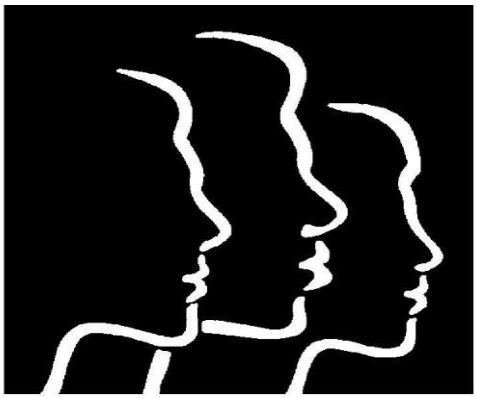
California's Child Welfare Continuum of Care Reform



CDSS

January 2015

STATE OF CALIFORNIA
Edmund G. Brown Jr., Governor
HEALTH AND HUMAN SERVICES AGENCY
Diana Dooley, Secretary
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
Will Lightbourne, Director

LEGISLATIVE MANDATE

SENATE BILL (SB) 1013, COMMITTEE ON BUDGET AND FISCAL REVIEW (CHAPTER 35, STATUTES OF 2012)

Welfare and Institutions Code Section 11461.2:

(a) It is the intent of the Legislature to ensure quality care for children who are placed in the continuum of Aid to Families with Dependent Children-Foster Care (AFDC-FC) eligible placement settings.

(b) The State Department of Social Services shall establish, in consultation with county welfare departments and other stakeholders, as appropriate, a working group to develop recommended revisions to the current rate-setting system, services, and programs serving children and families in the continuum of AFDC-FC eligible placement settings including, at a minimum, all programs provided by foster family agencies and group homes including those providing residentially-based services, as defined in paragraph (1) of subdivision (a) of Section 18987.71.

(c) In developing the recommended revisions identified in subdivision (b), the working group shall consider all of the following:

(1) How rate-setting systems for foster care providers, including at least, foster family agencies and group homes, can better support a continuum of programs and services that promote positive outcomes for children and families. This may include a process for matching the child's strengths and needs to the appropriate placement setting.

(2) How the provision of an integrated, comprehensive set of services including mental health and other critical services for children and youth support the achievement of well-being, permanency, and safety outcomes.

(3) How to ensure the provision of services in family-like settings including after care services, when appropriate.

(4) How to provide outcome-based evaluations of foster care providers or other methods of measuring quality improvement including measures of youth and families' satisfaction with services provided and program effectiveness.

(5) How changes in the licensing, rate-setting, and auditing processes can improve the quality of foster care providers, the quality of services and programs provided, and enhance the oversight of care provided to children, including, but not limited to, accreditation, administrator qualifications, and the reassignment of these responsibilities within the department.

(d) In addition to the considerations in subdivision (c), the workgroup recommendations shall be based on the review and evaluation of the current rate-setting systems, actual cost data, and information from the provider community as well as research on other applicable rate-setting methodologies, evidenced-based practices, information developed as a result of pilots approved by the director, and any other relevant information.

(e) The workgroup shall develop the content, format, and data sources for reports to be posted by the department on a public Internet Website describing the outcomes achieved by providers with foster care rates set by the department.

(f)(1) Recommendations developed pursuant to this section shall include the plan required under subdivision (d) of Section 18987.7. Updates regarding the workgroup's establishment and its progress toward meeting the requirements of this section shall be provided to the Legislature during 2012-13 and 2013-14 budget hearings. The revisions recommended pursuant to the requirements of subdivision (b) shall be submitted in a report to the appropriate policy and fiscal committees of the Legislature by October 1, 2014.

(2) The requirement for submitting a report pursuant to this subdivision is inoperative on October 1, 2018, pursuant to Section 10231.5 of the Government Code.

(g) The department shall retain the authority to extend the workgroup after October 1, 2014, to ensure that the objectives of this section are met and to reconvene this workgroup as necessary to address any future recommended changes to the continuum of AFDC-FC eligible placement settings pursuant to this section.

Welfare and Institutions Code Section 11467:

(a) The State Department of Social Services, with the advice and assistance of the County Welfare Directors Association, the Chief Probation Officer's Association, the California Mental Health Directors Association, research entities, foster youth and advocates for foster youth, foster care provider business entities organized and operated on a nonprofit basis, tribes, and other stakeholders, shall establish a working group to develop performance standards and outcome measures for providers of out-of-home care placements made under the AFDC-FC program, including, but not limited to, foster family agency, group home, and Transitional Housing Program-Plus (THP-P) providers, and for the effective and efficient administration of the AFDC-FC program.

(b) The performance standards and outcome measures shall employ the applicable performance standards and outcome measures as set forth in Sections 11469 and 11469.1, designed to identify the degree to which foster care providers, including business entities organized and operated on a nonprofit basis, are providing out-of-home placement services that meet the needs of foster children, and the degree to which these services are supporting improved outcomes, including those identified by the California Child and Family Service Review System.

(c) In addition to the process described in subdivision (a), the working group may also develop the following:

(1) A means of identifying the child's needs and determining which is the most appropriate out-of-home placement for a child.

(2) A procedure for identifying children who have been in congregate care for one year or longer, determining the reasons each child remains in congregate care, and developing a plan for each child to transition to a less restrictive, more family-like setting.

(d) The department shall provide updates regarding its progress toward meeting the requirements of this section during the 2013 and 2014 budget hearings.

(e) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 [commencing with Section 13340] of Part 1 of Division 3 of Title 2 of the Government Code), until the enactment of applicable state law, or October 1, 2015, whichever is earlier, the department may implement the changes made pursuant to this section through All County Letters, or similar instructions from the director.

EXECUTIVE SUMMARY

This report outlines a comprehensive approach to improving the experience and outcomes of children and youth in foster care. This report, based on over three years of collaboration with county partners and other stakeholders, consists of a series of inter-dependent recommendations to improve assessments of children and families to make more informed and appropriate initial placement decisions, emphasize home-based family care placements of children, appropriately support those placements with available services, change the goals for congregate (group home) care placements, and increase transparency and accountability for child outcomes.

Some of California's previous efforts to improve services have focused on providing prevention and early intervention to children and families at risk of removal and to strengthen service networks to support reunification or placement with families. This has contributed to a substantial decline in the number of out-of-home foster care placements over the past decade, and that focus should continue. However, this report addresses the placement and service needs of the significant number of children who continue to be cared for outside of their own homes despite prevention and early intervention efforts.

The availability of appropriate placements which meet the needs of these children also is a priority for the State. To this end, the Legislature requested recommendations to reduce the use of out-of-home care through Senate Bill (SB) 1013 (Chapter 35, Statutes of 2012). The continuum of placement settings and the array of available services and supports for children and youth in foster care is an interconnected system rather than isolated stand-alone components. Past progress has been made in placing children with relative caregivers and supporting relative caregivers financially, facilitating and supporting relatives to obtain guardianship and adopt children in their care, and eliminating congregate care as a placement option for young children. Strides have been made to provide valid and reliable assessment tools to county child welfare workers, to include child and family preferences in case plan goals, and to create training and clearinghouse resources to improve practice at the county level. Yet there remains much to do: recruit, train and support an adequate supply of home-based family care; provide needed services and supports in those care settings; limit congregate care to only situations in which adequate services cannot safely be provided while a child/youth lives in a family, and then for only the minimum time required for stabilization.

Children should live in their communities in home-based family care settings. Through this report's proposed restructuring of placements and services, children and youth will be able to receive their necessary services without being rotated between programs and placements. Under the new model of care, children who cannot initially safely be placed in home-based family care can still go into congregate care, but with specific

time-limited care plans. Once stabilized however, these children will transition into home-based family care with their services following them.

Several of the recommendations in this report will need short-term upfront investments as changes to the placement system are phased in. In the longer term, these recommendations are expected to become cost-neutral by creating placement cost savings and will permit strategic leveraging of federal Title IV-E and Title XIX funding to further improve child outcomes. It is worth noting that California is one of twelve states in which the state is responsible for policy, regulation and outcome monitoring, with counties responsible for operation of the program itself. California also is unique in its current financial relationship: The 2011 realignment of child welfare services transferred all of the non-federal placement costs and corresponding revenue to the counties. This realignment also provides that new administrative requirements, regulations, or enacted legislation after September 30, 2012, that has an overall effect of increasing the costs already borne by county child welfare or juvenile probation programs, applies to local agencies only to the extent that the State provides annual funding for the cost increase.

This reform effort is focused on improving outcomes and requires significant changes to current out-of-home care placements and supports. This reform effort will improve the assessment process and alter the roles of various placement settings and their service arrays, and occurs in the context of other system changes that serve to increase access to existing federally-entitled services. While this reform effort will change how and where services are provided, it does so without creating new services.

This report describes the substantial and needed steps that the Administration will pursue in collaboration with its partners, stakeholders, the courts and the Legislature, to achieve these improvements in child experiences and outcomes. The recommendations contained within this report are divided into the following areas: General; Home-Based Family Care; Residential Treatment; Fiscal; and Performance Measures and Outcomes. Successful implementation of these inter-dependent recommendations will take time and occur over multiple years. This will allow for development of critical elements including increasing the supply of home based family care, provider program statements, accreditation and training. The Department of Social Services, with its numerous partners and stakeholders, is committed to ongoing evaluation and improving outcomes using a continuous quality improvement approach.

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PURPOSE OF THE REPORT

It is well-documented that residing long-term in group homes with shift-based care is not in the best interest of children and youth. Not only is it developmentally inappropriate, it frequently creates lifelong institutionalized behaviors and contributes to higher levels of involvement with the juvenile justice system and to poor educational outcomes. The Background section of this report provides further details about the poor outcomes for children and youth placed in group homes, versus other placement settings. This reportd youth placed in group home model is premised upon eliminating the practice of long-term group home placements, in favor of utilizing congregate care only for placements that are time-limited in duration and focused on specific treatment goals. Increasing the capacity of home-based family care is a necessary first step to enable a reduction in group care.

As of July 1, 2014, there are roughly 60,000 children in out-of-home care, served by child welfare agencies and juvenile probation. Most children served by a child welfare agency are placed with families (relatives or foster homes). However, despite the known relatively poorer outcomes associated with group home placements, child welfare departments still have approximately 3,000 children and youth in group homes for more than one year, and approximately 1,000 of these children and youth have been in a group home for more than five years. Group homes also remain the placement setting most used by probation departments in lieu of locked settings. When we know that poor outcomes are most frequently associated with these group care settings, we need to better protect and serve children, youth and their families. This report recommends doing so, by transparently measuring and reporting performance, providing necessary services and supports in the appropriate care settings for individual children, and focusing on home-based family care settings where associated child outcomes are better.

This report proposes changes to the continuum of care resulting from three years of the Department's discussion with partners and stakeholders. These recommendations focus the child welfare and probation system of care on placing children in home-based family care settings with adequate and necessary services and supports, rather than in group care settings. Every child and youth needs and deserves to feel love, a sense of attachment and belonging, and to have the continuity of family and community to support and guide them in their lives. Preserving or reunifying the family is the first priority, when possible, for all children and youth. When reunification is not possible, securing a permanent family through adoption or guardianship is the next-preferred priority. The overarching goal, reflected in this report, is to reduce reliance on group homes as a long-term placement setting by narrowly defining the purpose of group care, and by increasing the capacity of home-based family care to better address the individual needs of all children, youth and caregivers.

BACKGROUND

Children and youth come into foster care because they cannot live safely with their parents. State and federal law requires that the county provide services to the family and child so the child can return safely to the parents. The preferred route to permanency is through safe reunification, but when that is not possible, services also must be provided for the child or youth to achieve an alternative permanent, stable family. Thus reunification, guardianship and adoptions are all forms of what is referred to as "Permanency."

