Appeal No. 06-55559

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Diana Bonta, et al., *Petitioner,*

v.

Katie A., et al., *Respondent.*

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
THE HONORABLE A. HOWARD MATZ
CASE NO. CV-02-05662

BRIEF OF *AMICI CURIAE* IN SUPPORT OF AN AFFIRMANCE

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Respectfully submitted August 10, 2006.

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I. INTEREST OF THE AMICI CURIAE

Amici Curiae American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, California District IX, California Alliance of Child and Family Services, California Adolescent Health Collaborative, California Association of Social Rehabilitation Agencies, California Nurses Association, California Public Health Association-N, California School Nurses' Organization, California Teachers' Association, Children's Advocacy Institute, Children's Law Center of Los Angeles, Federation of Families for Children's Mental Health, National Alliance for the Mentally Ill, National Association of Social Workers, National Council on Community Behavioral Health, National Mental Health Association, and the Southern California Public Health Association (collectively the "amici") respectfully submit this memorandum in support of affirmance of the March 14, 2006 ruling by the Honorable A. Howard Matz of the United States District Court for the Central District of California issuing a preliminary injunction in this action.[1]

The amici collectively include many of the foremost authorities on children's mental health issues in the United States. They include professionals who treat children with serious mental health needs, parents and family members of such children, teachers, and others who have considerable expertise with respect

[1] A brief description of each amicus organization is included herein as Exh. A.

to the needs of such children. Many of them have considerable experience in providing mental healthcare services to foster children in a community-based environment. As a result of this expertise and experience, amici are uniquely positioned to speak to the need for, and effectiveness of, wraparound services and therapeutic foster care.

For the reasons that follow, the *amici* believe that wraparound services and therapeutic foster care are medically necessary therapies that should be covered by California's Medi-Cal system. Such coverage is the only way to ensure that the thousands of children in the California foster care system with mental health needs are afforded the critical mental health care to which they are entitled, and the opportunity to live healthy and productive lives.

II. SUMMARY OF ARGUMENT

Every year, more than 40,000 children are placed into the California foster care system.[2] All too often, California inflicts further harm by failing to provide these children with necessary education and healthcare services.[3] Even though an estimated 70% of these children experience mental health disorders while dependents of the state, the California Department of Mental Health has nevertheless admitted that many of them are not receiving the care they need.[4] As a result, foster care all too often becomes "a heartless limbo" resulting in myriad "childhoods squandered by an unaccountable bureaucracy."[5] Unfortunately, the very system established to help these children heal their childhood scars often ends up inflicting additional trauma.[6]

Mental health problems in children are extremely debilitating. Anxiety disorders, attention deficit and behavioral disorders, development disorders, and

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[2] Little Hoover Commission, *Still in Our Hands: A Review of Efforts to Reform Foster Care in California* (February 2003)(hereafter "*Still in Our Hands*"), Excerpts of Record ("ER") 04538.

[3] *Id.*

[4] Little Hoover Commission, *Young Hearts & Minds: Making a Commitment to Children's Mental Health* (October 2001)(hereafter "*Young Hearts*"), ER 04624; *see also* California Health and Human Services Foster Care Slide Presentation, ER 05463-05464 (finding that 84% of a sample of 213 foster care children had mental health issues.)

[5] *Still in Our Hands*, ER 04538.

[6] *Id.*

mood disorders affect the daily lives of children.[7] Children in foster care are significantly more likely to have a mental health disorder than their peers; 1988 data revealed that foster care children constituted 4% of children enrolled in MediCal, but 55% of all visits to psychologists and 45% of MediCal-paid psychiatrist visits.[8] The California Institute for Mental Health estimates that "the incidence of emotional, behavioral and developmental problems, among children in foster care is *three to six times greater* than children in the community."[9] The consequences of untreated mental disorders for these vulnerable children are dire - unnecessary suffering, multiple failed placements, unnecessary institutionalization, juvenile delinquency, and even suicide.[10]

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[7] *Young Hearts*, ER 04611.

[8] M. Simms, *et al.*, *Health Care Needs of Children in the Foster Care System*, PEDIATRICS. 2000; 106; 909-918 (hereafter "Simms (2000)"), Exh. B at 913 *citing* N. Halfon, *et al.*, *Children in foster care in California; an examination of Medicaid reimbursed health services utilization.* PEDIATRICS. 1992; 89:1230-1237. Another study analyzing Washington State Medicaid data from 1990 compared children in Washington's foster care program with children receiving Aid to Families With Dependent Children (AFDC); 25% of foster care children utilized mental health services compared to 3% of AFDC children. *Id. citing* J. Takayama, *et al.*, *Children in foster care in the state of Washington: health care utilization and expenditures*. JAMA. 1994; 271:1850-1855.

[9] California Institute for Mental Health, *Evidence-Based Practices in Mental Health Services For Foster Youth* (March 2002)(hereafter "CIMH Report"), ER 04813. *See Id.*, ER 04832 ("[California] foster children were twenty times more likely to use outpatient services and nine time more likely to be hospitalized for mental health problems than MediCal children not in foster care.")

[10] *Id.*, ER 04826-04831; Simms (2000), Exh. B at 912. *See, e.g.*, *Code Blue: Health Services for Children in Foster Care* (December 1998), ER 04943 (noting

California, however, has failed to satisfy its obligation to provide these children with medically necessary mental health services. Although a few California counties have enacted wraparound services ("Wraparound") and therapeutic foster care ("TFC") with great medical and financial success, neither of these services is accessible to the majority of California's foster children. Even when and where these services are provided, only a fraction of the eligible children actually receive them, and often not until after their mental health issues have escalated far beyond the point where Wraparound and TFC first became medically necessary.

On March 14, 2006, the Honorable A. Howard Matz of the United States District Court for the Central District of California issued a preliminary injunction in this action, requiring the Directors of the California Department of Heath Services (hereafter "DHS") and the California Department of Social Services (hereafter "DSS")(collectively "State Defendants") to provide Wraparound and TFC to eligible foster children in California within 120 days. The amici seek to aid the Court in evaluating this appeal by illuminating: (1) the clinical effectiveness of Wraparound and TFC services; (2) the positive and cost-effective experience California and other states have had with both services; (3) California's

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that "[a]s wards of the state, children in foster care depend on government services for medical treatment").

recognition of the benefits of Wraparound and TFC services; and (4) despite this recognition, California's failure to consistently provide these services to the foster care children enrolled in MediCal.

III. ARGUMENT

A. Wraparound Services and Therapeutic Foster Care Are Two of the Most Effective Therapies for Children With Serious Mental Health Problems.

According to the California Institute for Mental Health, Wraparound and TFC are the "only two intervention models that have demonstrated effectiveness for the treatment of foster care children."[11] Furthermore, research has shown that Wraparound and TFC are the only interventions which may be beneficial to "foster children who are disruptive, aggressive, and defiant and who experience unstable placements."[12] Although not every foster child is in need of these services, the State must comply with its obligation to the multitude of children for whom these services are medically necessary.

1. Wraparound

Wraparound services are individualized, community-based services provided to children with mental health needs as an alternative to removal from their homes and communities and placement into more restrictive institutional settings such as hospitalization or incarceration. Grealish Declaration ("Decl."), ER 06501-06505,

[11] CIMH Report, ER 04834.

[12] *Id.*, ER 04818.

¶¶ 21, 25, 27. A panel of nationwide experts has agreed that the core elements of Wraparound services are that they be "family-driven, team-based, collaborative, community-based, culturally competent, individualized, strength-based, natural-support focused, unconditional, and outcome based." Bruns Decl., ER 06213, ER 06215, ¶¶22, 33.[13] Indeed, Defendant DSS defines Wraparound similarly.[14]

These terms are key to Wraparound's effectiveness. For example, "*community-based*" means that "services should be provided in the local community or rural area where the child and his/her family live" and that "[r]estrictive or institutional care should be accessed for brief stabilization only." Dennis Decl., ER 06396, ¶ 19(b). There is a lot of evidence supporting the superior outcomes of community-based treatment as compared to restrictive placements. Bruns Decl., ER 06213, ¶ 25. "*Individualized*" services are "based on specific needs of the child and/or family, and not on a particular categorical intervention model," and include both traditional services, such as therapy, tailored to the child and family's needs, as well as non-traditional services, such as using staff to provide services in the family home. Dennis Decl., ER 06396-06397, ¶

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[13] *See also* CIMH Report, ER 04835 (providing a similar description of Wraparound).

[14] DSS All-County Information Notice No. I-28-99 (April 7, 1999), ER 04497 ("Wraparound is a family-centered, strengths-based, needs-driven planning process for creating individualized services and supports for children, youth, and their families that facilitate access to normalized and inclusive community options, activities and opportunities.").

19(g). "*Family driven*" or what one expert calls "family choice and voice" means that, "[f]rom a clinically therapeutic standpoint, the research shows that voice and choice matters. One study showed that when therapists direct treatment, without family alliance, the results are poorer than where there is family buy-in on the treatment goals." Bruns Decl., ER 06214, ¶ 26; *see also id.*, ER 06213-06214, ¶¶ 23-28 (definitions of other terms). The principle of "*strength-based*" services necessitates that "the positive aspects of the child, family and community must be considered and be an integral part of treatment planning and service delivery." Dennis Decl., ER 06396, ¶ 19(d). As a last example, the critical "*unconditional*" element means "the team agrees to never deny services because of extreme severity or disability, to change services as needs of the child and family change, and to never reject the child or family from services." *Id.*, ER 06396, ¶19(c).[15]

Wraparound has received widespread recognition as an effective therapy for children with serious mental health needs. *See, e.g.*, Bruns Decl., ER 06207, ¶ 3 ("[W]raparound is generally cited among the most effective integrated community-based interventions for children with emotional, behavioral, and mental health disorders."); Friedman Decl., ER 06451, ¶ 4 (stating that Wraparound is "a research validated evidence-based practice"); Grayson Deposition ("Dep."), ER

[15] *See* E. Bruns, *et al., Ten Principles of the Wraparound Process* (2004) (attached to Bruns Decl.) for a discussion of many of these terms.

09645, p. 125:20-23 (noting that the Department of Social Services considers Wraparound to be an evidence-based practice). The Surgeon General shares this perspective, and has specifically cited Wraparound Services as a promising practice on more than one occasion. *See, e.g.*, Bruns Decl., ER 06212, ¶ 21. As such, wraparound must be an integral part of "any modern children's mental health system." Bruns Decl., ER 06207, ¶ 3.

