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Landmark Decision for California's Most Vulnerable Children

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On March 14, federal district court judge Howard J. Matz ordered the State of California to provide critically needed mental health services to thousands of Medi-Cal eligible children who are in foster care or at risk of foster care placement.¹ Without such services, mentally ill foster children risk being removed from their families and bouncing from placement to placement while their health further deteriorates. By requiring the state to systematically provide wraparound services and therapeutic foster care (TFC), the court's order should enable thousands of children to live with their families, succeed in school, and stay out of trouble with the law.

The ruling came in a three-year-old class action lawsuit known as *Katie A. v. Bonta*.² The suit challenges California's failure to provide home and community-based mental health care to children who are in, or at risk of entering, foster care.³ There are more than 80,000 children in foster care in California and an even greater number of children served by the system in their own homes.⁴

Mentally Ill Children Languish in Foster Care

California's Little Hoover Commission, a leading watchdog agency, estimates that nearly 70 percent of children in the state's foster care system "will experience a mental health problem."⁵ The California Health and Human Services Agency cites even higher estimates of the prevalence of mental illness among foster children, based on a study that found that 84 percent of a sample of 213 foster children had developmental, emotional, and/or behavioral problems.⁶

Researchers warn that "[m]ore than 50,000 children in foster care who may need mental health services do not get them."⁷ By one estimate, only 14 percent of foster children in Los Angeles County are receiving mental health services, whereas "research tells us...that between 40 and 80 percent of the kids in foster care would need mental health services."⁸

Foster children with high-level mental health needs often experience multiple placements and placement disruptions because they do

not get necessary mental health services.⁹ The California Department of Social Services, which is responsible for administering the foster care program, acknowledges that "many children have been caught in a revolving door of inappropriate placements" and that the "typical child in group care has experienced an average of five different placements before being put in a group setting."¹⁰ Multiple placements can subject foster children to the "trauma of repeated abandonment," such that they "come to expect they will fail and often give up trying to succeed."¹¹

The State's Current Approach: Congregate Care and Institutionalization

All too often, foster children who are not provided with necessary mental health services end up being needlessly confined in locked institutional facilities or placed in large group homes. In fact, approximately 9,000 foster children in California are placed in group homes.¹² A significant percentage of these children—perhaps more than 50

1 Order Granting Plaintiffs' Motion for Preliminary Injunction, *Katie A. v. Bonta*, No. CV02-05662, (C.D. Cal. granted March 14, 2006).

2 *Katie A. et al v. Diana Bontá*, No. 02-05662 (C.D. Cal. Filed July 18, 2002); Clearinghouse Review No. 54846

3 See Meg Wilkinson and Patrick Gardner, *LA County Fails to Meet the Mental Health Needs of Foster Children* Youth Law News July-September, 11-17.

4 California Department of Social Services, *Child Welfare System Improvements in California, 2003-2005: Early Implementation of Key Reforms* (Dec. 2005), http://www.dss.cahwnet.gov/cdssweb/ChildWelfa_2367.htm.

5 Michael E. Alpert, *Young Hearts & Minds: Making a Commitment to Children's Mental Health* (hereafter "Young Hearts"), Little Hoover Commission (2001) at 22.

6 CHHS Foster Care Slide Presentation at DHS014148, 014153, and 014154. See also Institute for Research on Women and Families, *Code Blue: Health Services for Children in Foster Care* (Dec. 1998). Fifty to 60 percent of foster children in California have "moderate to severe mental health problems"; California Mental Health Planning Council, *California Mental Health Master Plan: A Vision for California* (March 2003) at 48. Depending on the study, estimates of the percentage of children who enter the foster care system with significant mental health problems range from 35 percent to 85 percent.

7 *Young Hearts* at i. See also Little Hoover Commission, *Still in Our Hands: A Review of Efforts to Reform Foster Care in California* (Feb. 2003) (hereafter "Still in Our Hands") at 3.

