ARE THEY BEING SERVED (YET)?

Nearly Ten Years After the Voters' Approval of the Mental Health Services Act (MHSA), To What Extent Are Counties Using MHSA Funds to Serve the Needs of Transition Age Foster Youth?

Children's Advocacy Institute
University of San Diego School of Law
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CHILDREN'S ADVOCACY INSTITUTE

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ABOUT THE CHILDREN'S ADVOCACY INSTITUTE

The Children's Advocacy Institute (CAI) was founded in 1989 as part of the Center for Public Interest Law at the University of San Diego (USD) School of Law. CAI's mission is to improve the health, safety, development, and well-being of children. CAI advocates in the legislature to make the law, in the courts to interpret the law, before administrative agencies to implement the law, and before the public to educate Californians on the status of children.

CAI strives to educate policymakers about the needs of children—about their needs for economic security, adequate nutrition, health care, education, quality child care, and protection from abuse, neglect, and injury. CAI's goal is to ensure that children's interests are represented effectively whenever and wherever government makes policy and budget decisions.

For more information about this report or for additional copies, please contact:

Children's Advocacy Institute
University of San Diego School of Law
5998 Alcalá Park ◆ San Diego, CA 92110
(619) 260-4806 ◆ Fax: (619) 849-4753
info@caichildlaw.org ◆ www.caichildlaw.org

Sacramento Office
Children's Advocacy Institute
800 J Street, Suite 504 ◆ Sacramento, CA 95814
(916) 844-5646

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I. ABOUT THIS REPORT

Voters' 2004 approval of Proposition 63 — the Mental Health Services Act (MHSA) — gave California the unprecedented opportunity to lead the country in providing innovative and effective mental health services to its most vulnerable citizens. By assessing a 1% income tax on personal income in excess of $1 million, the measure was intended to provide funding, personnel, and other resources to support new and innovative county-based mental health programs for children, transition age youth, adults, older adults and families.

In 2010, the Children's Advocacy Institute (CAI) released a report analyzing each of California's 58 county plans created pursuant to the MHSA from its passage in 2004 through mid-2009 (*Proposition 63: Is the Mental Health Services Act Reaching California's Transition Age Foster Youth?*, available at www.caichildlaw.org). That Report determined how counties were using initial MHSA funding to address the needs of transition age foster youth (TAFY). CAI chose to evaluate this aspect of the MHSA because transition age youth (TAY) are specifically carved out in the Act to receive funding for new and expanded mental health services — and TAFY arguably comprise the subset of that population most in need of such services and resources.[1] In fact, TAFY experience serious mental illness and severe emotional disorders at rates that far exceed their peers who have not spent time in the foster care system. Given this reality, the fact that foster youth are the state's own children, and the amount of money the MHSA took in over the first several years of its existence, CAI believed that TAFY should have been receiving vastly improved services funded by the MHSA — services tailored specifically to their unique needs.

Unfortunately, CAI found that the counties were falling far short of developing adequate programs to address the mental health needs of TAFY with their MHSA funding. Many counties created programs that included TAFY Youth as a "priority population" for funding; however, such programs were generally extremely broad in their scope, TAFY was only one of several priority populations, and the number of TAFY served by such MHSA-funded programs was very small when compared to realistic estimates of the actual need. Finally, none of the programs examined included any means by which to determine the success of the MHSA intervention over the long term. CAI found there to be a disappointing lack of substantial outcome statistics, with no plan to study outcomes longitudinally.

In this Report, CAI revisits ten of California's counties to examine the developments and progress that have taken place over the past four years, in light of new developments surrounding child welfare and the MHSA. This Report examines the extent to which these ten diverse counties are serving TAFY with MHSA funding nearly ten years after voters passed the MHSA. In addition to reviewing whether any of the counties have yet designed a program specifically to serve TAFY, this Report analyzes the extent to which counties are meaningfully considering the mental health needs of TAFY in the course of their MHSA planning processes.

II. BRIEF BACKGROUND: TRANSITION AGE FOSTER YOUTH AND THE MENTAL HEALTH SERVICES ACT

A. California's Transition Age Foster Youth

One of the most significant features of the MHSA is that, as passed by the voters, it expressly requires certain programs established by counties to include services that address the needs of Transition Age Youth (TAY): "The programs established pursuant to [specified provisions of the Act] **shall include services to address the needs of transition age youth ages 16 to 25**."[2] In so doing, the voters acknowledged that transition age youth (TAY) is a distinct population with extraordinary needs; these young people are moving through a period in their lives wrought with changes and challenges — physical, emotional, psychological, social, financial, educational, et al.

Within the general TAY population is a subset of youth who have no one to guide them through this difficult period of life — youth who have experienced significant trauma and upheaval in their formative years, and who lack stable parent-figures in their lives to help them navigate the labyrinthine challenges that face young people transitioning into adulthood. These are California's Transition Age Foster Youth (TAFY), who are still in or have aged out of the foster care system. Four important features distinguish TAFY from other subsets within the transition age youth population:

- TAFY have no parental support to help them cope with their mental health challenges;
- TAFY have uniformly been abused and neglected, first by their parents, second by an underfunded and undervalued system that stubbornly tolerates poor outcomes;
- TAFY are the children of the State, and hence are owed a special moral as well as legal obligation; and
- TAFY have the most acute and urgent mental health needs of any subgroup of transition age youth.

In fact, the list of negative outcomes the MHSA specifically seeks to avoid reads like a description of the outcomes far too many TAFY face upon leaving California's foster care system: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.[3] As they age out of the foster care system, these young adults have not yet "failed" into homelessness, poverty, or incarceration — but statistics show us that many soon will.

With over 4,000 youth aging out of California's foster care system each year, the TAFY population has unique standing among priority populations for MHSA funding for numerous reasons. First, when the state places a child in the foster care system, it legally takes on the role of parent for that child. Like every parent, California has a responsibility to ensure the well-being of its children. California's parental responsibilities go beyond ensuring the physical well-being of its children; we as a state are required to ensure the emotional and mental wellness of these children and youth. Further, a responsible parent does not abandon his/her child at age 18, particularly if that child has a serious mental illness or the symptoms of the onset of such an illness. Responsible parents budget first for their children. Accordingly, California has the duty to give top priority to ensuring the health and well-being of the children for whom it is serving as parent.

Second, these youth are cloaked by a confidential child welfare system. They are not often heard from — nor are they easily accessible to officials who make local planning decisions. With this unique barrier to participation, counties will generally not hear about the needs of TAFY absent a specific, focused, and sustained strategy.

Third, beyond California's legal, ethical, and moral obligations to TAFY, these youth deserve priority because they are more highly at risk of mental health issues by virtue of being a part of the foster care system. These children enter California's foster care system because of neglect, abuse, and/or abandonment[4] and studies estimate that up to 85% of them have substantial mental health issues.[5] The incidence of emotional, behavioral, and developmental problems is three to six times greater among children in foster care than among other children in the community.[6] Children who suffer the chronic stresses of living in poverty are often over-represented in the foster care system.[7] Finally, foster youth often experience multiple placements for indeterminate and varying lengths of time, which may worsen emotional issues.[8] By the time they age out of the foster care system, these children have experienced more trauma in their young lives than most adults will experience over an entire lifetime. Consequently, TAFY have a higher incidence of serious mental illness than virtually any other group of people. The litany of statistics is staggering. For example, former foster youth:

- have a higher incidence of Post-Traumatic Stress Disorder (PTSD) than America's war veterans (21.5% among foster care alumni compared with 15% among Vietnam veterans, 6% among Afghanistan veterans and 13% among Iraq veterans);[9]
- experience panic disorder at a rate three times higher than that of the general population;
- experience seven times the rate of drug dependence and almost twice the rate of alcohol dependence as the general population;[10] and
- are more likely to experience a major depressive episode, generalized anxiety disorder and eating disorders (seven times more likely to have bulimia) than the general population.[11]

Fourth, not only do California's foster youth experience mental illness at a higher rate than their peers, TAFY experience each of the negative outcomes associated with mental illness that the MHSA specifically seeks to reduce at significantly higher rates than the general population:

- Suicide: A 2006 study found that adolescents who had experienced foster care were almost four times as likely as other adolescents to have attempted suicide and more than twice as likely to have thought seriously about killing themselves in the previous 12 months.[12] As noted above, foster youth experience mental illnesses associated with suicidal behavior, such as major depressive disorder and PTSD, at much higher rates than their peers in the general population; shockingly, alumni of foster care have been found to experience higher PTSD rates than American war veterans.[13]
- Incarcerations: About 25%–35% of former foster youth are incarcerated at some point after leaving care.[14] Their peers in the general population serve time in state or federal prison at a rate of 2.7%.[15]
- School Failure or Dropout: Foster youth complete high school at rates far below the average. A recent study found that foster youth had the highest high school dropout rate and the lowest high school graduation rate; even when their peers in other at-risk groups were included.[16]
- Unemployment: A recent study discovered that 90% of foster youth had no source of income when they left foster care and were expected to be on their own.[17] The unemployment rate among former foster youth is staggering: 60% of former foster youth are unemployed at age 19 compared with 42% of their peers with no history of foster care, and 50% of former foster youth are unemployed at age 21, compared with 35% of their peers with no history of foster care.[18] Of those former foster youth who are employed, 90% earn less than $10,000 a year after leaving foster care,[19] and 75% still make

less than $10,000 annually at age 21.[20] As a point of reference, the 2009 poverty level for a single individual in the 48 contiguous states is $10,830.[21]

- Prolonged Suffering: Even with overwhelming evidence that early intervention may be an important element in reducing long-term negative effects of mental illness, less than one-third of youth receive any type of mental health services during the year following their contact with the child welfare system.[22] Studies show that 35%–85% of current or former foster youth have serious mental health issues[23] — compared with the 8% of the transition age youth in the general population who suffer from serious mental illness.[24]

- Homelessness: Former foster youth experience homelessness at rates that not only exceed those of their peers with no history of foster care, but which exceed the homeless rates of individuals discharged from prison.[25]

Fifth, although many counties' MHSA plans identify various TAY populations as priority populations, TAFY comprise a population distinct from other high risk TAY in California. TAFY have endured abuse, neglect, or abandonment, and were removed from their parents, their home, their friends, often their siblings, and everything familiar to them at a very young age. When they are faced with making the difficult transition from youth to adult, they do not have the traditional familial or social supports to which their peers — including their at-risk TAY peers in other MHSA priority populations — have ready access.

Sixth, because they lack the traditional roots that a family structure provides, TAFY often move between counties as they exit the foster care system. For this reason, county programs that do not accept out-of-county TAY are especially disadvantageous to TAFY, particularly since the passage and implementation of AB 12, which allows youth to remain in foster care until age 21. TAFY move to different counties for any number of reasons, and must retain the ability to utilize any mental health services they require.

As a group, foster youth share experiences and characteristics that are distinctly unique from those of their peers; thus, any program attempting to address their mental health and well-being must be equally unique and specifically tailored to meet the issues that TAFY typically face. Though most counties name TAFY as a priority population or a target population for funding in their MHSA plans, it is not the only priority population and TAFY are typically lumped in with some or all of several other at risk TAY, such as youth who are exiting the juvenile justice system, those who have had their first psychotic break, those who are homeless or at risk of becoming homeless and those who are aging out of the children's system of mental health care who have a Severe Mental Illness or Serious Emotional Disorders. This broad spectrum of priority populations casts a wide net for the somewhat limited reach and capacity of the programs created with MHSA funding. This is not to suggest that counties stop offering programs serving other named TAY priority populations. Instead, counties should create and provide additional programs that are tailored exclusively to meet the needs of TAFY, and which complement other programs serving broader populations as well as other supports and services available to TAFY.

B. The Purpose and Intent of the Mental Health Services Act (MHSA)

The MHSA seeks to reduce the long-term adverse impact from untreated serious mental illness by expanding successful, innovative, and evidence-based practices, and defines serious mental illness as a condition deserving priority attention. It further stresses prevention and intervention, and seeks to reduce negative outcomes associated with serious mental illness such as suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

The stated purpose and intent of the MHSA is as follows:

(1) To define serious mental illness as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.

(2) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.

(3) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California.

(4) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under MHSA. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' families or insurance providers.

(5) Finally, to ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and the public.[26]

C. Components of the MHSA

The six components of the MHSA — Community Program Planning,[27] Community Services and Support,[28] Capital Facilities and Information Technology,[29] Education and Training Programs,[30] Prevention and Early Intervention Programs,[31] and Innovative Programs[32] — are described below.

a) Community Program Planning

The Community Program Planning component provides funding for counties to undertake efforts to involve community stakeholders in planning how to use the available MHSA funding. It is intended to provide a structure and process that counties can use to how best to utilize MHSA funds.[33] One of the major issues CAI examines in this Report is whether counties are taking steps to meaningfully include TAFY in their community planning processes so that the youth have an opportunity to tell county officials charged with developing plans with MHSA funds about their needs and challenges that they would like to see addressed.

b) Community Services and Support

The Community Services and Supports (CSS) component provides funding for programs that will address diagnosed serious mental illness in children and adults. The MHSA provides counties with funding in three different areas: Full Service Partnerships (FSP), General System Development Funds, and Outreach and Engagement Funding. Counties are required to request the majority of the funding for FSPs.

The priority populations for the CSS plans, as set out in the guidelines provided to the counties are as follows:

- Children and youth between the ages of 0–21 who have serious emotional disorders, and their families who are not being served;
- Transition Age Youth (TAY) between the ages of 16–25 who are unserved or underserved and who have serious emotional disorders and who are homeless or at risk of being homeless, youth who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems, are at risk for hospitalization or institutionalization, or have experienced their first break;
- Adults with serious mental illness and adults 60 and older with serious mental illness.

Again, the MHSA specifically carves out TAY for funding; in so doing, it prominently acknowledges the challenges unique to this age group as well as acknowledging the challenges of those transition age youth who are involved with the child welfare system.

The five essential elements each plan must include are (1) community collaboration; (2) cultural competence; (3) client/family driven mental health system for older adults, adults, and transition age youth; (4) family driven system of care for children and youth; and (5) wellness focus, which includes the concepts of recovery and resilience, integrated service experiences for clients and their families throughout their interactions with the mental health system.

c) Capital Facilities and Information Technology

The third component of the MHSA is Capital Facilities and Information Technology.[34] A portion of MHSA funding was set aside specifically for capital facilities and technology in fiscal years 2004–05 through 2008–09.[35] These funds were set aside to enable counties to implement the CSS, PEI, and Innovation components of the MHSA.[36] The counties are permitted to use capital facilities funding for clinics and housing, for example. The counties can use the technology funding to create data collection, reporting systems, and other technology necessary to implement planned programs.[37]

d) Education and Training

The intent of the Education and Training component is to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illness. [38] To achieve this, the Department of Mental Health first must collect data and do a statewide occupational needs assessment. The Act then requires the state to develop a five-year education and training development plan to address these needs.[39] The five-year plan is required to include the following:[40]

- Expansion plans for the capacity of secondary education to meet the needs of identified shortages in mental health occupations.
- Expansion plans for the loan forgiveness and scholarship programs offered for commitment to employment in California's Mental Health system and current employees of California's Mental Health System who are interested in furthering their education.
- Creation of a stipend program for those enrolled in academic institutions who want to be employed in the mental health field.
- Establishment of regional partnerships among the mental health system and the educational system to expand outreach and increase the diversity of the mental health workforce.
- Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs.
- Curriculum to train and retrain staff in accordance with the provisions of the Act.
- Promotion of the employment of mental health consumers and family members in the mental health system.
- Promotion of the meaningful inclusion of mental health consumers and their families and incorporating their viewpoint and experiences in training and education programs.
- Promotion of the inclusion of cultural competency in the training and education programs described above.

