Mental Health Commission

Children's Services Evaluation Committee Report – 2014-15

Introduction

AB 3632 History

The federal Individuals with Disabilities Education Act (IDEA) entitles all students with disabilities and/or mental health needs to a "free, appropriate public education" that prepares them to live and work in the community. The federal law includes a requirement for mental health services for children in special education in order to benefit from public education.

AB3632 was authored in 1984 amid concerns that students were not receiving needed and necessary mental health services requiring counties to provide them for qualifying students. Like other state mandates or requirements, counties were not fully reimbursed for these services forcing them to use other funding. Prior to 1984, schools were entirely responsible for providing these mental health services for students in special education who needed them. The Governor's suspension of AB3632 in 2011 with the passage of AB114 meant that the county mental health would no longer be responsible for providing these mental health services -- with responsibility again falling back on the schools and guidance services.

Medicaid's child health component that provided funds for health services is known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children. Since 1967, the purpose of the EPSDT program has been "to discover, as early as possible, the ills that handicap our children" and to provide "continuing follow up and treatment so that handicaps do not go neglected." The mental health component of this was TBS (Therapeutic Behavioral Services) provided by County Mental Health Departments. El Dorado County Mental Health Division currently contracts with county providers to provide specialty mental health services to Medi-Cal eligible children.

To remember the elements of EPSDT, use the name of the program:

Early	Identifying problems early, starting at birth
Periodic	Checking children's health at periodic, age-appropriate intervals
Screening	Doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnosis	Performing diagnostic tests to follow up when a risk is identified, and
Treatment	Treating the problems found.

Mental Health Commission Evaluation Committee Formed

Three events have occurred since June of 2011 which impact how children's mental health services are provided in El Dorado County. The first was the signing of AB114 making school districts solely

responsible for ensuring that students with disabilities receive the mental health services necessary to benefit from a special education program. The second was the decision by HHSA to use contract providers, rather than county staff for children's services for children identified as needing specialty mental health services. The third was the implementation of Katie A targeting children and youth in Foster Care with mental health needs.

The El Dorado County Mental Health Commission formed a committee in the fall of 2014 to address the question, "What is happening to children's services in El Dorado County in the wake of these changes?" This report attempts to clarify and raise awareness of the impact, challenges, and changes in how services for children are provided and funded. This report is not an in-depth analysis, but rather a general overview to provide a greater understanding of the current situation in mental health children's services.

The following providers and agencies were included and interviewed in this evaluation; El Dorado County Mental Health – Jamie Samboceti, El Dorado County SELPA – David Toston, Summitview – Anna Gleason, New Morning Youth and Family Services – David Ashby, Community Health Clinic – John Bachman, Sierra Child and Family Services – Barry Harwell and a few EDC families. Many more would have added greater detail and information, but time and resources limited the scope of this project.

Background

Half of all lifetime cases of mental illness begin by age 14. Scientists are discovering that changes in the body leading to mental illness may start much earlier, before any symptoms appear. Helping young children and their families manage difficulties early may prevent the development of disorders or improve the long term prognosis. Once mental illness develops and patterns of behavior, coping skills, and family attitudes become entrenched, it becomes more difficult to treat. Every child is different, and the treatments needed vary accordingly. The signs of a mental illness in a young child may be quite different from those in an older child or adult. Some families have a history of mental disorders, while some children have experienced physical or psychological traumas. Many children have difficulty expressing thoughts and feelings and are constantly changing and growing. Diagnosis and treatment must be viewed along with these changes adding to the challenge of providing mental health treatment for children.

School Based Mental Health Services

School-based mental health services offer the potential for prevention efforts as well as intervention strategies. Schools are the primary providers of mental health services for children by the very fact that that's where they are. These services range from minimal support services provided by a school counselor to a comprehensive, integrated program of prevention, identification, and treatment with the school itself or through collaborating agencies.

School based services should be looked at as a 3-tiered model of services and needs. The first tier is preventative. These are the ubiquitous activities that target all children in all school settings. These

activities include school wide discipline programs that are positive and build resilience, anti-bullying programs, welcoming community and family supports, etc.

The second tier consists of targeted mental health services that are designed to assist students who have one or more identified mental health needs, but who function well enough to engage successfully in many social, academic, and other daily activities. For students in special education who also have behavioral problems, this is the tier that consists of the behavioral components for student individualized education programs or IEPs that address these student's needs.