When children and youth are removed from their parents and placed in foster care, the Juvenile Court takes jurisdiction of the child, either as a "dependent", due to abuse or neglect, or as a "delinquent" due to criminal behavior on the part of the youth. Dependents are under the responsibility of a county child welfare agency; delinquents, the county probation agency. The vast majority of children in foster care (about 95 percent) are under the supervision of a child welfare agency. The role of the juvenile court is both to ensure due process for the parties involved and to provide oversight on an individual case by case basis. All federal, and some state, requirements apply to children under the responsibility of either the child welfare or probation agency.

Over the years, research has associated poor outcomes with children and youth in group homes.

- A 2008 study indicated that group home placement significantly increased the risk of arrest. (Hernandez, 2008).
- Children who leave group care to reunification have higher re-entry rates into foster care than children who are reunified from family-based care, are less likely to like the people with whom they are living, more likely to report never seeing a biological parent and to more frequently have visits with family cancelled. [1]
- A recently published report on the impact of foster care placement on educational achievement indicated:
    - A child's type of placement was correlated with student dropout and graduation rates. Among students in grades 9–12 living in group homes, 14 percent dropped out, compared to four percent of students placed in guardian placements.
    - Students in kinship and guardianship placements were the most likely of foster care grade 12 students to graduate from high school (64 percent and 71 percent, respectively).
    - Students in group homes (35 percent) were among the least likely to graduate.

[1] Institutions vs. Foster Homes: The Empirical Base for the Second Century of Debate. Barth, R.P. (2002)

- Achievement gaps in English and mathematics were particularly evident for students placed in group homes relative to other students in foster care: 61 percent tested below or far below basic in English and 66 percent tested at the lowest two levels in mathematics. Roughly two out of every three students in group homes failed to attain proficiency in either English or mathematics.[2]

Youth, themselves, articulate the same issues. Many former foster youth who resided in group homes have articulated the need for permanency, normal childhood and teenage experiences, and caregivers who understand their needs and are able to help with conflict resolution, educational support, and problem solving[3].

For over a decade, California has been implementing program and funding changes to reduce the likelihood of children growing up in foster care (see Figure 1 below). Initially, increased investments in programs for children to have permanent homes (kinship guardianship and increased adoptions) fueled the decline in the foster care population. Later, prevention and early intervention (e.g., Wraparound[4], Differential Response[5], etc.) efforts began reducing the number of children entering foster care. As the foster care population declined, the Title IV-E Waiver project allowed funding that otherwise would have been spent on foster care to be invested in services to prevent children from entering foster care, in participating counties. The focus on outcomes brought about through the federal - and later, the California- Child and Family Services Review enabled California to identify desired child welfare outcomes and to develop tools to monitor and understand performance.

While these initiatives have helped improve the practice and services for children who are victims or at-risk of abuse and neglect, the need for further policy development in the area of congregate care is evidenced by the fact that over two-thirds of the children placed in group homes by child welfare departments remained there longer than two years.

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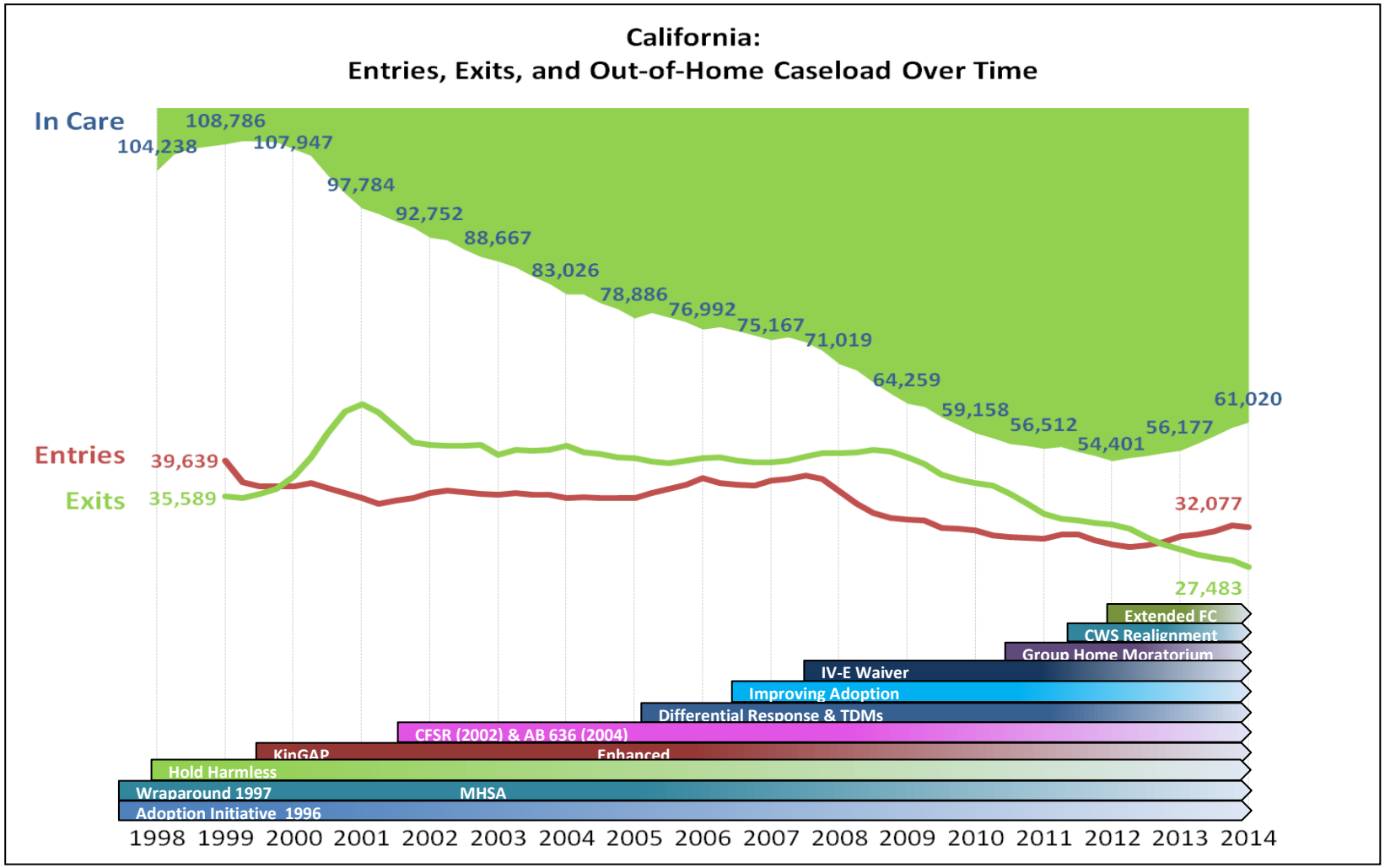
[2] Wiegmann, W., Putnam-Hornstein, E., Barrat, V. X., Magruder, J. & Needell, B. (2014). The Invisible Achievement Gap Part 2: How the Foster Care Experiences of California Public School Students Are Associated with Their Education Outcomes. Electronic.]

[3] California Youth Connection Policy Briefing, 2013

[4] The Wraparound model uses a team-based approach with families to provide intensive services to allow children and youth with complex needs to remain with families.

[5] Differential Response is a way of triaging children and families for various levels of services when abuse or neglect is alleged.

FIGURE 1



Agency Child Welfare. Age 0-20 years. Days in care: No restrictions. Episode counts: All children

California Child Welfare Indicators Project (CCWIP), CWS/CMS 2013

CURRENT OPPORTUNITIES TO BUILD UPON

This plan for reform builds from the principles, goals and program elements contained within the Katie A. Settlement Agreement, Quality Parenting Initiative (QPI), Residentially-Based Services Demonstration Project, Quality Improvement Project (QIP), California Partners for Permanency (CAPP) Project, and Continuous Quality Improvement (CQI) Project. These and other programs foundational to the success of the reform efforts are described in further detail below.

Katie A. Settlement Agreement and the Core Practice Model

The 2011 *Katie A. et al. v. Bonta et al. Settlement Agreement (Katie A.)* is aimed at ensuring children in foster care or at risk of being in foster care receive the medically necessary mental health services to which they are entitled under Medicaid law in their own home, a family setting, or the most homelike setting appropriate to their needs, in order to facilitate reunification, and to meet their needs for safety, permanence, and well-being. The Katie A. Settlement Agreement and Implementation Plan are comprised of activities that directly support several aspects of the CCR reform efforts. These activities include utilization of a Child and Family Team (CFT) that provides individualized care coordination, development and access to Therapeutic Foster Care (TFC), and access to Intensive Care Coordination (ICC) Intensive Home Based Services (IHBS). The ability to provide these services are dependent upon locally developed agreements and partnership between county child welfare agencies and local mental health plans. These activities are transforming the way California's children and youth who are in foster care or who are at imminent risk of foster care placements receive access to mental health services that include assessment and individualized treatments. The Katie A. Core Practice Model also includes a set of concepts, values, principles and standards of practice that provides an integrated approach to working with families involved with the child welfare system. It provides a behaviorally based framework for child welfare, mental health, service providers and community partners and their work with children and families. For more information on Katie A., see http://www.childsworld.ca.gov/PG3346.htm.

Concurrent with Katie A. activities the Department, counties and the California Social Work Education Center have been working on the California Child Welfare Core Practice Model (CPM), which is the guiding framework for California's child welfare community. Building upon and integrating key elements of current initiatives and proven practices including the Katie A. Core Practice Model, California Partners for Permanency (CAPP) Practice Model and other key practices employed in counties across California, the CPM will provide a framework to:

- Outline how services should be developed and delivered via a foundation of family and community engagement;
- Support consistent implementation of child welfare practice statewide with a focus on evidence informed practices;

- Allow child welfare and probation professionals to be more effective in their roles through teaming strategies, valid and reliable assessment tools and state of the art training; and
- Improve accountability and outcomes for children and families through coaching, appreciative inquiry and the use of continuous quality improvement techniques.

The CCR recommendations align with the goal of the CPM in building upon and integrating successful practices into a framework that supports the achievement of safety, permanency and well-being for children and their families served in the Child Welfare Services system. The CCR seeks to leverage the Katie A. Settlement Agreement by linking the mental health services delivery system to the foster care continuum, as foster children are entitled to Early Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Resource Family Approval

SB 103 (Chapter 35, Statutes of 2012) sought to accelerate achieving permanency and address some redundancies in foster home approval processes. The Department, county child welfare agencies and probation departments have begun implementation of a unified, family-friendly, and child-centered approval process for families wishing to provide foster care and/or adopt children, known as resource families. This new approval process replaces the existing multiple home approval processes and increases approval standards by incorporating a comprehensive psychosocial evaluation of all families that want to foster, adopt or provide legal guardianship to a child. Consistent with the goals of CCR, the resource family approval process seeks to improve the experience children and youth have in home-based family care placements by further emphasizing the capacity of the caregivers and the quality of parenting they provide to the children and youth in their care. Five counties are currently serving as early implementers, and the resource family approval process will replace the existing approval processes for relative and non-related families approved to foster, adopt, or take guardianship of children in foster care, with statewide implementation, including the expansion of this requirement to Foster Family Agency (FFA)-certified homes by 2017.

