

Keeping Youth Close to Home: Building a Comprehensive Continuum of Care for California's Foster Youth





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Executive Summary**

State efforts to implement both **California's Continuum of Care Reform (CCR)** (AB-403) of 2015, and **Family First Prevention Services Act** (FFPSA) of 2018, demonstrate that there are still gaps in the services available to young people in the foster care and juvenile justice system(s). System-involved youth present with unique (and often co-occurring) educational, behavioral, health, housing, prosocial, and familial challenges. Understanding and addressing those needs requires examining trend data, mapping services gaps, and identifying opportunities for action. Continuum gaps and opportunities for reform are briefly outlined herein; trend data and recommendations are detailed in the full report.

Strategies for building a comprehensive service continuum

As we rapidly approach the October 2021 FFPSA implementation deadline, a multi-pronged approach is needed in order to comply with both its provisions and those outlined in CCR. CA Alliance, in partnership with its member organizations, identified several opportunities for action.

- 1. Adequately invest in current programs and services:** California is ill-equipped to comprehensively meet the needs of highly-traumatized foster youth or provide essential support to their caregivers.
 - ⇒ **RECOMMENDATIONS:** (a) Reevaluate the cost of CCR implementation to account for real dollars required to provide services and the additional costs of new regulations and compliance.
- 2. Expand Wraparound service sustainability:** Wraparound presents our greatest opportunity to intervene early, before out-of-home care is necessary, keep families together, and provide alternatives to STRTP placement for youth with complex needs that require specialized care.
 - ⇒ **RECOMMENDATIONS:** (a) Strengthen Wraparound services through funding and statewide quality measures and standards. (b) Invest in keeping young people in biological or relative homes. (c) Incentivize local dollar matching to increase use of Medi-Cal funds for Wraparound implementation. (d) Execute contracts with Short Term Residential Therapeutic Programs to provide Wraparound.
- 3. Stabilize in-state Short Term Residential Therapeutic Programs (STRTPs):** The transition from higher-level group homes to STRTPs has been challenging without upfront investment in training, technical assistance, and systems changes.
 - ⇒ **RECOMMENDATIONS:** (a) Address funding risk to STRTPs with >16 beds. (b) Provide one-time emergency relief to STRTPs that lost revenue due to COVID-19. (c) Adequately fund mental health services in STRTPs. (d) Reduce unnecessarily burdensome regulations and excessive paperwork. (e) Reevaluate hiring criteria to prioritize professional competencies and retention. (f) Correct care and supervision rate inadequacies. (g) Develop educational alternatives for youth in STRTPs. (h) Expand permanency supports for 'hard-to-place' youth and their families.
- 4. Support Juvenile Justice Involved youth in STRTPs:** Young people placed in STRTPs through county probation present with unique challenges (e.g., history of violence, gang involvement), which must be collectively addressed by the placing agency, the behavioral health agency, the education system, and the STRTP provider.
 - ⇒ **RECOMMENDATIONS:** (a) Establish statewide taskforce to address this population's unique needs. (b) Identify and fund evidence-informed programming. (c) Increase funding and opportunities to provide community-based interventions.
- 5. Invest in families and natural supports:** Family Engagement and Family Finding must move beyond simply identifying family members to including their *full* engagement and equal decision-making input. Family Finding is a



fundamental cornerstone of CCR, and there has been inadequate funding and attention to this aspect of the reform.

- ⇒ **RECOMMENDATIONS:** (a) Require family finding and engagement for every youth in out-of-home care. (b) Fund specialized permanency services; particularly for youth in STRTPs. (c) Build a culture of shared responsibility across public and private organizations.

6. Ensure youth have access to all types of crisis stabilization services: Crisis stabilization gaps, including specialized care for youth with complex treatment needs, needs to be addressed immediately to ensure the safety of both youth with significant mental health and behavioral issues as well as the professionals who serve them.

- ⇒ **RECOMMENDATIONS:** (a) Implement the full-array of crisis stabilization services that includes Crisis Stabilization Units (23-hour facilities), Psychiatric Health Facilities, and Children’s Crisis Residential services through Psychiatric Residential Treatment Facilities (PRTFs). (b) Pilot county-level crisis service continuums with interventions that work with foster youth to stabilize a crisis in the least restrictive environment.

7. Invest in and incentivize prevention services: Additional “on the ground” prevention services are critical to reducing the number of families involved in the child welfare system.

- ⇒ **RECOMMENDATIONS:** (a) Develop a statewide strategy for allocating the state’s investment in FFPSA implementation. (b) Allocate ongoing state funding for Family Resource Centers. (c) Fund and support building networks of natural supports prior to out-of-home placement.

8. Narrow the educational achievement gap for Foster Youth: Foster youth continue to lag significantly behind other students in engagement, proficiency, and graduation.

- ⇒ **RECOMMENDATIONS:** (a) Encourage school districts to invest in supporting distance and hybrid educational needs still facing foster youth. (b) Include education entities in local placement determination processes. (c) Assess every youth placed in an STRTP for educational needs. (d) Make alternative education options available to youth in STRTPs.

9. Fund post-permanency services: Currently, there are no defined or consistent funding streams to provide ongoing support services to either the biological family after reunification or the adoptive/guardian family.

- ⇒ **RECOMMENDATIONS:** (a) Conduct a landscape review of current post-permanency services available in each county. (b) Gather information from providers and families in order to understand the supports needed and prioritize service investment.

10. Support youth with complex care needs: Program availability for foster youth battling complex behavioral issues, struggling with addiction, identifying within the Queer continuum, or being commercially sexually exploited (CSEC) is extremely limited.

- ⇒ **RECOMMENDATIONS:** (a) Develop specialized programs for youth based on individualized needs.

11. Facilitate cross-system Care Coordination for high-needs youth: The challenges of care coordination, particularly for foster youth in need of intensive services, continue to hamper our success as a system of care.

- ⇒ **RECOMMENDATIONS:** (a) Engage providers, youth, and their families in Trauma-informed System of Care efforts. (b) Build a state-wide database of vacancies with matching capability. (c) Coordinate care at the state level for youth with the most intensive needs. (d) Utilize the Child and Adolescent Needs and Services (CANS) tool to identify levels of services needed and to ensure care coordination between public agencies and private service providers.

12. Support STRTP aftercare expansion to include WRAP: FFPSA requires STRTPs to provide aftercare supports that extend into a young person’s subsequent placement

- ⇒ **RECOMMENDATIONS:** (a) Fully fund aftercare services for youth transitioning from STRTPs. (b) Ensure STRTPs have the opportunity to provide aftercare through Wraparound contracts or partnerships with Wrap providers.



- 13. Support transition age foster youth (TAY) as they prepare for adulthood:** When young people ‘age out’ of foster care their levels of development and access to natural supports vary significantly
 ⇒ **RECOMMENDATIONS:** (a) Utilize cutting-edge California research to develop individualized support plans. (b) Protect transitional housing programs from landlord/tenant laws. (c) Increase the quantity and quality of related behavioral health services and supports that are integrated with transitional housing programs.
- 14. Minimize administrative barriers to accessing appropriate care:** Complex financing and regulatory structures negatively impact service implementation and contribute to the ongoing fractures between child-serving systems
 ⇒ **RECOMMENDATIONS:** (a) Adopt the recommendations of the Child Welfare Council’s Behavioral Health Committee. (b) Take steps to shift from a compliance-oriented culture to an outcome-driven approach to supporting youth and families.
- 15. Develop an Integrated Framework for the Administration’s Statewide Initiatives for Children and Youth:** As California invests billions of dollars of one-time funding to design a full continuum of care to address behavioral health needs, provides new funds for foster youth with complex needs, and implements FFPSA, it is crucial that these efforts support one another rather than create more silos that keep youth from getting their mental health, social and emotional needs met.