8 Deposition of John Hatekayama at 125:19-126:15, 160:10-162:114, submitted as an exhibit to Plaintiffs' Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction, *Katie A. v. Bonta*, No. CV02-05662, granted, 2006 WL 1464445 (C.D. Cal. March 14, 2006).

9 See, e.g., Declarations of Dianne Magnatta, Letty Frakes, and Alison Brumbach, submitted with Plaintiffs' Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction, *Katie A. v. Bonta*, No. CV02-05662, granted, 2006 WL 1464445 (C.D. Cal. March 14, 2006).

10 California Department of Social Services, *Reexamination of the Role of Group Care in a Family-Based System of Care: A Status Report* (Aug. 2002) at 1, 11.

11 Declaration of Connie Burgess at ¶¶ 8, 13, submitted with Plaintiffs' Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction, *Katie A. v. Bonta*, No. CV02-05662, granted, 2006 WL 1464445 (C.D. Cal. March 14, 2006).

12 California Department of Social Services, *Reexamination of the Role of Group Care in a Family-Based System of Care* (June 2001) at 6, 9.

CA's Request for Stay DENIED

A federal appeals court has denied California's request for an emergency stay of an order requiring the state to provide community mental health services to tens of thousands of foster children and children at risk of being removed from their homes.

In a decision issued July 26, the federal appeals court for the 9th circuit denied the stay, forcing the state to adhere to all provisions of a district court order issued earlier this year, on March 14. The federal district court in Los Angeles said the state must provide comprehensive mental health services that will enable foster children to avoid institutional care. Under the order, the state had 120 days from the date of the order to begin providing this care.

The state has appealed the district court order and sought an emergency stay of the decision pending its appeal.

"The appeals court summary rejection of the state's request for delay sends a strong message that California must act now to provide services to thousands of foster children so they may return home to more stable and nurturing care," said NCYL attorney Patrick Gardner, co-counsel in the case.

percent—are in expensive, high-level group homes (Rate Classification Level [RCL] facilities of 12 and above).¹³ As of February 2004, Los Angeles County alone had 2,160 foster children in group homes, including 405 children under age 12 and 122 children under age 9.¹⁴

In addition to being inappropriate or ineffective for many children with significant mental health needs, high level group home placements are costly. Monthly costs per child range from \$5,613 for an RCL 12 facility to \$6,371 for an RCL 14 facility. On top of these expenses, the cost of providing mental health services is about \$120 per day for a child in an RCL 12 facility and about \$160 per day for a child in an RCL 14 facility.¹⁵ One county official in California estimated that the cost of group home placement is upwards of \$100,000 per youth per year.¹⁶ Community Treatment Facilities can cost \$9,000 to \$20,000 per child per month.¹⁷

The Litigation

Plaintiffs

In July 2002, five named plaintiffs filed suit on behalf of a class of children who are in, or at risk of entering, foster care in California, and who have behavioral, emotional, or psychiatric needs requiring individualized mental health services. The children are represented by the National Center for Youth Law, Western Center on Law & Poverty, Protection & Advocacy, Bazelon Center for Mental Health, the ACLU of Southern California, along with the law firm of Heller Ehrman LLP.

Some of the *Katie A.* plaintiffs have been subjected to more than 30 placement changes while in care. Instead of addressing their serious mental health needs, the Department of Children and Family Services shuttled these children "from one inappropriate placement to another...repeatedly warehousing [them] in psychiatric facilities" or other "temporary" facilities when there were no other available "slots" in which to place them.¹⁸ In June 2003, the court certified a plaintiff class of children who are in, or at imminent risk of being in, foster care; have diagnosable mental conditions; and need individualized mental health services.¹⁹

Throughout the course of the litigation the court has heard countless heart-breaking stories about the experiences of the plaintiff class. Plaintiffs have documented that time after time the absence of appropriate home-based mental health services has resulted in unnecessary and preventable declines in children's mental health.