The third tier of services targets the smallest population of students and addresses the needs of children with severe mental health diagnosis and symptoms. These students require the services of a multidisciplinary team of professionals, usually including special education services, individual and family therapy, pharmacotherapy, and school and social agency coordination. It is this tier that formerly was the purview of county mental health, but is now mandated to be provided by schools. It is in this tier that we find the severe emotional problems that impede the student's ability to be educated in a general education program. Services for students who qualify for special education on the basis of their mental health status may include special provisions to assist students in achieving educational goals. These provisions are determined through the IEP process that includes detailed behavior management plans, and may also include therapy, and medication management. These students may be able to stay in their regular classroom with support, or placed in special classrooms. Mental health services provided as part of a student's IEP should allow the student to be in the least restrictive school setting, have clear goals and objectives that are individualized to each student's particular needs. Funding for these services is reimbursed by Medi-Cal for students who are eligible for and enrolled in Medi-Cal. This is determined by a referral for assessment of medical necessity by County Mental Health and services may be provided by school staff, or referral to a contract mental health provider; New Morning, Summitview, among others.

Several challenges exist in school-based mental health care. First, services must be coordinated with multiple players; primary care physician, mental health providers, and social agencies. Second, these services must be integrated within the school environment as an integral part of the school environment to avoid stigma and lack of support from school personnel for space, scheduling, etc. Third, parents are a vital element in mental health treatment for children and strategies must be devised to encourage parental involvement in school-based intervention services. Finally, because of laws around confidentiality, a well-defined system that is designed to protect confidential information, but allow sharing of information that pertains to a student's education and socialization at school or that needs to be shared to ensure safety of students and staff. Without clearly defined policies, students and their families will not trust the mental health care system and may undermine the intent of the services.

Currently, the scope of mental health services delivered in the school setting is widely variable. Each school district and school provides varying degrees of services and programs depending on perceived student needs and available funding and staff ability to deliver services. Individual school climate and leadership also contributes to how well these services are delivered. Families experience the IEP process and school supports differently depending on the school. Effective leadership in promoting

school mental health is an essential part of school administration and should be evaluated systematically.

In meeting the challenge, schools need to broaden what they do about mental health concerns. This calls for more than just increasing or enhancing mental health services. The problems facing schools and the children they educate are myriad. Dropout rates, truancy, bullying, harassment, substance abuse, abuse, and a variety of other problems that interfere with learning and teaching. Combinations of neighborhood, family, peer, school, and individual factors can also lead to problems. The higher the risk factors, the greater number of learning, behavior, and emotional problems. Most teachers and many parents have little difficulty identifying students who need help. More difficult is determining what type of help they need and how to provide it.

Katie A Implementation

Katie A was the result of a lawsuit that was filed in 2002 and settled in 2011. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. The impact of this settlement was to change the way children and youth in foster care or at imminent risk of foster care receive access to mental health services, including assessment and treatment. The focus was to improve the collaboration between agencies using a strong team approach including families to reduce the length of stay in the child welfare system and the over reliance on congregate (group) care. While this lawsuit was pending for years, and the implementation was three years ago, it seemed to take the county by surprise. The laws around the use of Medicaid (Medi-Cal) dollars were not changed, but the effect on the county was of great consternation about the fiscal impact of the requirement that this group of children were now mandated to be assessed and if needed, given services. This subgroup was always Medical eligible but nonetheless has had an impact on budgets. This confusion was articulated by some of the providers having disparate views and understandings of how Katie A is paid for. It is concerning that more children/youth qualify than are receiving services in California. There are estimated 60,000 children in foster care in California. 35,000 of them meet Katie A criteria. The state is currently serving only 7,200.

Another concern was disclosed recently in a Federal Study about the extensive use of psychotropic medications for poor children (especially those in the Foster Care system) without ongoing careful monitoring. These powerful medications can have long term detrimental effects. The shortage of psychiatrists for children and the frequent turnover in staffing compounds the potential for problems in over utilization of medications without follow up care and monitoring. Our county providers utilizing psychiatrists for medication also have a regular schedule for monitoring. There is less consistency in monitoring when multiple agencies are involved and policies and procedures for determining responsibility are not clearly defined.