Realizing California’s Vision

As we attempt to overcome the myriad challenges to supporting the health and well-being of California’s most vulnerable youth, the Governor’s 2021-22 Budget and the Children & the Youth Behavioral Health Initiative should serve as key pillars. This requires deep investments in programs and services, collaborative development of funding mechanisms, and holistic community-based services that support young people and their families.

Keeping Youth Close to Home: Building a Comprehensive Continuum of Care for California's Foster Youth

State efforts to implement both **California's Continuum of Care Reform (CCR)** (AB-403) of 2015, and currently the **Family First Prevention Services Act (FFPSA)** of 2018, have highlighted gaps in the services available to young people in the foster care and juvenile justice system(s). System-involved youth present

California's Continuum of Care Reform (CCR) of 2015	Family First Prevention Services Act (FFPSA) of 2018
<p>Recognizing that young people do best in stable, nurturing family homes, CCR was enacted to strengthen placement and treatment options available to foster youth. It stipulates that by 2021:</p> <ul style="list-style-type: none"> (a) group care utilization will be limited to short-term intensive treatment facilities; (b) licensure for short-term residential facilities will require providers meet higher care standards, obtain accreditation, and offer a core set of mental health services; (c) Foster Family Agencies' core services will be trauma-informed and culturally-appropriate; (d) a state-wide Resource Family Approval processes will be implemented and include training for all families whether emergency, temporary, or permanent; and (e) services and supports will be tailored to each child based on their individual needs and strengths. 	<p>FFPSA is federal legislation focused on keeping children with their families and out of the foster care system by:</p> <ul style="list-style-type: none"> (a) investing in early intervention and prevention services, (b) providing federal reimbursement for certain specialized treatments, (c) reducing the frequency and length of group care placements (d) offering additional support to relative caregivers, (e) extending support services for youth transitioning from foster care, (f) incentivizing expedited placement permanency, and (g) requiring states to track and prevent child maltreatment fatalities.

with unique (and often co-occurring) educational, behavioral, health, housing, prosocial, and familial challenges. As such, accurately evaluating their needs is a crucial first step to creating a holistic service approach and securing effective interventions. As the state prepares for the October 1, 2021, FFPSA deadline, the final 2021-22 State Budget includes \$222.4 million, to be used over three years, for developing prevention services.

It is imperative that these and other funds provided in the 2022 state budget also address California's inconsistent approach to (a) evaluating youths' needs and (b) providing the necessary services and interventions instead of allowing youth to 'fail-up'¹ rather than receiving the most effective, clinically indicated level of care from the onset. The December 2020 decertification of out-of-state placements left providers, counties, and state-wide agencies scrambling to, within 45 days, secure *appropriate California* placements for the 133 foster and probation youth in out-of-state facilities and exacerbated the capacity

¹ 'Failing up' occurs when systems, often as a cost-saving measure, underserve youth who present with higher levels of medical necessity; resulting in a failure to meet their needs. The burden is then shifted onto the child to 'fail' through the lower levels in order to 'earn' access to the degree of care than originally recommended by a treating clinician.



crises already facing CCR. These extensive fiscal and administrative hurdles to providing youth with clinically effective levels of care were further compounded by the uncertainties presented by COVID-19. Throughout the pandemic, community-based organizations (CBOs) continued to provide services to those most in need. In fact, when we asked CA Alliance members, 95% of respondents indicated their staff remained in the field, providing in-person services throughout the global pandemic.

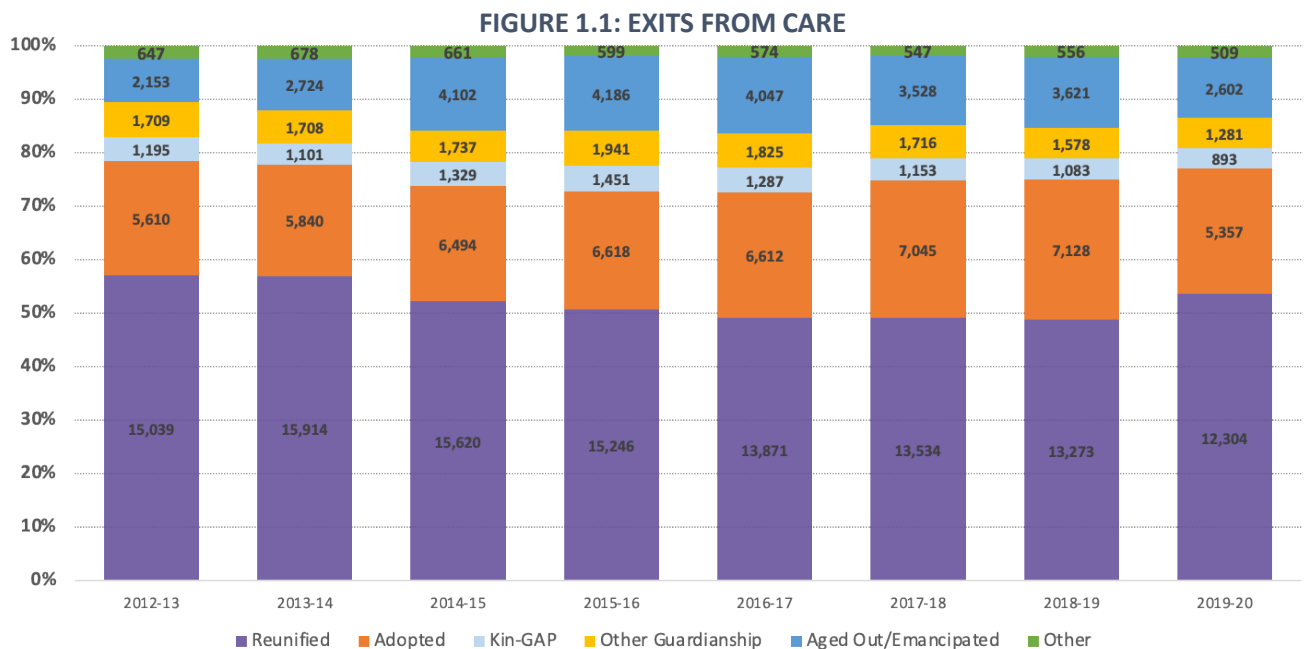
As essential personnel, residential care staff, social workers, and community-based behavioral healthcare workers, held fast; serving foster, probation, and other at-risk children and families to minimize the trauma of COVID-19 to the best of their ability. Since March 2020, they faced (a) additional costs related to distance learning, (b) new quarantine requirements for youth and staff, (c) limited resource family placement availability, (d) residential treatment admission freezes ordered by county public health departments, and (e) school-based mental health referral decreases due to school closures. Additionally, complicated financing structures, state regulations, and difficulty coordinating care across counties, has hindered treatment programs’ ability to provide safe and secure environments for children and youth; particularly those at high risk for self-harm or violence against others.

Despite a five-year long reform effort, we remain ill-equipped to meet the needs of our most traumatized youth and fail to consistently ensure inclusion of youth and family voice and choice in decision-making processes. Below we examine trend data, outline key service gaps, and provide critical recommendations for action.

Foster Care Trends

Demographic, clinical, and outcome data are requisite for making informed policy decisions and invaluable in collective agenda setting. Because few data are exported in real time and actionable analysis takes thoughtful consideration, a reporting lag of at least 6 months is expected.

Further, data integrity and insights were significantly impacted by COVID-19’s international scope and isolating nature. As such, metrics after 2019 should be interpreted with related caveats in mind and conclusions must be drawn cautiously to avoid false narratives of system success or failure.



