invariably involved in multiple child-serving systems, most commonly: special education, juvenile justice, child welfare, and specialty mental health.

The challenges of coordinating care for these multi-system children can be best understood with an example borrowed from Wraparound experts Eric Bruns, Jim Rast, and John VanDenBerg. The Evans family has 26 agency helpers, 13 plans, 35 treatment goals or objectives, and 42 monthly appointments. *See Figure 5.* The impacts of this approach can be seen in the comments from their agency files: *“Parents don’t respond to school’s calls; Attendance at family therapy not consistent; Mother is non-compliant with her psychiatrist; Numerous missed therapy sessions; Parents are resistant to treatment; Home is chaotic; Twins are at risk due to parental attitude, and; Family is dysfunctional.”* This is a common scenario when dealing with multi-system involved youth and families, and the results are predictably poor.

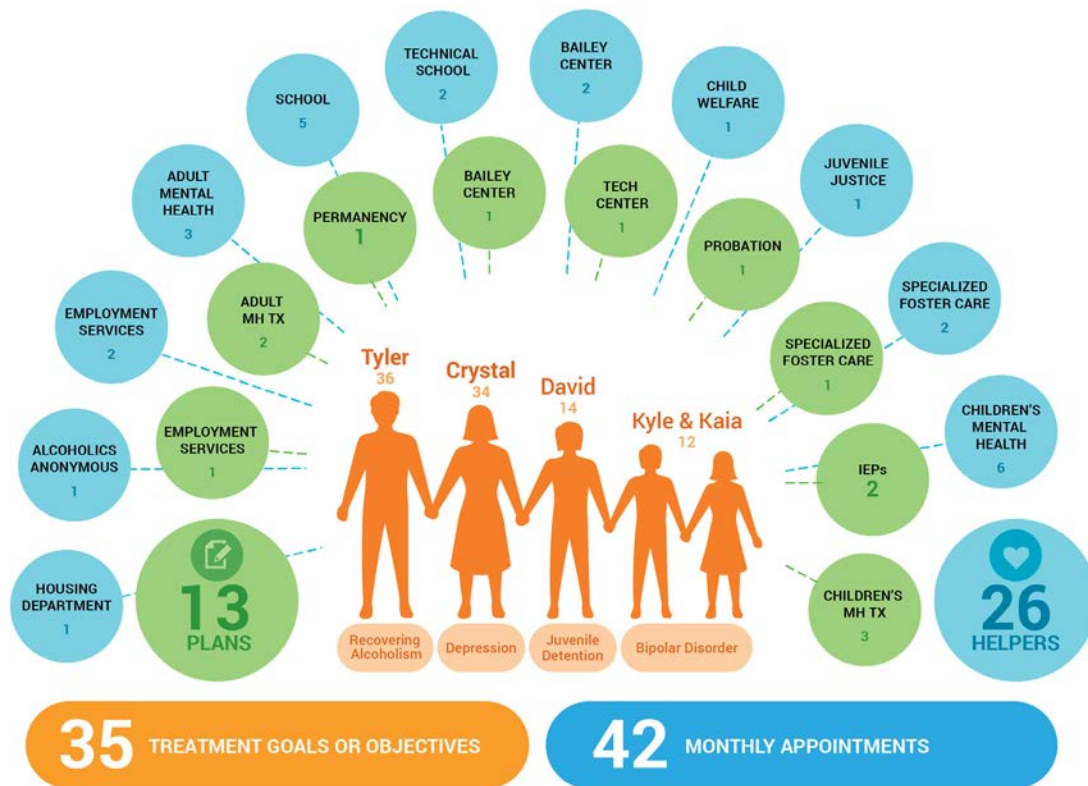
This uncoordinated multi-system approach was recognized as difficult to navigate and frustrating for users as far back as 1992, when California’s Children’s Mental Health Act was signed into law. Is it getting any better? The signs are not positive at the system level. Consider the case of the most consequential legislative enactment in the last decade addressing system coordination of children’s mental health services: the elimination of AB 3632.

Comparative SMHS Average Payments per Youth FY 2014/15



[FIG 4] Source: Performance Outcome Data for EPSDT Services FY 14/15.