Family Experiences with Mental Health Services in EDC

Families with children and adolescents receiving mental health services in El Dorado County have a variety of experiences, positive and negative. In general, the experience with school based services varies from excellent to discouragement and distrust. Much of this has to do with the particular school

climate of support for special needs students and the perceived role of parents as partners in the solutions to the presenting problems, behavioral or emotional, as well as the degree of impairment by the child. Of those families that were interviewed, there was much praise for individual providers; Summitview, Sierra Child and Family, and New Morning. Some of the difficulties within the system are usually with the IEP process (taking too long, lack of follow through), the referral process (often slow and cumbersome), and the continuity of services between providers/agencies. Where the system seems to break down the most is in more severe cases where multiple agencies are involved, especially CPS services and out of county placements for acute care and foster care in group homes.

Families faced with the trauma of a mentally ill child, coupled with making sense of a very complicated system of services, and the fear (especially if CPS is involved) of having their child placed out of county creates anxiety and distrust. Too often families feel that they are targeted as the "cause" of the problem, even when documented history would dispel this.

Katie A was the result of a lawsuit born of this sort of mistrust and lack of collaboration and cooperation in providing services mandated by Medicaid as children were being placed out of the home, locked up, and separated from their families for months and years in group homes and facilities. We have excellent providers utilizing the ICC TEAM model. However, when CPS becomes involved, these treatment plans are frequently ignored and discontinued. The goal of all children's services, treatment models, foster care systems, etc. is to treat the child in the least restrictive, home-based whenever possible, evidence based system of care. Families report fearing retaliation, feel disparaged and marginalized by the very system of care that is supposed to protect children and families and give them the skills and support they need to care for their special needs children with mental illness.

EDC Mental Health Providers for Children

County Mental Health – Jamie Samboceti

- Provides assessment for medical necessity only – no services provided. Referral to contract providers if assessment determines medical necessity.
- Referral for assessment may be initiated by parent, CPS, school district, or primary care physician. All children must be referred to Mental Health for assessment to establish medical necessity before receiving services.
- 50% of referrals for assessment will meet medical necessity. If child does not meet medical necessity, the IEP treatment plan stays at school. If they meet medical necessity, the county will provide services through contract providers.
- Monitoring system in place. A percentage of children's charts are evaluated every six months. This is a self- audit.
- Reassessment occurs every 6 months to establish continued necessity based on CalLocus (assesses need) and CANS (assesses outcomes).

- Children's programs are paid for with traditional funds except for specific MHSA/PEI programs, WRAP and Katie A services.
- Currently (at the time this interview was done) there are 60-70 children in the identified subclass known as Katie A.
- Twice that many would qualify for Katie A, but funds in that program are inadequate. Children are receiving services through other programs, FSP, WRAP, etc.
- Mild to moderate services are referred to Tribal Health, Community Health Center, New Morning, Sierra Child and Family.
- Does not place children in residential treatment. CPS, School Districts, Probation can place in children in residential treatment programs.

El Dorado County SELPA (Special Education Local Plan Area) – David Toston and Tamara Clay

- 2 SELPAs – 14 School Districts (West Slope) and Charter SELPA (statewide)
- Mental health services provided for special education students where academic progress is impeded by mental health issues. Must be an educational issue.
- Focus on preventative universal supports and screening systems to ensure educational needs.
- Improved awareness in schools.
- Support of severe illness in school environment.
- Changing roles. School districts have expanded expectations.
- Emphasis on prevention and early intervention
- IEP (Individual Education Plan) team determines a need and who is the best professional specialist to provide that need.
- AB114 mandated that services must be tied to the IEP and the school is required to see that those services are provided.
- Parents are supported through the IEP process and will help educate parents to advocate for their children. (This view is not universally supported by parents receiving services through IEPs)
- Multidisciplinary approach. All agencies involved with student invited to meetings. Annual meeting held with HHSA director, Mental Health director, and Office of Education Superintendent.
- Number of services in schools has increased.
- Continued growth over time utilizing school wide systems of direct student services.
- Team monitoring of interventions and responses.

Summitview Child and Family Services – Anna Gleason

- Provides psychiatric services with regular monitoring of patients.
- Provides Full Service Partnerships for children and youth.
- Both boys and girls served. Individual Education Plan (IEP) from school required.
- Focus on teens that self-harm.