Exits from care. From 2013-20, exit from care data have fluctuated but remained largely consistent proportionately. Reunification accounts for the majority of exits despite steadily decreasing until 2019-20² (see COVID data note) while adoptions increased by about 27%. Of concern is the increase in children aging out of foster care (21%) as it highlights our inability to identify stable, nurturing guardians that will support them into adulthood. ***It is unclear based on the data just where these youth are ending up, but we know that they are at high risk of homelessness.***

Public data from the [California Child Welfare Indicators Project](#) (CCWIP) does not comprehensively detail the overall decreases in both the number of youth placed in congregate care and the overall length of stays. Between Octobers 2016 and 2020, the number of group home or STRTP placements decreased by 1,211; on top of the [45% decrease](#) in children and youth in congregate care³ experienced between 2006-2016. However, no public data is available on how youth who transitioned out of STRTPs or aged out of care have fared. Available public data do not capture the various explanations for the decreases, nor do they account for our failure to achieve the systemic culture shift necessary for impactful reform.

Congregate care acuity. According to the California Department of Social Services' (CDSS) 2018 [Semi-Annual report](#) on the Title IV-E Well-Being Project, "securing placement homes for high acuity youth is difficult as there is currently a lack of families prepared for and/or willing to care for these youth." The placement gap continues to widen as the acuity level of youth who have experienced trauma increases and they present with behavioral health needs beyond the capacity and resources that STRTPs are funded to provide.

From late 2019 through early 2020, [CA Alliance surveyed 49 member organizations](#) with provisional or permanent STRTP licenses to (a) understand evolving pre- and post-licensure service challenges, and (b) develop recommendations for how to support STRTPs in achieving better outcomes for youth. Respondents indicated that it costs approximately 20% more to provide youth in their care with the minimum level of services and supports than is currently reimbursed through STRTP rates and Medi-Cal contracts in place. Compared to the year prior to STRTP licensure:

- staff turnover increased by 8%;
- discharges resulting from the youth requiring a higher level of care rose 41%;
- successful transition to kin/family placements or lower levels of service decreased by 19%;
- workers compensation claims increased by 32%; and
- lengths of stay decreased 23% as a direct result of runaways, psychiatric hospitalizations, and the need for a higher level of care.

FIGURE 1.2 below details the percent increase in incidents documented by facilities pre- and post-STRTP licensure. These data, collected in November 2019, demonstrate that the increased concentration of youth with high acuity needs funneled into STRTP - rather than being served by a range of level 10-14 group homes across the state - has contributed to an increase in critical incident reports.

² The reduction in 2019-20 is likely due to the limitations on court proceedings to finalize adoptions due to COVID-19 restrictions

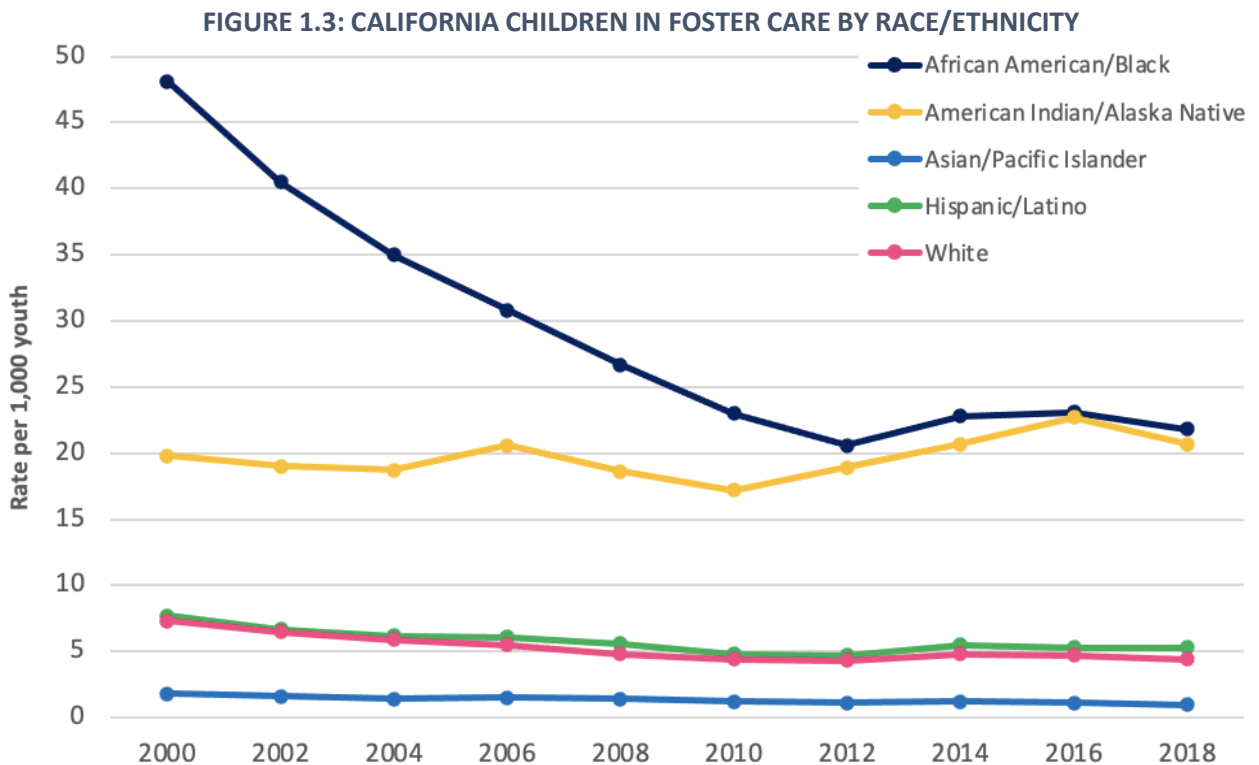
³ "Building a Robust Continuum of Care for Foster Youth in Family-Based Care", Alliance for Children's Rights, Public Counsel, Children NOW, SCP, June 2016



FIGURE 1.2: PRE- AND POST-STRTP LICENSURE, REPORTED INCIDENTS	
% INCREASE IN INCIDENCE PER 1,000 BED DAYS	
AWOL/Elopement	56%
Physical Assault on Peer	47%
Property Damage	38%
Self-Injurious Behavior	14%
Physical Assault on Staff	11%
STAFF RESPONSE	
Psychiatric Hold Written	50%
Restraint – (physical hold)	23%
Law Enforcement Involvement	10%

By the end of 2020, at least three high-profile programs with 197 licensed beds (12% of which were included in our survey) shut down for reasons detailed above and the compounding challenges that COVID-19 presented to staffing, occupancy, and distance education.

Disproportionate impact on communities of color. Black and brown youth are subject to social service intervention at higher rates both nationally and in nearly every local jurisdiction in the United States. This finding does not indicate that children of color are maltreated more frequently than White children but,



rather, reflects a reality where decision processes are created and exacerbated by institutional-level racism. In other words, disproportionate⁴ involvement and disparate⁵ outcomes in our systems (e.g., child welfare, juvenile justice, etc.) exist across racial groups as a product of system-level factors. They are not attributable to any individual group's inherent effort, success, or failure.

FIGURE 1.3 provides longitudinal race/ethnicity information about young people (ages 0-20) who were placed under the supervision of county welfare departments⁶. While the rate at which Black youth were placed into care sharply decreased during this century's first decade, it still outpaces the foster placement rate experienced in White communities - a ratio of 21.8 to 4.4 per 1000 youth⁷.

Key components of FFPSA include evidence-informed [prevention services](#) to keep families together, support for children in care with parents receiving substance use services, and congregate care stay reductions. While many of these services offer important interventions for children and families, they do not address the underlying structural issues, such as institutional racism and income inequality, that contribute to child welfare involvement.

Strategies for Building a Comprehensive Service Continuum

As we rapidly approach the October 2021 FFPSA implementation deadline, a multi-pronged investment approach is needed to comply with both its provisions and those outlined in CCR. Ensuring California's ability to support young people in-state and close to their communities, we must urgently address existing service gaps by (a) enhancing current interventions, (b) expanding permanency efforts like family finding & engagement, and (c) identifying additional programs and services that may be needed. The [Behavioral Health Committee of the Child Welfare Council's offers recommendations](#) on development of a full continuum of care, many of which are consistent with recommendation we propose here.

