AB 2083: Children and Youth System of Care Annual Technical Assistance Data 2021

Welfare and Institutions Code Section 16521.6 (b)(2)(A)(5)

Technical Assistance Overview

Assembly Bill (AB) 2083: Children and Youth System of Care (Chapter 815, Statutes of 2018), requires the establishment of a Children and Youth System of Care State Technical Assistance (TA) Team consisting of representatives from California Department of Social Services (CDSS), Department of Health Care Services (DHCS), Department of Developmental Services (DDS), and the California Department of Education (CDE). The statute requires the state to develop a process for local partner agencies that are parties to the Children and Youth System of Care Memorandum of Understanding to request interdepartmental technical assistance from the established Children and Youth System of Care State TA Team. The Children and Youth System of Care State TA Team partners with the CDSS Office of Tribal Affairs to appropriately seek out consultation from Tribal Partners. In addition, the Department of Rehabilitation is available to consult, as appropriate. The state technical assistance model is built upon the foundation of the prior Continuum of Care Reform technical assistance process and has broadened the scope of and participation in existing technical assistance meetings, consistent with AB 2083. The goal of the Children and Youth System of Care State TA Team is to provide high-level state and local interagency technical assistance, child-specific case consultation, and multisystem process recommendations.

Technical Assistance Process

A request for technical assistance may be made to the Children and Youth System of Care State TA Team by any county department, regional center, county office of education, or local educational agency. The intent is that the local resolution process has been exhausted first before local partners make a request for technical assistance. Documentation of attempts at resolution at the local level, barriers identified by system partners, and relevant background, inclusive of the history of involvement by various systems should be included in the request. Once a request is submitted, it is triaged, and a meeting is scheduled with active participation of the Children and Youth System of Care State TA Team. The Children and Youth System of Care State TA Team works with the local partner agencies and respective involved state agencies to ensure that necessary information and the appropriate team members are prepared in advance. The meeting is conducted via a facilitated format which reviews information on the youth's needs and strengths and an overview of the cross-system challenges. During the meeting subject matter experts from various Departments, branches and units provide recommendations for the local teams to review and consider for implementation with the local planning team. Barriers that can be supported or removed at the state level are flagged for action by the Children and Youth System of Care State TA Team members. Each meeting is followed with an email summary of the recommendations, follow-up meetings conducted by the Children and Youth System of Care State TA Team and follow-up meetings which are available at the request of the local system partners.

Although the TA process is not intended to solely serve as a crisis response protocol, the structures and relationships created through the MOU development process have shown to be beneficial for local partners in their responses in times of crises.

Technical Assistance Information Collection and Reporting

The development and implementation of the technical assistance framework has been a cross-system process, including evolving processes of how and what information to collect, beneficial facilitation and engagement frameworks informed by the local system partners and development of processes to include subject matter experts and intra and inter-

departmental and programmatic consultation. AB 153 (Chapter 86, Statutes of 2021) codified an annual tracking and reporting requirement for deidentified information about children and nonminor dependents in foster care who have been assisted to preserve, or secure new, intensive therapeutic options through the technical assistance process including the number of children and nonminor dependents served, characteristics of individuals served, and, as applicable, local and statewide systemic issues identified by the team. While there were already information and data collection processes in place, in response to this mandate, a reporting tool was developed to specifically collect information to meet the requirement. This annual technical assistance data and information report is required to be posted to the California Health and Human Services Agency website annually, beginning July 1, 2022. Utilization of this tool began December 2021, thus the reporting period for this report is December 2021 through June 2022. Subsequent years will have an annual calendar year reporting cycle for posting data annually in July.

Limitations

Data included in this report are reported by local system partners and as observed during the meetings and represents barriers presented at the time of case consultation. Given the highly individualized, dynamic and specific nature of these cases, aggregating statewide data presents a particular challenge in using or viewing the data collected to reflect or correlate to the strengths and challenges presented in these cases as being representative of systemic issues throughout the state.

County and Child Specific Information[1]

Age of Youth at the Time of the Call	
Ages 7-11	16%
Ages 12-14	35%
Ages 15-17	46%
Ages 18-19	2%
Jurisdiction	
Child Welfare	85%
Probation	9%
Dual (Child Welfare/Probation)	5%
Parent	1%
County of Jurisdiction for the Call[2]	
Riverside	13%
Los Angeles	12%
San Bernardino	12%
San Diego	8%
Sacramento	8%
San Joaquin	6%
Tehama	6%
Ventura	4%
Humboldt	4%
Fresno	4%
Orange	4%
Shasta	2%
Madera	2%
Butte	2%
Merced	2%
Lassen	2%

[1] Data throughout the document reflects duplicated information for youth who had multiple technical assistance calls.

[2] Tuolumne, Alameda, San Francisco, Kern, Imperial, Sonoma, and Kings were the counties that each had one percent of the calls.