## The Burden of Uncoordinated Care on Youth and Families



[FIG 5]

### *AB 3632 is Expelled*

Enacted in 1984, AB 3632 transferred responsibility for providing mental health services to students from schools to the county mental health departments. AB 3632 was passed following a damaging federal court decision finding a California school district incapable of fulfilling the IDEA mandate.<sup>44</sup> In restructuring California's service delivery system, AB 3632 was intended to better address the needs of students with emotional and behavioral disabilities by having county mental health agencies that were already providing mental health services to children and youth assume responsibility for serving special education students.<sup>45</sup>

From nearly the beginning, however, the AB 3632 program was fraught with political controversy over funding. Annual costs quickly outgrew categorical appropriations and counties were increasingly obliged to seek reimbursement through an administrative state mandate claims process.

Governor Schwarzenegger first proposed suspending

the AB 3632 mandate in 2005, but the Legislature demurred. By 2010, California owed counties \$133 million in unreimbursed costs.<sup>46</sup> Facing a \$19 billion budget deficit, the Governor proposed "deep reductions and program eliminations,"<sup>47</sup> including suspending the AB 3632 mandate and eliminating all state funding for mental health services delivered under this program. Although the Legislature rejected the Governor's proposal, within hours of receiving the 2010/2011 Budget Act, Governor Arnold Schwarzenegger used his line-item veto authority to eliminate state funding for AB 3632 services.<sup>48</sup>

Despite the initial criticisms of the Governor's decision to suspend the AB 3632 mandate, the Legislature moved quickly to make this change permanent. Just over seven months after Governor Schwarzenegger's veto of AB 3632 funding, state legislators passed AB 114, eliminating AB 3632. The bill relieved county mental health departments of responsibility for providing mental health services to special education students, shifting this obligation back to Local Education Agencies. The State also changed the funding structure

for Education Related Mental Health Services (ERMHS) by creating dedicated state and federal categorical funds for use by school districts to provide ERMHS.

What has been the long-term effect on children from replacing AB 3632 with AB 114? Because the Department of Education and other agencies do not monitor key aspects of special education performance for youth with mental health needs, it is difficult to be sure. There is growing evidence, however, that mental health services are harder to come by, are less intensive, and less valued by parents and youth. Also, the state Auditor found that IDEA-funded access to non-public schools for children with the most serious mental health needs has dropped precipitously.<sup>49</sup>

Another illustrative example of the difficulties with system collaboration involves *Katie A. v. Bonta*, a federal class action lawsuit filed in Los Angeles in 2002. Advocates filed the case seeking to better coordinate child welfare and mental health programs and to provide Medi-Cal-funded intensive home and community-based mental health services to foster youth. After litigating for almost a decade, in 2011, California agreed to add three new intensive mental health services to the Medi-Cal menu—Intensive Care Coordination, Intensive Home and Community-based Services, and Therapeutic Foster Care. In order to meet this commitment, the state promised to coordinate information, management, and clinical practice among CDSS, DHCS, county child welfare programs, and MHPs.

Six years later, the two State Departments have yet to match electronic information in their existing databases to accurately identify children who need services. Work on a common practice approach for delivering services has also not been completed, and there is no effective joint-governance structure with which stakeholders can engage to improve collaboration. The ultimate result, in part, is that only about a quarter of the more than 20,000 likely eligible child welfare-involved youth are receiving the intensive community-based mental health services they need.<sup>50</sup>

Children and youth involved with multiple systems need coordinated care. Recent trends in California have created new barriers to overcome, and promising opportunities have not been capitalized on. Developing a true system of care will require greater commit-

ment by decision-makers and managers to team up, as well as system changes that promote, rather than impede, collaboration.

## Overall Quality of Care Is An Unknown

Notwithstanding a growing patchwork of data collection efforts, mental health program managers cannot accurately or regularly report even the most rudimentary systemic information about our billion dollar programs: We do not know, with confidence, what we buy, we generally do not know who gets services and who does not, and we can only rarely say what impact the services provided have had on the children and families who received them.