- Average length in program was 18 months now shortening to 12 months. Average age is 14.
- Frequent diagnosis – PTSD, Bipolar Disorder, Depression
- All staff trained in Dialectical Behavior Therapy, Informed Care, and Cognitive Behavioral Therapy
- Focus on child's strengths.
- Non-public school providing special education through IEP process.
- Residential treatment program specializing in treating adolescent girls (8-18) who are suicidal and engage in self-harm behavior. Level 14 care –Referred through Social Services, Probation, or the school district.
- Day Rehabilitation program for girls, outpatient therapy, TBS, and Wraparound services for boys and girls.
- Four 6-bed group homes
- Medication management through a team approach
- Time delay from first Student Study Team meeting to IEP.
- Delayed scheduling for IEP creates problems in providing needed services
- Crisis intervention – 24 hr. on call clinician
- Disruption in placement can be a big concern affecting continuity of care, loss of trust.
- Concerns with crisis management with Marshall Hospital and County Crisis. Lack of available psychiatric hospital beds for children is a statewide problem and causes difficulties during holds at Marshall Hospital ER.
- Concerns with Placerville Police and lack of training for Crisis Intervention approach. Interactions with County Sheriff's CIT officers more positive.
- Funding through school district contracts, Federal and State EPSDT funding, Medi-Cal.
- Evaluation process ongoing – work, review, assessment, and monitoring – active case planning, team based, community care licensing guidelines.
- Accredited by the California Alliance of Child and Family Services.

New Morning – David Ashby

- NM casts a broad net in terms of services provided to children and adolescents. Provides a Children and Adolescent Shelter 24/7.
- Referred by school districts through IEP process. Provides services on site to 15-16 schools.
- Referred by teachers, administrators, family, friends.
- Focus on therapy, emotional support, safety, behavior. No psychiatric services available, so does not handle Axis 1 Mental Health Disorders; Schizophrenia, Bipolar Disorder, Major Depression, Schizoaffective Disorder.
- Parenting Skills – evidence based parenting program provided in multiple areas around the county. Funding through MHSA PEI contract. (Formerly known as "Incredible Years".)

- Latino Outreach – services from the MHD were transitioned to New Morning Jan. 2014, utilizing MHSA PEI funds. Target population for this program is Spanish-speaking or limited English-speaking Latino individuals and families.
- Confusion exists around who is responsible, who pays. Schools may be wary of IEP's which may indicate the need for high cost services. Services are very expensive and with multiple players, it may create problems and delays during the determination of who is responsible for services.
- Evaluation of services can be a struggle. Different agencies require/want different assessment tools. State wants numbers, which don't reflect the reality nor answer the important questions. Mental Health uses CANS, which is not received enthusiastically by New Morning staff. Client satisfaction surveys are given for parent and children over 10 years old internally.
- Biggest challenge is access to fiscal resources to provide the services.
- Effective criteria from Mental Health for services would allow evaluation of potential for impact so resources could be placed where they would have the greatest benefit.
- 50% of funds come from Medi-Cal, ~$200,000 from the State, contracts from local school districts through IEP and ERMHS, grants, and the community.
- Concern for all kids in county. Non-system kids need to be included. What do we do for children who do not qualify?
- Family involvement important, but children with non-responsive families should not be held "hostage" to the fact that their parents will not engage.
- Improved process with Mental Health to begin services utilizing a shorter process for beginning services.
- Utilizes 20 therapists working in the community.
- Phone assessments (20 min) with parent in an initial review by MHD do not give adequate information for determining need for services.
- Overall, process is improving. "We all want the same thing."
- Not able to provide Katie A services, but most of the children needing services are "Katie A". County is now releasing a RFA for those services and New Morning would like the option of working with these children.
- Biggest frustration is with the County. Youth are underserved and that kids must show significant impairment before qualifying often means they must wait until their symptoms are highly disruptive and more damage is done.
- Tension with Mental Health arises from the conflict born of the fiscal realities of mandated services only to the most severely mentally ill and the broader needs of the entire community.

Community Health Clinic – John Bachman

- The Community Health Clinic is open to all, regardless of ability to pay. It has been open 12 years with 3 clinics on the West Slope. These clinics were created in the 1960's to provide a medical safety net to the poor in communities across the nation.
- Approximately 10,000 appointments per year, over half are Medi-Cal patients.
- Behavioral Health services are open only to established patients of the CHC. Access to Behavioral Health for children and adults is through a clinic primary care doctor.