Where Wraparound has been implemented, the results have been "extremely encouraging." Bruns Decl., ER 06212, ¶ 21. As compared to "treatment-as-usual" programs such as group care, psychiatric hospitalization, and incarceration, Wraparound results in "greater declines in behavioral problems, greater increases in functioning, higher stability in residential placements, and an increased likelihood of permanent placement." Bruns Decl., ER 06121, ¶ 22(a). One study found that children receiving Wraparound "were significantly less likely to change placements," had lower rates of delinquency, and displayed fewer externalizing behaviors.[16] Moreover, older youths who received Wraparound were significantly more likely to be in permanent family settings or living on their own, rather than continuing to bounce around the system.[17] Just as importantly, the positive results continue after treatment ceased. During the post-intervention period, children with

[16] CIMH Report, ER 04836.

[17] *Id.*

histories of incarceration and running away display significant declines in these self-destructive behaviors when compared to their peers who received standard practice services.[18]

The State of California has repeatedly recognized the efficacy of Wraparound. The Department of Mental Health heralds the service as one "working to improve services/supports to our foster care populations and their families."[19] Similarly, DSS officials credit Wraparound with enabling foster children to live at home or in a home-like setting. Grayson Dep., ER 09266-09267, pp. 46:20-47:5.

2. Therapeutic Foster Care[20]

TFC is considered the least restrictive form of out-of-home placement for children with severe emotional disorders.[21] The service is provided by foster

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[18] *Id.*

[19] Department of Mental Health, *Talking Points, Responses to Little Hoover Commission Report*, ER 04745-04749. *See also* Department of Mental Health, *Out-Of-Home Care Report, Chapter 26.5* (1997), ER 04925 (wraparound services are among the "intensive efforts [that] are critical to the successful treatment of youth" with severe emotional disturbances and "help to minimize the need for future" out-of-home care and institutional care.)

[20] TFC is also called treatment foster care, specialized foster care, multidimensional therapeutic foster care, or multi-systemic therapeutic foster care.

[21] *Mental Health: A Report of the Surgeon General* (1999)(hereafter "1999 Surgeon General Report"), ER 04885. *See also* Chamberlain Decl., ER 06291, ¶ 9 (TFC "is widely considered to be the least restrictive and most integrating form of out-of-home placement for children with severe emotional and behavioral disorders.")

parents who are specially trained to work with children with mental health needs; these foster parents are an integral part of implementing a child's treatment plan and the child and foster parents are given ongoing supervision and support. Chamberlain Decl., ER 6292, ER 6294, ¶¶ 12(b), 12(d). Although TFC programs vary, common features include specially trained foster parents, foster homes that only take one child at a time, small and manageable caseloads for agency supervisors, higher stipends for therapeutic foster parents, extensive supervision and support during placement, continual contact with case managers and/or care coordinators, and the utilization of traditional mental health services on an as needed basis.[22]

TFC is sometimes the only option for youth unable to function in other facilities, such as group homes, due to mental health and behavioral problems, or simply a lack a skills to interact with peers. *See, e.g.*, Dennis Decl., ER 06391, ¶5; Dembrowsky Decl., ER 6330-6331, ¶ 16. Among other benefits, TFC provides crisis intervention, family counseling, access to other community support programs, assistance with child management, and skills to enhance family functioning. Friedman Decl., ER 06456-06458, ¶ 26, 28; Grealish Decl., 06494-06495, ¶¶ 3-4. Additionally, TFC also improves the rate of foster parent retention

[22] *Id.*

by increasing competency and decreasing stress among the foster parents.[23]

TFC has been called the "gold standard" of mental health intervention programs for children. Friedman Decl., ER 06450-06451, ¶ 4. Like Wraparound, TFC is also an extremely effective treatment for children with mental health needs, and it is widely considered to be an "evidence-based practice."[24] *Id.*, ER 06450-06451, ¶ 4; *see also* Neilsen Dep., ER 05871, p. 187:9-18 (noting that TFC is widely considered an evidence-based practice); Chamberlain Decl., ER 06297, ¶ 16 (stating that Multidimensional Therapeutic Foster Care is widely accepted as an evidence-based practice for controlling and allaying delinquency and anti-social behavior caused by the psychological, behavioral, or emotional impairments).

Experts agree that TFC is a critical mental health service for youth. In the opinion of one national expert, any "children's mental health system that does not include [TFC] as an available intervention is incomplete and inadequate." Chamberlain Decl., ER 06289, ¶ 3. See also Grealish Decl., ER 06506, ¶ 34 (TFC

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[23] *Id.*

[24] There are numerous references throughout the literature establishing an "evidence-based practice" as the highest standard in mental health clinical research. To be considered an "evidence-based practice" by the National Institute of Mental Health, a therapy must have: "(1) at least two control designs or a large series of single-case design studies; (2) a minimum of two investigators; (3) use of a treatment manual; (4) uniform therapist training and adherence; (5) true clinical samples of youth; (6) tests of clinical significance of outcomes applied; (7) both functioning and symptom outcomes reviewed; and (8) long-term outcomes beyond termination." CIMH Report, ER 04833.

is "a necessary component of a children's mental health system"); Friedman Decl., ER 06459, ¶ 31 (TFC is "widely thought of as essential to any modern children's mental health system.") According to Dr. Chamberlain, a psychologist who developed a TFC program "lauded by the federal government," providing treatment in "home-like settings" is "necessary for many children with serious behavioral or mental health needs." *Id.*; Order Granting Pls.' Mot. for Prelim. Inj., *Katie A. v. Bonta*, No. CV02-5662 AHM (Mar. 14, 2006), ER 14686.

Several studies have demonstrated the effectiveness of TFC in treating mental health issues in children. For example, a study that focused on youth with histories of chronic delinquency found that TFC youths were incarcerated less frequently and for fewer days that those in group care.[25] The youth in TFC were 44% less likely to be incarcerated after two years as compared to their counterparts who were not receiving these treatments.[26] Another study of children who had been previously hospitalized for mental health disorders found that the children who received TFC showed more behavioral improvement and lower rates of re-institutionalization than their peers who were placed in other out-of-hospital

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[25] 1999 Surgeon General Report, ER 04886.

[26] Although the TFC group was diverted from correctional institutions to foster care (and the control group was already in group care-type arrangements), the two groups had similar criminal backgrounds before the study; 69% of the TFC youth had prior felony charges, compared with 63% of the youth in group care. *See* R. Hahn, *et al.*, *The Effectiveness Of Therapeutic Foster Care for the Prevention of Violence*, American Journal of Preventive Medicine (2005) at 79.

settings, such as residential treatment homes or group care.[27] Additionally, a study comparing children in TFC to children in standard foster care over a two-year period found that the TFC children were less likely to run away or be incarcerated, and generally showed greater emotional and behavioral adjustment.[28]

Perhaps most telling, however, was a study by the National Institute of Mental Health where delinquent boys aged 14 to 17 were randomly assigned to either TFC or group care.[29] One year after the children left their placements, 41% of the TFC boys had no criminal referrals, compared with only 7% of the group care youth.[30] After two years had elapsed, the results were even more dramatic; a significantly greater number of the TFC children worked in legal jobs, reported no use of drugs, had a positive relationship with their parents, and had abstained from unprotected sex.[31] In evaluating the National Institute study, the 1999 Surgeon General's Report noted that children in TFC "showed significantly fewer criminal referrals, returned to live with relatives more often, ran away less often, and were confined to detention or training schools less often."[32]

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[27] 1999 Surgeon General Report, ER 04886.

[28] *Id.*

[29] *Id.* *See also* CIMH Report, ER 04837.

[30] *Id.*

[31] *Id.*

[32] *Id.*

B. California And Other States Have Implemented Wraparound And TFC Services With Great Successes.

1. Wraparound

California's Wraparound services have been overwhelmingly successful where given an opportunity. In particular, trials in California counties implementing Wraparound have consistently produced positive outcomes. Among other benefits, these services have resulted in increased permanency and stability of placements, as well as a corresponding decrease in disruptive behavior, hospitalizations, and anxious/depressed behavior among foster children.[33]

For example, while the breadth of these programs in Los Angeles county has been limited, the results thus far have been overwhelmingly positive. Of the twelve Los Angeles children who had graduated from Wraparound programs as of August of 2005, only one had re-entered foster care within the following year.[34] Furthermore, when compared to children who did not receive Wraparound services, the graduates of Wraparound were significantly less likely to re-enter the purview of the Department of Children and Family Services.[35]

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[33] Letter from Sylvia Pizzini, Deputy Director, Children and Family Services Division, Department of Social Services to Dr. Susan Orr, Ph.D., Associate Commissioner, Children's Bureau, Administration for Children, Youth and Families dated March 28, 2003 (hereafter "DSS Title IV-E Waiver Letter"), ER 04893, ER 04899. *See also* Grayson Dep., ER 09266-09267, pp. 46:20-47:15.

[34] Katie A. Advisory Panel, *Fifth Report to the Court* (August 16, 2005) (hereafter "Fifth Panel Report"), ER 05534.

[35] *Id. See also* Katie A. Advisory Panel, *Third Report to the Court* (September 7,

In Sacramento County, Wraparound programs reported positive outcomes for the youth involved, and also resulted in a cost savings to the county. Farr Decl., ER 06417, ¶ 2. One Sacramento study of foster children found that those who were receiving Wraparound services were less likely to be incarcerated than those who were not given the opportunity to benefit from these programs. Schroeder Decl., ER 07188, ¶ 23. The results were so remarkable that the Board of Supervisors voted to expand eligibility for Wraparound to all children who are placed in Rate Classification Level ("RCL")[36] facilities of level 10 and above, rather than limiting it to those children who had a RCL classification of 12 or higher. *Id.*

Mono County also reported positive results.[37] Mono County's 2004 Wraparound Report concluded that its Wraparound program improved emotional and behavioral adjustments and prevented placement into more restrictive environments.[38] The report specifically told the story of one child who was failing

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2004) (hereafter "Third Panel Report"), ER 05525.

[36] Group homes in California are classified into RCLs of 1 to 14, using a point system designed to reflect the level of care and services they provide. Department of Social Services, *Reexamination of the Role of Group Care in a Family-Based System of Care*, ER 04772.

[37] Letter from Ann Gimbel, Ph.D., Program Chief, Mono County Mental Health to Greg Rose, Bureau Chief, Resources Development and Training Support, DSS dated April 7, 2004 (hereafter "Mono County 2004 Wraparound Report"), ER 05467.