Quality Parenting Initiative

The Quality Parenting Initiative is a collaborative effort of CDSS, the County Welfare Directors Association (CWDA) and the Youth Law Center. The purpose of the initiative is to develop a statewide approach to recruiting and retaining high-quality caregivers to provide excellent care to children in California's Child Welfare System. Attracting and retaining quality caregivers is critical to achieving positive outcomes for children and families and to ensuring the success of child welfare improvement efforts. Implementing the QPI helps emphasize that a foster or relative family caring for a child provides the loving, committed, and skilled care that the child needs, while working effectively with the child welfare system to reach the child's goals. The QPI also clearly defines and articulates the expectations of caregivers, and aligns the expectations of the child welfare system to support quality foster care. These principles serve as a foundational component for CCR. Currently, 17 counties are implementing QPI, and its principles are being embedded in county-based recruitment, training, and retention

efforts. Findings show that quality foster families often are the best recruiters (word of mouth is a powerful tool); quality foster families are valued partners in the provision of service for the children/youth in their care; quality foster families are strong advocates for the children/youth in their care; and quality foster families expect assistance periodically from county staff when crises arise. The model QPI partnership agreement (to be executed by both the caregivers and case managers involved in children's lives) is provided as Appendix A.

Child Welfare Accountability

The Department utilizes the California Child and Family Services Review (C-CFSR) to monitor county child welfare and probation agencies' program performance. Mirrored after the federally-required Child and Family Services Review (CFSR), this evaluative process promotes the use of data and stakeholder input to examine the effectiveness of child welfare service delivery systems, focusing on safety, permanency and well-being of children and families. Since 2003, California's child welfare and probation agencies have been increasing their use of administrative data to manage and improve program quality and performance. Both of these programs have resulted in improved safety, permanency and well-being outcomes for children involved with the child welfare system. Unfortunately, these oversight mechanisms are limited to children and do not have elements that measure the effectiveness of foster care providers.

Recent directives from the federal Administration for Children and Families require states to enhance their oversight systems to include CQI. The CQI process combines the analysis of multiple sources of quantitative and qualitative data, and is dependent upon the active inclusion and participation of staff at all levels of the state and local agency, plus children, youth, families and stakeholders throughout the process.

Serving Young Adults in Foster Care

In 2010, California led the nation by passing and signing the Fostering Connections Act into law (AB 12, Chapter 559, Statutes of 2010) to extend foster care benefits to young adults through age 20 with the intent of better preparing youth to be successful in adulthood. To better serve these youth and their related developmental needs for greater independence, two additional placement types were created: Supervised Independent Living Placement and Transitional Housing Program Plus - Foster Care. For older youth, both of these settings offer alternatives to group home care.

Increased Support for Relatives

Non-federally eligible youth who do not meet federal eligibility rules for receipt of federal Title IV-E funding based on 1996 income standards for eligibility historically have received a California Work Opportunity and Responsibility to Kids (CalWORKs) child-only payment which is roughly one-third to one-half of what children placed with non-relatives are entitled to. In an effort to provide greater support to relative caregivers, the Budget Act of 2014 includes an additional $30 million to provide relative caregivers of non-federally eligible children a rate equal to the basic foster care rate. The Approved Relative Caregiver Funding Option Program takes effect starting in 2015. Counties that opt in can increase assistance payments to relatives caring for non-federally eligible

children and youth to better meet the basic needs of, and secure services for, the children and youth in their care.

2011 Child Welfare Services Realignment

The Budget Act of 2011 included a major realignment of public safety programs from the state to local governments. The realignment moves programs and fiscal responsibility to the level of government that can best provide the services, while eliminating duplication of effort, generating savings, and increasing flexibility. AB 118 (Chapter 40, Statutes of 2011) and ABX1 16 (Chapter 13, Statutes of 2011) realigned the California Department of Social Services' (CDSS) funding for Adoption Services, Foster Care, Child Welfare Services and Adult Protective Services, and programs from the state to local governments and redirects specified tax revenues to fund this effort.

In November 2012, California voters passed Proposition 30 to provide funding for public safety realignment and education. Proposition 30 also provides constitutional protection of funding for public safety services realigned from state to local governments. Additionally, California Government Code sections 30027.9 and 30029.07 (SB 1020, Chapter 40, Statutes of 2012), prioritizes Child Welfare Services for a cumulative $200 million in growth funding over several years, and counties retained approximately $100 million annually when AB 3632 requirements for mental health services for certain populations were returned to school districts.

California's Title IV-E Waiver Project

California's federal Title IV-E Waiver (the California Well-Being Project) provides participating counties flexibility with federal funds that previously were only allowed to be used for out-of-home placement and the administration of the Foster Care Program. A total of nine counties representing 50 percent of the child welfare caseload in the state are participating in the California Well-Being Project. These county child welfare organizations will be implementing Safety Organized Practice which promotes strategies for creating constructive working partnerships between frontline child welfare practitioners, the families they work with and community resources. These county juvenile probation departments will provide home-based services to avoid out of home placements. Beyond these waiver-wide activities, participating counties also may implement other activities specific to that county. Over the five-year duration of the Project, the interventions implemented by these counties are expected to increase well-being and permanency outcomes. Savings must be re-invested in their child welfare and probation programs and services.

Residentially-Based Services Demonstration Project

The Residentially Based Services (RBS) Demonstration Project was implemented in 2010 with four participating counties (Sacramento, San Bernardino, San Francisco and Los Angeles) and ten group home providers. The RBS project currently operates in three counties (Sacramento, San Francisco and Los Angeles) and is extended through July 1, 2016. San Bernardino County is no longer part of the pilot but has opted to fully implement its RBS model outside of the pilot. Participating counties are operating unique programs and fiscal models aimed at providing intensive treatment and

stabilization services while the child is in group care coupled with services and supports that follows and maintains the child in a family-based setting. RBS program and fiscal models are consistent with the goals of CCR.

Quality Improvement Project

Inappropriate use of psychotropic medications amongst children in foster care has been a growing concern in California and nationally. A 2008 sixteen-state study[6], including California, indicated that children in foster care in California were five times more likely to receive psychotropic drugs compared to non-foster care children, and of those children, more than half were prescribed two or more psychotropic medications at the same time. Children in foster care, particularly those placed in group homes, are prescribed psychotropic medications at disproportionate rates when compared with their non-foster care cohorts[7]. In 2012, in response to this growing awareness and also consistent with new federal requirements, the California Departments of Health Care Services and Social Services began working on "The Quality Improvement Project: Improving Psychotropic Medication Use in Children and Youth in Foster Care." The project aims to address concerns regarding the disproportionate prescribing of psychotropic medications to children in foster care, particularly those placed in group home care. The primary goals of the project include: enhancing psychotropic medication safety by establishing mechanisms to provide appropriate assessment, evaluation, and follow-up for children being considered for psychotropic medication treatment; increasing the use of psychosocial treatment in lieu of medications; providing educational materials to children and families involved in the foster care system; and, using data collection to track quality improvement and to conduct data analysis regarding psychotropic medication use.

Post-permanency Services

Counties have been using federal, state and local funding to provide necessary and appropriate supportive services to reduce the incidents of children re-entering the child welfare system after a permanent plan of adoption or guardianship. This funding contributes to a coordinated and integrated service system that emphasizes collaborative approaches, the early identification of issues, and the delivery of support services that promote continued permanency for children with kinship or adoptive families.

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[6] Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study: MMDLN/Rutgers CERTs Publication #1. Accessed on February 29, 2012, at: http://rci.rutgers.edu/~cseap/MMDLNAPKIDS.html

[7] Raghavan, R; Zima, BT; Anderson, RM; Leibowitz, AA; Schuster, MA; & Landsverk, J. (2005). Psychotropic medication use in a national probability sample of children in the child welfare system. *Journal of child and adolescent psychopharmacology*. 15(1):97.

RECOMMENDATIONS

The foundation of the following recommendations is that all children, including those in out-of-home care, deserve to grow up in families and develop a sense of community. Their families, including foster families, also at times need assistance and support to address stressors to avert crises. For those children and youth in crisis or whom otherwise initially cannot safely get the appropriate breadth and/or intensity of services they require in a family based setting, they can access high quality, short term, treatment oriented congregate care (which includes planning for a move to home-based family care as soon as reasonably possible).

The illustration on the next page depicts the vision, key strategies and the expected outcomes of the CCR, and served as a guide in the development of these recommendations.

CCR Theory of Change

Vision

All children live with a committed, permanent, and nurturing family.

Services and supports are tailored to meet the needs of the individual child and family being served with the ultimate goal of maintaining the family or when this isn't possible, transitioning the child or youth to a permanent family and/or preparing the youth for a successful transition into adulthood.

When needed, group home care is a short-term, specialized and intensive treatment intervention that is just one part of a continuum of care available for children, youth and young adults.

Strategies

1. Create a framework for:
   - **Services & Supports** that
     - Engage family & youth & respect voice and choice
     - Coordinate care and services
     - Address trauma
     - Are culturally-sensitive
     - Support aftercare
   - **Assessment & Placement Matching** that is:
     - Based on the child's needs and strengths and caregiver's ability to meet those needs
     - Reviewed and discussed by members of the child and family team
     - Revisited periodically
2. Create a **funding structure** that:
   - Funds needed services and supports
   - Maximizes federal funding across funding steams
   - Is flexible to meet individual needs
   - Incentives desired outcomes
   - Utilizes EPSDT to fund medically necessary mental health services
3. Create **provider performance measures** that are:
   - Performance-based
   - Fiscally accountable
   - Publically available
4. Develop **system capacity and alignment** that includes:
   - Adequate Capacity for lower levels of care
   - Training for provider and county staff
   - Data Collection
   - Licensing

Expected Short-Term System-Level Outcomes

- Reassessment of children who have been in group homes 12 months or longer
- Children and families will receive a core set of culturally-based and trauma-informed services
- Standards for provider performance are identified
- Increased transparency of provider performance
- Funding supports the level and array of needed services

Expected Short-Term Child-Level Outcomes

- Increased family engagement
- Improved family relationships
- Improved family/caregiver supports
- Improved care coordination
- Increased cultural connections
- Increased stabilizing behavior
- Fewer children in group home care

Expected Long-Term Outcomes

- Fewer children in foster care
- Reduced lengths of stay
- Decreased non-permanent exits
- Decreased re-entry rates
- Increased placement with relative or Tribe
- Increased reunification
- Decreased disparity in achieving all outcomes above

Beyond the issues described in the Background section of this report, in the current system's structure, it is the placement setting of the child or youth that drives the available services and supports rather than the individual needs of the child and family. Children and youth in foster care currently must "fail" in the foster home or kin placement in order to move into a group home to access the additional supports and services they need. To compound the problem, each change in placement and longer period without necessary services is detrimental to the child and family, and is costly. This additional emotional trauma, disrupted relationships, school changes, and other significant impacts also can lead to a perception that it is the child or youth himself or herself who is not capable of thriving in a home-based family-like setting, rather than inability of the placement system to address their individualized needs.