For example, a court-appointed expert recommended wraparound services and TFC for "Charlie," an emotionally disturbed 8-year-old subjected to prenatal drug exposure and early parental abuse, so he could eventually be placed with his loving and committed grandmother.²⁰ However, because wraparound services and TFC were not available in his county, Charlie deteriorated in foster care—"bounc[ing] from placement to placement for the next four years," each more restrictive and costly—only to end up in Metropolitan State Hospital, a locked state institution.²¹

Other class members' experiences are similarly appalling. One

13 See *Katie A. Advisory Panel, Third Report to the Court* (hereafter "*Third Panel Report*"), September 7, 2004, at 20. Nearly 60 percent of foster children in Los Angeles County who are in RCL facilities are in level 12 or higher facilities; group homes in California are classified into RCLs of 1–14, using a point system designed to reflect the level of care and services they provide. California Department of Social Services, *Reexamination of the Role of Group Care in a Family-Based System of Care* (June 2001) at 12.

14 *Third Panel Report* at 20–22.

15 Deposition of John Hateyama at 137:17–24, submitted as an exhibit in Plaintiffs' Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction, *Katie A. v. Bonta*, No. CV02-05662, granted, 2006 WL 1464445 (C.D.Cal. March 14, 2006).

16 Plaintiffs' Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction at 33, *Katie A. v. Bonta*, No. CV02-05662, granted, 2006 WL 1464445 (C.D.Cal. March 14, 2006).

17 *Id.*

18 First Amended Complaint for Declaratory and Injunctive Relief at 5–9, *Katie A. v. Bonta*, No. CV02-05662 (C.D.Cal. filed Dec. 20, 2002).

19 Order Re Class Certification at 22, *Katie A. v. Bonta*, No. CV02-05662 (C.D.Cal. granted June 18, 2003). The court defined "imminent risk of foster care placement" to mean that "within the last 180 days a child has been participating in voluntary family maintenance services or voluntary family reunification placements and/or has been the subject of either a telephone call to the Child Protective Services hotline or some other documented communication made to a local Child Protective Services agency regarding suspicions of abuse, neglect or abandonment." *Id.*

20 Declaration of Connie Burgess, at ¶¶ 3-5, submitted with Plaintiffs' Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction, *Katie A. v. Bonta*, No. CV02-05662, granted, 2006 WL 1464445 (C.D.Cal. March 14, 2006).

21 *Id.*

teenage girl was shunted through nine different residential placements and 11 psychiatric hospitalizations, including group homes many hours away from her family. She was physically assaulted in her group homes and sexually assaulted when she fled a group home and ended up on the streets. Despite this girl's history of suicide attempts, multiple placements, and diagnosis of severe depression, the local child welfare agency eventually told her family that the agency could not help and suggested that the family look to "probation" for assistance. Not surprisingly, this youth ended up in jail.²²

Defendants

Defendants in *Katie A.* are the director of the California Department of Health Services (DHS), the director of the California Department of Social Services (CDSS), the Los Angeles County Department of Children and Family Services (DCFS), and the DCFS director. DHS administers Medi-Cal, California's Medicaid program, while CDSS supervises and monitors child welfare services in the state.

Right to Legally Mandated Mental Health Services

The *Katie A.* plaintiffs charge Defendants with neglecting their duty to provide necessary and legally mandated mental health care to children in, or at risk of entering, foster care. Plaintiffs seek declaratory and injunctive relief under provisions of the Medicaid Act, the Due Process Clause of the Fourteenth Amendment, the Americans with Disabilities Act, the Rehabilitation Act, and state statutes. To date, the case has largely focused on plaintiffs' Medicaid claims—in particular, class members' rights to mental health care under the Early and Periodic Screening, Diagnostic, and Treatment

(EPSDT) provisions of the Medicaid Act. Earlier in the litigation, plaintiffs also sought and obtained the closure of MacLaren Children's Center in El Monte, CA. Plaintiffs successfully alleged that this "emergency shelter" was particularly egregious in its failure to meet the mental health needs of DCFS children in its care.