Adequately invest in current programs and services. California is ill-equipped to comprehensively meet the needs of highly-traumatized foster youth or provide essential support to their caregivers. We applaud initial 'front-end' investments, such as county allocations for foster parent recruitment and increased kinship family access to foster care payments equivalent to those received by resource (non-relatives foster) parents.⁸ Unfortunately, the cost-neutral approach to planning for CCR's rollout assumed that any cost-savings accrued from reducing congregate care stays would sufficiently fund the additional prevention and early intervention services required. However, investment neither accounted for the real dollars required to provide services nor did it consider additional costs associated with new regulations and compliance.

Expand Wraparound services (System of Care) sustainability. Despite the success of CA Surgeon General Dr. Nadine Burke Harris' [ACEs Aware Initiative](#) at raising awareness about Adverse Childhood Experiences (ACEs) and investments made to ensure healthcare providers screen for ACEs, we have yet to create assurances that children and youth who are at risk of, or have entered our child welfare system, are treated with a coordinated and comprehensive approach to address identified ACEs. Wraparound presents our greatest opportunity to intervene early, before out-of-home care is necessary, keep families

⁴ disproportionate: unequal [too large or too small] in comparison to the whole (e.g., racial population distribution)

⁵ disparate impact occurs when policies, practices, rules, or other systems that appear to be neutral result in a disproportionate impact on a protected group

⁶ Enrollment data prior to July 1, 2000 is not available through the KidsData portal

⁷ per 1,000 children/youth in race/ethnicity group; Data are based on unduplicated counts of children under the supervision of county welfare departments and exclude cases under the supervision of county probation departments, out-of-state agencies, state adoptions district offices, and Indian child welfare departments.

⁸ Prior to this change, housing nieces, nephews, or grandchildren was cost-prohibitive for many caring relatives



together, and provide alternatives to STRTP placement for youth with complex needs that require specialized care.

Wraparound services are provided, to varying degrees of success, across the state based primarily on each county's ability to support and invest in a 'whatever it takes' approach to keeping families together. From 2014-2019, The California Well-Being Project provided participating counties⁹ with the flexibility in allocating existing federal funds, through Federal Title IV-E waivers, to use innovative, outcome-supported approaches when working with youth in out-of-home placement or at risk of entering foster care. Since the project was terminated in October 2019, no concerted effort to maintain or expand current Wraparound programs has been made.

Further, the absence of a statewide infrastructure or finance models led many counties to rely solely on funding Wraparound through Medi-Cal's Early and Periodic Screening, Diagnostic, and Treatment Services¹⁰ (EPSDT), which, rather than allowing for unique interventions, limits the utilization of supportive services such as respite care, housing, tutoring, and other financial assistance that increase family stability.

Recognizing the growing need to strengthen Wraparound services, the University of California, Davis (UC Davis) released four broad recommendations and three immediate action steps in July 2020.

UC Davis' recommendations:

- 1) **Collaboratively define a common set of data to be collected** by every provider/county (include level of care and designations with an ability to sort target sub populations as needed).
ACTION: Develop a specific **logic model to establish a baseline** understanding of youth currently served; identify active care providers; describe services being implemented; collect outcome data; and improve implementation, measurements, and training.
- 2) **Ensure providers have the resources required to meet high-intensity child, youth' and family needs**, without incentive to transition service delivery before recommendation from the Child and Family Team (CFT) (potentially by linking payment for services directly to the Level of Care (LOC))
ACTION: **Clarify Integrated Core Practice Model (ICPM) implementation** requirement for establishing consistent CFTs and family-centered practices for all children who are dependents and wards in foster care. There must be a clear way to differentiate between the larger population of children, youth and families served by child welfare and those whose needs require higher levels of intensity, frequency, and coordination of services such as Wraparound.
- 3) **Require training in engagement and facilitation** for any staff position that includes care-coordination responsibilities.

⁹ Butte, Lake, Sacramento, San Diego, San Francisco, Santa Clara and Sonoma

¹⁰ From California's Dept. of Health Care Services: In accordance with the requirements in Section 1905(r) of the Social Security Act and Title 42 Code of Federal Regulations (CFR) Section 441.50 et seq., the Department of Health Care Services (DHCS) is responsible for providing full-scope Medi-Cal beneficiaries under the age of 21 with a comprehensive, high-quality array of preventive (such as screening), diagnostic, and treatment services under Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT). These services are covered without cost.



- 4) **Seek consultation on foundational, advanced, and specialist curriculum with skills development** (for both practitioners and supervisors) and consider use of tools that they have developed and would support high-fidelity implementation of the ICPM (CFT and Wraparound) including in the field skills coaching.

ACTION: Evaluate California's current Wraparound landscape by identifying and analyzing service delivery in the 42 Wraparound counties. This includes a non-punitive evaluation of provider/county compliance with standards in ACIN 1-52-15.

The 2021-22 [Trailer Bill Language](#)¹¹ (developed by CDSS), which outlines a requirement for utilizing high-fidelity Wraparound for all aftercare services required under [FFPSA](#), presents an opportunity to more deeply embed the practice into our systems-of-care. To ensure that funding can adequately meet the need, and the services are implemented effectively, it is imperative that providers are actively involved in designing service delivery and financing.

CA Alliance recommendations on Wraparound:

- 1) **Invest state and local funds in Wraparound to keep young people in biological or relative homes.** A fiscal strategy, developed through a stakeholder process that includes youth and families, to outline clear expectations for all counties to participate in designing and implementing this intervention is essential to building the full continuum of care. While recent budget allocations for aftercare services, as required under FFPSA, was an important first step toward investing in Wraparound for youth transitioning from STRTPs back to their communities, further investment is needed to support children and families up front.
- 2) **Incentivize counties to match federal investment with local dollars** and increase the use of EPSDT¹² MediCal funds to support high-fidelity Wraparound implementation. A critical component of Wraparound is that services are also family and youth defined, which requires flexible funding. The additional state funds proposed to provide aftercare for children placed in STRTPs will help reunify youth to family members with the supports they need.
- 3) **Ensure all willing and equipped STRTPs are given contracts to provide Wraparound for aftercare.** Results from a [Residentially Based Services \(RBS\)](#) pilot in the early 2000s demonstrated that continuity of care with staff from group homes assisting in the transition of youth returning to family-based care has positive effects on achieving timely permanence, shortening stays in group care, and reducing re-entry. This opportunity to engage more STRTP providers in developing continuums of care will best meet the needs of youth and their families.

Foster Family and Adoption Agencies

The 27% increase in the number of adoptions is a promising indicator that more children that may not have the option of living with a biological parent have found a forever family. While the data does not break down the relationships between the foster youth and adoptive parents, these are often relatives who are adopting their relative children. Twenty-five (25%) percent of adoptions from foster care in California are through organizations that are dually licensed Foster Family Agencies (FFAs) and Adoption agencies.

¹¹ Trailer Bill Language is the implementing language of the California State Budget Bill

¹² Early and Periodic Screening, Diagnostic, and Treatment Services



FFAs support one third (1/3) of all children in foster care in home-based placements. Their critical role in supporting families and children is curtailed by the lack of an ongoing annual rate increase to support the social worker salaries that are key to a child and resource families' stability.

This has been addressed temporarily in the 21-22 budget through an increase in one component of the rate. It does not address the long-term effect of not having cost of living increases for many years. The need for an annual COLA for FFAs is urgent if we are to be successful in increasing the family-based options for youth. Foster family agencies often work with youth with greater or specialized needs, providing 24/7 support to families and ensuring that supports and services that help move youth towards permanency are in place. Because of this reduction in resource family homes approved by FFAs that offer significant ongoing supports for children and youth, a gap in the continuum has developed that, if filled, could offer alternatives for youth prior to requiring residential care.

FFA rates are based on a level system that should be determined according to each child's service needs. Inconsistent implementation of this level system and continued challenges with the current level of care tool have also resulted in children being placed automatically at the lowest level of care, requiring that they "fail up" to higher levels, rather than providing greater stability early on to both the child and the family.