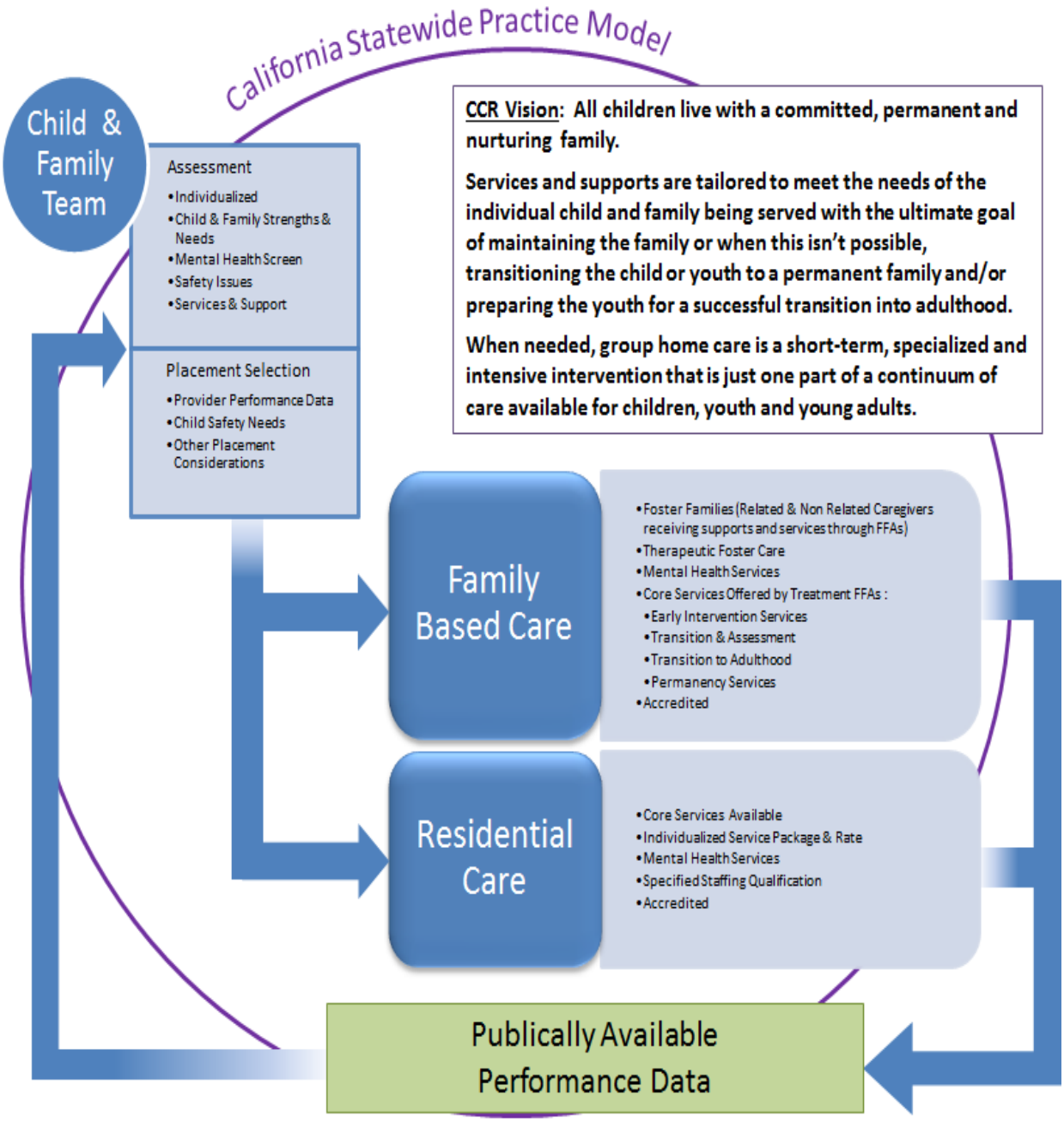
When it is determined that a child cannot safely remain in the home of their parent or guardian, the offerings of the first placement should match an accurate assessment of the child or youth's needs. Children should not have to experience multiple placements to get the services they need. Preserving or reunifying the family is the first priority, when possible, for all children and youth. When reunifying a family is not possible, the obligation to secure a permanent family through adoption or guardianship remains. Consistent with this priority is the principle that children who cannot be safely placed in home-based family care can go into residentially-based care with specific care plans and intensive therapeutic interventions. Such placements should be short-term in nature and have the goal of returning the child or youth to a home-based family care setting or other permanency option as quickly and safely as possible. These short-term placements will become the role of what currently are Rate Classification Level 12-14 group homes, hereafter known as Short-Term Residential Treatment Centers (STRTCs). As noted earlier, increasing the capacity of home-based family care is a necessary first step in this process.

Concepts and principles of the CCR are:

- Working with the child, youth and family as part of a team is fundamental. This child and family team, including extended family, community and/or tribe, is the primary vehicle for collaboration on assessment, case planning and placement decisions. This paradigm shift is modeled after Wraparound and breaks from traditional practice in which the caseworker makes decisions in isolation without the input and expertise of other practitioners.
- Recognition that children and youth in foster care have been affected by trauma, both by the fact that they have been abruptly separated from their family, as well as by the circumstances that led to their removal. Recognizing this trauma and minimizing additional trauma needs to be structured into how practice is implemented for children and youth in foster care.
- Culturally relevant services and supports need to be available to children, youth and their caregivers regardless of the placement setting and be individually tailored to their needs.

- The practice of public agencies, private agencies and service providers needs to be aligned through a common core practice model with county child welfare agencies retaining their case management responsibilities.
- Shifting the nomenclature surrounding foster care to emphasize “resource families” as “home-based family care.” These families are inclusive of related or unrelated families that are approved to foster, adopt or take guardianship of children in foster care, regardless of whether they are approved by a public or private agency.
- Decisions about placements with providers need to be informed by the provider’s performance on common indicators which is publicly available. Decisions about placement with a specific family need to be based on a determination that the family has the capacity and ability to meet the needs of the specific child.
- Assumes providers can continuously improve the quality of care by using data to manage performance.
- Medically necessary health and mental health services need to be available to children and youth in foster care regardless of the placement setting.
- Efforts to achieve legal permanency and emotional permanency are necessary for every child and youth. This includes maintaining and, if necessary, establishing important connections to siblings, extended family, culture, and if applicable, tribes.

The illustration that follows represents the framework for the new model and the intersection of the CFT to the assessment of the child and families’ strengths and needs. The family and child’s needs drive service delivery and placement, which in turn supplies information about provider performance. Provider performance measurement is part of the larger CQI cycle which allows for program and system modifications to improve outcomes if necessary.



While stakeholders participating in the CCR process generally agreed on the need for system change and there was general agreement on the model above, consensus does not exist on all recommendations. This lack of consensus is not surprising given that significant change is recommended for both public agencies and private non-profit providers.

Reducing the number of children and youth placed in group homes, and the duration of those placements, will require investment in the infrastructure of alternative home-based family care placements and the services they provide and are made available to them. It will require improved assessments of children and families, child and family team

input to placement decisions, a revised array of available services and supports in each placement setting, transformation in how those placements and services are financially supported, and transparency in outcome measures and performance data. In order to improve outcomes for, and the well-being of, children, youth and their families, the Department will be pursuing all of these recommendations through a comprehensive legislative proposal and associated budget adjustments, in consultation with partners and stakeholders.

While an upfront financial investment in home-based family care placements and necessary services and supports will be needed, over the long term, California's adherence to these recommendations is expected to become cost-neutral by creating placement cost savings and utilizing strategic leveraging of federal Title IV-E and Title XIX funding that can be used to further improve outcomes for children and youth.

Some of the recommendations in this report include activities that were realigned in 2011. Funding for these realigned activities now is included in the Local Revenue Fund (LRF). Counties leverage the LRF and federal Title IV-E to pay for these previously funded eligible activities such as placement costs, training, retention and recruitment of foster parents, family finding and engagement and increased case planning to include facilitated team meetings.

These recommendations are divided into four areas: Program, Fiscal, Outcomes and Performance Measures, and Implementation. The Program area has three sections: General Recommendations, Home-Based Family Care Recommendations and STRTC Program Recommendations. These recommendations are interdependent and successful implementation must take that into consideration.

GENERAL RECOMMENDATIONS

RECOMMENDATION 1:

All placing agencies will utilize tools with common domains and will utilize Child and Family Teams in assessing the child and family's needs and strengths and use that assessment for case planning and to match a child to the most appropriate placement setting.

The current regulatory framework requires child welfare case workers to complete an assessment for each child for whom child welfare services are to be provided[8]. These assessments include gathering and evaluating information relevant to the case situation and appraising case service needs based on child and family strengths. This recommendation envisions that the foundation for the assessment and subsequent case planning and service delivery rests with the Child and Family Team (CFT). Once identified, the needs of a child or youth will be supported with appropriate services that are to follow the child into their home-based placement setting. The term "matching" refers to the determination of the placement setting's ability to meet those specific needs (this is distinct from a formal, comprehensive mental health assessment completed by a mental health professional). For consistency and reliability across counties and placing agencies while also providing county flexibility in determining the most appropriate evidence-based tool(s) to be used for the assessment and matching process, the following domains must be included in the assessment of a child and family's strengths and needs and matching process. Assessments conducted by probation may have additional elements including the youth's protective factors and risk level for re-offending. These elements would not necessarily be required for child welfare. (See chart on the next page.)

[8] Consistent with Welfare and Institutions Code Section 16501.1

Domains	Child/Youth	Parent/ Guardian	Resource Family
Emotional/Behaviors	X	X	X
Physical Health/Disability	X	X	X
Education	X	X	X
Family Relationships	X		X
Child Development	X		X
Substance Abuse	X	X	X
Cultural Identity/Primary Language	X	X	X
Peer/Adult Social Relationships	X		
Delinquent Behavior	X		
Trauma	X	X	X
Strengths/Needs	X	X	X
Sexual Orientation, Gender Identity & Expression	X		X
Transition to Adulthood	X		
Household Relationship		X	X
Social Support System		X	X
Parenting Skills		X	X
Mental Health/Coping Skills		X	X
Placement Preference	X		X
Permanency	X		X

Intensive mental health needs should not automatically translate to a more specialized or restrictive placement prior to the consideration of other alternatives. Additional therapeutic options such as Intensive Care Coordination (ICC), IHBS, Therapeutic Behavioral Services (TBS) and TFC are entitled intensive services for children and youth with significant mental health needs and may be offered in home- and community-based settings.

The accuracy of the assessment and matching process, already implemented as part of the Katie A. Settlement, relies on effectively engaging the members of the CFT in order to gather all necessary information and develop a service plan for which members of the CFT have active participation and buy-in. If at all possible, the assessment should

occur in a safe and supportive environment with the involvement of all participants. When possible, the child and family needs and strengths assessment should occur as it does today upon initial contact with the foster care system (for children and youth supervised by either child welfare or probation agencies) and, thereafter, at least once every six months as it is today under court supervision, or as needed and determined by the CFT. Ongoing assessment is needed to continuously monitor the progress of the child, assist with planning for transitions to lower level placement settings or back home and identify further support that may be needed to best serve the child. The matching process should consider the assessed needs of the child and a review of the placement's ability to meet those needs. This is an existing responsibility for those entrusted with the care and supervision of these children and youth. This recommendation seeks an assessment tool covering key domains, and more participatory assessment and monitoring by emphasizing the CFT.

Implementation of this recommendation will require placing agencies to adapt their existing assessment tool(s) such that all domains are included. Currently, 54 county child welfare agencies utilize the Structured Decision Making (SDM) process which has a Family Strengths and Needs Assessment; the remaining counties utilize a Comprehensive Assessment Tool (CAT). For assessing the developmental and socio-emotional needs of younger children, some counties use the Ages and Stages Questionnaire. Juvenile probation agencies have a broader range of tools available that would also need to be modified to incorporate all of the identified domains. Counties will utilize one assessment tool or process as the CWS New System becomes operational in 2019.

RECOMMENDATION 2:

All STRTCs and FFAs must be accredited by a national accrediting body, selected by CDSS, as a condition of receiving a foster care rate.

In an effort to provide high quality services and effective organizational practices, it is recommended that any STRTC and FFA licensed in California and serving children and youth under the jurisdiction of the juvenile court as a foster care resource, be accredited through a national accrediting organization. Accreditation typically includes a specific process whereby an organization undergoes an in-depth review and receives a qualified endorsement that it conforms to recognized service standards. National accreditation brings benefits to an organization, such as professionalizing staff, establishing administrative best practices, improving service delivery, and promoting a culture of continuous quality improvement. Furthermore, through the re-accreditation process that occurs every three or four years, it is expected that the accrediting agency will validate the effectiveness of staff training and coaching to ensure staff possess the necessary knowledge, skills and abilities.

