AB 2083: CHILDREN AND YOUTH SYSTEM OF CARE
Legislative Report

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EXECUTIVE SUMMARY

Introduction

California's children and youth system of care is responsible for ensuring the safety and permanent connections to family, as well as supporting the development, health, education and well-being of children and youth in foster care. Each system partner has longstanding state and local responsibilities to provide a range of services and supports for youth in foster care that are unique to each system. Each partner is also individually responsible for evaluating and responding to gaps in the array of services and supports required to be provided by their systems.

Assembly Bill (AB) 2083: Children and Youth System of Care (Cooley, Chapter 815, Statutes of 2018) established a joint interagency resolution team comprised of the Department of Social Services (CDSS), Department of Health Care Services (DHCS), Department of Developmental Services (DDS), and Department of Education (CDE).

The statutes enacted by AB 2083 directed this team, in consultation with county agencies, service providers, and advocates for children and resource families, to develop and submit recommendations to the Legislature addressing any identified gaps in placement types or availability, needed services for children and resource families, or other identified issues for children and youth in foster care who have experienced severe trauma. These statutes also required the development of a multiyear plan for increasing the capacity and delivery of trauma-informed care to children and youth in foster care served by Short Term Residential Therapeutic Programs (STRTPs) and other foster care and behavioral health providers.

In 2020, the joint interagency resolution team submitted an initial report to the Legislature titled Recommendations to the Legislature on Identified Placement and Service Gaps for Children and Youth in Foster Care Who Have Experienced Severe Trauma that provides a detailed outline of the existing responsibilities of each system of care partner agency and a series of recommendations for determining placement and service gaps. This new report identifies gaps through an evaluation of a variety of quantitative and qualitative data sources, including stakeholder survey data and feedback, technical assistance data, and multi-departmental matched data, including recommendations for addressing those gaps, and includes a multiyear plan for increasing capacity and delivery of trauma-informed care.

Background

AB 2083 builds upon the implementation of Continuum of Care Reform (CCR), which, at its core, believes that all children served by the foster care system need, deserve, and have an ability to be part of a loving family, and not to grow up in a congregate setting. Additionally, there is a shared belief that agencies serving children and youth must collaborate effectively to surround children and families with needed supports, services and resources. Beginning in 2015, CCR provided significant investments in the practice of Child and Family Teaming, new funding for emergency caregivers, and increased funding and therapeutic standards for residential care in STRTPs.

Welfare and Institutions Code (WIC), section 16001.1, established pursuant to AB 2129 (Chapter 1089, Statutes 1993), requires county placement agencies to examine the adequacy of existing placement resources and programs and identify the type of additional placement resources and programs needed on a recurring basis. This statute also requires the CDSS to provide technical assistance in support of those efforts.

In addition, California has new fiscal investments that are currently being implemented and allocated by each partner agency involved in the system of care. The Budget Act of 2022 included significant investments across the multiples systems to expand and support partner agencies in reinforcing services and supports for children, youth and families and strengthening the system of care. Inclusion of an identified gap or recommendation in this report does not necessarily signify an identified need for a new fiscal investment. AB 2083 requires counties to design and implement a Memorandum of Understanding, framing a unified System of Care which coordinates timely, and trauma-informed services for foster children and youth, other vulnerable youth and their caregivers in a way that is comprehensive, culturally competent, timely, integrated, community-based, individualized, with strength-based services based on plans tailored to their individual needs.

Report Structure

This report is organized into sections outlining the current landscape, capacity gaps, recommendations, stakeholder input results, data addendums, investments made under each of the departments, and a multiyear plan for increasing the capacity and delivery of trauma-informed care.

Findings

As a part of the joint interagency resolution team's engagement with communities, the team conducted a survey regarding experiences in supporting children with complex needs to inform the recommendations included in this report. The survey was offered to approximately 120 individuals and completed by over 70 participants, including providers, advocates, and local county child welfare, educational, and regional center professionals.

In addition to data resulting from outreach, this report's findings are based on evaluation of a variety of quantitative and qualitative data sources, including data from technical assistance provided by the State and multi-departmental matched data.

The key findings include:

- Siloed practices in planning and delivering services are a major actionable cause of the gaps and inefficiencies in how systems assess and respond to the needs of children and families holistically.
- Implementation of trauma-focused program models within the system of care is incomplete across the state in terms of the availability of trained professionals, evidence informed assessments and evidence informed intervention models.
- A statewide gap exists in programming with specialized competencies capable of serving the needs of children, youth, and families who have multiple co-morbidities or cross-system needs.

- Children and families need more proactive and holistic services across systems to stabilize children in their own families and communities and to reduce the incidence of foster care.

Capacity Gaps and Recommendations

The following recommendations are intended to support state, county, Interagency Leadership Teams (ILTs), and local agencies in collectively evaluating and responding to the gaps in capacity and the continuum of services, supports, and practices identified below.

Gap 1: Unique Needs of Children and Families Involved with Child Welfare and Probation

Gaps identified by the state's system of care related to Gap 1 include:

- Children and families involved with child welfare and probation have needs that would benefit from evidence-informed clinical interventions that target trauma, caregiver attachment, and the state of the child's social environment.
- Existing clinical diagnostic and treatment protocols do not include a sufficient account of how a child's social environment and symptoms interrelate, leading to gaps in the identification and effective treatment of trauma-related symptoms.
- There is a need for available and committed family homes who are equipped with trauma-informed training, parenting supports and formal services that would enable them to care for children at all levels of the continuum.
- For some children, needed services are only available in a particular placement setting requiring a child to change placements to receive needed services, causing challenges for maintaining family connections, continuity of care, educational stability and administrative challenges to service delivery.

Key recommendations to address Gap 1 include:

- Utilize local MOU framework, with state collaboration, to evaluate Child and Adolescent Needs and Strengths data, utilization data, least restrictive placement settings, and other outcome measures to inform system of care capacity development and planning.
- Support providers' implementation of trauma-informed treatment models across the continuum of care.
- Support program models to include training focused on supporting the developmental role of parents/caregivers in helping the child heal from trauma.
- Increase training supports for resource parents, adoptive, biological, and other caregivers caring for trauma-affected children of all ages.
- Utilize local MOU framework to establish protocols that link children with needed supports timely upon the child's arrival in a new placement.
- Prioritize capacity building efforts that enable children with complex needs to have those needs coordinated within the child's home community and avoid out of county placements that result in disrupted clinical and non-clinical relationships.

Gap 2: Essential Competencies within Services, Supports, and Specialized Models of Care

Gaps identified by the state's system of care related to Gap 2 include:

- Local regions struggle to put immediate supports in place upon a child's arrival in a new placement, even when needs are identified in advance. There are challenges to accessing services and supports across multiple systems for children and families with complex needs at risk of entering foster care.
- Mental health provider competencies necessary to serve individuals with co-occurring intellectual and developmental disabilities and mental health conditions need to increase.
- System partners struggle to access residential or outpatient treatment programs for Substance Use Disorders (SUD) and provide responsive interventions to support children with Fetal Alcohol Spectrum Disorders (FASD).
- There is a need for an integrated continuum of care able to support children and youth with intersecting needs, including but not limited to: developmental disabilities, medical conditions, culturally relevant supports, and SUD.

Key recommendations to address Gap 2 include:

- Provide integrated early intervention and intensive trauma-focused treatment to infants, ages birth to five-years-old, and youth in foster care and their caregivers and enhance the standard of care by providing trauma-focused and integrated behavioral health assessments to all children in foster care.
- Provide upstream preventative and early intervention services to decrease the number of children in foster care with complex unmet needs such as SUD, Commercially Sexually Exploited Children (CSEC), and Posttraumatic Stress Disorder (PTSD).
- Establish highly specialized multi-agency assessment models for children and youth with exceptionally complex needs (such as SUD, CSEC, PTSD, Intellectual/Developmental Disability (I/DD)) to collaboratively assess and determine the appropriate level of care, needed array and intensity of services, and to ensure timely approval and implementation of services.

Gap 3: Care Coordination

Gaps identified by the state's system of care related to Gap 3 include:

- Planning occurs in silos, which fragments care coordination for children and families.
- Wraparound, a care coordination and planning process, reflects a patchwork of quality and consistency across the state's counties and is frequently limited to a specific subpopulation of children.

Key recommendations to address Gap 3 include:

- Develop Wraparound as a cross-system care coordination model, with a workforce able to address the needs of youth with intellectual and developmental disabilities and other co-occurring conditions and needs.
- Align the various notification, information sharing and confidentiality requirements, so the same requirements exist between relevant codes and California Rules of Court.
- Provide guidance and/or technical assistance on expediting Court processes regarding assignment of an educational/developmental rights holder for children who are referred to a regional center for Early Start intake.
- Develop technical assistance resources for all system partners to support cross-system teaming, planning, cross-system notification and education coordination.

Gap 4: Family Finding and Engagement

Gaps identified by the state's system of care related to Gap 4 include:

- Across the state, family-finding practices, ICWA compliance and outcomes are highly varied.
- Children with the case plan designation of "permanent placement," meaning the child is unlikely to be reunified with the parent from whom the child was removed, reside in congregate care settings, and/or with resource family caregivers. Some of these children are not moving toward permanency.

Key recommendations to address Gap 4 include:

- Establish multiagency recruitment strategies that target recruitment of families with unique experience and competencies important for children with complex needs and for Indian children.
- Strengthen reunification efforts through implementation of trial home visitation coupled with parent coaching and the use of permanency specialists and peer partners.

Gap 5: Education and School Stability

Gaps identified by the state's system of care related to Gap 5 include:

- County offices of education and school districts sometimes experience difficulties coordinating and aligning services for students in foster care.
- Not all school districts have transportation plans with child welfare agencies for providing transportation to a child's school of origin (SOO).
- When notification of a change in residential placement is not provided to LEAs and SELPAs by counties in a timely manner, this negatively impacts the enrollment of youth in foster care.

Key recommendations to address Gap 5 include:

- Develop individual academic intervention plans at the school level for each foster youth, that includes academic interventions, mentoring, parent engagement, and a team approach to supervising children and youth in care.
- Ensure that placing agencies have policies in place to address school stability and the SOO when making placement decisions and that they document

notification of placement moves and have plans to support transportation to the SOO.

Gap 6: Case Worker Ratios

Gaps identified by the state's system of care related to Gap 6 include:

- County caseload ratios reflect a much higher ratio than what is recommended for children in all program areas.
- Gaps exist in case coordination, preventative and upstream planning, transition planning, and cross-system competencies, which impact timely access to coordinated supports and services.

Key recommendations to address Gap 6 include:

- Utilize a completed workload study to inform policies outlining caseload or other practice standards.
- Implement reduced and/or specialized caseloads and training regarding care coordination and specialized competencies like medical, trauma, mental health, and intellectual disabilities to increase caseworkers' ability to help families achieve safety and permanency, regardless of their level of needs.

Gap 7: Administrative Processes

Gaps identified by the state's system of care related to Gap 7 include:

- Placement changes across county lines often lead to barriers to timely care due to confusion regarding administrative and referral processes, confidentiality and fiscal responsibilities, and overall procedural gaps in communication between all represented local agencies of each county.
- Contract timelines, scopes and other local administrative processes pose barriers to increasing local resources to provide services and supports to youth in foster care.
- Access to the educational rights holder, information sharing, and communication impact regional center intake and service access.
- The Resource Family Approval (RFA) process is a barrier for relatives who wish to take youth into their homes due to a lengthy process and other obstacles.

Key recommendations to address Gap 7 include:

- Further evaluate regional center intake and service access timelines for children in foster care to ensure there is not only timely intake processes, but also timely access to services.
- Explore variation in the authorization and medical necessity determinations for specific services and intensities of those services and evaluate the impact of other variables such as placement settings.
- Establish a state-local plan to improve consistency in the STRTP approval, certification, and contracting process.
- Establish partnership strategies within the ILT for resource family recruitment, and processes to facilitate ongoing and continuous support before and during placement.

Gap 8: Data Gaps – Local and State

Gaps identified by the state's system of care related to Gap 8 include:

- Local and state data systems are siloed.
- Aligning varying definitions for data elements, including definitions of children in foster care across departments, remains a challenge, resulting in a reduced ability to compare data.
- Medical and behavioral health information is often not provided to resource parents at the time of placement.
- Local systems lack concrete data sharing infrastructure, like data sharing and storage environments, data sharing governance structures, linkages or data match processes and de-identification practices.

Key recommendations to address Gap 8 include:

- Align Local Control Funding Formula, educational rights, and child welfare definitions to ensure one consistent definition of a child in foster care.
- Develop and align state and local metrics for shared system of care outcomes, both child-specific and system improvement.
- Create a Statewide Children and Youth System of Care data dashboard to indicate outcome measurements and transparency.
- Develop state technical assistance tools for local data-sharing pathways and models for local system partners.

Multiyear Plan

The multiyear plan for increasing the capacity and delivery of trauma-informed care is included as part of the Executive Summary below.

Departments included in the Children and Youth System of Care efforts have made significant investments including fiscal, policy, workforce, and state resources to address the identified gaps in the continuum. These investments, found in the governor's budget, are already implemented or in the process of being operationalized and many of which are ongoing, will have lasting impacts to many capacity gaps that have been identified. The multiyear plan spans efforts that began, or may begin, subject to the budget process, during five years, FY 19/20 through FY 23/24. The existing and recommended activities addressing the identified eight gaps include:

MULTI-YEAR PLAN

Department of Social Services

FY 19/20[1]	FY 20/21	FY 21/22	FY 22/23	FY 23/24
• Resource Family Approval Timeliness • Emergency Caregiver Support • Foster Parent Recruitment and Retention Support • Foster Family Agency Rate • Child and Adolescent Needs and Strengths • Family Urgent Response System • Bringing Families Home	• Alternate Models of Care (AB 2944) • California Parent and Youth Helpline • The Catalyst Center California Provider Helpline	• Stipends for Tribal Social Work Students • Child and Adolescent Needs and Strengths • Child Welfare Workforce Training and Coaching • Emergency Response Social Workers • STRTP Transitions • Family First Prevention Services Act (FFPSA) Parts 1 and 4 (Prevention activities, Nursing Support, Qualified Individual Assessment, High Fidelity Wraparound Aftercare) • Addressing Complex Care Needs: TA, Child Specific, Capacity Building, Innovative Models and Services, Crisis Continuum Pilot	• Excellence in Family Finding and Engagement Program • Removing barriers to relative placement • Foster Youth Independence Pilot • Flexible Family Supports for Home-based Care • Tribal Engagement to develop AB 2083 MOUs • Eliminated IV Agreement Tribes Share of Cost for Placement • Tribal Policy Engagement • Tribal Approved Homes Compensation • Legal Counsel for Tribes	• Trauma Informed Models implemented into providers programs • STRTP Models Redesign • Research and identify training models for professions to support the parent-child relationship and repair of attachment • Research and identify intensive training for parents and caregivers to understand the impact of trauma on their child's development and repair the attachment. • Operationalize amendments per AB 153, Chapter 86, Statutes of 2021, WIC, section 4648 to maximize funding and facilitate timely access to residential placements for dually served youth

[1] Departments' investment by FY can be found in: Addendum: Current Department Investment Details

Department of Health Care Services

FY 19/20[2]	FY 20/21	FY 21/22	FY 22/23	FY 23/24
• Proposition 56 • Cannabis Allocation • Peer Run Mental Health Warm Line • Proposition 64 • Full Scope Expansion Implementation Shift – ages 19-25 regardless of immigration status • Family Mosaic Project	• Family Mosaic Project	• Children and Youth Behavioral Health Initiative • Behavioral Health Continuum Infrastructure Program • CalAIM: revised access criteria, no wrong door, have areas pertaining to children and youth. • FFPSA After Care and QI Services • Family Mosaic Project	• Student Behavioral Health Incentive Program • Wellness and Resilience Building Supports for Children, Youth, and Parents • Peer Mental Health Support Programs for Youth • Behavioral Health Crisis Continuum of Care • Family Mosaic Project • FFPSA After Care and QI Services	• Enhanced care management for children and youth

[2] Departments' investment by FY can be found in: Addendum: Current Department Investment Details

California Department Education

FY 19/20[3]	FY 20/21	FY 21/22	FY 22/23	FY 23/24
• Prior to FY 19/20 and Ongoing: Foster Youth Services Coordinating Program (FYSCP) • Prior to FY 19/20 and ongoing: Foster youth school stability provisions • Prior to FY 19/20 and Ongoing: Multi-Tiered System of Support (MTSS) • Prior to FY 19/20 and Ongoing: Trauma Informed Practices (TIPS) Training • Project Cal-Well • Senate Bill 75 Report: Medi-Cal for Students Workgroup Recommendations • Funding for Special Education Mental Health Services	• FYSCP • Foster youth school stability provisions • MTSS • TIPS Training • Project Cal-Well • Senate Bill 75 Report: Medi-Cal for Students Workgroup Recommendations • Funding for Special Education Mental Health Services	• FYSCP • FY 21/22 through FY 23-24: Section 141 of AB 130: Foster Youth Direct Service Funding • Foster youth school stability provisions • MTSS • TIPS Training • Funding for Special Education Mental Health Services • Community Schools Partnership Program (CCSPP)	• FYSCP • FY 21/22 through FY 23-24: Section 141 of AB 130: Foster Youth Direct Service Funding • Foster youth school stability provisions • MTSS • TIPS Training • Funding for Special Education Mental Health Services • School Based Health Programs • CCSPP	• FYSCP • FY 21/22 through FY 23-24: Section 141 of AB 130: Foster Youth Direct Service Funding • Foster youth school stability provisions • MTSS • TIPS Training • Funding for Special Education Mental Health Services • School Based Health Programs • CCSPP

[3] Departments' investment by FY can be found in: Addendum: Current Department Investment Details

Department of Developmental Services

FY 19/20[4]	FY 20/21	FY 21/22	FY 22/23	FY 23/24
• Acute and Mobile Crisis Services • Acute crisis • Residential • System of Care	• Rate increase • Reduce Caseload Ratios • Residential • Wraparound: Complex needs	• Complex Needs • Direct Service Professional Workforce Training and Development • Service Access and Equity • Lanterman Act Provisional Eligibility • Rate Increase • Children's Support and Coordination • Reduced Caseload ratios • Residential • Wraparound: Complex needs	• Reduced Caseload Ratios • Direct Service Professional Workforce Training and Development • Children's' Support and Early Start Coordination • Service Access and Equity • Home and Community-Based Services • Residential	• Provide ongoing implementation and operational efforts to prior initiative and investments • Operationalize amendments per AB 153, Chapter 86, Statutes of 2021, WIC, section 4648 to maximize funding and facilitate timely access to residential placements for dually served youth • Provide ongoing implementation of HCBS Spending Plan for 21-22 through 23-24 • Provide ongoing staffing and workload allocation to State System of Care initiative • Provide ongoing review of activities to address capacity gaps • Utilize DDS System of Care State positions to support ongoing and existing System of Care deliverables and priorities

[4] Departments' investment by FY can be found in: Addendum: Current Department Investment Details

FY 19/20[4]	FY 20/21	FY 21/22	FY 22/23	FY 23/24
				• Review and reduce identified barriers for youth in foster care in accessing timely regional center intake and services and supports • Identify opportunities to address any needed system changes for youth in foster care in the Safety Net Plan update (2023)

Children and Youth System of Care (AB 2083)

FY 19/20[5]	FY 20/21	FY 21/22	FY 22/23	FY 23/24
• CDE, DHCS, CDSS and DDS CYSOC Positions • WIC, section 16521.6(b)(1)(B)(i): MOU Guidance • WIC, section 16521.6(b)(1)(B)(ii): System level Technical Assistance • WIC, section 16521.6(b)(1)(B)(ii): Child Specific Technical Assistance	• Ongoing MOU Technical Assistance • Ongoing System Level Technical Assistance • Ongoing Child Specific Technical Assistance • WIC, section 16521.6 (b)(1)(B)(ii)(2)(A): Identify Gaps in Placement Types, Services, or Other Issues	• Ongoing MOU Technical Assistance • Ongoing System Level Technical Assistance • Ongoing Child Specific Technical Assistance	• Ongoing MOU Technical Assistance • Ongoing System level Technical Assistance • Ongoing Child Specific Technical Assistance • WIC, section 16521.6(b)(1)(B)(ii)(3): Develop a Multiyear Plan for Increasing Capacity	• Build the capacity of local system partners by providing state-level trainings and technical assistance in areas of capacity gaps needs as identified. • Explore data transparency and analysis opportunities across systems. • Conduct policy review. • WIC, section 16521.6 (1)(2)(L): Provide technical assistance to Counties regarding inclusion in local MOUs a Processes, for engaging and coordinating with these tribes developed through tribal consultation with the federally recognized tribes • WIC, section 16521.6 (b)(2)(A): The joint interagency resolution team shall update its

[5] Departments' investment by FY can be found in: Addendum: Current Department Investment Details

FY 19/20[5]	FY 20/21	FY 21/22	FY 22/23	FY 23/24
				review and provide recommendations to the Legislature. • WIC, section 16521.6 (b)(5): Annually track and report (post on the CalHHS website) deidentified information of children and nonminor dependents in foster care who have been assisted to preserve, or secure new, intensive therapeutic options.

Conclusion
Meeting the needs of our children and families requires our continued collaboration as interagency teams. Multi-agency partnerships provide crucial opportunities for maximizing the impact of services and resources in supporting the safety, permanency, and well-being of the children and families we all serve. The Children and Youth System of Care State team remains dedicated to partnering with local entities and communities to support innovative and collaborative approaches to addressing the gaps and challenges we face.

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CURRENT LANDSCAPE

Children in Foster Care in California

A longitudinal study of families indicated that over a quarter of all children in California will come to the attention of child welfare at some point in their childhood, which is a broad indicator of children and families in need of support. Of those children, 10 percent will experience substantiated abuse or neglect and four percent will experience the traumatic disruption of being placed in out-of-home foster care. Of that four percent, just under 40 percent of children are placed with relative caregivers, and approximately 10 percent are reunified within three months of entry into foster care.[6]

In Fiscal Year (FY) 2020, there was an average monthly caseload of approximately 29,000 children who had an in-person emergency response from a social worker. Approximately 20,000 families in a given month are formally involved with the child welfare system while under court-ordered family maintenance. For children in out-of-home care, an average monthly caseload of approximately 20,000 are under family reunification, and approximately 34,000 have been determined to be unlikely to be reunified and remain in out-of-home foster care.[7] Between April 2020 and March 2021, 51 percent of the children entering foster care were female.[8]

Of children in out-of-home care, a monthly caseload of approximately 33,000 are in a family-based foster care setting receiving an Aid to Families with Dependent Children-Foster Care (AFDC-FC) (such as a Resource Family Home) and a monthly caseload of approximately 3,500 are cared for in a congregate care setting (such as an STRTP). An approximate monthly average of 17,000 children are cared for under Kinship Guardianship placements. Finally, approximately 86,000 children a month are cared-for by adoptive families receiving Adoption Assistance Payments.[9]

Along each stage of a family's involvement with the child welfare system, there are life-altering opportunities for California's system of care to decrease the likelihood of the family's deepening involvement with the child welfare system. From a child development and trauma perspective, removing a child from their biological family, even for a very short amount of time, is perhaps the most invasive intervention that could occur.

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[6] Putnam-Hornstein, E., Ahn, E., Pringle, J., Magruder, J., Webster, D., & Wildeman, C. (2021). Cumulative Rates of Child Protection Involvement and Terminations of Parental Rights in a California Birth Cohort, 1997-2017. *American Journal of Public Health, 11*(6), 1157-1163.

[7] California Department of Social Services (2022). Caseload Projections. *Estimate Methodologies, Local Assistance.*

[8] California Child Welfare Indicators Project Reports (2022). *Entries to Foster Care, 2011-2022.* University of California at Berkeley and California Department of Social Services, Research and Data Insights Branch.

[9] California Department of Social Services (2022). Caseload Projections.

Many of the needs that children and families have that result in child welfare involvement are best responded to by the natural child- and family-serving systems such as education, health care, childcare and early intervention, and behavioral health. When the needs of children and families at risk of child welfare involvement are met by all systems in a coordinated responsive manner, and families can rely on natural supports at the earliest stages, additional unmitigable trauma and more intensive interventions can be avoided. As California's system of care, all partners are critically important in developing new models of interventions and coordination that can avoid the traumatizing experience of a child's separation from family and home.

Children on Probation in Foster Care in California

A child who has been declared a "ward" of the court pursuant to WIC, section 602 for committing a violation of law may be placed in foster care if the court finds that returning the child home would be contrary to the child's welfare. Probation agencies are responsible for the provision of child welfare services for these youth who are under the supervision of the juvenile court.

As of July 1, 2022, the children ages 11 through 21[10] years of age, in which probation was responsible for the provision of child welfare, totaled 1,423. Of those children, 64 percent were between the ages of 18 through 21, 74 percent were males and 46 percent were on SILPS/Transitional Homes. The ethnicity of these children included 50 percent Latino, 27 percent Black, and 19 percent White.

Decertification of Out of State (OOS) Facilities Serving California's Foster Youth

Historically, when children and youth with complex needs were unable to be served by the continuum of supports and services in California, out-of-state facilities were used as a residential option for placing agencies. These youth were often identified as have the most complex constellation of needs with severe behavioral expressions requiring containment and intensive behavioral programming in a residential setting.

In 2020, following the death of a youth at a facility involving the use of manual restraints that occurred earlier in the year, CDSS conducted a reassessment of the 16 certified OOS facilities (12 total providers) that were being used for placement of California children in foster care. The reassessment found violations in all facilities, such as patters of improper and/or unwarranted use of manual restraints, which are inconsistent with CA licensure standards and are grounds for decertification.

Upon the conclusion of the review, in December of 2020, the CDSS made the decision to decertify all 16 OOS facilities and return 133-youth placed in certified and uncertified OOS facilities back to California. Some youth were immediately returned to California upon notification of the decertification, resulting in a total of 117 youth from 24 counties needing a placement identified in order to transition back to California or a transition

[10] CWS/CMS 2022 Quarter 2 Extract

support plan that addressed their needs in an identified placement. Bi-monthly reports of placement outcomes for this cohort of youth are published by CDSS.[11]

Based on the youth placed out of state and information gathered from the intensive technical assistance calls, California has approximately 150-200 youth with significant unmet complex needs that result in an ongoing lack of appropriate care options yearly. These youth require highly individualized integrated care coordination, access to timely and highly skilled trauma informed care, services and supports, intensive behavioral and therapeutic settings and timely access to acute mental health settings for stabilization.

In response to this need, a variety of investments and initiatives have been implemented and will continue to be embedded within the continuum of care in California to support these complex needs, including but not limited to, Child Specific Complex Care Funding, Capacity Building Complex Care Funding, Children's Crisis Continuum Pilot Program, and the Children and Youth Behavioral Health Initiative.

Specialty Mental Health Services for Children in Foster Care in California

DHCS administers California's Medicaid program (Medi-Cal). The Medi-Cal Specialty Mental Health Services (SMHS) program is "carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services under Section 1915(b) of the Social Security Act. DHCS is responsible for administrating and overseeing the Medi-Cal SMHS Program, which provides SMHS to Medi-Cal beneficiaries through county mental health plans (MHPs). MHPs are required to provide or arrange for the provision of outpatient and inpatient SMHS to beneficiaries in their counties who meet SMHS access criteria, consistent with the beneficiaries' mental health treatment needs and goals. For FY 2018, there were 82,252 youth in foster care eligible for Medi-Cal.[12] For FY 2018, 31,448 youth in foster care received SMHS.[13] Youth in foster care move between the SMHS System and the Medi-Cal Managed Care or Fee-for-Service delivery systems. The majority of children and youth, approximately 71 percent, are receiving SMHS, while a much smaller number (19 percent) are receiving both SMHS and non-SMHS behavioral health services. The fewest (10 percent) are solely receiving non-SMHS behavioral health services through either the Medi-Cal Managed Care or Fee-for-Service delivery system.[14] Most of the children receiving SMHS are between the ages of 6 to 11,[15] and 51 percent are male.[16]

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[11] California Department of Social Services (2022). *Youth Returning to California from Out-Of-State Programs.* CDSS Programs, Continuum of Care Reform.
[12] DHCS Addendum Figure 2
[13] DHCS Addendum Figure 1
[14] DHCS Addendum Figure 3
[15] DHCS Addendum Figure 5
[16] DHCS Addendum Figure 7

Youth In Foster Care Served by Regional Centers

For this section, “dually served youth” are individuals ages 0 through 21[17] who have been determined eligible for regional center services and are also involved in child welfare. In FY 19/20, approximately 10,370 individuals eligible for regional center services had child welfare involvement, which is five percent of all youth served by regional centers that year.[18] These youth may not have been served by both systems throughout the entire fiscal year but were concurrently receiving services through both systems for at least one month. On average, in each month of FY 19/20, approximately 7,080 regional center youth had child welfare involvement. Throughout the year, all but two months saw dually served youth caseload increases from the previous month.

The dually served youth population is disproportionately concentrated in the infant and toddler ages compared to the regional center youth population as a whole.[19] While only 23 percent of all regional center youth (ages 0 through 21) were in Early Start, individuals in Early Start are 63 percent of the dually served youth population.

Females and English-speakers are a higher share of both the Early Start and Lanterman dually served populations than of all regional center youth, with males and non-English-speakers somewhat underrepresented among dually served youth.[20] Children ages two and younger in Early Start are the largest share of the dually served population (71 percent). The shares of youth ages 10 to 14, 15 to 17, and 18 to 21 are similar among dually served Lanterman youth and all Lanterman-eligible youth served by regional centers. African American youth are disproportionately represented in the dually served population for both Early Start and Lanterman, compared to their share of all regional center youth. Asian, Hispanic, and White communities are underrepresented in the dually served population. Youth in the “Other” ethnicity category, which includes Native Americans, Russians, and those identifying with more than one ethnic community are roughly equal shares of the dually served and entire youth population.

Almost all regional center youth live with their families (93 percent of Early Start and 98 percent of Lanterman youth). In contrast, 80 percent of dually served Early Start youth and 60 percent of dually served Lanterman youth live with foster families. Dually served Lanterman youth are approximately six times as likely to reside in a congregate setting[21] as youth who do not have child welfare involvement (12 percent of dually served youth live in congregate settings compared to two percent of all regional center youth).

Dually served youth are also unevenly distributed geographically through the State. The majority of these youth (64 percent) are served by a minority of regional centers (6

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[17] This age category includes youth ages 18 through 21 who are in extended foster care per AB 12 (Chapter 559, Statutes of 2010).
[18] DDS Addendum Figure 1
[19] DDS Addendum Figure 1
[20] DDS Addendum Figure 2
[21] DDS Addendum Figure 2

of 21 regional centers). Three of those regional centers are located in Los Angeles County, where almost half of dually served youth reside. About 80 percent of dually served youth reside within only eight counties, including Los Angeles County. While Los Angeles County has more youth served by the regional centers than any other county, its share of dually served youth is significantly higher than its share of all youth served by the regional centers. In contrast, San Diego Regional Center and Central Valley Regional Center serve a similar or smaller share of youth involved in child welfare compared to the total youth population in their catchment areas.

Enrollment in California Schools

The total number of students in foster care enrolled in California schools is less than one percent of California's statewide enrollment and has been declining.[22] Of the 33,563[23] total enrolled of foster youth enrolled in school 51.3 percent were males. Students in foster care have been identified to receive special education services over two times the rate of students who are not in foster care.[24] The number of students in foster care enrolled in each county for the 2018-19 school year shows significant variation across counties in the state.[25] The percent of students in foster care who attend schools in juvenile detention facilities is indicative of multi-system involvement needed to provide care to foster youth.[26]

Diversity, Equity, and Inclusion in California Foster Care

There is a need to acknowledge and address the disproportionality of children of color in our child welfare system in California. The California Child Welfare Indicator Project (CCWIP) shows that in 2021 black children are 2.97 times more likely to have allegations of abuse and neglect than white children and 4.16 times more likely to enter care. This is an issue that requires more than improving training and understanding of diversity of social works. There is a need to address bias and ensure the inclusion of cultural navigators to support our families, all while improving resources, supports and culturally responsive services for our communities of color. There is a need for further evaluation and data collection to meet not only the cultural needs, but the linguistic needs of our children and families.

[22] CDE Addendum Figure 1
[23] 2018-19 census day enrollment (cite the 2020 FYSCP Legislative Report).
[24] CDE Addendum Figure 3
[25] CDE Addendum Figure 2
[26] CDE Addendum Figure 4

CAPACITY GAP 1: UNIQUE NEEDS OF CHILDREN AND FAMILIES INVOLVED WITH CHILD WELFARE

Decades of research demonstrates the essential role that lifelong secure attachments and enduring relationships[27] play in child development, mental health and well-being.[28] Traumatic life experiences and disrupted attachments that many children and their families in the foster care system experience elevate the risk for trauma and affects development in emotions, behavior, cognitive functioning, and health. Children involved with child welfare often reside outside the home of a life-long bonded parental caregiver, resulting in a very specific set of developmental, and behavioral considerations and needs. Also, children involved with child welfare are uniquely at risk of repeatedly losing their home, school and community when those needs are not met.

Early childhood trauma is associated with reduced size of the brain cortex, which may affect functioning and the ability to regulate emotions, and leaves children vulnerable for delayed development. Fortunately, this period of development for young children also offers a window of immense opportunity to promote resiliency and ultimately change the trajectory of young children involved with child welfare services. Exposure to early adversity does not necessarily result in a mental health disorder, but when the needs of the child and family are not met, it can alter the trajectory of development in such a way that undermines later mental and physical health. Small adjustments and brief interventions, especially when delivered early, can help children remain on a healthy developmental trajectory and prevent more serious challenges from developing later in life.[29] Traumatic experiences not only impact the child's life trajectory, but when needs are not met, also impacts the child in the context of their family by limiting their ability to maintain a safe, stable and resilient caregiving environment, potentially resulting in a spiral of loss and recurring trauma.[30] Across all system of care agencies, there is a need for the service array to incorporate evidence-informed clinical interventions that target the interrelationship between trauma, caregiver attachment, the state of the child's social environment, and the traditional scope of care inherent to that system. Services need to explicitly address risks to the stability of the caregiver relationship and

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[27] Iles-Hernandez, K. (2016). The Ties that Bind: Attachment Theory and Child Welfare—Considering the Benefits of Maintaining Biological Connections for Children in Foster Care. *Buffalo Public Interest Law Journal, 35*(1), 187.
[28] Centre for Parenting & Research (2006). *The Importance of Attachment in the Lives of Foster Children: Key Messages from Research*. New South Wales Department of Community Services.
[29] Schuengel, C, Oosterman, M, and Sterkenburg, P.S. (2009). Children With Disrupted Attachment Histories: Interventions And Psychophysiological Indices Of Effects. *Child and Adolescent Psychiatry and Mental Health, 3*(26). doi: 10.1186/1753-2000-3-26
[30] University of California, Davis (n.d.). *Early Intervention 0-5.* Continuing and Professional Education, Human Services.

the social environment, improve the ability of the caregiver[31] to form an attachment as a primary treatment objective, and target the ability of the caregiver and social environment to effectively help the child regulate amid emotional and traumatic stress and dysregulation. Child development and trauma-focused research indicate that interventions targeting traumatic stress-related disorders should be provided within the social environment of the child (i.e., at home, at school, and in other social environments that are important for the child) and be designed to assist the child and other supportive individuals in the social environment to respond effectively to stress-triggers and dysregulation. This requires inclusive engagement from all system of care partners, particularly when considering the interrelated needs of children and families caring for children with complex needs.

While most system partners and providers incorporate some training on trauma, trauma literature indicates that clinical diagnostic and treatment protocols do not include a sufficient account of how a child's social environment and symptoms interrelate, leading to gaps in the identification and effective treatment of trauma-related symptoms.[32] Caregivers, professionals, and other adults in the child's social environment may also misinterpret symptoms and behaviors, leading to a risk of overdiagnosis or misdiagnosis; when this occurs, the interventions can be detrimental to the child.[33]

Consideration should also be given to the experience of Indian children and families who have experienced historical trauma. In California, there are 109 federally recognized tribes and additional non-federally recognized tribes in which the Indian Child Welfare Act (ICWA) applies to protect the best interest of Indian children and promote the stability and security of Indian tribes and families. Indian tribes have a unique relationship to the U.S. government unlike that of any other group of Americans. The passage of ICWA in 1978 began to address the misuse of power of child protection agencies in the removal of Indian children and placement of them in non-Indian families. However, years of mistreatment have done damage to these families and tribes and Indian children today continue to enter foster care at three times the rate of non-Indian children.[34]

CDSS adopted the use of the Child and Adolescent Needs and Strengths (CANS) assessment tool to support service planning, with the CANS Early Childhood module used for children ages birth to five years old. The Praed Foundation analyzed CANS

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[31] Schuengel, C., Oosterman, M. & Sterkenburg, P.S. Children with Disrupted Attachment Histories: Interventions and Psychophysiological Indices of Effects. Child Adolesc Psychiatry Ment Health 3, 26 (2009).
[32] Saxe G., Ellis B.H., & Kaplow, J.B. (2007). *Collaborative Treatment Of Traumatized Children And Teens.* Guilford Press.
[33] Papovich, C. (2019). *Trauma And Children In Foster Care: A Comprehensive Overview.* Forensic Scholars Today.
[34] California Department of Social Services and the Office of Tribal Affairs (2020). Indian Child Welfare Act Desk Reference: *A Framework and Quick Reference Resource for the Practitioner*.

assessment data between July 1, 2020 and June 30, 2021.[35] Separate analyses were conducted on ages birth to five and six and over populations. These analyses highlight significant “actionable needs” related to complex trauma. Indicators of actionable needs correlate to the positive outcomes of children who are in foster care dependent on the interventions used to address their identified needs during these critical years. There is an opportunity at the state and local levels to further evaluate the rate of actionable needs identified to utilization rates for services across system of care partners, as well as placement settings and outcome measures, such as placement instability and long lengths of stay.

Family Preservation (Biological and Adopted)

Stakeholder feedback identified children and families with complex needs as at risk of entering foster care due to challenges that a biological or adoptive parent face when obtaining services and supports across multiple systems to meet the needs of their child. Family preservation is known to lessen trauma exposure by ensuring children remain with family and experience a secure attachment, thus a focus on family preservation and prevention services can be implemented to avoid system involvement.

Families who have become involved with the child welfare system at times need a higher level of coordination and support from system of care partners. When families are involved with multiple systems, siloed service models create barriers to accessing timely services. Service models may not provide the right “fit” for children with co-occurring complex needs; and may offer networks of services that have limited or delayed access; and may include optional services that are not provided in all counties. Families may not qualify for services, or the approved intensity of service may be far lower than needed due to variable interpretations of authorization requirements that do not take important factors into consideration such as trauma, co-occurring diagnoses, or risk of family disruption. These challenges have been observed through the state technical assistance efforts and supported in published literature regarding multi-system involved youth and families.[36]

The FFPSA and California’s Budget Act of FY 2021 provide new funding opportunities for placement agencies to increase prevention services that target a family's involvement with the child welfare system to prevent entry to care and increase family preservation. Some examples include:

- Nurse-Family Partnership (NFP)
- Safe Environment for Every Kid (SEEK)
- Triple P – Positive Parenting Program
- Parent-Child Assistance Program

[35] CDSS Addendum Figure 25

[36] Cleek, E.N., Wofsy, M., Boyd-Franklin, N., Mundy, B., & Howell, T.J. (2012). The Family Empowerment Program: An Interdisciplinary Approach to Working with Multi-Stressed Urban Families. *Family Process, 51*(2), 207-217.

Out of Home Care and Permanency: Relatives, Resource Parents, Tribally Approved Homes

When a child has been removed from their family, the goal is to return that child home as soon as it is safe. When that is not possible, the goal is most often to achieve a permanent family through adoption or guardianship. CDSS permanency outcomes illustrate the lengths of time children spend in foster care and their exits to reunification, adoption, and guardianship.

In 2010, California added Tribal Customary Adoption as a permanency option for Indian children. Tribal Customary Adoption allows Indian children who are dependents of California courts to be adopted through the customs, laws and traditions of the child's tribe without the termination of the parental rights of the child's parents. The Indian Child Welfare Act at section 25 U.S.C. § 1915 (b), allows federally recognized tribes to establish their own licensing/approval standards and to approve homes for the purpose of foster placement or pre-adoptive placement of an Indian child. Practices and policies related to Tribally Approved Homes and Tribal Customary Adoption, as well as culturally appropriate supports from system of care agencies that are geographically accessible, are essential for preserving the rights of Indian children and for meeting their needs.

According to the *2020 Realignment Report: Outcome and Expenditure Data Summary*, achieving permanency within 12 months of entry has decreased from 40.7 to 34.2 percent from 2011 to 2017, which fails to meet the national standard of 40.5 percent or above.[37]

"Compared with children living with one or both parents, children in non-parental care are in poorer health, are at higher risk for experiencing disruptions and instability in caregiving and are vulnerable to other social antecedents of child health (e.g., neglect, poverty, maltreatment)."[38] When a child experiences removal and placement into a new home environment, system of care agencies have an important role in supporting stable transitions. This includes assessing the short- and long-term ability of the new substitute caregiver to meet the overall needs of the child, and to plan and implement short- and long-term interventions that respond to those needs. The state technical assistance efforts identified a gap in the ability of many local regions to put immediate supports in place upon a child's arrival in a new placement, even when needs are identified in advance. This gap occurs when the level of intensity needed on a very short-term basis to assess and stabilize the child in their new home is not available. Frequently identified gaps include trauma-focused assessments of triggers in the social environment, trained respite care, trauma-focused parent coaching, and intensive clinical/behavioral supports provided in home or at school.

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[37] California Department of Social Services (2020). *Report to the Legislature Child Welfare and Adult Protective Services 2020 Realignment Report: Outcome and Expenditure Data Summary*. State of California.

[38] Beal, S., & Greiner, M. (2016). Children in Nonparental Care: Health and Social Risks. *Pediatric Research, 79*(1), 184-190.

Behavioral challenges[39] are often cited among the main reasons for placement disruption, however further analysis is needed to determine the extent to which a child's experience of placement disruption may precede and be an initial underlying cause for the cited behaviors in subsequent placement disruptions. The latent class analysis of CANS data[40] shows that across all of the identified classes of both age groups, a large proportion of children have actionable items related to disruption in caregiver attachment (CDSS Figure 25). An internal CDSS analysis of CWS/CMS data shows that 75 percent of children who have a first placement with relatives, and are still in care 12 months later, are still placed with that relative. Children without external behavioral challenges in their first placement are at risk of developing behavioral challenges if they are moved, given the disrupted attachment and additional trauma that accompanies the increased numbers of placements. Multiple placements have been found to lead to delayed permanency outcomes, academic difficulties, and struggles to develop meaningful attachments.[41]

Placement data from Child Welfare Services/Case Management System (CWS/CMS) of placements shorter than 14 days indicates[42] a need for available and committed trauma-informed family homes for children at all levels of the continuum; considering the known trauma, attachment, cognitive, and emotional impacts of caregiver disruption; and a continuum of services and supports for the family and child. Research has shown that resilience in children is correlated with a positive relationship with a consistent caregiver, through which there is a decrease in trauma symptoms, improved school performance, and an increase of interpersonal social skills.[43] However, in California for FY 2019, more than 5,000 children in foster care had short stays in resource family homes and more than 700 had short stays in an STRTP.[44] This indicates a gap in trauma-informed services that target placement preservation and services in the child's social environment and a need to develop models of care coordination and service delivery that are specifically designed to support children with complex needs who are cared for by a substitute caregiver.

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[39] CDSS Figure 19

[40] The Latent Class Analysis (LCA) is a statistical approach that is used to classify individuals into mutually exclusive and exhaustive latent groups (called classes) based in their pattern of answers on a set of variables, in this case the CANS items. LCA uses probability matching algorithms to determine the class to which each individual person is most similar.

[41] Beal, S., & Greiner, M. (2016). Children in Nonparental Care: Health and Social Risks. *Pediatric Research, 79* (1), 184-190.

[42] CDSS Addendum Figure 17 and 18

[43] Lieberman, A.F., (2011). *Babies and Parents Can't Wait: Addressing the Impact On Parental Trauma and Substance Abuse on the Parent-Child Relationship* [PowerPoint slides]. Child Trauma Research Program, University of California San Francisco and San Francisco General Hospital.

[44] CDSS Figure 17

Residential Therapeutic Settings

Long-standing and ongoing research regarding therapeutic residential care yields mixed outcomes.[45] Some studies conclude that residential therapeutic care is an important component of a care continuum as a short-term intervention for some children with complex needs. Others determine that intensive home-based interventions may have similar or better outcomes to residential care.

Research regarding residential care describes an absence of a developed evidence base for residential program models and describes risks associated with the transition of congregate child-care institutions into "de facto psychiatric residential facilities" without such evidence-based care models. Research also indicates that "residential care providers may be overly confident that evidence-based treatments sold as effective on the 'evidence-based market' will necessarily be producing positive results in their agencies."[46]

This research concludes that the evidence base "is sufficiently strong to advocate for a number of features in (therapeutic) residential care program models: small (family-like) units, a stable and well-trained residential care workforce, inclusion of caregivers, a solid behavioral management program for stabilization and the promotion of prosocial skills, trauma-informed elements, timely aftercare services and avoidance of lengthy stays or repeated episodes in residential care."[47] Trauma literature further highlights the importance of children and their families having an experience of "feeling cared for" within the system of care (specifically including the professionals interacting with the child and family) as a necessary precondition for engagement in treatment and to increase resiliency and emotional regulation capacities.[48]

STRTPs are child care institutions licensed by CDSS pursuant to the STRTP Interim Licensing Standards (ILS),Version 4 (Released 11/2/2021) and which also provide outpatient mental health services and meet standards established by DHCS under the STRTP Mental Health Program Regulations Version II. While trauma-informed care is a general requirement, there are no defined standards regarding implementation of a model of care or an array of services based on the above described child development and trauma literature nor a required trauma framework that guides individual clinical

[45] Office of Juvenile Justice and Delinquency Prevention (2019). Juvenile residential programs. *Literature Review: A Product of the Model Programs Guide*.
[46] James, S. (2017). Implementing Evidence-Based Practice in Residential Care: How Far Have We Come? *Residential Treatment for Children & Youth, 34*(2), 155-175. doi.org/10.1080/0886571X.2017.1332330
[47] James, S. (2017). Implementing Evidence-Based Practice in Residential Care: How Far Have We Come? *Residential Treatment for Children & Youth, 34*(2), 155-175. doi.org/10.1080/0886571X.2017.1332330
[48] James, S. (2017). Implementing Evidence-Based Practice in Residential Care: How Far Have We Come? *Residential Treatment for Children & Youth, 34*(2), 155-175. doi.org/10.1080/0886571X.2017.1332330

interventions, support, and the organizational culture of the program. As a result, STRTPs have widely varying program models, characteristics and cultures.

The CANS latent class analysis (CDSS Figure 25) showed that 27 percent of children comprised the three latent classes with the most actionable items. Like all latent classes, most children had actionable items related to disruption in caregiving and attachment losses, however this group had far more actionable items related to that need, as well as adjustment to trauma, emotional abuse and family functioning (CDSS Figure 25). This data combined with CDSS data related to placement instability and length of stay (see Gap 2 below) demonstrates that a significant number of children in foster care have highly complex trauma and attachment-related needs, as well as caregiver support needs and that the current models of care are not adequately addressing the needs of this population. It is recommended that state and local system of care partners work to evaluate the models of care provided within STRTP and ISFC programs, as well as service programs across the system of care, to determine adherence to child development and trauma literature.