The development of Intensive Services Foster Care (ISFC) has increased the availability of homes that can serve youth with higher level needs for support and services, and this has certainly helped to divert some youth from being referred to congregate care settings. However, the increase in ISFC homes has not changed the overall net loss of FFA homes; there has simply been a change to the types of homes and the necessary supports required to serve youth referred to FFAs. As with other non-ISFC FFA programs, there is no annual cost of living increase to the ISFC rate.

CA Alliance Recommendations on Foster Family Agencies:

1) Develop a stakeholder workgroup to finalize the rate structure for FFAs. It is important to move from an interim rate to a final rate structure for FFAs.

2) Provide an annual COLA for FFAs. The current rate structure does not include an annual COLA increase to the FFA rate. While there is an annual increase for the resource families, and now a portion of the rate that reimburses social worker costs received a one-time increase in budget year 2021-22 but without an ongoing COLA, the full FFA rate (including ISFC rate) needs to include an annual cost of living increase. This is one of only two rates in child welfare that does not include an annual rate increase, acknowledging that there are ongoing costs that must be covered to provide high quality services.

3) Redesign the level of care structure using the Child and Adolescent Needs and Services (CANS) assessment tool. This redesign has been discussed and is in very early stages – we would like to see this accelerated to replace the current LOC structure which has not been consistently utilized throughout the state.

Stabilize in-state Short Term Residential Therapeutic Programs (STRTPs). The transition from group homes to STRTPs has been challenging with the lack of upfront investment in training, technical assistance, and systems change, and impacted STRTPs' capacity to serve referred youth. Concurrent reductions in acute behavioral health (both mental health and substance use) treatment options have forced STRTPs to fill long-term psychiatric care gaps rather than perform their intended function, which is to provide short-term stabilization while permanency plans are implemented. During CCR design phases, the lack of involvement of DHCS, county behavioral health departments and the CA Department of



Education in the decision-making and financing strategies for STRTPs resulted in siloed approaches that have failed to provide the necessary coordination to meet the needs of youth placed in STRTPs.

Prior to CCR, California Department of Social Services, in partnership with Casey Family Programs and CA Alliance members piloted a [Residential Based Services Reform Project](#) in 4 counties. Its purpose was to use public/private partnerships “to test programs and funding models that could transform the existing system of long-term residential treatment and group-home care into residentially based services (RBS) to improve outcomes.¹³”

FIGURE 2.1: RESIDENTIAL BASED SERVICES REFORM PROJECT	
<p>Key project findings:</p> <ul style="list-style-type: none"> → Youth functioning improved in all areas, except for education and substance use → In most cases, RBS decreased youth length of stay. → About one-half of all youth served by RBS left a residential treatment or group home placement for a lower level of care, and youth had an increased likelihood of achieving legal permanency. → Youth and parents rated their engagement with services as positive throughout their RBS participation. 	<p>Key project components:</p> <ol style="list-style-type: none"> 1) Intensive and immediate family finding, engagement, and involvement. 2) Transformed campus environments designed to support shortened lengths of stay and extensive family inclusion. 3) Flexible staffing systems that permit the simultaneous delivery of parallel on-campus and home and community-based services to prepare youth, families and their community support networks for reunification. 4) Research-based individual and family therapeutic services with the specificity and intensity required to address the complex issues of attachment, trauma, parenting, family conflict, neurobiological challenge, and emotional and behavioral development faced by these children and those who are or will become their permanent family caregivers.³ 5) The capacity to provide continuity of care and crisis response wherever a youth may be located during the course of care, including interim placements in community settings such as treatment foster care. 6) The ability to provide aftercare assistance as needed following reunification. 7) Comprehensive, family-centered and strength-based care coordination from intake to closure.

Despite lessons learned through the pilot’s success, not one of the critical components of RBS were included in or funded through STRTPs when CCR legislation was developed. These program elements are essential to successfully transitioning youth from group to family-based care and reconnecting them with family members and natural supports. The following investment recommendations were developed through a collaborative member-driven white paper¹⁴ published by CA Alliance to stabilize California’s STRTPs.

¹³ Permanency, Partnership and Perseverance: Lessons from the Residentially Based Services. June 2013, Casey Family Programs.

¹⁴ CA Alliance Mental Health STRTP report – “STRTPs, Recommendations to Improve a Critical Component of Care for Foster Youth”, January 2021



CA Alliance recommendations on STRTPs:

- 1) **Address the urgent funding risk facing licensed STRTP organizations with more than 16 beds.**¹⁵ If under FFPSA, Qualified Residential Treatment Programs (STRTPs in California) are re-classified as Institutions for Mental Disease (IMD) without the exceptions afforded to youth-serving facilities, they will be prohibited from using federal Medicaid dollars (MediCal in California) to pay for the behavioral health services they provide. Additionally, these youth could not access MediCal for other health and dental services while placed in a QTRTP of more than 16 beds. This amounts to at least 1/3 of the necessary funding required to serve our youth. A detailed explanation of this risk is available [on the CA Alliance website](#).
- 2) **Adequately fund Mental Health Services in STRTPs**, by providing a minimum level of Specialty Mental Health Services available through contracts with the county behavioral health department that is contracting with the STRTP. Given the needs of youth placed in STRTPs, it is likely that a minimum of 7 hours of mental health services per week are needed to treat a youth's behavioral health needs.
- 3) Merge regulations developed through The California Department of Social Services and the Department of Health Care Services **to reduce contradictory and unnecessarily burdensome regulations and excessive paperwork**.
- 4) **Reevaluate hiring criteria to prioritize professional competencies and retention** rather than educational qualifications. Direct care staff stability and skillfulness in working with young people are key to breaking the cycle of interpersonal inconsistency often experienced by system-involved youth.
- 5) **Correct care and supervision rate inadequacies** by removing EPSDT¹⁶ funding from the calculation and reducing the occupancy percentage used in calculating the rate.
- 6) **Develop educational alternatives for youth in STRTPs** that more effectively meet their educational needs. The CA Alliance proposes that a workgroup be created to study potential options, as well as ensure that all youth placed in STRTPs receive an educational assessment.
- 7) **Expand permanency supports for 'hard-to-place' youth and their families.** While permanency for foster youth is emphasized throughout CCR legislation, guiding principles, and court [guidance documents](#), financial support to ensure the availability of permanency services at all levels of care has been lacking. Specialized interventions are particularly important for youth who have languished in foster care and experienced multiple placement failures.

Support Juvenile Justice Involved youth in STRTPs. STRTPs have become a placement of choice for county probation departments working hard to keep youth out of juvenile detention facilities and connect them with the rehabilitative treatment they need. Young people placed in STRTPs through county probation present with unique challenges (e.g., history of violence, gang involvement), which must be collectively addressed by the placing agency, the behavioral health agency, the education system, and the STRTP provider. Effectively supporting these vulnerable youth requires specialized programming to work on the behavioral issues that resulted in justice involvement and address the trauma many have experienced.

¹⁵ The number of beds is determined cumulatively by organizational entity, NOT individually by site. Under this formula, an organization that provides services at 3 locations, each with 6 beds, is considered an IMD.

¹⁶ Early and Periodic Screening, Diagnostic, and Treatment Services



CA Alliance recommendation for serving youth in Juvenile Justice

- 1) **Urgently, establish a statewide taskforce to address the needs of youth in the juvenile justice system.** This taskforce would also make recommendations on systems improvements, organizational practice, and legislative policies to increase coordination between law enforcement, public agencies, and private service providers. Coordination that assumes shared risk between public and private agencies protects professionals and facilitates placement stability for young people.
- 2) **Identify and fund evidence-informed programing** to serve justice-involved youth both in STRTPs and in the community. The modalities and services must address a young person’s specific trauma while holding them accountable for their actions. The chaos associated with a lack of accountability often mirrors the chaotic environment from which youth were removed and creates safety concerns for everyone inside a facility. Program structure and clear expectations can both reduce anxiety and build resiliency; allowing effective treatment to occur.
- 3) **Increase funding and opportunities for CBOs to provide community-based interventions for juvenile justice involved youth.** Programs such as Multidimensional Family Therapy, Multisystemic Therapy, and others have demonstrated efficacy with this population and should be implemented on a larger scale throughout the state.