The accrediting bodies will be selected by the Department after consultation with stakeholders. Based on this consultation, CDSS will establish a date by which all providers need to be accredited. The cost of accreditation will be amortized and

included in the new funding structure. The CDSS is proposing that maintenance of accreditation status be a requirement for continued receipt of a rate.

RECOMMENDATION 3:

Temporary transition strategies will be implemented to address the need for placement options and resources for older youth and young adults who do not wish to transition from current group care to home based placements.

The Department is making this recommendation after hearing from youth their desire to have options available to them in lieu of placement into home-based family care. Youth have noted that not every youth, especially older youth, want to live with another family. Rather, some older youth want placement options that support their desires to transition to adulthood. While it is expected that the youth's social worker will work to resolve objections to home-based family care and permanency, such options would include the Transitional Housing Placement Program (THPP), which provides supervised living settings for youth age 16 to 18 with services provided by a contracted/licensed provider, and the THP+FC, which provides older youth age 18 to 21 an opportunity to live independently and receive the supportive services from a housing provider. Both housing options also include the Host Family Model which allows for the youth to live with a permanent connection or caring adult who has been selected by the youth and has agreed to assist the youth in their transition and skill development.

HOME-BASED FAMILY CARE RECOMMENDATIONS

Home-based placements would encompass the full range of existing placement types including FFAs, relatives/non-related extended family members (NREFMs), foster family homes, etc. The following recommendations are specific to FFAs and resource families, known as home-based family care settings. As envisioned, the FFA Program will focus on two service levels-treatment and non-treatment. Consistent with TFC required under Katie A., the FFA Treatment (FFA/T) foster care homes will serve children and youth with significant mental health needs and will provide an individualized therapeutic home-based family care setting. The FFA Non-Treatment (FFA/NT) foster care homes will provide the full array of non-therapeutic supportive services.

RECOMMENDATION 4:

Allow public agencies to be licensed to operate an FFA.

Currently, licensed FFAs are operated by private, non-profit agencies. Public agencies should be allowed to be licensed to operate FFA/NT and FFA/T's to serve the children, youth and families in their care if appropriate and where FFA/T's are not available. This promotes counties' ability to develop programs focused on specific populations for which there may be a local need. This also may facilitate better integration with other

county services. Such agencies would be approved and evaluated on the same basis as private programs.

RECOMMENDATION 5:

Strengthen resource family recruitment, training requirements and retention strategies.

The supply of resource families has declined over the past several years. The Approved Relative Caregiver Funding Option Program, SB 855 (Chapter 29, Statutes of 2014), commonly known as the ARC program, has removed barriers for some relative caregivers to care for children and youth in foster care by creating parity with licensed homes with respect to financial support. Nonetheless, focused attention is needed to recruit new families and retain existing quality families as they are foundational to the reform effort.

This recommendation envisions that resource families will be will be active partners with public child welfare workers and service providers. As integral members of the CFT, resource families are also entrusted with the child's safety and well-being and thus must make a loving commitment to the child and a commitment to be involved with the child in the context of the community. Resource families will be assessed and matched with specific children and youth and should meet criteria for legal permanency options should family reunification not be achieved.

All resource families need the knowledge, skills and abilities that are trauma-informed and attachment-based to best support the children placed with them. Training given to resource families should include a basic curriculum that supports their role in parenting vulnerable children and youth. Consistent with existing requirements, the training for resource families will be both initial and ongoing in order to continually provide information on current new practices and/or changes within foster care. Training prior to approval will include:

- Permanence and well-being needs of children;
- Cultural needs of children;
- Child and adolescent development, including sexual orientation, gender identity and expression;
- Role of a resource family, including working cooperatively with the agency and other service providers to develop and implement the case plan;
- The rights of children in care and their responsibility to safeguard those rights; and
- Their responsibility with respect to acting as a reasonable and prudent parent, and maintaining the least restrictive, most family-like environment that serves the needs of the child.

In addition to the current training topics for resource families, training topics such as positive parenting, prudent parenting, trauma-informed care and attachment, the CPM, crisis intervention, behavior management, supporting children and youth in school and the effects of drug/alcohol abuse on children, should be added to the training curriculum.

Initial recruitment efforts will focus on building the supply of resource families. By integrating knowledge supportive of quality parenting will further the development of resource families skilled in working with probation youth and youth with behavioral health needs necessary to support the transition of youth from residential settings into home-based family care. The QPI, as previously discussed, will serve as a model for agency/caregiver partnership.

RECOMMENDATION 6:

FFA programs must provide core services and supports to FFA/NT and FFA/T placements. FFAs or other community based organizations using the same standards can, at county request, provide core services and supports to resource families, including relatives and NREFMs.

Each FFA/T must demonstrate the capacity to offer the following core services in order to support the range of needs for children, youth and families in foster care. Service and support types and intensities will be based on assessments as described in Recommendation 1. While not all children or youth will require all of these services, these core services can be characterized as:

1. Improved access to entitled medically necessary specialty mental health services that include but are not limited to the following, as appropriate: arranging for individual or group therapy, intensive care coordination, intensive home-based services, therapeutic behavioral services, therapeutic foster care, out-patient treatment, respite, and/or crisis intervention services 24-hours a day, 7-days a week. Note: Required for FFA/T programs.
2. Transitional Support Services Upon Discharge: Services that are designed to provide continued support after the child/youth has exited to permanency or their current placement setting by providing follow-up services in varying degrees of intensity and duration to stabilize and maintain the return home and to the community based upon the individual need of the child, youth and family. Community Services and Supports: Services designed to assist the youth and family in maintaining formal and informal connections in their community.

To increase the quality of and improve the consistency of services are provided to all children and youth in FFA and FFA/T programs across the state, all FFA and FFA/T programs must provide, or provide access to, the following core services:

3. Permanency-related Services: These are two-fold:
    a. Supporting efforts to reunify children and youth and an effort to achieve alternate permanency should reunification fail. The FFAs and FFA/Ts that are not licensed as adoption agencies must have formal agreements

(e.g., Memorandums of Understanding) with adoption agencies to support a seamless transition to adoption when possible.

b. Maintaining and/or Establishing Permanent Relationships: Services that support connections with siblings and extended family members, and that focus on building strong and enduring ties for every youth to one or more nurturing adults. Services may include specialized youth-centered permanency services.

4. Health Support: Services designed to promote a youth's physical, mental, emotional and spiritual health by providing appointment transportation, support and follow-up care per after visit instructions. As part of Health Care Oversight responsibilities, improving the administration and management of psychotropic medication is critical to improving health outcomes.

5. Educational Support: Services to promote the child/youth's educational plan by providing transportation to and from school and school-based activities, advocacy, as well as tutoring and other educational related supports not otherwise available directly from the school.

6. Life Skills to Support Youth Transitioning to Adulthood: Provide youth with age appropriate activities that support development and growth towards financial literacy, responsible decision-making, developing self-identity, values, character, health and nutrition, accessing resources, maintaining a network of support, healthy relationships and career development.

7. Biological Parent and Resource Family Supports: Services designed to engage and assist biological parents in the care of their children and eventual reunification, as well as services that enable a resource family to work with the biological parent in this process and provide a normalized childhood experience including reasonable and prudent parenting.

8. Services for Non-minor Dependents (NMD): Services based on the individual needs of the NMD would include transition strategies and options, specific independent living skills for older teens, access to mental health services, and referral for academic- and career-based services.

To increase support for resource families and reduce placement changes the Administration intends that FFA/Ts be authorized to offer the services described above, at county request, to all resource families not just those certified by their agency. This would include relatives and NREFMs based on a county referral. FFA/NTs will largely fill the role of resource parent recruitment.

In the development of this recommendation, county placing agencies reported that some FFAs currently provide specific types of services that meet the needs of individual counties. Although such specialization is not required, an FFA/T may choose to specialize in a particular service category. Such specialized services are best developed in collaboration with counties based on local needs.

RESIDENTIAL TREATMENT RECOMMENDATIONS

Under this framework, group homes will be transitioned into short-term, specialized and intensive treatment providers used for the minority of children and youth who cannot safely be served in their own homes or in home-based family care settings. These settings will operate as STRTC programs. The target population to be served by STRTC programs is children and youth (up to age 18 and, in specified circumstances, age 21) who are under the jurisdiction of the juvenile court, supervised by county child welfare or probation agencies. Placement into a STRTC shall be based upon the individualized assessment of needs and strengths and the recommendation of the CFT that placement is necessary because the child requires intensive services in a 24/7 supervised setting to maintain their or the public's safety. Placement of probation supervised youth into a STRTC could include the youth's need for behavioral or rehabilitation interventions. The STRTC placements are not intended to be long-term in nature.

The STRTC programs will provide the highest level of care and supervision, offering immediate access to an array of services that are tailored to meet the needs of the individual child, including intensive mental health treatment or intervention services for victims of commercial sexual exploitation. Building upon the residentially-based services model, STRTC providers will be required to have the capacity to transition children and youth to a home-based family care setting. This step-down into a home-based family care setting may be done in a number of ways, including through a wraparound program or Treatment Foster Care, and it may be provided by the STRTC provider organization or by partnering with a third-party agency, such as a FFA/T, as determined at the local-level. In addition, per the Katie A. Medi-Cal Manual, STRTC providers will provide intensive care coordination for up to 30 days to enable the transition to home-based family care in the community.

The STRTC providers can partner with county child welfare and/or probation and mental health agencies as a member of the CFT to develop and implement individual care plans engaging the youth and family voice and choice.

Finally, it is anticipated that the implementation of these recommendations over time will result in a significant decrease in the total number of youth currently placed in group homes as capacity is developed for quality lower-level placements and lower-level group homes are transitioned to other roles. In addition, length of stay for children in STRTC placements also is expected to decrease as STRTC programs are required to offer core services (described below) aimed at stabilization and transition to home-based family care. To enable this new STRTC role in the continuum of placement options, initial investments are necessary in the capacity of home-based family care options to enable access to such placement options.

RECOMMENDATION 7:

All STRTC programs will provide core services and support for children and youth that need short-term, intensive treatment interventions and who initially cannot be safely maintained in a home-based family care setting. Placements must be reviewed at intervals not greater than six months, with continued placement requiring county Deputy Director, Probation Chief or Assistant Chief approval.

Currently, some residential treatment settings serve more as a permanent residence to children and youth than a short-term intensive treatment intervention. As intended, the STRTC programs will provide short-term intensive treatment interventions aimed at stabilizing children and connecting or re-connecting children to their community in a home-based family care setting. However, residential care should be a temporary option that meets the needs of the child and family and builds on their strengths. "Short-term" as defined is based upon the individual needs of the child and family as determined by the CFT.

During the development of this recommendation, legislation was enacted that implemented two key provisions aimed at ensuring residential placements are short-term, intensive treatment interventions:

1. AB 74 (Chapter 21, Statutes of 2013) requires specific time limits on the length of stay in group homes for children under the age of 12; and
2. AB 74 also requires a re-assessment and determination of the suitability of group home placements for youth residing in group homes for one year or longer, by an executive of the child welfare or probation department.