Technical assistance calls and stakeholder feedback frequently cite a child's refusal to engage in treatment as a primary barrier to care. As noted above, the experience of children "as being cared for" within the system of care is central to successful engagement in treatment. While not specific to California, a qualitative participatory research study analyzed the lived experiences of children and youth in residential care and found that "young people had very challenging experiences in residential placement settings, frequently feeling shame, unworthiness, and undeserving of a family or place in society as a result."[49]

The report states that youth reported the following recurring experiences:

- Child welfare systems do not reliably use institutional settings as placements of last resort, nor do they follow assessment of clinical treatment needs, resulting in youth being placed inappropriately. Staff lacked training, and youth sometimes perceived them as unkind, untrustworthy, and cruel.
- The physical facilities, meals, clothing, and hygiene products were insufficient and not culturally sensitive for meeting basic needs. Youth had little privacy or personal choice to make decisions, and often felt unsafe.
- They experienced a lack of academic stability, opportunities, and resources, which impacted their success in adulthood.
- They experienced a lack of love. Trauma was not always addressed or tended to in a humane way.
- They felt isolated and unable to access basic technology in order to stay in touch with friends and family, confined, surveilled, restricted and degraded, as if in prison.

Research literature has found children who enter foster care who are placed in home settings with the appropriate level of therapeutic services to support the child and

[49] Fathallah, S., & Sullivan, S. (2021). *Away From Home: Youth Experiences of Institutional Placements in Foster Care*. Think Of Us.

caregiver, will reduce the risk for congregate care settings because the child's clinical needs are addressed.[50] This indicates there be a stronger effort to conduct intensive family-finding and engagement at the onset of the case and throughout the child's placement in residential care. Additionally, a focus on transition-related care coordination in the broader system of care, as well as aftercare and ongoing services that are specifically designed to support children with complex needs being cared for by a substitute caregiver. Further data analysis regarding placement changes, length of stay and exits to permanency is described below in the next capacity gap.

Trauma-Informed Best Practice

There have been broad investments in the larger system of care across California including, Adverse Childhood Experience (ACE) trauma screenings and training for providers on delivering trauma screening at wellchild checks and one time with parents and Emergency Child Care Bridge Program for Foster Youth to remove barriers for resource parents who bring children in foster care into their home. Through consultation with trauma experts providing state technical assistance, research in the field, and observation from state system of care technical assistance, the following can inform program, practice and service provisions for trauma-informed care:

- Address gaps between research knowledge and practice regarding the nature of complex developmental trauma and how to use applied neuroscience to screen, assess, and develop effective case plans and treatment interventions.
- Re-design program models so that professional interventions are aimed at assisting the parent or substitute caregiver to create a corrective attachment experience for the child or youth in which the focus is on the parent-child relationship.
- Build competency among professionals and caregivers to understand the impact of trauma and disrupted attachment on brain development, emotional regulation, mental health symptoms, and functioning of the child.
- Support professionals working with children and youth to demonstrate neuroscience-based proficiency to develop case plans and treatment interventions rooted in current applied neuroscience. Research indicates that ongoing neurophysiological contributors to children's and youths' behavioral, cognitive and emotional disorders must be addressed first or simultaneously.[51]
- Emphasize focus of the parent-child relationship on resolving the attachment wounding for the child or youth, and the primacy of the parent as the principal agent of repair and recovery needs to be realigned.
- Highlight the need for professionals working in in-home settings to reflect knowledge of the developmental process of emotional regulation and the impact on affective regulation from complex developmental trauma so that they may

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[50] Rose, R. A., & Lanier, P. (2017). A Longitudinal Study of Child Maltreatment and Mental Health Predictors of Admission to Psychiatric Residential Treatment Facilities. *International Journal of Environmental Research and Public Health*, *14*(10), 1141.
[51] Perry, B.D. (2009). Examining Child Maltreatment Through a Neurodevelopmental Lens: Clinical Application of the Neurosequential Model of Therapeutics. Journal of Loss and Trauma 14, 240-255.

teach and coach parents on how to effectively respond to a child's or youth's experiences of emotional need, emotional dysregulation, and amygdala hijack. Removing a child or youth to 'work through' daily life occurrences supplant the role of the parent and interferes with attachment and bonding between parent and child.

Treatment interventions should be:

- Integrated into all elements of professional engagement with a child.
- Inclusive of child-centered activities and services until a child signals readiness to engage in treatment.
- Implemented by direct service workers, social workers, therapists, caregivers, and parents who have knowledge and understanding of the trauma informed intervention.
- Aligned with administrative and funding sources, including child development and current trauma theory to allow professionals to focus on enhancing the parent-child bond in service of the child's recovery, versus the current paradigm of the child-professional relationship as the primary source of child recovery.

RECOMMENDATIONS

- Utilize the local MOU framework, with state collaboration, to evaluate Child and Adolescent Needs and Strengths data, utilization data, least restrictive placement settings and other outcome measures to inform system of care capacity development and planning.
- Invest in increased tribal consultation efforts that guide practice improvements and capacity investments to improve care for tribal youth with complex needs, including support for tribally approved homes and tribal customary adoptions.
- Immediately upon placement, provide services for all children in foster care that support the child's adjustment into the new social environment, promote trauma informed care giving, stabilization and a determination regarding the need for ongoing services.
- Utilize the local MOU framework to establish protocols that link children with complex needs with timely supports for the identified needs upon the child's arrival to placement.
- Support providers' utilization of trauma-informed treatment models across the continuum of care.[52]
- Support program models to include training that is focused on supporting the developmental role of parent/caregiver in helping the child heal from trauma.
- Increase training opportunities for resource, adoptive, biological, and other caregivers caring for trauma-affected children of all ages on the value of interactive play, sensory activities, yoga, drumming, or bilateral and cross-body movement in the child's or youth's recovery and corrective attachment opportunities.

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[52] Rose, R. A., & Lanier, P. (2017). A Longitudinal Study of Child Maltreatment and Mental Health Predictors of Admission to Psychiatric Residential Treatment Facilities. *International Journal of Environmental Research and Public Health*, *14*(10), 1141.

- Support child wellbeing activities to decrease the impact of trauma, improve resiliency and increase childrens' interpersonal skills.

CAPACITY GAP 2: ESSENTIAL COMPETENCIES WITHIN SERVICES, SUPPORTS, AND SPECIALIZED MODELS OF CARE FOR CHILDREN IN FOSTER CARE

A positive relationship with a consistent caregiver is a predictor for resilience in children, through which there is a decrease in trauma symptoms, improved school performance, and an increase of interpersonal social skills.[53] Analysis of state-level technical assistance including the California Wraparound program and the Active Supportive Intervention Services for Transition (ASIST)/Specialized Permanency program show that when children have specialized or complex needs, caregivers and professionals involved with the child and family often lack essential competencies and skills needed to support children and youth with complex needs. Even with enhanced financial support through the Intensive Services Foster Care (ISFC) program, Therapeutic Foster Care (TFC) program, and Level of Care (LOC) rate structure, additional resources and skill-building are needed to support resource parents in caring for children and youth with complex needs.

This section provides an overview of the common gaps in competencies that result in the system of care being unable to meet the relational and attachment-based needs of some children and families. Further expert consultation and data exploration at the state and local level using matched cross-agency data and CANS latent class analyses will support the development of quantifiable recommendations regarding local capacity-building needs related to these competencies and specialized needs.

Birth to Age Five

In 2021, just over one-third of the California children in foster care were ages birth to five years old and 86.8 percent of total entries into care were due to neglect. Data describing a four-year comparison of entries into foster care and data comparing incidence rates for all children entering care in California shows that children ages five years and under enter foster care at disproportionately higher rates than older children, with infants entering care at far greater rates than any other category.[54] For young children, this disruption occurs during a developmental period with the greatest influence on creating cognitive and emotional capacities, from which future life experiences and expectations are measured. Infancy and early childhood are critical periods in development, focusing on emerging relationship skills, experiencing and expressing emotions, and learning by absorbing what a young child's environment has

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[53] California Department of Social Services (2020). *Report to the Legislature, Child Welfare and Adult Protective Services 2020 Realignment Report: Outcome and Expenditure Data Summary*. State of California.

[54] CDSS Addendum Figure 8

to offer.[55] Our systems' responses to the special needs and opportunities in serving infants, toddlers and young children holds potential to impact what sometimes develops into more complex needs as the child grows older. The CANS latent class analysis (CDSS Figure 25) indicates that many young children involved in the child welfare system have a high number of identified actionable items which may benefit from higher intensity interventions provided to the child, family, and within the social environment.[56] This gap analysis highlights the significant opportunity to shift our system cultures to prioritize positively impacting trajectories for our youngest children served.

Early intervention services for infants and toddlers with or at risk of intellectual and developmental disabilities (I/DD) provide positive effects on time-critical social and emotional development and may minimize developmental delays.[57, 58, 59, 60] Access to services for youth involved in the child welfare system is particularly important given the compounding developmental impacts of trauma resulting from being system-involved. Referrals to regional center services should occur as early in the child's life as possible, and when a developmental disability is suspected, referrals should not be delayed. Yet over a third of children dually served by child welfare and the regional center (35 percent) first became eligible for Lanterman services at age six years and older, and almost 20 percent were found eligible after age ten years.[61] Through state technical assistance, delays in referrals and assessments to the regional center have been identified as impacting children's timely access to services, resulting in barriers to early intervention and stability.

System partners should work in collaboration to provide timely, comprehensive and developmentally appropriate supports for early development of all young children. It is important that system partners regularly evaluate the local screening, referral, assessment and service pathways for their respective systems, and collaborate in program design, contract structures and overall network of services and supports, with a

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[55] California Department of Social Services (2020). *Issue Brief: Medical Necessity Criteria in Medi-Cal Policy and the Impact on Young Children's Access and Use of Specialty Mental Health Services.*
[56] CDSS Addendum Figure 8
[57] Majnemer, A. (1998). Benefits Of Early Intervention For Children with Developmental Disabilities. *Seminars in Pediatric Neurology, 5*(1), 62-69. doi: 10.1016/s1071-9091(98)80020-x. PMID: 9548643.
[58] Scherzer A., Chhagan, M., Kauchali, S., & Susser, E. (2012). Global Perspective on Early Diagnosis and Intervention for Children with Developmental Delays and Disabilities. *Developmental Medicine & Child Neurology, 54*(12), 1079-1084. doi.org/10.1111/j.1469-8749.2012.04348.x
[59] Hebbeler, K., Spiker, D., Bailey, D., Scarborough, A., Sangeeta, M., Simeonsson, R., Singer, M., & Nelson, L. (2007). Early Intervention for Infants and Toddlers with Disabilities and their Families: Participants, Services, and Outcomes: Final Report of the National Early Intervention Longitudinal Study (NEILS). SRI International.
[60] Parenting Today Staff (2015). Why Early Intervention Programs Benefit Kids with Developmental Delays. *Child Development Institute*.
[61] DDS Addendum Figure 4

focused intention to prevent entry into foster care and to increase timely reunification when a child is removed from the home.

Substance Use

It is estimated that approximately 19 percent of children in foster care consume alcohol and approximately 56 percent use street drugs, which is a higher percentage than the national average.[62] A study published by the National Institutes of Health on children exiting foster care found they had a higher rate of Substance Use Disorders (SUD) than that of the general population and recommended "screening youth at high risk for SUDs and providing treatment prior to their exit from care."[63]

Analysis of the state technical assistance data provided to local system of care partners revealed that 48 percent of cases reviewed indicated a youth was struggling with substance use that was interfering with their functioning.[64] Not all system partners have a data collection and/or sharing process able to connect across systems and with current SUD privacy laws, the number of children in foster care currently using substances or diagnosed with a SUD is unknown. System partners struggle to access residential or outpatient SUD treatment programs, and available programs often lack child- and youth-focused programming and a workforce competent in addressing the constellation of comorbid needs prevalent in the child welfare population, such as SUD, mental health, and/or I/DD. Both the state and local system of care teams have identified through the technical assistance process a need for screening and referring these youth to services, as well as increasing the number of SUD Residential Treatment programs with a trained and competent workforce able to address SUD, mental health, and trauma responses of youth in child welfare.

Fetal Alcohol Spectrum Disorders (FASD) are estimated to impact 40,000 infants statewide per year. Affected children can experience mild to severe behavioral, mental, learning, and physical issues that may last a lifetime.[65] While there is some indication of the impact of FASD across the systems as evidenced through the state technical assistance, the system lacks a uniform screening and referral process to improve identification of FASD, as well as responsive, supportive. Further, research shows[66] that stability during early childhood is particularly essential for long-term outcomes of children impacted by FASD, potentially indicating a need for focused care coordination models to preserve families and greater supports within an initial placement with a substitute care provider. In response to the identified needs of this population of children, fetal alcohol syndrome was clarified in statute by SB 188, Chapter 49, Statutes

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[62] Substance Abuse – The Foster Care System

[63] Narendorf, S., & McMillen, J. (2010). Substance Use and Substance Use Disorders As Foster Youth Transition to Adulthood. *Children and Youth Services Review, 32*(1), 113-119. doi:10.1016/j.childyouth.2009.07.021.

[64] TA Addendum Figure 9

[65] Child Welfare Information Gateway. (2014). *Parental Substance Use and the Child Welfare System.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

[66] TA Addendum Figure 9

of 2022, Government Code Section 95014, as a condition with established harmful developmental consequences for infants and toddlers, and therefore they may be eligible for Early Start.

Mental Health

The engagement rate data for children in foster care receiving five or more days of Specialty Mental Health Services shows a 39.5 percent engagement rate for children placed with relatives or non-related extended family members (NREFM), a 47 percent rate in resource family homes, and an 82.9 percent rate at STRTPs. Although children in STRTP settings have the most complex needs and intensive level of care, children in foster care should receive medically necessary entitlement services.

Intellectual/Developmental Disability

Approximately 15 percent of youth in foster care receive regional center services[67] and it is estimated that 33 percent of individuals with I/DD have co-occurring psychiatric disorders.[68] Some studies have reported anywhere between 20 to 60 percent of youth in foster care have a disability, which indicates that California's data may be underreporting and/or not identifying youth in foster care with I/DD.[69]

While a more in-depth analysis is required as California further implements AB 2083 at the state and local level, there is evidence this vulnerable population is susceptible to higher rates of abuse, neglect, and isolation. Individuals with disabilities have a higher lifetime prevalence of experiencing abuse, experience violent crimes at twice the rate of people without disabilities, and are three times as likely to be sexually assaulted as their peers without disabilities.[70, 71] Specialized training and education for professionals across multiple systems may support systems to recognize and implement appropriate interventions at early onset, and assist with optimal mental health access for children and youth with co-occurring I/DD and mental health conditions who have experienced trauma.

Autism Spectrum Disorder

The DDS serves approximately 148,000 individuals with autism spectrum disorder (ASD), which is a 157 percent increase over the last 10 years. Most (78 percent) are children ages 0 to 21. Most (56 percent) enter the regional center system after their third birthday, missing critical early intervention services. Looking across all diagnoses eligible for regional center services, the share of ASD is 46 percent while I/DD is 53

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[67] DDS Addendum Figure 1

[68] Centers for Disease Control and Prevention. (2020, November 30). The Mental Health of People with Disabilities. Centers for Disease Control and Prevention.

[69] National Council on Disability (2008). *Youth with Disabilities in the Foster Care System: Barriers to Success and Proposed Policy Solutions*.

[70] Breiding, M., & Armour, B. (2015). The Association Between Disability and Intimate Partner Violence in the United States. *Annals of Epidemiology, 25*(6), 455-457

[71] Harrell, E. (2015). Crime Against Persons with Disabilities, 2009-2013 – Statistical Tables. U.S. Department of Justice: Office of Justice Programs, Bureau of Justice Statistics.

percent; however, soon ASD will represent the majority share of individuals served, and for children ages 0 to 21, ASD is already the majority at 67 percent. The increasing ASD population indicates a need to develop a system that involves screening children early, conducting early interdisciplinary evaluations and providing evidence-based early interventions.

Some counties report, via the state technical assistance processes, a lack of clinicians able to provide services to individuals with co-occurring diagnoses of I/DD and mental health conditions. At times, children with I/DD, ASD, complex mental health diagnoses and extensive trauma are determined ineligible for Specialty Mental Health Services (SMHS) based on the I/DD condition. This highlights an opportunity to increase the competencies and collaboration between the MHPs, MCO, and regional centers to increase mental health service access for eligible youth with I/DD and/or ASD.

Culturally Relevant Services and Supports

According to a 2019 study, Black children were four times more likely to enter care than White children, and Native American children were 3.8 times more likely.[72] This disproportionality raises questions about the training received by the entire system of care and the network of culturally responsive and relevant services and supports provided to the families and children within their communities.

Post Adoption

In 2021, there were 1,073 children under the age of 18 that re-entered foster care from their adoptive homes.[73] Adopted families and agencies have identified the need for specialized competencies for pre- and post-adoption services in the areas of mental, oral, and physical health. Understanding and responding to the specific needs of grief, loss, and adjustment to a new family must be demonstrated by professionals involved in the family's life. Access to services to support the family initially to form healthy attachments and address the trauma experienced by the child, while also stabilizing crises so not to disrupt the family can support children, youth, and families during this transition and into the future.

Residential Care Provider Competencies

A data analysis of all foster youth who resided in congregate care at any point from June 2020 through June 2021 identified a need to strengthen the competencies of residential care providers and develop specialized models of care:

- The median length of stay for children exiting congregate care during this time period was 243 days. The length of stay for the 75th percentile was 457 days with a maximum length of stay of 3,623 days in congregate care.
- Of the children included in the analysis, 910 (22 percent) of the 4,094 youth exited foster care during this time period with 580 (14 percent) of the 4,094 youth exiting from congregate care.[74]

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[72] University of California, Berkeley (2022). *California Child Welfare Indicators Project*.
[73] CDSS Addendum Figure 7
[74] CDSS Addendum Figure 22

- Of the over 900 children exiting foster care during this time, 46 percent reunified while nearly 53 percent exited without a permanent caregiver.[75]
- Within the study period, a point-in-time analysis of placement instability identified that the upper 75th percentile of children in care had between 7 to 38 placement changes as of January 2021.[76]
- Very short stays of less than 14 days potentially signify unplanned disruptions of a placement setting or challenges to upfront identification of less restrictive or more appropriate options. An analysis of placements of less than 14 days identified a unique count of 770 children in STRTP placements who experienced 939 placement moves within 14 days or less of placement into the STRTP.[77]
- This analysis also identified disproportionality among non-white youth experiencing STRTP placements. Black and Native American youth who experienced a STRTP placement within this time frame had the longest average overall duration in foster care (>1000 days) and the highest number of average placements (>5 placements).[78, 79]

A similar analysis of all foster youth who resided in STRTPs from July 1, 2019, through August 20, 2021 identified 454 children who experienced a STRTP placement within the study period and entered foster care under the age of six.[80] Linking this data point to the Early Childhood latent class analysis[81] further indicates an opportunity to impact child outcomes through a system of care focused on early intervention and family preservation that implements the trauma and attachment competencies identified earlier in this paper and addresses the actionable items identified through the CANS and other assessments.

Within this analysis, a review of STRTP placement changes for children experiencing a psychiatric crisis requiring a stay in an in-patient psychiatric setting shows that children who experienced five psychiatric stays had an average of 15 placements.[82] These types of needs are frequently the basis for county placement agencies seeking technical assistance due to a lack of placement options and, coupled with youth who have co-occurring developmental disabilities and complex medical needs, represent the most frequently discussed gap in our capacity to serve children within the system of care.

As of July 2022, 324 children[83] in foster care supervised by juvenile probation resided in a congregate setting. Observation from technical assistance calls and stakeholder feedback indicate the need for specialized competencies to address sexualized behaviors, restorations to competency, and anger management. Often these youth

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[75] CDSS Addendum Figure 23
[76] CDSS Addendum Figure 23
[77] CDSS Addendum Figure 17
[78] CDSS Addendum Figure 13
[79] CDSS Addendum Figure 13
[80] CDSS Addendum Figure 14
[81] CDSS Addendum Figure 25
[82] CDSS Addendum Figure 20
[83] CWS/CMS 2022 Quarter 2 Extract

experience the same risk factors as all children in foster care and are served by multiple systems, however their history of committing offenses adds an additional burden that providers must understand in order to serve and support the child's needs.

Integrated Continuum of Care

The above placement data indicating a disruption for children who have experienced a hospital or non-hospital inpatient level of care after stepping down, indicates the need for a well-connected model comprised of a continuum of settings and services that are informed by ongoing analysis of the needs of children who are not experiencing stable care in the least restrictive setting. Such models require careful consideration of how each level of the continuum will fit together, how each level of the continuum will be highly accountable to the level of care above and below, how transition planning will occur and how resource development will be supported when an individual need does not have readily available resources. California's establishment of the Children's Crisis Continuum Pilot is anticipated to advance this goal, with implementation occurring over the next five years.

An opportunity identified through technical assistance with local system of care agencies includes increased collaboration among MHPs and cross-system partners, including regional centers in identifying gaps in services, supports and capacity for children and youth with co-occurring mental health and I/DD, and to develop local continuums in partnership. At times, complex and co-occurring clinical needs result in delayed or prevented access to an inpatient care setting. This population is an intended focus for the Crisis Continuum Pilot Program enacted pursuant to AB 153 (Chapter 86, Statutes of 2021) which establishes a comprehensive continuum of care for foster children with complex needs. Additionally, pursuant to SB 188, Chapter 49, Statutes of 2022, WIC, section 4474.16, DDS in partnership with the stakeholder community will evaluate recommendations for the updated Safety Net Plan (2023), which may include, but is not limited to, best practices for supporting individuals at risk of placement in restrictive settings, expanding or refining existing service or models of care, and developing new models of care for individuals whom private sector vendors cannot or will not serve, the Safety Net Plan offers an opportunity to build upon the existing integrated continuum of care and support the needs of youth in foster care with intellectual and developmental disabilities and complex needs.

RECOMMENDATIONS

- Establish highly specialized multi-agency assessment models for exceptionally complex cases to collaboratively assess and determine the appropriate level of care, array and intensity of services needed, and to support timely approval and implementation of services.
- Expand the integrated continuum of care to promote transition to lower levels of care, including individualized trauma-informed small capacity STRTPs and Enhanced Intensive Services Foster Care Homes.
- Evaluate options for provision of respite care and additional childcare supervision within home-based settings.

- Establish a joint state and local framework that results in evidence informed child development and trauma trainings for social workers, treating clinicians and other professionals involved with foster care.
- Provide integrated early intervention and intensive Trauma Focused (TF) treatment to infants and youth in foster care age 0 to 5 years old and their caregivers.
- Provide upstream preventative and early intervention services to decrease the number of children in foster care with complex unmet needs such as SUD, Commercially Sexually Exploited Children (CSEC), and Posttraumatic Stress Disorder (PTSD).
- Enhance the standard of care by providing TF and integrated behavioral health assessments to all youth in foster care.
- Amend contracting solicitation and awards for inclusion of, or requirement of trauma-informed care, models that consider the applied neuroscience techniques and treatment strategies that correspond to current research.
- Contract directly with Tribes and Indian organizations to provide culturally responsive services.
- Establish ongoing training for the workforce across all systems to address the approach taken in different cultures and decrease the disproportionality of children of color entering care.
- Conduct a latent class analysis of CANS data and other assessment data to identify and compare the profiles of need within their local systems to the existing network of services and settings.
- Utilize ILTs to:
    - Review data including review of circumstances in which the local system of care was unable to identify appropriate placements, respond to emergency placement needs, prevent unplanned placement disruptions, or prevent long lengths of stay and add processes to MOUs that respond to the identified service gaps, care coordination practices and needed emergency resources. Engage the CYSOCT team when local efforts to address these needs are exhausted.
    - Include representation of the county entity responsible for substance use disorder service delivery on the local ILT.
    - Develop system of care processes to complete developmental screenings, including consideration of how the education and mental health systems can help facilitate developmental screenings for all foster youth.
    - Collaboratively implement data-informed resource family recruitment and support initiatives focused on specialized needs and initial stabilization services for new placements.
    - Evaluate and implement specialized and integrated trainings for professionals working with children and families across the system of care.
    - Engage Tribes in development and amendment of SOC MOU agreements.

CAPACITY GAP 3: CARE COORDINATION

Thoughtful, intentional, person-centered teaming is essential for proactive planning for children and families. Children with complex needs access a variety of systems and services, and multiple service providers are often involved in these children's lives. State system of care technical assistance data indicates that 27 percent of cases reviewed had physical health concerns,[84] 43 percent were in the 9th and 10th grade,[85] 25 percent received regional center services with 8 percent pending intake,[86] and 54 percent of them received specialty mental health services.[87] Children receive plans, providers, coordinators, meetings, and assessments for each of the systems they are involved in. The amount of system cross-over is significant for children and families receiving care and for the system partners providing care. Under the AB 2083 required MOUs, local partners have identified the need to collaborate on many of these planning and teaming processes so they can be inclusive of the appropriate system partners and reduce the child and family's need to navigate each of these systems individually. Cross-system teaming remains an unrealized opportunity to be fully integrated into practice. Teaming and care coordination promote prevention and family preservation, integrated services based on the needs of the child and family, and an improved child and family experience while in care.[88] Technical assistance and coaching provided by the state system of care team indicates that collaborative teaming and planning that occurs in siloes fragments care coordination for children and families.

Wraparound: Care Coordination

Several policy changes and practices have been developed to address challenges to coordinate care, including child and family teaming, California's ICPM and Child Welfare Core Practice Model, Intensive Care Coordination (ICC), AB 2083, and CCR. In California, many of these efforts were based on the principles and philosophy of Wraparound, which was formally funded and memorialized in California statute in 1997. Wraparound is an evidence-based, nationally recognized care coordination and planning process that occurs in a team setting to engage with children and their families.[89, 90, 91] Wraparound shifts focus away from a traditional service-driven, problem-based approach to care and instead follows a strengths-based, needs- and team-driven approach with defined principles, phases, standards, and philosophy.

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[84] TA Addendum Figure 6
[85] TA Addendum Figure 8
[86] TA Addendum Figure 5
[87] TA Addendum Figure 4
[88] Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee (2014). Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems. *American Academy of Pediatrics, 133*(5). 1451-1460.
[89] National Wraparound Iniative (2022). *Latest wraparound research.*
[90] The California Evidence-Based Clearinghouse for Child Welfare (n.d.). *Wraparound*.
[91] Title IV- E Prevention Services Clearinghouse (2022). *Intensive Care Coordination Using High Fidelity Wraparound.*

Culturally responsive and individualized crisis and care plans are developed and revised on a continuous basis to support ongoing and effective service implementation, delivery, and support of the family and Tribes. Currently, Wraparound in California reflects a patchwork of quality and consistency across the state's 58 counties and is frequently limited to a specific subpopulation of children.

Often children with complex needs require critical, timely crisis-level services. For example, when a youth receives a 14-day notice of placement change and the child is placed in another county, behavioral health services, school enrollment, transfer of regional center services, and the identification of providers must all be coordinated. Most of these processes require notification, communication, planning, and coordination between catchment areas, with delays negatively impacting the child's stability and well-being.

Educational Care Coordination

To coordinate services across county agencies, county Foster Youth Services Coordinating Programs (FYSCPs) developed MOUs with county child welfare agencies for the purpose of drawing down Title IV-E federal dollars for eligible case management activities. The FYSCPs also developed policies and procedures for information-sharing among county agencies that provide services to students in foster care. This shared information is used by education, child welfare, and probation agencies to track the progress of foster youth in both care and education and, when needed, quickly transfer students between districts. The county-administered FYSCPs have also developed agreements to address transportation to a child's school of origin (SOO) to promote school stability. CDE Figure 15 (located in the Data Addendums of this report) shows the number and percent of counties that reported having formal agreements, MOUs, or protocols established among county agencies during the 2018-19 school year.

Timely notification to local educational agencies (LEAs)[92] is important when a student in foster care experiences a change in residency that impact their school enrollment. Different notification requirements are found in California Rules of Court, Education Code (EC), and Government Code (GC). Alignment between these different sources has been cited as an issue by stakeholders. The notification requirements also do not state the information that is to be shared between representatives of the placing agency and the affected LEA, and when required, Special Education Local Plan Areas (SELPA).

RECOMMENDATIONS

- Develop Wraparound or Wraparound type programs as a cross-system care coordination model, with a workforce able to address the needs of youth with intellectual and developmental disabilities and other co-occurring conditions and needs, as well as trauma-informed and culturally relevant, home-based parent coaching approaches to support communication and emotional co-regulation.

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[92] A LEA means a school district, a county office of education, a nonprofit charter school participating as a member of a special education local plan area, or a special education local plan area pursuant to *EC, section 56026.3.*

- Assess and align, to the extent possible, the statutory requirements for each system partner for case planning, case coordination, and teaming requirements, statutes, and practices.
- Align the various notification and information sharing and confidentiality requirements, particularly between general education and special education so the same requirements exist between Welfare and Institutions Codes, Education Codes, Government Codes, and California Rules of Court.[93]
- Provide guidance and/or technical assistance on expediting Court processes regarding assignment of an educational/developmental rights holders for children who are referred to a regional center for Early Start intake.
- Develop technical assistance resources for all system partners to support cross-system teaming, planning, cross-system notification, and education coordination.
- Prioritize capacity building efforts that enable children with complex needs to have those needs coordinated within the child's home community and avoid out of county placements that result in disrupted provider relationships.

CAPACITY GAP 4: FAMILY FINDING AND ENGAGEMENT

When a child is removed from their family, placement with a relative or extended family member is shown to mitigate against additional trauma and support placement stability.[94] A 2014 meta-analysis reviewing 102 studies indicated that children in kinship vs. foster care experience fewer behavioral challenges, fewer mental health disorders, better well-being and less placement disruption than children in non-kinship foster care.[95]

In California, 75 percent of children with a first placement into a relative home are still with that relative 12 months later (if they are still in foster care). However, only about one-third of children[96] are placed with a relative as a first placement, suggesting that increased intensive upfront family-finding interventions could help children immediately stabilize in the home of a family member upon removal.

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[93] Special education and other State statutory requirements for public education are derived from Federal statutes and requirements. This can make it complicated to align requirements as state laws need to comply with each other and not be in conflict with Federal laws and requirements.

[94] Winokur M., Holtan A., & Batchelder, KE. (2014). Kinship Care for the Safety, Permanency, and Well-Being of Children Removed from the Home for Maltreatment (Review). *Cochrane Library, Database of Systemic Reviews,* (1). John Wiley & Sons, Ltd.

[95] Winokur M., Holtan A., & Batchelder, KE. (2014). Kinship Care for the Safety, Permanency, and Well-Being of Children Removed from the Home for Maltreatment (Review). *Cochrane Library, Database of Systematic Reviews,* (1). John Wiley & Sons, Ltd.

[96] University of California, Berkeley (2022). *California Child Welfare Indicators Project*. CCWIP Reports.

Research literature demonstrates that engagement and support of kin caregivers is important. A meta-analysis evaluating why kinship care promotes child well-being summarizes a body of research literature showing that kin caregivers have an increased likelihood of experiencing financial and health difficulties, being sole caregivers and grandparents, and receiving a lack of support.[97, 98] Kinship caregivers experience also greater caregiver strain, depressive symptoms, and social isolation than foster caregivers.[99] A systematic review of parenting interventions focused on kinship caregivers found that they benefit from parenting interventions with "a special focus" on kinship families, and that most of the interventions had a positive impact on the outcomes of both caregivers and children.[100] The study concluded that parenting interventions with a specific focus on kinship caregivers improve caregivers' parenting competency, reduce parental stress, and advance child wellbeing. Many children placed with kinship caregivers have complex medical, mental health, developmental or other needs indicating a need for specialized parental interventions that support the caregiver to meet the individual needs of the child. This data on kinship care indicates an opportunity to meaningfully improve child well-being through increased engagement and support for those served across the local system of care agencies.

Across the state, family-finding practices and outcomes are highly varied. In Los Angeles County a model of upfront family finding (UFF) was piloted. The program involved dedicated permanency partner social workers that perform intensive searches and documentation review for potential relatives and NREFMs, interview and engage relatives and age-appropriate children, provide education and assistance regarding court and licensure processes, and link relatives and children to community-based organizations. This program resulted in a significant increase in first placement with relatives, increased the number of relatives identified for each child, and led to increased relative connection and involvement with the child. Since UFF's inception in October 2016, there have been 7,958 children who have been the subject of new detention hearings in the involved offices during their time in the project, which has varied from office to office. The number of those children whose first placement was a kin placement (non-offending parent, relative or NREFM) has consistently been between 75 percent and 80 percent.

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[97] Hassall, A., Janse van Rensburg, E., Trew, S., Hawes, D.J., & Pasalich, D.S. (2021). Does Kinship Vs. Foster Care Better Promote Connectedness? A Systematic Review and Meta-Analysis. *Clinical Child and Family Psychology Review, 24*(4), 813-832.
[98] Taylor,M., Marquis, R., Coall, A.D., Batten, R., & Werner, J. (2017). The Physical Health Dilemmas Facing Custodial Grandparent Caregivers: Policy Considerations. *Cogent Medicine, 4*(1). doi: 10.1080/2331205X.2017.1292594
[99] Garcia, A., O'Reilly, A., Matone, M., Kim, M., Long, J., & Rubin, D. M. (2017). The Influence of Caregiver Depression on Children in Non-Relative Foster Care Versus Kinship Care Placements. *Maternal and Child Health Journal, 19*(3), 459-467.
[100] Wu, Q., Zhu, Y., Ogbonnaya, I., Zhang, S., & Wu, S. (2020). Parenting Intervention Outcomes for Kinship Caregivers and Child: A Systematic Review. *Child Abuse & Neglect, 106.*

CDSS established the ASIST program as a resource to provide short-term, targeted resources and technical assistance to counties with a focus on youth in residential group home facilities which were not converting to STRTPs to support the transition to family-based settings and permanency. Through this work, CDSS observed that the most successful ASIST counties implemented cultural and structural changes, including dedicated permanency specialists who worked closely with the case-carrying social worker, the youth, and the child and family team to build or strengthen a network of support.

The addition of permanency specialists led to increased family connections and non-paid caring adults that supported children and caregivers. This resulted in an increase in the number of youths who transitioned to family-based placements and permanency, and costs were avoided due to lower levels of care and exits from foster care.

Key variables for the success of both upfront and ongoing family finding include:

- Dedicated staff including social workers, clerical staff and supervisory support.
- Realistic caseloads.
- Specialized skills: linguistic and cultural competencies (including services for the Deaf and Hard of Hearing community).
- Child and Family Teams (CFTs) and ICPM high-fidelity practices.
- Reliable and timely access to natural and formal supports across system partners.
- Use of Tribally Approved Home for Indian Children

Ongoing Intensive Family Finding

Approximately 34,000 children[101] have a case plan designation of "permanent placement," meaning that the child is unlikely to be reunified with the parent from whom the child was removed. Just over 13,000 of these children are placed with guardians or relative caregivers. Further, over 1,200 children with this case plan designation reside in congregate care settings and nearly 13,000 are residing with resource family caregivers, some of whom are not moving toward permanency.

It is critical that placing agencies regularly review all permanent placement case plan designations to determine which children need intensive ongoing family-finding models such as the model in Los Angeles described above, Wendy's Wonderful Kinds and Destination Families and others. Additionally, the circumstances of children with permanent placement case plan designations should regularly be reviewed with the ILT to determine which children have complex needs that require additional focus from system of care partners to support permanency for the child. In particular, there is a need to review the needs of children who have permanent placement case plan designations residing in vendorized regional center facilities, such as Small Family Homes, as placement agencies may need additional assistance from the system of care to ensure children with developmental disabilities are achieving permanency with a family.

[101] Point in time count 7/11/2022

Resource Family Recruitment

When relatives or NREFMs are not identified, placement agencies hold a fundamental responsibility to recruit community resource families that reflect the cultural and overall needs that a child in their care has. System of care partners are essential for the success of this work, particularly when children have complex needs. Regional centers have essential expertise and are connected to communities that are experienced in caring for children with intellectual and developmental disabilities. Education partners offer opportunities to help placement agencies implement recruitment and support strategies for resource families within the proximity of particular schools or communities. Mental health partners are essential to developing family support models for TFC and ISFC. It is important for placement agencies to review local data and trends with their system of care partners to develop focused recruitment strategies that respond to specific identified recruitment needs.

RECOMMENDATIONS

- Develop local system of care policies and protocols to increase up-front family finding and engagement and increase rates of first placement with relatives and Tribes, consistent with ICWA, while ensuring that child and caregiver needs are met upon the child's placement in the home.
- Establish multiagency strategies that target recruitment of families, including local Tribes, with unique experience and competencies important for children with complex needs (e.g., joint recruitment strategies with regional centers for children with developmental disabilities, with local education partners to recruit families within the child's community, and Tribally Approved Homes (TAH) for Indian children).
- Implement rapid reunification models which leverage existing teaming models.
- Strengthen reunification efforts through implementation of trial home visitation coupled with parent coaching.
- Utilizing permanency specialists and peer partners to engage family and plan for successful transition and family reunification.
- Establish process for ILTs ongoing data review of child-specific trends, family recruitment progress, with particular attention to Indian children, and develop focused recruitment and support strategies.

CAPACITY GAP 5: EDUCATION AND SCHOOL STABILITY

The data[102] indicates that in relation to other student groups, students who are in foster care:

- Attend less school days. During the 2018-19 school year, foster youth were absent an average of 15.3 days—this figure is higher than other student groups including homeless youth, students with disabilities, socioeconomically disadvantaged youth, English learners, and migrant education youth.
- Experience less school stability. During the 2019-20 school year, the non-stability rate of students in foster care was over double the rate of migrant

[102] CDE Addendum

education youth, English learners, socioeconomically disadvantaged youth, and students with disabilities.
- Are suspended and expelled at higher rates. During the 2018-19 school year, the suspension rate of students in foster care was over twice the rate of other student groups, including homeless youth, students with disabilities, socioeconomically disadvantaged youth, English learners, and migrant education youth. Students in foster care were also expelled at a higher rate than the same student groups.
- Have lower mathematics and English language arts achievement.[103] During the 18-19 school year, 53 percent of foster youth did not meet ELA standards, and 63 percent did not meet math standards on the California Assessment of Student Performance and Progress.
- Have lower graduation rates. During the 2018-19 school year, foster youth had the lowest graduation rate among other student groups, including English learners, homeless youth, students with disabilities, migrant education youth, and socioeconomically disadvantaged youth.
- Attend college at lesser rates. During the 2017-18 school year, the percent of foster youth that graduated high school and enrolled in college within 12 months of graduating was 48 percent, which was a lower rate than socioeconomically advantaged students, migrant education youth, and homeless youth.
- Have higher rates of dropouts. During the 2018-19 school year, the dropout rate for foster youth was higher than other student groups, including English learners, homeless youth, students with disabilities, migrant education youth, and socioeconomically disadvantaged youth.

The findings from a stakeholder system review indicate that county offices of education and school districts may:
- Experience difficulties in coordinating and aligning services for students in foster care due to multiple definitions for who is a "foster youth".
- Are not fully integrated in county children and youth systems of care.
- Experience difficulties with notification requirements for when students in foster care experience a change in residential placement.

In addition, not all districts have transportation plans with child welfare agencies for providing transportation to the SOO. When notification of a change in residential placement is not provided to LEAs and SELPAs in a timely manner, this negatively impacts the enrollment of youth in foster care. Through the California Children and Youth System of Care State Technical Assistance (CYSOCSTA) process, counties often reported not providing this notification or being unaware if this step had been executed. Unclear and misaligned notification requirements are highlighted in FYSCP coordinators reporting that LEAs are not being notified when a change in residential placement occurs for a student in foster care. This can lead to foster youth not being enrolled in a timely fashion.

[103] California Department of Education. 2019. *DataQuest*.

As shown in the data, students who are in foster care experience low rates of school stability. The CDE believes that case planning can be improved, which would address school stability. Placing agencies have requirements for the contents of a case plan, with a limited section on education. When placing agencies do not have education information for foster youth the ability to address education in CFT and interagency placement committee (IPC) meetings is limited.

RECOMMENDATIONS

- Develop individual success plans at the school level for each foster youth that includes academic interventions, mentoring, parent engagement, and a team approach to supervising children and youth in care.
- Increase school stability through providing technical assistance and training to system partners on foster youth education rights, including but not limited to, the right to school of origin, transportation to school of origin, and immediate enrollment.
- Include information regarding the education of a youth in the case plan.
- Ensure that when a youth experiences a change in placement school stability, SOO, best interest determination (BID), and transportation to SOO be addressed.
- Include information in the case plan goals about the child's needs and experiences academically, socially, and emotionally at school.
- Increase capacity of transportation to school of origin.
- Ensure placing agencies have policies and procedures in place to address school stability and school of origin when making placement decisions, including in CFTs.
- Require that LEAs and placing agencies (child welfare/probation) have SOO transportation plans.
- Increase notification of residential placement changes.
- Ensure placing agencies document in CWS/CMS when they have provided notification to required entities upon placement move.
- Dedicate staffing to determine the feasibility of creating a data indicator that tracks the amount of time a foster youth is not enrolled in school between residential placements.
- Increase education's role in county social services planning and implementation efforts.
- Connect FYSCP coordinators to the development and implementation of county AB 2083 MOUs.
- FYSCPs assist child welfare and probation in securing and training resource families and providers of therapeutic foster care.
- Increased coordination and connections between county FYSCP Executive Advisory Council (EAC) and county ILT so that efforts are not duplicated and the FYSP program can be informed of county updates to System of Youth System of Care, connection to county Children and Youth System of Care stakeholders and promote the importance of an engaged FYSCP program within the county Children and Youth System of Care.

CAPACITY GAP 6: CASEWORKER RATIOS

Children identified as having complex needs are served by a variety of intersecting systems. Each of these systems requires a multitude of processes, including court-ordered work, assessment and planning, case documentation, service delivery, administrative, medical treatment coordination, pharmacological access, intake services, teaming processes, crisis response, ongoing cross-system communication, and collaborative services. When children have a more diverse constellation of needs, there are more system intersections and intensive service coordination. Navigating, accessing, coordinating, and integrating these responsibilities and deliverables takes time, competencies, and a breadth of cross-system knowledge to provide high-quality case and service coordination. In order for the system of care to meet the individualized needs of children with complex needs, the workload associated with fulfilling these responsibilities must be evaluated and aligned with a appropriate caseload that reflects realistic expectations for caseworkers, clinicians and other professionals. The complexity of a case varies based on risk level, intensity of services, child and family functioning, and how the various situations, needs, and dynamics of the case change over time.[104] Currently, child welfare workload is distributed across an agency in a variety of ways, with each county having individual practices and distributions.[105] An evaluation conducted pursuant to WIC, section 10609.5 (a), also known as the California SB 2030 Study, evaluated workload and proposed a maximum caseload for California Child Welfare Services be between 13 to 24 cases per worker, yet the ratios as of June 15, 1999, through December 15, 1999 were between 16 to 50.[106] The 2020 Realignment report shows county caseload and staffing information for all 58 counties and the caseload ratios of the Title IV-E Waiver/Well-Being Project counties compared to the optimum and minimum standards established in the California SB 2030 Study.[107] Some counties, such as Alameda and Santa Clara, utilize a weighted distribution for case distribution, but generally, county caseload ratios reflect a much higher ratio than what is recommended for children in all program areas.[108] However, despite the available data discussed here, data regarding the workload associated with each case, based on new and existing mandates and practices, is limited. As such, decisions

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[104] Chen, J. (2019). Research Summary: Caseload Standards and Weighting Methodologies. *The Academy of Professional Excellence, San Diego University School of Social Work.*

[105] American Humane Association (2000). *SB 2030 Child Welfare Services Workload Study: Final Report*.

[106] Chen, J. (2019). Research Summary: Caseload Standards and Weighting Methodologies. *The Academy of Professional Excellence, San Diego University School of Social Work.*

[107] California Department of Social Services (2020). *Report to the Legislature, Child Welfare and Adult Protective Services 2020 Realignment Report: Outcome and Expenditure Data Summary*. State of California.

[108] American Humane Association (2000). *SB 2030 Child Welfare Services Workload Study: Final Report*.

regarding funding for positions, caseload assignments, and impact of new policies and programs are negatively impacted.

Data collected from the state system of care technical assistance calls indicates that children who are identified as having complex needs intersect with at least two other systems. For most cases that were reviewed through the technical assistance process from April 1, 2021, and March 31, 2022, case coordination, preventative and upstream planning, transition planning and cross-system competencies were identified gaps and impacted timely access to coordinated supports and services.

According to a 2016 issue brief from the Child Welfare Information Gateway, workload distribution is dependent on the intersection of "case characteristics, like where the child resides, the number of children involved, the phase of the case process (e.g., intake, assessment, investigation, permanency), court involvement, permanency goals, task types (e.g., face-to-face contact, service planning, team meetings, and/ or documentation), and the complexity of the case,"[109] indicating a potential benefit in considering case complexity in caseload distribution.

Out of Home Family Settings

Federal laws such as the FFPSA per the California SB 2030 Study, are codifying the importance of placing children in the least restrictive, most family-like setting. Ideally, this means placement with relatives or close family friends with whom children are already connected. Per the California SB 2030 Study, family reunification caseloads sit at approximately 23:1 and Permanent Placement caseloads are approximately 49:1. As previously stated, based on the California SB 2030 Study and the 2020 Realignment Report, generally, county caseload ratios reflect a much higher ratio than what is recommended for children in all program areas and additional data about workloads associated with each case is needed. Relative or Non-Relative Extended Family Members (approximately 30 percent) are the second-highest setting youth are initially placed into next to Foster Family Agencies (approximately 35 percent) upon removal.[110] Supporting youth in a family-based setting remains a core value of the CCR and Federal mandates, such as FFPSA. These reforms are built on the reduction of reliance on congregate settings. To ensure that these reforms and the intentionality associated with them are fully realized caseworkers need to be able to provide proactive and upstream coordination, service referral, and access. However, it is difficult to fully determine the impacts of caseworker caseloads without more up-to-date data and evaluation regarding the workload associated with each case.

Congregate Settings

Youth residing in congregate settings have been determined via various processes including the Qualified Individual, courts, multidisciplinary teams, assessments, and

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[109] Child Welfare Information Gateway. (2016). *Caseload and Workload Management.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau

[110] California Department of Social Services (2020). *Report to the Legislature, Child Welfare and Adult Protective Services 2020 Realignment Report: Outcome and Expenditure Data Summary*. State of California.

CFTs to require a more restrictive setting to provide residential therapeutic environments. These youth have a much more robust constellation of needs. Therefore, the workload associated with coordinating their stability often does not lend itself to achieving effective permeance or meticulous family reunification planning and supports. To achieve the minimum case coordination required, case workers need time and competencies to fully address the complexity of those youth residing in congregate settings.

RECOMMENDATIONS

- Supplement current caseload data with an up-to-date evaluation of caseworker salaries and workload per case to inform decisions regarding funding for positions, caseload assignments, and impact of new policies and programs on workloads.
    - Ensure this data can be collected and analyzed on an ongoing basis with advancements in automation technology, such as CWS-CARES.
- Utilize a completed workload study to inform policies outlining caseload, workload, and other practice standards.
- Implement reduced and/or specialized caseloads and training regarding care coordination and specialized competencies like medical, trauma, mental health, and intellectual disabilities to increase caseworkers' ability to help families achieve safety and permanency regardless of their level of needs, which provides case workers the ability to hone skills and abilities to meet the unique needs of youth.[111, 112]

CAPACITY GAP 7: ADMINISTRATIVE PROCESSES

Administrative processes that create barriers can greatly impact access to timely and responsive services and supports for children in the foster care system. Children in foster care who have complex needs that are addressed by multiple systems are more affected due to the need to navigate multiple agencies and processes.