Invest in families and natural supports. Because Family Engagement and Family Finding are cornerstones of CCR, the Integrated Core Practice Model, outlined in [ACIN I-21-18](#), emphasizes youth and family input. Family Finding moves beyond simply identifying family members to including their full engagement and equal decision-making input. Similarly, the [State Child and Family Team](#) structure emphasizes the critical need for both youth and their family to participate in permanency planning. Unfortunately, inconsistent application of and commitment to this essential piece of the continuum has resulted in varied application and limited data availability regarding family involvement.

Despite substantial legal requirements¹⁷ to engage kin to the fifth degree throughout their foster care placement, there are youth for whom no family member can be identified as a support. Much of this is attributable to ongoing pressures for placement professionals to focus on “placement” rather than permanent connections. A deliberate and sustained culture shift is needed throughout our child welfare, behavioral health, and probation systems to embrace the importance of family and fictive kin so that youth have healthy adults with whom they can bond and turn to for guidance. Holding all system partners responsible for ensuring that family-finding and engagement are effectively integrated into every foster child’s case plan will go a long way towards building hope for every child and youth in care.

UC Berkeley’s California Social Work Education Center (CaSWEC) [provides tools and resources](#) for best practices related to family finding and engagement. No child in the child welfare system should be without a dedicated family finding staff whose primary function is to identify these connections and help build a network of natural supports to participate in decision making.

CA Alliance recommendations on Family Finding, Engagement and Permanency:

- 1) **Require and fund family finding and engagement** for every youth in out-of-home care. Without this tool being used for every child and youth, we cannot with confidence be certain that the system has done all it can to reunify youth with family members and natural supports.

¹⁷ [W&I §§309, 319, 361.3 and 628; CDSS ACL No. 09-86, *Cal Rules of Court 5.695(f)(g)*; *Family Code §7950*]



- 2) **Fund specialized permanency services** for youth in out-of-home placements, particularly those placed in STRTPs. More intensive services, including behavioral health services linked to permanency efforts will address the engagement of extended family members and support connecting the youth.
- 3) **Build a culture of shared responsibility** to engage immediate and/or extended family in case planning across public and private organizations.

Identified Gaps in the Current Continuum of Care

Responding to legislative requests per [AB-2083](#), California state agencies submitted “[recommendations to the Legislature on Identified Placement and Service Gaps for Children in Foster Care Who Have Experienced Severe Trauma](#)” in October 2020, which outlines the variety of system supports that have or are being put in place to realize a comprehensive service continuum. To reach our collective goal, there is much work to do on data gathering, cross department collaboration, financing strategies, and culture change throughout the system of care. The current momentum and engagement at the state-, county-, and provider-levels is encouraging.

As the state and counties continue their sustained effort to identify placement and service gaps, the need for crisis stabilization services, specialized care for youth with complex treatment needs, and reduced regulatory barriers are among the glaring gaps that need to be addressed immediately to ensure the safety of both youth with significant mental health and behavioral issues as well as the professionals who serve them.

Expand crisis stabilization services. Currently, only a handful of counties have a full array of crisis stabilization services. According to a 2019 [brief](#) published by the California Children’s Hospital Association, only 16 of CA’s 58 counties have inpatient psychiatric beds for children/adolescents. This often results in youth with urgent psychiatric needs ending up in hospital emergency departments or in endless cycles of law enforcement involvement.

The newly funded Family Urgent Response System (FURS) is a first step in providing supports to youth and families in the foster care system that reduce placement disruptions. However, without a full array of crisis services to support it, this system will not be successful. The final 21-22 state budget also include funding for Crisis Continuum pilots for the next five years. Services that will be available through these pilots include Crisis Stabilization Units (23-hour facilities), Psychiatric Health Facilities, Children’s Crisis Residential services, and individualized family-based care. These programs should be further supported fluidly with community-based Mobile Crisis Teams and Wraparound Services.¹⁸ Implementing local response systems will differ across counties based on the availability of local funds, and rural areas may require a regional approach.

Crisis Stabilization Units provide 23-hour intervention for youth in acute crisis and are equipped with staff trained in crisis intervention who work immediately to stabilize the situation. These facilities can substantially reduce hospitalization incidences and law enforcement involvement, while quickly identifying the next level of care needed, whether it be a longer-term stabilization or a return home with Wraparound supports and services.

¹⁸ High-End Children’s System Gaps in California and Critical Continuum Components, Seneca Family of Agencies, December 2020



Psychiatric Health Facilities (PHFs) provide hospital-level stabilization, for up to 14 days, with integrated assessment and planning services for young people in serious distress. They offer a secure facility, staffed according to state and federal regulations, where youth and families receive individualized treatment, psychiatric services, and linkages to community-based supports.

Children’s Crisis Residential Programs (CCRPs) provide a residential and therapeutic alternative to hospitalization for youth for a period of 10 to 15 days. The intended outcome of crisis residential programs is to decrease utilization of locked inpatient settings for young people, including PHFs. The [RBS Project](#) design built the creation of crisis beds in group facilities into its design so that discharged youth experiencing crisis can return to a facility where they have established provider relationships for up to 14 days. This approach supports youths’ success by stabilizing their behavior in a familiar environment and facilitating a timely transition back home. This type of stabilizing intervention can improve a youth’s ability to remain in a family-based setting.

While statutory regulations for CCRPs are currently in place, the financing structure limits a county's ability to utilize Medi-Cal funds to cover the full cost for non-Title IV-E eligible youth. The CA Alliance is currently sponsoring a bill, [AB-226](#) (Ramos), that would categorize Crisis Residential Programs under the federal designation of a Psychiatric Residential Treatment Facility ([PRTF](#)), allowing the county Mental Health Plan (MHP) to bill Medi-Cal for these services. Passage of this bill is a critical component to ensure these programs are available across the State.

Partial Hospitalization and Intensive Outpatient Services are available through Managed Care Plans, but not part of the Medi-Cal Specialty Mental Health Services array. While Day Treatment is available for Mental Health Plans, the structure of these services is overly prescribed and limits how services are delivered. Reviewing the Day Treatment program design and how it might more closely align with partial hospitalization could benefit all children and youth served through MHPs.

Crisis Mobile Response Teams are an essential component of the Family Urgent Response System included in the 2020-21 budget. These services are currently designed and developed locally, with some counties having utilized them for years. The implementation process, particularly the financing structures for these teams, requires extensive collaboration between local child welfare and behavioral healthcare departments.

CA Alliance recommendations on crisis services:

- 1) **Pilot county-level crisis service continuums** with interventions that work with foster youth to stabilize a crisis in the least restrictive environment. There is strong agreement across state agencies, counties, and providers that a lack of sufficient interventions for youth needing emergent care exists. Investment in these services through the development of pilot programs in regions in most need would begin to help reduce the number of youth we are losing to suicide, or violence against others due to severe trauma and dysregulation. These are supported in the final 21-22 budget.
- 2) **Implement PRTFs in California.** This level of care funded through MediCal is not available in California, which has resulted in no Children’s Crisis Residential Services being developed thus far. This level of care is clearly a gap in the crisis continuum, and the need has only increased during the past year and a half due to the COVID-19 crisis.

Invest in and incentivize prevention services. While there has been investment in early intervention for families at risk of having their children removed (e.g., supports for kinship family placements and family finding) additional “on the ground” prevention services are critical to reducing the number of families



involved in the child welfare system. Developing a network of community-based programs that include family resource centers, youth development, and community schools can support children and families that struggle due to poverty, racial disproportionality, and limited natural supports can reduce child welfare involvement.