[38] *Id.*, ER 05469.

in school and had also been caught shoplifting.[39] After receiving Wraparound services for 12 months, the boy was able to turn his life around, staying out of trouble with the law and also earning passing grades in school.[40]

Youth in Butte County also benefited from Wraparound services, achieving an 81% success rate during 2004.[41] Wraparound services reduced the average time Butte County children spend in foster care and group home placements, reunified children with their families more quickly, and reduced the suicide rate among children receiving these services.[42]

Mendocino County also reaped tremendous benefits from its Wraparound services. The county reported overwhelming success in keeping "at-risk" children out of residential placement and bringing other children home from residential treatment.[43] The county also found that Wraparound services improved a child's

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[39] *Id.*, ER 05468.

[40] *Id.*

[41] Letter from Patricia S. Cragar, Director, Butte County Department of Employment and Social Services to Greg Rose, Bureau Chief, Resources Development and Training Support, DSS (hereafter "Butte County 2004 Wraparound Report"), ER 05476.

[42] *Id. See also* Letter from Michael W. Clarke, Ph.D., Assistant Director, Butte County Department of Behavioral Health to Jake Donovan, Technical Assistance Liaison, California Department of Mental Health dated July 13, 2000, ER 05076 ("During the past ten years there have been no suicides involving children or youth under our care").

[43] Mendocino County Children's System of Care, SB 163 Wraparound Services Pilot Project Final Report (hereafter "Mendocino County Wraparound Report"),

family functioning, social performance, emotional and behavioral adjustments, school attendance, and academic performance.[44]

Other states have discovered similar results with the implementation of Wraparound services. Arizona provides Wraparound to all children with serious mental health needs who are Medicaid-eligible (which includes virtually all children in its state foster care system). Penrod Decl., ER 06877-06878, ¶ 20. Furthermore, the state is now making Wraparound available to all Medicaid-eligible children who are enrolled in the behavioral health system. *Id.*, ER 06877-06878, ¶ 20. Arizona cites many reasons for extending eligibility for Wraparound, including its effectiveness in improving children's well-being, as well as significant family satisfaction with the services. *Id.* Arizona's experience shows that, over time, Wraparound services strengthen a child's family-based support system and decrease his/her reliance on behavioral health services. *Id.*, ER 06879, ¶ 24.

Similarly, Wraparound Milwaukee began in 1995 and has since effectively served many children and families. Kamradt Decl., ER 06568-06599, ¶¶ 11-12. Wraparound Milwaukee has returned more than 80% of the children in residential treatment centers to their homes or communities, where they typically resumed

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ER 05470.

[44] *Id.*, ER 05472.

their education. *Id.*, ER 06599, ¶ 12. Some of those children with severe mental health needs subsequently attended colleges or trade schools, while others successfully obtained work upon turning age 18. *Id.* Follow-up data also indicates that recidivism rates for those children decreased while they were receiving Wraparound services and remained reduced through one- and three-year follow-ups. *Id.* Only a small percentage of Wraparound Milwaukee participants returned to residential treatment centers or psychiatric hospitals. *Id.*

2. **Therapeutic Foster Care**

California providers of TFC have had similar positive results. One provider, Walden Family Services ("Walden") has been providing a multi-dimensional treatment foster care service since January 2004. Watrous Decl., ER 07199, ¶ 5. Since implementing TFC with an initial group of ten children, Walden noticed several mental health symptom and treatment improvements, such as a staggering decrease in negative behaviors such as fighting, property destruction, stealing, and the use of obscene language. *Id.*, ER 07199-07200, ¶6. The provider also noted increased stability in educational and residential placements - from 1.6 to fewer than 0.1 changes per year in educational placements, and from 2.2 residential transfers per year to fewer than 0.25. *Id.*, ER 07200, ¶7. Significantly, no child receiving Walden's TFC service has been discharged to a higher RCL level of care, despite the fact that half of the participants were referrals from RCL 12 group

homes that would have been placed in more restrictive settings. *Id.*

Another provider from Humboldt County, and a foster parent, explains the dramatic difference access to TFC can make in a child's life:

> Being a therapeutic foster parent is a full-time job...These children need constant supervision, and work best with a very structured schedule.
>
> ...When kids with high needs are placed in foster homes that are not equipped to deal with their issues, almost without fail the placements are unsuccessful within a few weeks. As a result, a high needs kid will never spend enough time in one home to stabilize, and instead [will] bounce from home to home, losing self-confidence with each move and becoming less and less willing to attach to their foster parents.
>
> ...the TFC program and wraparound services give foster parents the training and support to cope with a child's behavioral issues, which means that a child will not quickly fall out of a placement. A TFC home has the opportunity to actually implement a service plan for their foster children and see it develop.
>
> ...TFC kids also get a chance to observe healthy family relationships, possibly for the first time in their lives.

Nunn Decl., ER 06866-06869, ¶¶ 19, 21, 23-24, 26.

C. **California Has Recognized The Benefits of These Therapies and Implemented Legislation to Provide Them.**

Wraparound services in California have been funded primarily through a state-funded program created by Senate Bill ("SB") 163 and through a joint State and federal pilot program in five counties known as the Title IV-E Waiver. Burgess Decl., ER 06265-06266, ¶¶ 9-10. Governor Pete Wilson signed SB 163 in 1998, expanding Wraparound from a pilot project in Santa Clara county to a five-

year and state-wide Wraparound pilot for foster care children in RCL facilities of 12 and higher. Two subsequent legislative measures, Assembly Bill ("AB") 2706 and 429, expanded Wraparound in California by allowing children in RCL facilities of 10 and higher to access Wraparound services, and removing the five-year limitation on the program.

Certain California counties also implemented Wraparound services through the Title IV-E waiver. The Title IV-E waiver is a "federal demonstration project that permits states to use their IV-E funds for services instead of using IV-E funds for board and care." Treadwell Dep., ER 05906, p. 17:3 - 6. Title IV-E itself is a federal funding program providing entitlements to children in foster care. *Id.*, ER 05905-05906, pp. 16:25 - 17:1. There were five "waiver counties" in 2004: Alameda, Los Angeles, Sacramento, Humboldt, and San Luis Obispo. *Id.*, ER 05906-05907, pp. 17:13 - 15, 18:23 - 25.

Interestingly, the State Defendants have historically been proponents of the benefits of Wraparound and TFC, often advocating for an expansion of the services under the state and federal funding programs. In 2003, in advocating for a five-year extension of the Title IV-E waiver, for example, DSS heralded several benefits of Wraparound, including: (1) a decrease in placement disruptions, (2) increased movement towards permanent arrangements, (3) a decrease in hospitalizations, and (4) a decrease in anxious and/or depressed behavior in the

studied youth.[45] DSS also emphasized the successes the "waiver counties" had experienced with Wraparound.[46]

D. Implementing Wraparound and TFC Would Save California Millions of Dollars.

The State of California will save a substantial amount of money by providing quality Wraparound and TFC services to all eligible children for whom they are medically necessary. In the short term, both Wraparound and TFC are generally considered to be cheaper than more restrictive placements such as institutionalization or incarceration. Kamradt Decl., ER 06594-06595, ¶ 3 (providing Wraparound and TFC to children with serious mental health needs "yields much better outcomes in terms of the child's development and stability in the community and costs approximately half as much as placing these same children in residential treatment centers or a fraction of the cost of psychiatric hospitals.").[47] For example, as noted by the Surgeon General, TFC services are inexpensive to start because of the few requirements for facilities or salaried staff.[48]

The benefits are even greater in the long term, as the children who pass

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[45] DSS Title IV-E Waiver Letter, ER 04893.

[46] *Id.*, ER 04899-04900.

[47] *See also* 1999 Surgeon General Report, ER 04885 (TFC and Wraparound tend to be cheaper to implement than many alternative and more restrictive treatments); *see also Young Hearts*, ER 04581, ER 04632.

[48] 1999 Surgeon General Report, ER 04885.

through these programs will mature into productive adults with a decreased likelihood of becoming homeless, institutionalized, incarcerated, or otherwise dependent on long-term social services.[49] The result will be a significant reduction of the financial burden that the State would otherwise incur from having to support and incarcerate another generation of adults who have been failed by a system charged with protecting them.

Wraparound and TFC services cost less than the more restrictive programs, such as residential treatment, state hospitals, and the juvenile justice system, all of which are extremely expensive to administer in California. For example, residential treatment facilities strain the state budget to the annual tune of $780 million. State hospitals consume another $48 million in annual taxpayer revenue.[50] California juvenile detention facilities spend approximately $130 per day to house the 11,529 children who are in these facilities at any given time, resulting in a staggering yearly cost of approximately $547 million.[51] With a monthly tab of $3,100 in housing costs and an additional $1,750 in treatment costs for each of the 7,200 youth whom it serves, the additional financial burden resulting from operating the California Youth Authority is in the neighborhood of $419 million

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[49] *See infra* at Sections A - B.

[50] *Young Hearts*, ER 04632.

[51] *Id.* , ER 04581, 04632.

annually.[52] The resulting total yearly expenditure for these highly restrictive settings alone is in excess of $1.7 billion.

The California counties that do provide Wraparound and TFC have already begun to realize cost savings as a result of these services. Sacramento County, for instance, was able to save approximately six million dollars in foster care funding over the course of a six months Title IV-E waiver project. Farr Decl., ER 06430-06432, ¶¶ 17-20. Mendocino County found that Wraparound services saved approximately $3,400 each month, per child.[53] Plumus County saved $105,812 in one year by keeping just eight children at home and providing Wraparound services rather than sending them to out-of-home placements.[54] In 2002, Butte County was able to save $1,601 per family, per month, by providing Wraparound services instead of the usual placements; in 2003, this number increased to $1,988 per month, presumably the result of the program's becoming more cost efficient over time.[55] Ex. 139 at 000978. Mono County also reaped the benefits of Wraparound services, realizing an annual savings of $110,000 per child when compared to placement in a level 14 facility, and another $1,400 annually per child

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[52] *Id.*, ER 04581.

[53] Mendocino County Wraparound Report, ER 05471.

[54] Plumas County, *SB 163 Final Evaluation Report* (March 17, 2004), ER 05475.

[55] Butte County 2004 Wraparound Report, ER 05478.

when compared to a level 11 placement.[56] Humboldt County saved almost $1,100 per month, per child, and found that these savings increased over time once the children and their families became stable.[57]

Arizona has also discovered that Wraparound cuts costs by keeping children out of expensive residential treatments. In at least one case, Arizona saved over a million dollars by using Wraparound services to successfully treat a child who would have otherwise required expensive out of home care. Penrod Decl., ER 06878, ¶ 21. Impressive savings have been achieved in similar cases. *Id.*, ER 06878-06879, ¶¶ 22-23.