The STRTC primary services are designed to provide all children and youth in residential care a standard array of services that are provided based on the individual needs of the child/youth and family. These services are designed to quickly stabilize youth and move them to a resource family or to return to their own family. While offering these services, providers will still have the latitude to tailor services to specific populations, e.g., sexual offenders, dual diagnosis, developmental disabilities, victims of commercial sexual exploitation and others. To increase the quality of and improve the consistency of services provided to all children and youth in STRTC programs across the State, all STRTC programs must provide, or provide access to, the following core services:

1. Intensive Treatment: Active, consistent delivery of culturally congruent, evidence-informed services based on an assessment and diagnosis. Treatment will be coordinated by a CFT working in their scope of knowledge to improve youth and family functioning to address a specific or multifaceted challenge with the goal of connecting or reconnecting with a home-based family care setting, school, community and tribal resources, as appropriate. The success of this service rests with the ability to partner at the local-level with county mental health plans and to

access the Medi-Cal funds for these services. This includes providing an array of Medi-Cal specialty mental health services such as rehabilitation, mental health services, targeted case management services, therapeutic behavioral services, EPSDT and/or supplemental specialty mental health services as defined in Department of Health Care Services' (DHCS') Medi-Cal Documentation and Claiming Manual.

2. Transitional Support Services Upon Discharge: For a period of time after the child or youth has exited the STRTC placement setting, provide follow-up services in varying degrees of intensity and duration to stabilize and maintain the return to the home-based family care setting, school and community. This also includes post-permanency supports provided to the youth after he/she has exited to permanency to stabilize and maintain the permanent placement, based on the individual needs of the child, youth and family.

The following STRTC services can further support transition to home-based family care settings:

3. Establishing/Maintaining Permanent Connections: Assist youth in maintaining, establishing or re-establishing a life-long permanent relationship that is reliable and consistent and that youth feel connected. The process of establishing or re-establishing this connection is youth-centered and based on the needs of the youth as identified by the youth. The life-long connection may or may not be with someone who can provide legal permanency, but must be someone willing to be a life-long supportive and permanent connection. This includes:

    i. Ongoing Youth Permanency: Provide a full array of services, such as intensive care coordination, intensive home based services, clinical and therapeutic services and educational supports to improve permanency outcomes, (reunification with parents or adoption or guardianship with a new family). Practice family finding and engagement by using formal and informal resources to locate and learn about family members and other supportive relationships, including tribes when appropriate, who are prepared and engaged to be available for placement and/or social support. While not all children, youth and their families may need the entire array of services, it is important that a comprehensive array be available in order to meet the specific needs of the child, youth and/or family.

    ii. Supporting sibling relationships, including but not limited to information, education and visitation supports. SB 1099 (Chapter 773, Statutes of 2014), in part, was enacted to facilitate this.

4. Health Care Support: Promote physical, mental, emotional and spiritual health by providing appointment transportation, support and follow-up care per instructions. Health care support includes monitoring the use of medications and following protocols and requirements for the administration of psychotropic and other medications.

5. Educational Support: Provide transportation, advocacy, tutoring and other educational related support to fulfill the educational plan.

6. Community Services and Supports: Support the youth and family in building and maintaining formal and informal connections in their community, including tribes as applicable, to sustain the youth and family after discharge. This includes partnering with natural neighborhood supports, schools, tribal supports, faith-based and other cultural community supports identified by families to coordinate case planning, decision-making and delivery of services.

RECOMMENDATION 7A:

County operated children's shelters will be phased out over a multi-year period.

Several counties have discontinued use of childrener a multi-year period.g and maintwith a preference for non-residential intake assessment centers and direct placement in either home-based or treatment settings. These assessment centers provide a safe location where children are assessed and their individual needs are considered and matched to an appropriate placement in under 24 hours.

Other counties currently operate "children's shelters" which provide care and supervision to children and youth, typically at the point of entry to foster care or during unexpected transitions between placements. These shelters are licensed under group home regulations and are non-treatment facilities. Children typically spend between a few days to a few months in these shelters.

Although these counties have invested significantly in shelters, their continued utilization as a standard part of the foster care continuum is inconsistent with the principles and goals of the CCR. In recognition that circumstances and needs that led to their development vary from location to location, and that the timetable by which alternative care resources can be made available, it is recommended that the counties operating shelters be provided a reasonable multi-year window to shift from this model to home-based family care treatment placements, and to develop locally appropriate re-use plans for their shelter facilities.

RECOMMENDATION 7B:

Group homes that are educationally-based boarding school models will adapt and align their programs to meet the CCR goals supporting home-based family care and permanency.

There are group home programs that focus on residentially-based education programs that have some success in supporting foster youth both in high school completion and college entry. Typical placements in these types of settings are for multiple years.

One county currently contracts for operation of a residential high school for foster children, and others have inquired about possible replication. The reported benefits of these programs include significantly higher graduation, college admission and college graduation than the general foster care population.

The conflicts such models present to the CCR principles and goals are in their de-emphasized commitment to home-based family care and permanency, and in the de facto choice a youth may have to make between education and home-based family care. Proponents of the model assert that the youth selected for admission are those for whom reunification is not considered by the county to be an option and for those whom may express skepticism or opposition to a foster family home, relative or NREFM placement. However, it is an underlying principle in the core practice model of CCR that prior experiences should not validate rejection of home-based care, and that it is the continuing responsibility of all providers and professionals to work with the youth to achieve normalcy in their living situation. Long-term foster care placement is not acceptable as a permanency plan.

In recognition of the possibility that some youth may do well in a "boarding school" environment, but also that model is understood to be a part-week, part-year setting with the students rooted in non-institutional home environments, the Department will work with the existing programs to validate the educational services and curriculum meet existing state requirements for high school graduation or its equivalent, define targets and standards for simultaneous placement in home-based family care and school, including for time spent in each, and options for retention in the education program after successful reunification, adoption or guardianship.

These programs will need to appropriately braid a number of funding streams, including but not limited to foster care funding from the Local Revenue Fund and Title IV-E, mental health funding from the Early and Periodic Screening Detection and Treatment program, and state school funding from the Average Daily Attendance and Local Control Funding Formula.

RECOMMENDATION 8:

Require all STRTCs and FFA/Ts to be certified by the DHCS or county mental health plans to provide medically necessary specialty mental health services.

Without the ability to deliver mental health services, STRTC programs could not meet the intensive treatment needs of children and families. With the intended role of STRTC programs to be short-term, intensive treatment interventions used to stabilize the child and quickly move them to a less restrictive environment or reunification, the ability to deliver specialty mental health services funded by federal Title XIX funding is critical. STRTCs and FFA/Ts will be certified by county mental health plans.

As part of the licensing requirement, all STRTCs must be certified by the DHCS or the county mental health plans in order to serve children and youth in California.

Additionally, revised program statements will be reviewed and approved by CDSS and counties to ensure the program is consistent with current practices and meets the needs of the communities in which they serve. The financial support for these services will account for, and be dependent upon, provider accountability for best practices and accepted standards for the duration of care and its outcomes.

RECOMMENDATION 9:

Children currently placed in group homes with a Rate Classification Level (RCL) 1-9 will be transitioned into home-based family care. Groups homes rated 10-14 will be either re-rated to the residential treatment rate or to a foster family agency rate.

Current group homes classified as an RCL 1-9 generally do not serve children with complex and enduring needs. Therefore, it is assumed that children currently placed in RCL 1-9 group homes soon could be placed in a home-based family care setting. The CDSS recommends that prior to any child currently placed in RCL 1-9 facilities being transitioned into a home-based family care setting, an assessment should be completed to determine the appropriate placement option. Older youth will have other options, including the THPP or THP+FC Program.

Providers with an RCL 1-9 eventually will be expected to revise their programs consistent with the recommendations for operating a STRTC or FFA/T or FFA/NT program, as described in Recommendations 14 and 18. Providers with an RCL 10-14 will need to choose to provide short-term intensive treatment interventions or to become home-based family care placements under the new framework, to continue as a placement option. These revisions will occur over time in each county, as home-based family care placement capacity is increased and other infrastructure and service arrays are implemented.

RECOMMENDATION 10:

Increase the minimum age for all newly hired STRTC child care workers.

Child care workers supervise, protect and care for children in STRTC settings. These workers assist children in group activities and in solving individual problems, provide behavior limits and corrective actions, track individual youth progress, identify professional service needs, and relay this information to treatment staff. Youth have been outspoken about the need to have staff that are older than the residents if they are to have supervisory responsibility for the youth. As a result, SB 855 Chapter 29, Statutes of 2014 was enacted to increase the age requirements for all staff and facility managers hired on or after October 1, 2014, to be at least 21 years old.

RECOMMENDATION 11:

Increase the minimum qualifications for all newly hired STRTC child care workers.

As noted in the prior recommendation, STRTC child care workers play a critical role in residential placements. In order to ensure that these STRTC staff is qualified, all newly hired STRTC child care workers must meet one of the following requirements prior to hiring:

1. Have a Bachelor of Arts or Sciences Degree;
2. Have a valid Child Development Teaching Permit;
3. Have completed 12 semester units of Early Childhood Education, Adolescent Development, or Foster and Kinship Care Education *and* have 100 hours of experience working with youth;
4. Have a valid Alcohol Counselor, Drug Counselor or Alcohol and Drug Counselor Certificate *and* have 100 hours of experience working with youth;
5. Have a valid Vocational Training Certificate, Credential or documentation stating the individual is a trade journeyperson and instructs vocational skills to children *and* have 100 hours of experience working with youth; or
6. Have previously been employed as a "STRTC Child Care Worker" or a "STRTC Volunteer," for at least one year in duration.

RECOMMENDATION 12:

Enhance the training for new and existing STRTC staff.

STRTC staff must be able to support the STRTCs' new model of intervention. Group home child care workers currently are required to complete eight hours of initial training before being left alone with a child. A maximum of four of those eight hours can be satisfied through "job shadowing" which is the process of following and observing an experienced facility member performing a specific job. Staff must receive adequate initial training and orientation before working independently with youth.

To improve consistency and improve the quality of training for STRTC child care workers across the state, a high quality training curriculum should be used, with materials and a portion of the training to be provided by a qualified youth trainer. Additional training topics should be added to the annual training requirements for STRTC staff as best practices evolve. Furthermore, STRTC providers are expected to train existing SRTRC child care workers in these areas as part of the ongoing training requirements. The following four items are recommended to immediately improve the training of STRTC child care workers:

- Annual training requirements for staff shall be increased to 40 hours per-year, as indicated by current best practice across the state.
- The 24 hours of initial training must be completed before being left alone with a child and this training must be completed within the first 90 days of employment for full-time employees or 180 days for part-time employees.
- At least 20 of the 40 hours of on-going training shall be provided by a CDSS-approved vendor and four of the 24 hours of initial training shall be provided by qualified youth trainers.
- In order to ensure STRTC child care workers are trained and qualified to work with the children and youth with complex needs, the following new training topics shall be required:
    - Interpersonal Communication Skills*
    - Grief and Loss
    - Youth Permanency
    - Crisis Intervention and Behavior Management*
    - Cultural Humility*
    - Sexual Orientation, Gender Identity, and Expression*
    - Trauma-Informed Care and Attachment*
    - Awareness and Identification of Commercial Sexual Exploitation
    - Medication Management and Monitoring of Psychotropic Medications
    - California Statewide Practice Model
    - Child Welfare/Probation 101*

    *Indicates training topics to be completed prior to working with youth.

RECOMMENDATION 13:

Establish "STRTC peer partner" and "STRTC volunteer" staff classifications and allow STRTCs to use these classification as needed to support their program.

The minimum age limitation of 21 for STRTC staff may in some cases limit their ability to function as a peer for children and youth. Two new staff job classifications should be established:

- STRTC Peer Partner: The STRTC peer partners must be a minimum of 18 years of age, and be able to provide "peer support" to either youth/young adults or parents.

- STRTC Volunteer: The STRTC volunteers must be a minimum of 18 years of age and have life experience that provides value to foster youth in areas such as tutoring, “life coaching,” creative arts, crafts, music, sewing or games.