In addition, the three-year plans submitted by each county mental health program must include identification of shortages in personnel and identification of additional assistance needed from the education and training programs established by the Act.[41]

The five-year plan was finalized and approved by the California Mental Health Planning Council; it covers the period April 2008 to April 2013, with subsequent plans to be developed every five years.[42]

e) Prevention and Early Intervention

The Prevention and Early Intervention (PEI) component requires the creation of new county prevention and intervention programs to ensure that persons showing early signs of mental illness access appropriate treatment quickly, before their illnesses become more severe.[43] The PEI programs must include:[44]

- Outreach to help recognize the early signs of potentially severe and disabling mental illness.
- Access and linkage to medically necessary care provided by county mental health programs.
- Reduction in stigma associated with mental illness diagnoses or seeking mental health services.
- Reduction in discrimination against people with mental illnesses.

The programs must emphasize strategies to reduce negative outcomes associated with mental illness. For purposes of examining the Act as it relates to California's Transition Age Foster Youth, it is important to note that the MHSA specifies a reduction in the following negative outcomes: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.[45]

Final PEI Guidelines were released to the counties in September 2007. Though children and youth in stressed families were named as a priority population, and the plan enumerates prevention for foster children and youth as a prevention focus area, TAFY were not specifically named as a priority population for MHSA PEI funding[46] — despite the fact that TAFY commonly experience the negative outcomes the MHSA specifically seeks to reduce through its PEI programs (as described above). At the time CAI released its 2010 Report, most counties either had recently approved plans or were in the process of submitting their PEI plans the Mental Health Services Act Oversight and Accountability Commission.[47]

f) Innovation

The sixth and final component is Innovative Programs,[48] the purpose of which is to encourage counties to create new county programs to experiment with ways to improve access to mental health services and increase the quality of those services. It is important to note that there is an emphasis on learning with Innovation funding. This funding is explicitly for counties to try out new, innovative approaches, defined as "novel, creative and/or ingenious mental health practices/approaches that are expected to *contribute to learning*, which are developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals and which are aligned with the General Standards identified in the MHSA and set forth in Title 9 of the California Code of Regulations, Section 3320."[49]

D. The MHSA's Nonsupplantation Clause and Prohibition on Reducing Mental Health Funding

The MHSA has received several billion dollars in revenues since its enactment,[50] and is projected to collect over $1.1 billion during the 2013–14 fiscal year.[51] Importantly, the initiative prohibits "supplantation"— the use of MHSA monies to provide existing services currently funded by other funding streams or sources. Such supplantation would essentially divert MHSA funds to other purposes as the state or counties use it to fund existing services and back out current appropriations. Accordingly, all MHSA monies must be expended on new services and programs for the target populations.

Specifically, the MHSA, as it was originally passed by voters in 2004[52], stated in relevant part:

"The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act…."[53]

Note the two important provisions in the above-quoted section of the Act. First, it clearly and unequivocally prohibits the state from decreasing entitlements, amounts of allocations from the General Fund, and formula distributions of dedicated funds for mental health services below 2004 levels.[54] These tow provisions are vital to the MHSA, and the vulnerable populations it was created to serve, including eligible Transition Age Foster Youth. When the legislature and the governor from the MHSA, it is taken from the pool of resources available to create programs to meet the needs of TAFY, who are among the populations of individuals in California who are highly at risk to develop serious mental illnesses.

The information distributed to educate the voters prior to the election in which Proposition 63 (MHSA) passed repeatedly emphasized that the initiative would *expand* mental health programs and prohibit the state from reducing financial support for mental health programs below 2003–04 levels.[55] This is particularly important because evidence of an initiative's purpose can be drawn from many sources, including ballot arguments distributed to the voters that favored the measure.[56]

Second, the MHSA specifically prohibits supplantation, which would occur if a county used MHSA funding to pay for services that the county originally funded with another federal, state or county source.[57]

The California legislature and the state's last two governors have engaged in questionable actions with regard to these two provisions of the MHSA:

- In support of Governor Schwarzenegger's 2007 line item veto which eliminated $55 million in funding for an AB 2034 program that served 4,700 previously homeless adults with severe mental illnesses, the Governor's staff argued that the individuals who were previously served by this program may continue to be served by MHSA programs.[58] This Schwarzenegger Administration action was questionable both because it eliminated an existing program, and as such potentially reduced funding below the 2004 levels that the MHSA required be maintained, and because the suggestion that counties use MHSA-funded programs to fill the resulting deficit of services for homeless veterans, looked very much like the supplantation the MHSA specifically prohibited. Mental health advocates brought suit, but the court upheld the cuts, holding that while the MHSA prohibits reductions in mental health spending below the total amount spent in the benchmark year, it does not protect individual programs from elimination. The Court also held that increased "indirect" costs to the counties from the loss of the program, such as higher jail and hospital costs did not violate the MHSA's restriction on changing the structure of mental health funding.[59]

- In 2004, in a statewide debacle that blurs the lines of legality under the Act, the state cut $20 million, including almost all funding for the Children's System of Care — eliminating mental health services for 4,000 children in California.[60]

- In 2011, California enacted AB 100, which allowed the state to take $862 million from the MHSA-created Mental Health Services Fund on a one time basis to fund existing mental health programs in an effort to address the state's fiscal crisis; this despite voter rejection of a similar proposal (Proposition 1E) in 2009.[61]

In addition to these controversial actions by the legislature and California's past two governors, over the years since the passage of the MHSA, counties have been encouraged to respond to shortfalls in core mental health funding by "transforming" programs — taking a program that has been shut down due to state cuts, tweaking it slightly to meet the Act's requirements, and reopening it as a "different" program, now funded with MHSA dollars. In fact, in a 2009 letter to the county mental health directors, the California Council of Community Mental Health Agencies told the counties that even though these programs provide the same services to the same clients through the same service provider, this is lawful and does not constitute supplantation.[62] The letter pointed out that many counties have already "transformed" their programs in this manner and have received approval from the state for so doing.

The Legislative Analyst's 2004 analysis of the MHSA stressed that the fund would be used to create "new county mental health programs and to *expand* some existing programs" (emphasis added). Voters did not intend MHSA funds to replace services already offered — the clear message to voters was that it would add to existing services. In many regards, that has not been the case. Voters in California reiterated this message in May 2009, when they resoundingly rejected Proposition 1E, which would have allowed the state to divert $230 million in funding from the MHSA to pay for mental health services for children and young adults provided through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.[63] Voters rejected Proposition 1E soundly with 66.5% of California voters voting no on the proposal.[64] Ultimately, the legislature simply passed AB 100 in 2011, which diverted $832 million rather than the $230 million proposed by the voter-rejected Proposition 1E — and in so doing, declaring that this action furthered the purpose of the MHSA.[65]

III. Major Developments to the MHSA and Child Welfare since 2010

A. MHSA Changes

CAI's 2010 Report examined the extent to which California's counties were utilizing MHSA funding to address the mental health needs of TAFY — and found that the counties were largely failing in this regard. Very few counties had designed MHSA-funded programs exclusively for TAFY. Although several counties named TAFY as one of several priority populations for which MHSA-funded TAY programs were designed, most of these programs lacked sufficient capacity to meet the needs of the eligible TAFY — let alone the capacity to meet the needs of all eligible populations. Thus, while the counties properly recognized TAFY as a group highly at risk for mental illness, they overlooked the unique situation of those who were transitioning out of the child welfare system without parental support or a social safety net comparable to that of their peers. In that 2010 Report, CAI graded the extent to which California's counties were using MHSA funds to address the unique needs of TAFY — and most counties failed.

Since CAI released its 2010 Report, there have been several major developments in California, related to the MHSA as well as child welfare and foster care, that impact TAFY and their access to appropriate services, including adequate mental health services. Some of these changes, like AB 12 and AB 989, represent strides forward for TAFY while others, such as AB 100, may be problematic.

1. AB 100 (Committee on Budget)

In the midst of California's budget crisis, the legislature passed and the governor signed AB 100 (Committee on Budget) (Chapter 5, Statutes of 2011) — substantially amending portions of the MHSA.

As originally approved by the voters, the MHSA gave counties a great deal of input and control over the funding they would receive and the programs they could create with the funding, but it also provided the state with a large degree of control and oversight responsibilities. For example, the Department of Mental Health (DMH) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) were to administer the MHSA Fund, create guidelines for the counties, and approve the county plans. Thus, the organization and efficiency of the state bureaucracy directly affected the counties' ability to create and implement programs with MHSA funding. Contrary to how the voters envisioned the MHSA would work, AB 100 wrested much of this control and oversight away from the state.

As noted above, AB 100 allowed the state to "shift" $832 million from the MHSA to the General Fund to cover funding obligations for Medi-Cal Specialty Mental Health services, mental health services for special education students, and the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. AB 100 allowed the state to shift these funds on a one-time basis,[66] and the $832 million in shifted funds are subject to repayment.

In addition to allowing the state to shift $832 million in funding from MHSA to other programs, AB 100 made several other changes to the state administration of the MHSA. Those most relevant to CAI's follow up of its 2010 Report are as follows: AB 100 eliminated the requirement that DMH and the MHSOAC annually review and approve expenditures for county MHSA plans[67]; it deleted the MHSA provision requiring counties to submit to the state an annual update for their three-year plan; and it deleted the requirement that the plans be approved by DMH after review and comment by the MHSOAC.[68]

AB 100 further amended the MHSA so that the state, rather than DMH, administers the MHSA Fund; post-AB 100, the Fund is continuously appropriated and funds are now appropriated to counties on a monthly basis rather than being released upon plan approval at the state level.

Finally, and importantly, AB 100 moved the responsibility for approving county MHSA programs from the state to the counties, and in so doing, "expect[ed] the state, in consultation with the Mental Health Services Oversight and Accountability Commission, to establish a more effective means of ensuring that county performance complies with the Mental Health Services Act."[69]

2. AB 989 (Mitchell)

In 2011, the legislature recognized that TAFY have unique circumstances and needs that may differ from the general TAY population when it passed AB 989 (Mitchell)[70], which was signed into law in October of that year. AB 989 amended the MHSA to require explicitly that "***county mental health programs shall consider the needs of Transition Age Foster Youth***"[71] in implementing California Welfare and Institutions Code section 5847(d), the provision of the MHSA which requires counties to include in their MHSA-funded programs services to address the needs of transition age youth ages 16–25.

3. AB 1467 (Committee on Budget)

AB 1467 (Committee on Budget) (Chapter 23, Statutes of 2012) was an omnibus health trailer bill for the 2012–13 state budget. While it did not make the major changes that AB 100 did the year before, it did amend the MHSA in several important ways. First, it requires counties to "demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations."[72]

Note that this provision, taken in concert with 2011's AB 989 (Mitchell) (discussed above), creates a substantial obligation for counties to ensure that the interests of TAFY are represented and considered throughout the entirety of the planning, implementation and evaluation processes associated with the MHSA.

Second, AB 1467 clarifies that counties must submit their MHSA Innovation plans to the MHSOAC for approval prior to expending any funds on these programs.[73] The MHSA Innovation component is now the only component that continues to require state-level approval.

Third, AB 1467 requires that county MHSA plans are certified by the county mental health director and the county auditor controller as complying with the MHSA.[74]

Finally, AB1467 requires that counties submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the MHSOAC within 30 days after adoption.[75]

B. Developments Impacting TAFY

1. The Federal Fostering Connections to Success Act & AB 12

As described in CAI's 2010 Report, President Bush signed the Federal Fostering Connections to Success and Increasing Adoptions Act into law in 2008.[76] The law makes a number of changes meant to improve foster care and the outcomes associated therewith. Chief among them and most notably for the purposes of this Report, the Fostering Connections Act gives states the option to continue providing Title IV-E reimbursable foster care, adoption, or guardian assistance payments to children up the age of 19, 20, or 21.[77] The Act requires that in order to be eligible for this extension, youth must meet one of five specified criteria: (1) completing secondary education or a program leading to an equivalent credential; (2) enrolled in an institution which provides postsecondary or vocational education; (3) participating in a program or activity designed to promote, or remove barriers to, employment; (4) employed for at least 80 hours per month; or (5) incapable of doing any of the above due to a medical condition.[78]

In 2010, California passed AB 12 to implements the Federal Fostering Connections to Success Act in California.[79] Under AB 12, a nonminor dependent is eligible for extended foster care. A nonminor dependent is defined as a nonminor who (1) has attained 18 years of age while under an order of foster care placement by the juvenile court or is under the transition jurisdiction of the juvenile court (as defined in Welfare and Institutions Code Section 450); (2) is in foster care under the placement and care responsibility of the county welfare department, county probation department, Indian tribe, consortium of tribes, or tribal organization that entered into an agreement pursuant to Section 10553.1; and (3) is participating in a transitional independent living case plan and as such satisfies one of five conditions of eligibility for extended foster care services.[80] A nonminor dependent must comply with one of the five conditions of eligibility enumerated in the federal law, discussed above.

AB 12 creates two new, more age appropriate living arrangements for nonminor dependents who are participating in AB 12. One is the Supervised Independent Living Placement (SILP), created for nonminor dependents who are ready to live rather independently and are fairly self-sufficient. A nonminor dependent must take a readiness assessment prior to placement in a SILP. The second placement type created for nonminor dependents is the Transition Housing Placement Plus Foster Care (THP-Plus FC) placement; these provides a number of specified services to nonminor dependents, perhaps including mental health services such as individual and group therapy and mentoring.[81] Some counties have already begun to incorporate MHSA-funded programs into their THP-Plus FC placements.

2. *Katie A.*

In 2002, a federal class action known as *Katie A.* was filed against the State of California and the County of Los Angeles on behalf of California foster youth and children at risk of out-of-home placement.[82] In December 2011, a Federal District Court Judge approved a proposed settlement in the case that seeks to accomplish systemic change for mental health services to children and youth within the class by promoting, adopting, and endorsing three new service array approaches for existing Medicaid covered services. Under the terms of the settlement agreement, California will make two types of mental health services, "Intensive Home-Based Services" and "Intensive Care Coordination," available to eligible children under Medicaid. These services include intensive mental health treatments such as wraparound, mobile crisis care, intensive case management, and several other services.[83] The December 2011 settlement agreement is expected to take three years to implement, meaning that California counties are in the midst of effecting the terms of *Katie A.* at this writing.

Katie A. is a significant development because it requires each county mental health department to work with its county child welfare department to assess the mental health needs specifically within the child welfare system and develop and implement a core practice model to ensure adequate and appropriate delivery mental health care services to foster youth and children at risk of out-of-home-placement. The case is also important because it demonstrates both the extent to which foster youth, and by extension TAFY, are at risk to develop severe mental illness or serious emotional disorders — and that, historically, the mental health services available to these youth have been profoundly inadequate. Many of the counties CAI reviewed for this Report were in the midst of extensive efforts to implement *Katie A*., some of which involve MHSA funding.

3. The Affordable Care Act

In 2010, President Barack Obama signed the Federal Patient Protection and Affordable Care Act (ACA) into law. The law overhauls the healthcare system in the U.S., and most of the major provisions will go into effect on January 1, 2014, including a provision that extends Medicaid coverage to youth who aged out of the foster care system up to age 26[84] (these youth were covered only up to age 21 prior to the ACA). In California, this means that youth who aged out of foster care are eligible for Medi-Cal up to age 26, beginning on January 1, 2014.