Placement changes across county lines often lead to significant care coordination challenges and obstacles to timely access to services and supports. As of January 2022, 23 percent of all youth in foster care were placed out of county, indicating that their local county provider network does not have sufficient capacity to support the needs of the children in their community. Of all youth placed with a resource family, 9.6

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[111] Child Welfare Information Gateway. (2016). *Caseload and Workload Management.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau
[112] Addresses stakeholder recommendation.

percent are placed in county, while 45 percent are placed out of county.[113] STRTP providers struggle at times to obtain the contract needed to expand setting options[114]

Intersection of Court Processes and System of Care

Each county has individual court practices related to the identification or assignment of an educational or developmental rights holder, who is required for consent to provide a service and share information like assessments, educational records, and service referrals. Delays in the identification of the rights holder, coordination with the courts and/or assigning a surrogate parent impacts access to child-specific information for care and service coordination. Throughout the state system of care technical assistance process, county practices have been identified as varying, ranging from assigning a rights holder at disposition hearings for all children, to maintaining rights of the biological parent(s), to limiting the rights of the biological parent(s) with an addition of a co-rights holder. Delays in these processes can impact the coordination of care and timely services in some circumstances.

Local Network of Care Capacity Development

Provider network development processes are locally driven and require effective communication and coordination across agencies, with providers, youth and families regarding the system of care needs, to design program models that are responsive to the identified system gaps. It is important for the local ILT to identify service, support, and placement setting capacity gaps as this will be an opportunity for the ILT to address gaps through their existing processes and program and utilize a collaborative strategy for program development and provider recruitment. System of care partners should be communicating and collaborating with all partners as needed for network planning conversations.

STRTP Approval, Certification and Contracting

STRTP providers serving children in foster care with complex needs must contract with county MHPs to deliver the specialty mental health services they are certified to provide. Based on technical assistance provided to STRTP providers, these contracting processes can present barriers for STRTPs. Barriers include:

- The county contracting cycle differs in counties.
- Some counties only permit applications during their open Request for Proposal (RFP) period, which is typically a one- or two-year cycle.
- County MHPs determine they have an adequate provider network and do not need the services the STRTP is providing.
- The quality of the programs is impacted due to the STRTPs lack of knowledge of Medi-Cal services.

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[113] California Child Welfare Indicators Project Reports (2022). *Out of County Placements*. University of California at Berkeley and California Department of Social Services, Research and Data Insights Branch.
[114] California Child Welfare Indicators Project Reports (2022). *Out of County Placements*. University of California at Berkeley and California Department of Social Services, Research and Data Insights Branch.

- Establishment of broad “exclusionary criteria”, such as requiring an autism diagnosis or a medical condition, leads to a narrow definition of commonality of need for serving children together and limits available options.

At times placing agencies will waive presumptive transfer. However, if the host county does not contract with the provider or complete the Medi-Cal Certification process the STRTP cannot receive their MHP approval and therefore not become fully licensed, unless they already have a MHP approval and a contract with the youth’s county of residence, resulting in the inability of the STRTP to provide the necessary SMHS needed for children in their program. In this instance, the MHP is responsible for providing or arranging for the provision of the necessary SMHS. Of all counties with youth placed in congregate settings, no counties serve 100 percent of their youth in county, which may indicate that they are unable to access needed levels of care within their county. Los Angeles County achieves the highest amount of in-county congregate care with 93.5 percent of youth served in county.[115]

Presumptive Transfer

While more analysis is needed, presumptive transfer processes and practices could benefit from evaluation and consideration of opportunities to attune the process to be more responsive to the individual needs of a youth. Although, presumptive transfer can permit for quick access to mental health services, placing agencies should consider the appropriateness of transferring a youth to another county since there are many factors to consider. These may include, but are not limited to, the planned length of stay, a new mental health assessment may be required, and often new providers to serve the youth as well as a new MHP that will be unfamiliar with the youth. Note: presumptive transfer applies only to specialty mental health services and does not apply to substance use disorder services. State technical assistance has identified instances when youth with an established history of a specific treatment approach, modality, and intensity, experiences changes in the services provided when the case is presumptively transferred, and at times has included a determination that the child no longer meets medical necessity.

More in-depth cross-system analysis is needed to review data on the length of time between referrals to mental health and the mental health assessment, school enrollment, and regional center referrals and intake. Network adequacy, different modalities, variation in the populations served, missed provider and community connections, intake and referral pathways and appropriate communication and collaboration amongst involved agencies are additional barriers in administrative processes that have been identified through state technical assistance. Often referral pathways and intake processes are slow and access to services delayed, when trying to frontload services to stabilize transitions to new placements.

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[115] California Child Welfare Indicators Project Reports (2022). *Out of County Placements*. University of California at Berkeley and California Department of Social Services, Research and Data Insights Branch.

Regional Center Intake Process

Children and families also experience impacts to regional center intake and service access especially when youth move between counties quickly and when access to the educational/developmental rights holder is delayed. A close look at the timing of the regional center intake process reveals that the process is not significantly longer for dually served youth referred for regional center intake.[116] Seventy-three percent (73 percent) of infants and toddlers referred for Early Start intake who are involved in child welfare experience an intake within the mandated 45-day time period. This is only slightly smaller compared to the 79 percent share of all infants and toddlers referred for Early Start intake.[117] Intake for Lanterman services that exceeded the mandated 120-day timeline is only slightly higher for youth involved with child welfare (18 percent) compared to all youth referred for Lanterman services (17 percent).[118] While there is not significant variation between the dually served regional center population when compared to the entire regional center youth population, there is still 18 percent of youth in foster care who exceed the 120-day timeline for children and 27 percent of infants and toddlers in foster care who exceed the 45-day timeline.[119] When a parent is unable to be located, an educational or developmental rights holder may need to be designated by the courts so that an assessment for Early Start and/or Lanterman eligibility can move forward. Timely coordination with the parent, courts and/or minor's counsel is key to successfully accomplishing timely intake and access to services. County practices related to limiting or terminating parental rights vary, which can result in lengthy processes in moving forward with Early Start and/or other regional center eligibility assessments and access to initiating services. Based on the state technical assistance, for those youth that are over the age of three, both intake and service access delays have been related to case coordination and effectively sharing of documentation and information while moving between regional center catchment areas.

Out of Home Family Settings – Resource Family Approval

Stakeholders report that the Resource Family Approval (RFA) process continues to be a barrier for relatives who wish to take youth into their homes. It is reported that the process is lengthy and potential caregivers must navigate many complex administrative steps, including passing a background check and disclosure of personal information to gain RFA approval. Stakeholders report that current RFA regulations often create barriers that leave families with no choice but to decline the placement due to situations such as lack of space in their home. Additionally, relatives and RFA families have shared that they do not receive the necessary training and support to provide care for youth who have complex behavioral health needs, which often leads to caregivers who are unable to provide the interventions necessary to create safety in the home. Recent enactment of SB 354 (Chapter 687, Statutes of 2021) seeks to address barriers some relative caregivers may experience in completing the Resource Family Approval process.

[116] DDS Addendum Figure 3
[117] DDS Addendum Figure 3
[118] DDS Addendum Figure 3
[119] DDS Addendum Figure 3

Congregate Settings

Stakeholders, as well as providers, report that the liability involved with accepting youth with specific behaviors is a risk due to concerns that community care licensing (CCL) will cite the program, even when their program statement outlines the emergency interventions that will be used. One example is elopement behaviors. Youth who display elopement behaviors make up 52 percent of the cases reviewed through the CYSOCSTA.[120] These youth are often discharged from placements with 14-day notices or are not admitted to placements because the program is not equipped, or they have had warnings from CCL in placement situations. Local system partners also report difficulties in accessing information about providers throughout the state, such as:

- The program design, including services offered and the trauma-informed model used in the facility.
- Exclusionary criteria for the program.
- The vacancy at programs.
- Accurate contact information for the facilities intake coordinator.
- The process for front-loading services and supports to stabilize the child upon intake.
- The facility does not provide a timely response to a referral.

RECOMMENDATIONS

- Evaluate court processes and key access points to System of Care with a focus on impacts to timelines and access to care, and the experience of youth, caregivers, and caseworkers in navigating processes.
- Further evaluate regional center intake and service access timelines for children in foster care to ensure there are not only timely intake processes, but also timely access to services.
- Implement regional center performance measures, including the measures specific to the intake process and timely service authorizations, which will incentivize regional centers to agree to develop and utilize a standard intake process.
- Review opportunities to improve practices around the presumptive transfer process.
- Explore variation in the authorization and medical necessity determinations for specific services and intensities of those services and evaluate the impact of other variables such as placement setting. Address variation through state-local technical assistance and determine the need for guidance.
- Establish a state-local plan to improve consistency in the STRTP approval, certification, and contracting process through regional technical assistance and training and determine the need for state policy changes.
- Establish updated policy regarding basis for exclusionary criteria and commonality of need determinations in STRTPs.

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[120] TA Addendum Figure 11

- Establish partnership strategies within the ILT for resource family recruitment and establish ILT processes to facilitate ongoing and continuous support before and during placement.
- Evaluate the ability to make emergency placements eligible for higher Level of Care or Specialized Care Increment funding until RFA approval.

CAPACITY GAP 8: LOCAL AND STATE DATA SHARING

The integration of administrative data across service agencies has come to the forefront as a foundational element in informing public policy and system reform.[121] In the System of Care service delivery approach, data and information sharing is a critical pillar.[122] Utilization of data to inform policy, practices and programs is vital for informing Californian's children and youth system of care and developing safety net services that are designed and responsive to the needs of individual children and families as well as to the systems responsible for administering the programs meant to support them. This need has been recognized and significant investments are underway to re-engineer the way California shares and utilizes data, including but not limited to CalHHS and Children's Data Network, AB 2083: System of Care Foster Youth Cross-System Landscape Analysis, Cradle to Career, AB 133: Health and Human Services Data Exchange Framework, the CalHHS Data Sharing Hub and the CalHHS Open Data Portal.

There are multiple data intersections in California, each with unique barriers, legal obligations, and responsibilities. These intersections include state and local data, administrative and child-specific data for each of the children and youth system of care state and local agencies, including Child Welfare, Behavioral Health, Developmental Services, Education, and Probation. Each of these programs captures data on a child's experience within its own system, but the ability to capture the experiences and circumstances of a child across the multiple systems they may be involved with or over a span of time has largely been a barrier.[123] Data systems both at the state and local levels are siloed by design, and sometimes exacerbated by information and privacy law. Therefore, information contained in each separate data system impairs both the state and local systems' ability to quickly and efficiently access data to obtain a holistic

[121] Culhane, D.P., Fantuzzo, J., Rouse, H.L., Tam, V., & Lukens, J. (2010). Connecting the Dots: The Promise of Integrated Data Systems for Policy Analysis and Systems Reform. *Intelligence for Social Policy, 1*(3). University of Pennsylvania, School of Policy and Practice.
[122] University of Maryland, Baltimore (2018). *Preinstitute: Building Systems of Care.*
[123] Foust, R., Hoonhout, J., Eastman, A., Prindle, J., Rebbe, R., Nghiem, H., Suthar, H., Cuccaro-Alamin, S., Mitchell, M., Dawson, W., Palmer, L., Raj, S., Ahn, E., Hammond, I., McNellan, C., Reddy, J., Chen, W.-T., Mayfield, K., Putnam-Hornstein, E., & McCroskey, J. (2022). The Children's Data Network. *International Journal of Population Data Science, 6*(3).

perspective of the child.[124] Additionally, data elements regarding Indian children, service providers, tribally approved homes and other relevant data needed to evaluate how the system of care effectively serve Indian children and tribal communities is frequently lacking across the system of care.

Aligning varying definitions for data elements, including definitions of children in foster care across departments, remains a challenge, resulting in a reduced ability to easily compare data. CDE tracks these different definitions and created a resource document titled Foster Youth Definitions in consultation with CDSS.[125] The different definitions and requirements for students in foster care illustrates gaps between how child welfare agencies and education programs identify foster youth.

Local AB 2083 Entities

At the local county level, the value of shared data and information carries importance as timely care coordination and service planning is dependent on shared data and information specific to the children and family, in addition to the value of understanding the needs of local systems for policy and programmatic planning and decisions. These two data and information categories can be defined as, 1) child-specific information/data; and 2) administrative/organizational data. Each of these data categories presents unique access challenges to local counties in fully realizing effective data and information sharing. Local counties have been tasked via AB 2083 to include within their MOU a process and agreement on how to share data and information among their local systems. To date the MOUs have shared their legal requirements without content that offers an opportunity to operationalize shared information or data. This fact, along with continuous expressions from local systems regarding the need for more requests for data-sharing technical assistance, as well as specific tools, guides, and tangible activities suggests there is high value in investing in supporting local systems in overcoming this gap. In September 2021, stakeholders engaged in a survey inquiring about local identified gaps (see *Stakeholder Input Results* section). Across the 13 narrative questions asked, 16 percent of respondents reported the need for improved data and information sharing. Additionally, other surveys presented to the local ILT members around the need for targeted MOU development technical assistance showed that 14 percent of the respondents indicated the need for support on data and information sharing. This self-identified gap by the local partners is reported to result in a lack of timely case coordination information-sharing as well as impacts to local policy and program planning.

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[124] Foust, R., Hoonhout, J., Eastman, A., Prindle, J., Rebbe, R., Nghiem, H., Suthar, H., Cuccaro-Alamin, S., Mitchell, M., Dawson, W., Palmer, L., Raj, S., Ahn, E., Hammond, I., McNellan, C., Reddy, J., Chen, W.-T., Mayfield, K., Putnam-Hornstein, E., & McCroskey, J. (2022). The Children's Data Network. *International Journal of Population Data Science, 6*(3).

[125] CDE Addendum

Child Specific Data/Information

Research indicates that resource parents report that medical and health information is not provided approximately 80 percent of the time at placement.[126] The level of coordination for children in foster care who have complex needs is interwoven across multiple systems, each with their own set of privacy laws, internal processes and practices and coordination with their local judicial system. Historically, each system partner has its own release of information forms for families and rights-holders to consent to share information. Currently, only three counties in the state utilize a single release of information form across the local systems, leaving most counties without this flexibility and local sharing ability.

Administrative

Integrated administrative data is vital for a system of care approach at the local level to provide important policy and program insights around what is successful, for whom and at what cost.[127] Each county varies in the array of services and supports available, geographical constraints, demographic diversity and various fiscal options. Therefore, shared metrics on gaps, needs and outcomes should be tailored by the local ILT. Across California's systems of care this remains an opportunity and, in its absence, leaves gaps in the ability of local communities to thoughtfully plan, work upstream and build responsive systems. State and federal regulations require certain protections of data through the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). In addition, child welfare confidentiality laws require local governments to implement privacy protections within their administrative data systems. Even if the local systems were to integrate their local data, they would be bound by the associated regulations, thus imposing higher responsibility on other system partners which they may not be adequately equipped to handle.[128] Local systems lack the concrete data sharing infrastructure, like data sharing and storage environments, data sharing governance structures, linkage or data match processes and de-identification practices. Absent data sharing governance structures, coordinating who has the authority to authorize and monitor the data sharing safeguards remains unclear.

RECOMMENDATIONS

- Align Local Control Funding Formula, educational rights, and child welfare definitions to ensure one consistent definition of a child in foster care.

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[126] Greiner, M.V., Ross, J., Brown, C.M., Beal, S.J., & Sherman, S.N. (2015). Foster Caregivers' Perspectives on the Medical Challenges of Children Placed in their Care: Implications for Pediatricians Caring for Children in Foster Care. *Clinical Pediatrics, 54*(9), 853-861. doi: 10.1177/0009922814563925

[127] Culhane, D. P., Fantuzzo, J., Rouse, H. L., Tam, V., & Lukens, J. (2010). Connecting The Dots: The Promise of Integrated Data Systems for Policy Analysis and Systems Reform. *Intelligence for Social Policy, University of Pennsylvania*.

[128] Culhane, D. P., Fantuzzo, J., Rouse, H. L., Tam, V., & Lukens, J. (2010). Connecting The Dots: The Promise of Integrated Data Systems for Policy Analysis and Systems Reform. *Intelligence for Social Policy, University of Pennsylvania*.

- Develop and align state and local metrics for shared system of care outcomes, both child-specific and system improvement.[129]
- Create a statewide Children and Youth System of Care data dashboard to indicate outcome measurements and create transparency across systems.[130]
- Develop state technical assistance tools for local data-sharing pathways and models for local system partners, including reviewing options for modeling the state data-sharing governance framework at the local level.[131]
- Support local ILTs to leverage existing technical assistance tools like the State Health Information Guidance (SHIG) 5.0 – Sharing Minors and Foster Youth Health Information.
- Applicable to all of the recommendations, support local ILTs to maintain children and youth's confidentiality and privacy to safely protect their information and data.

STAKEHOLDER INPUT

As part of the AB 2083 System of Care initiative the CYSOCSTA team, comprised of staff from the DHCS, CDSS, CDE, and the DDS and in consultation with the Department of Rehabilitation (DOR), conducted a survey to obtain the communities' experiences in supporting children with complex needs and inform recommendations included in this report.

The survey was offered to approximately 120 individuals and completed by over 70 professional participants within the system of care purview, including providers, advocates, county, educational, and regional center professionals. The survey consisted of 12 questions in narrative format that were coded for key themes and the prevalence of system gaps as identified by the stakeholders. Most respondents (approximately 56 percent) were CWS staff. The second highest response rate was by Behavioral Health (BH)/Mental Health (MH) system representatives (24 percent), and other system partners (20 percent).

Respondents report that within their systems of care, collaboration, partnerships, communication, teaming, and improved relationships were reported most successful. Survey questions asked respondents to share their experiences in and recommendations for accessing:

- Emergency Caregivers
  The leading response indicated a lack of options, particularly for children and

[129] Stroul, B.A. (2002). Systems of Care: A Framework for System Reforms in Children's Mental Health. *National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.*
[130] Stroul, B.A., Blau, G.M., & Larson, J. (2021). The Evolution of the System of Care Approach for Children, Youth, and Young Adults with Mental Health Conditions and Families. *The Institute for Innovation & Implementation, University of Maryland School of Social Work.*
[131] Addresses stakeholder recommendation.

youth with complex needs. Accessing emergency caregivers was identified as successful in a significant portion of the results. Barriers also identified include multi-system involvement impacting access and statutory barriers.

- Kin/Relative or Resource Families
  Responses identified a lack of training and skill development for families and resource families needed to provide complex care as well as a lack of availability of in-home services and supports. A significant portion of responses identified ineffective recruitment of kin/relative or resource family options. Limited capacity of resource families, as well as a lengthy RFA process were also identified as significant barriers. The need for available whole-family services was identified as significant.
- Therapeutic Foster Care (TFC)
  Most respondents identified TFC being unavailable and/or requiring out-of-county providers due to a lack of capacity. Geographical distance to available services, challenges in policy requirements or legal and statutory framework were the second leading response. A limited portion of responses reported successful TFC placements with cross-system collaboration.
- Congregate Care
  A large portion of respondents identified limited capacity of congregate settings, with challenges in the timely identification of congregate care placements as an issue. Several respondents identified difficulties in accessing congregate care locally, citing certain geographic locations require out-of-county placements and challenges implementing recently enacted federal requirements for use of congregate care settings.
- Inpatient Psychiatric Care
  Most responses identified a lack of inpatient psychiatric care capacity leading to extensive waiting periods for beds. A large portion of responses reported a child's behaviors as being determined to be "too severe" or acute for admission, with a number of responses indicating that youth are released when they no longer meet medical necessity yet are still unable to be supported in a congregate placement. Issues in accessing transitional or step-down options post-hospitalization was identified as a significant issue. Many respondents reported no local availability for inpatient psychiatric care. Responses also identified a lack of day treatment options. Nearly every respondent reported challenges in accessing inpatient psychiatric options.
- Supporting Complex Needs in the Least Restrictive Setting and Addressing Risk of Placement Disruption
  Most responses identified better engagement between system partners as vital for the youth and foster parents in accessing services. The second-leading response identified a need for local and immediate access to staff and professionals trained to navigate resources that can meet the needs of the child on an urgent 24/7 basis. A significant number of responses identified a need for more adequately trained caregivers that can provide complex care to increase family engagement. Most responses identified a need for more intensive BH/MH, education, and prevention services for maintaining and thriving in the least restrictive setting. A significant number of responses identified a need for

additional parent/caregiver training and support to meet the needs of the youth. Responses identified respite services and Wraparound as important to thriving in the least restrictive setting. Collaboration between system partners and providers was noted as critical to stabilization, timeliness of service access and implementation. Additionally noted was the importance of increased trauma-informed care and nontraditional and extracurricular activities, with family voice leading the way.

- Avoiding Unplanned Changes in Educational Placement
  Most responses identified placement stabilization as critical in maintaining educational stability and access to educational services that meet the needs of the youth. Other responses identified collaboration and constant communication between system partners, transportation to the SOO, and consistent IEP implementation as crucial in avoiding unplanned changes in educational placements. Several responses suggested that placement arrangements should consider educational placement at the same time.
- Timely, Quality and Appropriate Level of Intensity of Services
  Timeliness of services, staff turnover, lack of provider competencies, and challenges related to out-of-county transfers were identified as most problematic by the respondents. Additional responses identified problematic issues with the quality of services, lack of appropriate placement options, multiple placements causing disruptions for the child/youth, and a lack of communication among partners. Several responses also identified a need to improve the focus on trauma within provision of services. Other responses cited issues with medical necessity determination, as well as issues with billing, claiming and other administrative processes.
- A Committed and Loving Family
  The most-noted recommended strategy included reducing inappropriate placements by increasing caregiver/parent trainings and supports. Other responses identified a need to improve family- and youth-centered practices with tailored and individualized supports and services, improving care and competencies, and data sharing and communications across systems and providers to improve care coordination.
- Addressing the Cultural Needs of Indian Children
  The leading feedback by tribal partners is the need for ICWA to be fully implemented and for culturally relevant services, specifically those that will address the historical and generational trauma experienced. Additionally, Tribal inclusion must happen at the family level by including both the family and tribes in CFT meetings, policies and procedures in the county, and involving them in the implementation of the county MOUs.

ADDENDUMS AND GLOSSARY

AB 2083 MULTI-YEAR PLAN RECOMMENDATIONS	
CAPACITY GAP I: UNIQUE NEEDS OF CHILDREN AND FAMILIES INVOLVED WITH CHILD WELFARE	
1	Utilize the local MOU framework, with state collaboration, to evaluate Child and Adolescent Needs and Strengths data, utilization data, least restrictive placement settings, and other outcome measures to inform system of care capacity development and planning.
2	Invest in increased tribal consultation efforts that guide practice improvements and capacity investments to improve care for tribal youth with complex needs, including support for tribally approved homes and tribal customary adoptions.
3	Immediately upon placement, provide services for all children in foster care that support the child's adjustment into the new social environment, promote trauma-informed caregiving, stabilization and a determination regarding the need for ongoing services.
4	Utilize the local MOU framework to establish protocols that link children with needed supports timely upon the child's arrival in a new placement.
5	Support providers' utilization of trauma-informed treatment models across the continuum of care.
6	Support program models to include training that is focused on supporting the developmental role of parent/caregiver in helping the child heal from trauma.
7	Increase training opportunities for resource, adoptive, biological, and other caregivers caring for trauma-affected children of all ages on the value of interactive play, sensory activities, yoga, drumming, or bilateral and cross-body movement in the child's or youth's recovery and corrective attachment opportunities.
8	Support child wellbeing activities to decrease the impact of trauma, improve resiliency and increase childrens' interpersonal skills.
CAPACITY GAP 2: ESSENTIAL COMPETENCIES WITHIN SERVICES, SUPPORTS, AND SPECIALIZED MODELS OF CARE FOR CHILDREN IN FOSTER CARE	
9	Establish highly specialized multi-agency assessment models for exceptionally complex cases to collaboratively assess and determine the appropriate level of care, array and intensity of services needed, and to support timely approval and implementation of services.

10	Expand the integrated continuum of care to promote transition to lower levels of care, including individualized trauma-informed small capacity STRTPs and Enhanced Intensive Services Foster Care Homes.
11	Evaluate options for provision of respite care and additional childcare supervision within home-based settings.
12	Establish a joint state and local framework that results in evidence informed child development and trauma trainings for social workers, treating clinicians and other professionals involved with foster care.
13	Provide integrated early intervention and intensive trauma-focused (TF) treatment to infants, ages 0 to 5 years old, and youth in foster care and their caregivers.
14	Provide upstream preventative and early intervention services to decrease the number of children in foster care with complex unmet needs such as SUD, Commercially Sexually Exploited Children (CSEC), and Posttraumatic Stress Disorder (PTSD).
15	Enhance the standard of care by providing TF and integrated behavioral health assessments to all children in foster care.
16	Amend contracting solicitation and awards for inclusion of, or requirement of trauma-informed care, models that consider the applied neuroscience techniques and treatment strategies that correspond to current research.
17	Enhance the standard of care by providing TF and integrated behavioral health assessments to all youth in foster care.
18	Contract directly with Tribes and Indian organizations to provide culturally responsive services.
19	Establish ongoing training for the workforce across all systems to address the approach taken in different cultures and decrease the disproportionality of children of color entering care.
20	Conduct a latent class analysis of CANS data and other assessment data to identify and compare the profiles of need within their local systems to the existing network of services and settings.
21	Utilize ILTs to review data including review of circumstances in which the local system of care was unable to identify appropriate placements, respond to emergency placement needs, prevent unplanned placement disruptions, or prevent long lengths of stay and add processes to MOUs that respond to the identified service gaps, care coordination practices and needed emergency resources. Engage the CYSOCT team when local efforts to address these needs are exhausted.

22	Utilize ILTs to develop system of care processes to complete developmental screenings, including consideration of how the education and mental health systems can help facilitate developmental screenings for all foster youth.
23	Utilize ILTs to collaboratively implement data-informed resource family recruitment and support initiatives focused on specialized needs and initial stabilization services for new placements.
24	Utilize ILTs to evaluate and implement specialized and integrated trainings for professionals working with children and families across the system of care.
25	Utilize ILTs to engage Tribes in development and amendment of SOC MOU agreements.
CAPACITY GAP 3: CARE COORDINATION	
26	Develop Wraparound or Wraparound type program as a cross-system care coordination model, with a workforce able to address the needs of youth with intellectual and developmental disabilities and other co-occurring conditions and needs, as well as trauma-informed and culturally relevant, home-based parent coaching approaches to support communication and emotional co-regulation.
27	Assess and align, to the extent possible, the statutory requirements for each system partner for case planning, case coordination, and teaming requirements, statutes, and practices.
28	Align the various notification and information sharing and confidentiality requirements, particularly between general education and special education so the same requirements exist between Welfare and Institutions Codes, Education Codes, Government Codes, and California Rules of Court.
29	Provide guidance and/or technical assistance on expediting Court processes regarding assignment of an educational/developmental rights holders for children who are referred to a regional center for Early Start intake.
30	Develop technical assistance resources for all system partners to support cross-system teaming, planning, cross-system notification and education coordination.
31	Prioritize capacity building efforts that enable children with complex needs to have those needs coordinated within the child's home community and avoid out of county placements that result in disrupted provider relationships.

CAPACITY GAP 4: FAMILY FINDING AND ENGAGEMENT	
32	Develop local system of care policies and protocols to increase up-front family finding and engagement and increase rates of first placement with relatives and Tribes, consistent with ICWA, while ensuring that child and caregiver needs are met upon the child's placement in the home.
33	Establish multiagency strategies that target recruitment of families, including local Tribes, with unique experience and competencies important for children with complex needs (e.g., joint recruitment strategies with regional centers for children with developmental disabilities, with local education partners to recruit families within the child's community, or and Tribally Approved Homes for Indian children).
34	Implement rapid reunification models which leverage existing teaming models.
35	Strengthen reunification efforts through implementation of trial home visitation coupled with parent coaching.
36	Utilizing permanency specialists and peer partners to engage family and plan for successful transition and family reunification.
37	Establish process for ILTs ongoing data review of child-specific trends, family recruitment progress, with particular attention to Indian children, and develop focused recruitment and support strategies.
CAPACITY GAP 5: EDUCATION	
38	Develop individual success plans at the school level for each foster youth that includes academic interventions, mentoring, parent engagement, and a team approach to supervising children and youth in care.
39	Increase school stability through providing technical assistance and training to system partners on foster youth education rights, including but not limited to, the right to school of origin, transportation to school of origin, and immediate enrollment.
40	Include information regarding the education of a youth in the case plan.
41	Ensure that when a youth experiences a change in placement school stability, SOO, best interest determination (BID), and transportation to SOO be addressed.
42	Include information in the case plan goals about the child's needs and experiences academically, socially, and emotionally at school.

43	Increase capacity of transportation to school of origin.
44	Ensure placing agencies have policies and procedures in place to address school stability and school of origin when making placement decisions and that they document notification of placement moves and have plans to support transportation to the school of origin.
45	Require that LEAs and placing agencies (child welfare/probation) have SOO transportation plans.
46	Increase notification of residential placement changes.
47	Ensure placing agencies document in CWS/CMS when they have provided notification to required entities upon placement move.
48	Dedicate staffing to determine the feasibility of creating a data indicator that tracks the amount of time a foster youth is not enrolled in school between residential placements.
49	Increase education's role in county social services planning and implementation efforts.
50	Connect FYSCP coordinators to the development and implementation of county AB 2083 MOUs.
51	FYSCPs assist child welfare and probation in securing and training resource families and providers of therapeutic foster care.
52	Increased coordination and connections between county FYSCP Executive Advisory Council (EAC) and county ILT so that efforts are not duplicated and the FYSP program can be informed of county updates to System of Youth System of Care, connection to county Children and Youth System of Care stakeholders and promote the importance of an engaged FYSCP program within the county Children and Youth System of Care.
CAPACITY GAP 6: CASEWORKER RATIOS	
53	Supplement current caseload data with an up-to-date evaluation of caseworker salaries and workload per case to inform decisions regarding funding for positions, caseload assignments, and impact of new policies and programs on workloads. Ensure this data can be collected and analyzed on an ongoing basis with advancements in automation technology, such as CWS-CARES.
54	Utilize a completed workload study to inform policies outlining caseload, workload, and other practice standards.

55	Implement reduced and/or specialized caseloads and training regarding care coordination and specialized competencies like medical, trauma, mental health, and intellectual disabilities to increase caseworkers' ability to help families achieve safety and permanency regardless of their level of needs, which provides case workers the ability to hone skills and abilities to meet the unique needs of youth.
CAPACITY GAP 7: ADMINISTRATIVE PROCESSES	
56	Evaluate court processes and key access points to System of Care with focus on impacts to timelines and access to care, and the experience of youth, caregivers, and caseworkers in navigating processes.
57	Further evaluate regional center intake and service access timelines for children in foster care to ensure there is not only timely intake processes, but also timely access to services. Implement regional center performance measures, including the measures specific to the Intake Process and Timely Service Authorizations, which will incentivize regional centers to agree to develop and utilize a standard intake process that includes core elements and is focused on customer service and improves the number of days between annual IPP review and service authorization.
58	Review opportunities to improve practices around the presumptive transfer process.
59	Explore variation in the authorization and medical necessity determinations for specific services and intensities of those services and evaluate the impact of other variables such as placement settings. Address variation through state-local technical assistance and determine the need for guidance.
60	Establish a state-local plan to improve consistency in the STRTP approval, certification, and contracting process through regional technical assistance and training and determine the need for state policy changes.
61	Establish updated policy regarding basis for exclusionary criteria and commonality of need determinations in STRTPs.
62	Establish partnership strategies within the ILT for resource family recruitment and establish ILT processes to facilitate ongoing and continuous support before and during placement.
63	Evaluate the ability to make emergency placements eligible for higher Level of Care or Specialized Care Increment funding until RFA approval.

CAPACITY GAP 8: DATA GAPS LOCAL AND STATE	
64	Align Local Control Funding Formula, educational rights, and child welfare definitions to ensure one consistent definition of a child in foster care.
65	Develop and align state and local metrics for shared system of care outcomes, both child-specific and system improvement.
66	Create a Statewide Children and Youth System of Care data dashboard to indicate outcome measurements and create transparency across systems.
67	Develop state technical assistance tools for local data-sharing pathways and models for local system partners, including reviewing options for modeling the state data-sharing governance framework at the local level.
68	Support local ILTs to leverage existing technical assistance tools like the State Health Information Guidance (SHIG) 5.0 – Sharing Minors and Foster Youth Health Information.
69	Applicable to all of the recommendations, support local ILTs to maintain children and youth's confidentiality and privacy to safely protect their information and data.

ADDENDUM: CURRENT DEPARTMENT INVESTMENT DETAILS

The budget detail outlined in the following charts are categorized by each system of care department by year and describes the investments that will help address the gaps and implement recommendations. These investments will be implemented over time through cross-department and system collaboration and partnership. This information is not exhaustive of all investments, but rather key investments that are tied to the identified gaps and recommendations.

A: CDSS FY 19/20

Gaps	Investment Title	Cost	Summary
Gap 6, Gap 7	Resource Family Approval Timeliness	$4.7 million General Fund (GF)	Funding to continue to expedite processing of Resource Family applications.
Gap 2, Gap 7	Emergency Caregiver Support	$4.1 million GF	Allows payments to emergency caregivers prior to RFA up to 120 days, or 365 days with good cause.
Gap 1, Gap 2, Gap 3	Foster Parent Recruitment and Retention Support	$21.6 million GF	Provides funding to support counties in recruitment and retention of foster family homes.
Gap 6	Foster Family Agency (FFA) Rate	$6.4 million GF	Increase the FFA rate by 4.15 percent.
Gap 2, Gap 6	Child and Adolescent Needs and Strengths (CANS)	$9.8 million GF	Provided one time funding of social worker costs to implement CANS.
Gap 2	Family Urgent Response System	$15.0 million GF in FY 2019-20, and $30 million GF in FY 2020-21 and ongoing	Prevent disruptions of care, reduce the inappropriate use of law enforcement, and connect children and youth in foster care with immediate, in-home support and services. Establish county mobile response teams.

Gaps	Investment Title	Cost	Summary
Gap 4	Bringing Families Home	$24.3 million GF, one-time, available from July 2019 to June 2022 with an additional one-time funding available from July 2021 to June 2024.	Provides financial assistance and housing-related Wraparound supportive services to reduce the number of families in the child welfare system experiencing or at risk of homelessness, to increase family reunification, and to prevent foster care placement.

A: CDSS FY 20/21

Gaps	Investment Title	Cost	Summary
Gap 2	Alternate Models of Care (AB 2944)		Provides counties flexibility to develop and implement alternative funding models and request individualized rates for innovative Aid to Families with Dependent Children— Foster Care (AFDC-FC) programs or models of care and services that provide children with service alternatives to residential care, enhance the ability of children to remain in the least restrictive, most family-like setting possible, and promote services that address the needs and strengths of individual children and their families.
Gap 1, Gap 2	California Parent and Youth Helpline	$4.7 million GF	Provides support to children and their families who may be at risk of involvement with Child Welfare Services or entry to foster care.
Gap 2	Child Welfare Workforce Flexibility	n/a	Addresses workforce needs by allowing non-social worker personnel who meet certain minimum education and experience requirements to conduct health and safety assessments and complete the orientation of potential resource families.

A: CDSS FY 21/22

Gaps	Investment Title	Cost	Summary
Gap 2	Stipends for Tribal Social Work Students	$3.0 million GF	Provides education stipends for tribal social work students to pursue Masters in Social Work degrees.
Gap 1, Gap 2, Gap 6	Child and Adolescent Needs and Strengths	$3.4 million GF	Provided ongoing funding to support social worker completion of CANS assessment within the Child and Family Team (CFT).
Gap 1, Gap 2	Child Welfare Workforce Training and Coaching	$12.9 million GF	Funding for continued training and an investment in coaching, using a field-based training approach, for new social workers and supervisors throughout the State.
Gap 6	Emergency Response Social Workers	$50 million GF	Funding to support increased Emergency Response Social Workers in Child Welfare.
Gap 2	STRTP Transition	$10.4 million GF	Funding to support STRTP providers who reduce their facility capacity 16 beds or fewer.
Gap 1, Gap 2, Gap 3, Gap 6, Gap 7, Gap 8	Family First Prevention Services Act (FFPSA) Parts 1 and 4 (Prevention activities, Nursing Support, Qualified Individual Assessment, High Fidelity Wraparound Aftercare)	$254.2 million GF	Supports counties in their implementation of the Part I prevention services; 24/7 Nurse hotline; assessment of all new STRTP placements within 30 days of a placement; provides six months of Wraparound aftercare services following a youths exit from an STRTP.

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3. Gap 4, Gap 5, Gap 7, Gap 8	Addressing Complex Care Needs: TA, Child Specific, Capacity Building, Innovative Models and Services, Crisis Continuum Pilot	$139.2 million GF	Funding for System of Care activities for foster youth with acute and complex needs, including out-of-state youth.

A: CDSS FY 22/23

Gaps	Investment Title	Cost	Summary
Gap 2, Gap 3, Gap 4	Excellence in Family Finding and Engagement Program	$150 million GF	One time block grant funds to support family finding and engagement activities and establish permanency specialist.
Gap 7, Gap 8	Removing barriers to relative placement	$6.6 million GF	Allows relative and non-relative extended family member caregivers with whom a child has been placed through an emergency or court-ordered placement to receive payments through the ARC program regardless of the status of any criminal records exemption or resource family approval.
Gap 2, Gap 3, Gap 6	Foster Youth Independence Pilot	$1 million GF	Provides one-time funding that will support case management and support services to increase utilization of housing choice vouchers for former foster youth under 25 years of age who are, or are at risk of, experiencing homelessness.
Gap 1, Gap 2, Gap 3	Flexible Family Supports for Home-based Care	$50 million GF	Funding to increase the use of home-based family care and the provision of services and supports to children in foster care and their foster caregivers.

Gaps	Investment Title	Cost	Summary
Gap 2	Tribal Engagement to develop AB 2083 MOUs	$636,022 GF	County development of tribal consultation frameworks.
Gap 2, Gap 3, Gap 4, Gap 7	Eliminated IV Agreement Tribes Share of Cost for Placement	Varies	Tribal shares of costs for agreements between CDSS and tribal entities regarding the provision of services and sharing of costs related to the care and custody of Indian children are eliminated for Tribal-State Title IVE agreements.
Gap 1, Gap 4, Gap 7, Gap 8	Tribal Approved Homes Compensation	$5.2 million GF	Provide financial assistance with recruiting and approving homes for the purpose of foster or adoptive placement of an Indian child.
Gap 7, Gap 8	Legal Counsel for Tribes	$5.1 million GF	Provide funding to support legal counsel to represent an Indian tribe in California juvenile court proceedings.
Gap 2, Gap 3	Tribal Policy Engagement	$424,015 GF	Support to engage tribes in ongoing interagency efforts, to coordinate services and supports for youth who have experienced severe trauma.

B: DHCS FY 19/20

Screening

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2	Proposition 56	$30.8 million federal funds, 23.1 million Prop. 56 funds	Developmental screenings for children in the Medi-Cal program.
Gap 1, Gap 2	Proposition 56	$27.2 million federal funds, $13.6 million Prop. 56 funds	Trauma screenings for children and adults in the Medi-Cal program.

Youth Programs

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 4	Cannabis Allocation	$21.5 million in Proposition 64 funds	The Budget includes $21.5 million in Proposition 64 funds for competitive grants to develop and implement new youth programs in the areas of education, prevention, and early intervention of substance use disorders.

Peer Support

Gaps	Investment Title	Cost	Summary
Gap 8	Peer Run Mental Health Warm Line	$3.6 million (Mental Health Services Fund)	Supports phone and instant messaging to callers across California using peer counselors with lived experience of mental health challenges.

Coverage Expansion

Gaps	Investment Title	Cost	Summary
Gap 2	Full Scope Expansion - ages 19-25 regardless of immigration status	$96.1 million ($72.4 GF)	Expands full-scope Medi-Cal coverage to eligible young adults aged 19 through 25 regardless of immigration status.

Case Management

Gaps	Investment Title	Cost	Summary
Gap 2, Gap 3, Gap 7	Family Mosaic Project	$1,776,000 TF, $888,000 GF (anticipated costs)	The Department has a contract with the Family Mosaic Project, located in San Francisco, for case management of children diagnosed with emotional disturbance who are at risk for out-of-home placement.

B: DHCS FY 20/21

Case Management

Gaps	Investment Title	Cost	Summary
Gap 2, Gap 3, Gap 7	Family Mosaic Project	$555,000 Total Funds (TF), $2,863,000 GF (anticipated costs)	The Department has a contract with the Family Mosaic Project, located in San Francisco, for case management of children diagnosed with emotional disturbance who are at risk for out-of-home placement.

B: DHCS FY 21/22

Initiative Implementation

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3, Gap 5, Gap 7, Gap 8	Children and Youth Behavioral Health Initiative	$3.4 billion TF, $2.4 billion GF spread over 5 years	$4.6 billion ($3.4 billion General Fund) over five years, to transform California's behavioral health system for children and youth into an innovative and prevention-focused system where all children and youth are routinely screened, supported, and served for emerging and existing behavioral health needs regardless of payer. Of this funding, $3.4 billion ($2.4 billion General Fund), including $255 million from the Behavioral Health Continuum Infrastructure Program, is available for DHCS to implement specified components of the Initiative.

BH Services

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3	Behavioral Health Continuum Infrastructure Program	$2.2 billion TF, $1.7 billion GF over 3 years	Competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources.

Services

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3, Gap 5, Gap 7	CalAIM	$1.6 billion TF, $650.7 million GF	CalAIM components related to children and youth include revised access criteria for specialty mental health services, no wrong door for behavioral health, Enhanced Care Management, and Community Supports. This funding reflects all components of CalAIM.
Gap 1, Gap 2, Gap 3, Gap 6	FFPSA After Care and Qualified Individual Services	$25,215,000 Federal Fund (FF), $9,825,000 GF	Qualified Individual component: Requires the independently certified Qualified Individual to perform a detailed assessment to determine if home-based placement and services are more appropriate than residential care and if not, that the placement in a STRTP provides the most effective and appropriate care setting in the least restrictive environment, and the placement is consistent with the short-term and long-term mental and behavioral health goals and permanency plan for the child. Aftercare component: Requires states to provide discharge planning and family-based after care support for at least six months after a child or youth is discharged from an STRTP.

Case Management

Gaps	Investment Title	Cost	Summary
Gap 2, Gap 3, Gap 7	Family Mosaic Project	$1,547,000 TF, $1,547,000 GF (anticipated costs)	The Department has a contract with the Family Mosaic Project, located in San Francisco, for case management of children diagnosed with emotional disturbance who are at risk for out-of-home placement.

B: DHCS FY 22/23

Access to Student Behavioral Health Services

Gaps	Investment Title	Cost	Summary
Gap 2, Gap 3, Gap 5	Student Behavioral Health Incentive Program	$194 million TF, $97 million GF	The amount budgeted for this item in FY 2022-23 has been increased to $194 million total funds ($97 million GF), an increase of $65 million total funds ($32 million GF). The Department is also proposing to re-appropriate these funds through FY 2024-25

Behavioral Health Services

Gaps	Investment Title	Cost	Summary
Gap 2, Gap 3	Wellness and Resilience Building Supports for Children, Youth, and Parents	$175 million GF over the next 3 years	One-time funding, available over three years, to address urgent needs and emergent issues in behavioral health for children and youth age 25 and younger.
Gap 2, Gap 3, Gap 7	Behavioral Health Crisis Continuum of Care	$1.5 million GF	$1.5 million GF in 2022-23, to continue a contract that supports planning for the behavioral health crisis continuum of care.

Peer Support

Gaps	Investment Title	Cost	Summary
Gap 2, Gap 3	Peer Mental Health Support Programs for Youth	$10 million GF	$10 million one-time GF to develop and promote high quality peer-to-peer mental health support programs for youth through DHCS via a contract with The Children's Partnership.

Case Management

Gaps	Investment Title	Cost	Summary
Gap 2, Gap 3, Gap 7	Family Mosaic Project	$1,624,000 TF, $1,624,000 GF (anticipated costs)	The Department has a contract with the Family Mosaic Project, located in San Francisco, for case management of children diagnosed with emotional disturbance who are at risk for out-of-home placement.

Services

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3, Gap 6	FFPSA After Care and Qualified Individual Services	$30,163,000 FF, $15,053,000 GF	Qualified Individual component: Requires the independently certified Qualified Individual to perform a detailed assessment to determine if home-based placement and services are more appropriate than residential care and if not, that the placement in a STRTP provides the most effective and appropriate care setting in the least restrictive environment, and the placement is consistent with the short-term and long-term mental and behavioral health goals and permanency plan for the child. Aftercare component: Requires states to provide discharge planning and family-based after care support for at least six months after a child or youth is discharged from an STRTP.

C: DDS FY 19/20

Acute and Mobile Crisis Services

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3	Acute and Mobile Crisis Services	$5.3 million ($4.8 million GF) and $7.9 million ($4.7 million GF) annually thereafter	Expand Crisis Assessment Stabilization Team (CAST) crisis services.

Acute Crisis

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3	Increase in staffing to operate Stabilization Training Assistance Reintegration (STAR) Homes	$11.7 million ($7.3 million GF)	Additional STAR Home in Northern California and two Central Valley STAR homes and a Central Valley Crisis Assessment Stabilization Team.

Reduce Caseload Ratios

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 3, Gap 6	Specialized Caseload Ratios	$3.8 million ($2.6 million GF)	Establish a 1:25 service coordinator-to consumer caseload ratio for consumers with complex needs requiring intensive service coordination for stabilization in the least restrictive setting.

Residential

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3	Development of Community Crisis Homes for Children	$4.5 million one-time GF	To develop community crisis housing specifically for children.
Gap 1, Gap 2, Gap 3	Development of Community Crisis Homes and Enhanced Behavioral Support Homes for Children in Foster Care	$3.6 million one-time Community Placement Plan (CPP)	To develop two Community Crisis Homes and two Enhanced Behavioral Support Homes for youth in foster care.
Gap 1	Specialized Home Monitoring	$5.8 million ($3.9 million GF)	Increase monitoring of Enhanced Behavioral Support Homes and Community Crisis Homes.

System of Care

Gaps	Investment Title	Cost	Summary
Gap 3, Gap 7	State and Regional Center System of Care Staffing	$1.6 million ($1.1 million GF) and $158,000 ($134,000 GF)	Allow regional centers to hire 15 two-year limited-term staff statewide to design and implement the new initiative, one DDS position to implement the requirements of AB 2083, including participating in the joint interagency resolution team and carrying out ongoing functions.

C: DDS FY 21/22

Complex Needs

Gaps	Investment Title	Cost	Summary
Gap 2	Health and safety waivers	$3 million ongoing GF	To assist consumers with identifying and applying for health and safety waivers.

Direct Service Professional Workforce Training and Development

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2	Direct Service Professional Workforce Training and Development	$4.3 million TF ($2.9 million GF)	To establish a training and certification program for direct service professionals tied to wage differentials. The differentials aim to stabilize service access and professionalize and diversify the workforce.

Service Access and Equity

Gaps	Investment Title	Cost	Summary
Gap 1	Bilingual Staff Differentials	$3.6 million TF ($2.2 million GF)	To create a differential for bilingual service provider staff.
Gap 1	Language Access	$10 million ongoing GF	Language Access and Cultural Competency Orientations and Translations for regional center consumers and their families.
Gap 1	Implicit Bias Training	$5.6 million ongoing GF	Implicit Bias Training for all regional center staff as well as contractors involved with intake, assessment, and eligibility determinations.
Gap 1	Services for the Deaf Community	$3.7M RC Ops, $1.9M HQ ongoing GF	To build departmental and regional center expertise on the expansion of service resources for individuals who are deaf and have intellectual and/or developmental disabilities.
Gap 2	Tribal Outreach and Engagement	$0.5 million GF	Conduct engagement and outreach with tribal communities to improve access and utilization of Early Start services.