Consider the State Auditor’s 2013 report on MHSA accountability: “The state entities initially responsible for overseeing the Mental Health Services Act (MHSA) have historically provided ineffective oversight of the counties’ implementation of MHSA programs.” Although required to report extensive data, “in nearly all cases, [administrators] either failed to consistently obtain certain data or did not ensure that all counties reported required data.”<sup>51</sup> Indeed, there was no monitoring of “whether counties submitted the required data or verified the data’s accuracy.”<sup>52</sup> The result, concluded the Auditor, is that “the data are incomplete and of limited value in measuring MHSA program effectiveness.”<sup>53</sup> The Little Hoover Commission revisited this issue in 2015 and 2016, concurring: “After 10 years, the state cannot provide answers to basic questions.”<sup>54</sup>

An audit of the Department of Education’s data collection practices for mental health related services found similarly poor performance: “Federal law requires that student IEPs include the frequency with which a student will receive the services. For example, the IEP must indicate whether the student will receive individual counseling services daily, weekly, monthly, or annually. However, Education does not require [Local Education Agencies] to report this information, either in aggregate or by student.”<sup>55</sup> Mental health related expenses are not tracked or reported, either. “[Nor does Education] perform any analysis of the outcomes of students who receive mental health services.”<sup>56</sup>

In the case of Medi-Cal, most of the available data come from a cumbersome legacy billing system that

was not designed or intended to evaluate service performance, outcomes, or quality. The result is that even basic data are hard to get, and more refined queries are typically not possible. Recent efforts to make better use of existing data have provided useful information. DHCS' Performance and Outcomes System (POS), in particular, is now producing quarterly reports that provide new insight into who gets Medi-Cal services.

There are other sources of information that provide partial views of system quality and performance. For instance, we know from hospital data that psychiatric hospitalizations for young people have been rising fast for several years.<sup>57</sup> See pullout, below. Viewed as an access issue, this might be positive news. But the rapid increase is more likely explained by inadequate lower levels of care that could have prevented hospitalization. This is the critical problem with partial information: We cannot draw clear lessons about cause and effect.

Another partial picture comes from medication data. Here, we see several concerning trends. First, the use of medications on children, especially among foster youth, is very high. Especially troubling is the surprisingly common prescribing of anti-psychotics. These drugs cause strong side-effects and are being used for many more purposes than treating psychosis. Second, many children receiving psych meds get no other mental health services. Research shows that a combination of medication and therapy is typically more effective than medication alone. These data are red flags and warrant further investigation. They also reinforce the concern that our quality information is sketchy and inadequate.

An additional mental health data source called CSI (Client and Service Information System), combines client and service information from most counties on Medi-Cal, MHSA, and other clients. DHCS has used these data to evaluate program performance for the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid. In its quality analysis of an average of 257,000 children served each year from 2007 to 2010, DHCS reported that the vast majority of children (82.5 to 85 percent) made no progress in treatment. Just 2.2 to 2.4 percent experienced improved functioning.<sup>58</sup> See Figure 6. The study also reported how little Evidence-Based Practices (EBPs) have penetrated youth services in

California. Youth who did receive EBPs, although not very many, showed demonstrably better improvement than children who did not receive EBPs—except that children with less severe conditions, got markedly *worse*.<sup>59</sup> This result demonstrates how important it is to match proper treatment to a child's individual needs. However, appropriateness of care can only be hinted at using information from our state data systems.

Also noteworthy is a FY 2012/13 analysis of system performance in a well-funded urban California county. The study used reliable improvement from Child and Adolescent Needs and Strengths (CANS) reports to quantify performance by each of the county's children's behavioral health programs with more than 10 enrolled youth. The results reveal varied program accomplishments, from those with "no improvement" to those where more than 50 percent of the children showed reliable gains. This is consistent with what we often see in the system: variable results from poor

**According to An Analysis of State Data by The Sacramento Bee and The Center for Health Reporting:**

- » Mental health hospitalizations of California's youngest residents – those 21 and under – increased 38 percent between 2007 and 2012, jumping from 34,000 to 47,000.
- » The number of people 21 and under showing up in emergency rooms for mental health crises increased by 50 percent between 2007 and 2012. Some of those youth went on to be hospitalized.
- » The number of emergency-room visits involving suicide attempts among children and teenagers increased more than 20 percent statewide during that time; in Sacramento County, suicide attempts among young people increased more than 60 percent through 2012.
- » The number of children and youth landing in a psychiatric hospital multiple times in a given year increased 27 percent since 2007. About 5,200 young people – or 1 of every 4 hospitalized – were admitted at least twice in 2012.

to effective. What was disturbing about this analysis, however, was that when outcomes were aggregated over the entire county “system,” fewer children improved than what might be expected from the natural rate of improvement. Research shows that about a third of children will improve with no formal interventions; however, *less* than one-third of youth served by these programs got better. In other words, according to this study, the county system overall performed worse than doing nothing at all.