Well this is an important step forward for TAFY, it does not mean that they will not also require MHSA-funded services. Counties should consider this development when they are planning for MHSA expenditures and try to work with existing resources and services available to TAFY. MHSA funding is far more flexible than Medi-Cal funding and could supplement it well — if counties plan and utilize the funding to effectively serve this population.

4. Realignment of Child Welfare Services

In July 2011, the Legislature adopted a fiscal policy that shifts from the state to the county level a portion of the state sales tax, as well as responsibility for funding various programs. Included in those programs is Child Welfare Services, which—among other things—provides oversight and funding for the implementation of California's Fostering Connections.[85]

Realignment is cause for concern with regard to the availability of services for TAFY, particularly those between the ages of 21–25 and those who opt out of AB 12. This is because foster care is a federally-mandated program for which the federal government pays a portion under specified circumstances. California's budget realignment changes the process by which County Child Welfare Services programs are funded. Prior to realignment, the counties would pay a portion of foster care reimbursement payments, California would pay a portion, and, for

eligible children, the federal government would pay a portion. The state would set the priorities for funding and the funding would flow, according to those priorities, to the counties. After realignment, the federal government still pays its portion of the cost for foster care reimbursement payments to eligible children. However, instead of the California state government allocating budgets for child welfare services within each county, the state now provides a lump sum of money directly to the counties. Foster care maintenance reimbursement payments must come out of these funds. Under realignment, the counties are required to pay for foster care services with these lump sum funds they receive from the state each year. If the counties run out of money, they will have to take funding from other realigned services that are not federally-mandated. This means that other services that have been successfully serving TAFY may be cut if a county runs out of funding for foster care services.

Thus, if the counties have not created sufficient mental health services to meet the needs of TAFY (using, *e.g.*, MHSA funds), youth may be completely without a safety net if a county cuts vital foster care funding to other discretionary services currently available to TAFY who are not participating in, or have aged out of, AB 12.

IV. CAI's 2013 Review

During 2013, CAI reviewed ten diverse California counties to determine to what extent these counties are considering the needs of TAFY in planning and implementing programs funded by the MHSA and creating programs to serve TAFY. The counties that CAI reviewed are Alameda, Humboldt, Kern, Los Angeles, Merced, Orange, Riverside, Sacramento, San Diego, and San Joaquin. Most of the counties reviewed were continuing to provide the programs and services to the populations described in CAI's 2010 Report. Given the changes noted above, particularly the enactments of AB 12 and SB 989, the *Katie A.* settlement, and the increased responsibility entrusted to counties with regard to mental health and foster care services, CAI examined to what extent the counties are considering and addressing the needs of TAFY with their MHSA-funded programs and services. CAI's specific findings with regard to each county are presented in Section V, *infra*.

A. Criteria and Reasoning

CAI developed five criteria to utilize in its examination of the ten counties' MHSA-funded programs and the planning processes associated therewith. These criteria are drawn from the stated purpose and intent of the MHSA and subsequent legislation (AB 989) which requires counties to consider the needs of foster youth in their MHSA program planning process.

- **Does the County offer MHSA-Funded Programs Designed Exclusively for Transition Age Foster Youth?** While this is not necessarily indicative of a lack of meaningful consideration of the needs of TAFY, the absence of such a program, particularly in a large county, merits closer scrutiny. TAFY are a vulnerable and distinct population with unique needs related to mental health services. If there are not any programs created exclusively for TAFY, the county's mental health system must be more closely scrutinized to ensure that these needs are, in fact, being met adequately, which would require programming outside the MHSA.

- **What Type of TAFY Involvement was Included in MHSA Planning?** Stakeholder involvement has been a hallmark of the MHSA since its inception in 2004. Guidelines stress the importance of stakeholder input in the planning processes. More recently, AB 1467, which was enacted in 2012, requires counties to "demonstrate a partnership with constituents and stakeholders throughout the process that includes

meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations."[86] Given that TAFY are highly at risk to develop a serious emotional disorder or a severe mental illness, and that they are the state's own children, they are certainly stakeholders in the MHSA. The county must demonstrate that there is meaningful stakeholder involvement. If counties are not making efforts to ensure that TAFY are involved in MHSA planning, monitoring, and evaluation, they cannot credibly claim that TAFY are meaningfully involved in these processes. By extension, the county cannot credibly claim to be considering the needs of foster youth in their MHSA program planning process if they have not heard from TAFY about what those needs are.

- **Does the County Track TAFY Use of MHSA-Funded Programs?** A county must understand the extent to which TAFY are participating in its MHSA-funded programming so that county mental health officials fully comprehend the extent to which those services are meeting the needs of this unique population. For example, if there is a lack of TAFY participation in a particular program that designates these youth as a priority population, the implementing county must be aware of this deficiency so that it can effectively determine the cause and remedy the problem. The lack of participation may be an indication that there is an aspect of the program that needs to be modified and improved to better serve TAFY. Again, a county cannot credibly state that it is considering the needs of foster youth in their MHSA program planning process if they are not tracking TAFY use of the programs.

- **What Type of Collaboration is there with County Child Welfare Service Departments (Social Services)?** The county child welfare services department, tasked with the care of the county's foster youth, should know better than anyone, except the youth themselves, what the needs of TAFY are. Similarly, such departments should know what services are already available and where the holes are in the system — where MHSA funding would be the most beneficial for their clients. This collaboration and consultation with social services has taken on even greater importance with the passage and implementation of AB 12 and the *Katie A.* settlement. Thus, if a county's social services department is not prominently involved in planning for MHSA programs, the county cannot credibly state that they are considering the needs of TAFY.

- **Is there Any Meaningful Long-Term Outcome Analysis?** In its statement of purposes and intent, the MHSA states clearly that one of the primary purposes of the act is to "reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness."[87] It is not enough for counties simply to report the success of participants in MHSA-funded programs upon discharge. There is no way to know if a MHSA-funded program is, in fact, reducing the long-term adverse impact of mental illness unless counties have in place some mechanism to determine how participants are faring, for example, five years to ten years after discharge from the program. Thus, if a county is not doing any kind of significant longitudinal tracking and study of any TAFY who participate in its programs, the county cannot reliably claim that its programs are meeting the stated purposes and are consistent with the stated intent of the MHSA. Further, if a county cannot reliably claim that its program is serving the purpose of reducing the long-term adverse impact of mental illness, it cannot claim that it is considering the needs of the populations it is serving, in this case TAFY, because the county does not have reliable information that would indicate whether or not it is actually meeting those needs.

B. CAI's Conclusions and Recommendations

This Report is not intended to be a comprehensive review of the MHSA. It is intended only to examine how selected counties are utilizing MHSA funding to meet the needs of TAFY and whether these counties are truly considering the needs of TAFY in their MHSA planning and programming. Further, this Report is intended to make recommendations about how counties can improve their services to this population, and to provide information about what county practices have promise and should be replicated.

1) TAFY must be a priority; counties should explore additional approaches to designing more MHSA-funded programs to meet their unique needs.

None of the counties CAI reviewed had designed an MHSA-funded program exclusively for TAFY. While this is not necessarily indicative of a lack of meaningful consideration with regard to the needs of TAFY, it is an area where counties must devote some planning discussion and consideration. This is particularly true in cases where, for example, a county spends $8 million of MHSA funding on an education and public relations campaign — rather than using those funds to directly and meaningfully address the mental health needs of TAFY.

CAI recommends that counties continue to look at ways in which they can either design programs exclusively for TAFY or design programs that integrate them in an effective and meaningful way. The MHSA Innovation funding component provides counties with an opportunity to implement innovative programs — such as the Transition Life Coach program CAI proposed in its 2010 Report.[88]

2) Counties must have a TAY advisory board that includes a substantial number of TAFY, which the county should consult throughout the MHSA planning, implementation, and evaluation process.

The counties that CAI reviewed had varying degrees of involvement from TAFY in the MHSA planning activities. Merced, for example, pulled together TAFY from around the county into a large focus group and planning activity to ensure that their input was included in the design of MHSA programming. Alameda County and Humboldt County each have done extensive outreach to TAY in the community to create TAY advisory boards, and these boards have included TAFY to some extent. Some of the counties have programs that include peer mentoring, but the extent to which the youth participating in this peer mentoring (either as the mentors or as the mentees) is unclear. Further, because most of these counties do not track the participation in their programs, it is unclear to what extent transition age youth are involved in the evaluation piece of MHSA programs.

CAI recommends that counties strive to improve their efforts to include TAFY not only in the planning stage of MHSA-funded programs, but in the implementation and evaluation of these programs as well. TAFY are a valuable resource — their opinions and insights will help counties improve the MHSA programs and services designed to assist them. To this end, every county should convene a TAY advisory group which must include several TAFY. The county must meet regularly (at least six times a year) with its TAY advisory group, and it should consult its TAY advisory group on issues related to planning, implementation, and evaluation of MHSA programs.

3) Counties must track TAFY utilization of all MHSA-funded programs.

None of the ten counties reviewed by CAI track TAFY utilization of all available MHSA-funded programs in the county. However, San Diego County and some others are moving in the right direction by tracking TAFY utilization

of some programs, and Alameda County plans to start more thoroughly tracking TAFY utilization of its programs in 2014.

The MHSA now requires counties to consider the needs of TAFY when it is designing MHSA-funded programs for TAY. It is not possible for a county to understand the needs of a population if there is not complete data on to what extent available services are being utilized. If, for example, there is an MHSA-funded program which should be meeting the needs of TAFY, but none of these youth are participating, the county needs to know this so that it can begin to examine how and why this is the case. It is essential that a county understand to what extent TAFY are utilizing its MHSA-funded services, before it can meaningfully and fully consider the needs of this population.

CAI recommends that counties track TAFY utilization of all of MHSA-funded programs.

4) County departments of mental health must collaborate closely with county child welfare departments throughout the planning, implementation, and evaluation of MHSA-funded programs

The counties CAI examined engaged in varying degrees of collaboration and consultation with the county child welfare departments in planning and implementing MHSA-funded programs. While most counties at least consulted county child welfare departments in the planning phase, coordination with county child welfare varies with the actual implementation and evaluation of programs. Currently, progress is being made in this area. The *Katie A.* settlement has led to increased collaboration between county mental health departments and county child welfare departments. Most counties include county child welfare departments in the planning stages of their MHSA-funded plans. Alameda County is making strides with its TAY System of Care, which requires extensive collaboration between county mental health and county child welfare departments. Los Angeles County is also moving in the right direction here, largely due to its efforts around *Katie A.*

CAI recommends that the county departments of mental health and child welfare departments continue to collaborate more closely not only in the planning but in the implementation and evaluation of MHSA-funded programming for TAFY. This has taken on increased importance in light of the passage of AB 12; TAFY need to know about the MHSA-funded programs available to them and understand how and when to access and utilize them not only while they are in care, but also once they leave foster care, whether that is at age 18 or at age 21. Increased collaboration and cooperation between county mental health departments and child welfare services could ensure that MHSA-funded programs and other mental health programs are effectively developed, and delivered to the TAFY who need them.

5) Counties must collect longitudinal outcome data on TAFY who participate in their MHSA-funded programs.

None of the counties that CAI reviewed had any longitudinal outcome data related to TAFY who had participated in any of their MHSA-funded programs. This is a glaring oversight for two reasons. First, there is no way to know if MHSA-funded programs are serving the Act's stated purpose of "reducing the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness" if there is no data available with regard to the long-term impact of those programs. Second, a county cannot reliably claim that it is considering the needs of TAFY if it does not know whether the programs created to address those needs are successful over the long term.

CAI recommends that all counties implement a mechanism to gather longitudinal outcome data for TAFY who participate in their MHSA-funded programs.

6) Counties should use opportunities created by improvements in child welfare and healthcare programs to improve and expand the reach of MHSA programs to TAFY.

Several encouraging developments have occurred over the past three years regarding increasing the availability of mental health services to foster youth. However, none of these recent developments — including AB 12, *Katie A.*, or the ACA — excuse counties from any obligation to design and implement MHSA-funded programs to serve TAFY. In fact, the availability of these programs underscores the importance and the responsibility of county mental health departments to collaborate with county child welfare departments, consult with TAFY, and take meaningful steps to consider the needs of TAFY throughout the process of planning, implementing and evaluating MHSA-funded programs. The above-mentioned programs represent progress and create opportunities for counties to utilize MHSA funding to help bolster services for TAFY.

Additionally, the extension of foster care to age 21 in particular highlights the need for appropriate services for transition age (former) foster youth ages 21–25. County mental health departments must look specifically at the needs of TAFY between the ages of 21–25 who face a gap when they age out of foster care; at that point, they are no longer in foster care and no longer have access to many of the resources associated therewith, but many will still be struggling with various issues, including mental health issues, and will not yet be self-sufficient.

7) TAFY, advocates, and agencies need to know the members of their county board of supervisors and engage them frequently on TAFY issues.

Given the recent amendments to the MHSA, counties have far more power with regard to approving MHSA funding and plans than does the state, and if advocates and TAFY want to ensure that they are heard, they must become familiar with their county board of supervisors and county decisionmaking processes. CAI would recommend that TAFY, organizations that advocate for TAFY, and agencies that serve them know who their county supervisors are, know their county supervisors' staff, and be familiar with the process by which counties plan and approve MHSA-funded programs (this is also true of other mental health and child welfare services programs) (see Appendix C for the web addresses for each of California's County Board of Supervisors).

8) County Boards of Supervisors need to know and engage TAFY to identify issues and needs.

Over the course of the past three years, the state legislature has given enormous responsibilities to California's counties and to their boards of supervisors with regard to approving MHSA funding. County supervisors should undertake efforts to learn about the needs of the TAFY in their counties. The county supervisors should pay particularly close attention to the needs of those TAFY who have aged out of the foster care system (ages 21–25) or have opted out of extended foster care. These youth are all too often ignored as larger, well-funded and well-organized groups take up time and space on meeting agendas and supervisors' schedules.

9) An extensive independent audit must be conducted of the MHSA, use of MHSA funds, and the legality of recent amendments to the MHSA.

Finally, statewide implementation of the MHSA has been marred with questionable practices. In 2013, the California State Auditor recently released the results of an audit of the MHSA.[89] The audit found several issues with

MHSA oversight, guidance and accountability; the enactments of AB 100 and AB 1467 have the potential to lead to even more of these practices. There is a strong need for a comprehensive review of California's administration and oversight of the Mental Health Services Act, and that of California's counties. Every misappropriation of MHSA funding takes money from the vulnerable populations that this fund was intended to assist. The number of questionable practices that have been observed and reported merits a much deeper investigation into the issue, to protect both the vulnerable populations that this fund was meant to assist, the voters who expressed a very clear intent when they approved the MHSA and again when they rejected proposition 1E.

V. Counties Reviewed: Analysis

A. Alameda County

Alameda County was home to approximately 1,933 TAFY in July 2013.[90] This includes youth who had either aged out of foster care in Alameda County since 2006 (ages 18–25) or who are currently in foster care in Alameda County and are between the ages of 16–21. Conservatively assuming that 23% of the TAFY in Alameda County have mental health issues, approximately 445 potentially would qualify for MHSA-funded services.