Wraparound Milwaukee's extraordinary success has also been cost efficient as Wraparound services have proven to be much less expensive than residential treatment center placements. In 2004, the monthly cost of placement in a Milwaukee residential treatment center was approximately $7,400 per child; that figure became $8000 to $10,000 per month once the costs of case management, child welfare services and other necessary expenses were added. Kamradt Decl., ER 06601, ¶ 16. In contrast, the monthly cost of Wraparound Milwaukee services was approximately $3,900 per child in 2004; this figure covered all services for the

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[56] Mono County 2004 Wraparound Report, ER 05469.

[57] Humboldt County Department of Health and Human Services, Report to the Legislature on Humboldt County's Wraparound Services Program (April 1, 2004), ER 05474.

child, including foster care or group care, mental health services, and social or other support services. *Id.*, ER 06601, ¶ 17.

TFC services have also been proven to be cost-effective in several other states, including Oregon and Oklahoma. TFC services are billed at a rate of only $2,387.20 per month in Oregon, where non-profit organizations have partnered with state and local agencies to provide MTFC. Redman Decl., ER 06980, ¶ 26; Chamberlain Decl., ER 06289-06290, ¶¶ 5-6. Oregon's MTFC program was recently evaluated by the Washington State Public Policy Group ("WSPPG") and it ranked first among all evaluated juvenile justice programs in providing cost-savings to the taxpayer. Chamberlain Decl., ER 6300, ¶ 26. WSPPG's report found:

> Overall taxpayers gain approximately $12,836 in subsequent criminal justice cost savings for each program participant. Adding the benefits that accrue to crime victims increases the expected net present value to $87,622 per participant, which is equivalent to a benefit-to-cost ration of $43.70 for every dollar spent. *Id.*

Oklahoma's experience provides additional evidence of TFC's cost-effectiveness. TFC is billed in Oklahoma at a rate of $49.27 per day, or $1478.10 for a 30-day month. Redman Decl., ER 06980, ¶ 25. This rate is astoundingly low considering that it covers the behavioral management services provided by foster parents, as well as additional therapy services provided to the individual child and his/her family. *Id.*

The long term outlook is even brighter. By implementing Wraparound services and TFC, the State will be able to avoid the enormous costs that result from the need to support or incarcerate these children during their adult lives. Perhaps most important is a potential that is priceless - the opportunity these children will have to lead healthy, productive, adult lives.

E. Wraparound and TFC Services Are Only Available to California Children in Foster Care On A Limited and Ad Hoc Basis.

Most foster children who need help do not have access to these proven and remarkable services. Wraparound is "an elective service to be offered at the discretion of each county" in California. Burgess Decl., ER 06266, ¶ 11. Wraparound is only provided to California foster care children on an ad hoc basis, as each county can choose whether it wants to provide Wraparound services through one of two pilot programs – the state-funded SB 163, and the federally-funded Title IV-E waiver demonstration program. Grayson Dep., ER 09327-09328, pp. 107:24-108:24; Burgess Decl., ER 06266, ¶ 11; Treadwell Dep., ER 05904-05906, pp. 15:17-17:15. Unfortunately, only 24 out of 58 counties in California provided Wraparound services as of February 2004. Treadwell Dep., ER 05904, ER 05906, ER 05925-05943, pp. 15:20-23, 17:13-18:5, 69:20-87:17.

Even among the participating counties, Wraparound is only provided to a fraction of the eligible foster care children. Eligibility for Wraparound in California is currently limited to foster children who are residing in or at risk of

being placed in RCL facilities of 10 or above for SB 163 counties, and RCL facilities of 12 or above for Title IV-E waiver counties. Grayson Dep., ER 09258-09259, pp. 38:14-39:16; Treadwell Dep., ER 05910, p. 22:7-10. Counties wanting to provide Wraparound to children in lower RCL placements, like Marin County, must do so outside the parameters of SB 163. Treadwell Dep., ER 05923-05924, pp. 48:11 - 49:15.

Additionally, counties have complete discretion concerning the number of Wraparound "slots" that they wish to provide. Treadwell Dep., ER 05909, ER 05915, ER 05948, pp. 21:22-22:1, 31:21-25, 102:20-23. Counties are not required to provide Wraparound to all children in the target population for whom such services would be medically necessary or otherwise appropriate. *Id.*, ER 05901, ER 05903, ER 05913, ER 05918-05919, ER 05920, pp. 9:1-10:25, 13:3-13, 27:1-28:10, 38:20-39:1, 40:15-20. Counties are not even required to serve a minimum percentage of children in their target population. *Id.*, ER 05912, p. 24:10-13. As of February 2004, the 24 participating counties only had the combined capacity to provide services to approximately 1,500 children - a mere fraction of the children for whom these services are medically necessary. *Id.*, ER 05925-05943, pp. 69:20-87:17.

F. The Experience of Other States Shows That Federal Funding Is Clearly Available for Wraparound and TFC.

Besides providing evidence on effectiveness and cost-savings, the

experiences of other states clearly demonstrate that both TFC and Wraparound are eligible to be funded by Medicaid. Several states use their Medicaid programs to cover Wraparound, and nearly half of the states use Medicaid funds to cover TFC. Koyanagi Decl., ER 06645, ¶ 3. For example, Arizona covers its Wraparound and TFC services as "medically necessary" EPSDT services. Penrod Decl., ER 06872, ¶ 3; Redman Decl., ER 06973, ER 06977-06978, ¶¶ 3, 18. Similarly, Oregon and Oklahoma also bill Medicaid for the TFC services they provide. Redman Decl., ER 06978, ER 06980, ¶¶ 19-20, 25-26; Chamberlain Decl., ER 06300, ¶ 27. Thus, there can be no question that Medicaid can be used to fund these services.

IV. CONCLUSION

For the reasons stated, *amici curiae* urge the Court to affirm the Order granting appellees' motion for preliminary injunction in its entirety.

Dated: August 10, 2006

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EXHIBIT A

Amicus Curiae Descriptions

Amicus American Academy of Child and Adolescent Psychiatry (AACAP) is a non-profit organization whose membership includes over 7,400 child and adult psychiatrists. Established in 1953, the AACAP is the leading national medical association dedicated to treating the myriad of mental, behavioral, and developmental disorders that affect an estimated seven to twelve million American youth. The AACAP strives to improve the quality of life of the children and families subjected to these disorders by providing universal access to care for all children and adolescents, expanding research programs for prevention and treatment of mental disorders, and providing other integrated services that will meet the needs of the affected children and their families in a community setting. The AACAP is committed to protecting the well-being and rights of the children and families who are afflicted by these disorders.

Amicus the American Academy of Pediatrics, California District IX (AAP-CA) is a joint venture of the four regional AAP Chapters. AAP-CA is comprised of over 5,000 board-certified pediatrician members distributed statewide, representing over 80% of board-certified pediatricians in the state. The mission of the AAP-CA is to promote optimal physical, mental, and social health and well-being for all infants, children, adolescents and young adults living in California. To that end, the AAP-CA educates pediatrician members, the public and the press

regarding the essential health care needs of California's children, adolescents and young adults. In addition, the AAP-CA is a leader in the child advocacy community in designing, developing and implementing policies and collaborative strategies to improve and support quality child health care systems and delivery.

With numerous agencies dedicated to foster family-based care and treatment, mental health treatment services, therapeutic behavioral services, and wraparound services and support, *amicus* California Alliance of Child and Family Services (CACFS) is deeply committed to improving the lives of children with mental health disorders. CACFS is a statewide association of over 150 nonprofit child and family service agencies that reflect the cultural, racial, and ethnic diversity of the people of this State. The Alliance pursues an aggressive statewide agenda of legislative and regulatory advocacy designed to enhance the lives of the children and families that they serve. The member associations of the CACFS share a commitment to excellence and ardently strive to improve the quality of care and services that are available to at-risk children and their families.

Amicus California Adolescent Health Collaborative (AHC) is a statewide coalition with an established history of working to increase understanding and support for adolescent health and well-being across California. Founded in 1996, the collaborative includes over 800 organizations and individuals involved with

clinical care, policy development, research, public health, youth development, advocacy, legal aid, schools, and youth services. This work is of particular importance in California, as one out of every eight adolescents in the United States lives in our state. It is the only statewide organization whose primary role is to advance an adolescent health agenda that is comprehensive, integrated, and focused on prevention.

Amicus California Association of Social Rehabilitation Agencies (CASRA) was one of the first agencies in the nation to develop a system of community-based residential treatment alternatives for people with mental disorders. Founded in 1969, CASRA is dedicated to providing better services and improving social conditions for people with mental health disabilities. CASRA accomplishes their goals by promoting the recovery, rehabilitation, and legal rights of the millions of people who have mental health disorders. CASRA has vast experience in promoting and supporting the development and implementation of community-based systems of services.

Amicus California Nurses Association (CNA) and its national arm, the National Nurses Organizing Committee (NNOC), a is a nonprofit professional nursing association of more than 70,000 registered nurses, more than 60,000 of whom practice in the State of California. CNA's primary goal is to promote

patient advocacy that protects patients and ensures a single standard of high quality healthcare for all. CNA is a leader in the promotion of patient safety through advocacy for appropriate healthcare staffing and a leader in the professional and educational advancement of registered nurses designed to foster high standards of nursing practice.

Amicus California Public Health Association - North (CPHA-N) is an independent, member-supported association focused on the health of the public. It draws its membership from professionals working in all sectors of public health. CPHA-N provides leadership in California by studying public health needs and problems, initiating action to remedy problems, and providing an opportunity for persons actively engaged or interested in the broad field of public health to share knowledge and experiences in order to achieve the primary goal of protecting and promoting public, environmental, and personal health. CPHA- N influences the development of statewide health policy through strong working relationships with the State legislature and administration, local health officials and elected representatives; close ties with schools of public health, teaching hospitals, and the research community; collaboration with community-based organizations and coalitions, advocates, and labor unions; and dialogue with public and private health care providers. CPHA-N functions actively as an affiliate of the American Public Health Association, supporting and contributing to the work of the national

organization.