Lanterman Act Provisional Eligibility

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 3, Gap 6	Lanterman Act Provisional Eligibility (Eligibility for children 3-4)	$23.8 million TF	Provide children ages three and four with provisional Lanterman Act service eligibility.

Rate Increase

Gaps	Investment Title	Cost	Summary
Gap 2, Gap 3	Service Provider Rate Reform	$89.9 million GF	Provider rate increases based on the DDS 2019 Rate Study.

Children's Support and Coordination

Gaps	Investment Title	Cost	Summary
Gap 1	Social Recreation and Camp	$19 million GF	Restore access to regional center services including camping services, social recreation activities, educational services, and nonmedical therapies.
Gap 1, Gap 2, Gap 3	Community Navigators	$5.3 million ongoing GF	Contract with family resource centers for the implementation of a statewide navigator program to provide education on resources, advocacy, and mentorship to parents of individuals served by regional centers.

Reduced Caseload Ratios

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 3, Gap 6	Enhanced Service Coordination for Low-No POS	$10 million TF	Establish an enhanced caseload ratio (1:40) to improve service delivery, benefitting consumers in underserved communities.

Residential

Gaps	Investment Title	Cost	Summary
Gap 1	Specialized home monitoring	$470,000 ($320,000 GF)	Updated for monitoring additional Enhanced Behavioral Support and Community Crisis Homes.
Gap 1, Gap 2, Gap 3	Youth Returning from Out-of-State Foster Care	Increase of $900,000 ($500,000 GF)	Support youth in their transition back to California.

Wraparound: Complex Needs

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3	Systemic, Therapeutic, Assessment, Resources, and Treatment (START) Teams	$8 million GF	Expansion to support individuals in their current residential arrangement and prevent disruptions and admissions into more restrictive settings, such as Institutions for Mental Diseases, out-of-state services, acute psychiatric settings, Community Crisis Homes, and STAR services through the provision of 24-hour crisis services and planning, and by providing training to families, direct support staff, and local partners (e.g., police, hospital staff, teachers) on person-centered, trauma-informed, and evidence-based support services for individuals with co-occurring developmental disabilities and mental health needs.
Gap 1, Gap 2, Gap 3	Forensic Diversion	$3.2 million ($2.0 million GF)	To provide wrap-around services to individuals with I/DD.

Home and Community-Based Services

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2	Home and Community-Based Services (HCBS) American Rescue Plan (ARPA) Act	$1.6 billion TF ($1.1 billion ARPA)	The Budget includes approximately $1.1 billion in HCBS funding made available by ARPA through FY 2023-24. The funding is allocated to six initiatives: Service Provider Rate Reform, Social Recreation and Camp Services, Language Access and Cultural Competency, Coordinated Family Support Services, Enhanced Community Integration for Children and Adolescents, and Modernization of Developmental Services Information Technology Systems.

Early Start Part C (ARPA)

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3	Early Start Part C	Early Start Part C, $26.9 million through January 2024	Support family wellness, develop culturally and linguistically sensitive services, outreach, technology, technical assistance and monitoring, collaboration with CDE and to improve transitions from Part C to B.

C: DDS FY 22/23

Reduced Caseload Ratios

Gaps	Investment Title	Cost	Summary
Gap 3	Enhanced Service Coordination for Low No POS	$14.2 million TF	Establish an enhanced caseload ratio (1:40) to improve service delivery, benefitting consumers in underserved communities.

Gaps	Investment Title	Cost	Summary
Gap 3	Specialized Caseload Ratio for Complex Needs	$4.4 million TF	Establish a 1:25 service coordinator-to consumer caseload ratio for consumers with complex needs requiring intensive service coordination for stabilization in the least restrictive setting.
Gap 3	Reduced caseload ratios for children through age five	$51.5 million	Support families navigating multiple public systems where challenges may limit the benefits and outcomes of Early Start

Wraparound: Complex Needs

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3	START Services	$17.9 million TF	Expansion to support individuals in their current residential arrangement and prevent disruptions and admissions into more restrictive settings, such as Institutions for Mental Diseases, out-of-state services, acute psychiatric settings, Community Crisis Homes, and STAR services through the provision of 24-hour crisis services and planning, and by providing training to families, direct support staff, and local partners (e.g., police, hospital staff, teachers) on person-centered, trauma-informed, and evidence-based support services for individuals with co-occurring developmental disabilities and mental health needs.

Direct Service Professional Workforce Training and Development

Gaps	Investment Title	Cost	Summary
Gap 2, Gap 7	Workforce Stability	$186.4 million GF	To address challenges in recruiting and retaining regional center service coordinators and direct support professionals (DSPs).

Children's Support and Early Start Coordination

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2	Increase preschool inclusion	$10.0 million TF	Resources to increase preschool inclusion of children served by RCs
Gap 1, Gap 2, Gap 3	IDEA Technical support	$3.2 million TF	IDEA Technical support for service coordinators
Gap 1, Gap 2, Gap 3	Coordination and monitoring for Part C to Part be Transitions (DDS HQ Budget Change Proposal)	$1.2 million TF	DDS Coordinating and monitoring actives of Children's Support and Early Start Coordination transitions from Part C to Part B
Gap 1, Gap 2	Early Start Eligibility: Developmental Delay Threshold and Fetal Alcohol Syndrome	$6.5million TF	Support adjustments in identifying children with qualifying signs of developmental delays and highlighting Fetal Alcohol Syndrome as a risk factor for intellectual and/or developmental delays.
Gap 1, Gap 2	Social Recreation & Camp Services	$51.9 million TF	Restore access to regional center services including camping services, social recreation activities, educational services, and nonmedical therapies.

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3	Lanterman Act Provisional Eligibility	$17.4 Million TF	Provide children ages three and four with provisional Lanterman Act service eligibility.

Service Access and Equity

Gaps	Investment Title	Cost	Summary
Gap 1	Communications Assessments for Consumers Who Are Deaf	$15 million ($9 million GF)	One-time funding to support communication assessments that will be used in developing individual program plans to improve services for individuals with intellectual and developmental disabilities who are deaf (Deaf+).
Gap 1, Gap 2	Service Access and Equity Grant Program	$11.8 million GF	Increase the resources currently available for DDS to award to regional centers and community-based organizations through its Service Access and Equity Grant Program, which focuses on supporting strategies to reduce disparities and increase equity in regional center services.

Home and Community-Based Services

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2	Home and Community-Based Services (HCBS) American Rescue Plan (ARPA) Act	($1.6 billion TF, $1.1 billion ARPA)	The Budget includes approximately $1.1 billion in HCBS funding made available by ARPA through FY 2023-24. The funding is allocated to six initiatives: Service Provider Rate Reform, Social Recreation and Camp Services, Language Access and Cultural Competency, Coordinated Family Support Services, Enhanced Community Integration for Children and Adolescents, and Modernization of Developmental Services Information Technology Systems.

Early Start Part C (ARPA)

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3	Early Start Part C	Early Start Part C, $26.9 million through January 2024	Support family wellness, develop culturally and linguistically sensitive services, outreach, technology, technical assistance and monitoring, collaboration with CDE and to improve transitions from Part C to B.

Residential

Gaps	Investment Title	Cost	Summary
Gap 1	Clinical Monitoring Team Support for Specialized Community Homes	$698,000 ($558,000 GF)	Support the development and monitoring of specialized community homes and services for consumers currently placed in, or at risk for placement in, congregate/institutional type settings and/or consumers in crisis.
Gap 1	Specialized Home Monitoring	$12.3 million TF	Monitoring additional new homes.

D: CDE FY 19/20

Foster Youth Services Coordinating Program (FYSCP)

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3, Gap 4, Gap 5	FYSCP	Approximately $26 million	The FYSCP was established by the Legislature in 2015 so that the county office of education (COE) could support interagency collaboration and capacity building, both at the system and individual pupil level, focused on improving educational outcomes for pupils in foster care.

Foster Youth School Stability Provisions

Gaps	Investment Title	Cost	Summary
Gap 5	Foster Youth School Stability Provisions	Policy implementation	• School of origin: EC, section 48853.5[g]; EC, section 48853.5[f][5][B]; EC, Section 48853.5[f][9] • Transportation to school of origin: 20 U.S.C., section 6312[c][5][B] • Immediate enrollment: EC, section 48853.5[f][8][A]-[B] • Timely transfer of records: EC, section 49069.5[d]; EC, section 48853.5[f][8][C]; EC, section 49069.5[e] • Partial credits: EC, section 51225.2[b][1]; EC, section 51225.2[d]; EC, section 51225.2[e] • Graduation under the state minimum requirements (AB 167/216): EC, section 51225.2[a]

Multi-Tiered System of Support (MTSS)

Gaps	Investment Title	Cost	Summary
Gap 5	MTSS	Policy Implementation	In California, MTSS is an integrated, comprehensive framework that focuses on CCSS, core instruction, differentiated learning, student-centered learning, individualized student needs, and the alignment of systems necessary for all students' academic, behavioral, and social success.

Trauma Informed Practices (TIPS) Training

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	TIPS Training	Technical Assistance and Training Resource	TIPS training for educators, teachers, school staff. Development and dissemination of TIPS Newsletter that is shared with caregivers, foster youth liaisons regarding information on how to identify trauma and possible support strategies.

Project Cal-Well

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	Project Cal-Well	$1,188,000	Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Project Cal-Well is designed to raise awareness of mental health and expand access to school and community-based mental health services for youth, families, and school communities.

Senate Bill (SB) 75 Report: Medi-Cal for Students Workgroup Recommendations

Gaps	Investment Title	Cost	Summary
Gap 7	SB 75 Report: Medi-Cal for Students Workgroup Recommendations	State funds	Section 50 of Senate Bill 75 (Chapter 51, Statutes of 2019) added Section 56477 to the EC requiring CDE, DHCS, and DDS to jointly convene one or more workgroups that include representatives from LEAs, appropriate county agencies, regional centers, and legislative staff to provide input and recommendations in the following areas: 1. Improving transition of three-year-old children with disabilities from regional centers to local educational agencies, to help ensure continuity of services for young children and families. 2. Improving coordination and expansion of access to available federal funds through the LEA Medi-Cal Billing Option Program, the School-based Administrative Activities Program, and medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment benefits.

Funding for Special Education Mental Health Services

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	Special Education Mental Health Services	Funding information: Funding details for Special Education Mental Health Services website.	Funds are apportioned to special education local plan areas (SELPA) based on average daily attendance. The purpose of these funds is to provide educationally mental-health related services for students with or without an individualized education program, including out-of-home residential services for emotionally disturbed pupils, pursuant to the federal Individuals with Disabilities Education Act and as described in the EC, sections 56836 and 56836.07.

D: CDE FY 20/21

Foster Youth Services Coordinating Program (FYSCP)

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3, Gap 4, Gap 5	FYSCP	Approximately $26 million	The FYSCP was established by the Legislature in 2015 so that the county office of education (COE) could support interagency collaboration and capacity building, both at the system and individual pupil level, focused on improving educational outcomes for pupils in foster care.

Foster Youth School Stability Provisions

Gaps	Investment Title	Cost	Summary
Gap 5	Foster Youth School Stability Provisions	Policy implementation	• School of origin: EC, section 48853.5[g]; EC, section 48853.5[f][5][B]; EC, section 48853.5[f][9] • Transportation to school of origin: 20 U.S.C., section 6312[c][5][B] • Immediate enrollment: EC, section 48853.5[f][8][A]-[B] • Timely transfer of records: EC, section 49069.5[d]; EC, section 48853.5[f][8][C]; EC, section 49069.5[e] • Partial credits: EC, section 51225.2[b][1]; EC, section 51225.2[d]; EC, section 51225.2[e] • Graduation under the state minimum requirements (AB 167/216): EC, section 51225.2[a]

Multi-Tiered System of Support (MTSS)

Gaps	Investment Title	Cost	Summary
Gap 5	MTSS	Policy Implementation	In California, MTSS is an integrated, comprehensive framework that focuses on CCSS, core instruction, differentiated learning, student-centered learning, individualized student needs, and the alignment of systems necessary for all students' academic, behavioral, and social success.

Trauma Informed Practices (TIPS) Training

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	TIPS Training	Technical Assistance and Training Resource	TIPS training for educators, teachers, school staff. Development and dissemination of TIPS Newsletter that is shared with caregivers, foster youth liaisons regarding information on how to identify trauma and possible support strategies.

Project Cal-Well

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	Project Cal-Well	$1,188,000	Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Project Cal-Well is designed to raise awareness of mental health and expand access to school and community-based mental health services for youth, families, and school communities.

Senate Bill (SB) 75 Report: Medi-Cal for Students Workgroup Recommendations

Gaps	Investment Title	Cost	Summary
Gap 7	SB 75 Report: Medi-Cal for Students Workgroup Recommendations	State funds	Section 50 of Senate Bill 75 (Chapter 51, Statutes of 2019) added Section 56477 to the EC requiring CDE, DHCS, and DDS to jointly convene one or more workgroups that include representatives from LEAs, appropriate county agencies, regional centers, and legislative staff to provide input and recommendations in the following areas: 1. Improving transition of three-year-old children with disabilities from regional centers to local educational agencies, to help ensure continuity of services for young children and families. 2. Improving coordination and expansion of access to available federal funds through the LEA Medi-Cal Billing Option Program, the School-based Administrative Activities Program, and medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment benefits.

Funding for Special Education Mental Health Services

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	Special Education Mental Health Services	Funding information: Funding details for Special Education Mental Health Services website.	Funds are apportioned to special education local plan areas (SELPA) based on average daily attendance. The purpose of these funds is to provide educationally mental-health related services for students with or without an individualized education program, including out-of-home residential services for emotionally disturbed pupils, pursuant to the federal Individuals with Disabilities Education Act and as described in the EC, sections 56836 and 56836.07.

Community Schools Partnership Program (CCSPP)

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	CCSPP	$44,550,000	The CCSPP supports schools' efforts to partner with community agencies and local government to align community resources to improve student outcomes. These partnerships provide an integrated focus on academics, health and social services, youth and community development, and community engagement. A community school is a "whole-child" school improvement strategy where the district and school work closely with teachers, students, families, and partners.

D: CDE FY 21/22

Foster Youth Services Coordinating Program (FYSCP)

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3, Gap 4, Gap 5	FYSCP	Approximately $26 million	The FYSCP was established by the Legislature in 2015 so that the county office of education (COE) could support interagency collaboration and capacity building, both at the system and individual pupil level, focused on improving educational outcomes for pupils in foster care.

Section 141 of Assembly Bill (AB): Foster Youth Direct Service Funding

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 3, Gap 5	Foster Youth Direct Service Funding	$30 million of one-time funding; funds must be expended by June 30, 2024	Allocates $30 million of one-time funding to COEs to provide direct services to foster youth, including, but not limited to, tutoring, mentoring, counseling, and direct interventions addressing reengagement, learning recovery, educational case management or advocacy, postsecondary preparation and matriculation, and the social and emotional needs of pupils in foster care enrolled in kindergarten or grades 1 to 12, inclusive. At least $5 million shall be used to provide direct services to improve postsecondary education enrollment and outcomes, including, but not limited to, postsecondary preparation and matriculation.

Foster Youth School Stability Provisions

Gaps	Investment Title	Cost	Summary
Gap 5	Foster Youth School Stability Provisions	Policy implementation	• School of origin: EC, section 48853.5[g]; EC, section 48853.5[f][5][B]; EC, section 48853.5[f][9] • Transportation to school of origin: 20 U.S.C., section 6312[c][5][B] • Immediate enrollment: EC, section 48853.5[f][8][A]-[B] • Timely transfer of records: EC, section 49069.5[d]; EC, section 48853.5[f][8][C]; EC, section 49069.5[e] • Partial credits: EC, section 51225.2[b][1]; EC, section 51225.2[d]; EC, section 51225.2[e] • Graduation under the state minimum requirements (AB 167/216): EC, section 51225.2[a]

Multi-Tiered System of Support (MTSS)

Gaps	Investment Title	Cost	Summary
Gap 5	MTSS	Policy Implementation	In California, MTSS is an integrated, comprehensive framework that focuses on CCSS, core instruction, differentiated learning, student-centered learning, individualized student needs, and the alignment of systems necessary for all students' academic, behavioral, and social success.

Trauma Informed Practices (TIPS) Training

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	TIPS Training	Technical Assistance and Training Resource	TIPS training for educators, teachers, school staff. Development and dissemination of TIPS Newsletter that is shared with caregivers, foster youth liaisons regarding information on how to identify trauma and possible support strategies.

Funding for Special Education Mental Health Services

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	Special Education Mental Health Services	Funding information: Funding details for Special Education Mental Health Services website.	Funds are apportioned to special education local plan areas (SELPA) based on average daily attendance. The purpose of these funds is to provide educationally mental-health related services for students with or without an individualized education program, including out-of-home residential services for emotionally disturbed pupils, pursuant to the federal Individuals with Disabilities Education Act and as described in the EC, sections 56836 and 56836.07.

California Community Schools Partnership Program (CCSPP)

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	CCSPP	$4.1 billion one-time funding, available through June 30, 2031 Funding Information: California Community Schools Partnership Program website.	The CCSPP supports schools' efforts to partner with community agencies and local government to align community resources to improve student outcomes. These partnerships provide an integrated focus on academics, health and social services, youth and community development, and community engagement. A community school is a "whole-child" school improvement strategy where the district and school work closely with teachers, students, families, and partners.

D: CDE FY 22/23

Foster Youth Services Coordinating Program (FYSCP)

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 3, Gap 4, Gap 5	FYSCP	Approximately $26 million	The FYSCP was established by the Legislature in 2015 so that the county office of education (COE) could support interagency collaboration and capacity building, both at the system and individual pupil level, focused on improving educational outcomes for pupils in foster care.

Section 141 of AB: Foster Youth Direct Service Funding

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 3, Gap 5	Foster Youth Direct Service Funding	$30 million of one-time funding; funds must be expended by June 30, 2024	Allocates $30 million of one-time funding to COEs to provide direct services to foster youth, including, but not limited to, tutoring, mentoring, counseling, and direct interventions addressing reengagement, learning recovery, educational case management or advocacy, postsecondary preparation and matriculation, and the social and emotional needs of pupils in foster care enrolled in kindergarten or grades 1 to 12, inclusive. At least $5 million shall be used to provide direct services to improve postsecondary education enrollment and outcomes, including, but not limited to, postsecondary preparation and matriculation.

Foster Youth School Stability Provisions

Gaps	Investment Title	Cost	Summary
Gap 5	Foster Youth School Stability Provisions	Policy implementation	• School of origin: EC, section 48853.5[g]; EC, section 48853.5[f][5][B]; EC, section 48853.5[f][9] • Transportation to school of origin: 20 U.S.C., section 6312[c][5][B] • Immediate enrollment: EC, section 48853.5[f][8][A]-[B] • Timely transfer of records: EC, section 49069.5[d]; EC, section 48853.5[f][8][C]; EC, section 49069.5[e] • Partial credits: EC, section 51225.2[b][1]; EC, section 51225.2[d]; EC, section 51225.2[e]

Gaps	Investment Title	Cost	Summary
			• Graduation under the state minimum requirements (AB 167/216): EC, section 51225.2[a]

Multi-Tiered System of Support (MTSS)

Gaps	Investment Title	Cost	Summary
Gap 5	MTSS	Policy Implementation	In California, MTSS is an integrated, comprehensive framework that focuses on CCSS, core instruction, differentiated learning, student-centered learning, individualized student needs, and the alignment of systems necessary for all students' academic, behavioral, and social success.

Trauma Informed Practices (TIPS) Training

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	TIPS Training	Technical Assistance and Training Resource	TIPS training for educators, teachers, school staff. Development and dissemination of TIPS Newsletter that is shared with caregivers, foster youth liaisons regarding information on how to identify trauma and possible support strategies.

Funding for Special Education Mental Health Services

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	Special Education Mental Health Services	Funding information: Funding details for Special Education Mental Health Services website.	Funds are apportioned to special education local plan areas (SELPA) based on average daily attendance. The purpose of these funds is to provide educationally mental-health related services for students with or without an individualized education program, including out-of-home residential services for emotionally disturbed pupils, pursuant to the federal Individuals with Disabilities Education Act and as described in the EC, sections 56836 and 56836.07.

School-Based Health Programs

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	School Based Health Programs	Request for Applications Information: Lead Local Education Agency Medi-Cal Billing Option Program Specialist website. School Health Demonstration Project Technical Assistance Teams Selection website. School Health Demonstration Project Local Education Agency Pilot Participant website.	Successful School-based Health Programs are built through collaboration and support between school and district administrators, school nurses, mental health professionals, school counselors, psychologists and social workers, state and federal partners, statewide local agencies, community-based organizations, and other partners. Through these programs, school health and mental health professionals are able to develop and implement preventative programming and intervention strategies to address students' physical, mental, and behavioral health needs.

Community Schools Partnership Program (CCSPP)

Gaps	Investment Title	Cost	Summary
Gap 1, Gap 2, Gap 5	CCSPP	$4.1 billion one-time funding, available through June 30, 2031 Funding Information: California Community Schools Partnership Program website.	The CCSPP supports schools' efforts to partner with community agencies and local government to align community resources to improve student outcomes. These partnerships provide an integrated focus on academics, health and social services, youth and community development, and community engagement. A community school is a "whole-child" school improvement strategy where the district and school work closely with teachers, students, families, and partners.

DATA ADDENDUMS

LIMITATIONS

The data contained in this report provides current analysis of the needs and circumstances of children and families in foster care in California. It highlights information collected via various data sources across departments, as well as information collected via the State TA process regarding youth that have demonstrated the most complex and acute needs over the past year – needs that are often difficult to support within the current California continuum of services and supports, including placement. While more thorough analysis with rigorous methodologies will be produced in December 2022 utilizing linkage keys to link foster care data across DHSC, CDSS, DDS, and CDE to provide a multi-system landscape analysis, offering for the first time an opportunity to understand service system interactions, this report confirms many of the barriers and challenges that have been identified by stakeholders and local agencies regarding support of youth with significant trauma.

Data sources and data elements were selected from available data sets, individual departments' data sets, and data sets as self-reported by the local partners. These data sets have varying reporting lags, so data time periods for some topics may not align across all sources. Additionally, values between one and ten in some data sets are suppressed for confidentiality: some counties' data may not be represented. Additional values (the lowest available) are sometimes concealed to prevent calculation of values of ten or less from totals. The CYSOCSTA team has been able to observe local county decisions and processes, which has provided a unique lens in understanding the currently limited data.

Cross-departmental data matching across all four departments is not yet available; however, it is a primary objective to utilize cross-agency matched data across all four departments for subsequent reports.

CDSS ADDENDUM

The data and information presented within this section of the gaps analysis report and for AB 2083 was extracted from the Child Welfare Services/Case Management System (CWS/CMS), publicly available data on the CDSS webpage, the CCR Oversight Report to the California State Legislature (January 2022), and additional sources as noted. Administrative data examined and presented include:

- Youth breakdown by age
- Sex at birth
- Ethnicity
- Entries of youth into foster care
- 1-year period: Length of time of youth in foster care by placement type
- Disruptions of placements of youth in Resource Family Homes
- Disruptions of placements of youth in STRTPs
- Early childhood data analyses
- STRTP data analyses
- Child and Family Team Meetings
- Relative Placement Indicators
- First placement comparison data (entry cohort data when children placed with relatives as first placement where are they one year later versus stranger foster care first placement where are they one year later)

CDSS Figure 1: Children in Foster Care[132]

Age Group	January 1, 2022 (n)
Under 1	3,650
1-2	7,581
3-5	7,917
6-10	11,150
11-15	11,945
16-17	5,731
18-21	7,565
Missing	0
Total	55,539

[132] Data Source: CWS/CMS 2021 Quarter 4 Extract. Program version: 2.00 Database version: 74DA965E

Ethnic Group	January 1, 2022 (n)
Black	11,653
White	11,928
Latino	29,266
Asian/P.I.	1,175
Nat Amer	668
Missing	849
Total	55,539

Sex at Birth	January 1, 2022 (n)
Female	27,975
Male	27,559
Intersex	0
Missing	5
Total	55,539

CDSS Figure 2: Children in Foster Care[133] (Probation)[134]

Age Group	January 1, 2022 (n)
Under 1	0
1-2	0
3-5	0
6-10	0
11-15	119
16-17	465
18-21	1,042
Missing	0
Total	1,626

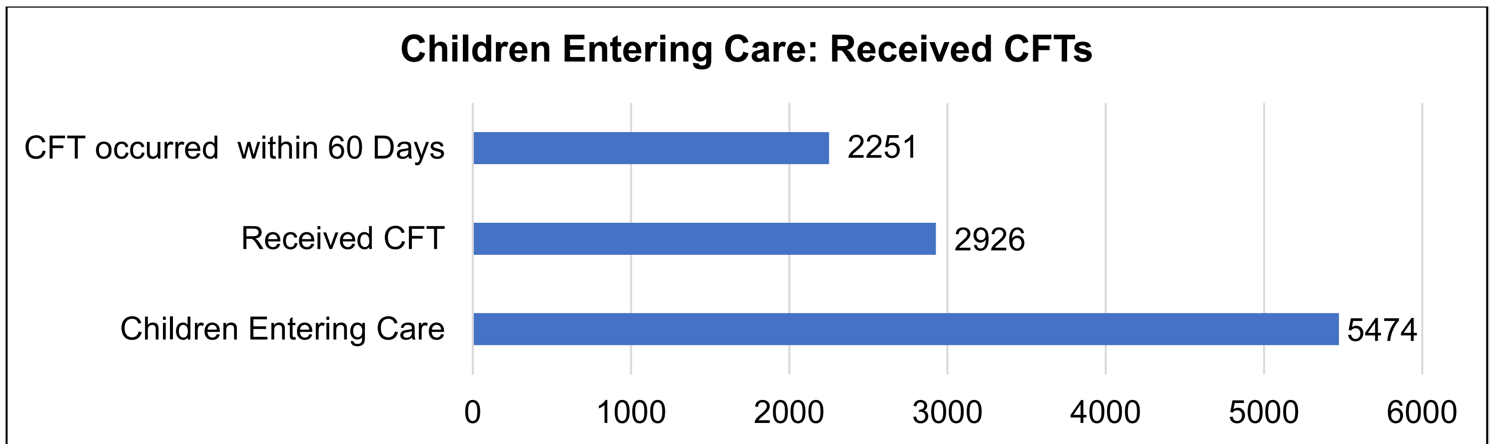
[133] This section refers to youth between 12 years of age and 17 years of age who have been adjudged a ward of the juvenile court, pursuant to WIC, section 602, whom probation is responsible for the provision of child welfare services and who are under the supervision of the juvenile court but are not dually served by child welfare and probation, per WIC, section 241.1.

[134] Data Source: CWS/CMS 2021 Quarter 4 Extract. Program version: 2.00 Database version: 74DA965E

Ethnic Group	January 1, 2022 (n)
Black	451
White	327
Latino	781
Asian/P.I.	33
Nat Amer	14
Missing	20
Total	1,626

Sex at Birth	January 1, 2022 (n)
Female	370
Male	1,256
Intersex	0
Missing	0
Total	1,626

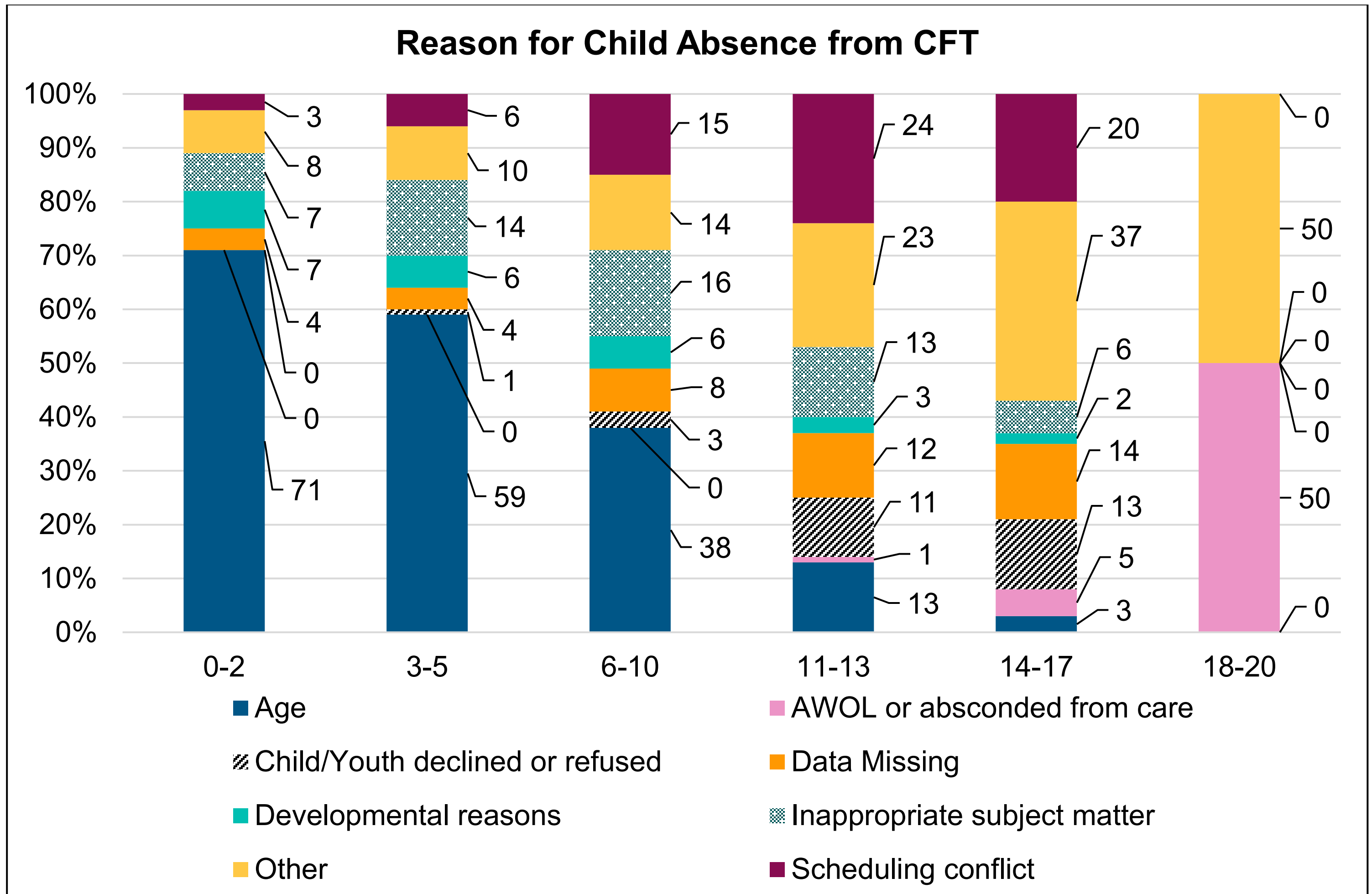
CDSS Figure 3: Children Entering Care: Received CFTs[135]



Note: CDSS Figure 3 numeric data is located on page 158.

[135] Data Source: CWS/CMS as of 4/3/2022; Timeframe: 7/1/2021 – 9/30/2021; Of the 5,474 youth who entered care during 7/1/2021 through 9/30/2021, 2,926 received a CFT and, of those, 2,251 received it timely.

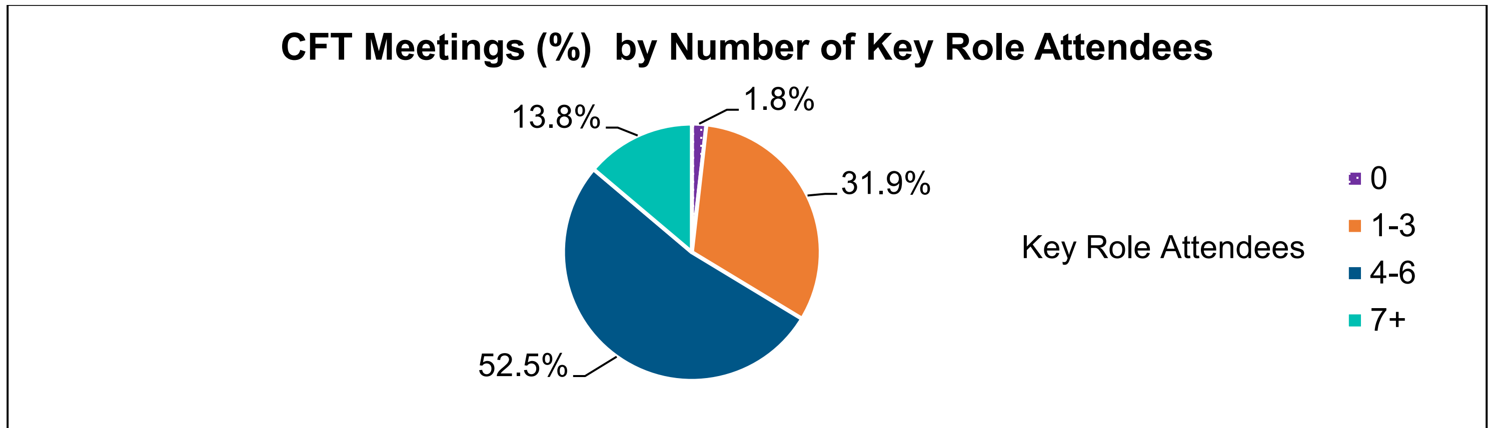
CDSS Figure 4: Child and Family Team Meetings: Participation[136]



Note: CDSS Figure 4 numeric data is located on page 158.

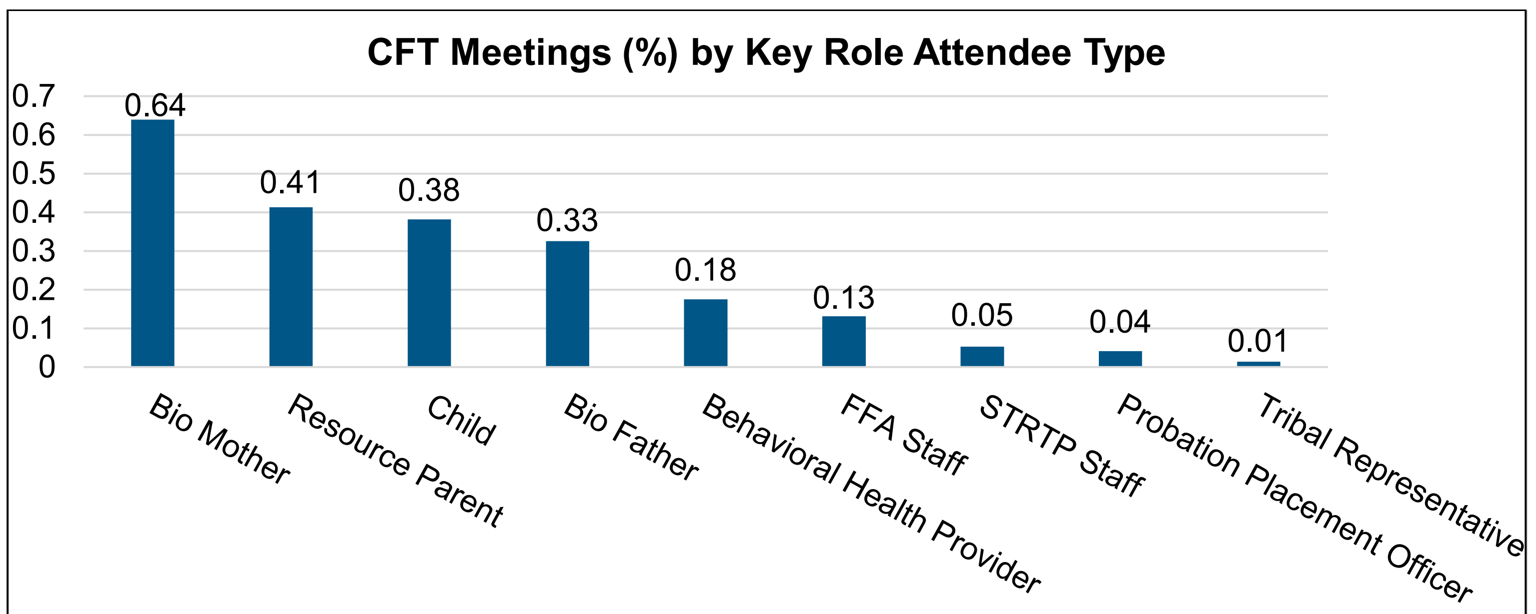
[136] Data Source: CWS/CMS as of 4/3/2022; Timeframe: 7/1/2021-9/30/2021; Report does not include children and youth who were in care for less than 60 days, based on their longest placements that started during the quarter; Multiple reasons can be selected per absence; 'Legal',' 'Medical,' 'No Access to Technology,' 'Recommendation of Clinician,' and 'Transportation' are combined with 'Other.'

CDSS Figure 5: CFT Meetings (%) by Number of Key Role Attendees[137]



Note: CDSS Figure 5 numeric data is located on page 158.

CDSS Figure 6: CFT Meetings (%) by Key Role Attendee Type[138]



Note: CDSS Figure 6 numeric data is located on page 159.

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[137] Data Source: CWS /CMS as of 4/3/2022; Timeframe: 7/1/2021-9/30/2021; Definition of Key Role Attendees: The CFT composition always includes the child or youth, family members, the current caregiver, a representative from the placing agency, and other individuals identified by the family as being important. A CFT shall also include a representative of the child or youth's tribe or Indian custodian, behavioral health staff, foster family agency social worker, or short-term residential therapeutic program (STRTP), when applicable (ACL No. 16-84/MHSUDS No. 16-049).

[138] Data Source: CWS/CMS as of 4/3/2022; Timeframe: 7/1/2021-9/30/2021; Report does not include children and youth who were in care for less than 60 days, based on their longest placements that started during the quarter.

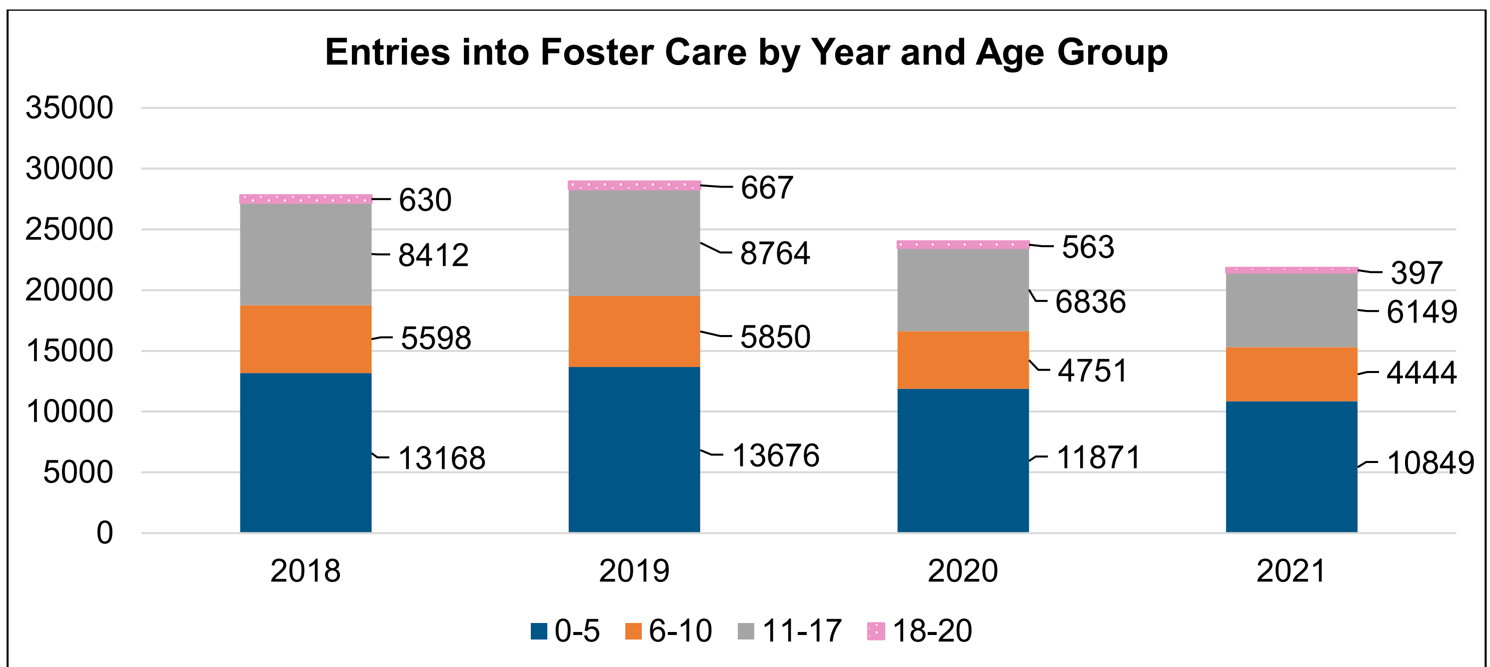
CDSS Figure 7: Previously Adopted Youth in Foster Care 2021

Age	Count
Under 18 Years	1,073
18 Years and Older	624
Total	1,697

Figure 7 is a subset of foster children who re-enter the child welfare system as “Previously Adopted”. “Previously Adopted" is defined as any youth adopted prior to entering foster care through either a private or public adoption agency and identified as being previously adopted through the use of the "Previously Adopted" indicator selected in the CWS/CMS. Age was calculated as of January 1, 2021 if the foster care episode began before 2021, or as of the start of the episode if it started during 2021.

Early Childhood Needs

CDSS Figure 8: Entries into Foster Care by Age Group and Year[139]



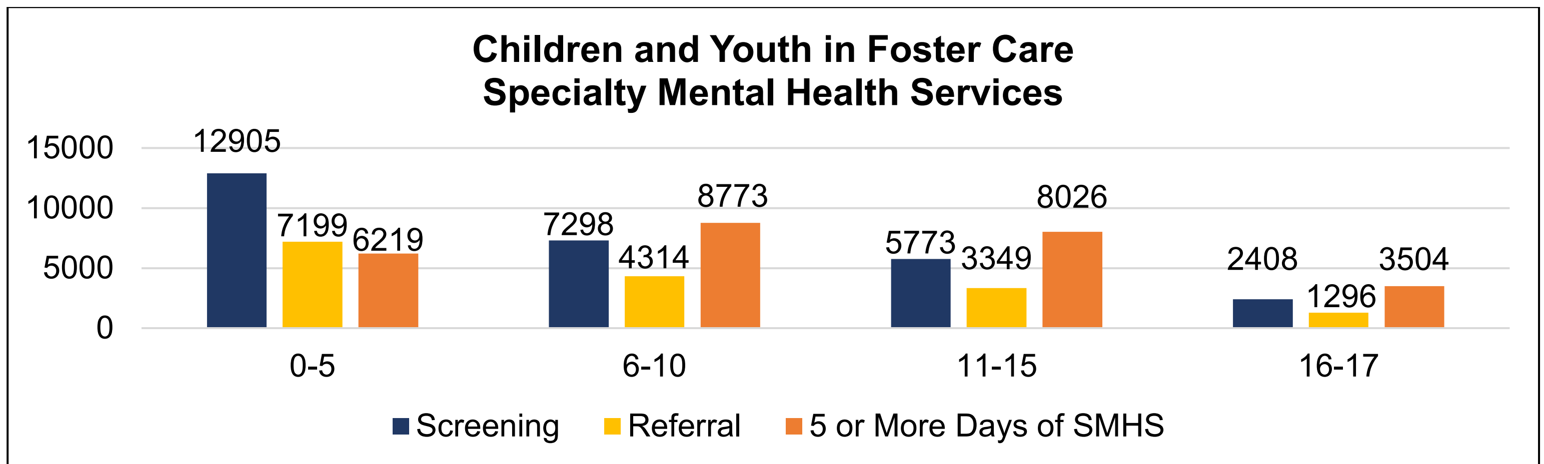
Note: CDSS Figure 8 numeric data is located on page 159.

Figure 8 shows that the overall number of children entering foster care has decreased by 21 percent between 2018 to 2021. However there has been a 2.3 percent increase in proportion of children 0-5 entering foster care. It should also be noted that half of all children entering foster care in 2021 were 0-5.

139 Data Source: CCWIP; CWS/CMS 2021 Quarter 4 Extract; Includes Child Welfare and Probation; All Children Entries into Care, 8 Days or More

CDSS Figure 9: Children and Youth in Foster Care – Specialty Mental Health Services[140]

Figure 9 shows the total number of children in care for whom Mental Health Screening requirements were met (shown in blue) and those with a Mental Health Referral (orange). Additionally, the chart shows how many youths received five or more days of Specialty Mental Health Services regardless of if they were screened or referred. The chart is broken out by Age Group for the period of January through December 2017. This dataset includes children already receiving SMHS upon entry into foster care.



Note: CDSS Figure 9 numeric data is located on page 159.

Level of Care Protocol (LOC) Protocol and Intensive Services Foster Care (ISFC)

The passage of AB 403 necessitated the implementation of a new rate setting system to support the goals of the CCR effort, and although the LOC Protocol is focused on the rate determination, it recognizes the value and importance of the role of the Resource Family when caring for a child. An eligible child for ISFC is a child or nonminor dependent in foster care who requires a higher level of care and supervision as determined by the LOC Protocol.

The LOC Protocol's primary focus is on the role of the Resource Family in meeting the care and supervision needs of the child, based on five Core Domains. Within each domain, there are increasing levels of expectations that correlate with a point system and the LOC protocol allows social workers and probation officers to score each domain based on the child's care and supervision needs.[141]

The goal of the ISFC program is to ensure that youth in foster care receive the services they need in a home-based family care setting or to avoid or exit a short-term residential therapeutic program or group

[140] Data Source: CDSS Continuum of Care Reform Data Dashboard: Related Services – Mental Health Care: Screenings and Referrals, Specialty Mental Health Services – Total Number of Children; January-December 2017. (Note: includes children already receiving SMHS upon entry into foster care)
[141] ACL No. 17-11, ACL No. 17-111, and ACL No.18-06

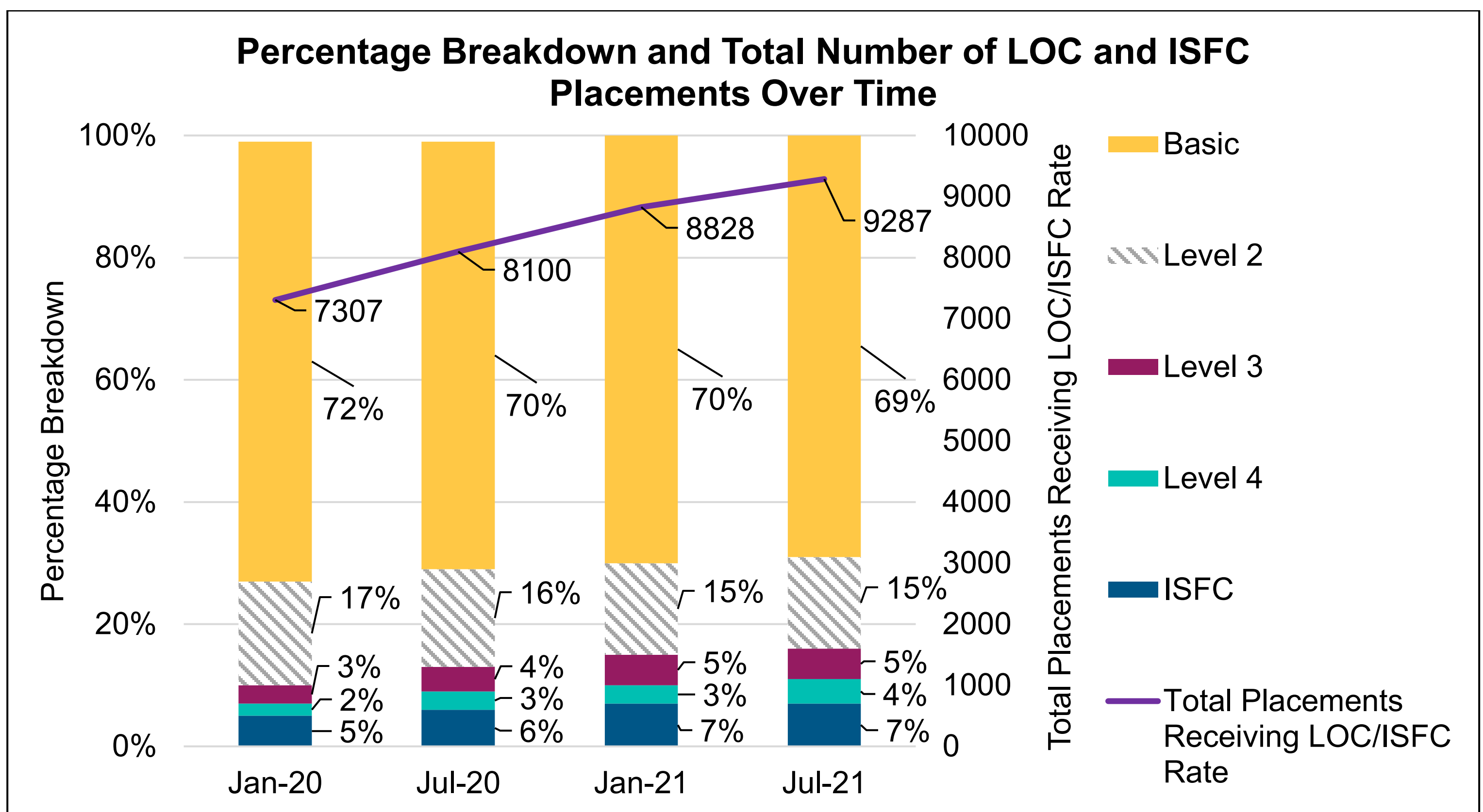
home (GH). The program requires specially trained resource parents and professional and paraprofessional support.

Consistent with CCR, the ISFC program provides core services and supports to a child in foster care. These core services may include, but are not limited to, arranging access to mental health treatment, providing trauma informed care, and providing transitional support from foster placement to permanent home placement.[142]

On July 1, 2021, there were 9,287 FFA and other home-based placements that received an LOC/ISFC rate statewide.

Below (Figure 10) is a percentage breakdown of the placements by LOC and ISFC for the first day of January and July in 2020 and 2021.

CDSS Figure 10: Percentage Breakdown and Total Number of LOC and ISFC Placements[143]



Note: CDSS Figure 10 numeric data is located on page 160.

[142] ACL No.18-25
[143] Data Source: CWS/CMS; Point-In-Time 7/1/2021

Specialty Mental Health Services (SMHS) Utilization:

DHCS released Behavioral Health Information Notice (BHIN) No. 21-073 to clarify SMHS access within the California Advancing and Innovating Medi-Cal (CalAIM) initiative. For youth under 21 years of age, SMHS sustain, support, improve, or make more tolerable a mental health condition and are covered Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

The provision of SMHS is available for youth who have a mental illness or condition discovered by a screening service and county MHPs shall provide medically necessary SMHS for youth who are placed at high risk for a mental health disorder due to experiencing trauma as evidenced by:

- scoring in the high-risk category of a trauma screening tool,
- involvement in the child welfare system,
- involvement in the juvenile justice involvement, or
- are experiencing homelessness.[144]

Figure 11 shows the penetration and engagement rates broken down by placement facility type for the 2020 Calendar Year. In order to assess penetration and engagement rates by placement facility type, the "predominant placement" for services or placement duration was calculated.

A higher proportion of children in STRTPs, GHs, and county shelter/receiving homes received SMHS ("Penetration Rate") than children in other placements. More than half of children placed in foster family homes received one or more SMH service during this time period, with similar rates for FFA approved and Relative/NREFM Homes. This overall pattern holds for engagement rates as well, except that the rate for county shelters/receiving homes (40.3 percent) more closely resembles Relative/NREFM and foster family homes than STRTPs and GHs. The STRTPs and GHs were the only facility types wherein more than half of the children received five or more services, and STRTPs are associated with an exceptionally high engagement rate (82.9 percent), which also indicates that nearly everyone in an STRTP who receives one service eventually receives five or more.[145]

[144] Behavioral Health Information Notice (BHIN) No. 21-073

[145] Continuum of Care Reform Oversight Report, Continuum of Care Reform Branch, California Department of Social Services, August 2021, California Department of Social Services. Continuum of Care Reform Branch. Continuum of Care Reform Oversight Report, 2021.

CDSS Figure 11: Penetration and Engagement Rate of SMHS for Children in Foster Care

Predominant Placement Type[146]	Total # of Children[147]	Children with 1+ Days of SMHS	Penetration Rate	Children with 5+ Days of SMHS	Engagement Rate
STRTP	4,152	3,710	89.4%	3,440	82.9%
County Shelter/Receiving Home	588	454	77.2%	237	40.3%
Group Home	784	506	64.5%	447	57.0%
Foster Family Agency Certified Home	15,026	8,774	58.4%	7,077	47.1%
Foster Family Home	9,722	5,603	57.6%	4,571	47.0%
Relative/NREFM Home	24,774	12,459	50.3%	9,797	39.5%
Transitional Housing	1,729	755	43.7%	586	33.9%
Pre-Adoptive Home	1,308	497	38.0%	358	27.4%
Guardian Home	975	366	37.5%	315	32.3%
Non-Foster Care	731	254	34.7%	170	23.3%
Supervised Independent Living Placement	2,573	598	23.2%	436	16.9%
Court Specified Home	329	43	13.1%	33	10.0%
Missing	1,131	308	27.2%	217	19.2%
Total (not including children served only at home)	63,822				
In Foster Care at Some Point During Time Period but Served Only While in Home	1,232				
Total	*65,054*	*34,327*	*52.8%*	*27,684*	*42.6%*

[146] Data Source: CWS/CMS; Point-in-time 6/22/2021 from 2021 Q1 data set. DHCS data pulled on 4/29/2021 from 2020 Q4 data set. Engagement Rate is the percentage of kids who received five or more days of Specialty Mental Health Services in a year. Similarly, Penetration Rate is the percentage who received at least one SMHS in a year.

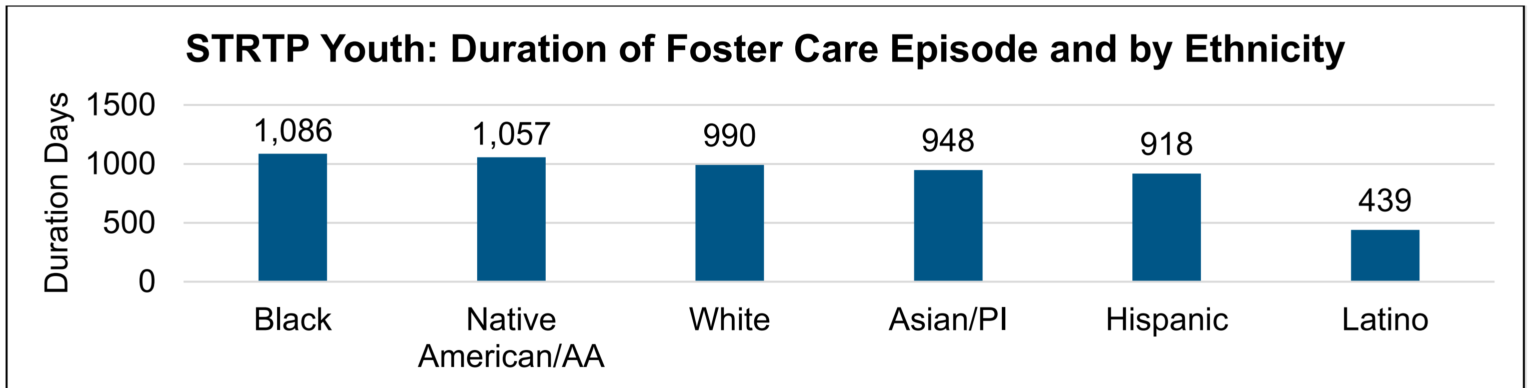
[147] The total population for each facility type is determined by combining the predominant placements by services for those who received an SMHS with the predominant placement by duration of stay for those who did not receive any SMHS services.

STRTP Demographics

The charts below reflect an analysis of all youth who experienced an STRTP placement at any point between July 1, 2019 and August 20, 2021 and then looked back at their placement history, starting from when their episode began.

Figure 12 reflects the disproportionality of youth experiencing a placement in an STRTP with respect to the total duration of the child's foster care episode. The longest average cumulative duration in STRTPs (>1000 days) are for Black and Native American youth (note that this looks at totals over multiple placements into an STRTP). The highest number of average placements (>5 placements) again are for Black and Native American youth.

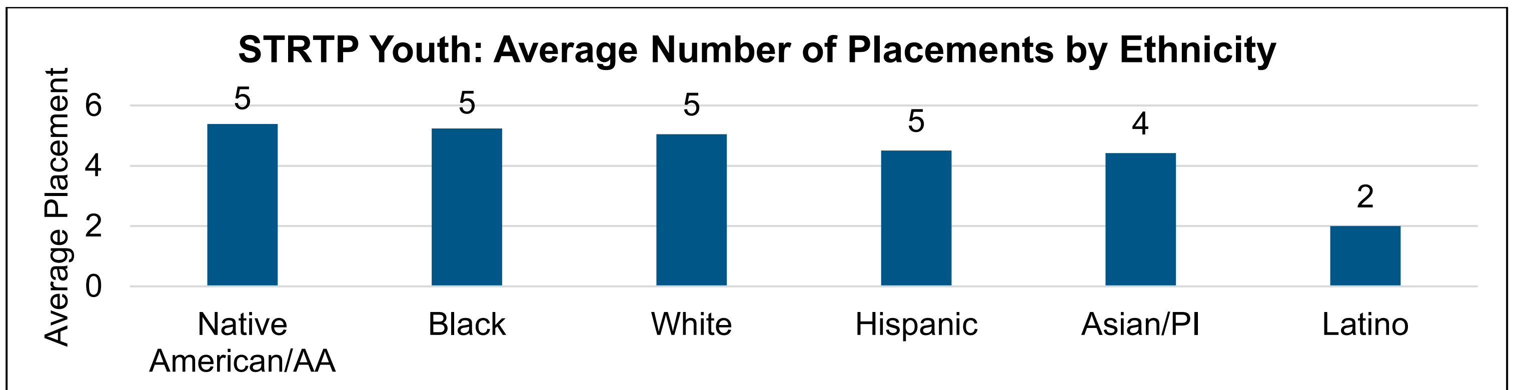
CDSS Figure 12: STRTP Youth: Duration of Foster Care Episode and by Ethnicity[148]



Note: Duration is a CWS/CMS definition for the length of the entire placement episode for the entire time in Care, regardless of what type of Care. CDSS Figure 12 numeric data is located on page 160.

CDSS Figure 13: STRTP Youth: Average Number of Placements and by Ethnicity[149]

The data in Figure 13 compares the average number of placements for all placement types by ethnicity for youth who were in an STRTP at any point during the period of 7/1/2019 through 8/20/2021.

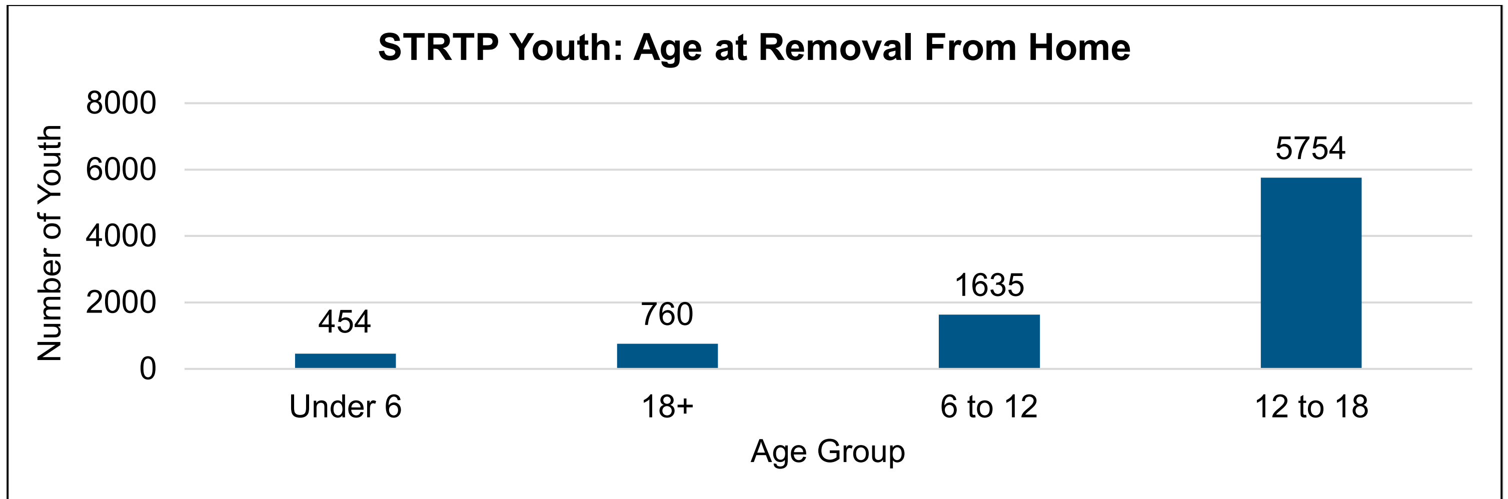


Note: CDSS Figure 13 numeric data is located on page 160.

[148] Data Source: CWS/CMS 9/20/2021; Time Period: 7/1/2019 through 8/20/2021
[149] Data Source: CWS/CMS 9/20/2021; Time Period: 7/1/2019 through 8/20/2021

CDSS Figure 14: Age of Youth at Removal within Current Episode[150]

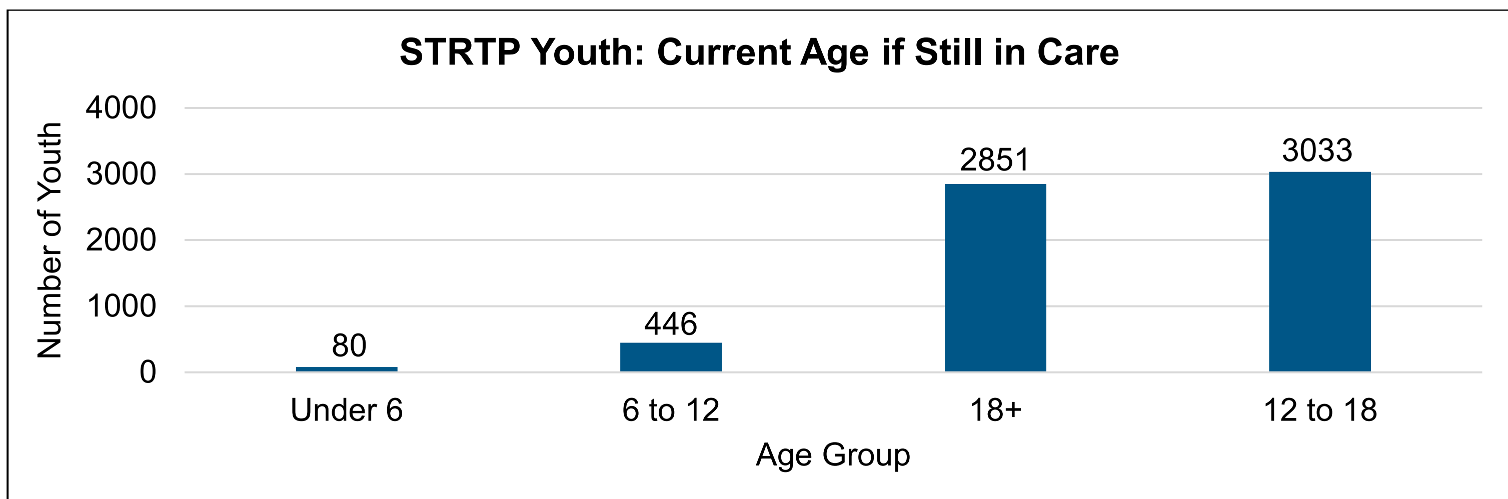
Figure 14 depicts the Age of Removal from Home for youth that were in an STRTP at any point between July 1, 2019 through August 20, 2021. The majority of youth (5,754) were between 12 and 18 years old when they entered foster care. It is significant to note that for the children experienced an STRTP placement during this time period, 454 children entered care when they were under the age of six.



Note: CDSS Figure 14 numeric data is located on page 161.

CDSS Figure 15: STRTP Youth: Current Age if Still in Care[151]

The data in Figure 15 reflect age of youth on August 20, 2021 if they were still in care on that date and placed in an STRTP at any point during the period of July 1, 2019 through August 20, 2021.



Note: CDSS Figure 15 numeric data is located on page 161.

[150] Data Source: CWS/CMS 9/20/2021; Time Period: 7/1/2019 through 8/20/2021
[151] Data Source: CWS/CMS 9/20/2021; Time Period: 7/1/2019 through 8/20/2021

CDSS Figure 16: Available Home Data - Child Welfare and Juvenile Probation Supervised Placements[152]

Although CWS/CMS does not have an indicator to identify homes that are approved to accept ISFC placements, we are able to look at youth receiving the ISFC rate and thereby identify homes through the youth placed. This would not account for homes that have been approved but have never taken an ISFC placement. Using ISFC placements as a proxy to identify ISFC homes, we found that on March 1, 2020 there were 464 with an ISFC placement, and an additional 136 homes that had at least one ISFC placement in the preceding 12 months, for a total of 600 ISFC homes. There was a total of 366 STRTP facilities with at least one placement between March 1, 2019 and March 1, 2020.

Type of Home	# Homes with at least 1 placement on March 1, 2020	# Homes with no placements on March 1, 2020, but at least 1 placement between March 1, 2019 and February 28, 2020*	Total Homes
TOTAL HOMES/ FACILITIES	31,556	24,034	55,590
Court Specified Home	325	262	587
FFA	1,552	2,230	3,782
Foster Family Home	505	502	1,007
Group Home	210	144	354
Guardian-Dependent	571	1,318	1,889
ISFC	464	136	600
Pre-Adopt	1,539	2,844	4,383
RFH FFA Non-Relative	4,198	1,995	6,193
RFH FFA Relative/NREFM	221	131	352
RFH Non-Relative	4,449	2,092	6,541
RFH Relative/NREFM	10,934	5,420	16,354
Relative/NREFM Home	905	1,469	2,374
SILP	3,510	4,556	8,066
STRTP	338	28	366

[152] Data Source: CWS/CMS 2022 Q1; Placement Type is based on the most recent placement in the home/facility; Counts only include homes/facilities that were not end-dated as of 3/1/20

Type of Home	# Homes with at least 1 placement on March 1, 2020	# Homes with no placements on March 1, 2020, but at least 1 placement between March 1, 2019 and February 28, 2020*	Total Homes
Shelter	10	10	20
Transitional Housing	1,825	897	2,722
Trial Home Visit	N/A	N/A	N/A

Short Stays (<14 days)

In the charts below, the data reflects placements and stays shorter than 14 days between January 1, 2019 through June 30, 2020. The figures highlight the need for the availability of committed and trauma-informed family homes for youth, considering what is known about trauma, attachment, cognitive, and emotional impacts of caregiver disruption.

CDSS Figure 17: Placements Less Than 14 days – by Facility Type[153]

Facility Type	Total # of Unique Youth	Total Placements Under 14 Days	Total Indicated as Emergency Placements
County RFA/NREFM	2,165	2,398	212
FFA Certified or RFA	3,245	3,598	201
Court Specified Home	34	35	4
Guardian Home	23	23	0
Tribe Specified Home	6	6	0
SILP	129	139	0
Small Family Home	10	10	0
STRTP	770	939	1
TSCF	1,148	1,660	1,241
Grand Total	7,042	8,808	1,659

[153] Data Source: CWS/CMS 9/28/2021; Time Period: 1/1/2019 through 6/30/2020

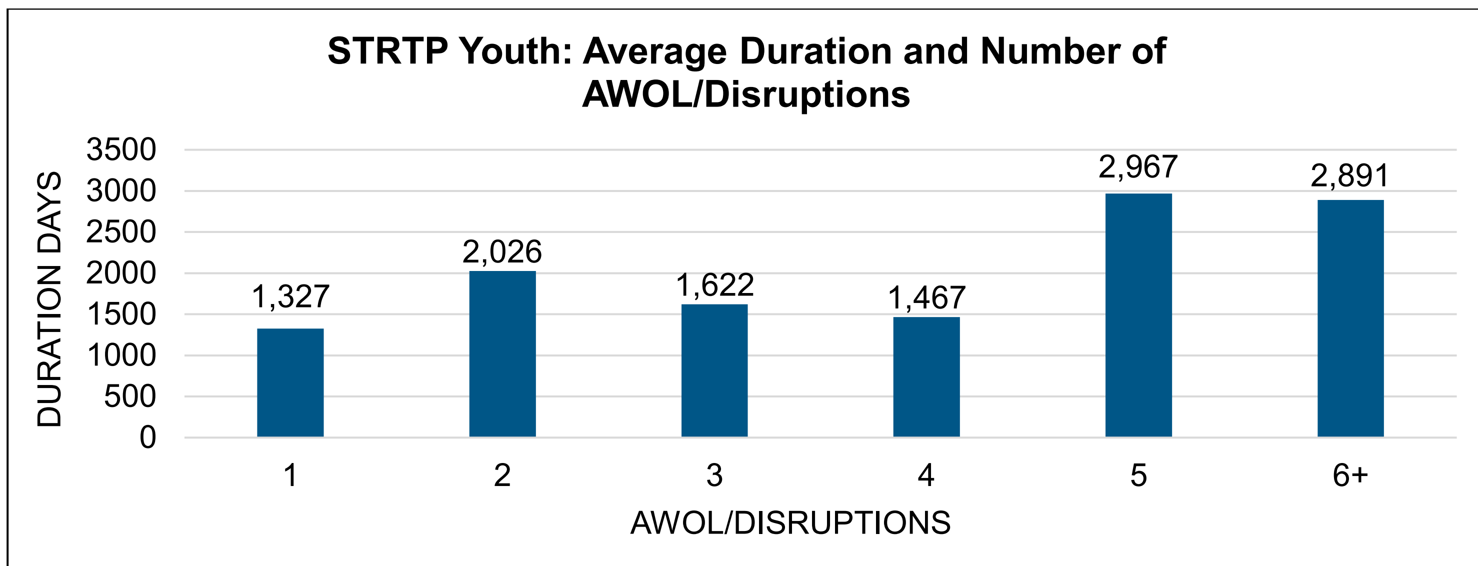
CDSS Figure 18: Placements Less than 14 Days by Age Group

Placements Less than 14 Days - By Age Group[154]

Age Group	Total # of Unique Youth	Total Placements Under 14 Days	Total Indicated as Emergency Placements
Less than 1	240	253	50
1 to 2	1,082	1,182	256
3 to 5	1,060	1,196	234
6 to 10	1,494	1,701	282
11 to 14	1,179	1,588	349
15 to 17	1,250	1,808	284
18 to 20	694	1,034	204
All Youth	6,999	8,762	1,659

CDSS Figure 19: STRTP Youth: Average Duration and Number of AWOL/Disruptions[155]

The data in Figure 19 reflect the average duration and the number of AWOL/Disruptions for youth placed in an STRTP at any point during the time period of July 1, 2019 through August 20, 2021. AWOL Days are included in the total days in care. For children who were placed in STRTPs at any point in their time in foster care, those who had a longer duration in care had an increase in the number of disruptions.

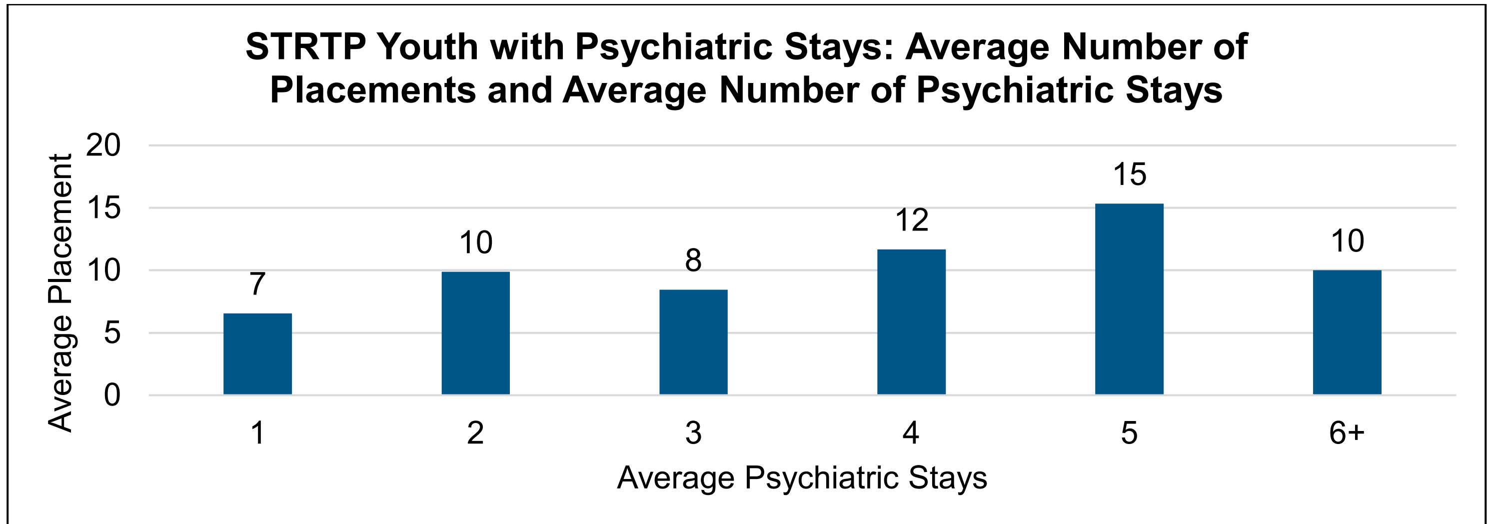


Note: Disruptions are related to provider request for removal, runaway, lack of engagement in program, child's behaviors, unapproved placement. CDSS Figure 19 numeric data is located on *page 161*.

[154] Data Source: CWS/CMS 9/28/2021; Time Period: 1/1/2019 through 6/30/2020
[155] Data Source: CWS/CMS 9/20/2021; Time Period: 7/1/2019 through 8/20/2021

CDSS Figure 20: STRTP Youth with Psychiatric Stays: Average Number of Placements and Number of Psychiatric Stays[156]

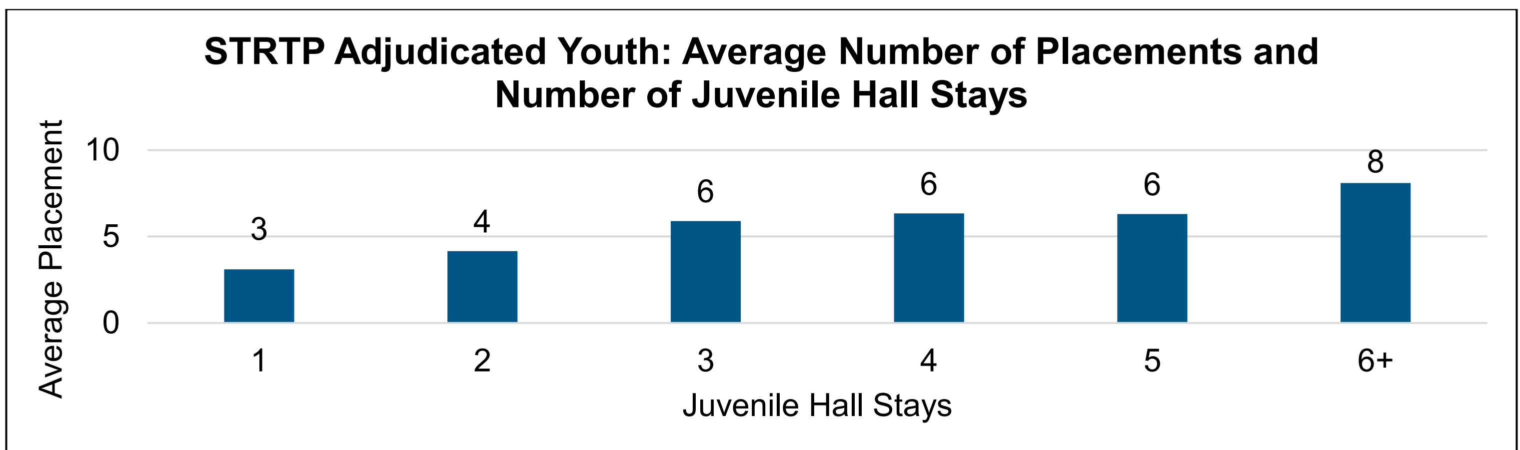
The data below reflects the average number of all placements and number of psychiatric stays for a total of 345 unique youth placed at an STRTP at any point during the period of 07/01/2019 through 8/20/2021.



Note: CDSS Figure 20 numeric data is located on page 161.

CDSS Figure 21: STRTP Youth: Comparison of Average Number of Placement and Number of Juvenile Hall Stays[157]

Figure 21 shows the relationship between the average number of placements and the number of Juvenile Hall stays for a total of 1,208 unique youth who were both placed at an STRTP and were adjudicated youth at any point during the period of July 1, 2019 through August 20, 2021.

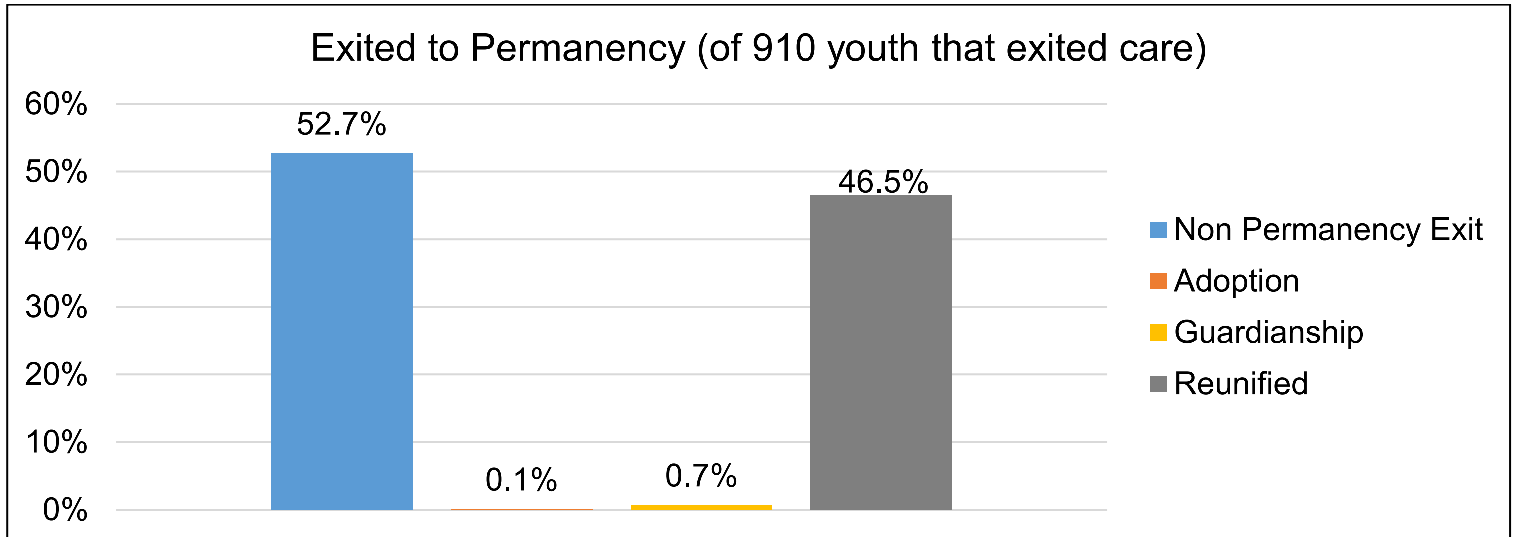


Note: CDSS Figure 21 numeric data is located on page 162.

[156] Data Source: CWS/CMS 9/20/2021; Time Period: 7/1/2019 through 8/20/2021
[157] Data Source: CWS/CMS 9/20/2021; Time Period: 7/1/2019 through 8/20/2021

CDSS Figure 22: Exited to Permanency (of 910 youth that exited care)[158]

Figures 22-24 show youth placed in an STRTP at any point during the timeframe of June 1, 2020 through June 30, 2021.



Note: CDSS Figure 22 numeric data is located on page 162.

CDSS Figure 23: Percent Exiting Care From Congregate Care vs After Congregate During Study Period (n=910 youth)[159]

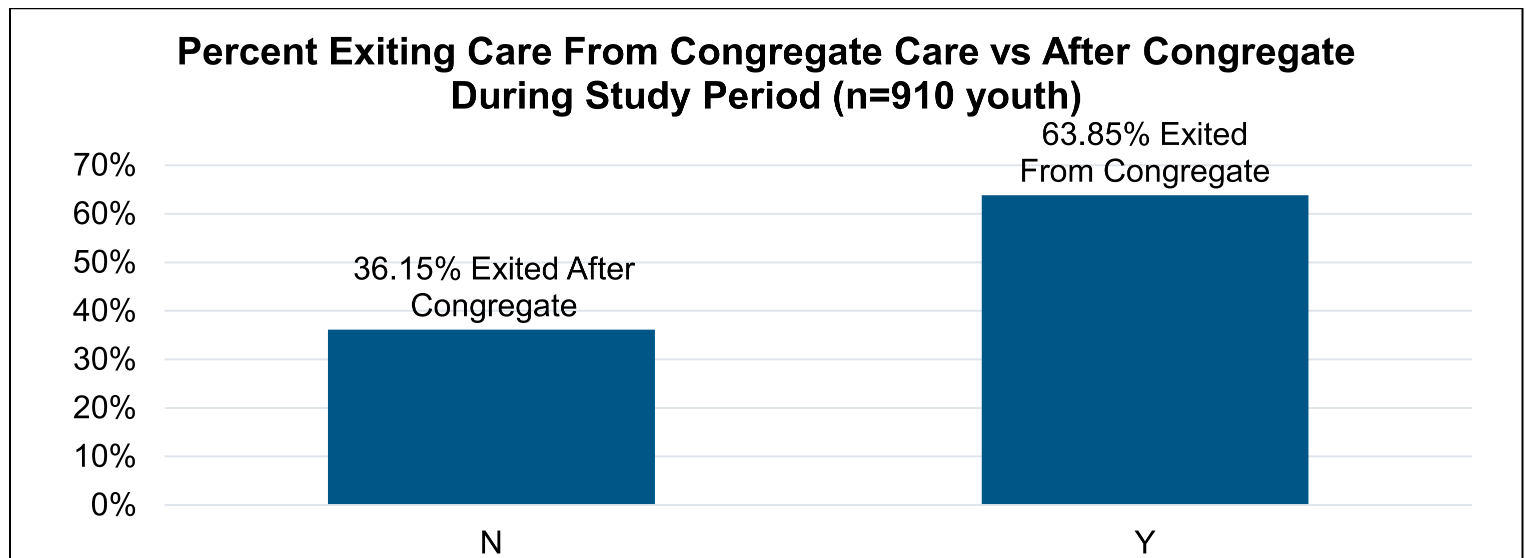


Figure 23 above, shows that nearly 64 percent of the children exiting foster care are exiting from congregate settings. Note: CDSS Figure 23 numeric data is located on page 162.

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[158] Data Source: CWS/CMS 7/8/2021; Time Period: 6/1/2020 through 6/30/2021; Blank indicates that children in foster care exited with no permanent plan.

[159] Data Source: CWS/CMS 7/8/2021; Time Period: 6/1/2020 through 6/30/2021

CDSS Figure 24: Total Placements in Episode (Percentage of Youth)[160]

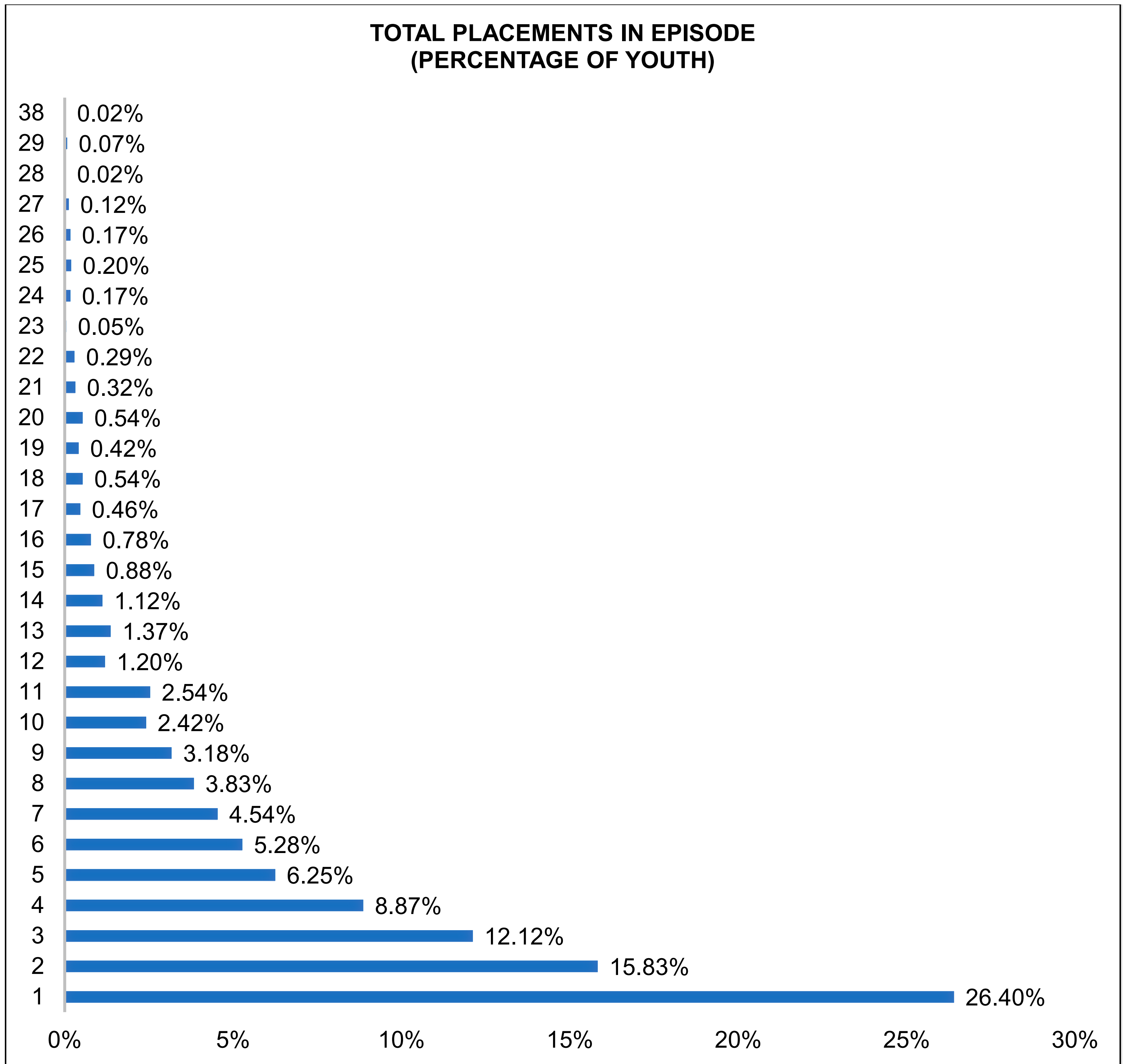


Figure 24 above shows the distribution of total number of placements youth in Congregate Care (STRTP or GH) between June 1, 2020 to June 30, 2021. Note: CDSS Figure 24 numeric data is located on page 163.

[160] Data Source: CWS/CMS 7/8/2021; Time Period: 6/1/2020 through 6/30/2021

CDSS Figure 25: Latent Class Analysis[161]: Ages 0-5 and 6+

*Please click the following Latent Class Analysis Ages 0-5 and 6+ image to access the PDF:

[161] The Latent Class Analysis (LCA) is a statistical approach that is used to classify individuals into mutually exclusive and exhaustive latent groups (called classes) based in their pattern of answers on a set of variables, in this case the CANS items. LCA uses probability matching algorithms to determine the class to which each individual person is most similar.

DHCS ADDENDUM

Child Welfare Children/Youth Usage of Specialty Mental Health Services FY 2015 to 2020

Direct Data Sources:

- Short-Doyle/Medi-Cal II (SD/MC II) claims with dates of service in FY 15/16 through FY 20/21.
- Medi-Cal Eligibility Data System (MEDS) data from the Management Information System/Decision Support System (MIS/DSS) FY 15/16 through FY 20/21.
- Child Welfare Services/Case Management System (CWS/CMS) data for children in FY 15/16 through FY 20/21.

The most current data available for each data element are presented in this report. The different data presented throughout this report does not all cover the same time span.

Prepared Data Sources:

Data were also obtained from:

- Performance Outcome System (POS), Foster Care (FC), and Open Child Welfare (OCW) archived reports:
    - Performance Outcomes System/Performance Dashboards reports
    - Children and Youth with an Open Child Welfare Case and in Foster Care Placement
- Children/Youth in Foster Care Placement dashboard data
- Children/Youth with an Open Child Welfare Case dashboard data

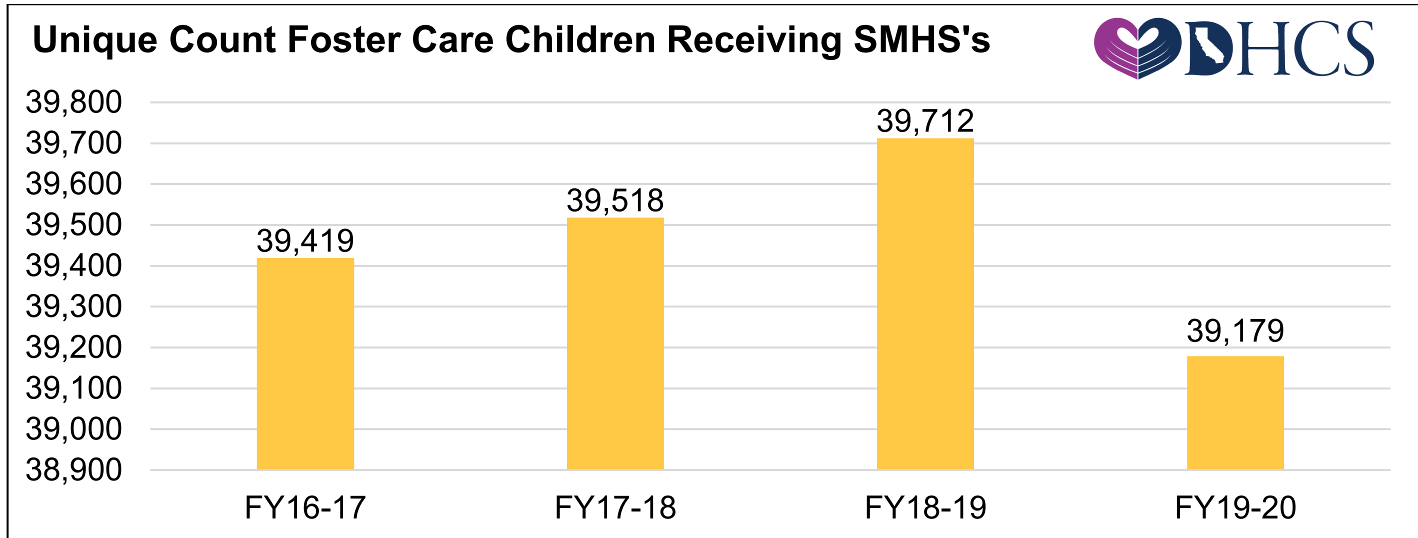
Key Definitions

- Foster Care (FC) Youth: The Primary Child Welfare Service and Program is Foster Care. Foster care is the 24 hour out-of-home care provided to children in need of substitute parenting because their own families are unable or unwilling to care for them. Data for the Foster Care Program captures children and youth who are primarily under the age of 21, have an open Foster Care case and are in out-of-home placement. Children in the Foster Care Program are a subset of Children in the Child Welfare Services System and will therefore be captured in both counts.

- Specialty Mental Health Services (SMHS): Medi-Cal entitlement services for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria. This data is intended to provide an overview of Children and Youth being served in the Foster Care System who are receiving Specialty Mental Health Services (SMHS).

- Non Specialty Mental Health Services (NSMHS): Medi-Cal entitlement services for adults who are 21 years of age and older with mild-to-moderate distress, or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders, or children who are under the age of 21 regardless of the level of distress or impairment, or the presence of a diagnosis.

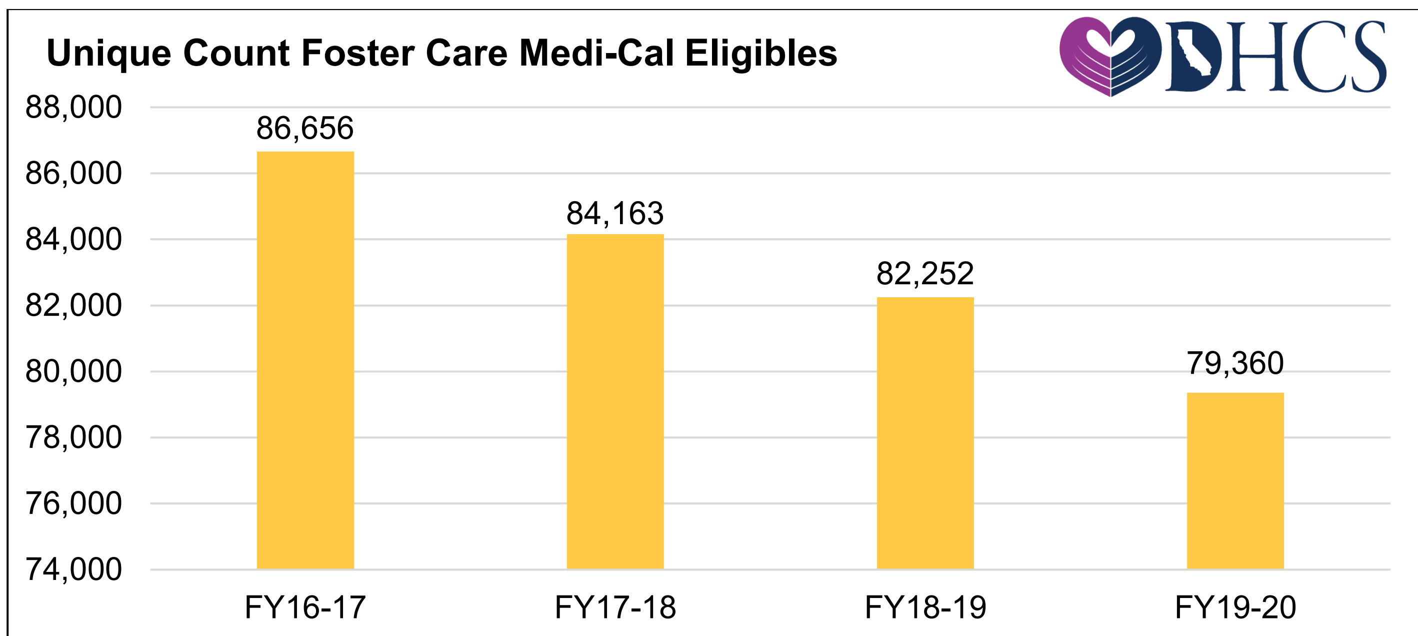
DHCS Figure 1: The Number of Children/Youth in Foster Care Placement Receiving SMHS by Fiscal Year



Note: DHCS Figure 1 numeric data is located on page 164.

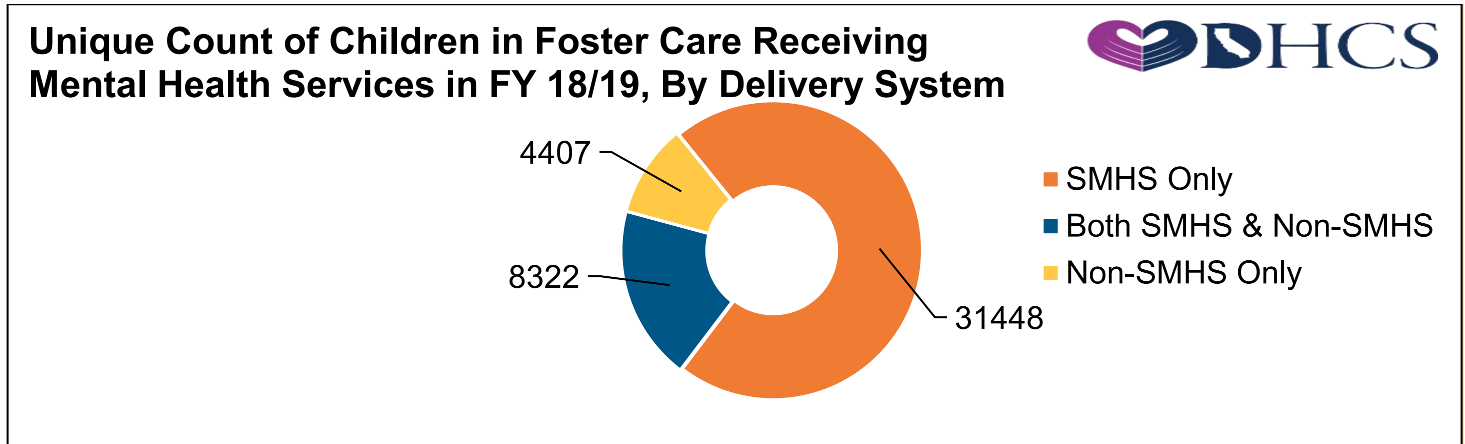
There has been a decline in the number of youth in foster care receiving SMHS. This corresponds with decreases in the youth in foster care population overall. Consultation with Policy and Research Staff from CDSS indicates that these declines are in line with implemented policies and practices aimed at reducing these populations.

DHCS Figure 2: Unique Count of Children in Foster Care who are Medi-Cal Eligibles



Note: DHCS Figure 2 numeric data is located on page 164.

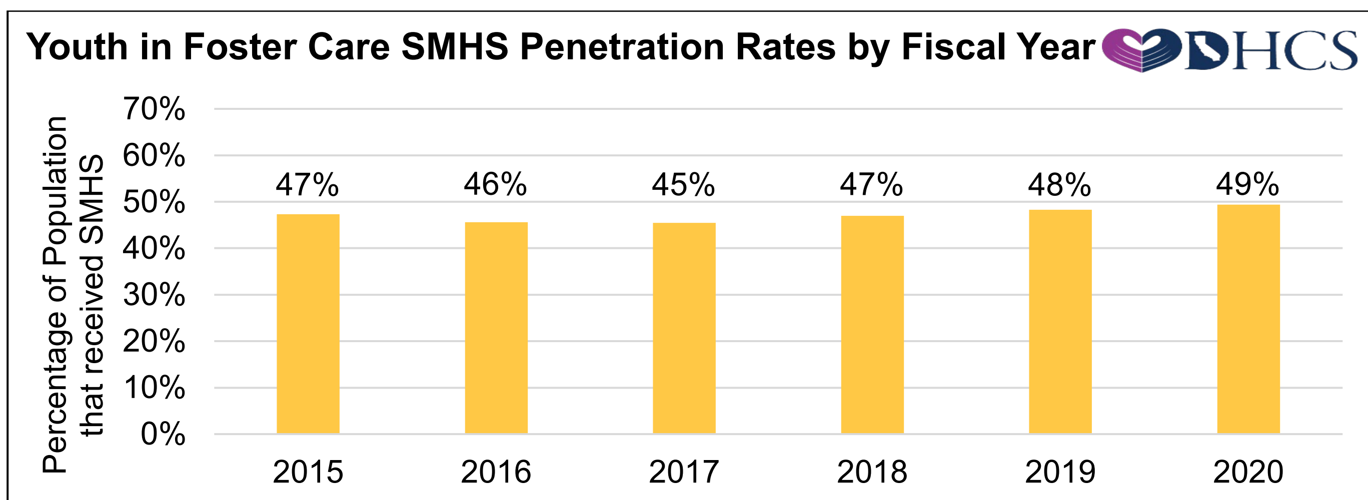
DHCS Figure 3: Unique Count of Children in Foster Care Receiving Mental Health Services in FY 18/19, By Delivery System



For Figure 3, the majority of children (n=31,448 or 71 percent) are receiving SMHS while a much smaller number (n=8,322 or 19 percent) are receiving both SMHS and non-SMHS and the fewest are receiving just non-SMHS (n=4,407 or ten percent). Note, DHCS Figure 3 numeric data is located on page 164.

Charts 4 through 7 are an examination of penetration rates for the Foster Care population. ***Penetration rate*** is defined as one or more SMHS visit within a FY. Penetration rate is a measure of access that indicates how many youths were able to access SMHS in a FY. Children in foster care show patterns in penetration rates in that they are uniformly high in comparison to penetration rates seen in the overall population of youth on Medi-Cal receiving SMHS. The rates for children in FC have shown steady increases in penetration rates since 2017 despite a decline in numbers in each population.

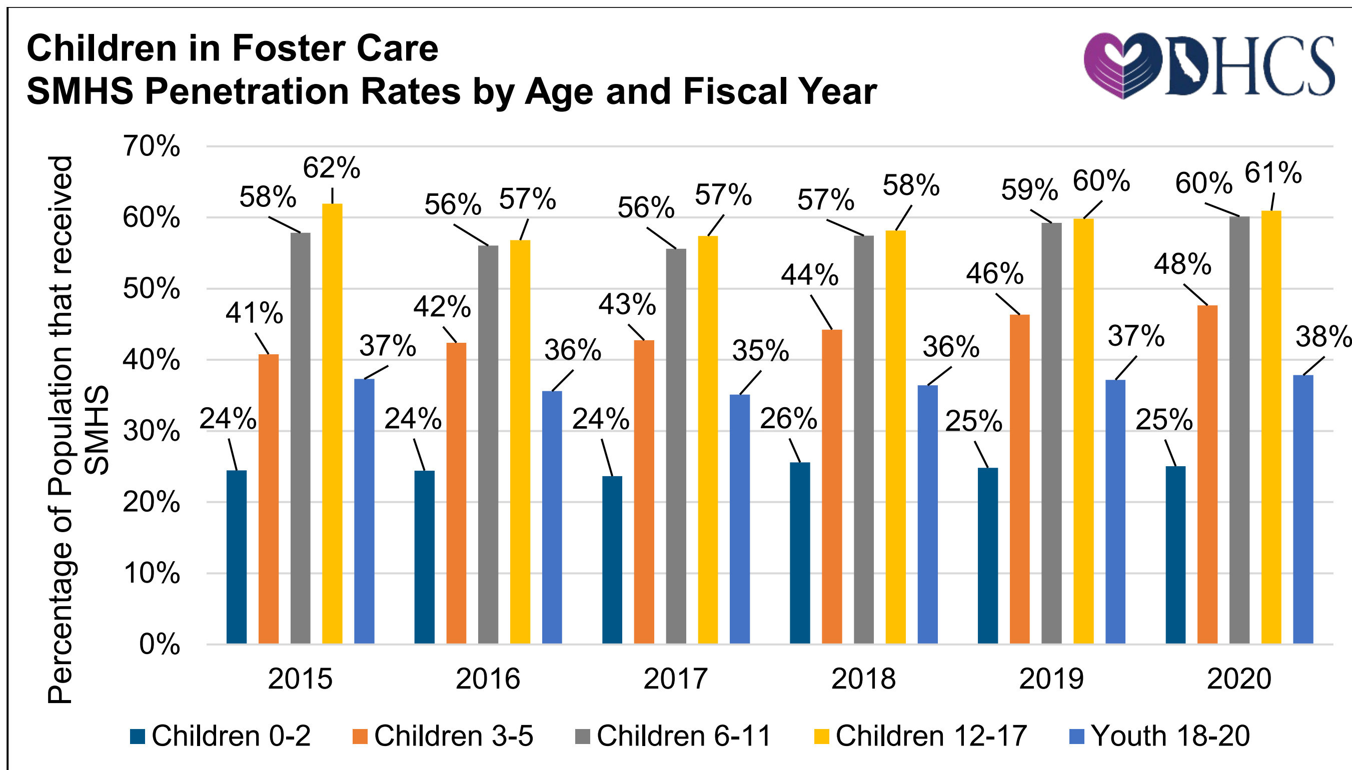
DHCS Figure 4: Children in Foster Care, SMHS Penetration Rates by Fiscal Year: 2015-2020



Note: DHCS Figure 4 numeric data is located on page 165.

Penetration rates by age by FY show significant variation across age categories for every FY but more stable rates within the age categories when looking by FY.

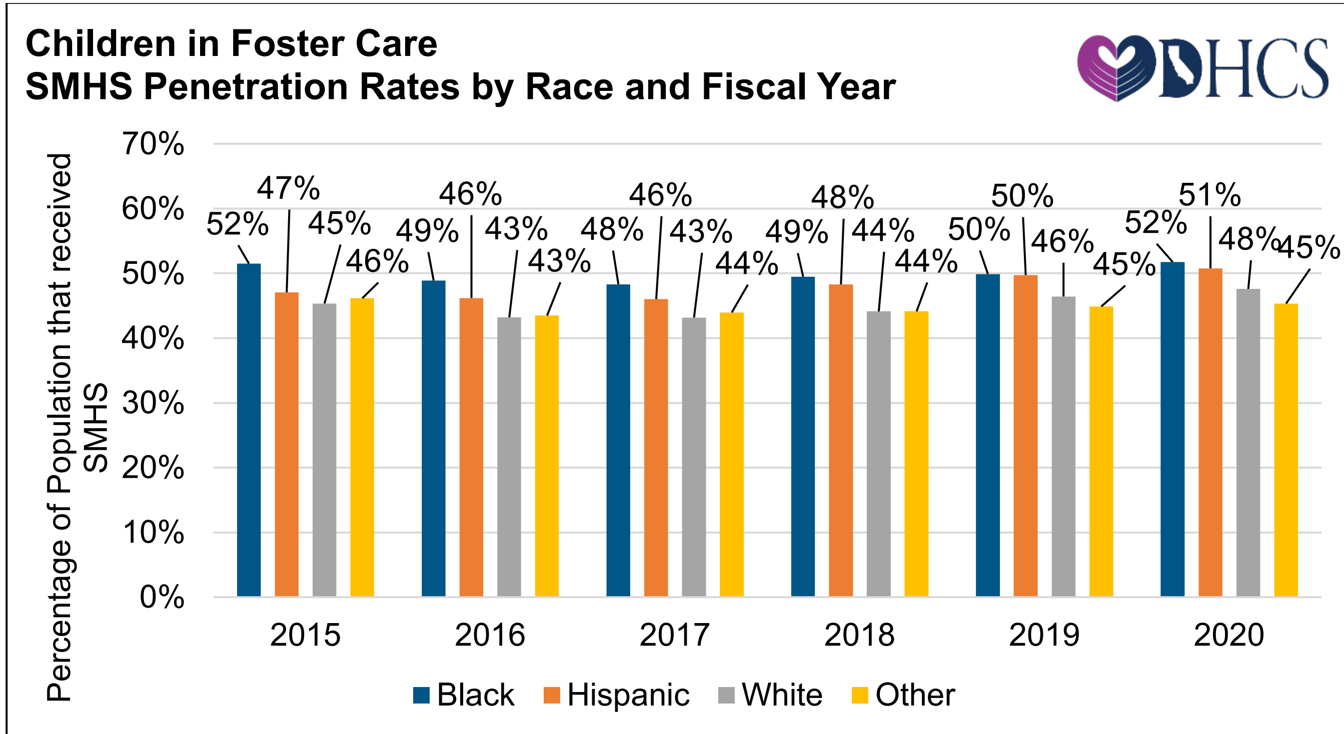
DHCS Figure 5: Children in Foster Care, SMHS Penetration Rates by Age and Fiscal Year



Note: DHCS Figure 5 numeric data is located on page 165.

Penetration rates by race and by FY show more consistency across groups and FY's. Children ages 0-2 have uniformly lower rates in all FY's (ranging from 24 percent to 26 percent) than children ages 3-5 (ranging from 41 percent to 48 percent), youth ages 6-11 (ranging from 56 percent to 60 percent), and youth ages 12-17 (ranging from 57 percent to 62 percent), and youth ages 18-20 have rates (ranging from 35 percent to 38 percent). This variation between age groups in penetration rates by age group remains consistent across FY's such that those in the same age category show similar rates across the six FY's displayed. For example, children ages 0-2 have an average penetration rate of 24.7% across FY's. Children ages 3-5 have an average penetration rate of 44 percent, youth 6-11 have an average of 57.7 percent, youth 12-17 have an average of 59.1 percent, and youth 18-20 have an average of 36.5 percent.

DHCS Figure 6: Children in Foster Care, SMHS Penetration Rates by Race and Fiscal Year

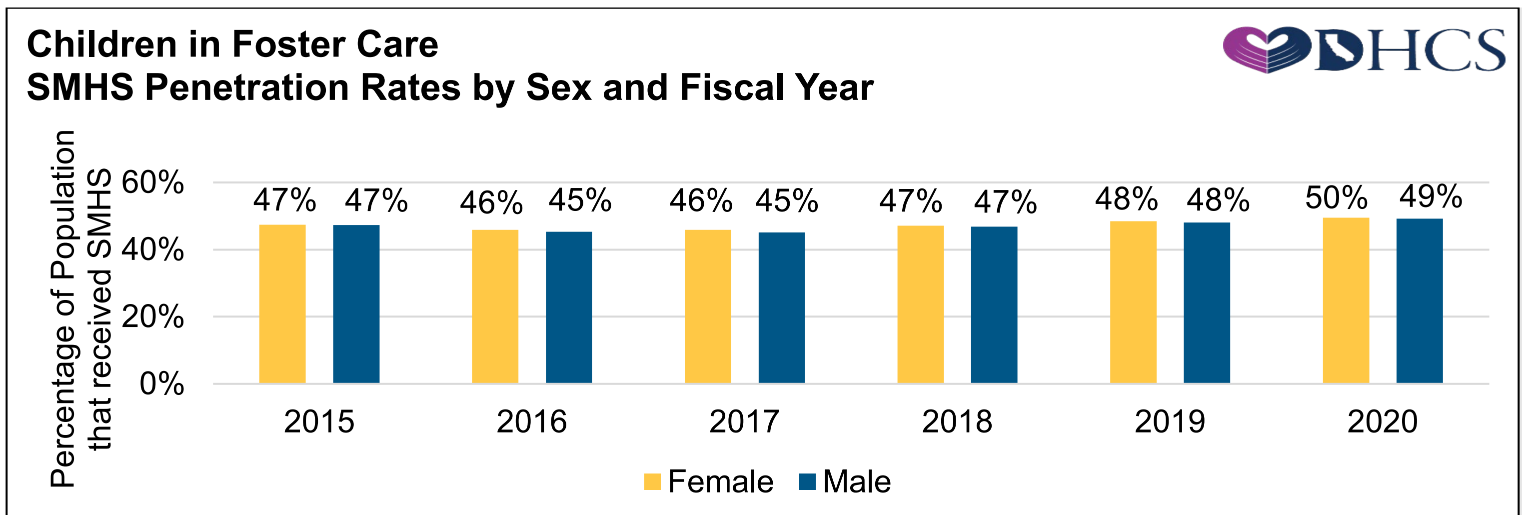


Note: DHCS Figure 6 numeric data is located on page 165.

Children in foster care show fairly consistent penetration rates across racial groups across FY's. Children in foster care average penetration rates across FY's are as follows: Black (50 percent), Hispanic (48 percent), White (44.8 percent), and Other (44.5 percent).

DHCS Figure 7: Children in Foster Care, SMHS Penetration Rate by Sex and Fiscal Year

In Figure11 below, penetration rates by sex and by FY show uniformly high consistent penetration (Male in FC average = 47.3 percent; Female in FC average = 46.8 percent). Note, DHCS Figure 7 numeric data is located on page 166.

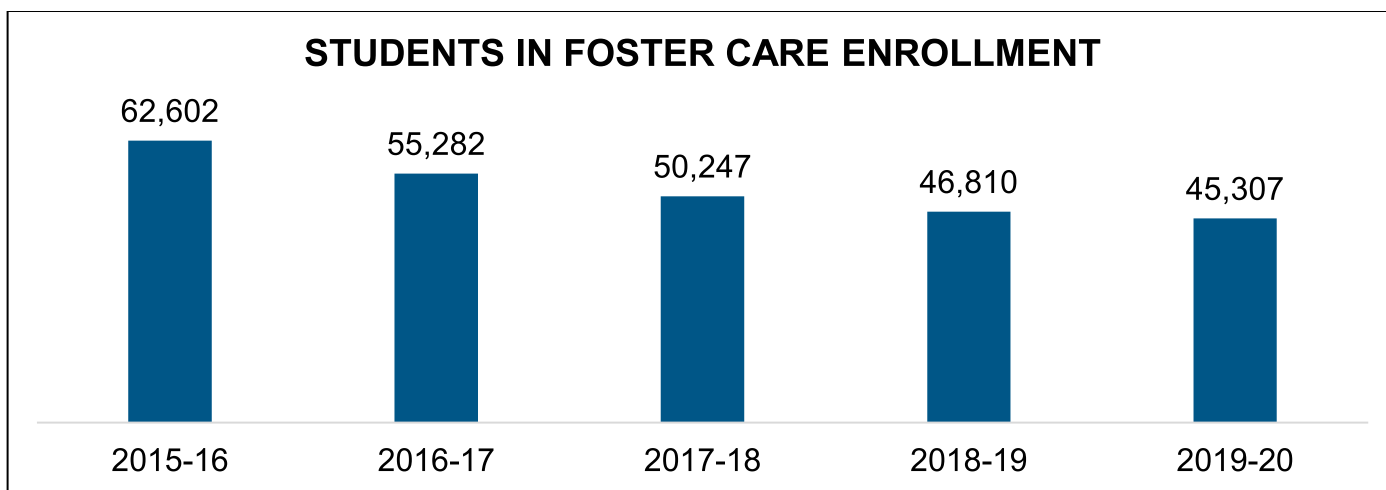


CDE ADDENDUM

CALIFORNIA DEPARTMENT OF EDUCATION DATA AND OUTCOMES FOR STUDENTS IN FOSTER CARE

The data presented within this section of the Gaps Analysis Report and Multi-Year Plan for *Children and Youth System of Care (AB 2083)* was extracted from publicly available data on the California Department of Education's (CDE) webpage and stakeholder engagement conducted by the CDE's Foster Youth Services Coordinating Program (FYSCP). The majority of the data presented here are from the 2018-19 school year, which is the most recent school year of data available prior to school closures and virtual instruction due to COVID-19. According to the CDE's data de-identification protocols to protect student privacy, values less than 11 are not reported. Pursuant to *EC, section 49085,* the data provided in this report have been matched to data from CDSS in order to identify students who are in foster care. The stakeholder data comes from activities conducted during 2020 with county FYSCP Coordinators. The information in Figures 1 through 3 and Figures 5 through 14 are from publicly reported enrollment, attendance, behavior, high school completion, and college enrollment data posted on the CDE's public data reporting site, DataQuest.[162] Figure 4 is from data included in the bi-annual report to the Legislature on the Foster Youth Services Coordinating Program pursuant to *EC, section* 49085(c).

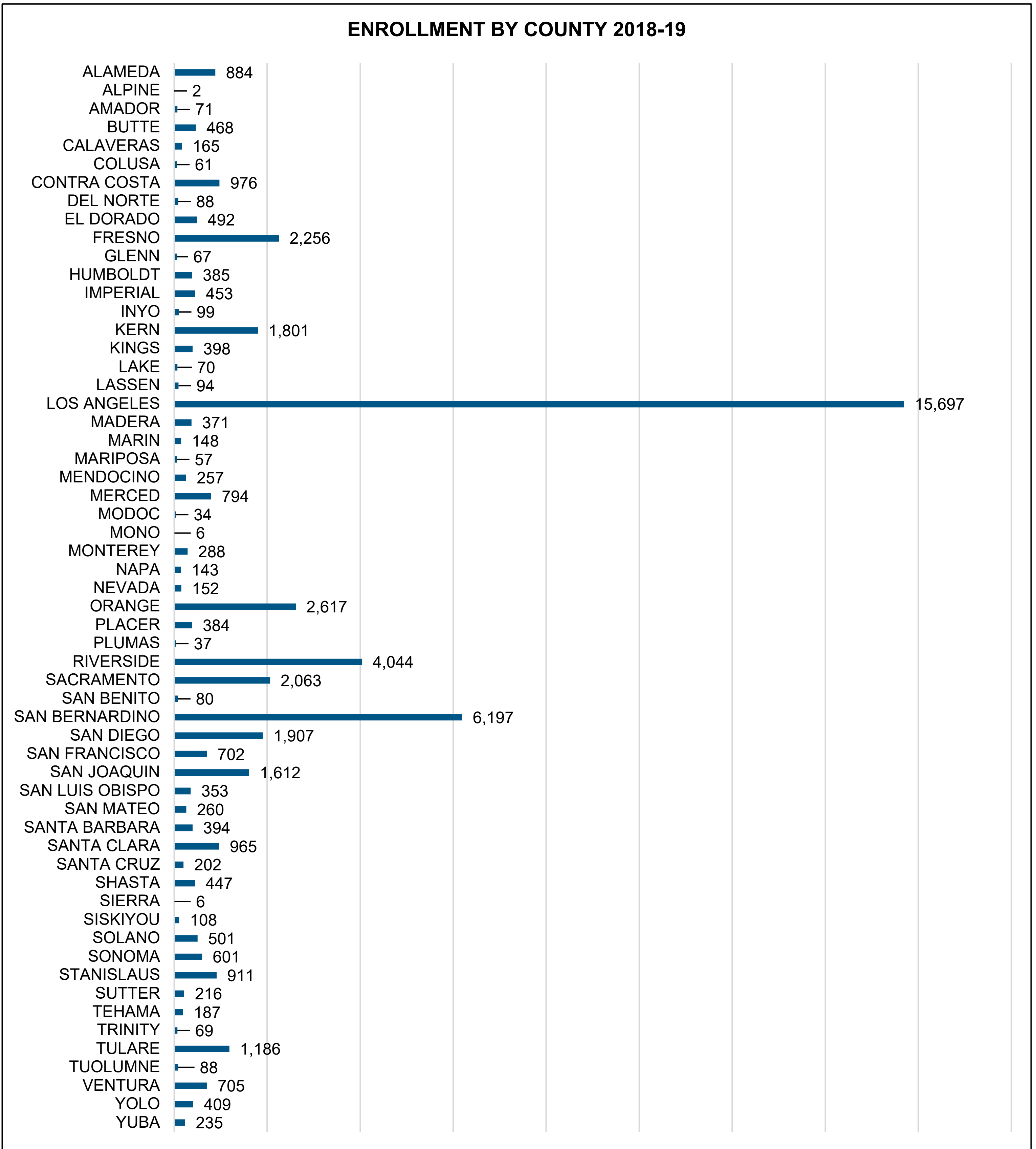
CDE Figure 1: School Enrollment by Year



Note: CDE Figure 1 numeric data is located on page 166.

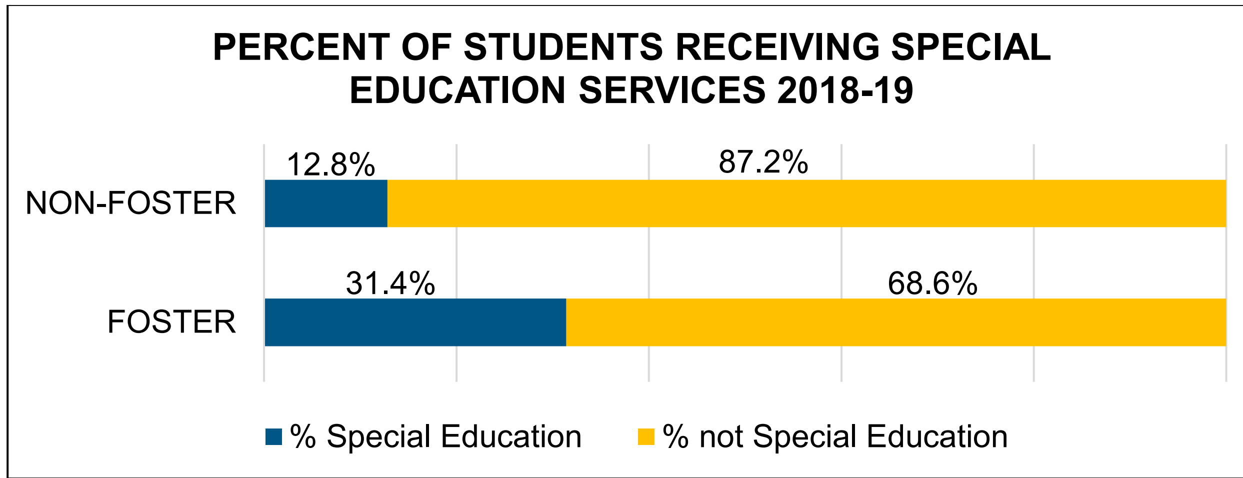
[162] Access the CDE's public date reporting site, on the DataQuest website.

CDE Figure 2: Students in Foster Care Enrollment by County



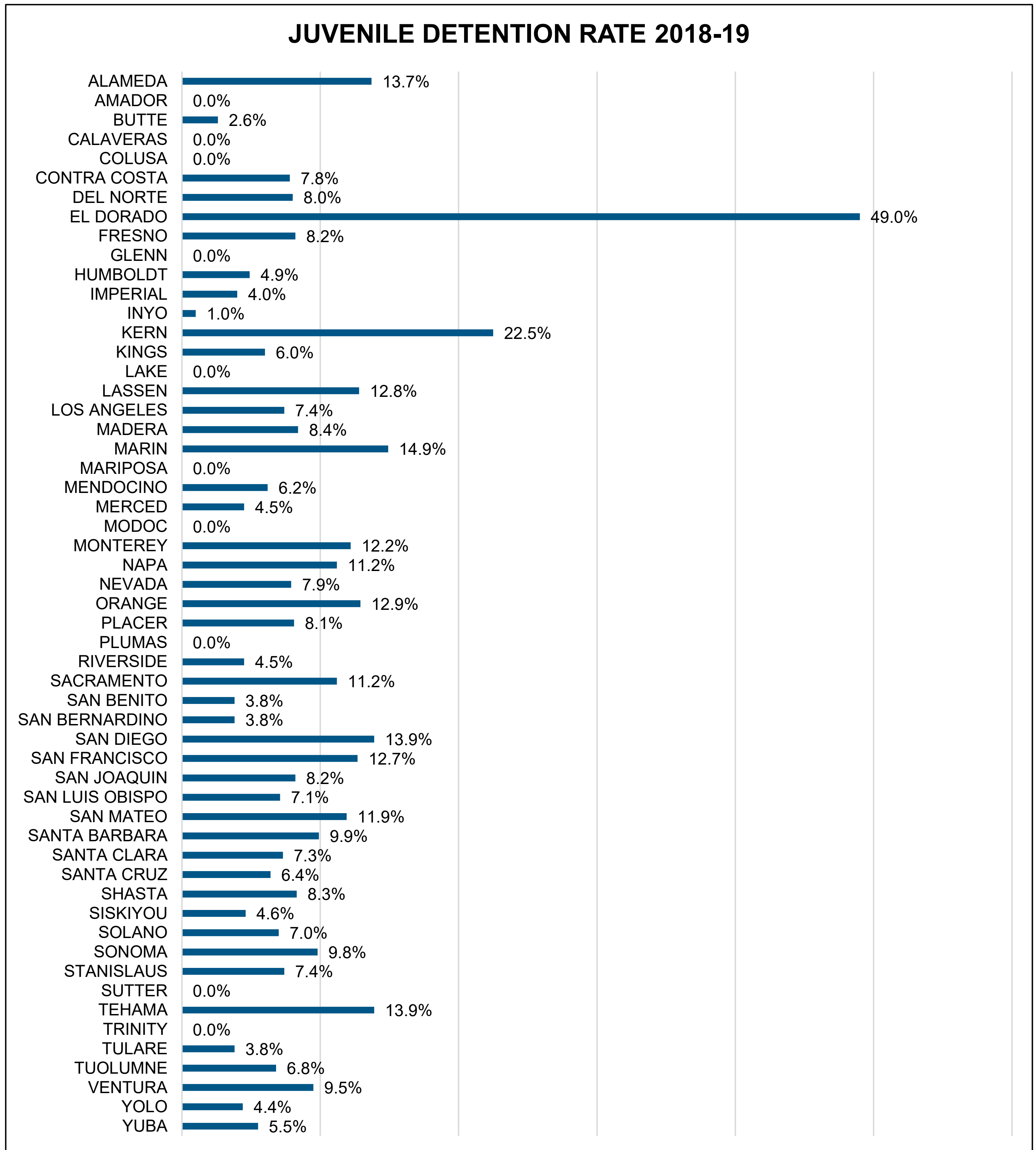
Note: CDE Figure 2 numeric data is located on page 166.

CDE Figure 3: Special Education Identification



Note: CDE Figure 3 numeric data is located on page 168.

CDE Figure 4: Juvenile Detention Rate for Students' in Foster Care by County

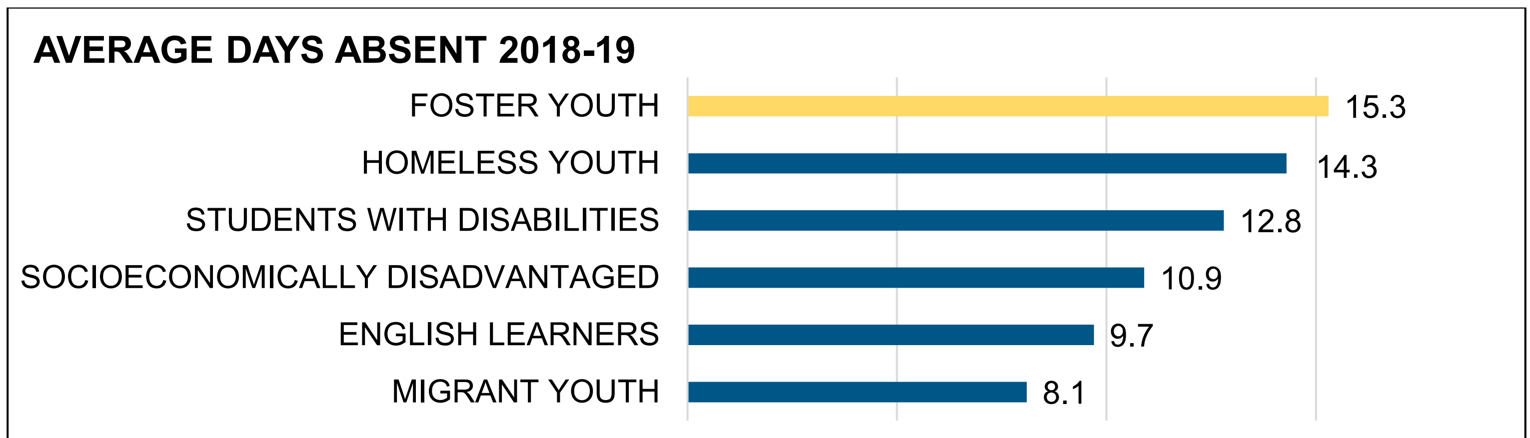


Note: CDE Figure 4 numeric data is located on page 168.

School Attendance

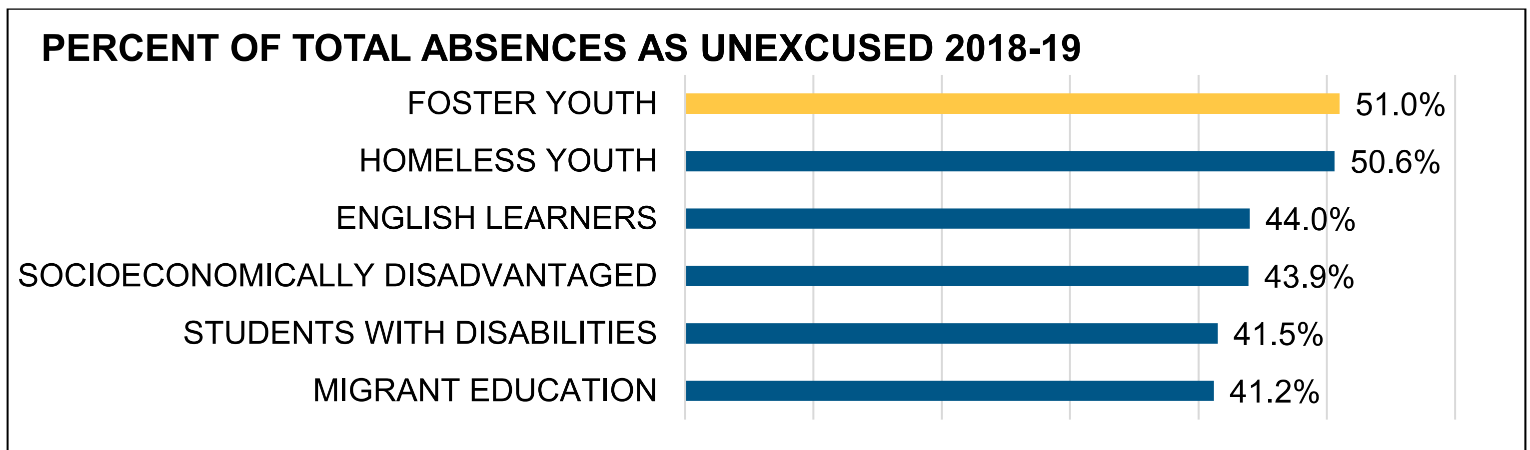
Attending school is foundational to learning and success. However, the average number of days students in foster care miss school is significantly higher than any other student group in the state, seen in Figure 5 below. When looking at the type of reported absences, students in foster care experience more unexcused absences than any other student group as seen in Figure 6. Figure 7 illustrates similar levels of disparity for school attendance that students in foster care experienced when comparing the percent of students who are chronically absent from school (students are considered chronically absent when they miss ten percent or more of the school year) by student group and by county.

CDE Figure 5: Average Days Absent from School by Student Group



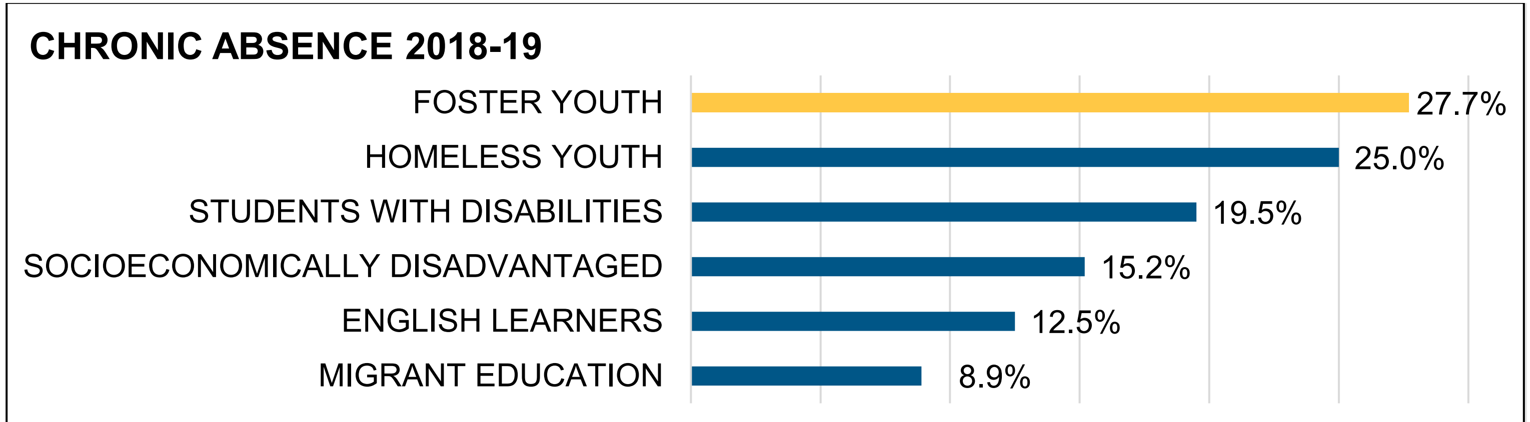
Note: CDE Figure 5 numeric data is located on page 170.

CDE Figure 6: Percent of Total Absences Reported as Unexcused by Student Group



Note: CDE Figure 6 numeric data is located on page 170.

CDE Figure 7: Percent of Students Chronically Absent by Student Group

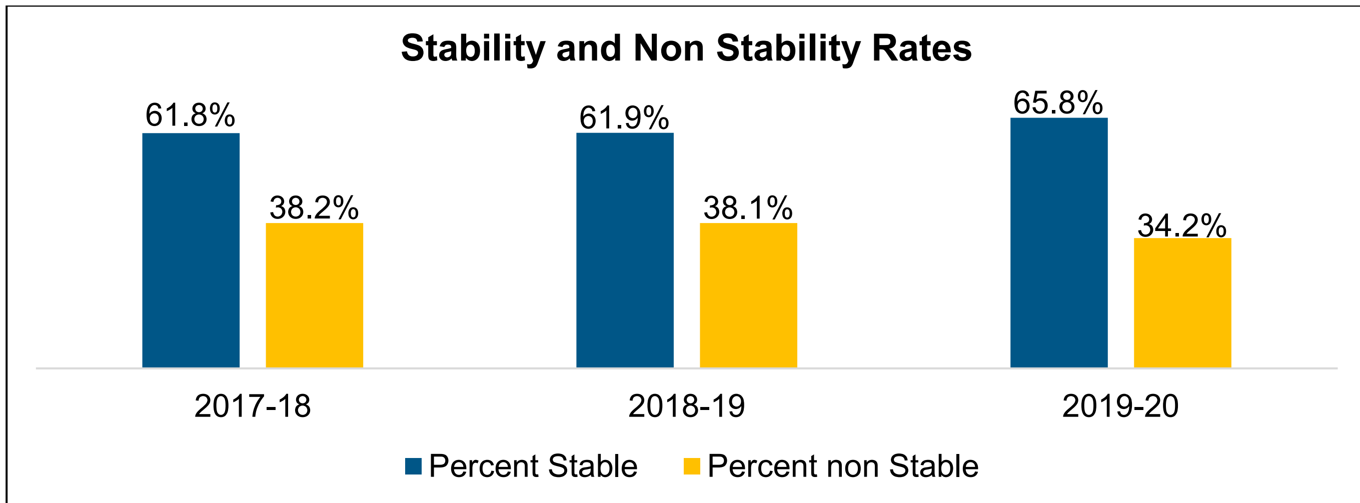


Note: CDE Figure 7 numeric data is located on page 171.

School Stability

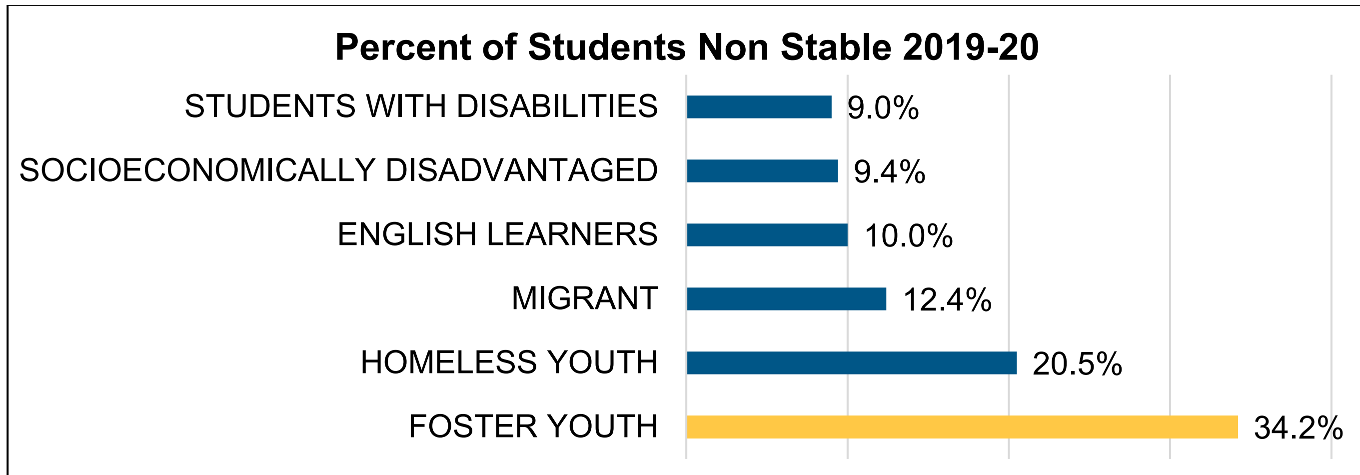
In 2021 the CDE developed and published a new report on school stability to better understand whether students remain in the same school for an entire school year. Despite the many federal and state mandates focused on ensuring students in foster care do not have to change schools as a result of entering foster care (School of Origin entitlement), the percent of students who are stable in school is significantly lower for students in foster care than that of other student groups and is consistently low across academic years as seen in Figures 8 and 9 below.

CDE Figure 8 Stability and Non Stability Rates for Students in Foster Care by School Year



Note: CDE Figure 8 numeric data is located on page 171.

CDE Figure 9: Non Stability Rate by Student Group 2019-20

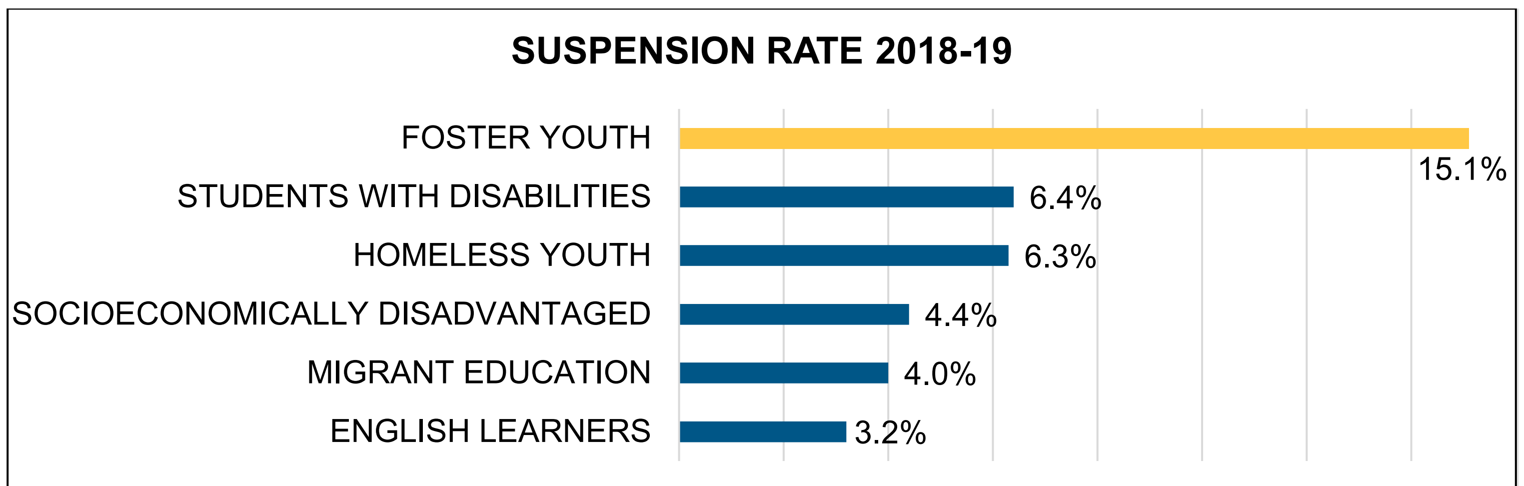


Note: CDE Figure 9 numeric data is located on page 171.

School Climate and Student Behavior

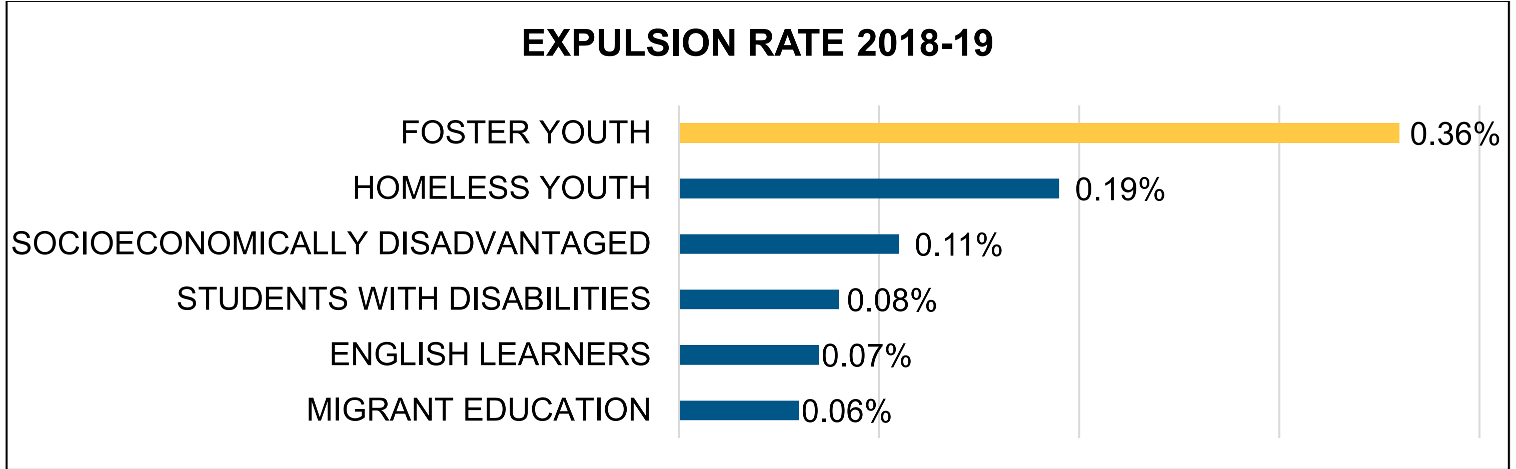
Students may be suspended from school for specific behaviors such as fighting or substance abuse pursuant to *EC, sections 48900*, *48900.2*, *48900.3*, *48900.4*, and *48900.7*, and in certain instances, severe behaviors result in students being expelled from school (*EC, section 48900*). The suspension and expulsion rates for students in foster care are higher than any other student group, and rates vary by county. Figures 10 and 11 illustrate the disproportionality in student behavior outcomes for students in foster care.

CDE Figure 10: Suspension Rates by Student Group



Note: CDE Figure 10 numeric data is located on page 172.

CDE Figure 11: Expulsion Rates by Student Group

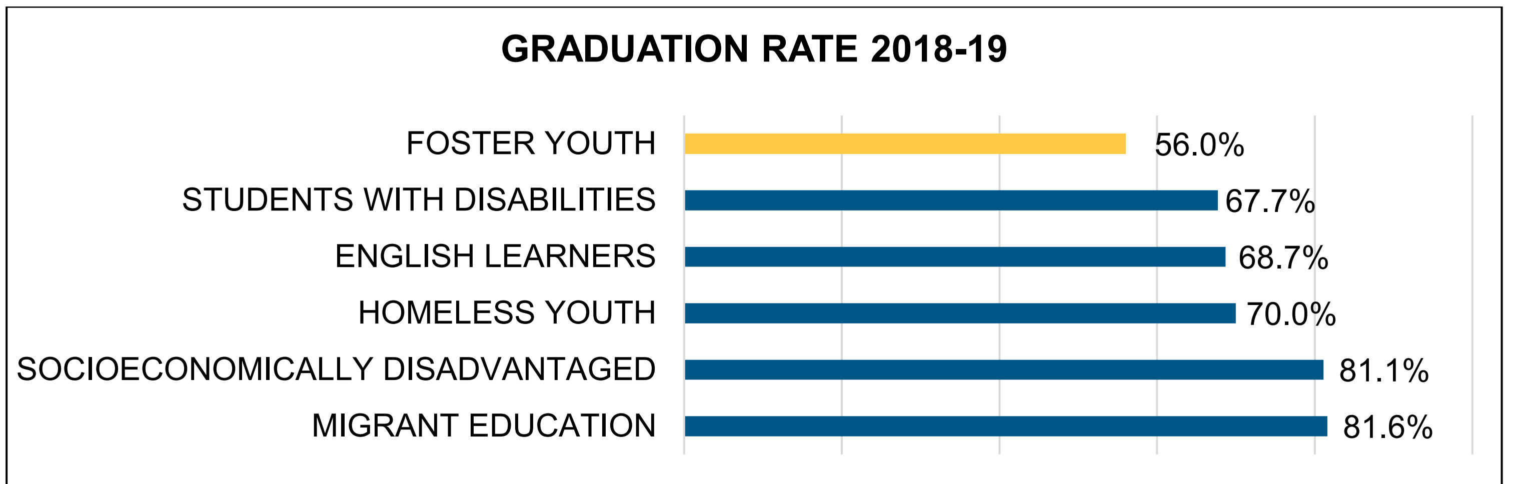


Note: CDE Figure 11 numeric data is located on page 172.

High School Completion and Post-Secondary Enrollment

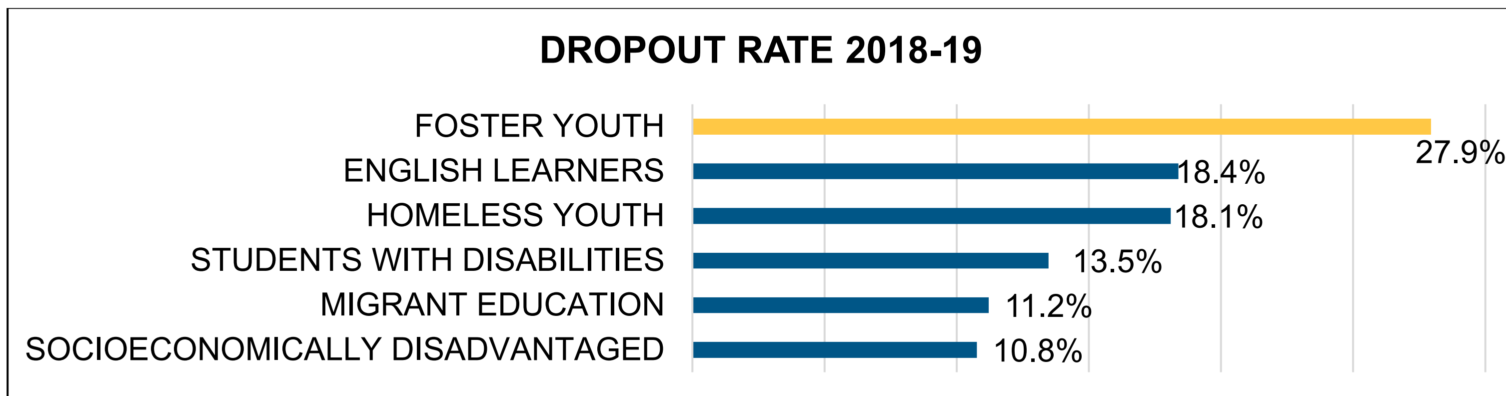
The challenges of students in foster care represented in the figures above serve to explain one of the many reasons for the low graduation rates, high drop-out rates, and low college enrollment of students in foster care (seen in Figures 12 through 14).

CDE Figure 12: Statewide Graduation Rates by Student Group



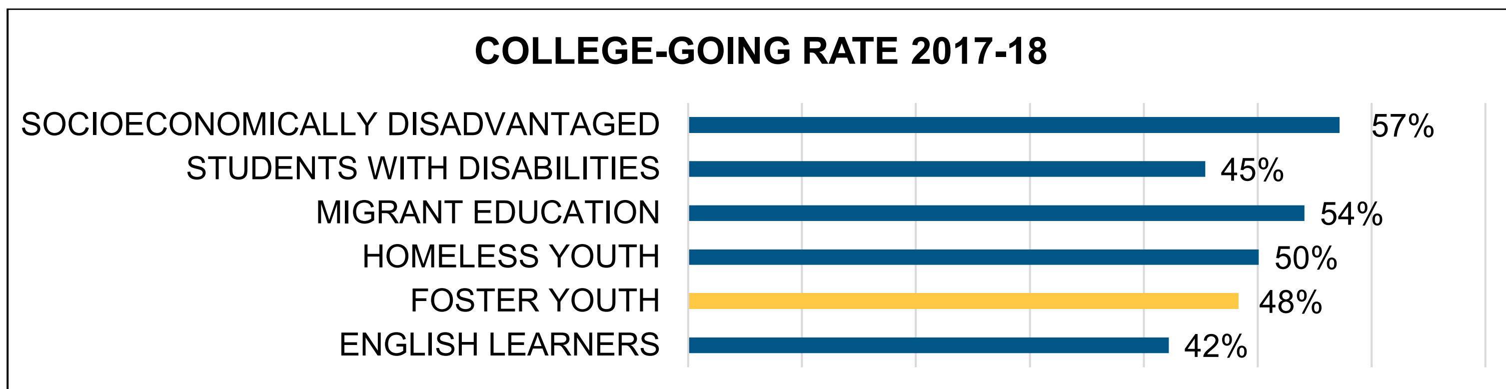
Note: CDE Figure 12 numeric data is located on page 172.

CDE Figure 13: Statewide Dropout Rate by Student Group



Note: CDE Figure 13 numeric data is located on page 173.

CDE Figure 14: Percent of 2017-18 High School Graduates Enrolling in College within 12 Months of Graduating High School



Note: CDE Figure 14 numeric data is located on page 173.

CDE Figure 15: Number and Percent of Formal Agreements among County Agencies for 2018-19

MOUs/Agreements	2018–19 (N)	2018–19 (%)
Information sharing Agreements	41	75
Countywide ESSA Transportation Requirement Agreements	30	55
Title IV-E Draw Down Agreements	33	60
Post-Secondary	12	22
Executive Advisory Council	23	42
Co-location	26	47
Other Agreements[163]	23	42

[163] The category "Other" includes agreements to support data tools development to provide schools, social workers, and probation officers by supplying real time data about foster youth education. They also

CDE Figure 16: Overview of Different Definitions and Services for Students in Foster Care

CATEGORY OF FOSTER YOUTH	Included in LCFF	Included in ESSA	Included in CDSS' Definition of Care and Placement	CA Foster Youth Educational Rights
OUT-OF-HOME Child Welfare	Yes	Yes	Yes	Yes
OUT-OF-HOME Probation	Yes	Yes	Yes	Yes
FAMILY MAINTENANCE	Yes	Not Included	Not Included	Yes
IN-HOME Probation	Not Included	Not Included	Not Included	Not Included[164]
NON-MINOR DEPENDENTS	Yes	Yes	Yes	Yes
VOLUNTARY PLACEMENT AGREEMENTS	Yes*	Yes	Yes	Yes*
TRIBAL FOSTER YOUTH (AB 1962)	Yes	Only for Title IV-E tribes	N/A	Yes*
EMERGENCY REMOVALS	Not Included	Does not differentiate between emergency removal and placement	Yes	Yes

DDS ADDENDUM

"Dually served youth" are individuals ages 0 through 21[165] who have been determined eligible for regional center services and are also involved in child welfare. The dually served population reflected in this report includes youth identified in regional center data sets as having a legal status of being a court dependent and/or as residing in a foster home or with a foster family agency.

This section provides information for two groups of dually served youth: the Early Start population, which primarily includes infants and toddlers ages 0 through 2 (inclusive),[166] and the Lanterman population, which is primarily ages 3 through 21 but can also include children ages 0 through 2 when Lanterman

included MOUs with probation departments and tribal courts to support the coordination of services for foster youth.

[164] Effective 1/1/2022 as amended by AB 1055, Chapter 287, Statutes of 2021.

[165] This age category includes youth ages 18 through 21 who are in extended foster care per AB 12 (Chapter 559, Statutes of 2010).

[166] While Early Start eligibility ends at 35 months, children leaving Early Start are often still coded in regional center datasets in the month of their third birthday; when this happens, they are represented in data as Early Start age 3.

eligibility requirements are met. It also compares the characteristics of dually served youth to the characteristics of all regional center youth. These comparisons reveal areas for further analysis and provide a baseline for potential gaps that currently exist in practice and access to services. This analysis also provides an opportunity to identify areas for drilling down to specific barriers and suggest areas for targeted technical assistance.

DDS Figure 1: Number and Share of Dually Served Youth and All Regional Center Youth, by Early Start and Lanterman Eligibility

STATUS	INDIVIDUALS REPORTED BEING DUALLY SERVED (N=10,370)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464)
Early Start	63%	23%
Lanterman	37%	77%
Total	**100%**	**100%**

Demographics and Residence of Dually Served Youth

Almost all regional center youth live with their families (93 percent of Early Start and 98 percent of Lanterman youth). In contrast, 80 percent of dually served Early Start youth and 60 percent of dually served Lanterman youth live with foster families. Dually served Lanterman youth are approximately six times as likely to reside in a congregate setting[167] as youth who do not have child welfare involvement (12 percent of dually served youth live in congregate settings compared to two percent of all regional center youth).

Dually served youth are also unevenly distributed geographically through the State. The majority of these youth (64 percent) are served by a minority of regional centers (six of 21 regional centers) and three of those regional centers are located in Los Angeles County where almost half of dually served youth reside. About 80 percent of dually served youth reside within only eight counties, including Los Angeles County. While Los Angeles County has more youth served by the regional centers than any other county, Los Angeles County’s share of dually served youth is significantly higher than its share of all youth served by the regional centers. In contrast, San Diego Regional Center and Central Valley Regional Center serve a similar or smaller share of youth involved in child welfare compared to the total youth population in their catchment areas.

[167] Percentage includes the totals of Community Care Facilities, Other and Intermediate Care Facilities.

DDS Figure 2: Demographic Characteristics of Dually Served Youth and All Regional Center Youth[168]

Gender	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Early Start (N=6,568)	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Lanterman (N=3,802)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Early Start (N=47,155)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Lanterman (N=155,309)
Female	45%	32%	37%	27%
Male	55%	68%	63%	73%

Language	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Early Start (N=6,568)	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Lanterman (N=3,802)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Early Start (N=47,155)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Lanterman (N=155,309)
English	84%	87%	78%	73%
Spanish	16%	12%	20%	23%
All Other Language	<1%	1%	3%	4%

Age	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Early Start (N=6,568)	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Lanterman (N=3,802)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Early Start (N=47,155)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Lanterman (N=155,309)
0-2 years old	71%	1%	33%	0%
3-9 years old[169]	29%	41%	67%	38%
10-14 years old	-	26%	-	27%
15-17 years old	-	16%	-	15%
18-21 years old	-	16%	-	20%

[168] Throughout the DDS data tables, "-" or dashes Indicates there are no data associated with this field. "*" or asterisks indicates data has been suppressed to comply with data reporting confidentiality requirements.
[169] Youth aged 3 and older in Early Start data generally reflect a lag in coding the status change at the child's third birthday.

Ethnicity	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Early Start (N=6,568)	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Lanterman (N=3,802)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Early Start (N=47,155)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Lanterman (N=155,309)
Asian	1%	2%	7%	11%
Black or African American	12%	24%	4%	7%
Hispanic	38%	37%	44%	46%
Other[170]	33%	14%	26%	13%
White	16%	23%	34%	24%

Residence Type	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Early Start (N=6,568)	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Lanterman (N=3,802)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Early Start (N=47,155)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Lanterman (N=155,309)
Resource Family and Foster Family Agency	81%	60%	7%	1%
Own Home/Parent/Guard	19%	29%	93%	98%
Community Care Facility[171]	*	6%	<1%	1%
Other[172]	*	4%	<1%	<1%
Intermediate Care Facility[173]	<1%	2%	<1%	<1%

[170] “Other” ethnicity includes Native American, Russian, multiple, unknown, and missing ethnicities.
[171] Community Care Facilities (CCFs) are licensed by the Community Care Licensing Division of the California Department of Social Services to provide 24-hour non-medical residential care to children and adults with developmental disabilities who are in need of personal services, supervision, and/or assistance essential for self-protection or sustaining the activities of daily living.
[172] “Other” residence includes forensic, psychiatric, acute medical and adult settings. Consumer counts are masked for deidentification.
[173] Intermediate Care Facilities (ICF) are health facilities licensed by the Licensing and Certification Division of the California Department of Public Health (CDPH) to provide 24-hour-per-day services. There are three types of ICFs, which all provide services to Californians with developmental disabilities.

Regional Center	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Early Start (N=6,568)	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Lanterman (N=3,802)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Early Start (N=47,155)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Lanterman (N=155,309)
Inland Regional Center	15%	15%	11%	11%
North LA County Regional Center	15%	14%	7%	9%
South Central LA Regional Center	11%	9%	6%	5%
San Diego Regional Center	10%	6%	9%	10%
Harbor Regional Center	7%	6%	4%	5%
Central Valley Regional Center	6%	5%	7%	6%
All other regional centers	37%	45%	56%	56%

County	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Early Start (N=6,568)	CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370) Lanterman (N=3,802)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Early Start (N=47,155)	REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464) Lanterman (N=155,309)
Los Angeles	46%	41%	31%	32%
San Bernadino	8%	8%	5%	5%
San Diego	8%	6%	8%	8%
Riverside	7%	6%	6%	5%
Orange	5%	3%	7%	6%
Kern	3%	3%	2%	3%
Fresno	2%	3%	3%	3%
San Joaquin	*	3%	3%	3%
Sacramento	*	5%	3%	5%
All other counties	18%	22%	31%	31%

Regional Center Intake and Eligibility Process

Timely referral and eligibility determinations are critical for all youth in accessing the supports, services and generic resource coordination. Understanding how youth involved in child welfare move through regional center intake and eligibility determinations is helpful as youth in child welfare have high placement mobility and the complexity of their needs can impact their navigation of the regional center service delivery system.

Regional center eligibility is established by assessments and regional center eligibility panels conducted by psychologists and other clinicians. If a child is determined to be eligible for regional center services, the regional center assigns the child a service coordinator who works with the parent(s) or guardian(s) to develop, coordinate, and monitor a service plan specific to the child and their developmental disability. If the assessment staff determine a child is not eligible for regional center services, the referring source may appeal the determination of ineligibility, presenting new information about the child's challenges which may warrant reconsideration of eligibility.

Regional Center Intake for Infants and Toddlers (Early Start)

The Early Intervention Program for Infants and Toddlers with Disabilities was enacted in 1986 under the Individuals with Disabilities Education Act (IDEA; 20; U.S.C., Section 1431 et seq.). The Early Start program is California's response to federal legislation ensuring that early intervention services for infants and toddlers (ages 0 through 2) with disabilities and their families are provided in a coordinated, family-centered system of services that are available statewide. The Early Start program provides early intervention services and supports to help eligible infants and toddlers with disabilities or delays in their development. These services are intended to help eligible children learn new skills, overcome challenges, and increase their success in life.

An infant or toddler (ages 0 through 2) who is at risk of having a developmental disability or who has a developmental delay may qualify for services and should be referred to the regional center for Early Start intake and eligibility determinations. Infants or toddlers should be referred for services as soon as possible to obtain the optimal benefits from services, as early intervention services provide increased developmental trajectories for children. Per California WIC, section 95020, for an infant or toddler who has been evaluated for the first time, a meeting shall be conducted within 45 calendar days of receipt of the referral to share the results of the evaluation, to determine eligibility and, for children who are eligible, to develop the initial individualized family service plan shall be conducted. Written parental consent to evaluate and assess shall be obtained within the 45-day timeline.

Per WIC, section 95014 and California Code of Regulations, Title 17, Chapter 2, Section 52022, infants and toddlers, ages 0 through 2, may be eligible for early intervention services through Early Start if, through documented evaluation and assessment, they meet one of the criteria listed below:

- Have a developmental delay of at least 33 percent in one or more areas of cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing; or
- Have an established risk condition of known etiology, with a high probability of resulting in delayed development; or
- Be considered at high risk of having a substantial developmental disability.

Regional Center Intake for Lanterman Provisionally Eligibility (Ages 3 and 4)

If a child who is three or four years of age is not otherwise eligible for regional center services pursuant to WIC, section 4512(a)(1), the child may be provisionally eligible for regional center services if the child has a disability that is not solely physical in nature and has significant functional limitations in at least two of the following areas of major life activity: as determined by a regional center and as appropriate to the age of the child, self-care, receptive and expressive language, learning, mobility or self-direction. To be provisionally eligible, a child is not required to have one of the developmental disabilities listed in WIC, section 4512(a)(1).

An infant or toddler eligible for early intervention services from the regional center pursuant to GC, section 95014 must be assessed by the regional center at least 90 days prior to the date that they turn 3 years of age for purposes of determining their ongoing eligibility for regional center services. That assessment initially shall determine if the child has a developmental disability under WIC, section 4512(a)(1). If the regional center determines that the child does not have a developmental disability as defined in WIC, section 4512(a)(1), the regional center must determine if the child is provisionally eligible for regional center services. If the regional center determines the child is not provisionally eligible, the regional center must give adequate notice pursuant to WIC, section 4701.

A child who is provisionally eligible must be reassessed at least 90 days before turning five years of age. The child must meet the definition set forth in WIC, section 4512(a)(1) to continue to be eligible for regional center services at five years of age. Regional center services for a child who was provisionally eligible and who does not meet the definition in WIC, section 4512(a)(1) shall end when the child is five years of age unless an appeal was filed pursuant to WIC, section 4715.

Regional Center Intake for Children and Adults (Lanterman Services)

Eligible individuals with a developmental disability are covered by the Lanterman Act, regardless of age. Qualifying conditions include intellectual disability, cerebral palsy, epilepsy, autism, and other disabling conditions as defined in WIC, section 4512. Per WIC, section 4642, any person believed to have a developmental disability, and any person believed to have a high risk of parenting a developmentally disabled infant shall be eligible for initial intake and assessment services in the regional centers. A developmental disability covered under the Lanterman Act is a disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. A substantial disability means significant functional limitations in three or more of the following areas of major life activity: self–care, receptive and expressive language, learning, mobility, self–direction, capacity for independent living, and economic self–sufficiency.

Once a referral is made, initial intake shall be performed within 15 business days following the request for assistance. During intake, pertinent medical reports, previous psychological assessments, school and other records are collected. This initial intake shall include a decision to provide an assessment. If there is a decision to move forward with an assessment, the collected records along with current psychological assessments are reviewed by an Eligibility Panel. After initial intake the regional center has 120 calendar days to determine eligibility. Per WIC, section 4643(a), if the delay in the intake process would result in an unnecessary risk to the person's health and safety, then the regional center shall determine eligibility within 60 days. Eligibility is established through diagnosis and assessment arranged for by regional centers and upon review of a multidisciplinary regional center Eligibility Panel.

Youth in Child Welfare and Regional Center Eligibility Determinations

Smooth and seamless eligibility determinations and transitions are important for youth and families to ensure service access, continuity of care and reduce service disruptions. This continuity is especially important for youth involved in the child welfare system who have already experienced loss, grief and trauma. Data indicates that when toddlers who are dually served transition out of Early Start (and out of regional center services), approximately 20 percent come back to the regional center after the age of three and are found eligible for Lanterman services. Additionally, over a quarter of youth who are determined not eligible for regional center services are found eligible after a second evaluation.

- Approximately half of dually served youth identified as being eligible for Lanterman services were previously eligible for Early Start.
- By the end of FY 19/20, 1,620 youth involved in child welfare were determined ineligible for regional center services. Of these, 585 went through intake later and were found eligible for regional center services as of September 2021.
- As of September 2021, 4,354 youth involved in child welfare who had been referred for regional center services were identified as not having an open case with the regional center:
  - 1,950 youth had cases closed for an undetermined or other reason;
  - 1,804 youth were identified as being ineligible for regional center services; and
  - 600 youth were in identified as eligible for services but inactive.

Timing of Regional Center Intake

A close look at the timing of the aforementioned intake process (DDS Figure 3) reveals that the process is not significantly longer for dually served youth as a subset of all youth referred for regional center intake. Seventy-three percent (73 percent) of infants and toddlers referred for Early Start intake who are involved in child welfare experience an intake within the mandated 45-day time period, this is only a slightly smaller compared to the 79 percent share of all infants and toddlers referred for Early Start intake. Intake for Lanterman services that exceeded the mandated 120-day timeline is only slightly higher for youth involved with child welfare (18 percent) compared to all youth referred for Lanterman services (17 percent).

DDS Figure 3: Length of Regional Center Intake Process for Referred Youth in Child Welfare

CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370)

LENGTH OF INTAKE (DAYS)	**CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370)** Early Start (N=6,568)	**CONSUMERS REPORTED BEING DUALLY SERVED (N=10,370)** Lanterman (N=3,802)	**REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464)** Early Start (N=47,155)	**REGIONAL CENTER CONSUMERS 0-21 YEARS OLD (N=202,464)** Lanterman (N=155,309)
0 - 45	73%	27%	79%	25%
46 – 60	11%	8%	11%	8%
61 – 90	10%	21%	7%	21%
91 – 120	3%	26%	2%	29%
>120	3%	18%	1%	17%
Total	**100%**	**100%**	**100%**	**100%**

DDS Figure 4: Average Age of Youth in Child Welfare at the Time Regional Center Eligibility was Determined

Over a third of youth dually served (35 percent), first became eligible for Lanterman services at age six and older. More than half of the dually served youth (53 percent) became eligible for Lanterman services between the ages of three and five and almost 20 percent were found eligible after age ten. Early intervention services for youth with intellectual and developmental disabilities provide positive effects for developmental competence and minimizing developmental delays,[174] and access to these services for youth involved in the child welfare system are valuable given the inherit nature of trauma resulting from being system involved. Referrals to regional center services should not be delayed.

DDS Figure 4: AGE OF REGIONAL CENTER ELIGIBILITY BREAKDOWN[175, 176]

Services	0-2 years old	3-5 years old	6-9 years old	10-13 years old	14-17 years old	18-21 years old	Total
Early Start	99.83%	0.17%	-	-	-	-	100%
Lanterman	11.59%	53.28%	15.57%	10.47%	7.92%	1.17%	100%

Geographic Impact on Age at Eligibility Determination

The average age of eligibility determination for dually served youth varies widely based on the county or regional center catchment area. Nearly half of dually served youth live within the catchment areas of the seven regional centers within Los Angeles County. The average age of eligibility determination for Early Start consumers within Los Angeles County is eight months old, in line with the statewide average age. Likewise, the average age of eligibility determination for Lanterman service is 5 years and 11 months old, nearly the same as the statewide average age of 5 years, 9 months old. However, within the county some variation is found. Some Los Angeles County regional centers (HRC and WRC) have an average determination age for Early Start as young as six months old, while South Central Los Angeles Regional Center (SCLARC) and North Los Angeles County Regional Center (NLACRC) have a higher average age of determination (nine months old). Eastern Los Angeles Regional Center's (ELARC) average age for Lanterman determination is nearly a year older than the statewide average (6 years, 8 months compared to 5 years, 9 months).

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[174] Majnemer, A. (1998). Benefits Of Early Intervention For Children With Developmental Disabilities. *Seminars in Pediatric Neurology, 5*(1), 62-69. doi: 10.1016/s1071-9091(98)80020-x. PMID: 9548643

[175] Monthly CMF files from 1998 to 2020 were reviewed to track status change of each individual; age was calculated as of a given month when individual's status first changed (previous/prior status were not examined for youth in foster care); individuals could belong to both ES and Lanterman categories.

[176] Throughout the DDS data tables, "-" or dashes indicates there are no data associated with this field. "*" or asterisks indicates data has been suppressed to comply with data reporting confidentiality requirements.

DDS Figure 5: Individual Count and Average Ages of Youth in Child Welfare at the Time Regional Center Eligibility, by County

DDS Figure 5 (a): AGE YOUTH BECAME EARLY START ELIGIBLE[177]

County	Count[178]	Average Age
Yolo	*	1 year 5 months
Trinity		1 year 2 months
Contra Costa	75	1 year 2 months
Del Norte	19	1 year 2 months
Amador	12	1 year 1 month
Marin	*	1 year old
Merced	17	1 year old
Out-of-State	*	1 year old
Unknown	*	1 year old
Mendocino	19	11 months old
Sacramento	123	11 months old
San Mateo	12	11 months old
Napa	16	11 months old
Siskiyou	*	11 months old
Yuba	*	11 months old
El Dorado	15	11 months old
Sutter	13	11 months old
Placer	24	10 months old
Alameda	71	10 months old
Humboldt	23	10 months old
Butte	78	9 months old
Shasta	73	9 months old
Solano	50	9 months old
Riverside	558	9 months old
Modoc	*	9 months old
Tehama	31	9 months old
San Bernardino	723	9 months old
Kern	222	9 months old
Santa Clara	89	8 months old
Glenn	13	8 months old
Imperial	103	8 months old
Santa Barbara	50	8 months old
Los Angeles	3,697	8 months old
Fresno	203	8 months old
Lassen	*	8 months old

[177] Throughout the DDS data tables, "-" or dashes indicates there are no data associated with this field. "*" or asterisks indicates data has been suppressed to comply with data reporting confidentiality requirements.
[178] For counties with smaller counts of youth becoming eligible, the average age of referral for that county impacts the total average age. Counties are ranked from the highest to lowest average ages of eligibility.

County	Count[178]	Average Age
San Joaquin	213	8 months old
Monterey	49	7 months old
Lake	18	7 months old
Orange	398	7 months old
Stanislaus	91	7 months old
San Diego	670	7 months old
San Francisco	24	7 months old
Madera	15	6 months old
Kings	45	6 months old
Calaveras	*	6 months old
Nevada	*	6 months old
Sonoma	58	6 months old
Ventura	159	6 months old
Santa Cruz	*	5 months old
Tulare	144	5 months old
San Luis Obispo	74	5 months old
Tuolumne	*	5 months old
Colusa	*	4 months old
Inyo	*	3 months old
San Benito	11	3 months old
Mono	*	newborn
Plumas	*	newborn
Total	**8,392**	**8 months old**

DDS Figure 5 (b): AGE YOUTH BECAME LANTERMAN ELIGIBLE[179]

County	Count	Average Age
Yolo	14	10 years old
Santa Barbara	*	9 years old
Trinity	*	9 years old
Sutter	13	8 years 8 months
San Francisco	22	8 years 2 months
Sonoma	22	8 years 1 month
Colusa	*	8 years old
San Mateo	11	7 years 5 months
Merced	17	7 years 1 month
Calaveras	*	7 years old
Out-of-State	*	7 years old
Lassen	*	6 years 10 months
San Luis Obispo	15	6 years 9 months
Kern	119	6 years 7 months

[179] Throughout the DDS data tables, “-“ or dashes indicates there are no data associated with this field. “*” or asterisks indicates data has been suppressed to comply with data reporting confidentiality requirements.

County	Count	Average Age
Alameda	72	6 years 7 months
Fresno	108	6 years 7 months
Solano	39	6 years 6 months
Humboldt	24	6 years 2 months
Ventura	31	6 years 1 month
Yuba	11	6 years old
Sacramento	200	5 years 11 months
Los Angeles	1,620	5 years 11 months
Lake	12	5 years 10 months
San Benito	*	5 years 10 months
Orange	127	5 years 10 months
Del Norte	14	5 years 9 months
San Diego	233	5 years 9 months
Madera	11	5 years 9 months
Stanislaus	41	5 years 8 months
Tulare	45	5 years 8 months
Riverside	253	5 years 7 months
Contra Costa	98	5 years 7 months
Santa Clara	46	5 years 7 months
Kings	14	5 years 6 months
El Dorado	14	5 years 5 months
Monterey	16	5 years 4 months
Mendocino	24	5 years 3 months
Amador	*	5 years 2 months
Placer	39	5 years 1 month
Siskiyou	*	5 years old
San Bernardino	352	4 years 11 months
San Joaquin	111	4 years 11 months
Santa Cruz	*	4 years 10 months
Nevada	*	4 years 8 months
Plumas	*	4 years 6 months
Shasta	40	4 years 5 months
Tehama	20	4 years 4 months
Butte	49	4 years 4 months
Imperial	27	4 years old
Inyo	*	4 years old
Marin	*	4 years old
Modoc	*	4 years old
Tuolumne	*	4 years old
Napa	*	3 years 4 months
Mono	*	3 years old
Unknown	*	3 years old
Glenn	*	2 years 6 months
Total	**4,013**	**5 years 9 months**

ADDENDUM: SYSTEM OF CARE TECHNICAL ASSISTANCE (TA) CALL DATA

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 CDSS, DHCS, DDS, and 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 current Continuum of Care Reform technical assistance process and has broadened the scope and participation of 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

Once the local resolution process has been exhausted, 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. Documentation of attempts at resolution at the local level, barriers identified by system partners, and relevant background inclusive of the educational history 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 state TA team members. Each meeting is followed with an email summary of the recommendations, and follow-up meetings 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

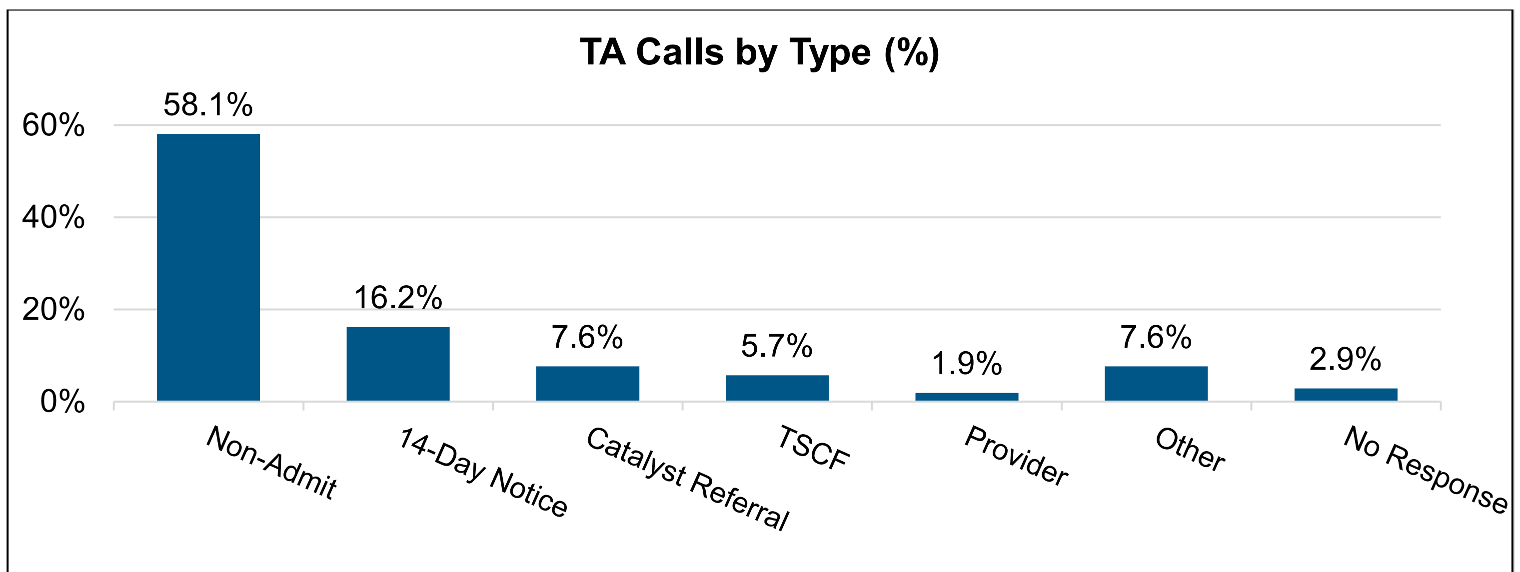
The development and implementation of the technical assistance framework has been a cross-system process, including evolving processes on how and what information to collect, beneficial facilitation and engagement frameworks informed by the local system partners and development of processes to include subject matter experts and intra- and inter-departmental and programmatic consultation. The following charts are an analysis of the TA Calls conducted by the CDSS System of Care Branch. There were 105

calls included between April 1, 2021 and March 31, 2022. The 105 calls include duplicated counts for youth who were the subject of multiple calls.

Limitations

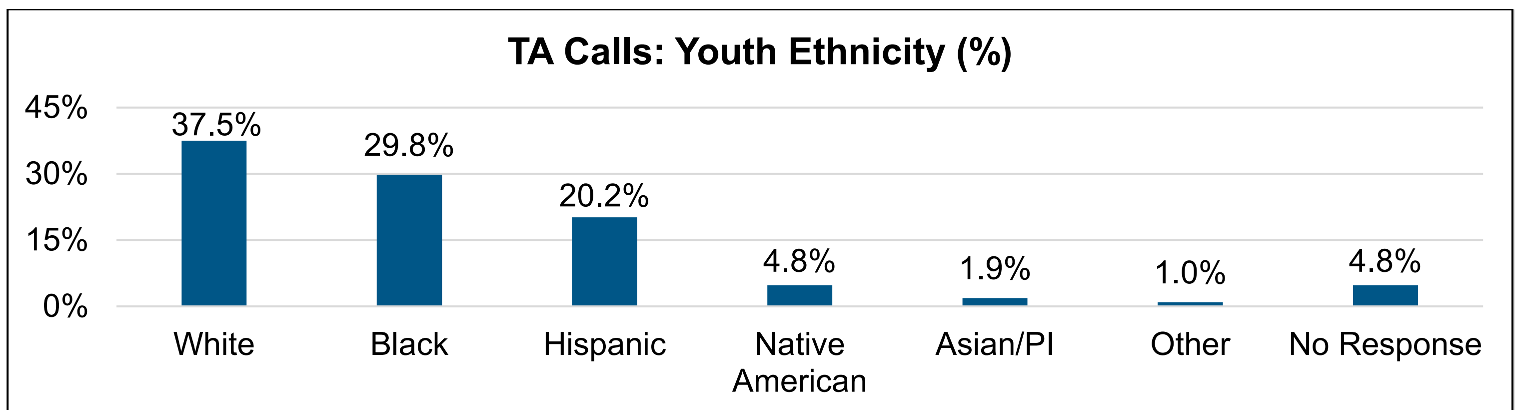
Data included in this report are as reported by local system partners and as observed during the meetings in a point in time and represents barriers presented at the time of case consultation. It does not represent a direct correlation between the information provided and systemic gaps or barriers. Given 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 the strengths and challenges presented in these cases as being representative of systemic issues throughout the state.

TA Figure 1



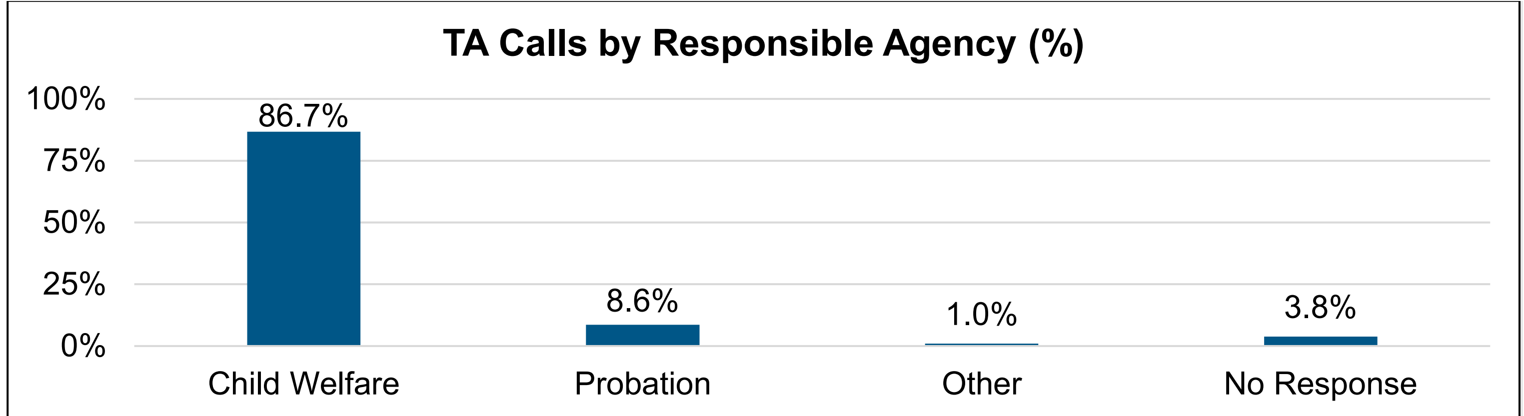
Note: TA Figure 1 numeric data is located on page 173.

TA Figure 2



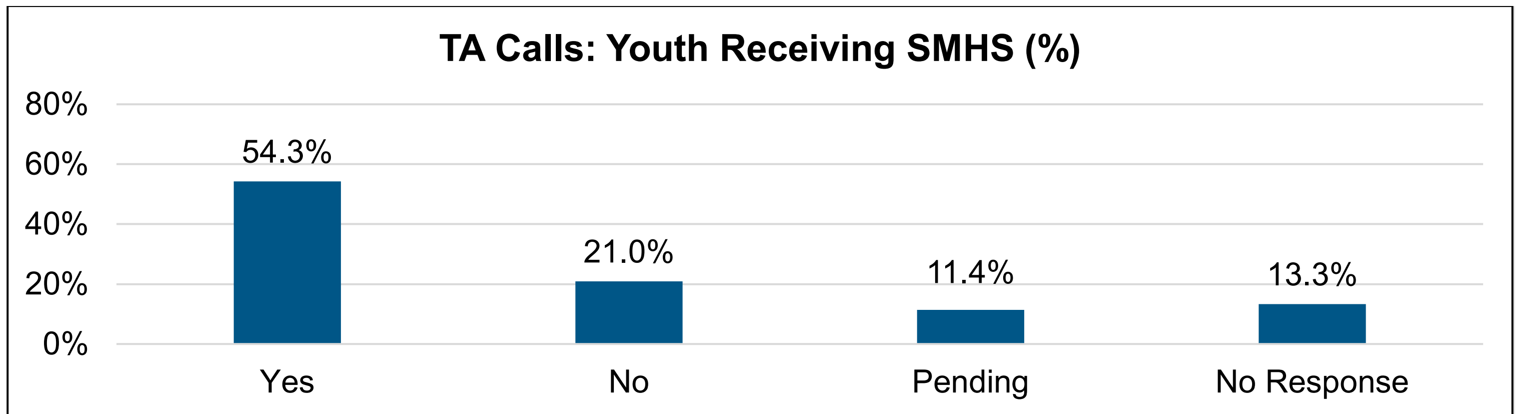
Note: TA Figure 2 numeric data is located on page 174.

TA Figure 3



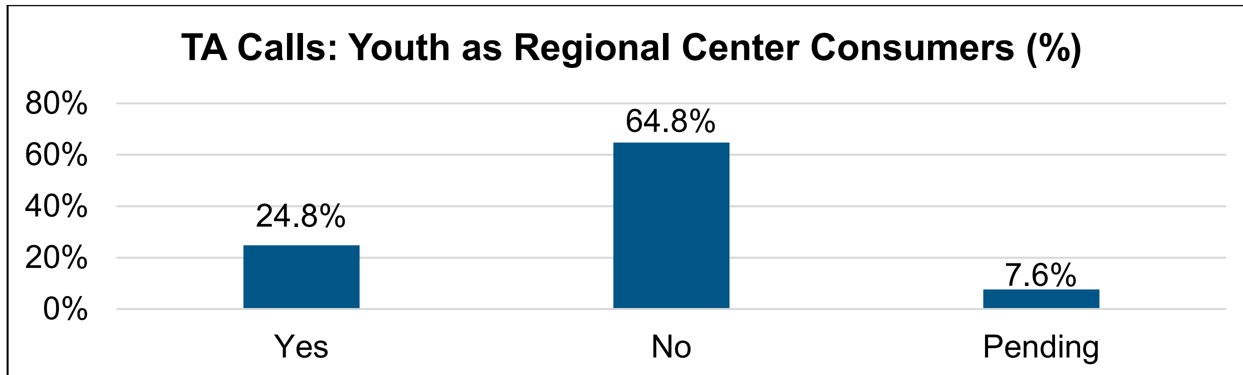
Note: TA Figure 3 numeric data is located on page 174.

TA Figure 4



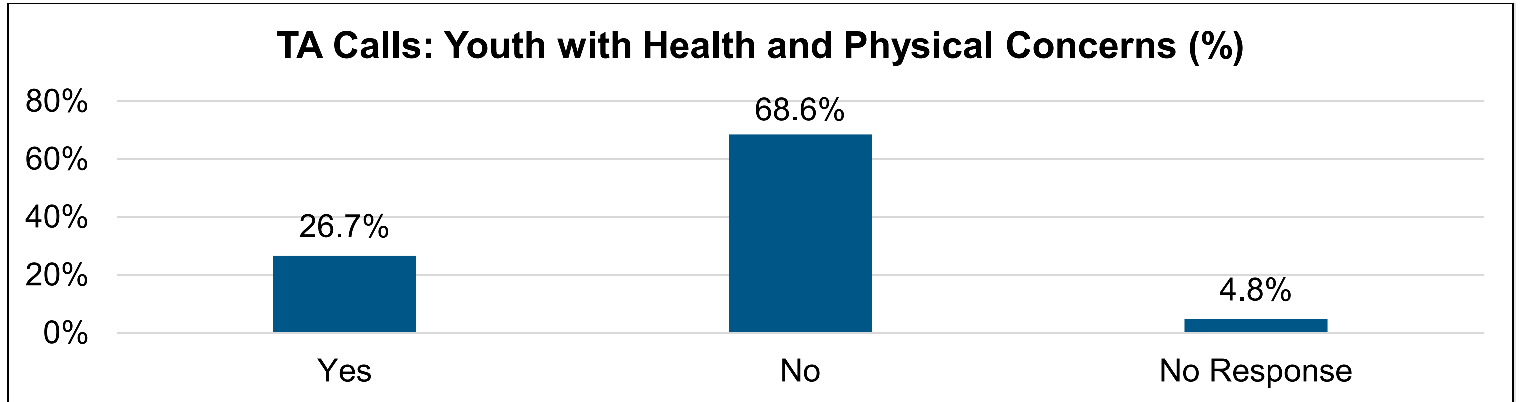
Note: TA Figure 4 numeric data is located on page 174.

TA Figure 5



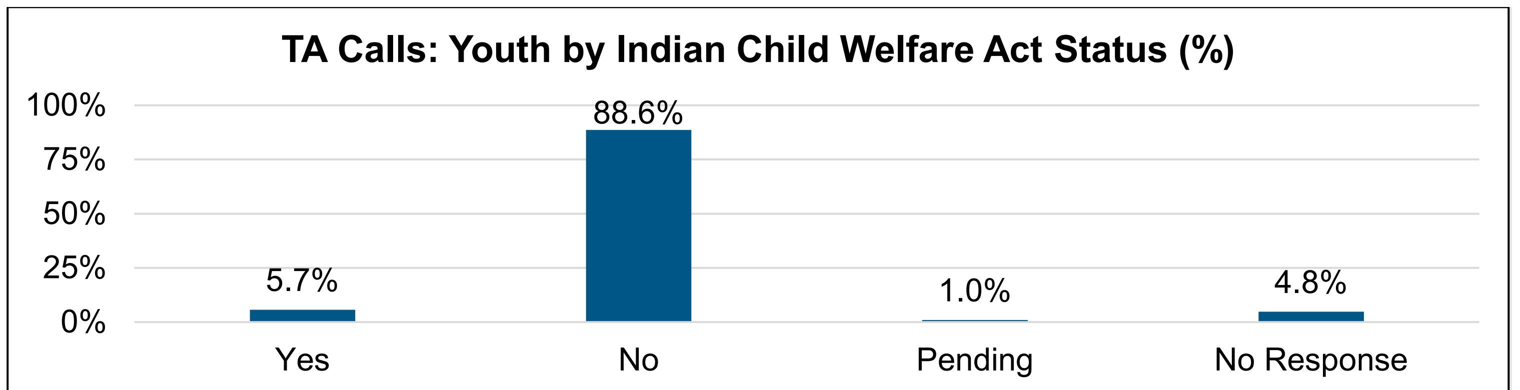
Note: TA Figure 5 numeric data is located on page 174.

TA Figure 6



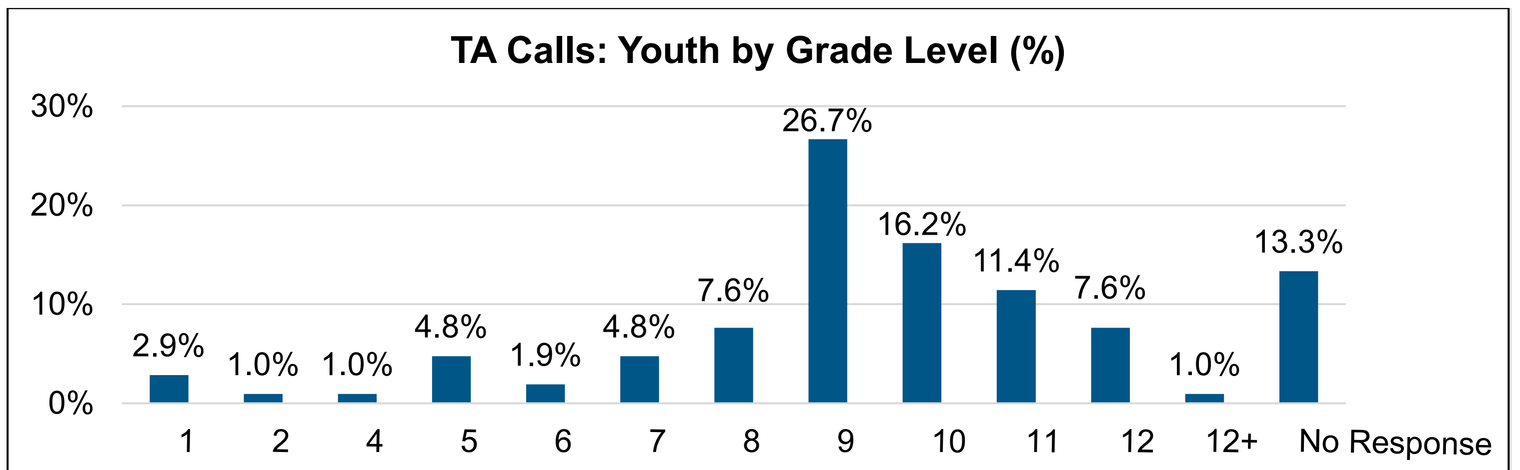
Note: TA Figure 6 numeric data is located on page 175.