Neither STRTC Peer Partners nor STRTC Volunteers should be primarily responsible for the direct supervision of children and youth in a STRTC. Staff hired into either classification must clear a criminal background check before beginning work. In addition, both classifications must receive training on the following topics:

- Confidentiality*
- Active Listening Communication Techniques*
- Overview of the Foster Care System
- Achieving Permanency
- Working with Youth in Foster Care
- Foster Youth Rights*
- Trauma Informed Care and Attachment
- Awareness and Identification of Commercial Sexual Exploitation
- Cultural Humility*
- Crisis Intervention
- Child and Youth Development including, Sexual Orientation, Gender Identity and Expression*

*Indicates training topics to be completed prior to working in a STRTC.

FISCAL RECOMMENDATIONS

It is essential that an appropriate fiscal structure supports the CCR Program design. Some of the recommendations that follow will require ongoing work or an upfront investment as changes to the system are developed and implemented. The Department will communicate with the field on an ongoing basis for review and comment. The recommendations below align Title IV-E, Title XIX and the LRF to focus on culturally- and developmentally-appropriate, trauma-informed, family- and community-based care as well as short-term intensive residential care as needed. Funding decisions should follow the care decisions that address the needs and strengths of the child and family and must be based upon the cost of effective services, the benefits such services are expected to bring and the likely consequences of deferring or failing to make necessary investments in children, youth and families. Local governments should collaborate with the private sector, communities and with providers to allocate funds and other resources wisely. This collaboration is critical to maximizing the effectiveness of care and treatment and optimizing child, youth and family outcomes.

RECOMMENDATION 14:

Replace the group home RCL system with a statewide residential rate for all STRTCs.

Currently, California uses a tiered system known as “Rate Classification Levels” for compensating group home care providers. Funding is based on the experience, education and tenure of staff. A group home with more qualified, educated, and tenured staff receives a higher RCL and, thereby, a higher rate. This funding is not tied to the individual needs of the child or youth. The funding model being recommended by the Department would have three different components: (1) funding for board and care, (2) funding for individualized treatments and therapies, and (3) funding for services and supports.

The board and care component cost assumes that AFDC-FC would reimburse 50 percent of Title IV-E allowable costs for federally eligible children and that some STRTC child care staff will be involved in treatment-related activities that are Title XIX eligible. Because Title XIX matching rates are significantly higher than Title IV-E, the Department and county child welfare and probation agencies could maximize reimbursement by working with providers to modify their programs in order to access Title XIX funding for eligible staff, activities and costs.

It is likely that the STRTC rate will be higher than the existing group home rates as a result of increasing training, staff qualifications, additional intensive program requirements, the short-term nature of these placements, and specific administrative activities like accreditation that will improve the quality and operation of the programs. These savings will ultimately be available to offset the costs of recommendations in this report.

In addition to the recommended board and care rate, STRTC providers can receive additional funding for the delivery of individualized medically necessary mental health services via Title XIX, which can help maximize funding for the provider. Under the recommended STRTC model, specified child care staff can become active participants in the CFT and may assist in certain activities related to a child's individualized service plan. Such activities would not be eligible for Title IV-E reimbursement, but may be eligible for Title XIX reimbursement, and would be billed as such through the provider or appropriate county agency. Therefore, success of building this rate will require agreements with the local mental health plans to maximize federal benefitting programs including Title IV-E and Title XIX.

RECOMMENDATION 15:

Implement a new STRTC program audit in accordance with the proposed program plan and treatment competencies. Program, fiscal and health and safety reviews coordinated with joint activity by the Department's Children and Family Services Division, Community Care Licensing Division (CCLD), and the Department of Health Care Services (DHCS) Mental Health Division.

Audits of group home providers currently conducted by the Department follow the existing RCL regulations. Auditors use these regulations as the basis for auditing facility staff's paid-awake hours, licensing requirements, education and experience, training, social work activities and mental health treatment services. This audit process determines whether a group home is receiving the appropriate funding rate for the services they provide but does not measure a program's effectiveness in improving outcomes for children, youth, and families.

Future audits will include these fundamental administrative activities, but also will involve a multi- departmental review team that will focus on the programs' administrative and service practices, outcome performance and claiming to ensure that the providers are operating programs that are reflective of best practices and local needs.

RECOMMENDATION 16:

Revise the FFA rate structure to account for two types of FFAs: 1) FFA/Ts that provide core services, intensive treatment foster care and therapeutic foster care, and 2) FFA/NTs which function as specialty or home-finding agencies. Also, increase the FFA Social Worker Rate to account for expanded core services and supports to be provided to resource families.

With the implementation of CCR, FFA/NT and FFA/T social workers will provide services to foster homes certified by the FFA and other resource families, including kinship families, at county request. The FFAs will be responsible for performing psychosocial assessment of each resource family so that the needs and strengths of children and youth in foster care can be provided services by the most appropriate family. FFA staff will participate in the CFTs. In addition, a treatment FFA will recruit,

train and support Therapeutic Foster Care and Intensive Treatment Foster families who will become an eligible Medicaid provider as defined by the DHCS and federal law.

To maximize federal financial participation FFA/T's will need to make administrative changes to access all cost benefitting programs. The existing FFA rate will be revised to fund two types of FFAs, a treatment agency and specialized agency. The FFA/NT rate is comprised of an amount varied by the age of the child and youth for the resource families to provide care and supervision, plus an amount for social work activities including participation in child and family teams and county requested support services, plus an amount for administrative activities that includes payment for the training and recruitment of foster parents.

PERFORMANCE MEASURES AND OUTCOMES RECOMMENDATIONS

The reform of the state's continuum of placement resources is aimed at changing how the State, counties, and private providers conduct business in order to improve outcomes for children and families. A part of this overall effort is the need for a data-driven system that will promote change by encouraging accountability through transparent dissemination of STRTC and FFA performance and outcome measurement, which in turn will encourage improvements to services to meet the needs of the children and families being served. The measures will be concise, but comprehensive. The number of measures and the degree of complexity also will be limited initially in order to make sure that the measures are understood and reflect a meaningful assessment of performance.

In the short term, provider performance will contain baselines derived from key process measures, satisfaction surveys, qualitative case reviews and administrative information including audit findings, licensing actions and accreditation. The performance measurement and outcome system will build from a number of existing and developing activities at the state and local levels including Katie A., the QIP and DHCS' Performance Outcome System. From these efforts and in consultation with national experts, the Department will establish baselines or norms for performance.

RECOMMENDATION 17:

Evaluate STRTC and FFA provider performance based on a series of performance domains and measures.

A relatively small number of performance and outcome measures will be used in six domains with existing data sources that will improve as access to additional sources of administrative data become available through cooperative agreements with partner agencies and implementation of improved tools, such as the CWS New System. The domains and initially recommended measures are as follows:

OUTCOME	PERFORMANCE MEASURE	INDICATOR	INDICATORS FOR NEAR TERM DEVELOPMENT	PROPOSED DATA SOURCE
	Domain 1: Safety			
Children are cared for in a safe and secure environment.	No reported or substantiated cases of abuse or neglect involving the residential contractor during the service period.	(1) Count/rate of reports of alleged maltreatment; and (2) count/rate of substantiated reports of maltreatment.		CWS/Case Management System (CWS/CMS)
Children are cared for in a safe and secure environment.	Public agency is providing regular facility inspections according to timelines established in regulation.	(1) Date of last facility inspection. (2) Number and type of physical plant citations		CCLD reports
Children are cared for in a safe and secure environment.	No complaints of abuse involving other youth in the placement home or facility.	Number of facility citations broken out by date and type: (1) high-level health/safety issue; and (2) lower-level concern.		CCLD reports
	Domain 2: Stable & Permanent Connections			
Children are served and supported to develop stable and permanent connections during care.	Stability of the treatment environment	(1) Median number of days youth are in care	(2) % of youth that AWOL (3) Median days away from the facility due to AWOL (4) % of youth who completed the program	CWS/CMS
Children are served and supported to maintain stability following discharge.	The effectiveness of provider efforts to deliver services and promote connections that allows children to make stable transitions to lower levels of care/return to family.	(1) % of children who were discharged from the program within 3, 6, 12, 18 months of entry. (2) % of children who did not re-enter STRTC placement (look at time between discharge and re-entry). (3) % of children who remained in home-		CWS/CMS

		based family care after discharge from STRTC		
	Domain 3: Health			
Children's physical and mental health needs are met.	Children receive appropriate and timely medical and dental care.	(1) Number and percent of clients with timely medical exams (per the EPSDT schedule) (2) Number and percent of children with timely dental exams.	(3) % of youth receiving timely substance use disorder treatment when indicated by an assessment (4) Facility compliant with existing psychotropic medication monitoring protocols	CWS/CMS/ audits/CCLD Licensing
	Domain 4: Education			
Children Receive Active Educational Support.	If/when child changes schools, provider requests and follows-up on transcripts as documented in the case.	(1) % of children whose transcripts are received by provider within 30 days (2) % of children enrolled in school within 30, 60 or 90 days of placement		CWS/CMS
Children Receive Active Educational Support.	Caregiver tracks school attendance, and ensures child attends 90 percent of scheduled school sessions.		(1) % of children who have attended school over 90% of their time in current placement (FFA) (2) Number and percent of clients who meet this attendance threshold.	CWS/CMS, CALPADS

The CDSS, in partnership with the Office of Systems Integration and county child welfare and probation and court agencies, has begun procurement activities aimed at replacing the current CWS/CMS. When deployed statewide, the CWS New System will greatly enhance the availability and quality of aggregate and case-level data in many ways, such as remote data entry through a variety of devices, as well as data exchanges with automated systems for other programs serving the same children, youth and families. Statewide implementation of the New System is expected to occur in spring 2019, and until then, data sharing agreements for other information will complement the information contained within the CWS/CMS. This information will be shared with county probation and child welfare as well as STRTC and FFA providers.

RECOMMENDATION 18:

Utilize a client satisfaction survey that captures the perception of children and their families regarding services they have received from STRTC and FFA/T providers.

In addition to the development of the performance measures described above, a trauma-informed client satisfaction survey will be utilized to understand youth and family perception of services and provide feedback essential to continuous quality improvements. Self-reported consumer satisfaction with services is an important outcome measure and quality assurance indicator, and to meet the need for this information, the survey developed over the past two years during the CCR process will be utilized.

The Youth Services Survey (YSS) for Youth and the YSS for Families (YSS-F) are national consumer survey tools developed for the Mental Health Statistics Improvement Program and are widely used by California behavioral health agencies and the RBS Reform Project. Portions of the YSS and YSS-F will be combined for the purpose of CCR in assessing satisfaction with services, the child and family "voice and choice," involvement with mental treatment plans including prescription of psychotropic medication, well-being, and educational progress. The Department is also recommending inclusion of the following questions which seek to better understand the experience of youth in foster care:

1. Have existing connections with your family, school, tribe and other informal supports been maintained?
2. Were you involved in the assessment of your needs and development of your case plan?
3. Were your opinions and preferences considered in the assessment/case planning process?
4. Did you receive an explanation of the treatment plan developed for you? Did this include therapeutic options to psychotropic medications?
5. Did you receive individual assistance with school work/tutoring?

Suggested thresholds for the survey measures should include:

1. Percent of children/youth who report a satisfaction score of 80 percent or above based on the youth satisfaction survey.
2. Percent of children/youth that report feeling empowered in their treatment planning based on the client satisfaction survey (threshold to be established).

Youth participating in the CCR process further provided input as to how to make this combined satisfaction survey more youth-friendly by establishing a five-star scale where '5' indicates the greatest satisfaction. The implemented survey will be a web-based instrument to support data collection and reporting needs and to obtain a high rate of participation.

As with other recommendations, use and contents of the survey and the data derived from it periodically will be evaluated to establish and retain ongoing validity.