Amicus California School Nurses Organization (CSNO) is a non-profit organization whose membership includes approximately 1,400 school nurses across California. It is a unified affiliate member of the National Association of School Nurses (NASN), having a seat on the NASN Board of Directors. The role of school nurses is that of the primary health professional within the educational community. CSNO was formally organized in 1950 for "the promotion of comprehensive and constructive school health programs and for the promotion of professional advancement of school nurses." Since the 1950's, CSNO has been promoting and strengthening the role of school nurses in the educational community. Today the organization's goals are professional development, legislative advocacy, communication among school nurses, membership recruitment, public relations, governance, and leadership development.

Amicus California Teachers Association has 330,000 members comprised of teachers, school counselors and nurses, librarians, and other certificated employees who work in California public schools. The vast majority of public school certificated employees belong to CTA, an organization that represents employees not only in their employment relations, but also provides resources for employees' professional development. One of the purposes of the Association is to further the

educational interests of the State of California, to give increasing efficiency to its school system, and to furnish a practicable basis for united action among those devoted to the cause of education in California. The Association is guided in its legislative and advocacy efforts by policies that call for effective social services to be available to students and their families, positive and preventative programs aimed at reducing child abuse and neglect, and full state funding for psychological, counseling, health and social services.

Amicus Children's Advocacy Institute (CAI), founded in 1989 as part of the University of San Diego School of Law, is a nonprofit academic and advocacy center dedicated to improving the health, safety, and well-being of California's children. *Amicus* CAI operates legal clinics representing abused and neglected children in juvenile dependency court and engaging in policy advocacy on behalf of children; operates advocacy offices in Sacramento and San Diego; and engages in legal and budget research relevant to children, which is published in several sources, including *Child Rights & Remedies* (a law school text), the *California Children's Budget*, the *Children's Regulatory Law Reporter*, and the *Children's Legislative Report Card*. CAI's goal is to educate policymakers about children's needs for economic security, adequate nutrition, health care, education, quality child care, and protection from abuse, neglect, and injury.

Amicus Children's Law Center (CLC) of Los Angeles is a nonprofit, public interest legal organization funded by the California State Courts. The CLC serves as the voice of abused and neglected youth in the Los Angeles County foster care system. The CLC, which represents more than 80% of the nearly 30,000 children under the jurisdiction of the Los Angeles County Juvenile Dependency Court System, is the largest representative of foster children in California. With more than 185 attorneys and staff, the CLC is dedicated to advocating for the critical services and support that these at-risk youth need to flourish and mature into productive adult members of society. The attorneys and staff of the CLC passionately endeavor to secure the well-being and future success of each child who comes under their care.

Amicus Federation of Families for Children's Mental Health (FFCMH) is a national, family-run organization that serves as a voice for children with mental health disorders. Founded in 1989 as a grassroots organization, the FFCMH now has thousands of members and over 140 chapters spread among 48 different states and the District of Columbia. *Amicus* FFCMH uses their strong national presence to help educate both state and federal policy makers about the issues that affect the daily lives of the millions of children and families affected by mental health disorders. The Federation is avidly dedicated to helping these children and their families achieve a better quality of life and a successful future.

With chapters in all 50 states as well as the District of Columbia and Puerto Rico, the National Alliance for the Mentally Ill (NAMI) is the nation's largest grassroots mental health organization. Founded in 1979, *amicus* NAMI has blossomed into a national organization with over 220,000 members and chapters in over 1,200 local communities throughout the United States and its territories. By facilitating numerous advocacy, research, support and education programs, NAMI strives to improve the quality of life of the millions of people and families in this country who are affected by mental disorders. The Alliance's strong national presence combined with their vast network of local members and volunteers enables them to effectuate wide-ranging policy changes while simultaneously helping the individuals and families who cope with mental disorders every day.

The National Association of Social Workers (NASW), and the NASW California Chapter, is the largest organization of professional social workers in the world. Founded in 1955, *amicus* NASW currently has 56 chapters and over 150,000 members who are dedicated to improving the quality and effectiveness of social work in the United States. The California Chapter of NASW represents 12,000 social workers. NASW is devoted to promoting the quality and effectiveness of social work practice, advancing the knowledge base of the social work profession, and improving the quality of life though utilization of social work knowledge and skills. NASW members provide services to individuals and

families in a variety of settings including mental health clinics, group homes, private practice, and in all facets of child welfare.

One of the country's foremost advocates for the effectiveness of community-based rehabilitative services, *amicus* National Council for Community Behavioral Health (NCCBH) is a nonprofit organization of 1,300 behavioral healthcare organizations. The National Council provides treatment and rehabilitation to nearly six million adults, children and families who are afflicted with various mental disorders. Since its inception in 1970, the NCCHN has served as a testament to the increased effectiveness of medical, social, psychological, and rehabilitation services when they are offered in community-based settings. The NCCHN and its members bear testimony to the fact that such programs help people with mental disorders recover from their ailments and lead productive lives.

The National Mental Health Association (NMHA) is the country's oldest and largest nonprofit mental health organization. *Amicus* NMHA has over 340 affiliates who are dedicated to improving the mental health of all Americans, especially the 54 million people who have severe mental disorders. Through various forms of advocacy, education, research, and service, the NMHA helps to ensure that the mentally ill are accorded respect, dignity, and the opportunity to achieve their full potential. The Association is deeply committed to enabling the

mentally ill to blossom into fully functional adults who are free from the burdens of stigma and prejudice often imposed upon them by society.

The Southern California Public Health Association (SCPHA) is an affiliate of the American Public Health Association representing more than 300 health professionals in Southern California. SCPHA provides public health leadership to maintain and enhance health promotion, disease and injury prevention, and health protection efforts in California. SCPHA strives to improve the health of people in Southern California by: working with public health and other agencies in health promotion and disease prevention activities; providing opportunities for public health professionals to enhance their knowledge; and formulating and advocating sound public health policy. SCPHA actively collaborates, educates, and advocates with organizations and individuals who share this common vision.

EXHIBIT B

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Health Care Needs of Children in the Foster Care System

Mark D. Simms, Howard Dubowitz and Moira A. Szilagyi

Pediatrics 2000;106;909-918
DOI: 10.1542/peds.106.4.S1.909

Health Care Needs of Children in the Foster Care System

Mark D. Simms, MD, MPH*; Howard Dubowitz, MD, MS‡; and Moira A. Szilagyi, MD, PhD§

Abstract. **Nearly 750 000 children are currently in foster care in the United States. Recent trends in foster care include reliance on extended family members to care for children in kinship care placements, increased efforts to reduce the length of placement, acceleration of termination of parental rights proceedings, and emphasis on adoption. It is not clear what impact welfare reform may have on the number of children who may require foster care placement. Although most children enter foster care with medical, mental health, or developmental problems, many do not receive adequate or appropriate care while in placement. Psychological and emotional problems, in particular, may worsen rather than improve. Multiple barriers to adequate health care for this population exist. Health care practitioners can help to improve the health and well-being of children in foster care by performing timely and thorough admission evaluations, providing continuity of care, and playing an active advocacy role. Potential areas for health services research include study of the impact of different models of health care delivery, the role of a medical home in providing continuity of care, the perception of the foster care experience by the child, children's adjustment to foster care, and foster parent education on health outcomes.** ***Pediatrics*** **2000;106:909–918;** ***foster care, child welfare, children with special health care needs.***

ABBREVIATIONS. HIV, human immunodeficiency virus; ASFA, Adoption and Safe Families Act of 1997; AFDC, Aid to Families With Dependent Children; MCO, managed care organization; CATCH, Community Access to Child Health.

Despite efforts to prevent child abuse and neglect, decrease the rate of out-of-home placement of maltreated children through family preservation programs, and increase the number of adoptions of children out of foster care, nearly three-quarters of a million children are currently in foster care in the United States.[1] Over the past 2 decades, the greatest increase in placements has occurred among African-American children and infants and children <5 years old. Increasingly, there is a preference for placing children deemed in need of substitute care with kin. In some cities and states, in 1994 there were more children in kinship care than in regular foster care.[2] (In this article we use the generic term foster care to encompass care provided by both relatives, and nonrelatives, unless otherwise specified.) Nonetheless, in 1995 the Child Welfare League of America reported that out of a total of 483 000 children then living in out-of-home care, 49% were living in family foster care, 23% in kinship care, 15% in residential group care, 1.7% in therapeutic foster care, and 11.3% in other facilities such as emergency shelters and psychiatric hospitals.[3]

The vast majority of children are placed in foster care as a result of neglect, physical abuse, parental substance abuse or abandonment.[4] Contrary to a prevailing misconception, only approximately 10% of children for whom abuse or neglect is substantiated (approximately one-third of those reported) are removed from parental care. Consequently, children in foster care are a very high-risk group of children and youth. Some children spend a substantial portion of childhood in foster care. For example, an analysis of national data on the characteristics of children in foster care revealed that approximately 37% had been in out-of-home care for 2 years or more, and approximately 12% had been in care for more than 5 years,[5] while in some large urban centers (eg, Cook County, Illinois) the median duration of placement approached 5 years in 1994.[6]

Many children enter foster care with chronic health, developmental, and psychiatric disorders, reflecting the neglect and abuse experienced before placement in addition to the trauma from being separated from their parents. More disturbing, however, is evidence that their health care is often neglected while in foster care. In 1995, the US General Accounting Office found that young foster children do not receive adequate preventive health care while in placement, many significant problems go undetected, or, if diagnosed, are not evaluated and treated.[7] Among other things, this neglect of children's basic health care needs is a result of inadequacies in the foster care system, as well as inadequacies in the health care system.

Several efforts have been made to remedy this problem. More than a decade ago the Child Welfare League of America, in collaboration with the American Academy of Pediatrics, published guidelines for health care of foster children.[8] Class action lawsuits in at least 21 states have challenged state agencies to ensure adequate care, including health care, for this very high-risk group.[9] With a few notable exceptions, obstacles to delivering ade-

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Received for publication Apr 11, 2000; accepted Jul 10, 2000.

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quate care to these children have persisted. The idealistic assumption that removing children from their parents obligates the state to provide exemplary care has seldom materialized. Thus, clinical and research challenges continue for health care providers and others involved in the lives of these children.

The purpose of this article is to review what is known about the health status and health care needs of children in the foster care system, offer practical guidelines for primary health care practitioners who care for children in foster care, and suggest areas for further medical, mental health, and developmental services research.