Goals of the Litigation

Plaintiffs contend that class members have a fundamental entitlement to appropriate community-based mental health services. Within this framework, *Katie A.* focuses on the systematic provision of two specific services – wraparound and TFC.

Wraparound

What is Wraparound?

Wraparound services are highly individualized, community-based services for youth with emotional or mental health needs who are at risk of being removed from their homes.²³ The development and coordination of services is a team-driven process. Agencies, community service providers, the family, and the child work together to develop a service plan that incorporates the unique strengths, needs, and cultures of the child and family.²⁴ The type of services in the plan vary from child to child and team to team. The array of discrete wraparound services is designed to achieve improved family and child functioning, school and community performance, and overall quality of life. Typical wraparound services include comprehensive assessment, service plan development and modification, crisis stabilization, individual or family therapy, intensive home-based services, medication management, and child respite.

Essential Elements of Wraparound

Although wraparound services are highly individualized, there has been

a national effort to identify and define principles that are critical to the success of wraparound.²⁵ The following 10 elements have been deemed essential to the delivery of high-quality wraparound services:²⁶

1. *Family Focused:* Families are active partners at every level of the process.
2. *Team Based:* Development and implementation of a child's service plan must be a collaborative, team-driven process involving the family, child, agencies, and community services working together
3. *Natural Supports:* Service plans are developed with an emphasis on the natural supports available to the child through his/her family and the family's networks of interpersonal relationships, including neighbors, co-workers, community institutions and associations.
4. *Collaboration:* Additional emphasis is placed on team members reaching "collective agreement" in a mutually supportive environment throughout the development, delivery, and evaluation of the service plan.
5. *Community Based:* Wraparound services are provided in the local community where the child and his/her family live.
6. *Culturally Competent:* The child and family's religious customs, regional, racial, and ethnic values and preferences are integrated into the planning and delivery of services
7. *Individualized:* Services are tailored to meet the unique needs of the child and family
8. *Strengths Based:* Services and supports are built on positive features of the child and family.
9. *Persistence:* Wraparound professionals and team members make a commitment to achieve the goals in the child's service plan regardless of the severity of the child's behavior or other adverse outcomes.

22 Plaintiffs' Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction at 6, *Katie A. v. Bonta*, No. CV02-05662, granted, 2006 WL 1464445 (C.D. Cal. March 14, 2006).

23 Burchard, J. D., Bruns, E. J., & Burchard, S. N. (2002). The Wraparound Approach. In Burns, B. and Hoagwood, K. (Eds.), *Community Treatment for Youth: Evidence-based Treatment for Severe Emotional and Behavioral Disorders*. Oxford: Oxford University Press.

24 *Id.*

25 Walker, J.S., Bruns, E.J., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (2004). *Ten principles of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

26 *Id.*

10. *Outcome Based*: A system is developed as part of the service plan to measure and evaluate the progress of the child and family. This information is used to modify the service plan as needed to promote the success and safety of the child and family.

Research on Wraparound

Wraparound is one of the few mental health interventions for which there is “strong” evidence of efficacy, with significant expert support and a growing research base.²⁷ Although the majority of research on wraparound was initially based on individual case studies, more recent randomized clinical trials comparing youth in traditional foster care and youth receiving wraparound have also demonstrated wraparound’s effectiveness.²⁸ Compared to children placed in traditional foster care, children receiving wraparound have shown greater declines in behavioral problems, greater increases in functioning, greater stability in residential placements, and greater likelihood of placement permanence.²⁹ Moreover, by enabling children to remain in less restrictive and less costly settings, wraparound services have generated significant cost-savings.³⁰