A [report](#) published by the Center for the Study of Social Policy in December 2020, outlines five protective factors identified through [Strengthening Families™](#) to reduce the likelihood of abuse and neglect: (a) parental resilience, (b) social connections, (c) knowledge of parenting and child development, (d) concrete support in times of need, and (e) social emotional competence of children. Until we build a prevention-oriented infrastructure that helps families build these factors, we will continue to see too many children and youth placed in the child welfare system. We must continue to invest in early childhood, child care, and other preventative measures that support low-income families most at risk of involvement with the child welfare system. We are pleased that the final 21-22 state budget includes \$222.4 million to support these types of services for the next three years.

CA Alliance recommendations on prevention services:

- 1) **Develop a statewide strategy for allocating the state’s \$222.4 million investment in FFPSA implementation to fund the required prevention services.** While many of these have historically been provided through the behavioral healthcare system in California, FFPSA stipulates that prevention programs must meet the evidence-informed standards of promising¹⁹, supported²⁰, or well-supported²¹ practices as detailed in the [Title IV-E Prevention Services Clearinghouse Handbook](#). Because of issues surrounding the “payer of last resort”, most prevention services can and should be funded first through MediCal, with Title IVE paying for components that are not funded through MediCal. Thus far, no clear approach has been identified as to how county agencies should approach this matrix of funding, leaving every county to develop their own financing plan.
- 2) **Allocate ongoing state funding for Family Resource Centers.** There is significant evidence that place-based service hubs, such as Family Resource Centers or Community Schools, both increase access to support services and improve outcomes for children and families. However, because they are not featured in the Title IV-E Clearinghouse, their eligibility for federal reimbursement is limited to programming supported by the clearinghouse. Given what we know about the connection between poverty and child welfare involvement, we must fund ongoing community-level support programs such as family resource centers.
- 3) **Fund and support building networks of natural supports prior to out-of-home placement.** When families are referred to the child welfare system, it is a critical time to assist them in building their own social and familial support network through family finding and engagement

¹⁹ A program or service is designated as a **promising practice** if it has at least one contrast in a study that achieves a rating of moderate or high on study design and execution and demonstrates a favorable effect on a target outcome.

²⁰ A program or service is rated as a **supported practice** if it has at least one contrast in a study carried out in a usual care or practice setting that achieves a rating of moderate or high on design and execution and demonstrates a sustained favorable effect of at least 6 months beyond the end of treatment on at least one target outcome.

²¹ A program or service is rated as a **well-supported practice** if it has at least two contrasts with non-overlapping samples in studies carried out in usual care or practice settings that achieve a rating of moderate or high on design and execution and demonstrate favorable effects in a target outcome domain. At least one of the contrasts must demonstrate a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.



and community supports. The state's investments in prevention services that can be developed locally will assist in further identifying community-based supports that address the support needs identified by youth and families.

Narrow the educational achievement gap for Foster Youth. Foster youth continue to lag significantly behind other students. Unfortunately, the focus on finding a “placement” without intentional consideration on a young person's educational needs negatively impacts their prospect of completing high school. In fact, the [four-year cohort graduation rate](#)²² for the 2018-19 academic year was 56.0% for foster youth compared to 84.5% when looking at the entire student population in California. When foster youth exit our public school system without a diploma, their risk of experiencing homelessness or entering the criminal justice system is compounded.

Despite efforts to funnel targeted services to foster youth, low-income, and English language learners through the Local Control Funding Formula (LCFF), foster youth continue to perform well below their peers academically. On [2018-19 testing](#), only 23.6% of foster youth met Language Arts proficiency standards as compared to 51.5% of non-foster youth; in Math, the comparison is 14.6% to 39.9%. On measures such as chronic absenteeism and suspension, foster youth have much higher rates than the rest of their peers. The [California School Dashboard](#) indicates that during the 2018-19 academic year, 27.7% of foster youth were [chronically absent](#) compared to 12.1% of all students. Even more concerning is the elevated rate at which foster youth are [suspended](#), 5x that of the general population (15.1% compared to 3.5%). The educational losses that occur when youth change placements will impact them for the long term. While many districts use LCFF to create support youth in these three categories, others have used the funds to support general programming or teacher salaries without aligning funding to outcomes.

CA Alliance recommendations on foster youth education:

- 1) **Encourage school districts to invest the state budget's \$30 million allocation in holistic approaches to supporting distance and hybrid educational needs still facing foster youth.** This includes technology needs, including noise cancelling headphones (especially for youth in STRTP's); tutoring programs; one on one supports; priority access to learning loss mitigation programs, Extended Day support and individualized approaches to engagement of students who have been struggling with attendance.
- 2) **Include education entities in local Interagency Placement Committee (IPC) processes.** Currently, there is no requirement for educational representatives to participate when placement is determined. This is a consequential gap in the IPC design, particularly for youth in need of special education services.
- 3) **Assess every youth placed in an STRTP for educational needs.** Just as a comprehensive mental health assessment is needed for developing a treatment plan, a complete assessment of their educational needs should be completed if it did not occur prior to STRTP placement. Similarly, youth in Intensive Services Foster Care (ISFC) need an educational assessment to ensure that they are getting adequate supports and services.

²² calculated as the number of students who graduate from high school in four years with a regular high school diploma divided by the number of students who form the adjusted cohort for the graduating class. The four-year cohort is based on the number of students who enter grade 9 for the first time adjusted by adding into the cohort any student who transfers in later during grade 9 or during the next three years and subtracting any student from the cohort who transfers out, emigrates to another country, transfers to a prison or juvenile facility, or dies during that same period



- 4) **Make alternative education options available to youth in STRTPs.** When a young person’s behavioral health acuity level necessitates an STRTP placement, sending them to a local school often compounds the distress experienced during their transition. Unfortunately, balancing educational stability with the intervention’s short-term design was not thoroughly considered when recent STRTP regulations were developed. In order to best meet the unique education needs of youth in these facilities, there must be a range of individualized educational options; including, but not limited to, online schools, personalized curriculum, residential schools, and in home services.

Fund post-permanency services. Once permanency is achieved, whether through reunification, guardianship or adoption, it is imperative that post-permanency services are available to ensure the continued stability, safety and well-being for traumatized children and youth. Currently, there are no defined or consistent funding streams to provide ongoing support services to either the biological family after reunification or the adoptive/guardian family. These services should be available and easy to access to meet the needs of children and the families after they exit the child welfare system. Supports such as information and referral; education (e.g., parenting skills, advocacy skills with school systems, etc.); clinical and therapeutic services; access to material resources; and connection to community-based networks (e.g., support groups, recreational activities, and respite care) should be readily accessible to children and families exiting the child welfare system.

CA Alliance recommendations on post-permanency services:

- 1) **Conduct a landscape review of** current post-permanency services available in each county that includes evidence-informed program identification for gaps and provides cost/benefit ratios for avoiding re-entry.
- 2) **Gather information from providers and families** who successfully achieved permanence as well as those who struggle to maintain stability in order to understand the supports needed and prioritize service investment.

Support youth with complex care needs. Program availability for foster youth battling complex behavioral issues, struggling with addiction, identifying within the Queer continuum, or being commercially sexually exploited (CSEC) is extremely limited. As the state continues its work on identifying gaps in services, it is critical that we increase our capacity to target investments in specialized programming.

A 2020 amendment ([AB-2944](#)) to California’s Family Code, which allows for federal reimbursement through Title IV-E, created a pathway to design individualized and specialized programs to meet the needs of a specific foster youth. It allows the state to establish an individualized rate based on county and provider approval of the program design. This approach offers much greater flexibility for providers to meet children where they are, build services around their unique needs, and keep the close to their communities. It is particularly beneficial for youth with complex mental health, developmental, neurological, and behavioral issues for which a STRTP or other group setting is contraindicated. Development of an “STRTP for one” or Intensive Services Foster Care (ISFC) with 24/7 support can provide intensive intervention for youth that includes engagement with the familial and support networks.