BRIEF HISTORY OF FOSTER CARE IN THE UNITED STATES

Until nearly 150 years ago, families who could not raise their own children relied for help on extended family members, charity from religious organizations, or orphanages. Many older children were apprenticed to tradesmen as a means of preparing them for adulthood.[10] State-supported foster care in the United States arose in the 19th century from social welfare programs that sent children from Eastern cities to the Midwest, where they lived with farm families as an escape from the dangers of urban life. In 1863, the Massachusetts State Board of Charities approved funding for a system of state-supported foster homes, paying nonrelatives a weekly stipend of $2.00 to care for children in need of out-of-home placement. Federal support for foster care was established in 1933 under Title IV of the Social Security Act. In the 1960s the number of children placed in foster care rose dramatically in response to increased awareness of the problem of child abuse. However, by the late 1970s social service researchers had documented that many children remained adrift in the foster care system because little effort was made to either reunify them with their biological families or arrange for adoptions.[11,12] In 1980, the Child Welfare Reform Act (PL 96-272) directed social service agencies to prevent out-of-home placements when possible, to make reasonable efforts to reunify them with their biological families when feasible, or to find adoptive placement when necessary. Although the number of children in foster care initially declined in the early 1980s, increases in the incidence of substance abuse, single-parent families, homelessness, child poverty and child abuse, as well as the emergence of human immunodeficiency virus (HIV) infection, resulted in even greater expansion of the foster care population.[13] Current efforts to reduce the number of children in foster care include increased use of family preservation programs to prevent out-of-home placement, more attention to returning children home quickly from foster care, accelerating termination of parental rights proceedings, and greater efforts to adopt these children.

The Adoption and Safe Families Act (ASFA) of 1997 is the most significant recent legislation affecting children in foster care. The context for this law was the pervasive view that the pendulum had swung too far to the side of preserving families, and away from protecting children. ASFA establishes the health and safety of children in the child welfare system as clear priorities. Well-justified concern persists regarding the length of time children linger in care; ASFA requires states to begin terminating parental rights if a child has been in care for 15 of the prior 22 months. Under aggravated circumstances, such as when a parent has been convicted of a felony against a child or a parent's rights to a sibling have been involuntarily terminated, AFSA enables (but does not require) the states to proceed with terminating parental rights without providing further justification for doing so. For all children in foster care, states must obtain a court order at least every 12 months and demonstrate that reasonable efforts have been made toward establishing a permanent plan for reunification, or toward legal guardianship or adoption. The legislation also offers fiscal incentives for states to increase the number of children adopted. Clearly, the intent is to limit foster care drift.

TRADITIONAL VERSUS KINSHIP FOSTER CARE

Nonrelative care was the norm in foster care until the early 1990s. However, as more women entered the labor force the number of nonrelative foster family homes declined from about 147 000 in 1984 to 100 000 in 1990.[14] In response to this trend, public agencies sought assistance from the children's relatives to provide kinship foster care homes. In current practice, the term kin includes any relative, by blood or marriage, or any person with close ties to the family.[15]

Kinship care may offer certain advantages. Children may find placement with known family members less traumatic than placement with strangers. Cultural and religious practices are more likely to be continued, and this has been a major factor for advocates of kinship care. Kin frequently have a special commitment to helping their own (blood is thicker than water). Contact with parents is often more frequent, and may facilitate eventual reunification. There may also be disadvantages to kinship care compared with regular foster care. Skeptics question whether the extended family members of these inadequate parents are appropriate surrogates to provide kinship care.

Although each situation should be individually weighed, it is crucial to ask how kinship care can be helped to succeed given the strong ideological preference for first seeking placement with kin. Potential kinship caregivers must be carefully screened, especially because they are often not required to meet the same standards used for licensed foster homes. Frequently, informal kinship placements (ie, no court involvement and no legal transfer of custody) are arranged by public or private social service agencies, and it is uncertain what services kinship families receive and what obligations the agencies impose under these circumstances. Moreover, we know little of how children fare in these informal arrangements. In most situa-

tions involving abuse or neglect, it is probably preferable that care and custody be formally transferred to a social services agency, to enable ongoing support and oversight.

On the other hand, we do know that children in kinship care have needs similar to those in nonrelative foster care, especially regarding their mental and dental health. We also know that kinship caregivers tend to be older, less educated, less financially stable, and in poorer health than nonrelative foster parents.[16,17] Proponents of kinship care believe kin will/should provide for their own; but these families have typically received fewer services, even when the public agency has had legal custody. Therefore, because children in kinship and traditional foster care face similar conditions, in terms of reasons for their placement, their levels of health, mental health and developmental needs, and financial difficulties confronting many of the families who provide such care, more uniform approaches are necessary with respect to placement and support of all children in care, regardless of type of placement. Furthermore, children in kinship care have averaged longer stays than those in nonrelative foster care, largely because less vigorous efforts have been made to reunify them with their parents and to determine a permanency plan. Again, it is incorrect to assume that because the child is with family there is little urgency to return him or her to the biological parents. All children in foster care need secure arrangements, and careful long-term planning is needed to reduce the uncertainties in their lives.

Health and Mental Health of Children in Foster Care

For nearly 3 decades, researchers have noted a high prevalence of health and mental health problems in foster children. In 1972 and 1973 Kavaler and Swire[18] systematically studied the health status of 668 children 0 to 15 years old who had been in foster care in New York City for at least 1 year. Approximately half (45%) of the children had 1 or more chronic medical problems and more than a third (37%) required a referral to a specialist for further evaluation and treatment. Nearly one-third (29%) of the preschool children were suspected of having delayed development and more than half (55%) of the school-aged children were suspected of having borderline or retarded mental development. Moderate to severe mental health problems were noted in approximately 70% of the children. Since then, cross-sectional surveys of children living in different cities or regions of the country,[11,19–25] statewide population-based studies[26,27] and a multicity comparison study[7] have confirmed Kavaler and Swire's initial observations.

The findings of consistently high rates of physical, mental health, and development problems in this population raise several important questions. To what extent did children bring these problems with them into foster care? To what degree are these (or additional) problems attributable to the foster care experience? Does the foster care system attend to the special needs of these children and help to improve their health status and overall functioning? A review of existing data sheds some light on these questions.

HEALTH PROBLEMS AT THE TIME OF PLACEMENT

For the most part, children enter foster care in a poor state of health. In addition to abuse or neglect that commonly results in out-of-home placement, their poor health reflects exposure to poverty, poor prenatal care, prenatal infection, prenatal maternal substance abuse, family and neighborhood violence, and parental mental illness.[13] Children entering foster care are also more likely to have received inadequate routine preventive health care before placement than their peers. Similarly, children entering foster care may be at especially high risk for HIV infection, given the association between child maltreatment and substance abuse. For example, Flaherty and Weiss[28] reviewed the physical examination findings of 5181 children taken into protective custody in Chicago over a 22-month period. Nearly half (44%) had an identified health problem, including acute infections (otitis media, sexually transmitted diseases), anemia, and lead poisoning. In addition, approximately 5% of the children evaluated for physical abuse were found to have occult fractures not suspected by their caseworkers. Chernoff et al[21] reported that of 2419 children assessed shortly after placement in foster care in Baltimore, almost all (92%) had at least 1 abnormality on physical examination, including disorders of the upper respiratory tract (66%), skin (61%), genitals (10%), eyes (8%), abdomen (8%), lungs (7%), and extremities (6%). Nearly one-quarter (23%) of younger children failed a developmental screening and 22% of older children were already receiving special education services before placement. As a result of these evaluations, 53% of the children were referred for further medical services.

PSYCHOLOGICAL PROBLEMS AT THE TIME OF PLACEMENT

A child's experience before placement plays a significant role in determining how he or she will fare emotionally in foster care. According to Bowlby,[29,30] infants whose early needs are appropriately met form a secure attachment to their caregivers. This is the foundation for trust, important for forming relationships throughout life. Young children who have experienced chronic physical abuse or emotional neglect often show insecure, avoidant, or ambivalent attachment to their primary adult caretakers.[31,32] Thus, if children enjoy a loving and supportive relationship with parents early in life, there may be a stronger likelihood of forming positive relationships with the foster family. Conversely, and more commonly in foster care, children who lack the experience of loving relationships with parents may be unable to establish healthy relationships with new caretakers.

Children in foster care experience psychological difficulties for many reasons.[33] Placement in foster

care is rarely a planned transition for children. Many children do not understand why a stranger has suddenly taken them to an unfamiliar setting. Some children may be unable or afraid to even ask where they are going, when they can go home, and where their siblings or parents are. They are often tired, hungry, dirty, and confused, and some may be in pain or distress from recent physical abuse or untreated medical conditions. Most children feel a combination of fear of the unknown, guilt in having somehow brought about separation from their family, and a sense of being punished. Removal from one's family, even an abusive one, is generally traumatic for children.

CHILDREN'S ADAPTATION TO FOSTER CARE PLACEMENT

Although childrens' patterns of adaptation to placement are quite individual and vary with age, several themes are common. For example, many children go through an initial period of appearing to adapt well to their new foster homes, although this is most likely a period of intense emotional turmoil during which they do not manifest overt behavioral disturbance. However, after a short period of time, often within 3 months, foster parents may notice a significant increase in negative behavior marked by provocative acting-out or limit-testing. These children behave as though they need proof that their foster parents really care for them before they can open themselves to a trusting relationship. Conversely, children may withdraw or be depressed, angry and aggressive, and resist the efforts of foster parents to comfort them. These children, initially cautious and wary of their new surroundings, are not willing to get too close to their foster parents. Both patterns may resolve favorably if foster parents respond with sensitivity and understanding. Many foster parents need support to manage the difficult psychological challenges of a foster child.

Less common are children with severe attachment disorders. Although they may at first seem to adapt well, these children have great difficulty developing relationships with their foster parents and remain emotionally detached. They often act in an indiscriminate fashion toward adults. Many exhibit extreme behavior problems, such as hiding or hoarding food, excessive eating (polyphagia) or drinking (polydipsia), rumination, self-stimulating and repetitive behaviors (masturbation, rocking or head banging), and sleep disturbance. Despite excessive appetites, these children may fail to gain weight or grow normally while in placement. Unfortunately, these children frequently experience a succession of foster homes because their extreme behaviors and lack of emotional reciprocity challenge the abilities of foster parents. Children with symptoms of attachment disorder and their foster parents clearly require the support and guidance of a mental health professional to interrupt this dysfunctional pattern of behavior.