California’s efforts to evaluate mental health program performance and outcomes have been uneven and inadequate. Does California’s children’s mental health system provide quality care? Is it possible that quality and results could be as bad as some studies suggest? We really do not have adequate information to answer these questions. One thing seems clear: Not knowing should no longer be considered acceptable.

### Realignment of Resources Is a Barrier to Greater Accountability

As related above, Governor Schwarzenegger used his veto authority to drive mental health policy, and the results disadvantaged youth and families. One could

argue this was inevitable because his administration was facing the worst recession since WWII. Has a rebounding economy and a new administration and new party led by Governor Jerry Brown changed the trend and returned the Capitol to a more substantive policy-making process? A close look at Realignment 2011 suggests just the opposite.

### Realignment, Take 2

In his 2011 inaugural address, Governor Brown presented the idea of Realignment as something that he would be exploring as a way to balance California’s budget, which was facing a \$20 billion shortfall.<sup>60</sup> In essence, Realignment was intended to remove a number of public safety and human services programs from the general budget process and instead, fund them using a dedicated portion of sales tax revenues and vehicle licensing fees.

Policy-makers hoped that this shift would result in an increase in local administrative flexibility and stabilization of local funding. A key component of the strategy was Proposition 30, enacted by the voters in November 2012. Proposition 30 requires the State to convey the Realignment funds to the counties, and allows counties to avoid new programs or services

## DHCS Needs Assessment: Most Youth Did Not Improve with Treatment as Usual, 2008-2010



- Saw Improvement (2.3%)
- Stayed the Same (84.2%)
- Exited Care (11.8%)
- Decreased Functioning (1.8%)

[FIG 6] Source: Technical Assistance Collaborative, “California Mental Health and Substance Use System Needs Assessment,” (February 2012), Analysis included more than 100,000 youth in the Client and Services Information (CSI) data set. Chart does not include 2007 data.



mandates that do not also include new funding.

When the dust settled, where the State's General Fund once contributed a substantial share of state funding for children's mental health services, California now "pays for public mental health services primarily through dedicated revenue sources not directly subject to the annual state appropriations process."<sup>61</sup> But, redirecting funds from state sales tax receipts and vehicle licensing fees to pay for existing mental health and other human services programs did not change the fundamental income and expense equation for state government. Instead, what Realignment did was limit available state revenue for programs that were realigned to a fixed percentage of the taxes and fees collected. That means when the economy heats up, tax revenues climb. Conversely, when the economy slows down, receipts decline. This cyclical nature of tax revenues does not align well with federal entitlement programs, including Medi-Cal's EPSDT program, whose costs typically increase year over year as population numbers grow and inflation erodes purchasing power. Significant problems for Realigned mental health programs may be expected when the current business cycle turns down.

How has Realignment 2011 impacted children's mental health so far? Initially, counties responded by slowing EPSDT spending. In addition, allocation of funding among the counties was linked to historical spending with the result that, in many cases, low-spending counties—those with lower penetration and service intensity rates—received proportionately less funding than higher performing counties. This aggravated the distributional inequity of the system, especially for children living in the Central Valley.

Perhaps more importantly, Realignment removed the state legislature from a decision-making role over Medi-Cal spending—the cornerstone of the children's mental health system. In addition, because the State's authority to allocate funds to counties is limited, by statute, to Realignment growth funds, with each passing year, the Administration will control relatively fewer and fewer program dollars. This means that state administrators with the legal obligation to comply with federal Medicaid rules—for example, the state-wide-ness requirement that ensures that comparable services are offered statewide—will have far less leverage to bring poor performing counties into compliance with

state and federal law.

Realignment devolved resources and control over key mental health programs from the state to the counties. It remains to be seen whether state leaders retain the interest and capability to provide oversight over the billions in shifted funding, or accountability for providing adequate supports and services to the hundreds of thousands of young people and their families who are entitled by state and federal law to appropriate mental health care. That puts a substantial burden on community stakeholders to monitor and engage county and state decision-makers to ensure that programs and managers are held accountable to families and youth.

## V. Recommendations for a Better Future

The great strength of the children and youths' stakeholder community is its members' knowledge, training, experience, dedication, and compassion. But these strengths alone have not been sufficient to ensure that our system of care collaboratively treats all children and youth in need, or systematically achieves improved outcomes for the young people and families served. To do this, the community of stakeholders needs to come together to set goals, establish priorities, and put into motion concerted action that will promote, and ultimately ensure, access, collaboration, quality, and accountability for California's Children and Youths' System of Care.

The following recommendations (and examples of opportunities for action) are intended to provide a framework for exploring and choosing specific activities that can be combined into a proactive stakeholder agenda for achieving better outcomes for thousands of California's children and youth with unmet mental health needs.

### *A. Provide Children and Youth Full and Equal Access to Mental Health Care*

Mental health needs are the number one healthcare challenge facing young people, and a leading cause of poor outcomes in every child-serving "system," including the family. Promoting mental health and wellness for all children and youth is as essential as clothing, feeding, protecting, teaching, and loving them.

**1. Fulfill Our Promises:** California's existing laws and policy commitments promise most children adequate mental health care and support. Notwithstanding, the State and counties put many roadblocks in the way of keeping these promises. Keeping our promises by clearing these roadblocks would improve access to care for tens of thousands of youth and families. Barriers that have been intentionally constructed to control demand should be the easiest to eliminate. These include inconsistent utilization controls among counties,

irrational reimbursement rates, onerous record-keeping or accounting practices, and contract caps that arbitrarily limit access to care. We also need to change attitudes such that decision-makers and managers view the delay and denial of promises and commitments as failure (due to increased harm and long-term costs), rather than success (due to avoided short-term costs).

**2. Identify Needs:** The first imperative for any children's mental health system is to identify and assess children with unmet mental and behavioral health needs. Proactively identifying children in need of mental health services is already required under Medi-Cal, is a policy goal for all child welfare and many juvenile justice systems in California, and is required by the Child Find and assessment requirements of IDEA and Section 504. Greater effort to identify youth with mental health needs early would reduce harm and save money.

It is equally important to educate leaders, decision-makers, managers, professionals, parents and youth about how critical meeting mental health needs is to positive youth development, and how improved mental health care for young people can help achieve the core goals and objectives for child welfare, juvenile justice, education, health, disability, and other child-serving systems. In this way, we may be able to encourage government partners to become cheerleaders for better mental health care rather than competitors for personnel, funding, and control.

**3. Allocate Funds Equitably to Ensure Equal Access to Care:** California needs to allocate public mental health funding to cities, counties, and regions so as to ensure that all children and youth have equal access to care--regardless of disability, religion, race, ethnicity, gender or sexual preference; where they live; or who their parent, guardian, or primary caretaker is.

**4. Close Gaps in Coverage:** Most children in California already have an entitlement to care. All foster youth do. Every child with full-scope Medi-Cal does. So do children in state custody, many children

with private insurance, young people enrolled in Obamacare, most children with an IEP, and youth with disabilities. Recent research has concluded that more than 96 percent of California’s children have or are eligible for health insurance.<sup>62</sup> It’s time to close the insurance coverage gap altogether and guarantee all children and youth in Californian full access to quality mental health care.

Making a commitment to full access to mental health care would reap large benefits. First, it would lower the cost of care by simplifying the exceedingly burdensome administrative challenges that attend the existing fragmented, “only the deserving shall be served,” approach. Second, making mental health care more universally available would reduce the stigma associated with mental illness and its treatment. Third, a full access policy would better reflect the central importance of positive mental health to the development of self-sufficient adults.

### **Opportunities for Action:**

- » Analyze and report on the costs and benefits of full and equal access.
- » Evaluate and promote promising models for strategies and methods to implement full and equal access.
- » Convene a Working Group to evaluate barriers to care, and their impacts, due to county variability in service availability, reimbursement mechanisms, contracting procedures, documentation and licensing requirements, and utilization controls.
- » Develop a plan to fully implement EPSDT services including *Katie A.* services, Therapeutic Behavioral Services (TBS), SUD treatment, Behavioral Health Treatment, crisis services, and Short Term Residential Treatment Programs (STRTP) within three years.
- » Establish and fund consistent statewide standards and tools for adequate and effective screening covering the entire child developmental arc from birth to age 21 or, in some cases, age 26.
- » Reform methods for allocating state funds among counties to ensure that publicly-funded services are provided equitably.