Alameda County is unique for two important reasons. First, Alameda County has a Transition Age Youth (TAY) System of Care in addition to its adult system of care and its children's system of care. Second, the County began to build this system of care in 2003, just one year prior to the passage of the MHSA and as such, it had a number of services for Transition Age Foster Youth either in place or in development at the time that the MHSA took effect in 2004. Because of these new services and the MHSA's prohibition on supplantation, Alameda County did not initially direct a large portion of MHSA funds to the TAY population.

Alameda County's TAY System of Care. Due to the timing of Alameda County's development of its TAY system of care, this analysis of Alameda County's use of MHSA funding to address the needs of TAFY will include a discussion of the county's TAY system of care and it will consider the programs provided thereby. Alameda County's TAY system of Care encompasses a number of programs that serve TAFY along with several other transition age youth populations. Between 2003–05, Alameda County undertook to greatly expand the mental health services it offered to the county's large transition age youth population. To accomplish this expansion, Alameda County used Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) funding to create nine mental health programs, at a cost of $14 million, for TAFY. Appendix B contains a chart which details the programs and funding sources associated with Alameda County's TAY System of Care.

Alameda County undertook efforts to include the voice of TAY and TAFY, in particular, in its expansion of the TAY system of care. These efforts included convening 18 focus groups around Alameda County designed to elicit feedback and opinions from transition age youth with regard to needed services and the creation of effective programs. The county did not provide specific numbers of how many of the TAY consulted were TAFY; however, the focus groups included groups at TAFY-serving organizations such as Fred Finch and the California Youth Connections. The county also formed a stakeholder group, which included social services, foster youth, and foster care providers. A development of note that came from the county's stakeholder and planning process for the TAY system of care, was the creation of the TAY Initiative (TAY-I), Alameda County's TAY advisory board consisting of TAY representing a number of different perspectives and includes several alumni of foster care.

Analysis: To What Extent Is Alameda County Considering the Needs of TAFY?

- **MHSA-Funded Programs**. Alameda County is unique in that it has created a TAY System of Care (discussed above and detailed in Appendix B). The TAY System of Care includes mental health programs created specifically for TAFY, some of which are funded, at least in part, by the MHSA.

- **Consultation with TAFY / Outreach and Engagement in Planning**. Alameda County has created the TAY-I (Transition Age Youth Initiative), which is a group of TAY, including several TAFY, that advises Alameda County Mental Health on issues related to TAY and who weigh in on the planning process for MHSA expenditures and other expenditures related to TAY mental health in Alameda County. This group is included in stakeholder meetings and in various different aspects of planning. TAY-I designed one of Alameda County's funded Innovation projects (it is not currently included in the listing of programs because the funding to the program has ended).

- **Tracking TAFY Use of MHSA-Funded Programs.** Alameda County has not tracked usage of its MHSA-funded programs specific to TAFY; however, the county plans to begin tracking this data in 2014.[91]

- **Collaboration with Child Welfare Services.** Alameda County has a TAY System of Care, which is unique among California's counties. The TAY System of Care provides a number of benefits not only for Transition Age Foster Youth, but also for other TAY in the county. It focuses on the individuals rather than the systems from which they entered to ensure that the individual is receiving the care that he or she requires. Officials in both the Alameda County Department of Behavioral Health and the Alameda County Child welfare services meet and collaborate on a regular basis to ensure that their clients are receiving the most effective and appropriate services, regardless of the system from which they are coming.

- **Meaningful Long-Term Outcome Analysis.** On paper, Alameda County appears to be doing exceptionally well in its approach to serving TAFY with MHSA Funds. Unfortunately, at this time there is no way to reliably determine with any confidence whether or not this approach is working as well as it appears that it should. This is because, as is the case with all ten of the counties at CAI examined, Alameda County fails to do any longitudinal tracking of the outcomes in any of the programs it has designed to serve TAFY. The MHSA was enacted specifically to "reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness."[92] Thus, there must be some kind of indication as to whether or not MHSA-funded programs are actually serving the purposes for which they were intended. Given Alameda County's ambitious approach to meeting the needs of TAY in general and TAFY in particular, it seems that this is a disservice not only to Alameda County, but to other counties who would greatly benefit from data indicating whether such approaches are successful over the long term.

B. Humboldt County

Humboldt County is a small county, and was home to approximately 152 TAFY in July 2013. [93] This includes youth who had either aged out of foster care in Humboldt County since 2006 (ages 18–25) or who are currently in foster care in Humboldt County and are between the ages of 16–21.

One distinguishing characteristic of Humboldt County with regard to TAFY is that the county is home to one of the only two-year community colleges (College of the Redwoods) in California that offers housing to its students.[94] This access to housing may lead more nonminor dependents to move to Humboldt County. Several mental health-related issues may present when TAFY first move into a more independent placement such as a dormitory. These may include problems with medication management, depression, and other issues related to difficulties adjusting to a new and unfamiliar situation without the social and familial safety net on which most of their peers with no history of foster care can rely. To address this reality, Humboldt County is currently utilizing MHSA funding to assist TAFY and other TAY who are attending college in the county. MHSA funding is used to provide TAFY attending college in the county with a social worker, to meet the needs of TAFY while in county. Counseling, case management, flexible funding and other services are also provided as needed.[95] The county should continue this, and continue to look at ways in which it can utilize MHSA funding to serve TAFY who are participating in AB 12 as well as those TAFY who have chosen to opt out of extended foster care, to ensure that they do not slip through the cracks.

The TAY services that are funded in Humboldt County generally serve a variety of priority populations of which TAFY is one. The County uses a braided funding approach to fund its TAY programs, with funding coming from several sources, including the MHSA.[96] While Humboldt County's outreach and engagement efforts to the TAFY population have been strong, it does not have any MHSA-funded programs that are created solely and specifically to serve TAFY. However, the County does has several MHSA-funded programs from which TAY and TAFY may benefit.

Analysis: To What Extent Is Humboldt County Considering the Needs of TAFY?

- **MHSA-Funded Programs.** Humboldt County has not created any programs with MHSA funding exclusively to serve Transition Age Foster Youth. According to the county, this is due to consultation with Transition Age Foster Youth, who requested that services be provided to all TAY to reduce the stigma that may be related to foster care. This is an area in which the county should continue to consult with their Transition Age Foster Youth advisors and monitor need, particularly given the recent implementation of AB 12 for this county in particular, and as the county proceeds with *Katie A.* implementation.

- **Consultation with TAFY / Outreach and Engagement in Planning.** Humboldt County's strength is in its efforts to reach out to TAY and include their input, perspectives and experiences in their planning processes. This approach is applied to with MHSA funds as well as programs created in other areas of Humboldt County's Department of Health and Human Services.

  In 2008, Humboldt County embarked upon an extensive outreach and engagement campaign designed to involve TAY in the planning and design of MHSA and other programs to serve that TAY and ensure that those who could benefit from the services offered by Humboldt County's Health and Human Services Departments were aware of the services and how to access them. The effort was not funded entirely by MHSA funding and was not created solely and specifically for TAFY. It began with the creation of the Humboldt County Transition Age Youth Collaborative (HCTAYC). The TAFY population in Humboldt County has been very active in HCTAYC and its ongoing activities. The California Youth Connection (CYC), comprised of current and former foster youth, was one of the organizations heavily involved with the formation HCTAYC. The HCTAYC was started in 2008 with five years of funding dedicated to engaging TAY in the creation and improvement of systems, including mental health, and delivery of services. The most recent county budget continues funding for HCTAYC.[97] Also encouraging is Humboldt County's collaboration with foster youth advocacy organizations like Youth in Mind, and the Y.O.U.T.H. training project.

  The HCTAYC was instrumental in developing Humboldt County's MHSA-funded PEI Transition Age Youth Partnership Program and continues to play an important role in the program.[98] TAFY have had a voice in the development and functioning of this program from the beginning, due to the County's outreach and collaboration with CYC and the HCTAYC as a part of the program development and administration. Humboldt County's Transition Age Youth Partnership Program includes three elements: Transition Age Youth Plus, Transition Age Youth Advocacy, and Transition Age Youth Education and Outreach.[99] The program brings together representatives from mental health, public health and social services to identify potential evidence-based practices from which TAY may benefit; (2) advocate for TAY in Humboldt County; and (3) provide youth-led trainings focusing on TAY experiences in human services and empower youth to advocate for change.[100]

  Although it is small, Humboldt County provides an excellent model to which other counties can look as they undertake efforts to include TAFY perspectives and experiences in their MHSA programming and planning processes.

- **Tracking TAFY Use of MHSA-Funded Programs.** Humboldt County does not track the number of TAFY served in all MHSA-funded programs each year. However, the County does track TAFY participation in its MHSA-funded TAY and innovation programs.[101]

- **Collaboration with Child Welfare Services.** Humboldt County has performed well with regard to including TAFY in its planning and has taken steps to effectively communicate with social services regarding the needs of TAFY in the County. The county has a TAY division, which includes co-located behavioral health services, independent living skills and peer mentorship services.[102] The TAY division has a weekly joint case consultation that focuses specifically on TAFY who are receiving services from both the behavioral health unit and the ILS units.[103]

  Humboldt County's Child welfare services agency is included in the MHSA-funded Transition Age Youth Partnership. Finally, the County holds a bi-monthly multi-disciplinary team meeting to discuss AB 12 youth. The continued cooperation and coordination between Child Welfare Services and the Department of Mental Health with regard to TAFY is especially important in this County, given the recent passage and ongoing implementation of AB 12.

- **Meaningful Long-Term Outcome Analysis.** Humboldt County does not have any information on the long-term impact of its MHSA-funded programs, including those programs that serve TAFY. However, the County is currently in the process of implementing one program which will generate longitudinal outcome data for participants in that program. The program will serve TAFY along with other populations.[104]

C. Kern County

Kern County was home to approximately 1,107 TAFY in July 2013.[105] This includes youth who had either aged out of foster care in Kern County since 2006 (ages 18–25), or who are currently in foster care in Kern County and are between the ages of 16–21.

Since CAI's 2010 Report, Kern County has developed one PEI program exclusively for TAFY.[106] The Future Focus Program targets emancipated foster youth to address the needs specific to successful transition into adulthood.[107] Future Focus is a 90-day program which provides a temporary place of shelter, while assisting TAFY to develop life skills, receive psychotherapy, and learn social and community engagement skills so that they can successfully obtain stable financial stability in the community.[108] The Future Focus Program served 40 TAFY in 2011–12.

The TAY Program in Kern County utilizes a TAY Team, which works with 80–120 TAY at any time. TAFY are one of the priority populations for this program. The program includes a drop-in center, assistance with studies, case management, flexible funding, a housing component, and therapy. The County is currently working on developing a mentoring program. Specifically, regarding TAFY, the TAY Team has started to work with child welfare services to address the needs of AB 12 nonminor dependents.

Analysis: To What Extent Is Kern County Considering the Needs of TAFY?

- **MHSA-Funded Programs.** Kern County has improved its performance since CAI examined the County in 2010 in that it has created one program, Future Focus, specifically to meet the needs of TAFY. Additionally, the County has focused a great deal of attention on TAFY in another of its programs, WeCAN, with its TAY Program and TAY Team.

- **Consultation with TAFY / Outreach and Engagement in Planning.** Kern County has engaged in various outreach efforts that targeted TAFY. The County made efforts to schedule some of their stakeholder and planning meetings at times that would accommodate the schedules of TAFY who may be at work or at school during the times that these meetings may ordinarily be scheduled. In addition, the County's Mental Health Department sent flyers to agencies to encourage TAFY to attend and participate in planning and stakeholder meetings. The Department also undertook efforts to encourage TAFY clients to attend and participate in these meetings. The County also consulted with a group of TAY, which has since disbanded; the County is undertaking efforts to recruit other TAY with which they can consult, and is making efforts to include TAFY in this group.[109] Kern County's efforts are commendable, but it could go farther to ensure that it is reaching TAFY by, for example, working with organizations like CYC which advocate for TAFY in Kern County.

- **Tracking TAFY Use of MHSA-Funded Programs.** Kern County tracks how many TAFY participate in the Future Focus Program because the program was designed specifically for this population. The County also tracks how many TAFY participate in the housing component of the TAY program. However, the County does not track TAFY usage of the other MHSA-funded programs, whether they serve TAY or a broader population. The County must track this information so that it will have a better understanding of the needs of TAFY, identify which programs are underserving TAFY where the population would benefit from access to the program, and identify areas where the County needs to improve its outreach to TAFY.

- **Collaboration with Child Welfare Services.** Kern County has not collaborated with child welfare services to the extent that some of the other counties herein examined have. However, the County has started to collaborate with child welfare services to address the needs of TAFY who are participating in AB 12, particularly with regard to the housing component of the MHSA-funded TAY program. The County must continue to build on this cooperation and communication as the implementation of both the MHSA and AB 12 move forward.

- **Meaningful Long-Term Outcome Analysis.** Kern County does not have any information on the long-term impact of its MHSA-funded programs, including those programs that serve TAFY. This is oversight must be remedied. Long-term analysis examines the impact of MHSA-funded programs in the years following a participant's exit from the program. There is no way to know if MHSA-funded programs are serving the Act's stated purpose of "reducing the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness" if there is no data available with regard to the long-term impact of those programs. Further, Kern County cannot adequately assess or consider the needs of TAFY, as the law requires,[110] without information about how the programs it has created to address those needs are performing over the long-term. Kern County must put in place a process by which it can assess the long-term impact of its MHSA funded programs on TAFY who participate in these programs.

D. Los Angeles County

Los Angeles County has the largest population of foster children and youth in the nation. The County was home to approximately 12,772 TAFY in July 2013.[111] This includes youth who had either aged out of foster care in Los Angeles County since 2006 (ages 18–25) and those who are currently in foster care in Los Angeles County and are between the ages of 16–21.

Los Angeles County Mental Health has a Transition Age Youth Division that focuses on the TAY population. The County has identified several priority populations on which to focus its MHSA-funded TAY programming. The priority populations are as follows:

- TAY struggling with substance abuse disorders;
- TAY who are homeless or at risk of becoming homeless
- TAY who are aging out of the children's mental health, child welfare, or juvenile justice systems
- TAY leaving long-term institutional care
- TAY experiencing their first episode of major mental illness

Los Angeles County is currently undertaking a large effort to implement several mental health programs designed to provide mental health services to foster youth pursuant to the settlement agreement in *Katie A.*[112]

In addition to MHSA-funded services for TAY, and *Katie A.* programs, Los Angeles County has several other programs from which TAFY may benefit. For example, the County operates an Independent Living Program which incorporates mental health services.

Analysis: To What Extent Is Los Angeles County Considering the Needs of TAFY?

- **MHSA-Funded Programs.** Despite having the largest foster care population in the nation, Los Angeles County has not used MHSA funding to create even one program exclusively to meet the needs of this population. The closest Los Angeles County has come to a MHSA-funded program for TAFY is its MHSA-funded Tier II Wraparound program that serves primarily children and youth involved with the Department of Children and Family Services (DCFS).

- **Consultation with TAFY / Outreach and Engagement in Planning.** Los Angeles County has undertaken efforts to reach out to TAY in general by creating Transition Age Youth Advisory Groups (TAYAG). These are County-wide and may include TAFY at some of the independent living programs (ILPS) that serve Transition Age Foster Youth and Probation TAY. TAYAG are intended to provide a means by which TAY can incorporate their perspectives, voices and input in the planning, development and evaluation of services and supports that are provided to them. TAYAG facilitate communication between TAY consumers and staff to encourage advocacy, recovery and the use of outpatient mental health services.