TA Figure 7



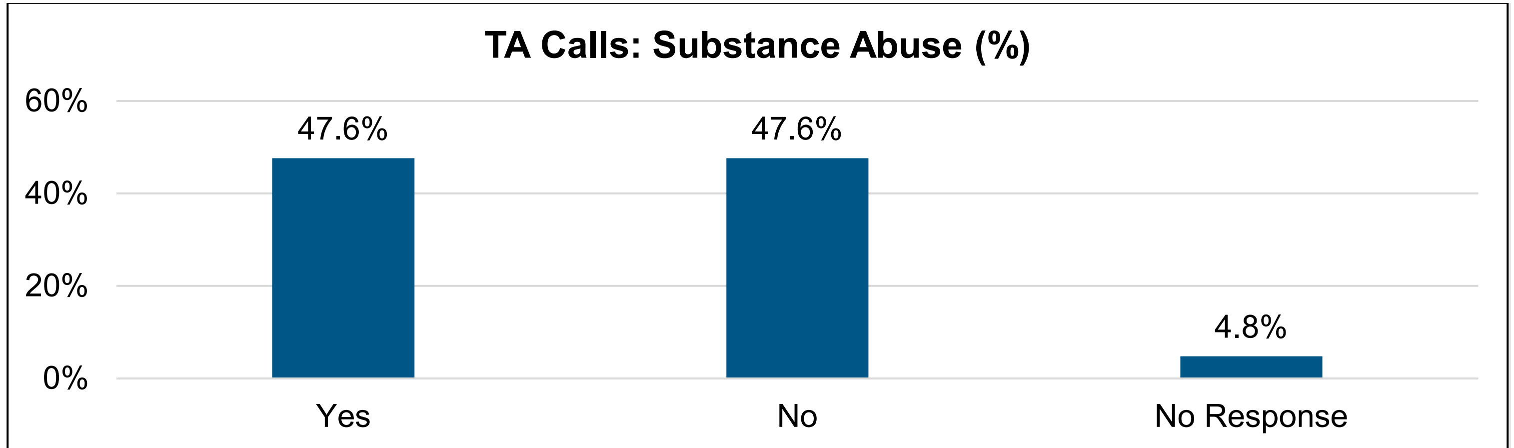
Note: TA Figure 7 numeric data is located on page 175.

TA Figure 8



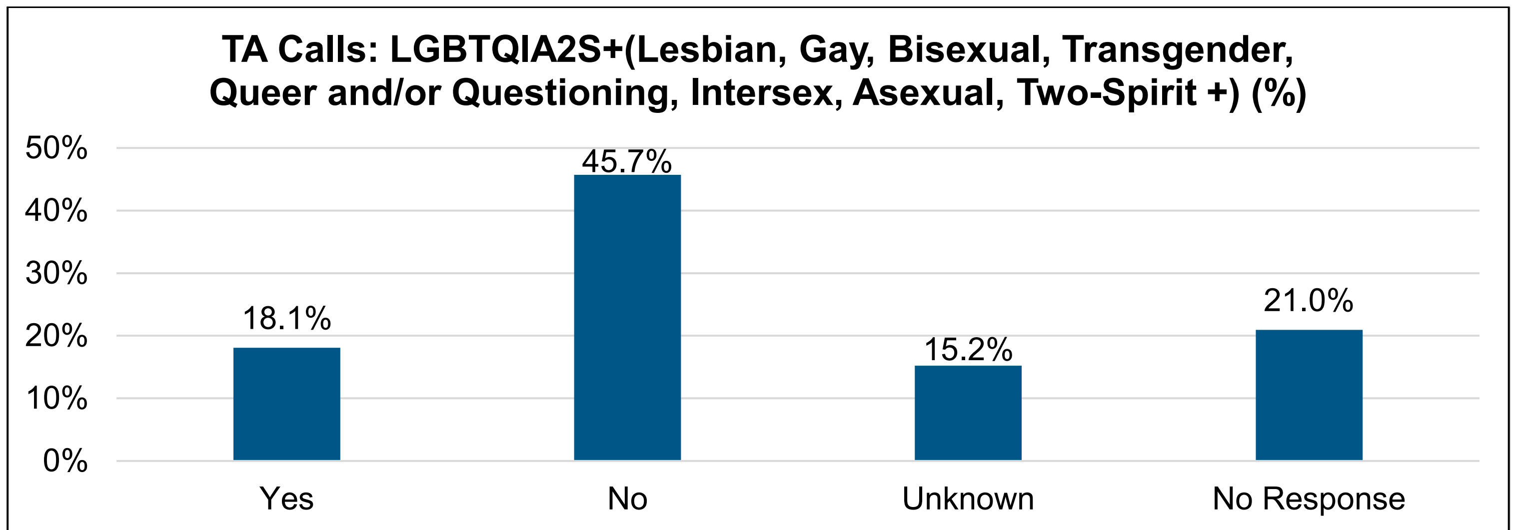
Note: TA Figure 8 numeric data is located on page 175.

TA Figure 9



Note: TA Figure 9 numeric data is located on page 176.

TA Figure 10



Note: TA Figure 10 numeric data is located on page 176.

TA Figure 11

Identified Area of Need	Percentage of Calls With Identified Need (Duplicated Counts) N=105 Calls
Aggressive/Disruptive	66%
Runaway/AWOL/Truancy	52%
Mental Health Diagnosis	46%
Suicidal/Self-harm	46%

Identified Area of Need	Percentage of Calls With Identified Need (Duplicated Counts) N=105 Calls
Youth Experienced Trauma	36%
Hospitalizations	35%
Psychotropic Medication Management	35%
Adjustment to Trauma	30%
Alcohol/Substance Use	30%
Mood Disturbances	22%
CSEC/At-Risk	21%
Developmental Disability	17%
Sexual Behaviors	16%
Educational Needs	16%
Other	15%
Medical Management	14%
ISFC	11%
Physical Health diagnosis	9%
Youth Age	8%
Hypervigilant/Anxiety	8%
Reaching Transitional Age	6%
ICWA	4%
Avoidance	4%
Language Barrier	3%
Adjudicated NSE	2%
Unaccompanied Refuge Minor	2%
Non-Ambulatory	1%
Pregnancy/Parenting	1%

APPENDIX

CDSS Figure 3: Children Entering Care: Received CFTs

Category	Count
Children Entering Care	5,474
Received CFT	2,926
CFT occurred within 60 Days	2,251

Note: CDSS Figure 3 chart is located on page 109.

CDSS Figure 4: Child and Family Team Meetings: Reason for Child Absence from CFT

Age Group	Age	AWOL or Absconded from Care	Child/ Youth Declined or Refused	Data Missing	Developmental Reasons	Inappropriate Subject Matter	Other	Scheduling Conflict
0-2	71%	0%	0%	4%	7%	7%	8%	3%
3-5	59%	0%	1%	4%	6%	14%	10%	6%
6-10	38%	0%	3%	8%	6%	16%	14%	15%
11-13	13%	1%	11%	12%	3%	13%	23%	24%
14-17	3%	5%	13%	14%	2%	6%	37%	20%
18-20	0%	50%	0%	0%	0%	0%	50%	0%

Note: CDSS Figure 4 chart is located on page 110.

CDSS Figure 5: CFT Meetings by Number of Key Role Attendees

Key Role Attendees	Percent
0	1.8%
1-3	31.9%
4-6	52.5%
7+	13.8%

Note: CDSS Figure 5 chart is located on page 111.

CDSS Figure 6: CFT Meetings by Key Role Attendee Type

Key Role Attendee Type	Percent
Bio Mother	63.9%
Resource Parent	41.3%
Child	38.1%
Bio Father	32.6%
Behavioral Health Provider	17.5%
FFA Staff	13.1%
STRTP Staff	5.3%
Probation Placement Officer	4.1%
Tribal Representative	1.4%

Note: CDSS Figure 6 chart is located on page 111.

CDSS Figure 8: Entries into Foster Care by Age Group and Year

Age Group	2018	2019	2020	2021
0-5	13,168	13,676	11,871	10,849
6-10	5,598	5,850	4,751	4,444
11-17	8,412	8,764	6,836	6,149
18-20	630	667	563	397

Note: CDSS Figure 8 chart is located on page 112.

CDSS Figure 9: Children and Youth in Foster Care – Specialty Mental Health Services

Age Group	Screening	Referral	5 or More Days of SMHS
0-5	12,905	7,199	6,219
6-10	7,298	4,314	8,773
11-15	5,773	3,349	8,026
16-17	2,408	1,296	3,504

Note: CDSS Figure 9 chart is located on page 113.

CDSS Figure 10: Percentage Breakdown and Total Number of LOC and ISFC Placements Over Time

Level of Care	Jan-20	Jul-20	Jan-21	Jul-21
Basic	72%	70%	70%	69%
Level 2	17%	16%	15%	15%
Level 3	3%	4%	5%	5%
Level 4	2%	3%	3%	4%
ISFC	5%	6%	7%	7%
Total Placements Receiving LOC/ISFC Rate	7,307	8,100	8,828	9,287

Note: CDSS Figure 10 chart is located on page 114.

CDSS Figure 12: STRTP Youth: Duration of Foster Care Episode and by Ethnicity

Ethnicity	Duration Days
Black	1,086
Native American/AA	1,057
White	990
Asian/PI	948
Hispanic	918
Latino	439

Note: CDSS Figure 12 chart is located on page 117.

CDSS Figure 13: STRTP Youth: Average Number of Placements and by Ethnicity

Ethnicity	Average Number of Placements
Native American/AA	5
Black	5
White	5
Hispanic	5
Asian/PI	4
Latino	2

Note: CDSS Figure 13 chart is located on page 117.

CDSS Figure 14: Age of Youth at Removal within Current Episode

Age Group	Number of Youth
Under 6	454
18+	760
6 to 12	1,635
12 to 18	5,754

Note: CDSS Figure 14 chart is located on page 118.

CDSS Figure 15: STRTP Youth: Age if Still in Care

Age Group	Number of Youth
Under 6	80
6 to 12	446
18+	2,851
12 to 18	3,033

Note: CDSS Figure 15 chart is located on page 118.

CDSS Figure 19: STRTP Youth: Average Duration and Number of AWOL/Disruptions

AWOL/Disruptions	Duration Days
1	1,327
2	2,026
3	1,622
4	1,467
5	2,967
6+	2,891

Note: CDSS Figure 19 chart is located on page 121.

CDSS Figure 20: STRTP Youth with Psychiatric Stays: Average Number of Placements and Number of Psychiatric Stays

Average Psychiatric Stays	Average Number of Placements
1	7
2	10

Average Psychiatric Stays	Average Number of Placements
3	8
4	12
5	15
6+	10

Note: CDSS Figure 20 chart is located on page 122.

CDSS Figure 21: STRTP Youth: Comparison of Average Number of Placement and Number of Juvenile Hall Stays

Juvenile Hall Stays	Average Number of Placements
1	3
2	4
3	6
4	6
5	6
6+	8

Note: CDSS Figure 21 chart is located on page 122.

CDSS Figure 22: Exited to Permanency (of 910 youth that exited care)

Exit Care Type	Percent
Non-Permanency Exit	52.70%
Reunified	46.50%
Adoption	0.10%
Guardianship	0.70%

Note: CDSS Figure 22 chart is located on page 123.

CDSS Figure 23: % Exiting Care from Congregate vs After Congregate During Study Period

Category	Percent
Exited from Congregate	63.85%
Exited after Congregate	36.15%

Note: CDSS Figure 23 chart is located on page 123.

CDSS Figure 24: Total Placements in Episode (% of Youth)

Total Placements	Percent
1	26.40%
2	15.83%
3	12.12%
4	8.87%
5	6.25%
6	5.28%
7	4.54%
8	3.83%
9	3.18%
10	2.42%
11	2.54%
12	1.20%
13	1.37%
14	1.12%
15	0.88%
16	0.78%
17	0.46%
18	0.54%
19	0.42%
20	0.54%
21	0.32%
22	0.29%
23	0.05%
24	0.17%
25	0.20%
26	0.17%
27	0.12%
28	0.02%
29	0.07%
38	0.02%

Note: CDSS Figure 24 chart is located on page 124.

DHCS Figure 1: The Number of Children/Youth in Foster Care Placement Receiving SMHS by Fiscal Year

Fiscal Year	Unique Count Receiving SMHS
FY16-17	39,419
FY17-18	39,518
FY18-19	39,712
FY19-20	39,179

Note: DHCS Figure 1 chart is located on page 127.

DHCS Figure 2: Unique Count of Children in Foster Care who are Medi-Cal Eligible

Fiscal Year	Unique Count of Medi-Cal Eligibles
FY16-17	86,656
FY17-18	84,163
FY18-19	82,252
FY19-20	79,360

Note: DHCS Figure 2 chart is located on page 127.

DHCS Figure 3: Unique Count of Children in Foster Care Receiving Mental Health Services in FY 18/19, By Delivery System

Delivery System	Unique Count of Children in Foster Care Receiving Mental Health Services
SMHS Only	31448
Both SMHS and Non-SMHS	8322
Non-SMHS Only	4407

Note: DHCS Figure 3 chart is located on page 128.

DHCS Figure 4: Children in Foster Care, SMHS Penetration Rates by Fiscal Year: 2015-2020

SFY	Percentage of Population that Received SMHS
2015	47%
2016	46%
2017	45%
2018	47%
2019	48%
2020	49%

Note: DHCS Figure 4 chart is located on page 128.

DHCS Figure 5: Children in Foster Care, SMHS Penetration Rates by Age and Fiscal Year

SFY	Children 0-2	Children 3-5	Children 6-11	Children 12-17	Youth 18-20
2015	24%	41%	58%	62%	37%
2016	24%	42%	56%	57%	36%
2017	24%	43%	56%	57%	35%
2018	26%	44%	57%	58%	36%
2019	25%	46%	59%	60%	37%
2020	25%	48%	60%	61%	38%

Note: DHCS Figure 5 chart is located on page 129.

DHCS Figure 6: Children in Foster Care, SMHS Penetration Rates by Race and Fiscal Year

SFY	Black	Hispanic	White	Other
2015	52%	47%	45%	46%
2016	49%	46%	43%	43%
2017	48%	46%	43%	44%
2018	49%	48%	44%	44%
2019	50%	50%	46%	45%
2020	52%	51%	48%	45%

Note: DHCS Figure 6 chart is located on page 130.

DHCS Figure 7: Children in Foster Care, SMHS Penetration Rate by Sex and Fiscal Year

SFY	Female	Male
2015	47%	47%
2016	46%	45%
2017	46%	45%
2018	47%	47%
2019	48%	48%
2020	50%	49%

Note: DHCS Figure 7 chart is located on page 130.

CDE Figure 1: School Enrollment by Year

Year	Students in Foster Care Enrollment
2015-16	62,602
2016-17	55,282
2017-18	50,247
2018-19	46,810
2019-20	45,307

Note: CDE Figure 1 chart is located on page 131.

CDE Figure 2: Students in Foster Care Enrollment by County

County	Students in Foster Care Enrollment
Alameda	884
Alpine	2
Amador	71
Butte	468
Calaveras	165
Colusa	61
Contra Costa	976
Del Norte	88
El Dorado	492
Fresno	2,256
Glenn	67

County	Students in Foster Care Enrollment
Humboldt	385
Imperial	453
Inyo	99
Kern	1,801
Kings	398
Lake	70
Lassen	94
Los Angeles	15,697
Madera	371
Marin	148
Mariposa	57
Mendocino	257
Merced	794
Modoc	34
Mono	6
Monterey	288
Napa	143
Nevada	152
Orange	2,617
Placer	384
Plumas	37
Riverside	4,044
Sacramento	2,063
San Benito	80
San Bernardino	6,197
San Diego	1,907
San Francisco	702
San Joaquin	1,612
San Luis Obispo	353
San Mateo	260
Santa Barbara	394
Santa Clara	965
Santa Cruz	202

County	Students in Foster Care Enrollment
Shasta	447
Sierra	6
Siskiyou	108
Solano	501
Sonoma	601
Stanislaus	911
Sutter	216
Tehama	187
Trinity	69
Tulare	1,186
Tuolumne	88
Ventura	705
Yolo	409
Yuba	235

Note: CDE Figure 2 chart is located on page 132.

CDE Figure 3: Special Education Identification

Student Group	% Special Education	% not Special Education
Non-Foster Care	12.8%	87.2%
Foster Care	31.4%	68.6%

Note: CDE Figure 3 chart is located on page 133.

CDE Figure 4: Juvenile Detention Rate for Students in Foster Care by County

County	Juvenile Detention Rate
Alameda	13.7%
Amador	0.0%
Butte	2.6%
Calaveras	0.0%
Colusa	0.0%
Contra Costa	7.8%
Del Norte	8.0%

County	Juvenile Detention Rate
El Dorado	49.0%
Fresno	8.2%
Glenn	0.0%
Humboldt	4.9%
Imperial	4.0%
Inyo	1.0%
Kern	22.5%
Kings	6.0%
Lake	0.0%
Lassen	12.8%
Los Angeles	7.4%
Madera	8.4%
Marin	14.9%
Mariposa	0.0%
Mendocino	6.2%
Merced	4.5%
Modoc	0.0%
Monterey	12.2%
Napa	11.2%
Nevada	7.9%
Orange	12.9%
Placer	8.1%
Plumas	0.0%
Riverside	4.5%
Sacramento	11.2%
San Benito	3.8%
San Bernardino	3.8%
San Diego	13.9%
San Francisco	12.7%
San Joaquin	8.2%
San Luis Obispo	7.1%
San Mateo	11.9%
Santa Barbara	9.9%

County	Juvenile Detention Rate
Santa Clara	7.3%
Santa Cruz	6.4%
Shasta	8.3%
Siskiyou	4.6%
Solano	7.0%
Sonoma	9.8%
Stanislaus	7.4%
Sutter	0.0%
Tehama	13.9%
Trinity	0.0%
Tulare	3.8%
Tuolumne	6.8%
Ventura	9.5%
Yolo	4.4%
Yuba	5.5%

Note: CDE Figure 4 chart is located on page 134.

CDE Figure 5: Average Days Absent from School by Student Group

Student Group	Average Days Absent
Foster Youth	15.3
Homeless Youth	14.3
Students with Disabilities	12.8
Socioeconomically Disadvantaged	10.9
English Learners	9.7
Migrant Youth	8.1

Note: CDE Figure 5 chart is located on page 135.

CDE Figure 6: Percent of Total Absences Reported as Unexcused by Student Group

Student Group	Percent of Total Absences as Unexcused
Foster Youth	51.0%
Homeless Youth	50.6%

Student Group	Percent of Total Absences as Unexcused
English Learners	44.0%
Socioeconomically Disadvantaged	43.9%
Students with Disabilities	41.5%
Migrant Education	41.2%

Note: CDE Figure 6 chart is located on page 135.

CDE Figure 7: Percent of Students Chronically Absent by Student Group

Student Group	Percent Chronic Absence
Foster Youth	27.7%
Homeless Youth	25.0%
Students with Disabilities	19.5%
Socioeconomically Disadvantaged	15.2%
English Learners	12.5%
Migrant Education	8.9%

Note: CDE Figure 7 chart is located on page 136.

CDE Figure 8: Stability and Non Stability Rates for Students in Foster Care by School Year

School Year	Percent Stable	Percent Non Stable
2017-18	61.8%	38.2%
2018-19	61.9%	38.1%
2019-20	65.8%	34.2%

Note: CDE Figure 8 chart is located on page 136.

CDE Figure 9: Non Stability Rate by Student Group 2019-20

Student Group	Percent Students Non Stable
Students with Disabilities	9.0%
Socioeconomically Disadvantaged	9.4%
English Learners	10.0%
Migrant	12.4%
Homeless Youth	20.5%
Foster Youth	34.2%

Note: CDE Figure 9 chart is located on page 137.

CDE Figure 10: Suspension Rates by Student Group

Student Group	Suspension Rate
Foster Youth	15.1%
Students with Disabilities	6.4%
Homeless Youth	6.3%
Socioeconomically Disadvantaged	4.4%
Migrant Education	4.0%
English Learners	3.2%

Note: CDE Figure 10 chart is located on page 137.

CDE Figure 11: Expulsion Rates by Student Group

Student Group	Expulsion Rate
Foster Youth	0.36%
Homeless Youth	0.19%
Socioeconomically Disadvantaged	0.11%
Students with Disabilities	0.08%
English Learners	0.07%
Migrant Education	0.06%

Note: CDE Figure 11 chart is located on page 138.

CDE Figure 12: Statewide Graduation Rates by Student Group

Student Group	Graduation Rate
Foster Youth	56.0%
Students with Disabilities	67.7%
English Learners	68.7%
Homeless Youth	70.0%
Socioeconomically Disadvantaged	81.1%
Migrant Education	81.6%

Note: CDE Figure 12 chart is located on page 138.

CDE Figure 13: Statewide Dropout Rate by Student Group

Student Group	Dropout Rate
Foster Youth	27.9%
English Learners	18.4%
Homeless Youth	18.1%
Students with Disabilities	13.5%
Migrant Education	11.2%
Socioeconomically Disadvantaged	10.8%

Note: CDE Figure 13 chart is located on page 139.

CDE Figure 14: Percent of 2017-18 High School Graduates Enrolling in College within 12 Months of Graduating High School

Student Group	College-Going Rate
Socioeconomically Disadvantaged	57%
Students with Disabilities	45%
Migrant Education	54%
Homeless Youth	50%
Foster Youth	48%
English Learners	42%

Note: CDE Figure 14 chart is located on page 139.

TA Figure 1: TA Calls by Type (%)

TA Call Type	Percent
Non-Admit	58.1%
14 Day Notice	16.2%
Catalyst Referral	7.6%
TSCF	5.7%
Provider	1.9%
Other	7.6%
No Response	2.9%

Note: TA Figure 1 chart is located on page 153.

TA Figure 2: TA Calls: Youth Ethnicity

Ethnicity	Percent
White	37.5%
Black	29.8%
Hispanic	20.2%
Native American	4.8%
Asian/Pacific Islander	1.9%
Other	1.0%
No Response	4.8%

Note: TA Figure 2 chart is located on page 153.

TA Figure 3: TA Calls by Responsible Agency

Responsible Agency	Percent
Child Welfare	86.7%
Probation	8.6%
Other	1.0%
No Response	3.8%

Note: TA Figure 3 chart is located on page 154.

TA Figure 4: TA Calls: Youth Receiving Specialty Mental Health Services

Response	Percent
Yes	54.3%
No	21.0%
Pending	11.4%
No Response	13.3%

Note: TA Figure 4 chart is located on page 154.

TA Figure 5: TA Calls: Youth as Regional Center Consumers

Response	Percent
Yes	24.8%
No	64.8%
Pending	7.6%

Note: TA Figure 5 chart is located on page 154.

TA Figure 6: TA Calls: Youth with Health and Physical Concerns

Response	Percent
Yes	26.7%
No	68.6%
No Response	4.8%

Note: TA Figure 6 chart is located on page 155.

TA Figure 7: TA Calls: Youth by Indian Child Welfare Act Status

Response	Percent
Yes	5.7%
No	88.6%
Pending	1.0%
No Response	4.8%

Note: TA Figure 7 chart is located on page 155.

TA Figure 8: TA Calls: Youth by Grade Level

Grade Level	Percent
1	2.9%
2	1.0%
4	1.0%
5	4.8%
6	1.9%
7	4.8%
8	7.6%
9	26.7%
10	16.2%
11	11.4%
12	7.6%
12+	1.0%
No Response	13.3%

Note: TA Figure 8 chart is located on page 155.

TA Figure 9: TA Calls: Substance Abuse

Response	Percent
Yes	47.6%
No	47.6%
No Response	4.8%

Note: TA Figure 9 chart is located on page 156.

TA Figure 10: TA Calls: LGBTQIA2S+

Response	Percent
Yes	18.1%
No	45.7%
Unknown	15.2%
No Response	21.0%

Note: TA Figure 10 chart is located on page 156.

GLOSSARY

Assembly Bill 2083

AB 2083 (2018, Cooley) requires each county to develop a memorandum of understanding (MOU) to describe the roles and responsibilities certain entities that serve children and youth in foster care who have experienced severe trauma, and instructs the Secretary of California Health and Human Services, and the Superintendent of Public Instruction to establish a joint interagency resolution team.

Assembly Bill 403

AB 403 (2015, Stone) began the process of reforming the continuum of care (CCR) for foster children and youth. The reform effort aimed to make sure that children and youth in foster care have their day-to-day physical, mental, and emotional needs met; that they have the greatest chance to grow up in permanent and supportive homes; and that they have the opportunity to grow into self-sufficient, successful adults. AB 403 advanced California's long-standing goal to move away from the use of long-term group home care by increasing youth placement in family settings and by transforming existing group home care into places where youth who are not ready to live with families can receive short-term, intensive treatment.

Capacity Building for Complex Care

AB 153 provides $43.3 million in funding to both county welfare agencies and probation departments to support counties with establishing a high-quality continuum of care designed to support foster children/NMDs in the least restrictive setting, consistent with the child/NMD's permanency plan.

Child and Adolescent Needs and Strengths (CANS) Tool

CANS is a multi-purpose tool that supports decision-making, including level of care and service planning, which allows for the monitoring and outcome of services. When used as part of the Child and Family Team (CFT) process, as California is doing, the CANS tool can help guide conversations among CFT members about the well-being of children and youth, identify their strengths and needs, inform and support care coordination, aid in case planning activities, and inform decisions about placement. Visit the CANS website to learn more about the CANS tool.

Child and Family Team (CFT)

The CFT process begins when a child or youth enters foster care, and a child welfare social worker or juvenile probation officer engages with a child or youth and his or her family and then uses a variety of strategies to identify other team members, the child or youth's strengths, the child, youth, and family's concerns, and a plan to help achieve positive outcomes for safety, permanency, and well-being. These strengths-based approaches to practice recognizes that families are experts in their own lives, and they can achieve success when they have an active role in creating and implementing solutions. The CFT process aligns with recent implementation of the Child and Adolescent Needs and Strengths (CANS) Assessment tool by CDSS and the Department of Health Care Services (DHCS). Visit the CFT website to learn more about how the CANS and the CFT process work together.

Continuum of Care Reform (CCR)

CCR draws together a series of existing and new reforms to our child welfare services program designed out of an understanding that children who must live apart from their biological parents do best when they are cared for in committed nurturing family homes. Assembly Bill 403 provides the statutory and policy framework to ensure services and supports provided to the child or youth and his or her family are tailored toward the ultimate goal of maintaining a stable permanent family. CCR is designed to meet the

individualized needs of children and youth in foster care who have experienced trauma, abuse and neglect, and meaningfully supports for the families that care for them. The reform is founded on child development research, including research related to adverse childhood experiences, and practice knowledge showing that resilience and recovery from trauma is best supported by loving, accepting and healthy parenting, while recognizing that state and local programs must support caregivers in meeting the educational, developmental, physical and behavioral health needs of children and youth involved in the child welfare and probation systems. For more information on CCR, visit the CCR website.

County Offices of Education

There are 58 county offices of education that provide services to the state's school districts. The county offices have elected governing boards and are administered byelected or appointed county superintendents. The county superintendent is responsible for examining and approving school district budgets and expenditures.

County offices of education support school districts by performing tasks that can be done more efficiently and economically at the county level. County offices provide or help formulate new curricula, staff development and training programs, and instructional procedures; design business and personnel systems; and perform many other services to meet changing needs and requirements. When economic or technical conditions make county or regional services most appropriate for students, county offices provide a wide range of services, including special and vocational education, programs for youths at risk of failure, and instruction in juvenile detention facilities.

County Managed Care Plan

Medi-Cal Managed Care provides high-quality, accessible, and cost-effective health care through managed care delivery systems and contracts for health care services through established networks of organized systems of care, which emphasize primaryand preventive care. Medi-Cal beneficiaries in all 58 California counties receive their health care through six main models of managed care: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model (RM), Imperial, and San Benito. Medi-Cal providers who wish to provide services to managed care enrollees must participate in the managed care plan's provider network. For more information on county managed care plans, visit the Medi-Cal Managed Care website.

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)

The EPSDT benefit provides comprehensive health coverage for all children under age 21 who are enrolled in Medicaid, or Medi-Cal in California. Consistent with state and federal law and regulations for EPSDT, Medi-Cal covers all medically necessary services, including those to "correct or ameliorate" defects and physical and mental illnesses or conditions. This includes, but is not limited to, physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; and treatment for vision, hearing, and dental diseases and disorders. All of these services are at no-cost to individuals under age 21 who have full-scope Medi-Cal. Visit the EPSDT website for more information on the EPSDT services.

Early Start

The Department of Developmental Services (DDS) oversees the coordination and provision of services and supports for most Early Start infants and toddlers. The Early Start program (California Early Intervention Services Act [CEISA], Government Code, Title 14, Sections 95000-95029.5) is California's

early intervention program for infants and toddlers with disabilities and their families. Early Start is a multiagency effort by the Department of Developmental Services, in collaboration with the California Department of Education. Early Start services are available statewide and are provided in a coordinated, family-centered system and may be accessed through regional centers and local educational agencies.

Excellence in Family Finding and Engagement

The 2022/23 Budget to provide a one-time block grant for family finding, support, and engagement activities to be expended over five years. Funds are for permanency specialists who will focus exclusively on family finding as well as the tools, trainings and resources to support the specialized work. These specialists will have no additional case carrying duties and will work solely as permanency specialists.

Family Educational Rights and Privacy Act (FERPA)

FERPA is a federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students." Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the followingconditions (34 CFR § 99.31):

- School officials with legitimate educational interest;
- Other schools to which a student is transferring;
- Specified officials for audit or evaluation purposes;
- Appropriate parties in connection with financial aid to a student;
- Organizations conducting certain studies for or on behalf of the school;
- Accrediting organizations;
- To comply with a judicial order or lawfully issued subpoena;
- Appropriate officials in cases of health and safety emergencies; and
- State and local authorities, within a juvenile justice system, pursuant to specific State law.

Family Resource Centers (Early Start)

Families of infants and toddlers can receive parent-to-parent support from Early Start Family Resource Centers. Family Resource Centers (FRC) actively work in partnership with local regional centers and education agencies and help many parents, families and children get information about early intervention services and how to navigate the Early Start system.

Family Urgent Response System (FURS)

FURS is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth.

Federal Family First Prevention Services Act (FFPSA) Part 1

Implementation of Title IV-E prevention services under the FFPSA will further California's efforts to transform child protection and the foster care system to a child well-being system within a reimagined Child and Family Well Being Continuum. California is working towards shifting the mindset from a reactionary approach to a child welfare and juvenile justice system of care focused on prevention and early intervention. FFPSA Part 1 changes the financial structure of Title IV-E, which has historically been limited

to supporting the care and maintenance costs for children removed from their homes and placed into foster care, by allowing states to access these dollars for prevention services.

FFPSA Part 4

The FFPSA Part IV establishes new requirements for placements in child-care institutions to be eligible for Title IV-E FFP with the aim of limiting reliance upon such settings and making certain any placement in congregate care is necessary. Additionally, the FFPSA Part IV requires that an assessment by a Qualified Individual (QI) be completed any time a child is placed in a QRTP (e.g. STRTP) to determine if a child's needs can instead be met with family members, in a family home, or in one of the other approved settings and to make other specified determinations.

Foster Youth Executive Advisory Council

Foster Youth Services Coordinating Programs (FYSCP) were established by the Legislature in 2015 so that the county office of education could support interagency collaboration and capacity building, both at the system and individual pupil level, focused on improving educational outcomes for pupils in foster care. This is a key component to the successful implementation of the local control funding formula (LCFF). The FYSCPs support and facilitate collaboration and capacity building while preserving the ability to provide direct services such as tutoring, mentoring, counseling, transition, school-based social work, and emancipation assistance when there are identified gaps in service at the local level for foster youth. Each FYSCP established a local Executive Advisory Council (EAC) whose members include local or tribal welfare probation departments, the courts, and other stakeholders. The EAC establishes that these services are needed, coordinates services to avoid redundancy, and aligns its efforts with local control and accountability plan priorities.

Foster Youth Services Coordinating Program

The Foster Youth Services Coordinating Program was established by the Legislature in 2015 so that the county office of education (COE) could support interagency collaboration and capacity building, both at the system and individual pupil level, focused on improving educational outcomes for pupils in foster care.

Health Insurance Portability and Accountability Act of 1996 (HIPPA)

HIPPA is federal legislation that provides data privacy and security provisions for safeguarding medical information. HIPPA required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. To fulfill this requirement, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule, or *Standards for Privacy of Individually Identifiable Health Information*, establishes national standards for the protection of certain health information. The *Security Standards for the Protection of Electronic Protected Health Information* (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form. The Security Rule operationalizes the protections contained in thePrivacy Rule by addressing the technical and non-technical safeguards that organizations called "covered entities" must put in place to secure individuals' "electronic protected health information" (e-PHI).

Individuals with Disabilities Education Act (IDEA)

The Individuals with Disabilities Education Act (IDEA) is a law that makes available a free appropriate public education to eligible children with disabilities throughout the nation and ensures special education and related services to those children. The IDEA governs how states and public agencies provide early intervention, special education, and related services to more than 6.5 million eligible infants, toddlers,

children, and youth with disabilities. Infants and toddlers, birth through age 2, with disabilities and their families receive early intervention services under IDEA Part C. Children and youth ages 3 through 21 receive special education and related services under IDEA Part B.

Individual Family Service Plan (IFSP)

Infants and toddlers ages zero to three, with or at risk of a developmental disability and/or delay may be found eligible for early intervention services through the Early Start program. Once an infant or toddler is determined to be eligible for services, an Individual Family Service Plan (IFSP) is developed with a multidisciplinary planning team, including the parents.

An IFSP is a written document or plan based on an assessment of the child's needs and the needs and concerns of the family. An IFSP will address the strengths, and needs of the infant or toddler, parental concerns, and early intervention services identified. Specifically, the IFSP contains 1) information on the child's present level of development in five developmental domains; 2) outcomes for the child and family; 3) services the child and family will receive to help them achieve the outcomes; 4) timelines; and 5) steps to be taken to support the transition of the toddler with a disability to preschool or other appropriate services.

The federal Individuals with Disabilities Education Act (IDEA, 303.26) states that services are to be provided in the child's "natural environment." Therefore, services contained in the IFSP are often provided in the home and can include childcare settings, Early Head Start, preschools, or other community settings in which young children without disabilities are typically found.

Individual Program Plans (IPP)

The Lanterman Developmental Disabilities Act (Lanterman Act) requires that a person who is found eligible for regional center services, have a person-centered Individual Program Plan (IPP). The IPP is a written plan and agreement between the consumer and the regional center, which assists persons with developmental disabilities and their families to build their capacities and capabilities. This planning effort is not a single event or meeting, but a series of discussions or interactions among a team of people including the person with a developmental disability, their family (when appropriate), regional center representative(s) and others.

The planning team decides what needs to be done, by whom, when, and how, if the individual is to begin (or continue) working toward the preferred future. The IPP is a record of the decisions made by the planning team. The IPP identifies 1) outcomes the consumer is working towards; 2) who will provide the services and/or supports; and 3) if there is a cost associated with the service or support, who will fund it.

Individualized Education Program (IEP)

Each public-school child who receives special education and related services must have an Individualized Education Program (IEP). Each IEP must be designed for one student and must be a truly individualized document. The IEP creates an opportunity for teachers, parents, school administrators, related services personnel, and students (when appropriate) to work together to improve educational results for children with disabilities. The IEP is the cornerstone of a quality education for each child with a disability. To create an effective IEP, parents, teachers, other school staff--and often the student--must come together to look closely at the student's unique needs. These individuals pool knowledge, experience and commitment to design an educational program that will help the student be involved in, and progress in, the general curriculum. The IEP guides the delivery of special education supports and services for the student with a disability.

Intensive Care Coordination (ICC)

ICC is a targeted case management service that facilitates assessment of care planning for, and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the ICPM, including the establishment of the Child and FamilyTeam (CFT) to ensure facilitation of a collaborative relationship among a child, their family, and involved child-serving systems.

The CFT includes formal supports (such as the care coordinator, providers, and case managers from child-serving agencies), natural supports (such as family members, neighbors, friends, and clergy), and other individuals who work together to develop and implement the client plan and are responsible for supporting children and their families in attaining their goals. ICC also provides an ICC Coordinator who:

- Ensures that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, client-driven, and culturally and linguistically competent manner.
- Ensures that services and supports are guided by the needs of the child.
- Facilitates a collaborative relationship among the child, their family, and systems involved in providing services to them.
- Supports the parent or caregiver in meeting their child's needs.
- Helps establish the CFT and provides ongoing support.
- Organizes and matches care across providers and child serving systems to allow the child to be served in their community.

Intensive Home-Based Services (IHBS)

IHBS are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child or youth's family's ability to help the child or youth successfully function in the home and community. HBS services are provided according to an individualized treatment plan developed in accordance with the ICPM by the CFT in coordination with the family's overall service plan, which may include, but are not limited to assessment, plan development, therapy rehabilitation, and collateral. IHBS is provided to beneficiaries under 21 who are eligible for full scope Medi-Cal services and who meet medical necessity criteria.

Intensive Technical Assistance Program

Recently CDSS has launched an Intensive Technical Assistance program. This innovative approach brings together the Department of Social Services, the county Child Welfare Department, the necessary system partners (at the state and county level), and over ten subject matter experts that the Department contracts with. This program is an opportunity for the Department to co-design solutions at all levels and to work together to support a county's organization and practice, with the goal that no youth spends time in unlicensed settings and that all youth are fully supported by their community in a way that is trauma informed and child and family centered.

Interagency Leadership Team (ILT)

AB 2083 provides that the MOUs that are required to be established by counties include establishment and operation of a local interagency leadership team comprised of the county child welfare agency, county probation department, county behavioral health agencies, county office of education, regional center or

centers and (in an advisory capacity) foster care or other child welfare advocacy groups, as deemed appropriate by the organizations that will be parties to the memorandum. AB 2083 provides guidance regarding the sharing of information and data between members of the interagency team.

Integrated Core Practice Model (ICPM)

The Integrated Core Practice Model (ICPM) articulates shared values, core components and standards of practice expected from those serving California's children, youth and families. The primary purpose of the document is to provide practical guidance and direction to support county child welfare, juvenile probation, behavioral health staff, and their community partners in using best practices for the delivery of timely, effective, and collaborative services to children, youth, non-minor dependents and families. Derived from a compilation of Pathways to Well-Being Services, the ICPM is the enhanced rendition of previous service models that moves from working in an individual system/agency to working in a cross-system teaming environment. Visit the ICPM website for more information about ICPM.

Lanterman Developmental Disabilities Services Act

The Lanterman Developmental Disabilities Services Act and related laws are codified in the California Welfare and Institutions Code Divisions 4.1, 4.5, and 4.7 and Title 14 of the Government Code. The Lanterman Act outlines the rights of individuals with developmental disabilities and their families and the responsibilities of local regional centers and service providers. The Lanterman Act created an entitlement to services that enables Californians with intellectual and developmental disabilities and their families to the right for services and supports which will enable them to make decisions and choices about how, and with whom, they want to live their lives; achieve the highest self-sufficiency possible; and lead productive, independent and satisfying living as part of the community in which they live. This entitlement ensures that Californians with intellectual and developmental disabilities receive the right to live independent and productive lives in the community with individualized planning and to live in appropriate, quality, community-integrated homes.

Local Education Agencies

As defined by Education Code section 56026.3 for special education a "local educational agency" means a school district, a county office of education, a nonprofit charter school participating as a member of a special education local plan area, or a special education local plan area. It can also be defined as, A public board of education or other public authority within a state that maintains administrative control of public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a state. School districts and county offices of education are both LEAs. Under the Local Control Funding Formula, charter schools are increasingly treated as LEAs.

Managed Care Plan/Organization

Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care. A managed care organization is an organization that practices managed care principles. Most managed care systems utilize an HMO, EPO, PPO, or POS network design, limiting to varying degrees the number of providers from which a patient can choose, whether the patient has to use a primary care physician, and whether out-of-network care is covered under the plan. It is a health plan or health company which works to provide quality medical care at a cost-effective price. Healthcare organizations include providers such as hospitals, doctors and other medical professionals and facilities who work together on behalf of patients.

Multi-Tiered System of Support (MTSS)

The California Department of Education defines MTSS as an integrated, comprehensive framework that focuses on core instruction, differentiated learning, student-centered learning, individualized student needs, and the alignment of systems necessary for all students' academic, behavioral, and social success. MTSS offers the potential to create needed systematic change through intentional design and redesign of services and supports that quickly identify and match the needs of all students.

Non-Minor Dependents (NMD)

The Non-Minor Dependent (NMD) is a current dependent child or ward of the juvenile court, or a nonminor under the transition jurisdiction of the juvenile court, who satisfies all of the following criteria: 1) has attained 18 years of age while under an order of foster care placement by the juvenile court, and is not more than 21 years of age; 2) is in foster care under the placement and care responsibility of the county welfare department, Indian tribe, consortium of tribes, or tribal organization; and 3) has a transitional independent living case plan. The NMD meets the legal authority for placement and care by being under a foster care placement order by the juvenile court, or the voluntary reentry agreement, and is otherwise eligible for AFDC-FC payments. Payments shall continue if the NMD is completing secondary education or a program leading to an equivalent credential, enrolling in an institution which provides postsecondary or vocational education, participating in a program or activity designed to promote or remove barriers to employment, employed for at least 80 hours per month, or unable to engage in the activities listed above due to a medical condition.

Project Cal-Well

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Project Cal-Well is designed to raise awareness of mental health and expand access to school and community-based mental health services for youth, families, and school communities.

Rate Flexibility for Innovative Models of Care

The passage of Assembly Bill (AB) 2944 (Chapter 104, Statutes of 2020) provided the Department under Welfare and Institutions Code (WIC) section 11460(a)(3), the ability to develop, implement, and approve individualized rates, which may be program-specific or child-specific, for an innovative program or model of care and services, consistent with existing statewide licensing and AFDC-FC program requirements.

Regional Center

Regional centers are nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate community-based services and supports for individuals with developmental disabilities. There are 21 regional centers, with offices throughout California which provide local resources to help plan, access, coordinate, and monitor the many services available to individuals and their families. Seven regional centers serve different regions of Los Angeles County. Each remaining county is served by one of the remaining centers.

Resource Families

A resource family is an individual or family that a County or Foster Family Agency has determined to have successfully met the application and assessment criteria necessary for providing care for a child or nonminor dependent who is under the jurisdiction of the juvenile court, or otherwise in the care of a county child welfare agency or probation department.

School Attendance Review Board

State law (*EC* Section 48321) provides for the establishment of School Attendance Review Boards (SARBs) at the local and county level that support enforcement of compulsory education laws and seek to divert students with school attendance or behavior problems from the juvenile justice system. Additionally, *EC* Section 48325 established a State SARB for statewide policy coordination and personnel training.

School-Based Health Programs

School-based Health Programs are built through collaboration and support between school and district administrators, school nurses, mental health professionals, school counselors, psychologists and social workers, state and federal partners, statewide local agencies, community-based organizations, and other partners. Through these programs, school health and mental health professionals are able to develop and implement preventative programming and intervention strategies to address students' physical, mental and behavioral health needs.

School Education Local Plan Areas (SELPA)

Special Education Local Plan Areas (SELPAs) are regional consortiums of school districts that provide for all special education service needs of children residing within the region boundaries. In each region SELPAs developed a local plan describing how it would provide special education services and ensure that all students who are eligible for special education must be provided with a free appropriate public education in the least restrictive environment. SELPAs are responsible to ensure that there is a regional in place for the identification, assessment and placement of disabled students, including broad community engagement, and that a required annual compliance monitoring system is implemented.

Special Education Mental Health Services

Funds are apportioned to special education local plan areas based on average daily attendance. The purpose of these funds is to provide educationally mental-health related services for students with or without an individualized education program, including out-of-home residential services for emotionally disturbed pupils, pursuant to the federal Individuals with Disabilities Education Act and as described in the California Education Code sections 56836 and 56836.07.

Specialty Mental Health Services (SMHS)

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal). The Medi-Cal Specialty Mental Health Services (SMHS) program is "carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services under Section 1915(b) of the Social Security Act. DHCS is responsible for administering and overseeing the Medi-Cal SMHS Waiver Program, which provides SMHS to Medi-Cal beneficiaries through county mental health plans (MHPs). MHPs are required to provide or arrange for the provision of outpatient and inpatient SMHS to beneficiaries in their counties who meet SMHS access criteria, consistent with the beneficiaries' mental health treatment needs and goals, as documented in their client plans. In accordance with Medicaid Early and Periodic Screening, Diagnostic, and Treatment provisions, the intervention criteria for beneficiaries under the age of 21 are less stringent than they are for adults. SMHS intensive services for children and youth under the age of 21 include, but are not limited to, Intensive Care Coordination (ICC), intensive home-based services (IHBS), Therapeutic Foster Care (TFC), and Therapeutic Behavioral Services (TBS). There are other services included in SMHS.

Short-Term Residential Therapeutic Programs (STRTP)

A Short-Term Residential Therapeutic Program (STRTP) is a children's residential facility licensed by the California Department of Social Services and operated by a public agency or private organization. An STRTP provides specialized 24-hour care and supervision, treatment, and services and supports, to children and non-minor dependents.

Systemic, Therapeutic, Assessment, Resources and Treatment (START)

The Systemic, Therapeutic, Assessment, Resources and Treatment (START) program serves individuals residing in-home and out-of-home. It provides person-centered, trauma-informed, evidence-based, positive support for individuals ages six and older. The local START teams provides; 24-hour case coordination to improve supports and service outcomes, whole-person assessment (I/DD, mental health, medical, access to services, personal strengths, satisfaction, etc.), individualized map of individual's connections to others/systems, cross-system linkage (connecting I/DD providers, crisis teams, mental health providers, first responders, hospital/psych staff, etc.), community education, and family/staff/provider support and education (in-home therapeutic coaching). The Center for START Services at the University of New Hampshire Institute on Disability/UCED, provides a model of services to meet the crisis needs of individuals with I/DD.

System of Care

Assembly Bill 2083 requires counties to design and implement a Memorandum of Understanding, framing a unified System of Care which coordinates timely, and trauma-informed services for foster children and youth, other vulnerable youth and their caregivers in a way that is comprehensive, culturally competent, timely, integrated, community-based, individualized, with strength-based services based on plans tailored to their individual needs. Children in out of home placement are inherently served by multiple systems and programs including the placing agency (child welfare or probation), education, county mental and/or behavioral health, and sometimes the local regional center. The challenges of navigating these various systems leads to service gaps and placement instability, and ultimately compounded trauma for the child and family. A single, uniform System of Care, when well delivered, closes these gaps and improves outcomes.

Therapeutic Foster Care Services (TFC)

Therapeutic Foster Care (TFC) is a short-term, intensive, highly coordinated, trauma-informed and individualized rehabilitative service covered under Medi-Cal that is provided to a child/youth up to age 21 with complex emotional and behavioral needs who is placed with trained and supported TFC parents.

Wraparound Services

Collaborative and coordinated system of support for an individual through a team that includes family members, friends, service providers, peer specialists, advocates, and others. Addresses crisis with the goal of keeping an individual in their current living arrangement, through identification of strengths, goals, and needed supports. Provides an array of services and supports, including respite, case management, activities, support groups, advocacy, treatment, family training, home/school services, psychiatric services, and coordination with community services.