### **B. Coordinate Services and Resources**

Young people with serious mental health needs are clients of many systems. Coordinating systems that

serve children is necessary to ensure access, quality, efficiency, and results. Improving cross-system relationships among professionals and employing child and family teaming is helpful, but without more, cannot overcome complex systemic barriers to effective collaboration. To surmount these challenges, we need system solutions that align agencies’ values, missions, practices, and funding.

**1. One Child, One Plan:** Most child-serving agencies and programs center their interventions and support around a plan. Whether it is called a treatment plan, an IEP, a permanency plan, a safety plan, or something else, the basic idea is that the plan is developed as a goal, a guide, and an assurance that beneficiaries’ needs will be met in an organized and thoughtful way. Unsurprisingly, youth who are served by multiple agencies have multiple plans. What may be surprising is that these various plans are not often shared among helper agencies or programs. These plans set numerous independent goals that are cumulative and often conflicting. Three plans can easily contain 20 or even 30 goals, making compliance by the youth and family a practical impossibility.

One Child, One Plan would calm the cacophony of confusing and alienating interventions and goals confronting youth and their families. It would also facilitate “no-wrong door” policies or approaches. Developing a joint plan would require agencies to team up to align their efforts to serve the best interest of a youth and family. Program managers and decision-makers would be obliged to reconcile competing or conflicting program purposes and goals. This would improve accountability and efficiency. To be successful, however, funding and resources will need to follow the child to a much greater extent than they do now.

**2. Funds and Resources Must Follow the Child:** The most straightforward approach to implementing One Child, One Plan is to have “the money follow the child” as directed by the One Plan. Team planning and coordination are much harder if the One Plan that evolves is not backed by the combined funds and resources of the entire team that produced it. Team decision-making will also require managers’ attention and problem-solving skills to navigate among competing program rules and regulations. If money is directed by the team, the door will be opened to reconfiguring funding to address actual identified needs, rather than

by the cost-plus budgeting or historic spending of each agency.

**3. Use a Shared Wraparound Practice Model for All Multi-System Involved Youth:** The wraparound service practice model is consistent with the system of care approach, and is designed to address the needs of more challenging, multi-system involved youth. As part of the wraparound model, each multi-agency youth would have a formal Child and Family Team (CFT) that has authority over resources. Many counties already use a wraparound model or wraparound services in a variety of programs and domains. The State needs to bring together these program threads so that special education, child welfare, juvenile justice, specialty mental health, and substance abuse treatment providers, among others, are working with a common practice model that has consistent performance and quality standards and the formal authority needed to combine, or “braid,” funding sources.

**4. Develop a Collaborative, Culturally Competent Workforce That Practices Cross-System Teaming:** Development of the skills needed to effectively serve multi-system youth will require changes in workforce training and supervision, which will necessitate engagement by higher education and healthcare leaders. Embedded in this challenge is the need to identify and reconcile practice models and attitudes that differ across domains. Bureaucracy isn’t the only impediment to collaboration: Different approaches and views about how to address challenging child behaviors also impede effective teaming. Finally, redoubling our efforts to develop and provide culturally appropriate care, for individuals and groups, is needed.

### **Opportunities for Action:**

- » Identify eligibility and provider constraints that impede access to services for multi-system youth. Develop a plan to integrate services whereby government agencies are responsible for reconciling differences and resolving conflicts, rather than providers, clinicians, or parents and youth.
- » Create a Children’s Programs Coordination Administrator in the Health and Human Services Agency whose office has authority over team decision-making procedures and reconciling resource allocations among state-funded child-serving agencies.
- » Continue to reduce privacy and confidentiality bar-

riers to sharing information among child-serving agencies and programs.

- » Use Continuum of Care Reform (CCR) as a beachhead for One Child, One Plan for children who are clients of mental health and either (or both) child welfare or juvenile justice, building on the *Katie A.* service model.
- » The IEP is an excellent foundation on which to build a One Child, One Plan model. Stakeholders should explore which counties or jurisdictions may be willing to pilot this approach.
- » Fully implement the *Katie A.* agreement, including providing services to expanded populations. When fully implemented, 40,000 children should receive Medi-Cal funded home and community-based services using a wraparound model.