Sexual Orientation Gender Identify and Expression (SOGIE)	
Male	44%
Female	36%
Transgender or Gender Fluid	17%
LGBTQ+	3%

Call Specific Information

Frequency of Call By Youth	
First Call	77%
One Prior Call	15%
Two Prior Calls	3%
Three Prior Calls	3%
Four Prior Calls	1%
Identified Youth Needs and/or Challenges[3]	
Distressed Behavioral Expressions	24.8%
Mental Health	12.0%
Trauma	11.1%
Aggression	10.4%
Substance Use Disorder (SUD)	8.6%
Absent From Placement	7.9%
Developmental	6.5%
Supports Related to SOGIE	6.0%
Sexualized Behaviors	3.2%
Forensically Involved	2.5%
Commercially Sexually Exploited Children (CSEC)	1.9%
Educational Needs	1.4%
Reported Reason for the Call[4]	
Non-Admit to Placement[5]	42%
Lack Of Options: Setting and/or Services	14%
Temporary Shelter Care Facility (TSCF)	13%
14 Day Notice	12%
Placement Preservation	5%
Needs A Higher Level of Care Than an Institution for Mental Disease (IMD)	3%
Hospital Overstays	3%
Specialized Request for Out of State Placement	2%
Unlicensed Care	2%
Referral For Regional Center Eligibility	2%

Regional Center Information

Youth Served by the Regional Center	
No	57%
Yes	33%
Referral pending	7%
No suspected need	2%
Regional Center Qualifying Diagnosis as Reported During the TA Call [6,7]	

[3] Complex medical need, suicidal/homicidal, siblings remain together, cultural and/or citizenship considerations, fire setting history, in-utero drug exposure, report that youth is doing well, gang affiliation, and property damage were each identified as one percent or under of youth needs and/or challenges.

[4] Referral to the Managed Care Plan (MCP) and three day notice were each identified as under one percent of the reported reasons for the call.

[5] Non-Admit is defined as children rejected from admittance to a Short-Term Residential Therapeutic Program or Resource Family Home.

[6] Of youth receiving regional center services who were the focus of a call, more than half have a diagnosis of ASD.

[7] Youth served by the regional center can have more than one qualifying condition. Seven percent of the youth served by the regional center had two (2) diagnoses.

Autism Spectrum Disorder (ASD)	51%
Intellectual Disability	40%
Epilepsy	6%
Other (5th Category)	3%

Mental Health Information

Mental Health Diagnoses as Reported by the Local System Partners[8,9]	
Attention Deficit Hyperactivity Disorder (ADHD)	16.74%
Post-Traumatic Stress Disorder (PTSD)	15.02%
Major Depressive Disorder	9.01%
Mood Disorder	6.87%
Substance Use Disorder	4.72%
Anxiety	4.29%
ASD	4.29%
Bipolar Disorder	4.29%
Schizoaffective Disorder	4.29%
Intellectual Disability (Mild)	4.29%
Conduct Disorder	3.86%
Oppositional Defiant Disorder (ODD)	3.43%
Intermittent Explosive Disorder	3.00%
Pervasive Developmental Disorder (PDD)	1.72%
Adjustment Disorder	1.72%
Impulsive Control	1.72%
Reactive Attachment Disorder	1.29%
Specialty Mental Health Services Access at the Time of the Call[10]	
Yes, receiving	63%
No, referred	11%
Eligible, but not engaging/refusing	10%
Not eligible	6%
Youth is in restrictive setting where services cannot be pushed in, like an IMD	2%
Eligible, but not currently receiving	2%
Presumptively Transferred Specialty Mental Health Services[11]	
No	68%
Yes[12]	22%
Topic was not addressed during the call	8%

Child and Family Team Meetings

Conducting Regular Child and Family Team Meetings	
Yes, as needed	31%
Yes, every 6 months	21%
Yes, every 3 months	17%

[8] Youth can have more than one diagnosis .77/88 youth had a least one (1) mental health diagnosis and those 77 youth had a combined total of 228 mental health diagnoses.

[9] Traumatic Brain Injury, pending assessment, refusing a mental health assessment, Hyperactive Type, Personality Disorder, Compulsive Disorder, Insomnia Disorder, Speech Sound Disorder, Gender Dysphoria, and Attention Deficit Disorder (ADD) were each identified as under one percent of the Mental Health Diagnoses as reported by the local system partners.

[10] One percent of the Specialty Mental Health access where the youth was eligible but not receiving SMHS due to presumptive transfer challenges, receiving SMHS but had a problem with an interpreter, were not accessing SMHS due to AWOL or placement mobility, not engaged in services, and during the call, the topic was not addressed.

[11] 'Unknown' which represents those calls for which the local team was not able to speak to the status of presumptive transfer was identified on one percent of the calls and presumptive transfer pending was identified in one percent of the calls.

[12] 'Yes', includes some youth who may have had delays in services starting.