Psychological and behavioral problems are more common among children in foster care than in normative or community-based samples, even when compared with children who have backgrounds of similar deprivation.[34,35] Prevalence estimates of depression, conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder, attachment, and anxiety disorders in this population range from 29% to 96%.[18,20,23,36–40] In Chernoff et al's[21] study, the prevalence of extreme psychological problems was also quite elevated: 15% of children entering foster care reported suicidal ideation; 7% reported homicidal ideation.

Possible overuse of psychotropic medications in children in foster care has been raised as a significant problem,[41] although the use of such medications in this population may actually be too low given the prevalence of mental health problems. For example, Zima et al[42] conducted structured mental health evaluations on a sample of 6- to 12-year-old children living in foster care in Los Angeles and noted that only 16% had ever been treated with psychotropic medication; the most commonly prescribed agents were stimulants (62%), antidepressants (31%), and mood stabilizers (31%). However, less than half (48%) of the children with a psychiatric diagnosis for which treatment with medication was indicated had received any psychotropic medication in the previous year.

MAINTAINING FAMILY TIES DURING PLACEMENT: PARENTAL VISITS

Family reunification is a major objective of foster care placement for most children, and ongoing contact with parents during placement is an important factor with regard to determining if children eventually return home.[43] Visits may also be a source of much emotional stress for children and their biological and foster parents.[44] Most children respond to visits with parents with a combination of anticipation and anxiety and it is not uncommon for behavior problems to occur before and after visits. Children may feel anger at their parents, whom they feel have abandoned them. They may perceive the end of the visit as another abandonment when they cannot go home with their parents. Less commonly, they may be afraid of being subjected to further abuse or neglect during the visit. Where visits take place and how they are conducted may influence their impact on the children, but these factors have received scant research attention. Many agencies have specific programs to facilitate visits but some visits take place in the foster parents' home, at a public site (eg, fast food restaurant) or in the biological parents' home. The last is particularly problematic if not supervised, because behavioral problems, skin marks, or the child's verbal account of the meeting after the visit may too readily be interpreted by foster parents or caseworkers as evidence of maltreatment by the biological parents.

Although visits with biological parents during placement are often stressful, such contact should reassure children that their parents still care about them. Visitation may help strengthen the biological family's functioning and lead to more successful

outcomes once the child is returned home. Thus, child welfare agencies should carefully plan and implement visits, paying particular attention to the purpose of visits for the individual child and family.[45–47] However, visits that subject the child to repeated neglect by the parent(s), exposure to violence, or conflict between the biological parents and the foster parents or child welfare agency may aggravate the child's adjustment to placement and should be avoided until the situation can be improved.

HEALTH CARE UTILIZATION BY CHILDREN IN FOSTER CARE

As might be expected from the high prevalence of physical and mental health problems in this population, children in foster care are also heavy utilizers of health care services. In 1992, Halfon et al[26] documented greater utilization and costs of medical care for children in foster care in California compared with other children receiving medical assistance coverage. The major health care expenses for children in foster care resulted from hospitalization for perinatal complications, infectious diseases, and mental health disorders. Length of stay was 36% greater for mental health conditions and 27% greater for perinatal problems for children in foster care. Most striking was this population's use of outpatient mental health services. Although children in foster care comprised only 4% of all children enrolled in MediCal in 1988, they accounted for 55% of all visits to psychologists and 45% of visits to psychiatrists paid for by the program.

Takayama et al[27] compared Washington State Medicaid claims data for children in foster care 0 to 7 years old with those receiving Aid to Families With Dependent Children (AFDC) benefits in 1990. The mean cost of health care for children in foster care was $3075 versus $543 for AFDC children. The greatest expenditures for children in foster care were for mental health, supportive care, hospitalization, and medical equipment. Mental health services were used by 25% of children in foster care, compared with only 3% of AFDC children; and supportive services of visiting nurses and physical therapists were used by 13% of children in foster care, compared with only 1% of AFDC children. More than twice as many children in foster care used medical equipment or specialist services or were hospitalized, compared with AFDC children. Most striking was the finding that a small group of children in foster care (8%), who suffered from psychiatric disorders, neurologic conditions, and other complex, chronic medical diseases, often of congenital origin, had health care expenses that exceeded $10 000 per year, and accounted for 63% of the total medical expenditures for children in foster care.

CHANGE IN HEALTH STATUS DURING PLACEMENT IN FOSTER CARE

The impact on children of removal from their parents and placement in a foster home is a critical issue for the child welfare field. However, only a few studies have examined how these children change over time while in out-of-home placement. Children who experience long-term, stable placement show significant improvements in health status, physical growth, and educational achievement. For example, Fanshel and Shinn[11] followed approximately 600 children who remained in foster care in New York City for 5 years and found substantial improvements in their intellectual and academic performance. A study of children who entered foster care in Baltimore in different time periods found that better health status was positively associated with length of placement.[48] A recent study of preschool children who entered foster care for the first time in Connecticut noted that nearly half the children, regardless of their height at the time of placement, experienced dramatic catch-up growth in height during the first year of placement.[49] Nevertheless, a subset of children does not do well in foster care, and this raises several questions: Is this a particularly disadvantaged subset of children, or are these children whose foster families do not provide adequate nurturance? Can we identify and remediate the factors that contribute to their poor outcome? Alternatively, what can be learned from children who thrive in foster care?

THE IMPACT OF WELFARE REFORM ON FOSTER CARE

Recent changes in family policy, particularly in relation to federal and state programs that provide financial support to families with dependent children may have a dramatic impact on the number of children requiring placement in foster care and on their health status. The passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PL 104-193), known as welfare reform, has resulted in substantial changes in the structure of public assistance for poor families and children by ending benefits under the AFDC program, reducing the Food Stamps program and reducing eligibility for benefits under the Supplemental Security Income program. As a result, the number of families receiving public support has declined dramatically. However, the extent to which these families have been absorbed into the general workforce is not clear at present.

Although the impact of these changes on the health and welfare of children is uncertain, there is concern that without adequate support to escape poverty, many families' ability to care adequately for their children will be compromised, increasing rates of maltreatment and the number of children who require out-of-home placement. Additionally, lack of affordable high-quality day care may further compromise these parents' ability to remain in the workforce, or influence parents to place their children in inappropriate care settings. The current economic boom and large number of low-level jobs generated may also mask the true impact of welfare reform on this population. Once the economy returns to a more normal pace, the number of former

welfare recipients unable to find work may increase significantly.

THE IMPACT OF HEALTH CARE FINANCING REFORM ON FOSTER CARE

For nearly 40 years the Medicaid program has been the nation's principal source of health care coverage for poor children. Yet, despite increased expenditures generally for this program, reimbursement to physicians, dentists, and mental health practitioners has not kept pace with inflation, and the number of physicians willing to care for these children has decreased.[50] In an effort to control program costs and improve access to care, some state governments enroll Medicaid recipients in privately owned and operated managed health care organizations (MCOs). Because MCOs share some burden of financial risk for the health care of children in their program, they have an incentive to provide effective services in an efficient manner by offering access to primary health care providers and a network of specialty providers. In addition, MCO centralized data collection and tracking systems may permit child welfare agencies to monitor health utilization patterns of children in their care.[51] Nonetheless, despite their potential for rectifying many problems of the fee-for-service reimbursement system, MCOs have come under criticism for restricting access to newer pharmacotherapeutic agents, pediatric subspecialty care, mental health, and other health services (eg, speech, occupational, and physical therapy). Again, the impact on the health of foster children enrolled in MCO programs is not yet clear.

BARRIERS TO HEALTH AND MENTAL HEALTH CARE FOR CHILDREN IN FOSTER CARE

Despite more than 30 years of concern by health care and social service professionals about the health and mental health of children in foster care, relatively little progress has been made in improving the delivery of needed services. The causes for this inertia are complex and widespread.

Among barriers to providing health and mental health care for this population are problems within the child welfare system itself. Anecdotally, children have become ill or died after placement because neither social workers nor the foster parents were aware of childrens' immediate health care needs. Frequent moves among foster homes or out of and back into foster care also contribute to children receiving care from many different physicians with little or no continuity.

Many child welfare agencies lack specific policies regarding health care of children in foster care. For the most part, caseworkers rely on foster parents to exercise sound judgment to determine when children require health and mental health care, yet foster parents are not empowered to give legal consent for treatment. In some jurisdictions, biological parents must provide direct consent for health, developmental, and mental health care their children receive while in placement, introducing a potential obstacle or delay to necessary services. Although many parents sign consent for routine health care at the time of placement, caseworkers must locate and encourage parents to sign separate consents for other specific evaluations (eg, mental health, developmental, or educational) or treatments, including any psychotropic medications. Child welfare agencies are responsible for ensuring that children in their care and custody receive services necessary to optimize their health and development. However, most agencies have continued to struggle with significant resource shortages in the face of increasing case loads, and children's health care has not been a priority for the child welfare system. Both the Child Welfare League of America[8] and the American Academy of Pediatrics[52] have provided general guidelines for health care to children in foster care, but these have not been widely implemented. State agency regulations are needed to specify how this should be accomplished.[53] There is clearly a need for creative and collaborative initiatives between the child welfare and health care systems to improve the health care of foster children.

The continuing lack of comprehensive and coordinated health programs for children in foster care was apparent in a recent study conducted by the US General Accounting Office.[7] Despite state and county regulations requiring comprehensive routine health care, nearly one-third of young children in foster care in Los Angeles, Philadelphia, and New York City had received no immunizations, one-third had identified health care needs that were not met, and an estimated 12% of children had received no routine health care services. Although 78% of the children were considered to be at high-risk of HIV infection resulting from parental drug abuse, only 9% had been tested for the virus. That children fail to receive even basic health care despite the presence of many adults and professionals who share responsibility for them, including biological parents, foster parents, caseworkers, guardians' ad litem, judges, and health care providers, points to the need to clarify roles these individuals should play to ensure that children receive needed services.

Health care professionals share responsibility for poor care children receive in the foster care system. Although many physical, psychological, and developmental problems of these children are similar to those occurring in the general population, especially among low-income families, many health care providers and mental health professionals have had little training regarding issues specific to children in foster care and may not recognize problems or refer these children for appropriate care. In particular, community health care providers are more likely to identify and refer young children entering foster care for evaluation and treatment of physical health and educational concerns than for developmental and mental health problems.[54]

Addressing the health care needs of children in foster care has not attracted many pediatricians. The children's complex social situations, the extra time required to provide care, and the modest reimbursement may explain why many health care

providers have been deterred from becoming involved.[55] Lack of communication with professionals in the child welfare system and frustration with the limitations of that system may also discourage health care providers.