- **Tracking TAFY Use of MHSA-Funded Programs.** Los Angeles County has no MHSA-funded programs designed exclusively for TAFY, and it does not track TAFY use of its MHSA-funded programs.[113]

- **Collaboration with Child Welfare Services.** Los Angeles County does not have a TAY System of Care, as exists in Alameda County (see above). However, the Transition Age Youth Division of the Los Angeles Department of Mental Health does collaborate on a regular basis with the Los Angeles County child welfare services with regard to both planning and implementation of MHSA-funded programs, *Katie A.* programming, and EPSDT-related mental health services for TAFY.

- **Meaningful Long-Term Outcome Analysis.** Los Angeles County does not have any information on the long-term impact of its MHSA-funded programs, including those programs that serve TAFY.[114] This is a profound oversight — particularly in light of the size of the County's TAFY population. Meaningful long-term analysis would examine the impact of MHSA-funded programs in the years following a participant's discharge from the program. There is no way to know if MHSA-funded programs are serving the Act's stated purpose of "reducing the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness" if there is no data available with regard to the long-term impact of those programs. Further, Los Angeles County cannot adequately assess or consider the needs of TAFY, as the law requires,[115] without information about how the programs it has created to address those needs are performing over the long-term. Los Angeles County must put in place a process by which it can assess the long-term impact of its MHSA-funded programs on TAFY who participate in these programs.

E. Merced County

Merced County was home to approximately 370 TAFY in July 2013.[116] This includes youth who had either aged out of foster care in Merced County since 2006 (ages 18–25) or who are currently in foster care in Merced County and are between the ages of 16–21.

Analysis: To What Extent Is Merced County Considering the Needs of TAFY?

- **MHSA-Funded Programs.** Merced County has not created any programs to serve TAFY exclusively. While the MHSA-funded CUBE program was actually designed specifically for TAFY, it does not serve TAFY exclusively, as other TAY populations are able to participate in the program as well.[117]

- **Consultation with TAFY / Outreach and Engagement in Planning.** Merced County has done extensive outreach to TAFY in designing its programs. The County has a TAY resource center and a large proportion of

the population served by the center is comprised of TAFY. County officials meet monthly with TAY, including TAFY, to obtain feedback on planning activities and program implementation. The Merced County Department of Mental Health is currently developing a system to more effectively measure program outcomes and is consulting with TAY, including TAFY, in the development of this program. TAFY were also instrumental in the County's development of a program to provide transportation assistance to programs and meetings for TAY and in the development of the county's TAY mental health court.[118]

Further, the County held a CUBE kick-off in January 2009 and invited youth from group homes and foster care. There were approximately 40 in attendance. The CUBE was not named at the time and did not have any programming. The TAY in attendance at this event made suggestions and had discussions around issues such as the mission of the center, programming, and activities. From the event, a focus group was developed (which then became the Transitional Age Advisory Committee). The group synthesized the ideas and information, identified activities and community resources to be brought into the center, discussed rules of conduct to support a welcoming youth environment and selected a meaningful name of the center. All MHSA activities in Merced County include TAY and TAFY input. Finally, each year the County organizes an outcomes event in which TAY are a vital part. Focus groups, which include TAY and TAFY, are setup at the CUBE.

- **Tracking TAFY Use of MHSA-Funded Programs.** Merced County tracks TAFY usage of its TAY programs, and is currently in the process of developing a more comprehensive data-gathering system to examine outcomes.

- **Collaboration with Child Welfare Services.** Merced County has a Children's System of Care in which the County's Department of Mental Health collaborates extensively with Child Welfare Services. In addition, Child Welfare Services is involved in the stakeholder process in which MHSA plans are developed, and they are involved, as stakeholders, in regular meetings regarding the implementation of MHSA programs.[119]

- **Meaningful Long-Term Outcome Analysis.** Merced County does not have any information on the long-term impact of its MHSA-funded programs, including those programs that serve TAFY. The County has started putting plans in place to begin to track post-discharge data for clients in at least one of its programs.[120] This is an encouraging first step, but the County must ensure that it is tracking TAFY-specific outcome data for all of its MHSA-funded TAY programs. There is no way to know if MHSA-funded programs are serving the Act's stated purpose of "reducing the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness" if there is no data available with regard to the long-term impact of those programs. Further, Merced County cannot adequately assess or consider the needs of TAFY, as the law requires,[121] without information about how the programs it has created to address those needs are performing over time.

F. Orange County

Orange County was home to approximately 1,652 TAFY in July 2013.[122] This includes youth who had either aged out of foster care in Orange County since 2006 (ages 18–25) or who are currently in foster care in Orange County and are between the ages of 16–21.

Analysis: To What Extent Is Orange County Considering the Needs of TAFY?

- **MHSA-Funded Programs.** Orange County has not designed any MHSA-funded programs exclusively to serve TAFY.[123]

- **Consultation with TAFY / Outreach and Engagement in Planning.** It is not clear to what extent Orange County has done outreach with TAFY. The County held numerous stakeholder meetings, community forums, and focus groups throughout its planning process. The Steering Committee has 65 members, and notes that some of its members are from child welfare. The Steering Committee is divided into Subcommittees that are organized by MHSA component and by each of the age groups within Community Services and Supports.[124]

One Subcommittee is CSS Children and TAY, but it is not clear how many (if any) TAFY are on this Subcommittee. The County also has a Community Action Advisory group, which meets monthly and provides input into the MHSA planning process.[125] Again, it is not clear how many, if any TAFY are on this Advisory Group.

- **Tracking TAFY Use of MHSA-Funded Programs.** While Orange County tracks the numbers of clients it serves in its programs, it does not specifically track TAFY use of its MHSA-funded programs.

- **Collaboration with Child Welfare Services.** To some extent there is a Social Services (child welfare) presence on the Steering Committee that contributes to Orange County's MHSA planning process; this Committee meets six times a year (in odd-numbered months). Members of the Steering Committee (and members of the public) may join two subcommittees, one of which focuses on Children and Transition Age Youth. There is also a Social Services presence on this Subcommittee, which meet six times a year (in even-numbered months).[126] The County also maintains a Community Action Advisory group comprised of "consumers and family members"; this group meets monthly and provides input to the Steering Committee and the MHSA planning process. Although there may be Social Services involvement with these bodies, there is no indication that there are any AB 12-eligible foster youth, former foster youth, or other TAFY participating on the Steering Committee or in the Community Action Advisory group.[127]

- **Meaningful Long-Term Outcome Analysis.** Orange County does not have any information on the long-term impact of its MHSA-funded programs, including those programs that serve TAFY.[128] This oversight must be addressed. Long-term analysis examines the impact of MHSA-funded programs in the years following a participant's exit from the program. There is no way to know if MHSA-funded programs are serving the Act's stated purpose of "reducing the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness" if there is no data available with regard to the long-term impact of those programs. Further, Orange County cannot adequately assess or consider the needs of TAFY, as the law requires,[129] without information about how the programs it has created to address those needs are performing over time. Orange County must put in place a process by which it can assess the long-term impact of its MHSA-funded programs on TAFY who participate in these programs.

G. Riverside County

Riverside County was home to approximately 2,748 TAFY in July 2013.[130] This includes youth who had either aged out of foster care in Riverside County since 2006 (ages 18–25) or who are currently in foster care in Riverside County and are between the ages of 16–21.

In addition to the CSS and PEI programs that Riverside County had in place when CAI released its 2010 Report, the County has designed several programs funded with MHSA Innovation funds, including the Recovery Arts Core Project, Recovery Learning Center, Family Room Project, and Older Adult Self-Management Health Team Project.[131] Although none of these programs were designed exclusively for TAFY, the TAY age group is one of several populations served in these new projects.

Analysis: To What Extent Is Riverside County Considering the Needs of TAFY?

- **MHSA-Funded Programs.** Riverside County has not designed any programs exclusively for TAFY. Since 2010, the County has continued its CSS and PEI programs, and has added three programs funded with MHSA Innovation dollars. Although TAFY may benefit from at least three of the four programs by virtue of being in the TAY age group, none of Riverside County's Innovation programs were created exclusively for TAFY.

- **Consultation with TAFY / Outreach and Engagement in Planning.** Riverside County organized a TAY Collaborative, which includes several members who had experience in the foster care system. This collaborative was heavily involved in the initial planning for the MHSA. Currently, MHSA Planning Committees

meet monthly. One of these planning committees is the TAY planning committee. The County's 2013–14 update notes that consumer and family member perspectives are included in the stakeholder process as their representation and participation is a membership requirement for all the MHSA Committees, but does not specify whether TAFY have been actively involved in any of these committees. Finally, Riverside has done outreach to elicit TAY feedback to the participants in the TAY FSP, which include TAFY, and has worked with CYC.[132]

- **Tracking TAFY Use of MHSA-Funded Programs.** Riverside County tracks foster youth in some of its programs, but not all of them. TAFY participation will be tracked if they are participating in Riverside County's Children's Integrated Service Program, which provides Multidimensional Treatment Foster Care. However, the County generally does not track participation rates specific to TAFY in MHSA-funded programs. Notably, TAFY participation is not specifically tracked in the MHSA-funded TAY programs.

- **Collaboration with Child Welfare Services.** Riverside County has worked with Child Welfare Services in the design of the County's MHSA Wraparound programs and is collaborating with Child Welfare Services to expand mental health programs for foster youth, including TAFY, pursuant to the *Katie A.* settlement agreement.[133]

- **Meaningful Long-Term Outcome Analysis.** Riverside County does not have any information on the long-term impact of its MHSA-funded programs, including those programs that serve TAFY. This oversight must be addressed. Long-term analysis examines the impact of MHSA-funded programs in the years following a participant's exit from the program. There is no way to know if MHSA-funded programs are serving the Act's stated purpose of "reducing the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness" if there is no data available with regard to the long-term impact of those programs. Further, Riverside County cannot adequately assess or consider the needs of TAFY, as the law requires,[134] without information about how the programs it has created to address those needs are performing over time. Riverside County must put in place a process by which it can assess the long-term impact of its MHSA-funded programs on TAFY who participate in these programs.

H. Sacramento County

Sacramento County was home to approximately 2,537 TAFY in July 2013.[135] This includes youth who had either aged out of foster care in Sacramento County since 2006 (ages 18–25) or who are currently in foster care in Sacramento County and are between the ages of 16–21.

Sacramento County continues to lack any MHSA-funded programs designed exclusively for TAFY as of this writing. However the County does have one MHSA-funded PEI program — Independent Living 2.0 — for which the vast majority of the participants in the program are TAFY.[136] The number of TAFY served by Sacramento MHSA programs has increased substantially since 2010.

Additionally, since CAI's 2010 Report, Sacramento has designed a program funded with MHSA Innovation dollars. The project, the Respite Partnership Collaborative project, awards grants to local non-profit agencies to increase mental health respite service options and offer alternatives to psychiatric hospitalization. To date, seven grants have been awarded, including TAY mental health respite program planned for implementation in late 2013 from which TAFY may benefit.[137]

Analysis: To What Extent Is Sacramento County Considering the Needs of TAFY?

- **MHSA-Funded Programs.** While Sacramento County has not designed any programs exclusively for TAFY, the County's Independent Living 2.0 program comes very close. The program serves foster youth, former foster youth and non-foster homeless and LGBTQ youth. The vast majority of the participants in this program are

TAFY; in 2012–13, 435 individuals, representing 93% of the participants in the Independent Living 2.0 program, were TAFY.[138]

- **Consultation with TAFY / Outreach and Engagement in Planning.** Sacramento elicits stakeholder input during its planning process. However, there is no indication that the County has made efforts to reach out to TAFY or organizations that advocate for TAFY to get input, or to find TAFY to participate in stakeholder meetings.

- **Tracking TAFY Use of MHSA-Funded Programs.** Sacramento tracks TAFY participation in most of its MHSA-funded programs and was readily able to provide information about how many TAFY were participating in its programs. The County's performance in this area far exceeds most of the others we examined.

- **Collaboration with Child Welfare Services.** The Sacramento Department of Mental Health coordinates with the County Child Welfare Services Agency and provides foster youth, including TAFY, with MHSA-funded programs — the WRAP programs (40% of the total TAY served in 2012–13 were TAFY) and intensive mental health services through the Transition Age Program (TAP). Additionally, the following non-MHSA programs are administered through cooperation and coordination between Child Welfare Services and the Department of Mental Health: the Flexible Integrative Treatment program (5% of TAY served were TAFY), the Youth Permanency Program (31% of the TAY served were TAFY), and the Another Choice, Another Chance program (10% of the TAY served were TAFY).[139]

- **Meaningful Long-Term Outcome Analysis.** Sacramento County collects outcome data on its programs and tracks the progress of program participants. However, it does not have any information on the long-term impact of its MHSA -funded programs, including those programs that serve TAFY. This oversight must be addressed. Long-term analysis examines the impact of MHSA-funded programs in the years following a participant's exit from the program. There is no way to know if MHSA-funded programs are serving the Act's stated purpose of "reducing the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness" if there is no data available with regard to the long-term impact of those programs. Further, Sacramento County cannot adequately assess or consider the needs of TAFY, as the law requires,[140] without information about how the programs it has created to address those needs are performing over time. Sacramento County must put in place a process by which it can assess the long-term impact of its MHSA-funded programs on TAFY who participate in these programs.

I. San Diego County

San Diego County was home to approximately 2,575 TAFY in July 2013.[141] This includes youth who had either aged out of foster care in San Diego County since 2006 (ages 18–25) or who are currently in foster care in San Diego County and are between the ages of 16–21.

Since CAI's 2010 Report, San Diego County has created an innovation program that represents a large portion of the County's MHSA Innovation Funding ($1.8 million per year); the Transition and Foster Youth Program, which was designed to enhance life skills, increases self-sufficiency and self-esteem, improves behavioral and mental health conditions, and overall wellness for TAY and Foster Youth.[142] The program has three components (coaching, mentoring, and teaching), and activities focus on education/higher education, vocational training, comprehensive independent living skills, and employment preparation and supports.[143] Though TAFY are a major target group of this population and the program design specifies that one half of the participants are expected to be TAFY, it was not designed exclusively for this unique population.

Analysis: To What Extent Is San Diego County Considering the Needs of TAFY?

- **MHSA-Funded Programs.** San Diego County has not created any MHSA-funded programs exclusively for TAFY. Although its new innovation program (discussed above) names TAFY as a major target population, and despite

extensive advocacy by TAFY themselves and by organizations advocating for and supporting them, the County did not design the program specifically for TAFY.

- **Consultation with TAFY / Outreach and Engagement in Planning.** San Diego County Mental Health funds programs at the TAY Academy. The TAY and Foster Youth program that San Diego County created with MHSA Innovation funding is administered by San Diego Youth Services and located at the TAY Academy. The TAY Academy has a group of TAY, some of whom are TAFY, that provide the County with opinions, feedback, and information related to TAY programming, including MHSA TAY programming. Also, a number of TAFY participated in stakeholder meetings and in public hearings in San Diego regarding MHSA funding decisions; however, those meetings were often held at times and in places that were difficult for TAFY to access and attend.

- **Tracking TAFY Use of MHSA-Funded Programs.** San Diego County tracks foster children and TAY who participate in its MHSA-funded FSPs and it tracks the participation of TAFY in its MHSA-funded Transition Age and Foster Youth Innovation program discussed above.[144] However, the County does not specifically track TAFY participation in any of its other MHSA-funded programs.