Wraparound in Practice

Wraparound services are being implemented around the country.³¹ In Wisconsin, “Wraparound Milwaukee,” has consistently demonstrated positive outcomes. The program, established in 1995, provides wraparound ser-

vices to over 900 youth at risk of placement in residential treatment centers, juvenile correctional facilities, or psychiatric hospitals. In 2004, the program reported a 60 percent decrease in the use of restrictive residential treatment and an 80 percent decrease in inpatient psychiatric hospitalization (since the program’s inception).³² Wraparound Milwaukee has also demonstrated significant cost savings.³³ The average cost of services per child has dropped from more than \$5,000 per month to less than \$3,300 per month.³⁴ These savings have been reinvested allowing the program to serve more youth.

In California, Eastfield Ming Quong (EMQ) provides wraparound services in collaboration with several counties across the state. These programs have also reported promising results. For example, in 2004, Sacramento County’s wraparound program reported that 91 percent of youth were living with their families at the culmination of services. Similarly, in 2005, the U.S. Department of Health and Human Services reported that, Alameda County children receiving wraparound services were more likely to be living in family-based environments at the end of treatment than children receiving traditional child welfare services.³⁵ Alameda County’s wraparound participants also reported improved emotional/behavioral adjustment and improved satisfaction with services.³⁶

Although California has begun to see the benefits of wraparound, only a small fraction of eligible children currently have access to this critical service. Fewer than half of California’s counties currently provide wraparound.³⁷ Moreover, those counties that do offer wraparound do so primarily through limited state and federal pilot programs.

Therapeutic Foster Care (TFC) What is TFC?

TFC is a service for children with serious emotional or behavioral needs who cannot be cared for in their homes of origin, but who can benefit from a home-like setting rather than institutional care.³⁸ With TFC, professional foster parents are trained in behavior management strategies and other techniques for supporting children with special needs.³⁹ Like wraparound, TFC employs a strengths-based, needs-driven approach. Services are implemented through an individualized treatment plan including home-based programming, mental health services, and crisis intervention. TFC programs also provide foster families with on-going support and supervision.⁴⁰

Research on TFC

TFC is considered the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders.⁴¹ Randomized clinical trials comparing TFC with traditional foster care programs have shown that children receiving TFC demonstrate greater behavioral

27 Marsenich, L. (2002) *Evidence-based Practices in Mental Health Services for Foster Youth*. California Institute for Mental Health. Sacramento, CA.

28 Burns, B., and Goldman, S. (1999). *Promising Practices in Wraparound for Children With Serious Emotional Disturbance and Their Families*. 1998 Series, Vol. 4. Rockville, MD: Child and Adolescent Services Branch, Center for Mental Health Services. p. 16.

29 Clark, H.B., (1996) *Journal of Child and Family Studies*, 5(1), 39-54; Burchard, J., Bruns, E., J. & Burchard, S.N. (2002). The Wraparound Approach. In Burns, B. and Hoagwood, K. (Eds.), *Community Treatment for Youth: Evidence-based Treatment for Severe Emotional and Behavioral Disorders*. Oxford: Oxford University Press.

30 Burns, B., et al. (2000). Comprehensive community based interventions for youth with severe emotional disorders: Multisystemic Therapy and the Wraparound Process. *Journal of Child & Family Studies*, 9(3), 283-314.

31 Burns, B., and Goldman, S. (1999). *Promising Practices in Wraparound for Children With Serious Emotional Disturbance and Their Families*. 1998 Series, Vol. 4. Rockville, MD: Child and Adolescent Services Branch, Center for Mental Health Services. p. 15.

32 Kamradt, B. (2000) Wraparound Milwaukee: Aiding youth with mental health needs. *Juvenile Justice Bulletin*, 7(1), 14-23

33 *Id.*

34 *Id.*

35 U.S. Dept. of Health and Human Services, Profiles of Child Welfare Waiver Demonstration Projects, http://www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/2005/california.htm#noteone (June 30, 2005); see also Center for Social Services Research. (2004). *The California Title IV-E Child Welfare Waiver Demonstration Study Evaluation: IV-E Child Welfare Waiver Project: Progress and Process Reports, and Final Report*. Chapter 7, p. 1. Retrieved July 11, 2006, from University of California at Berkeley, Center for Social Services Website: <http://cssr.berkeley.edu/childwelfare/researchdetails.asp?name=waiver> (evaluation of five California counties implementing wraparound found “modest” findings on the efficacy of the programs, however evaluators offered a “qualified endorsement of Wraparound,” citing “implementation and operation issues that may have muted Wraparound’s overall effect”).

36 *Id.*

37 Deposition of Cheryl Treadwell, at ¶¶ 15:20-23, 17:13-18:5, 69:20-87:17, submitted as an exhibit to Plaintiffs’ Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction, Katie A. v. Bonta, No. CV02-05662, granted, 2006 WL 1464445 (C.D.Cal. Mar. 14, 2006).

38 U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health (1999).

39 *Id.*

40 *Id.*

41 *Id.* at 176.

improvements, greater reductions in psychiatric symptoms, and more successful transitions to less restrictive environments.⁴² TFC programs have also proven to be more cost-effective than restrictive placements.⁴³

TFC in Practice

TFC has rapidly proliferated across the country, and many states implementing TFC services have reported positive outcomes and significant cost savings.⁴⁴ One of the first programs to provide integrated, needs-based services to foster youth was developed in Chicago, Illinois.⁴⁵ Today, this program, called Kaleidoscope, serves over 400 youth. In 2005, Kaleidoscope reported that 92 percent of children receiving services remained with their foster family in a stable, nurturing environment.⁴⁶

Multidimensional Treatment Foster Care (MTFC), a TFC program developed at the Oregon Social Learning Center, has also demonstrated positive clinical outcomes.⁴⁷ Initially developed as an alternative to residential and group care for serious and chronic juvenile offenders, MTFC was subsequently expanded to serve foster youth. A recent evaluation found that hospitalized youth who received MTFC were placed in the community more quickly and demonstrated fewer behavior problems upon follow-up.⁴⁸ In addition to demonstrating positive clinical outcomes, MTFC has been identified as providing the largest cost saving to taxpayers of all juvenile justice programs nationally.⁴⁹

Patricia Chamberlain, MTFC's founder and the senior research scientist at the Oregon Social Learning Center in Eugene, OR, partnered with several colleagues in 2002 to form TFC Consultants, Inc. The group recently began collaborating with the California Institute for Mental Health and others to establish replication sites in several California counties. In 2004, TFC Consultants teamed with Walden Family Services to offer MTFC to San Diego County foster youth. Participating foster youth have experienced significant improvements in education and residential placement stability, and substantial reductions in mental health symptoms and negative behaviors.⁵⁰

Despite these promising results, California's existing TFC capacity is insufficient to serve the foster children who are eligible for, and desperately need, this service.⁵¹ In fact, less than half of California's counties currently have state approval to develop TFC-type programs.⁵² The court order granting plaintiffs' preliminary injunction requires California to rapidly expand its TFC program in order to offer this valuable service on a "consistent, statewide basis."⁵³

The Los Angeles County Settlement

Less than a year after *Katie A.* was filed, Los Angeles County and the Los Angeles County Department of Children and Family Services entered into a settlement agreement with plaintiffs. The settlement obligates the County to institute a number of comprehensive reforms, including better identification of mental

health needs, enhanced permanency planning, and prompt provision of individualized services designed to promote stability and ensure quality care. The County also agreed to offer family-based wraparound services to children with mental, emotional, or behavioral issues, with the aim of facilitating family reunification and reducing multiple and arbitrary placements. Lastly, the settlement mandated the immediate closure of MacLaren Children's Center and the rerouting of its funding to family- and community-based programs.

The settlement has four major requirements. Los Angeles County agreed to ensure that all children who are in, or at risk of entering, foster care in Los Angeles County:

- Promptly receive necessary, individualized mental health services in their own home, a family setting, or the most home-like setting appropriate to their needs;
- Receive the care and services they need to prevent them from being removed from their families or, if keeping them in the home is impossible, to facilitate reunification and meet their needs for safety, permanence, and stability;
- Be afforded stability in their placements whenever possible, as multiple placements are harmful to children and disrupt family contact, mental health treatment, and the provision of other services; and
- Receive care and services consistent with good child welfare and mental health practice and the requirements of federal and state law.⁵⁴

42 Chamberlain, P. (2003). The Oregon multidimensional treatment foster care model: Features, outcomes, and progress in dissemination. *Cognitive and Behavioral Practice*, 10, 303-312.

43 U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health (1999), at 176.

44 Chamberlain, P. (2003). The Oregon multidimensional treatment foster care model: Features, outcomes, and progress in dissemination. *Cognitive and Behavioral Practice*, 10, 303-312. 45 *Id.* at 21.

46 Shaping Better Lives for Kids, Annual Report (2005), <http://www.kaleidoscope-4kids.org/2005ar.pdf>.

47 Chamberlain, P. (2003). The Oregon multidimensional treatment foster care model: Features, outcomes, and progress in dissemination. *Cognitive and Behavioral Practice*, 10, 303-312.

48 Chamberlain, P. (2003). The Oregon multidimensional treatment foster care model: Features, outcomes, and progress in dissemination. *Cognitive and Behavioral Practice*, 10, 303-312.

49 Aos, S., Phipps, P., Barnoski, R. & Lieb, R. (2001). The comparative costs and benefits of programs to reduce crimes, <http://www.wsipp.wa.gov/rptfiles/costbenefit.pdf>.

50 Declaration of Mindy Watrous, at ¶¶ 5-7 submitted with Plaintiffs' Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction, *Katie A. v. Bonta*, No. CV02-05662, *granted*, 2006 WL 1464445 (C.D.Cal. Mar. 14, 2006).

51 Plaintiffs' Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction at 16, *Katie A. v. Bonta*, No. CV02-05662, *granted*, 2006 WL 1464445 (C.D.Cal. Mar. 14, 2006).

52 Deposition of Sheilah Dupuy, at ¶¶ 18:25-19:4 submitted as an exhibit to Plaintiffs' Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction, *Katie A. v. Bonta*, No. CV02-05662, *granted*, 2006 WL 1464445 (C.D.Cal. Mar. 14, 2006).

53 Plaintiffs' Memorandum of Points and Authorities in Support of Their Motion for Preliminary Injunction at 20, *Katie A. v. Bonta*, No. CV02-05662, *granted*, 2006 WL 1464445 (C.D.Cal. Mar. 14, 2006).

54 Settlement Agreement Between Plaintiffs and County Defendants at 3-4, *Katie A. v. Bonta*, No. CV02-05662 (C.D.Cal. notice lodged April 18, 2003).

By way of fulfilling these mandates, the agreement cites seven specific measures Defendants must implement. These additional requirements include: improving the consistency of DCFS's decision making through the implementation of "Structured Decision Making"; expanding wrap-around services; implementing "Team Decision Making" (TDM) at significant decision points for a child and his/her family; ensuring that class members' mental health needs are identified and that appropriate services are provided; and enhancing permanency planning, increasing placement stability, and providing more individualized, community-based emergency and other foster care services to foster children.⁵⁵

The settlement also created an expert advisory panel to monitor and report on DCFS's efforts. In its fifth and most recent report to the court, issued August 16, 2005, the panel found that Los Angeles County had failed to address adequately the mental health needs of the children in its care. The panel noted that, although DCFS had undertaken efforts to fulfill most of the seven specific measures required by the settlement, it had not met any of the four overarching objectives at the heart of the agreement. The panel concluded that "a much broader system improvement strategy is needed to assure for class members the provision of necessary mental health services, safety, permanence and stability, and care and services consistent with good mental health and child welfare practice."⁵⁶