Nationally, the inflexibility of existing state-operated Medicaid health care funding structures, and the move to managed care contracting without appropriate consideration of the special needs of children in foster care, have made it difficult to develop new approaches to delivering health and mental health services to this population. Furthermore, private foundations have shown little interest in supporting this aspect of child welfare. A notable exception has been the American Academy of Pediatrics, in cooperation with Wyeth Lederle Vaccines, which has supported several grass-roots efforts to develop innovative clinical programs for children in foster care through its CATCH (Community Access to Child Health) initiative.

IMPROVING THE HEALTH CARE OF CHILDREN IN FOSTER CARE

Health care services for children in foster care should not only enhance the health of individual children, but also facilitate and reinforce permanency plans. To these ends, several broader goals must be met, including development of an individualized health care plan for each child in foster care, and integration of that health care plan into the child welfare plan. The latter requires good communication between child welfare and health professionals.

Although it can be very difficult to obtain information from distraught, often angry, and sometimes absent parents, caseworkers or agency health care management personnel should try to collect as much health information as possible about the child, including current medical conditions, use of medication, past health history, previous health care providers, past hospitalizations, allergies, and need for ongoing services. Parental consent should be obtained to release all of the child's health care records to the child welfare agency, which should then make them available to new health care providers. Children in need of immediate medical care should be seen in an emergency care facility; an appointment for an initial health screening examination should be arranged with a primary care practitioner. Ideally, agencies should identify a medical home for each child in their care and custody. Whenever possible, foster parents should be encouraged to continue children in the care of their usual health care provider. However, if this is not possible, child welfare agencies should recommend a provider in the community who has a particular interest in the health care of children in foster care. Continuity of health care, at least while in the system, will decrease the fragmentation of care that has been a serious problem for these children.

Health care professionals can play valuable roles in the care of foster children. Because of the high rates of health, developmental, behavioral, and educational problems, foster children generally require more frequent visits and more time than most children. Many states require that children newly placed in foster care have a comprehensive health assessment within 30 to 60 days of placement. In addition to the usual health maintenance activities required at each age, young children entering foster care should be screened for anemia, elevated lead level, sickle cell disease (when appropriate) and tuberculosis exposure. Signs or symptoms of physical abuse, neglect, or sexually transmitted diseases should prompt referrals for more complete evaluation, if possible, to an interdisciplinary team specializing in these problems. Developmental and psychosocial screening should include direct examination with standardized measures because studies have shown that reliance on caseworker and foster parent history for developmental information identifies only about 30% of all children with developmental delays.[40] Thus, initial comprehensive medical evaluation should include mental health and developmental assessments. A follow-up visit should be arranged within 1 to 2 months to monitor the child's adjustment to the foster home and to evaluate his or her development and emotional well-being. After their health status has been fully assessed, children in foster care should be followed closely to monitor their progress.

Each child's risk for HIV, hepatitis B and C, and congenitally acquired infection (in particular, syphilis) should be assessed and followed with appropriate laboratory tests to confirm the diagnosis and ensure prompt treatment.[56] Identification of children who are HIV-positive is critical because pneumocystis pneumonia prophylaxis and early antiretroviral therapy should be implemented along with modifications of the immunization schedule. For example, varicella vaccine should be withheld until a child's HIV status is known to be negative.

A health plan should be developed by the health care provider for each child, updated at each health care encounter, and communicated to the caseworker and the foster family. Child welfare agencies should also maintain a centralized medical file so that health information can be included in case-planning decisions. Foster parents should be encouraged and supported to accompany the child on visits. In some areas of the country, Foster Care Medical Passports have been created to share medical information among professionals involved in the child's care.[44,57] These abbreviated medical record forms are usually kept by foster parents and brought to each health care visit. When used consistently, medical passports contain essential health information (eg, immunization history, a list of known chronic medical problems, routine screening test results, etc). However, more effective solutions to the problems of collecting, maintaining, and disseminating information about the health and mental health status of children in the foster care system will require the development of state-of-the-art computerized databases

that integrate data from a variety of sources and incorporate appropriate security and confidentiality safeguards.

Health care providers can be effective advocates for children in foster care in several key ways. Caseworkers may need assistance in obtaining appropriate records from previous health care providers and interpreting the information. Individuals responsible for the child's care must have a thorough understanding of the child's health problems and the reasons for treatment recommendations. Foster and biological families may also benefit from support and advice health care providers can offer about child development and parenting issues. The health care providers' ability to coordinate medical referrals and recommend specific community resources can ensure that children receive appropriate care in a timely manner. Adherence to recommendations should be monitored at each visit and health care providers should alert caseworkers if the plan has not been followed. Efforts should be made to identify reasons why actions are not taken, as this may help determine if foster or biological families need additional support to care for their children. Finally, health care providers should document both concerns and positive developments, and offer written opinions and recommendations to courts when necessary.

PREPARING ADOLESCENTS TO AGE OUT OF FOSTER CARE

As adolescents turn 18 they are generally no longer eligible for services through the foster care system, and their foster families may no longer accept responsibility for them. Clearly, this can result in a very difficult transition to independent living. Many states provide assistance to adolescents in foster care, such as help with housing, college, and job training to ease this transition. The responsibility for preparing adolescents for this transition rests primarily with the child welfare system. However, studies have found that adolescents who age out of foster care are generally poorly prepared for employment and independent living.[58] Recent federal legislation (Title IV-E Independent Living Program) has doubled support for these efforts, from $70 million to $140 million. States are allowed to use some of these funds for easing the transition to independent living for youth aged 19 to 21 by, for example, covering room and board or offering medical assistance. Advocates need to work with states to help ensure these funds will be well-used to serve these very high-risk youth during a difficult transition period.

Health care providers can help prepare these youth by discussing future plans and preparation. Ensuring continued medical coverage may be another important issue, and the health care practitioner may offer to continue being the primary care provider for some period. Alternatively, assistance with finding a new provider is needed. There may also be a need to guide the foster family on how to encourage and support autonomy, but also to maintain an important emotional connection. The transition to independent living can raise many complex emotional and practical issues. Although there are few easy answers, health care providers can play a valuable role by supporting the teen and foster family in preparing for the challenges ahead.

RESEARCH ISSUES

Many important questions about foster care involve health, developmental, and mental health issues. Health care professionals, working with colleagues in social work and mental health, can help advance knowledge in this field, improve policy and practice in child welfare, and improve the lives of many children.[59,60] Potential areas for research include the following:

Models of Health Care Delivery

Systematic and coordinated approaches to meeting health and mental health needs of children in foster care are needed, but salient elements remain to be identified. Delivery models have included specialized health clinics, primary care practices, hospital outpatient clinics, and use of medical consultants by social service agencies.[44,61,62] There have been no comparisons of the impact of these varied approaches on health service utilization patterns, health status indicators of children, or costs. Given the high prevalence of health, developmental, and mental health problems in this population, it should be possible to measure favorable outcomes by reduction in the overall burden of illness and increases in positive outcomes such as the rate of physical growth, improvement in achieving developmental milestones, and/or emotional functioning, measured by standardized instruments.

Role of Primary Health Care Providers

Although many children in foster care require the services of pediatric subspecialists and mental health providers, all children should have a medical home where preventive health services can be provided and both acute and chronic problems treated appropriately. The effectiveness of coordinated primary health care services may be reflected in reduced reliance on inappropriate emergency department visits, subspecialist consultations, and laboratory investigations.

Health care practitioners need to be sensitized to the many issues raised in this article, and such efforts should be evaluated. Indeed, pediatricians seem willing to be primary health care providers for these children,[55] but ways to involve them and improve their communication with other professionals involved in the care of these children (eg, social workers, lawyers, judges, etc) need to be developed.

How Foster Care Is Perceived by Children

Another potentially valuable area to evaluate concerns the children's thoughts, feelings, concerns, and wishes. Understanding childrens' views of their foster homes, foster parents, and caseworkers, the health care system and health care provid-

ers, and what they would like to see changed, may help to improve their experiences in foster care.

Children's Adjustment to Foster Care

Studies should be conducted of how children of different ages adjust to placement in foster care. Very little information currently exists about childrens' adjustments to care over time, and the impact of such critical junctures as termination of parental rights, changes in placement, changes in visitation patterns, or separation from siblings. A better understanding of foster care's impact over time may assist foster parents in supporting children in their care. This knowledge may also help to identify children who are not adapting well early in the placement process, and may avert breakdown of placements through appropriate interventions.

The Impact of Foster Parent Health Educational Programs

Foster parents are usually required to participate in an educational program as part of the initial licensing process. However, little attention has been paid to the relationship between foster parents' knowledge and skill in the area of health, developmental and mental health care, and the subsequent health status, developmental achievement, and emotional adjustment of children in their care. Foster parents can be trained to provide specialized medical care for chronically ill children, to provide developmental stimulation through play and recreational activities, and to assist in the treatment of serious emotional and behavioral problems by implementing specific behavior management programs.

The Impact of Other Specific Interventions

Little is known about the impact of specific interventions on the well-being of children in foster care. For example, early childhood educational programs, peer support groups, and/or enrollment in normal childhood activities such as sports teams, and community centers with structured activities, might be particularly valuable interventions. Also, peer-mentoring programs that use experienced foster parents to assist new foster families may result in more stable placements, improved child outcomes, and higher rates of foster parent retention.

CONCLUSIONS

Unfortunately, the population of children in foster care has increased dramatically over the past 2 decades. As a result of the circumstances that lead to placement, children entering the foster care system often have serious health and mental health disorders. Many of the children spend a significant portion of their childhood in foster care and there is little evidence that they receive comprehensive health care while in placement. In many respects, foster care remains a poor system for poor children. However, placement in foster care provides an opportunity and a responsibility to address all of the health care needs of this very high-risk group of children. Health care practitioners can play a significant role in providing care and assisting foster parents and caseworkers to ensure that children receive appropriate services in a timely fashion. Researchers can examine promising strategies for achieving these goals.

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August 10, 2006
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PROOF OF SERVICE BY MAIL

I am a citizen of the United States and employed in Los Angeles County, California, at the office of a member of the bar of this Court at whose direction this service was made. I am over the age of eighteen years and not a party to the within action. My business address is 400 South Hope Street, Los Angeles, California 90071-2899. On August 10, 2006, I served the following:

BRIEF OF AMICI CURIAE IN SUPPORT OF AN AFFIRMANCE

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I declare under penalty of perjury under the laws of the United States that the above is true and correct. Executed on August 10, 2006, at Los Angeles, California.

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