RECOMMENDATION 19:

Create a method for ensuring public transparency of provider performance.

In order to ensure transparency, the Department will make STRTC and FFA provider performance indicators available via a public website, similar to child welfare and probation data presently published on a website developed and maintained by the University of California, Berkeley under a contract with the Department. The website also will include licensing information:

- Dates of CCLD visits
- Other types of visits
- Citations
- Number of inspections and inspection dates
- Substantiated and inconclusive complaints
- Provider contact information, facility number, capacity and address

This licensing information already is available online at the following URL: https://secure.dss.ca.gov/CareFacilitySearch. Additional performance measures described in this report's recommendations also will be included on the public transparency website.

IMPLEMENTATION STRATEGY

Full rollout of the new framework is expected to take several years, assuming associated statutory and budget and county/provider changes are achieved. The main components of implementation include:

- Communication – Information about the changes, timeframes, process and the resources available to support the transition.
- Policy Framework – The statute, regulations and all-county letters that establish the requirements for the new framework.
- Supporting Agency Transition or Closure – Support to providers through technical assistance, training and toolkits in understanding and meeting the new requirements for STRTCs and FFAs.
- Oversight Structure – State level oversight related to fidelity to the framework, program performance, licensing requirements, fiscal accountability and transparency.
- Performance Measure Testing and Implementation – An ongoing process for testing the provider performance measures with a few providers, making refinements, implementing the measures, building county and provider capacity to use data in placement decisions and ongoing evaluation and refinement.
- Ongoing Training – A training infrastructure for providers.
- Integration/Alignment with Related Initiatives: Katie A., California Child Welfare Core Practice Model, RFA, QPI, etc.

CONCLUSION

Over the past two years, the Department has begun the programmatic and administrative efforts to develop a continuum of foster care placement options and services consistent with principles established by CDSS and its partners through the CCR and other efforts. This report collectively addresses many of the systemic barriers to the goals of improving services, aligning funding mechanisms with desired outcomes, and improving performance and accountability to achieve increased permanency and well-being for children and youth in foster care.

Implementing these inter-dependent recommendations will require a sustained and coordinated effort over several years to complete. Recent statutory and budget changes already are paving the way for these system changes: time limits on group home placements, new funding for Approved Relative Caregivers of non-federally eligible children, and increased age requirements for group home staff, all are steps toward implementing the CCR framework.

The Department is committed to pursuing the recommendations in this report, and to ongoing evaluation and improving outcomes using a continuous quality improvement approach for children, youth and families involved with the child welfare and juvenile probation system.

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ACRONYMS

AB	Assembly Bill
AFDC-FC	Aid to Families with Dependent Children – Foster Care
CALPADS	California Longitudinal Pupil Achievement Data System
CalWORKs	California Work Opportunity and Responsibility to Kids
CAPP	California Partners for Permanency
CAT	Comprehensive Assessment Tool
C-CFSR	California Child and Family Services Review
CCLD	Community Care Licensing Division
CCR	Continuum of Care Reform
CDSS	California Department of Social Services
CFT	Child and Family Team
CPM	Core Practice Model
CQI	Continuous Quality Improvement
CWS/CMS	Child Welfare Services/Case Management System
DHCS	Department of Health Care Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FFA	Foster Family Agency
FFA/NT	Foster Family Agency/Non-Treatment
FFA/T	Foster Family Agency/Treatment
ICC	Intensive Care Coordination
IHBS	Intensive Home Based Services
LRF	Local Revenue Fund
NMD	Non-Minor Dependent
NREFM	Non-Related Extended Family Members
QIP	Quality Improvement Project
QPI	Quality Parenting Initiative
RBS	Residentially Based Services

RCL	Rate Classification Level
SB	Senate Bill
SDM	Structured Decision Making
SILP	Supervised Independent Living Plan
STRTC	Short-term Residential Treatment Center
TFC	Therapeutic Foster Care
THP + FC	Transitional Housing Placement Plus Foster Care
THPP	Transitional Housing Placement Program
W&IC	Welfare and Institutions Code
YSS	Youth Services Survey
YSS-F	Youth Services Survey – Families

APPENDIX A

California Partnership Plan for Children in Out-of-Home Care

Teamwork, Respect, Nurturing, Strong Families

All of us are responsible for the well-being of children in the custody of child welfare agencies. The children's caregivers along with the California Department of Social Services, county child welfare agencies, private foster family agencies, and contractors and staffs of these agencies undertake this responsibility in partnership, aware that none of us can succeed by ourselves.

Children need normal childhoods as well as loving and skillful parenting that honor their loyalty to their biological family and their need to develop and maintain permanent lifelong connections. The purpose of this document is to articulate a common understanding of the values, principles, and relationships necessary to fulfill this responsibility. The following commitments are embraced by all of us. This document in no way substitutes for or waives statutes or rules; however, we will attempt to apply these laws and regulations in a manner consistent with this agreement.

Caregivers and Agency Staff Work Together as Respected Partners

1. Caregivers and child welfare agency staff will work together in a respectful partnership to ensure that the care we provide to children supports their healthy development and gives them the best possible opportunity for success.
2. Caregivers, the family and agency staff will conduct themselves in a professional manner, will share all relevant information promptly, and will respect the privacy and confidentiality of all information related to the child and his or her family.
3. Caregivers, the family, and agency staff will participate in developing the plan for the child and family, and all members of the team will work together to implement this plan. Caregivers will participate in all team meetings and court hearings (including review and post-permanency hearings) related to the child's care and future plans. Agency staff will support and facilitate caregiver participation through timely notification, an inclusive process, and the provision of alternative methods of participation for caregivers who cannot be physically present.
4. The Agency will honor and respect the caregiver's right to take a time-limited break from accepting the placement of children into their family without fear of adverse consequence from the agency.
5. Caregivers will work in partnership with agency staff to obtain and maintain records that are important to the child's well-being including, medical records, school records, photographs, and records of special events and achievements.

Nurturing Children and Youth

1. Excellent parenting is an expectation of caregivers. Caregivers will provide and agency staff will support excellent parenting. Excellent parenting includes:
    - a loving commitment to the child and the child's safety and well-being;
    - equal participation of the child in family life;
    - awareness of the impact of trauma on behavior;
    - respect for the child's individuality, including likes and dislikes;
    - appropriate supervision;
    - positive, constructive methods of discipline;
    - involvement of the child in the community;
    - a commitment to enable the child to lead a *normal life;*
    - encouragement of the child's strengths; and
    - providing opportunities to develop the child's interests and skills.

2. Agency staff will provide caregivers with all available information in a timely manner to assist them in determining whether they are able to appropriately care for the child. Children will be placed only with caregivers who have the ability and willingness to accept responsibility for caring for the child in light of the child's culture, religion and ethnicity, physical and psychological needs, sexual orientation, gender identification and expression, family relationships, and any special circumstances affecting the child's care. Agency staff will assist them in obtaining the support, training, and skills necessary for the care of the child.

3. Caregivers must be willing and able to learn about, be respectful of and support the child's connections to his/her religion, culture, and ethnicity.

4. Agency staff will provide caregivers with information on expectations for excellent parenting. Caregivers will have access to and be expected to take advantage of all training they need to improve their skills in parenting children who have experienced trauma due to neglect, abuse, or separation from home; to meet these children's special needs; and to work effectively with child welfare agencies, the courts, biological families, the schools, and other community and governmental agencies.

5. Agency staff will provide caregivers with the services and support they need to enable them to provide quality care for the child. Caregivers will be expected to identify, communicate, and seek out their needs without fear of judgment or retaliation.

6. Caregivers will fully incorporate the child/youth into their family, including equal participation in family activities such as vacations, holiday celebrations, and

community activities. Agency staff will support families in overcoming barriers to full participation in family life and activities.

7. Once the caregiver accepts the responsibility of caring for the child, the child will remain with the caregiver unless:
   - the caregiver is clearly unable to care for him/her safely or legally;
   - the child and his/her family of origin are reunified;
   - the child is to be placed with a relative or non-relative extended family member;
   - the child is being placed in a legally permanent home in accordance with the case plan or court order; or
   - the removal is demonstrated to be in the child's best interest as determined through consultation with agency staff and other resource partners.
8. If the child/youth must leave the caregiver's home for one of the above reasons and in the absence of an unforeseeable emergency, the transition will be accomplished according to a plan developed jointly between the caregiver and agency staff. The development of the plan should involve cooperation and sharing of information among all persons involved. This transition will respect the child's developmental stage, psychological needs and relationship to the caregiver family, ensure they have all their belongings, and allow for a gradual transition from the caregiver's home, and, if possible, for continued contact with the caregiver after the child leaves.

Supporting Families

1. When the plan for the child includes reunification, caregivers and agency staff will work together to support that plan and to provide continuity for the child by assisting the biological parents in improving their ability to care for and protect their child, including as appropriate, participation in medical/related care, school, and other important activities. Agency staff will support caregivers in the reunification process, respect their input, and will not *retaliate* against them as a result of this advocacy.
2. When the plan for the child includes adoption, relative placement, or a move to a new foster family, with the support of the agency, the existing and the prospective caregiver will work together, with the support of the agency, to facilitate a smooth transition by sharing information about the needs, experiences and preferences of the child. To provide continuity for the child, prospective families are encouraged to participate in medical/related care, school, and other important activities. Continued contact between the child and the initial foster family is encouraged as long as it is in the child's best interest. The transition plan from foster care to adoption or relative home shall focus on meeting the developmental and other needs of the child.
3. Caregivers will respect and support the child's ties to family (parents, siblings, extended family members), and other significant relationships, and will assist the child in maintaining these relationships through facilitating appropriate visitation and

other forms of communication in accordance with the case plan. Agency staff will provide caregivers with the information, guidance, training, and support necessary for fulfilling this responsibility.

Strengthening Communities

1. Caregivers will advocate for children with the child welfare system, the court, and community agencies, including schools, child care, health and mental health providers, and employers. Agency staff will support them in doing so, respect their input and will not retaliate against them as a result of this advocacy.

2. Caregivers will participate fully in the child's medical, psychological, and dental care, including:

   - identifying doctors and needed specialists;
   - scheduling regular and necessary appointments;
   - accompanying children to appointments;
   - sharing information with medical, psychological and dental professionals as needed to provide care to the child and as permitted by law;
   - supporting and comforting children during and after visits; and
   - implementing any needed follow-up care in the home.

Agency staff will support and facilitate this participation. Caregivers and agency staff will share information with each other about the child's health and well-being.

3. Caregivers will support the child's school success through activities, including:

   - participating in school activities and meetings, including IEP (Individualized Education Plan) meetings, back to school nights and other school events;
   - assisting with school assignments;
   - accessing and supporting tutoring;
   - meeting with teachers, including teacher conferences;
   - coordinating school transportation;
   - working with the biological parent as educational rights holder or educational representative or surrogate if one has been appointed;
   - encouraging and supporting the child's participation in extra-curricular activities; and
   - Agency staff will support and facilitate this participation. Caregivers and agency staff will share information with each other about child's progress and needs,

academic performance, behavioral functioning and issues regarding school placement.

4. Caregivers will provide developmentally appropriate opportunities to allow children and youth to learn and practice life skills and have hands-on experiences in preparation for transition to adulthood, including:

   - participation in family decisions;
   - routine age appropriate household activities and chores;
   - conflict resolution;
   - money management and financial planning;
   - assistance with job and career exploration/development;
   - assistance with higher education and financial aid exploration/processes;
   - obtaining housing;
   - obtaining legal documents; and
   - support the youth in accessing and taking advantage of agency and community resources.

Caregiver Signature:

Name:

Agency Staff Signature:

Name:

Date: