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ASSEMBLYMEMBER REYES
CHAIR

Informational Hearing

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State Capitol Room 437

Caring for youth across county lines: How has "presumptive transfer" impacted the provision of mental health services to foster youth?

BACKGROUND PAPER

Child Welfare Services

California's Child Welfare Services (CWS) system exists to protect children from abuse and neglect, and in doing so, to provide for their health, safety, and overall well-being. When suspicions of abuse or neglect arise, often as a result of a report by a mandated reporter like a doctor or teacher, Child Protective Services is tasked with investigating the report. If the allegation of abuse or neglect is substantiated, it is then determined whether it is in the best interest of the child to remain in their parent's custody or be placed within the CWS system. If a child is suspected to be at risk of neglect, abuse, or abandonment, the juvenile court holds legal jurisdiction, and the CWS system appoints a social worker to ensure that the needs of a youth are met. As of October 2018, there were 59,487 youth between the ages of 0 and 21 placed in California's CWS system.[i]

The goal of the CWS system is to provide the best placement for youth, while trying to preserve families whenever possible. Family maintenance services are offered to families when it is determined that a child should remain in the home, but that the family would benefit from the supervision of a social worker. The CWS system also provides reunification services, such as family therapy, parenting classes, or substance use treatment, to families in instances where it is determined to be in the best interest of the child to be reunited with their parents. When a youth is removed from the home, it has been the practice of the CWS system to preserve familial ties. This goal is furthered by requirements placed on social workers to locate relatives and non-relative extended family members (NREFMs) who may serve as caregivers for children removed from their parents' custody.

Over the past four years, California has enacted legislation to improve placement and treatment options for youth in foster care. AB 403 (Stone), Chapter 773, Statutes of 2015, sponsored by the California Department of Social Services (CDSS), sought to improve outcomes for children and youth served by the CWS system by working to ensure that foster youth have their day-to-day physical, mental, and emotional needs met, that they have the opportunity to grow up in permanent and supportive homes, and have the opportunities necessary to become self-sufficient and successful adults. This legislation, known as "Continuum of Care Reform," or CCR, also sought to reduce the use of congregate care (sometimes referred to as group homes) as a frequently used placement option for youth, as data has demonstrated that youth placed in congregate care settings experience poorer outcomes than youth placed in family settings. As discussed in a later section, CCR includes a number of efforts aimed at improving the identification and addressing of mental health needs of foster youth. Subsequent legislation to further facilitate implementation of CCR efforts include AB 1997 (Stone), Chapter 612, Statutes of 2016, AB 404 (Stone), Chapter 732, Statutes of 2017, and AB 1930 (Stone), Chapter 910, Statutes of 2018.

Mental health services for foster youth

Research on early brain development has demonstrated that infancy and early childhood are critical periods during which children develop attachments and form the foundation for future skills such as trust, empathy, and problem solving; the effects of childhood abuse and neglect often experienced by foster youth can lead to an increased need for mental health services. According to a 2012 publication by the American Psychological Association, nearly half of youth in foster care were determined to have clinically significant emotional or behavioral health problems, and children under age 7 who enter foster care show increased rates of developmental problems.[ii] Additionally, youth involved in the CWS system are more likely to face poorer outcomes than their non-system-involved peers; for example, foster youth are more likely to struggle in school, face difficulty finding employment, and experience substance use issues.[iii]

The State of California's responsibilities related to foster youth mental health is rooted in both state and federal statute. The Foster Youth Bill of Rights was codified by AB 899 (Liu), Chapter 683, Statutes of 2001, and explicitly states that foster youth in California have the right to receive medical, dental, vision, and mental health services.[iv] Later, in 2008, the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) made changes to the federal Social Security Act (42 USC § 622) to require state plans for child welfare services to respond to the health care needs of children in foster care placements through a coordinated strategy that must include an outline of how health needs are identified and what steps can be taken to ensure continuity of health services.[v] Finally, as part of the Bipartisan Budget Act of 2018 (P.L. 115-123), the Families First Prevention Services Act sought to reduce the use of congregate care placements for foster youth, known as qualified residential treatment programs, with certain exceptions. The Act requires these programs to use a trauma-informed model, and further requires that the youth placed in these facilities be assessed within 30 days of placement for the purpose of determining whether their needs may be met by placement with family members, in a foster home, or an alternative setting.[vi]

Katie A. v. Bonta

In addition to responsibilities rooted in state and federal legislation, a June 2002 lawsuit, *Katie A. v. Bonta*, was filed on behalf of California foster youth against Los Angeles County and the State of California, and cited violations of the Americans with Disabilities Act, federal Medicaid laws, and parts of the Rehabilitation Act, among others.[vii] The lawsuit discussed the experience of the lead plaintiff, Katie A., who had never received therapeutic treatment in her home, and by age 14, had experienced 37 different placements within the Los Angeles County foster care system, in addition to 19 trips to psychiatric facilities.[viii] The lawsuit sought to improve the provision of mental health services to foster youth through the state, and in December 2011, nearly a decade after the lawsuit was initially filed, the Federal District Court issued an order approving a proposed settlement of the case, thereby changing the way in which youth with the most severe needs are assessed for mental health services.

Continuum of Care Reform

CCR, in its efforts to reduce reliance on congregate care, also seeks to improve the integration of foster care and mental health services: every youth, regardless of placement type, should receive adequate, coordinated supports and services to address their mental health needs. To achieve this goal, California adopted the following reforms:

- *Child and Family Teams (CFTs):* CFTs utilize a youth- and family-centered decision making process in order to assess and plan for the needs of a youth and their family. CFTs are required to provide input regarding the development of a child and family plan that is strengths-based, needs-driven, and culturally relevant, as well as the placement decision made by the placing agency and the services to be provided to the youth. CFTs are comprised of various individuals who provide certain formal supports to the youth, including caregivers, caseworkers, and county mental health representatives, among others. The frequency with which CFTs meet varies based on the needs of the youth and the length of time the youth has been in care.

- *Functional assessment of needs:* The Child and Adolescent Needs and Strengths (CANS) functional assessment was chosen by CDSS in response to CCR's emphasis on utilizing one comprehensive assessment to inform placement decisions and service provision. The CANS is based on a youth's strengths and is intended to be used by CFTs to support case planning and coordination of services. Both county welfare agencies and county mental health plans are responsible for ensuring that a single CANS assessment is conducted for every youth placed in foster care, and that foster youth who are receiving specialty mental health services are assessed by CANS certified providers and certified county staff every six months.[ix]

- *Short-term residential therapeutic programs (STRTPs):* This new licensing category was created in order to further CCR's goal to move youth out of congregate care and into family homes. Under CCR, traditional group homes may transition to STRTPs, which provide short term, 24 hour care and supervision to youth, and are intended to provide mental health interventions to stabilize, support, and transition youth with high-level mental health needs to lower levels of care. STRTPs must make available a core set of trauma-informed, culturally

relevant services, including specialty mental health services, and are further required to "provide and ensure access to mental health services, including specialty mental health services and mental health supports, as appropriate to the needs of the child or nonminor dependent."[x] In January 2017, CDSS issued interim licensing standards that require an STRTP to obtain in good standing a mental health program approval, which must include a Medi-Cal mental health certification, within 12 months of licensure.

- *Foster Family Agency (FFA) requirements:* FFAs, like STRTPs, are required to make available certain core services and supports, including specialty mental health services. FFAs are also required to have a current Medi-Cal certification as an organizational provider of a county mental health plan in order to provide specialty mental health services directly to youth in care. An FFA that does not have a Medi-Cal certification is required to provide access to appropriate mental health services, rather than obtain a Medi-Cal certification to provide specialty mental health services directly to youth.

- *Intensive Services Foster Care (ISFC):* This new licensing category was created in order to provide supports and services to youth who require intensive treatment, such as treatment for behavioral or specialized health care needs. ISFC seeks to provide necessary services, including access to mental health treatment, trauma-informed care, and transitional support, to youth in a home-based family setting, thereby allowing youth to avoid or exit congregate care placements. ISFC requires specific training of resource parents, which includes professional and paraprofessional support.

Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT)

Medi-Cal (California's Medicaid program), which provides free or low-cost health coverage to low-income adults, families, seniors, individuals with disabilities, pregnant women, and foster youth, is administered by the Department of Health Care Services (DHCS). Medi-Cal contains a child health component, known as Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT). EPSDT provides comprehensive health care services to children under the age of 21 who have full-scope Medicaid eligibility; all foster youth are categorically eligible for Medi-Cal, and therefore EPSDT.

The EPSDT benefit includes screening, diagnostic, and treatment services aimed at ensuring that children and youth receive adequate health care, including dental, developmental, and mental health care. It is important to note that, while EPSDT services are available to all children with full-scope Medicaid eligibility, and not just youth in the foster care system, it is the main source of funding for mental health services for youth in care.

The mental health services provided under Medicaid include "specialty mental health services," which are available for children through the EPSDT benefit, and adults who meet certain medical necessity criteria (while EPSDT also covers "non-specialty" mental health services for children or youth, these services are often delivered through a fee-for-service provider, or a managed care plan). Medical necessity criteria differs for children and youth under the age of 21 and adults; under EPSDT, children and youth must have a covered diagnosis and meet the following criteria:

1) Have a condition that would not be responsive to physical health care-based treatment; and,

2) The services are determined to be necessary in order to correct or address a mental illness and condition discovered by a screening conducted by a qualified provider.

Therefore, children with lower levels of impairment may meet the medical necessity criteria to receive specialty mental health services. Adults, however, must have a significant level of impairment to meet the medical necessity criteria in order to receive specialty mental health services.

Specialty mental health services include: assessment, collateral (working with a caregiver or other significant support person to address mental health needs), therapy, rehabilitation (including skills training), crisis intervention, crisis stabilization, medication support, psychiatric health facility services, and targeted case management, among others.

In California, of the 124,875 children with an open child welfare case, (which includes youth in a foster care placement, and youth receiving child welfare services while living at home) during the one year period between April 2016 and March 2017, 42.3% received some form of specialty mental health service.[xi] During the same one-year period, 82,665 children were in foster care in California; of those youth, 47.3% received some form of Medi-Cal specialty mental health service.[xii]

Out-of-county placement of foster youth

In instances where it is necessary to remove a child from their parents' custody, the youth's care becomes the responsibility of the county in which they lived when they first became dependents of the state (known as the "county of jurisdiction"[1]). The youth's social worker is then tasked with locating an appropriate placement within the county, while prioritizing placement options with relatives or NREFMs. The most common placement options include: foster family homes, placement with relatives, or congregate care settings, although CCR has placed particular emphasis on reducing placement in congregate settings.

As of October 1, 2018, the percentage of youth in the following placement types were as follows:

- Foster family homes – 34.9%
- Relatives/NREFMs – 32.5%
- Guardians – 10.2%
- Group homes – 5.3%
- Pre-adoption – 3.8%[xiii]

The placement that can best fit a youth's needs, however, may not always be located in their county of jurisdiction for a variety of reasons. For example, a relative who is able and willing to provide care may not live in the same county, or a youth may be best served by a specialized facility that exists elsewhere in the state. As such, and in order to adequately meet their needs, youth are sometimes placed out of county. Out-of-county placements can create disruptions in a youth's school performance, social development, relationships, and ongoing supports and

[1] Sometimes referred to as the "county of origin" or "county of adjudication."

services. An October 2011 report by the Child Welfare Council determined that out-of-county placements tended to be:

- For youth who were older and in care longer.
- More likely to be the second or greater placement.
- Far less likely to be foster family homes or guardian homes.
- More likely to be a group home.
- More likely to have youth diagnosed with a serious mental health disorder.
- Less likely to receive mental health services compared to their in-county placed peers.[xiv]

As of July 1, 2018, the number of youth in the CWS system was 59,223; of those, 13,206 (22.3%) youth were placed out of county.[xv]

Of the 13,206 youth placed out of county, 30% (4,032 youth) were placed with relatives/NREFMS, 11% (1,459 youth) were placed in group homes, and 35% (4,662 youth) were placed in foster family homes.

It should be noted that the percentage of youth placed out of county and received from out of county is based on the number of youth relative to each individual county. For example, Alpine County places 100% of youth in-county; however Alpine County had a total of two youth in care as of July 1, 2018. Los Angeles County has an out-of-county placement rate of 17.3%, which is five percentage points below the state average; however, this placement rate means that 3,610 youth who have Los Angeles as their county of jurisdiction were placed out of county. (For perspective, this number represents 27% of all youth in the state who are in out-of-county placements).

Efforts to address access to mental health services for out-of-county foster youth

For years, it was recognized that foster youth placed across county lines often faced long delays in receiving appropriate mental health services, if they received these services at all. Public mental health services in California are administered at the county level; DHCS contracts with county mental health plans for the provision of Medi-Cal specialty mental health services and the mental health plans, in turn, use county mental health staff or contract with local private mental health services providers to deliver services. Prior to recent statutory changes (discussed later in this paper), when youth in the CWS system were placed in a county other than their county of jurisdiction, the county of jurisdiction maintained responsibility for the arrangement for or provision of specialty mental health services (including the costs of services) regardless of the youth's county of residence.[2] It was the mental health plan in the county of jurisdiction's responsibility to ensure a youth's receipt of necessary mental health services, regardless of the youth's county of residence. This arrangement, combined with the complexities related to county-level administration of services, contributed to concerns regarding the extent to which foster youth placed in counties other than their county of jurisdiction were receiving medically necessary mental health services. Problems would arise related to locating providers and services in a youth's county of residence, contracting for care, securing treatment authorizations, coordinating care, monitoring care, and obtaining adequate reimbursements from local, state, and

[2]Some exceptions would exist in instances where there was a written contract in which the county of residence accepted responsibility for payment.

federal authorities. The ultimate concern was the harm that not receiving sufficient levels of service – services to which youth were entitled – might be having on foster youth's development and well-being.

Over time, there have been various formal discussions, reports, legislation, regulatory changes, and administrative actions aimed at addressing issues of out-of-county foster youth's access to timely and adequate mental health services. Below, this paper highlights some key attempts to understand and address these issues, recognizing that this is not an exhaustive review of the extent and breadth of work that multiple individuals and entities have put into examining the issue and identifying possible solutions over the past two-plus decades.

In 2000, SB 745 (Escutia), Chapter 811, Statutes of 2000, adopted, among other things, the requirement that each local mental health plan establish a procedure for ensuring access to EPSDT-required outpatient specialty mental health services for any youth in foster care who has been placed outside of their county of jurisdiction. Attendant regulations[3], made operative in 2008, required: 1) the mental health plan of the county of jurisdiction to authorize services for youth placed outside their county within three working days after the date of request for service (with certain allowable extensions) and to notify the county of placement and the requesting provider of the authorization decision; 2) the mental health plan of the county of jurisdiction to arrange for reimbursement for services provided to the youth through the county of residence or requesting provider within 30 days of the authorization of service; and, 3) the mental health plans of both the county of jurisdiction and the county of residence to resolve any disagreements through a specified arbitration process.

SB 785 (Steinberg), Chapter 469, Statutes of 2007, sought to "facilitate the receipt of medically necessary specialty mental health services by a foster child who is placed outside of his or her county of original jurisdiction."[xvi] This bill required the Department of Mental Health (now, DHCS) to standardize certain contracts, authorization procedures, and documentation standards and forms. It also, for certain foster youth who either became the subject of legal guardianship or whose adoption was finalized and who met other criteria, required responsibility for provision of medically necessary specialty mental health services to transfer from the county of jurisdiction to the county of residence of their legal guardians or adoptive parents. In this respect, this bill could be seen as a first legislative adoption of "presumptive transfer": the shifting of responsibility for arrangement for or provision of mental health services from the county of jurisdiction to the county of residence. While SB 785 sought to address administrative barriers to out-of-county foster youth's access to mental health services, its limited focus on youth who were adopted or subject to legal guardianship, among other things, led some to argue that the bill was not comprehensive enough to fully address issues related to out-of-county access to mental health services.

In December of 2010, the California Mental Health Directors Association (now the County Behavioral Health Directors Association [CBHDA]) and the County Welfare Directors Association (CWDA) jointly presented an "Out of County Foster Care Action Plan" to the Child Welfare Council.[4] The action plan's stated goal was that "every child in the foster care system

[3] Title 9, CCR Section 1830.220(b)(4)(A)

[4]Established by AB 2216 (Bass), Chapter 384, Statutes of 2006, the California Child Welfare Council is an advisory body that is charged with improving the collaboration and processes of the many agencies and courts that serve

will receive timely specialty mental health services when needed, regardless of their county of placement [residence]," and the plan outlined five issues to be addressed in order to improve statewide access to out-of-county mental health services: restoration of base funding in CWS; identification, screening, and communication; authorization and payment; provision of services and capacity; and outcomes and accountability.

After being presented this plan, the Child Welfare Council established the Out-of-County Mental Health Services Workgroup, charged with developing a work plan that, as a whole, was intended to establish clear, consistent practices that counties could follow to ensure that all foster youth readily received mental health services. Specifically, the work plan looked at: 1) a fiscal analysis; 2) recommendations around screening and assessment; and, 3) criteria for when a child placed out of county would receive needed mental health services from the county of residence and criteria for receiving needed mental health services from the county of jurisdiction – i.e., an examination of presumptive transfer and exemptions thereof. According to a November 2011 report of the Child Welfare Council's Out-of-County Mental Health Services Workgroup Report, "the Workplan recommendations include framing presumptive transfer as individualized decision-making by a Collaborative Team whenever possible, based on existing state statutes that apply to former and current foster youth."[xvii]

To support the Out-of-County Mental Health Services Workgroup's examination of the problem, the workgroup collaborated with another sub-group of the Child Welfare Council – the Data Linkage and Information Sharing Committee – to create the Out-of-County Data Mining Project, which analyzed child welfare and mental health data to examine differences in the receipt of mental health services for foster youth placed in their counties of jurisdiction versus those placed out of county. Such differences were found. Some of the key findings reported by this effort in 2011 included the following:

- While many foster youth in the state received mental health services, there was significant variation across counties;
- Foster youth placed in their county of jurisdiction, on average, received greater access to services and higher intensity of care (including 26% more days of service per month) than their out-of-county counterparts; and
- When compared to in-county placements, out-of-county placements were, among other things, more likely to: be the second or greater placement, be a group home, and have youth diagnosed with a serious mental illness in nine of eleven reported categories.

In subsequent years, discussions continued. Some of these discussions were led by the state Health and Human Services Agency (CHHSA), and resulted in CWDA and CMHDA (now CBHDA) putting forward a proposed plan in 2013 that included recommendations for improving access to mental health services for foster children placed out of county. Further discussions

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youth in the child welfare services system. The Council is co-chaired by the Secretary of the California Health and Human Services Agency and the Chief Justice of the California Supreme Court (or their designee), and counts among its members the directors of a number of relevant state entities, four foster youth or former foster youth, legislators appointed by the Speaker of the Assembly and the President pro Tempore of the Senate, and the State Foster Care Ombudsperson, among others. It has met quarterly since November 2007 and is required to report to the Governor, Legislature, Judicial Council, and the public at least once a year. It may also issue advisory reports as it deems appropriate.

resulted in a joint state/county set of recommendations that DHCS presented to the Child Welfare Council.

Annual reports from the Child Welfare Council during this period consistently mention the work of the Out-of-County Mental Health Services Task Force, and also point to continued efforts to grapple with the issue of presumptive transfer. The Council's 2012-13 Annual Report states that, "Despite considerable efforts over the years by multiple task forces, including this one, a complete solution to presumptive transfer and inter-county payments for foster children's mental health services has not been achieved." The following year, the 2013-14 Annual Report makes a similar statement: "Despite considerable efforts over the years by multiple task forces, including this one, a complete solution to presumptive transfer and inter-county payments for foster children's mental health services has not yet been fully achieved, although the efforts of the past year show promise of success when the provisions of the *Katie A.* settlement are fully implemented."

The Child Welfare Council's 2014-15 Annual Report mentions the Council's continued monitoring of DHCS's progress on a proposed policy to improve access to timely and effective mental health services for all foster children placed outside their county of jurisdiction. It is also during this time period, in 2015, when Assemblymember Ridley-Thomas introduced AB 1299 as a way of addressing out-of-county foster youth access to mental health services.

AB 1299

AB 1299 (Ridley-Thomas), Chapter 603, Statutes of 2016, provided for presumptive transfer of specialty mental health services for foster youth placed out of county in California.[5] This bill states Legislative intent "to ensure that foster children who are placed outside of their county of original jurisdiction are able to access specialty mental health services in a timely manner, consistent with their individual strengths and needs and the requirements of federal [EPSDT] services," and "to overcome any barriers to care that may result when responsibility for providing or arranging for specialty mental health services to foster children who are placed outside of their county of original jurisdiction is retained by the county of original jurisdiction."

AB 1299 requires CHHSA to coordinate with DHCS and CDSS in order to facilitate the prompt receipt of medically necessary specialty mental health services by foster youth placed out of county. Per the bill, "upon presumptive transfer, the mental health plan in the county in which the foster child resides shall assume responsibility for the authorization and provision of specialty mental health services and payments for services. The foster child transferred to the mental health plan in the county in which the foster child resides shall be considered part of the county of residence caseload for claiming purposes from the Behavioral Health Subaccount and the Behavioral Health Services Growth Special Account."

The bill allows for presumptive transfer to be waived on a case-by-case basis when consistent with the medical rights of the youth and when specified reasons for exemption exist, including:

[5] An earlier, and somewhat differently structured, attempt to adopt presumptive transfer was proposed by AB 1808 (Galgiani) in 2010. This bill was held on the Assembly Appropriations Committee Suspense File.

- Presumptive transfer would disrupt continuity of care or delay access to services;
- Presumptive transfer would interfere with family reunification efforts;
- It is anticipated that a youth's placement out of county will last less than six months; or,
- The youth's residence is located within 30 minutes of travel time from their specialty mental health care provider in their county of jurisdiction.

Per the bill, a foster youth, an individual or agency responsible for making mental health care decisions on behalf of the youth, the placing agency (probation or child welfare), and any other interested party owing a legal duty to the youth regarding their health or welfare may request a waiver of presumptive transfer. The placing agency, in consultation with parties including the youth, their parent(s), the child and family team, and other professionals as appropriate, determines the appropriateness of the waiver. Relevant parties may request judicial review of this decision, and the court may confirm or deny the transfer or exception based on the best interest of the child.

AB 1299 stipulates that "a waiver processed based on an exception to presumptive transfer shall be contingent upon the mental health plan in the county of original jurisdiction demonstrating an existing contract with a specialty mental health care provider, or the ability to enter into a contract within 30 days of the waiver decision, and the ability to deliver timely specialty mental health services directly to the foster child. That information shall be documented in the child's case plan."

AB 1299 required DHCS, in coordination with the CHHSA and CDSS, and in consultation with various stakeholders, to issue policy guidance regarding the conditions for and exceptions to presumptive transfer. CHHSA, DHCS, and CDSS issued All County Letter (ACL) 17-77/Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice (IN) on July 14, 2017. This initial guidance, among other things, highlighted the importance of engaging the child and family team in considerations of the possible benefits of presumptive transfer versus existence of an exception, and stated that placing agencies shall make their determination of the waiver request in consultation with the child and family team.

Subsequent guidance was issued on June 22, 2018; ACL 18-60/MHSUDS IN 18-027, among other things, provided direction regarding expedited transfers. AB 1299 states the policy guidance it requires must ensure that there is a procedure for expedited transfer within 48 hours of placement of a youth out of county; the guidance states that, "in situations when a foster child or youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition, [mental health plans] must provide [specialty mental health services] immediately, and without prior authorization. There may be instances when a child or youth must be moved to a new placement outside of the county of original jurisdiction for his or her safety and a [child and family team] meeting is unable to be convened prior to placement. In these instances, the county placing agency must immediately contact the [mental health plan] in the county of residence to notify the [mental health plan] of the placement and the need to provide or arrange and pay for [specialty mental health services] to meet the needs of the child or youth."

ACL 18-60/MHSUDS IN 18-027 also provided further guidance regarding presumptive transfer and the child and family team process, stating that:

> "Presumptive transfer must be discussed by the [child and family team] in situations in which a child or youth is to be placed outside the county of original jurisdiction. The use of an effective [child and family team] process is especially important when an out of county placement is being considered, and is the primary vehicle for coordinating care. The [child and family team] process can help families develop and maintain respectful, trusting relationships that can, over time, lead to greater stability and improved outcomes. In the context of presumptive transfer, the [child and family team] process informs placement decisions, as well as the child or youth's foster care case plan, and mental health treatment plan. If an out of county placement occurs and [specialty mental health services] are presumptively transferred to the county of residence, the [specialty mental health services] provider(s) from the county of residence [mental health plan] becomes part of the child or youth's [child and family team].
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> The child welfare agency or probation department that maintains jurisdiction of the foster care case must ensure a [child and family team] exists for the child or youth in foster care and is responsible for convening the [child and family team] meetings regardless of the county of residence or the [mental health plan] responsible for providing [specialty mental health services]. The county of original jurisdiction child welfare or probation agency responsible for placement must collaborate with the county of residence [mental health plan], and the [mental health plans] contract providers if applicable, to ensure a [child and family team] exists and meetings occur."

Presumptive transfer per AB 1299 became effective on July 1, 2017. DHCS reports that it does not collect data on the number of out-of-county foster youth whose specialty mental health services were subject to presumptive transfer or waiver thereof. Therefore, it is unclear how many youth across California have been subject to presumptive transfer and waivers of presumptive transfer.

Discussion and questions

The reforms to California's child welfare services system brought about in recent years through CCR are promising. The state has made numerous significant changes aimed at achieving a reality of *every* foster youth having the opportunity to live and thrive in a safe, loving, supportive family home, with necessary supportive services "wrapped around" each youth and their caregivers. One crucial factor in achieving this goal is ensuring that these youth have timely and adequate access to the mental health services to which they are entitled, in a manner that meets youth where they are – regardless of level of need, regardless of placement type, regardless of which county they were living in when they entered into foster care, and regardless of the county in which they are currently placed.

Presumptive transfer, ideally, can bolster and complement CCR efforts by supporting those foster youth who are placed out of county with appropriate mental health care, ensuring that they receive the services for which they are eligible and to which they are entitled. However, implementation of presumptive transfer has not been without its complications and registration of questions and concerns by various stakeholders. A number of factors contribute to the complicated landscape in which presumptive transfer operates, including, among others: realigned funding streams; split responsibilities across state departments; varying and multiple contract requirements and processes for providers; payment and reimbursement

requirements and timelines related to the provision of mental health services that can be confusing and significantly burdensome for counties and providers; the involvement of different county-level agencies responsible for child welfare services and mental health services; and changes resulting from the much-needed reform driven by CCR, including the conversion of group homes to STRTPs. Not all of these factors are negative, but they can complicate the intent and implementation of presumptive transfer.

As the Legislature continues to work alongside other stakeholders to address the long-recognized need for out-of-county foster youth's equitable access to timely and adequate mental health services, it may wish to consider the following questions:

- How can statewide data collection and reporting be improved to provide a full picture of: the frequency and duration of presumptive transfer; the number of instances in which, and reasons for which, presumptive transfer is waived; and the impact of presumptive transfer and waivers thereof on outcomes for foster youth placed out of county?

- What avenues exist for addressing concerns of "receiving" providers and counties who report experiencing fiscal strain, sometimes substantial, as a result of having previously unanticipated placements of youth from other counties due to presumptive transfer?

- Would creating greater uniformity in contracting processes and requirements between providers and mental health plans assist providers who operate in multiple counties in their provision of timely and appropriate services to youth? If so, how might this uniformity be accomplished?

- Could out-of-county foster youth access to mental health care be improved as a result of increased communication between providers and county agencies, particularly concerning expectations and responsibilities related to presumptive transfer? If so, what steps are needed to facilitate this improved communication?

- Are child and family teams being appropriately and consistently involved in decision-making related to presumptive transfer, and informed about the benefits and consequences of presumptive transfer versus waiving presumptive transfer? If not, how can informing and involving child and family teams regarding presumptive transfer be improved?

[i] http://cssr.berkeley.edu/ucb_childwelfare/PIT.aspx
[ii] https://www.apa.org/pi/families/resources/newsletter/2012/01/winter.pdf
[iii] http://pediatrics.aappublications.org/content/138/5/e20161118
[iv] http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=16001.9.&lawCode=WIC
[v] https://www.law.cornell.edu/uscode/text/42/622
[vi] http://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx
[vii] https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx
[viii] https://chronicleofsocialchange.org/analysis/katie-a-the-present-and-future-of-californias-mental-health-mandate/8419
[ix] https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN-18-007%20CANS/IN_18-007_CFT_CANS_Joint_Letter.pdf
[x] http://www.cdss.ca.gov/Portals/9/STRTPILSV2.pdf?ver=2017-02-17-103558-33
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