On February 16, 2006, plaintiffs filed a motion to compel Los Angeles County to comply with the settlement. In doing so, plaintiffs asked the court to empower the advisory panel to affirmatively develop an implementation plan for the County. Judge Matz denied this motion on June 15, 2006, preferring to leave responsibility for

the "initial formulation of the plan" in the hands of "the persons and authorities who are charged with carrying out [that plan]."⁵⁷ Nevertheless, the court refused to deem the County in compliance with the settlement agreement – the County, it noted, had "achiev[ed] unacceptably low targets."⁵⁸ The court also offered eight "contemplated required modifications to the County's Plan" addressing the most "compelling or troublesome" aspects of the implementation process to date.⁵⁹ These contemplated modifications will be addressed at a status conference scheduled for August 2006.

The Case Against the State

The State agencies did not participate in the settlement. Accordingly, the lawsuit against them is ongoing. On September 9, 2005, plaintiffs filed a Motion for Preliminary Injunction to compel the California Departments of Health Services, Social Services and Mental Health to make wraparound services and therapeutic foster care available to all class members on a consistent statewide basis through the Medi-Cal program or other means.

On March 14, 2006, Judge Matz granted plaintiffs' motion for a preliminary injunction. The Judge ordered California to provide "wraparound services" and "therapeutic foster care," to thousands of Medi-Cal eligible children who are in foster care or at risk of foster care placement. In doing so, the Judge stressed that "the health of thousands of children in California" is "at stake in this lawsuit."⁶⁰ The Judge also acknowledged the gravity of "the unmet health needs [of the statewide class] and the harms of unnecessary institutionalization."⁶¹ Furthermore, Judge Matz found "substantial evidence that wraparound services and therapeutic foster care actually save the State money, compared to alternatives involving institutionalization."⁶²

The State of California has appealed Judge Matz's order to the U.S. Court of Appeals for the Ninth Circuit.

Despite the appeal, the preliminary injunction currently remains in full force and effect. The order requires the parties to develop an implementation plan "identif[ying] the responsibilities of the different State agencies, the need for additional providers, the eligibility criteria for wraparound services and therapeutic foster care, methods and procedures to inform class members of the availability of services, and a timeline for accomplishing needed tasks."⁶³ Accordingly, plaintiffs are working with Defendants to ensure that class members quickly begin receiving quality wraparound and therapeutic foster care services. Both sides are collaborating with local stakeholders, providers, and state and national experts to devise a comprehensive implementation strategy. Although there is much work ahead, the court's March 14th order should ultimately enable tens of thousands of foster children to avoid institutional care and receive critical mental health services in their communities.

Robyn Gould was a summer 2006 law clerk at NCYL and is in her second year at Boalt Hall School of Law, UC Berkeley. **Laura Townsend** is an Equal Justice Works fellow at NCYL, coordinating NCYL's Juvenile Mental Health Court Initiative. **Leecia Welch** is a senior attorney at NCYL and co-counsel on the Katie A. case. She specializes in child welfare/foster care and the educational needs of foster youth.

55 *Id.* at 4.

56 See Katie A. Advisory Panel, *Fifth Panel Report to the Court*, August 16, 2005, at 24.

57 Order Re Plaintiffs' Motion Re Advisory Panel Plan at 2, Katie A. v. Bonta, No. CV02-05662, (C.D.Cal. denied April 18, 2003).

58 *Id.* at 4.

59 *Id.* at 3-5.

60 Order Granting Plaintiffs' Motion for Preliminary Injunction at 3, Katie A. v. Bonta, No. CV02-05662, (C.D.Cal. granted March 14, 2006).

61 *Id.* at 19.

62 *Id.* at FN5.

63 *Id.* at 21.