## **C. Provide Effective, Quality Care**

If there is a silver bullet “solution” to the challenges of California’s children’s mental health system, it is quality improvement. The demand for EBPs, performance contracting, managed and accountable care organizations, among other innovations, reflect the concern that our mental health systems are not delivering the treatment that we are capable of, and that better quality care would significantly improve the lives of children and families living with mental illness.

**1. Close the Science-Practice Gap for Children’s Mental Health Treatment:** Researchers have been drawing attention to the substantial quality gap between what science says we can accomplish and the results we now achieve in the children’s mental health service system. Key challenges include: poor fit between services and clients; inadequate client engagement and transitions to the community; and using interventions without demonstrated effectiveness. Closing the gap could double reliable improvement system-wide. Using fidelity wraparound and other evidence-supported interventions would advance us well down this path. Reducing reliance on unproven treatment modalities would also improve mental health outcomes.

**2. Measure, Assess, Report, Improve. Repeat!:** While thousands of people struggle every day to do good by youth and families, our inability to manage the system discourages their efforts and undermines their success. Without adequate, useful, and timely

information, accountability is impaired, and chances for developing better quality programs or improving outcomes are slim.

Fixing these problems does not require a top-to-bottom overhaul of our systems. Rather we need to: (i) Consistently and reliably measure and report, in real time, what we are doing so we understand what is happening at the clinical, program, and system level; and (ii) Provide an information feedback loop at every level of the service system, so that we can inform and improve practice. This will require an attitude shift by state and county agencies that see themselves as users, not as providers, of information. It will also require thoughtful consideration of the information needs of clinicians and clients—not just program managers. By assuring that data we gather are useful and timely reported to treating professionals, as well as youth and families, we can maximize the potential for quality improvement.

**3. The State Needs to Fund the Core Functionality of California’s Performance and Quality Improvement System:** By funding the basic infrastructure for a statewide quality and performance system, the State would improve its leverage in pursuing system integration and increase standardization, accuracy, transparency, and the utility of information. These benefits would also lead to greater efficiency and lower system costs.

**4. Quality Improvement Must Become Embedded in Routine Practice and Decision-Making:** Performance and quality information cannot remain the province of arcane IT departments or be communicated in ways that can be understood only by a narrow cadre of experts. Information has to become the daily companion of clinicians, supervisors, program managers, decision-makers—and, just as importantly—families and youth.

#### **Opportunities for Action:**

- » Require publicly-funded child and youth-serving agencies to develop and demonstrate an ability to measure, assess, and report on what their children’s interventions are and do, who is served, the costs of these activities, and what results are obtained.
- » Borrowing from the Performance Outcome System

(POS) model, develop and coordinate quality and performance metrics *across* child-serving agencies and programs.

- » Fund quality assessment and improvement infrastructure for child-serving agencies with State General Funds or MHSA dollars. Regularly publicize easy-to-understand and timely data on spending, access, quality, and outcomes.
- » Develop pay-for-performance-and-quality contracting by child-serving agencies and providers that, among other things, accelerate EBP use with fidelity. Increase service reimbursement rates to incentivize greater use and development of EBPs, especially for minority or special populations.
- » Explore workforce incentives to grow the results-based clinical community, including, for example: specialization in home and community-based services; greater use of paid peers in the service delivery model; and higher reimbursement rates for bilingual or other cultural competencies and clinicians who practice in rural areas.

#### **D. Develop Leadership, Support Engagement, and Increase Accountability**

California’s children and youths’ mental health system is too complicated to run on autopilot. This collaborative system needs leadership—from the State, cities and counties, health care agencies, school systems, program beneficiaries and their allies, and other stakeholders. Together, these organizations and their leaders need to find common ground on which they can work together to set clear and accountable goals, and then together move an agenda that improves access, quality, collaboration, and accountability for the children and youths’ System of Care.