Topic was not addressed during the call	14%
No	11%
Yes, monthly	6%
System Partners are Included and Attending the Child and Family Team	
Yes	41%
No	33%
Some partners not included	16%
Topic was not addressed during the call	8%
CFT meeting pending	1%

Education Information

Youth's Grade as of the Technical Assistance Call	
12	8%
11	14%
10	13%
9	24%
8	7%
7	5%
6	3%
5	3%
4	3%
3	1%
Grade Unknown	2%
Topic was not addressed during the call	17%
High School: Are Students' Credits on Track to Graduate	
Topic was not addressed during the call	51%
Information was unknown	32%
Not on target	10%
On target	7%
Disability and Education[13]	
Child/Youth has an Individualized Education Program (IEP)	75%
No disability, 504 or IEP not needed	15%
Topic was not addressed during the call	6%
Information was unknown	2%
Is the IEP Up to Date	
Yes	40%
Information was not provided	25%
No	24%
Topic was not addressed during call	11%
School Enrollment[14]	
Student is attending school	55%
Student is enrolled[15]	22%
Youth is not enrolled in school	7%
Topic was not addressed during call	3%

[13] For disability and education, both a referral for an IEP eligibility assessment and a 504 eligibility assessment was identified in one percent of the calls.

[14] Working on GED, in process of being enrolled (school on break), youth has graduated, Non-Minor Dependent and is in restrictive acute setting like an IMD not attending school, not permitted to attend current school were each identified as school enrollment statues in one percent of the calls.

[15] A student can be enrolled, however that does not equate to attendance.

Refuses to attend	3%
Mental health and hospitalization preventing attendance	2%
Student was expelled or suspended	2%

Identified Barriers and Gaps for Placement [16]

Identified Gaps for Placement[17]	
Access to specialized services: CSEC, I/DD/MH, SOGIE, SUD, Tribal, etc.	16.8%
Linkage and coordination to appropriate mental health services	14.4%
Access to Short-term Residential Therapeutic Program (STRTP) (14 day notices, denials, lack of capacity for specialized needs)	13.6%
Lack of Intensive Services Foster Care (ISFC) home	11.5%
Lack of Child and Family Teams (CFT)	9.6%
Integrated services delivery across systems	8.8%
Lack of Therapeutic Foster Care (TFC) home	7.5%
Access to appropriate regional center services (services and setting options)	5.9%
Lack of Foster Family Home	4.0%
Lack of enrollment and lack of attendance in school	3.7%
Access to a higher level of care than an acute setting like an MHRC, PHF or IMD	2.4%
Barriers to Placement Identified by System of Care Partners[18]	
Specialty Mental Health Services (SMHS) not provided	10.4%
No system individually meets the youths' needs	9.9%
Child and Family Teams (CFT) not comprehensive	9.7%
Complexities in serving child/youth involve multiple systems' services	9.4%
Lack of cross-system competency	8.5%
Regional center residential options limited based on the complex needs of the child/youth	7.7%
SUD	7.7%
School attendance	5.6%
Individualized Education Program (IEP) is not up to date	5.1%
Lack of systems working together	4.6%
Lack of system partners communicating and talking with one another	3.6%
Youth/Family voice not present or heard	3.6%
Parents are unable to have youth in the home due to youth's level of need	3.4%
Interagency Placement Committee (IPC) not functioning optimally	1.0%
Youth has been in a locked setting for an extended amount of time exceeding 1 year	1.0%
Presumptive Transfer (PT) (placing agency did not notify Mental Health Plan (MHP) of PT)	1.0%
Lack of youth engagement in services	1.0%
Provisionally licensed STRTP	1.0%
Identified System Strengths Observed during the TA Call[19]	

[16] Gaps and barriers are as reported by system partners and as observed by the Children and Youth System of Care TA Team. These are duplicated, as youth have multiple needs and gaps in the case receiving TA.

[17] Lack of medically fragile home, not able to front load services for a move due to out of county placement, providers not available in youths' native language, siblings needing to be placed together were each identified less than one percent of the calls as gaps for placement.

[18] Referral needed for IEP assessment to add new related services, trauma and loss of attachments, due to hospitalizations, difficult to engage in services and constant changes in medication, services not requested/identified to stabilize the child in the home, siblings want to be placed together, services not addressing needs, need placement to support reunification, need for assessment across all systems, RFA home not available, needs regional center re-evaluation with new diagnostic information, youth could be served in ISFC setting; not available for youth with I/DD, county seeking congregate setting for a toddler, extended family; housing instability, and lacking transition planning to adulthood were each identified under one percent of the calls as barriers to placement identified by system of care partners.

[19] Each of the following were identified system strengths in one percent of the calls: full array of supports and services were being accessed for the youth, team was open to problem solving, child's team worked upstream in a proactive and preventative way, the Tribe was involved in the case and present on the TA call.

Cross-System collaboration is present	40%
Team was open to, or provided, creative and out of the box integrated strategies	30%
Team communicated effectively and timely	16%
Team was child-focused, keeping the child's wants, needs and family connections culturally driven and at the forefront of the conversation	4%
Team displayed clear respect and trust for each of their areas of expertise	4%