- **Collaboration with Child Welfare Services.** San Diego County does not have a TAY System of Care such as exists in Alameda County (discussed above). The TAY population is a focus of both the Children's System of Care and the Adult System of Care in San Diego County. The County has a TAY work group that brings together members of both of these systems of care and includes the County's Child Welfare Services Agency, County Behavioral Health, and several agencies around the County that serve at-risk TAY, including TAFY.

- **Meaningful Long-Term Outcome Analysis.** San Diego County collects outcome data on its programs and tracks the progress of program participants. However, it does not collect any substantial information on the long-term impact of its MHSA-funded programs, including those programs that serve TAFY. This oversight must be addressed. Long-term analysis examines the impact of MHSA-funded programs in the years following a participant's exit from the program. There is no way to know if MHSA-funded programs are serving the Act's stated purpose of "reducing the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness" if there is no data available with regard to the long-term impact of those programs. Further, San Diego County cannot adequately assess or consider the needs of TAFY, as the law requires,[145] without information about how the programs it has created to address those needs are performing over time. San Diego County must put in place a process by which it can assess the long-term impact of its MHSA-funded programs on TAFY who participate in these programs.

J. San Joaquin County

San Joaquin County was home to approximately 807 TAFY in July 2013.[146] This includes youth who had either aged out of foster care in San Joaquin County since 2006 (ages 18–25) or who are currently in foster care in San Joaquin County and are between the ages of 16–21.

Analysis: To What Extent Is San Joaquin County Considering the Needs of TAFY?

- **MHSA-Funded Programs.** San Joaquin County has one program that serves TAFY between the ages of 16–18, the Foster Youth FSP. The program came about as an expansion of the Child and Youth FSP, which was designed exclusively for foster youth (though not TAFY specifically). The County has expanded its Child and Youth FSP in response to data analysis that revealed foster youth would benefit from this expansion.[147]

  The County's Comprehensive Youth Outreach and Intervention program at a teen drop-in center and the county's TAY FSP (serving youth ages 18–25) were created for TAFY, but serve other populations as well. Finally, the County is in the process of implementing its *Katie A.* plan, which provides mental health services, some of which are MHSA-funded, to children, youth and TAY in the foster care system.

- **Consultation with TAFY / Outreach and Engagement in Planning.** San Joaquin County held several Stakeholder meetings throughout the course of planning for MHSA-funded programs. None of these planned stakeholder events were conducted at an organization or facility where TAFY would have been the target population. Further, there is no indication that the County consulted with any advocacy organization that serve TAFY or conducted any focus groups for TAFY participation. The County did plan one PEI meeting in 2013 that focused on youth and teens.[148]

- **Tracking TAFY Use of MHSA-Funded Programs.** While San Joaquin County does not specifically track TAFY use of each of its MHSA programs, it does track TAFY participation in its TAY programs and in programs designed for foster children and youth. The County has made commendable efforts to study, identify, and address the mental health needs of foster youth and their families. The County responded to the results of a chart audit it conducted by expanding its Mental Health Services for Foster Care Children and Youth.

- **Collaboration with Child Welfare Services.** The San Joaquin County Department of Mental Health works with San Joaquin County Child Welfare Services to implement and improve its Child and Youth Full Service Partnership. The departments further collaborate to implement their *Katie A.* programing, which is funded in part by the MHSA.

- **Meaningful Long-Term Outcome Analysis.** San Joaquin County collects outcome data on its programs and tracks the progress of program participants. However, it does not have any information on the long-term impact of its MHSA-funded programs, including those programs that serve TAFY. This oversight must be addressed. Long-term analysis examines the impact of MHSA-funded programs in the years following a participant's exit from the program. There is no way to know if MHSA-funded programs are serving the Act's stated purpose of "reducing the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness" if there is no data available with regard to the long-term impact of those programs. Further, San Joaquin County cannot adequately assess or consider the needs of TAFY, as the law requires,[149] without information about how the programs it has created to address those needs are performing over time. San Joaquin County must put in place a process by which it can assess the long-term impact of its MHSA-funded programs on TAFY who participate in these programs.

ENDNOTES

[1] Cal. Welf. & Inst. Code § 5847(c).

[2] Cal. Welf. & Inst. Code § 5847(e). In addition to the MHSA's express mandate that county programs meet the needs of Transition Age Youth, the Mental Health Services Oversight and Accountability Commission requires that counties dedicate at least 51% of their Prevention and Early Intervention (PEI) funding for individuals ages 0–25. Mental Health Services Oversight and Accountability Commission, *Mental Health Services Act Prevention and Early Intervention: County and State Level Policy Direction* (as amended Sept. 11, 2007) at 3 (available at www.dmh.ca.gov/MHSOAC/docs/MHSOAC_PEI_PolicyDirection_07Sep9.pdf).

[3] Cal. Welf. & Inst. Code § 5840(d).

[4] Marsenich, Lynn, *Evidence-Based Practices in Mental Health Services for Foster Youth*, California Institute for Mental Health (March 2002) at 24 (available at http://www.cimh.org/sites/main/files/file-attachments/fostercaremanual.pdf).

[5] *Id.* The wide variation is due to the different instruments used to measure mental health problems. *See also* Casey Family Programs, *Young Adult Survey 2006* ("[a] disproportionate number of respondents had mental health problems. Almost one-fourth (23.0%) of the young adults were experiencing a clinically significant level of mental health symptoms according to a global measure, while over one third (36.0%) were considered to be a "positive case" for having mental health problems"). The survey also found that half (49.4%) had alcohol problems. The Casey Family Programs survey is available at http://www.casey.org/Resources/Publications/pdf/CaseyYoungAdultSurvey2006_FR.pdf. *See also* Child Trends Research Brief Publication 2003-23 (Dec. 2003) (available at http://www.childtrends.org/files/FosterHomesRB.pdf), which estimates that 40% of 11–14-year-olds in foster care and 47% of 6–11-year-olds in foster care have a clinical level of behavioral or emotional problems. *See also* National Resource Center on Homelessness and Mental Illness: Davis, M, *The Transition to Adulthood among Adolescents Who Have Serious Emotional Disturbance* (available at http://www.caeqro.com/webx?293@915.R3bJaJmdhpr.28@.ee7dab4). Within the child

welfare, child protective, and foster care systems, an estimated 50–90% of children have serious emotional disturbance (Bryant et al., 1995; Trupin et al., 1993; Thompson & Fuhr, 1992; McIntyre & Keesler, 1986).

[6] *Supra* note 4 at 25.

[7] *Id.* The author is citing Franck, E. J. (1996), *Prenatally drug-exposed children in out-of-home-care: Are we looking at the whole picture?* Child Welfare, 75, 19–34.

[8] *Id.* The author is citing McIntyre, A., & Kessler, T. Y. (1986), *Psychological disorders among foster children*, Journal of Clinical Child Psychology, 15, 297–303.

[9] Casey Family Programs, *The Foster Care Alumni Studies: Assessing the Effects of Foster Care: Mental Health Outcomes from the Casey National Alumni Study* (available at http://www.casey.org/Resources/Publications/pdf/CaseyNationalAlumniStudy_MentalHealth.pdf).

[10] *Id.*

[11] *Id.*

[12] Pilowsky, D.J. and L.T. Wu, *Psychiatric Symptoms and Substance Use Disorders in a Nationally Representative Sample of American Adolescents involved with Foster Care*, JOURNAL OF ADOLESCENT HEALTH 38(4) (2006) at 351–358.

[13] Casey Family Programs, *Casey Northwest Foster Care Alumni Study* (2005) (available at www.casey.org/Resources/Publications/pdf/CaseyNationalAlumniStudy_MentalHealth.pdf).

[14] O'Sullivan, J. & Lussier-Duynstee, P., *Adolescent Homelessness, Nursing, and Public Health Policy*, POLICY, POLITICS, & NURSING PRACTICE 7 (2006) 73–77. California Youth Connection, *Facts on Emancipation*, distributed at Summer Policy and Leadership Conference (August 2008). For other similar findings, *see also* Courtney, Mark, Piliavan, Irving and Grogan-Kaylor, Andrew, *The Wisconsin Study of Youth Aging Out of Out-of-Home Care: A Portrait of Children About to Leave Care Madison*, Wisconsin: School of Social Work, University of Wisconsin (1995); Nevada KIDS COUNT, *Transition From Care: The Status and Outcomes of Youth Who Have Aged Out of the Child Welfare System in Clark County, Nevada*, Issue Brief II, Las Vegas: University of Nevada (2001); *Foster Care – Hope Emerges*, SAN FRANCISCO CHRONICLE (Dec, 22, 2005) (available at http://sfgate.com/cgi-bin/article.cgi?file=/c/a/2005/12/22/EDGABGB5LE1.DTL&type=printable); Casey Family Programs, *Improving Outcomes for Older Youth in Foster Care* (2008) at 4 (available at www.casey.org/Resources/Publications/pdf/WhitePaper_ImprovingOutcomesOlderYouth_FR.pdf).

[15] 2001 statistic obtained from the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (available at www.ojp.usdoj.gov/bjs/crimoff.htm#prevalence).

[16] Barrat, V. X., & Berliner, B., *The Invisible Achievement Gap, Part 1: Education Outcomes of Students in Foster Care in California's Public Schools.* San Francisco: WestEd. (2013) at 36 (available at: www.stuartfoundation.org/docs/default-document-library/the-invisible-achievement-gap-report.pdf?sfvrsn=2.

[17] Human Rights Watch, *My So-Called Emancipation* (2010) at 4 (available at http://www.hrw.org/en/reports/2010/05/12/my-so-called-emancipation-0).

[18] Mark E. Courtney, *et al., Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19*, Chapin Hall (2007) (available at www.chapinhall.org/sites/default/files/ChapinHallDocument_4.pdf).

[19] *Id.*

[20] *Id*.

[21] Federal Register, January 23, 2009 (Volume 74, Number 14) at 4199–4201 (available at http://aspe.hhs.gov/poverty/09fedreg.shtml).

[22] *See supra* note 12.

[23] *Supra* note 4 at 25. The wide variation is due to the different instruments used to measure mental health problems. For example, *see* Casey Family Programs, *Young Adult Survey 2006* ("[a] disproportionate number of respondents had mental health problems. Almost one-fourth (23.0%) of the young adults were experiencing a clinically significant level of mental health symptoms according to a global measure, while over one third (36.0%) were considered to be a "positive case" for having mental health problems"). The survey also found that half (49.4%) had alcohol problems (available at http://www.casey.org/Resources/Publications/pdf/CaseyYoungAdultSurvey2006_FR.pdf). *See also* Child Trends Research Brief Publication 2003-23 (Dec. 2003) (available at http://www.childtrends.org/files/FosterHomesRB.pdf), which estimates that 40% of 11–14-year-olds in foster care and 47% of 6–11-year-olds in foster care have a clinical level of behavioral or emotional problems. *See also* Casey Family Programs, *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study* (2005), finding that within the previous 12 months, more than half of the alumni (54.4%) had clinical levels of at least one mental health problem and one in five (19.9%) had three or more mental health problems (available at http://www.casey.org/Resources/Publications/pdf/ImprovingFamilyFosterCare_FR.pdf).

[24] This statistic is an average taken from statistics on the California Department of Mental Health website (www.dmh.cahwnet.gov/Statistics_and_Data_Analysis/CNE2/Calif_CD/q5asr_htm/California/q5asr2k_wsmi01_ca000_p0.xls).

[25] M.William Sermons and Peter Witte, *National Alliance to End Homelessness, State of Homelessness in America: A Research Report on Homelessness* (January 2011) at 26 (available at www.endhomelessness.org/library/entry/state-of-homelessness-in-america-2011).

[26] Mental Health Services Act, Section 3(a)–(e).

[27] Cal. Welf. & Inst. Code §§ 5847, 5848, 5892.

[28] Cal. Welf. & Inst. Code §§ 5847, 5878.1–5878.3, 5813.5, 18257.

[29] Cal. Welf. & Inst. Code § 5847.

[30] Cal. Welf. & Inst. Code §§ 5820-5822, 5847.

[31] Cal. Welf. & Inst. Code §§ 5840, 5847.

[32] Cal. Welf. & Inst. Code §§ 5830, 5847.

[33] Mental Health Services Act: Community Planning Process (available at www.dmh.ca.gov/Prop_63/MHSA/Community_Planning/default.asp).

[34] Cal. Welf. & Inst. Code § 5847.

[35] *MHSA: Proposed Guidelines for the Initial Capital Facilities Component of the County's Three-Year Program and Expenditure Plan* (available at www.dmh.ca.gov/Prop_63/MHSA/Capital_Facilities/default.asp).

[36] *Id.*

[37] Information available at the DMH MHSA website at www.dmh.ca.gov/Prop_63/MHSA/Technology/default.asp.
[38] Cal. Welf. & Inst. Code §§ 5820–5822; 5847.
[39] *Id.*
[40] Cal. Welf. & Inst. Code § 5822.
[41] Cal. Welf. & Inst. Code § 5847(a)(6).
[42] California Department of Mental Health, Mental Health Services Act Five-Year Workforce Education and Training Development Plan For the Period April 2008 to April 2013 (available at www.dmh.ca.gov/Prop_63/MHSA/Workforce_Education_and_Training/default.aspMHSA/docs/MHSA_FiveYearPlan_4-22-08.pdf).
[43] Cal. Welf. & Inst. Code §§ 5840, 5847. See also California Attorney General's Office, *Proposition 63: Mental Health Services Expansion, Funding, Tax on Personal Incomes Above $1 Million. Initiative Statute* (2004).
[44] Cal. Welf. & Inst. § 5840(b).
[45] Cal. Welf. & Inst. §5840(d).
[46] MHSA Prevention and Early Intervention Resource Materials (available at http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp).
[47] *See* California Department of Mental Health's MHSA website at www.dmh.ca.gov/MHSOAC/Prevention_and_Early_Intervention.asp.
[48] Cal. Welf. & Inst. Code §§ 5830, 5847.
[49] Mental Health Services Act Oversight and Accountability Committee, *Innovation Resource Paper* (Nov. 19, 2007) at 2 (available at http://www.mhsoac.ca.gov/Counties/Innovation/docs/InnovationResourcePaper.pdf).
[50] Mental Health Services Act Expenditure Reports (Estimated Revenues) available online at http://www.dmh.ca.gov/Prop_63/MHSA/Publications/default.asp. *See also* California State Budget Department of Mental Health Fund Condition Statement (Mental Health Services Fund) at 3-4 (available at hhttp://www.ebudget.ca.gov/2013-14/pdf/GovernorsBudget/4000/4260FCS.pdf).
[51] Department of Finance, *Mental Health Fund Condition Statement 2013-2014* at 3-4 (available at http://www.ebudget.ca.gov/2013-14/pdf/GovernorsBudget/4000/4260FCS.pdf).
[52] In a controversial move in 2011, in response to California's budget crisis, the legislature amended and the governor approved AB 100 (Chapter 5, Statutes of 2011), allowing the state to take funds from the MHSA to fund existing mental health programs on a one-time basis to address California's fiscal crisis.
[53] Cal. Welf. & Inst. Code § 5891.
[54] *Id. See also* information distributed to educate voters about MHSA (specifically the summary prepared by the Attorney General) at http://www.smartvoter.org/2004/11/02/ca/state/prop/63/.
[55] Voter information on Proposition 63 prepared by the Attorney General in 2004 and distributed prior to the 2004 election states: "Prohibits state from decreasing funding levels below current levels". *See also* Smartvoter archives at www.smartvoter.org/2004/11/02/ca/state/prop/63/, which also states that Proposition 63 "Prohibits state from decreasing funding levels below current levels".
[56] *Amwest Surety Insurance Company v. Pete Wilson* (1995) 11 Cal. 4th 1243, 48 Cal.Rptr.2d 12.
[57] Available at www.voterguide.sos.ca.gov/pdf-guide/text-of-proposed-law.pdf#prop1e; *see also* summary available at www.voterguide.sos.ca.gov/pdf-guide/props/prop1e-analysis.pdf.
[58] Steve Lopez, *Lives May Flounder as Yacht Sales Flourish*, Los Angeles Times (Aug. 29, 2007) at B1.
[59] National Center for Youth Law: Youth Law News (Jan.-March 2011) (available at www.youthlaw.org/publications/yln/2011/jan_mar_2011/ca_court_of_appeal_upholds_elimination_of_homeless_individuals_mental_health_program/).
[60] Sue Fox, *Children's Care Effort left to Wither Away,* Los Angeles Times (August 22, 2004) (available at http://articles.latimes.com/2004/aug/22/local/me-mental22).
[61] AB 100 (Chapter 5, Statutes of 2011) at Section 7.
[62] 2009 Letter to the County Mental Health Directors from Rusty Selix on behalf of the California Council of Community Mental Health Agencies.
[63] California Statewide Special Election, Tuesday, May 19, 2009, Official Voter Information Guide. Text of Proposition 1E is available at http://vig.cdn.sos.ca.gov/2009/special/pdf-guide/text-of-proposed-law.pdf#prop1e.
[64] California Secretary of State, Debra Bowen, *Statement of Vote, May 19, 2009 Statewide Special Election* at 9 (available at www.sos.ca.gov/elections/sov/2009-special/complete-sov.pdf).
[65] *See supra* note 61.
[66] *Id.*
[67] *Id. See also* California Mental Health Directors Association, *AB 100 (Committee on Budget), Statutes of 2011 Mental Health Services Act: Fact Sheet* (Dec. 2011) (available at http://bit.ly/18zYkCT).
[68] *Id.*
[69] *Id.*
[70] AB 989 (Mitchell) (Chapter 640, Statutes of 2011), codified at Cal. Welf. & Inst. Code § 5847(d) (emphasis added).
[71] *Id.*
[72] AB 1467 (Committee on Budget) (Chapter 23, Statutes of 2012), codified at Cal. Welf. & Inst. Code § 5848(a).
[73] AB 1467 (Committee on Budget) (Chapter 23, Statutes of 2012), codified at Cal. Welf. & Inst. Code § 5830(e).
[74] AB 1467 (Committee on Budget) (Chapter 23, Statutes of 2012), codified at Cal. Welf. & Inst. Code § 5847.
[75] *Id.*
[76] P. L. 110-351 (Oct. 7, 2008) 122 Stat. 3949
[77] 42 U.S.C. §675(8)
[78] *Id.*
[79] AB 12(Beall) (Chapter 559, Statutes of 2010).
[80] Cal. Welf. & Inst. §11400(v).
[81] Information from THP-Plus Statewide implementation project (available at www.thpplus.org).

[82] The case is known as *Katie A. v. Bonta* (information can be found at http://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx#references; http://www.bazelon.org/In-Court/Current-Litigation/Katie-A.-v.-Bonta/Resources.aspx; and http://www.youngmindsadvocacy.org/how-we-work/advocating/litigation/katie-a-v-bonta/).
[83] See information available at http://www.youngmindsadvocacy.org/how-we-work/advocating/litigation/katie-a-v-bonta/.
[84] 42 USCS § 1396a(a)(10)(A)(i)(IX).
[85] Mac Taylor, Legislative Analyst's Office, *2011 Realignment: Addressing Issues to Promote Its Long-Term Success* (Aug. 19, 2011) (available at www.lao.ca.gov/laoapp/main.aspx).
[86] *See supra* note 72.
[87] California Mental Health Services Act (2004), Section 3(b).
[88] For more information on CAI's proposed TLC program, see Appendix A.
[89] California State Auditor, *Mental Health Services Act: The State's Oversight Has Provided Little Assurance of the Act's Effectiveness, and Some Counties Can Improve Measurement of Their Program Performance*. Report 2012-122 (August 2013) at 3–5 (available at https://www.bsa.ca.gov/pdfs/reports/2012-122.pdf).
[90] Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Williams, D., Yee, H., Hightower, L., Mason, F., Lou, C., Peng, C., King, B., & Lawson, J., *CCWIP reports* (retrieved 10/28/2013 from University of California at Berkeley California Child Welfare Indicators Project website) (2013) (available at http://cssr.berkeley.edu/ucb_childwelfare. Note that this is an estimate. Some of the youth who emancipated between 2012 and 2013 may have re-entered, thus, there may be a small amount of duplication. However, the count is a close estimate.
[91] Email to the Children's Advocacy Institute from Michelle Burns, Transition Age Youth (TAY) System of Care Director, Alameda County Behavioral Health Care Services (Oct. 14, 2013).
[92] Mental Health Services Act (2004) at Section 3(b).
[93] *See supra* note 90.
[94] The College of the Redwoods Housing website is available at http://www.redwoods.edu/eureka/housing/.
[95] Email to the Children's Advocacy Institute from Heather Muller on 12/10/2013.
[96] *Id.*
[97] Humboldt County, *2012–2013 Budget* at D-52-53 (available at http://co.humboldt.ca.us/portal/budget/2012-13/00_fullbudget.pdf).
[98] Humboldt County Department of Health and Human Services Mental Health Branch, *Mental Health Services Act Fiscal Year 2012/2013 Annual Update* (June 2012) at 55–56.
[99] *Id.*
[100] *Id.*
[101] Email to the Children's Advocacy Institute from Heather Muller (Nov. 25, 2013).
[102] *Id.*
[103] *Id.*
[104] The program utilizes the Transition to Independence model and will generate longitudinal outcomes using a progress tracker called MOSAIC; *see id.*
[105] *See supra* note 90.
[106] Information from an interview with Brenda Story, Supervisor, Kern County Transition Age Youth Program. See also Kern County Mental Health, *Mental Health Services Act Fiscal Year 2013–2014 Annual Update* (June 2013) at 8 (available at www.co.kern.ca.us/kcmh/mhsa/MHSA_Update_2013_pt1.pdf).
[107] *Id.* at 31.
[108] *Id.*
[109] Email to the Children's Advocacy Institute from Brenda Story, Supervising MH Clinician TAY Team, Kern County Department of Mental Health (Nov. 19, 2013).
[110] Cal. Wel & Inst Code § 5847(c)
[111] *See supra* note 90.
[112] Information on Los Angeles' *Katie A.* programming can be found at http://dcfs.co.la.ca.us/katieA/programs_resources/index.html.
[113] Email to the Children's Advocacy Institute from Belen Fuller, Los Angeles County TAY Program Head (Nov. 5, 2013); confirmed in a review of Los Angeles County, *MHSA Annual Update 2013–2014* (available at http://file.lacounty.gov/dmh/cms1_191091.pdf), and in a review of the Los Angeles County TAY program website (http://dmh.lacounty.gov/wps/portal/dmh/our_services/tay) and Los Angeles County Department of Mental Health Implementation and Outcome Division's website (http://1.usa.gov/18Ksu2s).
[114] Long-term outcomes are defined for the purposes of this report as outcomes reported two years or more after the client has exited the program; *see id.*
[115] Cal. Welf. & Inst. Code § 5847(c).
[116] *See supra* note 90.
[117] Information from an interview with Sharon Jones, Merced County Department of Mental Health, MHSA Coordinator, Project Lead (May 2, 2013).
[118] *Id.*
[119] *Id.*
[120] The WeCAN program is set to begin tracking post-discharge outcome data, possibly in 2013–2014. *See* Merced County Department of Mental Health, *2013-2014 MHSA Annual Update* at38 (available at www.co.merced.ca.us/pdfs/mentalhealth/mhsa/final_msha_update_09_30_2013.pdf).
[121] Cal. Welf. & Inst. Code § 5847(c).
[122] *See supra* note 90.
[123] Orange County, *MHSA Plan Update FY 13/14* (available at http://ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=27651).

[124] *Id.* at 14.
[125] *Id.*
[126] *Id.*
[127] *Id.*
[128] Long-term outcomes are defined for the purposes of this report as outcomes reported two years or more after the client has exited the program.
[129] Cal. Welf. & Inst. Code § 5847(c).
[130] *See supra* note 90.
[131] Riverside County, *MHSA Plan Update 2013–14* at 59–70 (available at http://rcdmh.org/opencms/english/mhsa/2013_PLAN_UPDATE/DRAFT_Riverside_County_Plan_FY13_14_April_1_2013_R.pdf).
[132] Email to the Children's Advocacy Institute from Bill Brenneman, MHSA Manager, Riverside County Department of Mental Health (Nov. 21, 2013).
[133] *Id.*
[134] Cal. Welf. & Inst. Code § 5847(c).
[135] *See supra* note 90.
[136] 93% of the participants in Independent Living 2.0 in 2012–2013; information from Sacramento County response to CAI request for information (dated Nov. 13, 2013) at 2.
[137] Sacramento County, *MHSA Fiscal Year 2013–2014 Annual Update to the Three-Year Program and Expenditure Plan* at 38–39 (available at www.dhhs.saccounty.net/BHS/Documents/Advisory-Boards-Committees/Mental-Health-Services-Act-Committee/MHSA-SC-2013/MN-MHSA-SC-2013-04-18-Att-B-FY2013-14-MHSA-Annual-Update--Sacramento-County--DRAFT.pdf. *See also* information from Sacramento County response to CAI request for information (dated Nov. 13, 2013) at 3.
[138] Sacramento County response to CAI request for information (dated Nov. 13, 2013) at 2.
[139] *Id. at* 4–5.
[140] Cal. Welf. & Inst. Code § 5847(c).
[141] *See supra* note 90.
[142] County of San Diego, *Mental Health Services Act: Innovation Project Plan Summary* (Oct. 3, 2013) at 1 (available at http://sandiego.camhsa.org/files/INN-Program-Summary-SOC-meetings-10-03-13.pdf.
[143] County of San Diego Health and Human Services Agency, *Behavioral Health Services: Mental Health Services Act (MHSA) Innovation (INN) Programs and Services* at 5 (available at http://sandiego.camhsa.org/files/INN-Prg-Serv-Summ-Current.pdf).
[144] 75 Transition Age Foster Youth participated in the County's MHSA-funded innovation program in 2012–13. Information taken from an email to the Children's Advocacy Institute from Adrienne Yancey (dated Nov. 25, 2013) and from County of San Diego, *MHSA Annual Program & Expenditure Plan: Fiscal Year 2013–14* at 32 (available at http://sandiego.camhsa.org/files/MHSA-Annual-Plan-Board-Report-FY13-14-DRAFT-09302013.pdf).
[145] Cal. Welf. & Inst. Code § 5847(c).
[146] *See supra* note 90.
[147] San Joaquin County Behavioral Health Services, *Mental Health Services Act DRAFT 2013 Annual Update for the Program and Expenditure Plan* at 37 (available at http://sjmhsa.net/documents/2013%20Annual%20Update%20Draft%20for%20Public%20Review.pdf).
[148] *Id.* at 5.
[149] Cal. Welf. & Inst. Code § 5847(c).

APPENDIX A: THE TRANSITION LIFE COACH (TLC) PROGRAM

Several studies demonstrate the importance of mentors or other adults whose stability and consistency contribute to the mental health and well-being of foster youth.[1] Accordingly, the Children's Advocacy Institute (CAI) has developed the Transition Life Coach (TLC) Program, which would pair every TAFY with such a person—a Transition Life Coach, who would be appointed by the court on or as soon as possible after the youth's 16th birthday. The Coach would be an adult who is trusted by the youth and a part of the youth's life. The Coach would take on many of the roles generally filled by the parent of a transition age youth, thus helping to prevent the trauma and isolation to which foster youth have been subjected and the stress associated with the transition into adulthood from developing into a mental illness. For youth already experiencing mental illness, a consistent, caring, trusted adult may be even more important to moving toward recovery.

The Coach would be responsible for monthly distribution of a flexible fund of money meant to assist the youth in a successful transition to a productive and healthy adult life. The amount of money in each fund would be the equivalent of the amount of money average parents spend on their children post-18, with consideration given to any special needs the youth may have and adjusted annually according to the Consumer Price Index.[2] The Coach would be responsible for overseeing distribution the fund in accordance with a court-approved plan designed by each TAFY with input from his/her attorney, social worker, Transition Life Coach, and where applicable, Court Appointed Special Advocate.

The Transition Life Coach would answer to either the Juvenile or Probate court — which would have jurisdiction over the Coach and the fund but not the Transition Age Foster Youth. The program would be flexible, it would closely resemble the relationship that non-foster care youth have with their parents, and it would help TAFY transition to a successful, healthy adulthood.

Many TAFY are transient, moving from county to county for various reasons. Currently, each county has a different and complex patchwork of limited public and private services to assist TAFY. This often causes problems for youth moving between counties, and it causes disruption in services. The Transition Life Coach proposal provides a plan that is simple, customized to the needs of each youth and it is flexible, allowing the youth to move between counties without experiencing potentially harmful disruption in services.

The Transition Life Coach program is simple, it is new, and it is a smart use of public resources.

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[1] Perry, Brea L. *Understanding Social Network Disruption: The Case of Youth in Foster Care*. Social Problems, Vol. 53, Issue 3, pp. 371–391 (discusses mental health and well-being impact of instability in foster care). *See also* Farrugia, Susan P., *et al. Perceived Social Environment and Adolescents' Well-Being and Adjustment: Comparing a Foster Care Sample with a Matched Sample*. Journal of Youth and Adolescence. 35 (3) June 2006 at 349–358.

[2] The fund would be $46,700 in 2008 dollars. Schoeni, Robert F. and Ross, Karen E. Chapter 12: *Material Assistance Received From Families During Transition to Adulthood. On the Frontier to Adulthood: Theory, Research and Public Policy.* Edited by Richard A. Settersten, Jr., Frank F. Furstenberg, Jr., and Rubén G. Rumbaut (available online at www.transad.pop.upenn.edu/projects/frontier.htm). The average amount parents pay to assist their children post-18 is $38,340 (in 2001 dollars; the figure is $46,701 in 2008 dollars). The yearly average tends to be larger during the earlier years when the young person is in school and decreases over time. *See also* Bahney, A., *The Bank of Mom and Dad,* The New York Times (April 20, 2006) at G2, p.1.

Program	Populations Served	Services	Funding Source(s)[1]	Capacity	Additional Information
Alameda County Youth Offender	High level probation TAY	Mental health counseling, Case management	California State Dept. of Juvenile Justice	30+	
BAYC Bay Area Youth Center	Ages 15-21 TAY	foster care youth oonly Mental health counseling, case management, housing	EPSDT Medi-Cal	105	www.baycyouth.org
Berkeley Youth Alternatives (BYA)	Children, TAY, families	Mental health counseling, Case management, Peer groups	EPSDT Medi-Cal	75	www.byaonline.org
Casa de la Vida	TAY ages 18-24+	Mental health counseling, Housing, Peer groups	MHSA	26	
City of Berkeley TIP Program	TAY exiting foster care or juvenile justice system, and homeless TAY (ages 18-24)	Mental health counseling, Case management, Medication support	MHSA – CSS	20	www.cityofberkeley.info
East Bay Community Recovery Project (EBCRP)	TAY ages 16 – 24: In the early-onset stages of psychosis	Mental health counseling, Case management, Multi-family groups, Medication support	MHSA Prevention Early Intervention	60	
East Bay Community Recovery Project (EBCRP), EPSDT Services, Hayward	Children, youth, and TAY up to age 21	Mental health counseling, Case management, and Peer groups	EPSDT Medi-Cal	26	
Fred Finch STAY Program	TAY ages 18-24 who are leaving the foster care, the criminal justice system or are homeless	Mental health counseling, Case Management, Housing, Flexible funding, Assistance with education, Vocational assistance, Peer mentors, Living skills, Prescription assistance	MHSA – CSS	50	www.fredfinch.org
Transitions at Alameda County ILSP	TAY ages 16-21	Mental health counseling, Case management, Prescription assistance	EPSDT Medi-Cal	90	
STARS TAY Program	TAY ages 18-25	Mental health counseling, Case management, Peer groups, Prescription assistance, Linkages	Med-Cal (regular)	110	www.starsinc.com

[1] Information in this chart comes from the following sources: TAY system of care flyers and information located online at: http://www.acbhcs.org/TAY/tay_default.htm, Alameda County MHSA information located at: http://www.acbhcs.org/MHSA/overview.htm, Alameda County 2010-11 Annual update at: http://www.acbhcs.org/MHSA/docctr/docs/ACmhsafy10-11PlanUpdate.pdf, Email from Michelle Burns, Transition Age Youth System of Care Director, Alameda County Behavioral Health Care Services. October 13, 2013.

Program	Populations Served	Services	Funding Source(s)	Capacity	Additional Information
Youth Uprising	Youth and TAY ages 13-24	Mental health counseling, Peer groups, Case management	MHSA Prevention	50	www.youthuprising.org
West Coast Children's Clinic (WCC) Transition Age Youth Services	TAY ages 16 –21	Mental health counseling, Psychological assessments, Case management, Peer groups	EPSDT Medi-Cal	26	www.westcoastcc.org
Woodroe Place	TAY ages 18-21	Housing, Case management, Peer groups, Prescription assistance.	EPSDT Medi-Cal	78	www.bayareacs.org

APPENDIX C: LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
TAY MENTAL HEALTH PROGRAMS AND FUNDING SOURCES

Program	Populations Served	Services	Funding Source(s)	Capacity	Additional Information
TAY Full Service Partnership	Severely Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY who are: • Struggling with substance abuse disorders • Homeless or at risk of homelessness • Aging out of the children's mental health, child welfare or juvenile justice system • Leaving long-term institutional care • Experiencing their first episode of major mental illness	• Counseling and psychotherapy • Treatment-related transportation assistance • Medication assistance • Assistance obtaining physical health care • Housing assistance • Educational assistance • Assistance securing financial and health benefits • Substance abuse treatment • Employment / vocational assistance • Flex Funding	MHSA CSS	1,651 unique clients served in 2011-2012	TAY FSP Brochure: http://file.lacounty.gov/dmh/cms1_159348.pdf L.A. County MHSA Annual Update 2013-2014 p. 34: http://file.lacounty.gov/dmh/cms1_191091.pdf
Field Capable Clinical Services (FCCS)	TAY who are SED/SPMI but do not have the intensive service needs of individuals who qualify for Full Service Partnerships and who are: • Struggling with substance abuse disorders • Homeless or at risk of homelessness • Aging out of the children's mental health, child welfare or juvenile justice system • Leaving long-term institutional care • Experiencing their first episode of major mental illness • Otherwise at high risk, but do not qualify for FSP, ACT or are transitioning out of those services • Having difficulty engaging through traditional clinic-based services	• Outreach and Engagement • Bio-psychosocial assessment • Individual and family treatment • Medication support • Specialized assessment and treatment • Interventions for co-occurring disorders • Linkage to self-help and family support groups, health services, benefits establishment, temporary and/or permanent housing • Family education and support • Support for employment, education, and social support development • 24/7 Telephone response • Case management support • Flex Funding	MHSA CSS	2,156 unique clients served in 2011-2012	County of Los Angeles-Department of Mental Health Transition Age Youth Division Field Capable Clinical Services (FCCS) Guidelines: http://file.lacounty.gov/dmh/cms1_159333.pdf L.A. County MHSA Annual Update 2013-2014, p. 38: http://file.lacounty.gov/dmh/cms1_191091.pdf

Program	Populations Served	Services	Funding Source(s)	Capacity	Additional Information
Probation Camp Services	TAY ages 16 to 20 who are residing in Los Angeles County Probation Camps; particularly youth with SED, SPMI, those with co-occurring substance disorders and/or those who have suffered trauma.	• Assessments • Substance-abuse treatment • Gender-specific treatment • Medication support • Aftercare planning • Transition services (including FSP and other intensive community-based mental health services)	MHSA CSS	3,725 client contacts in 2011-2012	County of Los Angeles Dept. of Mental Health TAY Probation Camp Services Website: http://1.usa.gov/1ee3eq5 L.A. County MHSA Annual Update 2013-2014, p. 37: http://file.lacounty.gov/dmh/cms1_191091.pdf
TAY Drop-In Centers	TAY who are Seriously Emotionally Disturbed (SED) or Severe and Persistently Mentally Ill (SPMI) and are living on the streets or in unstable living situations.	• Showers, meals, clothing • Social Activities • Peer Support Groups • Linkage to Mental Health and Case Management Services • Linkage to Substance Abuse Treatment Information • Educational Services • Employment Assistance • Housing Assistance	MHSA CSS	876 client contacts in 2011-2012	TAY Drop-In Center Flyer, Available online at: http://file.lacounty.gov/dmh/cms1_159330.pdf L.A. County MHSA Annual Update 2013-2014, p. 35: http://file.lacounty.gov/dmh/cms1_191091.pdf
Enhanced Emergency Shelter Program (EESP)	Seriously Emotionally Disturbed (SED)/Severely Persistently Mentally Ill (SPMI) TAY ages 18-25 who are: • Indigent • Homeless or at imminent risk of homelessness • Lacking any income, benefits, or any other resources to pay for shelter • Not a danger to self, others, or gravely disabled	• First of three housing supports programs created for SED SPMI TAY • Temporary shelter • Hygiene facilities; hot meals (breakfast, lunch, and dinner); • Case management services • Assistance securing long-term housing	MHSA CSS	Annual Target is 300 Clients 2011-2012 731 youth There were 1,238 "Client contacts" for 2011-2012 for the three housing programs combined	TAY Enhanced Emergency Shelter Program (EESP) Flyer, Available online at: http://file.lacounty.gov/dmh/cms1_159331.pdf L.A. County MHSA Annual Update 2013-2014, p. 36: http://file.lacounty.gov/dmh/cms1_191091.pdf
Permanent Supportive Housing/Project-Based Operating Subsidies for Permanent Housing	SED/SPMI TAY who are • Eligible for Full Service Partnerships (FSP) or • Coming directly from transitional housing programs or • Coming directly from foster care or group homes	This is the second of three housing supports programs created for SED/SPMI TAY. The program provides permanent housing to address the long-term housing needs of SED/SPMI TAY who, with sufficient support, could live independently in community settings.	MHSA CSS	Annual Target is 72 clients. There were 1,238 "Client contacts" for 2011-2012 for the three housing programs combined	Permanent Supportive Housing Website: http://1.usa.gov/IdhZxD L.A. County MHSA Annual Update 2013-2014, p. 36: http://file.lacounty.gov/dmh/cms1_191091.pdf

Program	Populations Served	Services	Funding Source(s)	Capacity	Additional Information
Housing Specialist Services	SED/SPMI TAY	Housing Specialists are the third of three housing supports for SED/SPMI TAY they: • Develop comprehensive housing resource lists, • Assist SED/SPMI TAY with completing applications for rental subsidies, • Prepare consumers for the interview with prospective property owners or housing managers. • Act as an advocate and negotiator for consumers with poor credit and poor housing histories	MHSA CSS	There were 1,238 "Client contacts" for 2011-2012 for the three housing programs combined	TAY Housing Specialists webpage: http://1.usa.gov/1dbNXcr L.A. County MHSA Annual Update 2013-2014, p. 36: http://file.lacounty.gov/dmh/cms1_191091.pdf
TAY System Navigators	SED/SPMI TAY (families, children, and adults also served by system navigators)	• Engaging with TAY to quickly identify currently available services, including supports and services tailored to a client's particular cultural, ethnic, age and gender identity. • Provide linkages to needed mental health, housing, and other essential services. • Collaborate with the Children's Court, the LA	MHSA CSS	Not Available	TAY System Navigators webpage: http://1.usa.gov/1fPVYBd L.A. County MHSA Annual Update 2013-2014, p. 39: http://file.lacounty.gov/dmh/cms1_191091.pdf
Partners in Suicide Prevention Team (PSP)	Children, TAY, Adults and Older Adults	• Increase public awareness • Reduce stigma/discrimination associated with mental illness, substance abuse and suicide • Provide education and training • Identify underserved communities • Promote prevention/early intervention • Provide linkages & referrals • Assist care providers	MHSA PEI		Partners in Suicide Prevention webpage: http://1.usa.gov/1aCgW4F L.A. County MHSA Annual Update 2013-2014, p. 53: http://file.lacounty.gov/dmh/cms1_191091.pdf

Program	Populations Served	Services	Funding Source(s)	Capacity	Additional Information
Juvenile Justice Transition Aftercare Services (JJTAS):	Children and TAY youth transitioning from Probation camp settings back to their home communities	• Program engages individual youth before their release from the Los Angeles County Probation camp facilities • Outreach to families • Provides linkages to services in the community, • Case management, • Collaboration with community and other County Departments • Cognitive Behavioral Therapy, • Group Cognitive Behavioral Therapy for Depression. • Aggression Replacement Training Functional Family Therapy	MHSA PEI		JJTAS Webpage: http://1.usa.gov/1f9OMm1 L.A. County MHSA Annual Update 2013-2014, p. 53: http://file.lacounty.gov/dmh/cms1_191091.pdf
TAY Wraparound: Tier II	• TAY struggling with substance abuse disorders; • TAY who are homeless or at-risk of homelessness • TAY aging out of the children's mental health, child welfare, or juvenile justice systems; • TAY leaving long-term institutional care; or • TAY experiencing their first episode of major mental illness • TAY solely under the jurisdiction are NOT eligible • This program is not solely for TAFY, but does focus a great deal of its effort on Child welfare-involved children and youth (foster youth)	• intensive field based program designed to address the total needs of the youth, who is experiencing significant, emotional, psychological & behavioral problems that are interfering with the youth's well-being. • Provides an array of services and supports (services and supports "wrap around" the individual as needed) • Mental health consumers create their own plans for recovery, with support from professionals and peers • 24/7 support	MHSA CSS Medi-Cal EPSDT	Approx. 560 each year – on average (2011 update estimated that 2800 children /. TAY would be served over the next 5 years)	Guidelines for claiming for funded programs: Revised March 18, 2011, pp. 36-37. Available online at: http://file.lacounty.gov/dmh/cms1_159842.pdf

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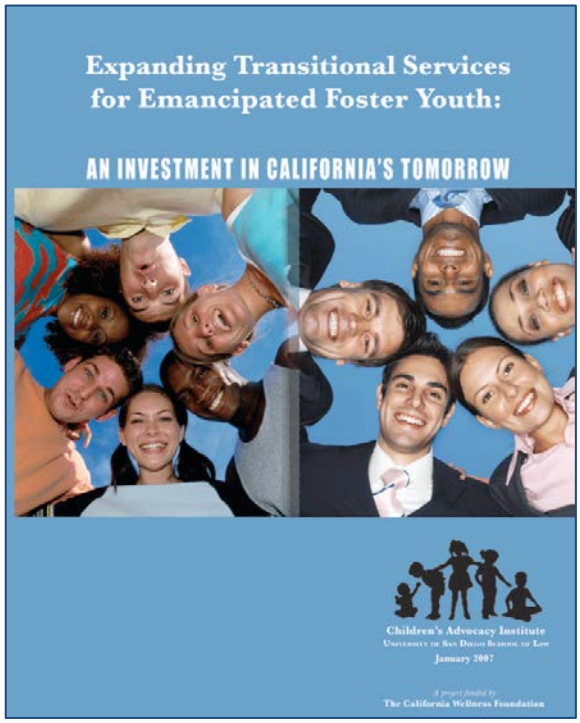

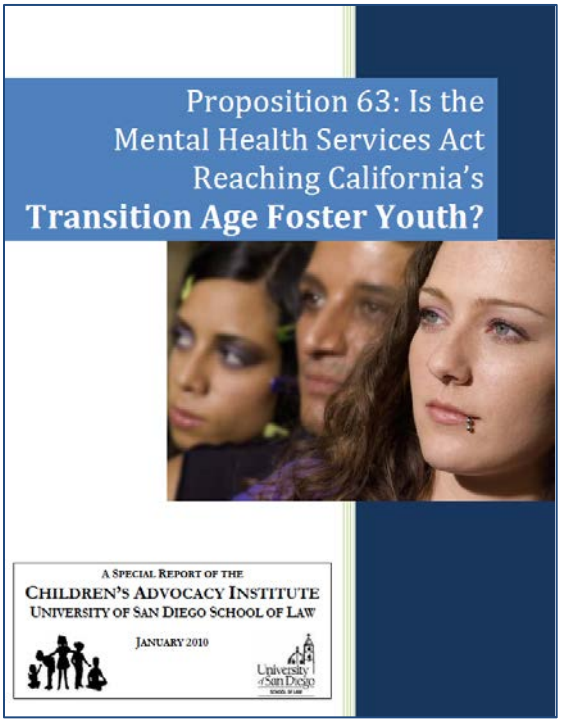

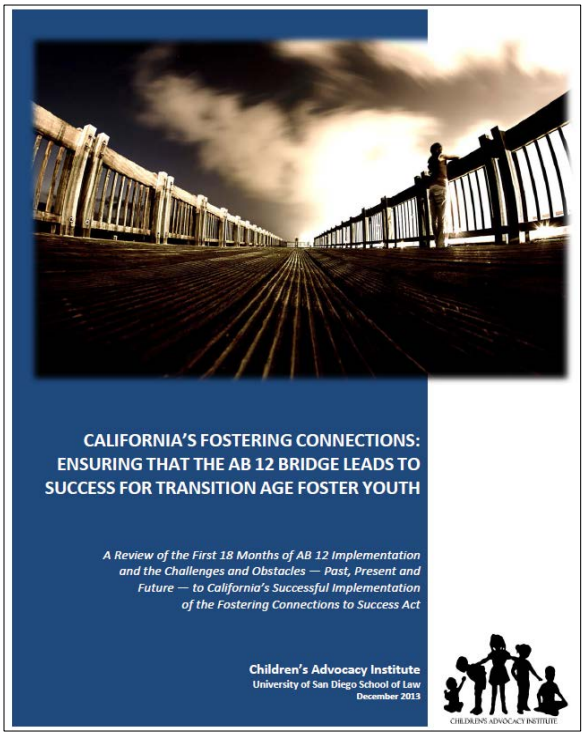

For copies, please contact CAI:

Children's Advocacy Institute
University of San Diego School of Law
5998 Alcalá Park / San Diego, CA 92110 (619) 260-4806 / (619) 260-4753 (fax)
info@caichildlaw.org / www.caichildlaw.org

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Children's Advocacy Institute
University of San Diego School of Law
5998 Alcalá Park
San Diego, CA 92110
(619) 260-4806 / fax: (619) 260-4753
info@caichildlaw.org / www.caichildlaw.org

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