- Primary care physician's training is generalized with little background in mental health disorders.
- The CHC does not have psychiatric services. Difficulty in referring children to County Mental Health for specialty mental health services.
- Contract with New Morning to place two licensed clinical social workers at the clinic two days a week.
- Concern with lack of continuity of care. Difficulty to get discharge summary for patients released from psychiatric hospitals.
- Medical providers at the CHC are MDs, Family Nurse Practitioners, and Physicians Assistants. License types include LCSW, MFTs are not allowed.
- All services must be provided within the clinic to be reimbursed. If a clinician attends an IEP at a school site, they are not paid.
- Behavioral Health serves mild to moderate mental health needs through managed Medi-Cal insurance. More severe mental illness (Axis I) is provided by County Mental Health. These lines were created by an insurance industry and create an artificial divide in mental illness that is difficult to navigate, especially in children.

Sierra Child and Family Services – Barry Harwell

- Serves children and families through Foster Care Therapeutic Services, Non-Public School (K-12), Foster adoptions, and programs contracted with County Mental Health, Katie A, AB114 at schools, traditional (Medical), Full Service Partnerships (MHSA). All programs have prior approval from County Mental Health.
- Children are referred to SCFS by County Mental Health or School Districts ~ 140 children seen countywide.
- IEP team at school recommends/requests assessment. Contract with each school district.
- If child meets medical necessity (Medi-Cal eligible) services are provided to child and family. Approximately 50% of children assessed have Medi-Cal.
- SCFA has multiple offices in other areas and counties providing continuity of clinical care between counties and across the state creating a network of care.
- Accreditation by California Alliance – continual certification
- County programs evaluated by an 80 point check-list, also uses CANS and Cal LOCUS tools to monitor programs. Staff is trained in the use of these evaluation tools.
- Funding limits and mandated services present challenges. Prior approval and contract limits by county are set, but the number of kids needing services may not fit the set limit.
- Continuum of care reform dovetails with Katie A implementation.
- Good working relationship with other providers/agencies. Children are shared.
- Service to both children and their families, although bio parents for foster kids may not initially be included.
- Programmatically, excellent working relationship with MH and more children served with increased identification in schools. The number of children served has tripled over the last few years.

- Prior to the County contracting out services, all stakeholders would meet to discuss problems/solutions to cases. Currently, HHSA and Community Based Organizations meet bi-monthly to discuss system issues and concerns. There is a need to have more open communication during these meetings so that issues and concerns can be resolved and to reduce possible conflicts between agencies and improve collaboration.
- Contract with Mental Health spells out exactly what the Provider is required to do. This may be in conflict with CPS goals and objectives. Children and families are caught in the middle.
- Continued challenge to stay "ahead of the curve". County always playing from behind. Mental health services for foster children have always been required by law. Katie A now requires us to track it and make sure it happens. It added the "teeth" necessary to Medi-Cal to make sure the children receive what they are entitled to under Medi-Cal.
- Competition for and access to funding can be challenging and frustrating. With different ideologies, policies, paradigms, and realities, each provider must figure out how to access funding from multiple sources, while responding to county RFPs.

Conclusions and Recommendations

The mental health system statewide is fragmented, often unaccountable, and frequently bewildering for families with children with severe emotional disorders. Responsibility for authorizing, contracting for or providing, and paying for educationally related mental health services remains a challenge for the State and our County.

Children and youth in El Dorado County have a wide array of resources to assist them and their families when mental health problems arise. We are fortunate to have so many excellent providers in El Dorado County. Many of the providers that were interviewed for this report have been working in their field, if not for the very same agency, for 18-20+ years. Their knowledge, passion, and compassion for those they serve are commendable. Every day they deal with the fragmentation, funding limits, policies, laws, and emotions that are part of working in this field, while trying to make a difference in the lives of the children and families they serve.

One in 10 children and adolescents will have serious problems that derail social and educational development. That's not counting their parents, when 1 out of 4 will experience a mental health problem. Mental illness is eminently treatable, and most people can improve and build satisfying lives, just like other people with common physical illnesses such as diabetes or heart disease. As with those, the earlier the treatment is received, the better.

Several challenges exist in school-based mental health care. First, services must be coordinated with multiple players; primary care physician, mental health providers, and social agencies. Second, these services must be integrated within the school environment as an integral part of the school environment to avoid stigma and lack of support from school personnel for space, scheduling, etc. Third, parents are a vital element in mental health treatment for children and strategies must be devised to encourage parental involvement in school-based intervention services. Finally, because of laws around confidentiality, a well-defined system that is designed to protect confidential information, but allow

sharing of information that pertains to a student's education and socialization at school or that needs to be shared to ensure safety of students and staff. Without clearly defined policies, students and their families will not trust the mental health care system and may undermine the intent of the services.

Currently, the scope of mental health services delivered in the school setting is widely variable. Each school district and school provides varying degrees of services and programs depending on perceived student needs and available funding and staff ability to deliver services. Individual school climate and leadership also contributes to how well these services are delivered. Families experience the IEP process and school supports differently depending on the school. Effective leadership in promoting school mental health is an essential part of school administration and should be evaluated systematically.

In meeting the challenge, schools need to broaden what they do about mental health concerns. This calls for more than just increasing or enhancing mental health services. The problems facing schools and the children they educate are myriad. Dropout rates, truancy, bullying, harassment, substance abuse, abuse, and a variety of other problems that interfere with learning and teaching. Combinations of neighborhood, family, peer, school, and individual factors can also lead to problems. The higher the risk factors, the greater number of learning, behavior, and emotional problems. Most teachers and many parents have little difficulty identifying students who need help. More difficult is determining what type of help they need and how to provide it.

Our system of care would be improved with greater collaboration among all the stakeholders to share the burden and provide the safety net needed to ensure quality services are provided when needed. Our children and youth should be receiving care and treatment that is safe (every part of psychiatric treatment, especially the monitoring of psychotropic medications), evidence and measurement based, comprehensive and continuous (especially when multiple agencies are involved), collaborative (including patient and family), culturally sensitive, and recovery oriented. Barriers exist due to conflicting roles, policies, and bias within and between County agencies, providers, and families.

Looking at the results of the interviews that were conducted for this report the following points of agreement appear:

1. The need for children's mental health services is expanding even while greater numbers of children are served.
2. There is an ongoing shortage of child and adolescent psychiatry. However, with the recent privatization of the PHF, it has allowed Dr. Robert Price, a child psychiatrist, to provide more services to the child and adolescent population.
3. Access to services can be lengthy and frustrating for all concerned.
4. Communication and cooperation between agencies may be clouded by conflicting goals and policies. However, this is an issue that has been identified by HHSA and they recently hired an LCSW in CPS who is responsible for assessing foster children and working with Mental Health to ensure services are being provided. The providers support this direction and feel it will improve the process.

5. Continuum of programs and services is not generally available between agencies.
6. Competing funding realities and limited resources make sharing and collaboration more difficult between agencies/providers. This is an issue that has been identified by HHSA. Mental Health has never completed a formal solicitation for contracted mental health services. As a result, there has been a lack of consistency relative to services required, service expectations, and costs. To address this issue, HHSA is currently going through a formal solicitation process, with the assistance of the Mental Health Commission, in order to establish service level needs and clear funding amounts.
7. Evaluating effectiveness of programs needs to be based upon measurable data, but numbers do not tell the whole story. Better methods of measuring quality should include measures of youth and families' satisfaction with services provided and program effectiveness. In January 2013 HHSA finalized an agency wide strategic plan. One of the goals is Program Effectiveness/Integration, and objective 3.1.14 is to develop and implement the use of performance indicators that measure the effectiveness of services and inform the decision making process. The project team is currently working on this objective.
8. There is a need to developing and implement consistent standards for evidence based treatments, policies, and protocols that define expectations for all providers. This is an issue that has been identified by HHSA and is being addressed through a recent RFP for children's services providers. Specifically, the RFP states the successful Proposer shall minimally track the outcome measures identified in Exhibit D of the RFP. (*Attachment I).* Staff and a member of the Mental Health Commission are currently reviewing the proposals that were submitted in response to the RFP.

In January 2015, the California Department of Social Services published a document titled, California's Child Welfare Continuum of Care Reform. This report attempts to clarify the progress and potential problems with the foster care system. It gives a road map for the future direction in children's services. Our county needs to look at this report closely and begin planning and implementing recommendations to avoid the situation we experienced when Katie A arrived. Following the recommendations will improve the assessment process, the way children are placed, how they receive mental health services, and access to Medi-Cal entitled services. Given the long term impact and importance of this issue, the County would be well advised to direct more General Funds toward implementing these reforms and best practices in mental health services for the children and youth of El Dorado County.