**1. Community Members Need to Build a Sustainable Stakeholder Coalition:** A high-quality children’s mental health system is an ongoing challenge that requires continuous and effective community involvement. Leaders from the many stakeholder communities, including provider agencies, youth representatives, parents, adult client groups, children’s and mental health advocates, professional organizations, researchers, educators, and leadership groups, must build and sustain a collaborative network to actively promote information sharing and goal-setting that can replace *ad hoc* and unilateral responses to issues

and challenges. The coalition must also help to identify and provide the resources needed to improve the knowledge and information base, budget and policy analysis, and education and strategic communications capabilities that are essential for effective advocacy. The coalition also needs leadership that can balance listening to many voices and speaking with one.

**2. Broaden the Focus and Reach of Children and Youths' Mental Health Policy:** Children and youth with unmet mental health needs, and the families they live in, may struggle in every social domain. Indeed, few social or community programs can succeed when the children and youth they work with have serious unmet mental health needs. Educating others about the costs and benefits of both mental illness and mental health offers the opportunity to broaden the base of the children and youth stakeholder coalition, and reduce competition among child-serving (and possibly adult) domains, agencies, and resources. Such alliances may be critical to making headway on a children and youths' mental health agenda.

**3. Government Leadership at the State and County Level is Needed to Support a Collaborative System of Care:** Managing the State's children's mental health system requires so much more than managing MHP contracts or approving MHSA county plans. The real challenge is building and maintaining a System of Care that integrates services across child-serving domains to efficiently deliver effective care that meets the needs and improves the lives of children and families. To do this, leaders need to articulate and embrace an operational vision for the whole system. They also need to create a transparent mechanism to co-manage information, funding, policies, and programs that involves decision-makers at the highest level of government in order to turn this vision into practice across multiple agencies. In addition, county and state leaders need to agree on their roles in a model of shared responsibility that ensures both appropriate, transparent state oversight, as well as consistent and effective county implementation of program responsibilities.

**4. Leaders and Managers Must Set Clear, Accountable, Data-Driven Short and Long Term Goals:** Concerted action cannot be successful without planning, and planning is pointless without timely and accurate information, clear goals, and actionable dead-

lines. Lacking these elements, "working an issue" is typically substituted for "delivering a desired result." Results are not the only casualty--so is stakeholder involvement. As work plans are extended, deadlines postponed, and results delayed, families and youth drop out, advocates move on to other issues, and providers withdraw to avoid further lost productivity. Providing relevant and timely information, establishing a clear agenda, and setting and meeting an aggressive timetable for achieving it are essential management capabilities for building and sustaining California's children and youths' System of Care.

### **Opportunities for Action:**

- » Build a stakeholder coalition to bring the children and youths' mental health community's interests and energy to bear on policy-making, program design and implementation, and funding. Develop champions in administrative and legislative positions, and among parents and youth. Integrate the hopes, experiences, and goals of those who are served in policy and decision-making.
- » Develop information to educate potential allies about the costs and benefits of children's mental health and illness in their own domains. Build alliances that help others to achieve their goals through improved mental health.
- » Develop a stakeholder process that joins with county and state leaders to crystalize concrete and accountable purposes and goals for the children and youths' mental health system. The annual California Mental Health Advocates for Children and Youth (CMHACY) meeting could be a forum for this work.
- » Draft a plan to publicly fund and institutionalize stakeholder engagement in the children and youths' mental health system, building on the OAC's advocacy contracts for TAY and Parents and Children.
- » End the tug-of-war between counties and the State over program goals, rules, spending, and service delivery by clarifying the roles of each. Establish service and program standards in order to limit local variations that impede access to care.

## VI. Conclusion

The Great Recession and recent policy changes have battered California's children's mental health system. The result has been declining access to treatment, inadequate overall quality of care, uncoordinated care among child-serving agencies, and minimal accountability for the intended outcomes of better health and stronger families. Turning this around will require setting clear goals; better-informed and more responsive leadership; more effective engagement by stakeholders; and the roll-out of essential infrastructure to measure and report performance and outcomes. Accomplishing these goals will be necessary to improve quality of care and to hold the State, counties, and healthcare providers accountable to the children and families they serve, and the public.

One surprising result of this study is that, notwithstanding the overriding fixation with funding, more money may not play the leading part in resolving the policy and program challenges we face. That is not to say money does not matter, or that there are not real hardships due to insufficient resources. The real challenges for developing and sustaining an effective system, however, lie in other arenas: measuring and ensuring quality, providing individually appropriate treatment, coordinating resources and services, and re-investing in and sustaining a *System of Care* that puts children, youth, and families first.

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