While the state, counties, and providers are working diligently to identify potential providers and develop fiscally viable programs, building the infrastructure needed to sustain these types of programs will take time.



CA Alliance Recommendation on supporting youth with complex needs:

- 1) With service providers, county and state agencies, promptly **develop a minimum of 75 specialized programs for youth based on individualized needs by 2022**. The Alliance and its member organizations are working with counties and state departments to design and pilot these programs. Additional resources for providers and counties are needed to support this effort going forward. In partnership with Casey Family Programs, the CA Alliance's technical assistance arm, the Catalyst Center, is supporting providers and counties that are interested in designing these programs through the [Youth First project](#).

We are pleased to see that the 2021-22 budget includes additional resources to assist counties and providers in developing individualized programs and services. Ongoing investments in these interventions will be needed.

Facilitate cross-system Care Coordination for high-needs youth. The challenges of care coordination, particularly for foster youth in need of intensive services, continue to hamper our success as a system of care. The complicated web of financing from Title IV-E, Medi-Cal, regional center, local and state dollars is often the barrier to youth accessing the interventions they need. While each county is working to develop its own trauma-informed system of care ([AB-2083](#)) plan to facilitate county-level coordination and communication, the absence of cross-county and statewide efforts limit the our overall effectiveness at meeting youths' complex needs.

Further, while CCR places great emphasis on Child and Family Teams (CFTs), not all county placing agencies are ensuring that family members and natural supports are engaged. It is unclear just what barriers exist to this most critical component of CCR but understanding and actively dismantling them is urgent. Until this culture shift is fully realized, children, youth and their families will continue to feel disenfranchised and dismissed as nonessential, which is precisely the opposite of the vision for CCR in California.

As siloing between child serving systems persists (e.g., behavioral health, child welfare, juvenile justice, special education, etc.) issues related to care coordination have been exacerbated, particularly for youth with complex needs and cross-system involvement. As such, there is no centralized approach to responding to a youth's needs until issues are raised to the level of the state whereby the urgency of simply finding a placement becomes more important than designing an appropriate plan to meet their treatment and safety needs.

The recent crisis presented with out-of-state youth has clearly demonstrated the need for greater coordination of care, and for state-level intervention when serving specialized populations because the capacity to meet all youths' needs is inconsistent across counties. CDSS Technical Assistance efforts have certainly helped to engage all parties involved in a young person's care but building the infrastructure needed for this type of coordination and, for ensuring the inclusion of family and youth, requires sustained resources and statewide commitment.

CA Alliance recommendations on care coordination:

- 1) **Engage providers, youth, and their families in Trauma-informed System of Care efforts.** Currently, state and local planning efforts have been limited to agency partners. Because community-based organizations are the primary service providers, they understand the complexity of working with multiple child-serving systems and can offer a wealth of knowledge to the planning process. It should go without saying that youth and parent voice in the design of AB-2083 memorandums of understanding, and the design of interagency structures is vital.



- 2) **Build a state-wide database of vacancies with matching capability.** Because California lacks a centralized database with information on available foster homes, STRTPs or Transitional Housing Programs (THP) for foster and probation youth, caseworkers have to develop specific knowledge of, and relationships with, service providers. As the center of technology in the United States, designing a system that can save tens-of-thousands of caseworker hours seems within reach. More importantly, using the technology at our disposal would maximize our ability to match youth to programs that meet their clinically-indicated needs in the least-restrictive environment. The recent out-of-state youth project prompted CA Alliance’s Catalyst Center to begin gathering detailed information about available programs and services, but will require ongoing funding. The cost savings in caseworker time alone would easily pay for such a system.
- 3) **Coordinate care at the state level for youth with the most intensive needs.** The current statewide technical assistance process focuses on placement preservation and often comes too late in a youth’s placement to effectively address their level of need. We need a more robust and proactive approach to (a) identifying gaps in services, (b) designing interventions, (c) securing the best placement for a youth from on the frontend, and (d) ensuring all elements of the Integrated Core Practice Model are used. In addition to targeted funding, this will require a cultural and practical shift in county referral processes to emphasize finding an appropriate match instead of simply looking for an available placement.
- 4) **Utilize the Child and Adolescent Needs and Services (CANS) tool** to identify levels of services needed and to ensure care coordination between public agencies and private service providers.

Support transition age foster youth (TAY) as they prepare for adulthood. Historically, when young people ‘aged out’ of foster care their levels of development and access to natural supports varied significantly. Fortunately, growing acceptance that most 18-year-olds are ill-prepared to lead fully self-sufficient lives resulted in states offering an array of services that (a) extend foster care benefits, (b) provide access to education resources, and (c) facilitate the development of supportive networks.

FFPSA made several improvements to extended foster care programing²³ particularly by (a) emphasizing that eligibility begins at age 14 and (b) extending service access to age 23 (e.g., financial, housing, counseling, employment, education, etc.) and age 26 (education and training vouchers).

CA Alliance recommendations for supporting transitioning foster youth:

- 1) **Utilize [cutting-edge California research](#) to develop individualized support** plans that increase the likelihood that foster youth will experience successful transitions to adulthood and earn a livable wage. Children who grow up and turn 18 in foster care are at a higher risk of experiencing homelessness, struggling with addiction, and facing incarceration than their peers. A strengths-based approach of customized plans helps them develop the life skills that build a foundation for self-sufficiency.
- 2) **Increase the quantity and quality of related behavioral health services** and supports that are integrated with transitional housing programs.

Minimize administrative barriers to accessing appropriate care

Complex financing and regulatory structures negatively impact service implementation and contribute to the ongoing fractures between child welfare and behavioral health systems. Our realigned fiscal structure leads the state to limit new required programs due to Proposition 30’s requirement that new

²³ Currently: “John H. Chafee Foster Care Program for Successful Transition to Adulthood”; Formerly: “John H. Chafee Foster Care Independence Program”



state mandates must be funded by new state dollars. Therefore, FFPSA's prevention services will be implemented as an "opt-in" program for counties, rather than a required one. To create a true system of care for foster youth under FFPSA, there must be statewide consistency in service delivery that is designed based on where youth need services.

With the October 1, 2021 FFPSA implementation deadline swiftly approaching, the structure of how services are financed (through behavioral health, through child welfare, or a hybrid) must also be coordinated and streamlined so that community-based organizations (and children and families) are not caught between these systems as they work to provide these services.

Fiscal. California's state and local fiscal structures perpetuate the siloing that impedes our ability to build a true continuum of care. For example, child welfare services are funded through Titles IV-E and IV-B, without regard for how these services may intersect with Medi-Cal, which pays for behavioral health services for all low-income children and youth, including those in foster care. Medi-Cal's [Early, Periodic Screening, Diagnosis and Treatment](#)²⁴ (EPSDT) benefit offers a wide range of behavioral health services through a mix of local, state, and federal dollars. Despite every [adolescent](#) beneficiary's right to these interventions (up to age 21), less than 4% of low-income children, and about 35% of foster youth receive five or more specialty mental health service visits per year.²⁵ Due to the local funding match requirements, each county behavioral healthcare agency's annual budget includes an allocation for developing contracts with Community-Based Organizations (CBOs). Unfortunately, budget constraints lead to artificial 'caps' on those contracts and limits the availability of specialty mental health services (SMHS).

The fracturing between systems means that intake processes, assessments, financing, documentation, and service delivery are separate, distinct, and often duplicative. This wreaks havoc on children, youth, and families trying to navigate a system they understand as largely singular. While professionals discuss and understand distinctions between child-serving institutions, most families view them all as part of **THE** system interfering in their lives. Add to this the complexity of the education, developmental services, and probation systems, it is clear why many families simply give up trying to advocate for themselves.

In June of 2020, the Department of Healthcare Services' (DHCS) [California Advancing and Innovating Medi-Cal](#) (CalAIM) initiative established a [Foster Care Model of Care Workgroup](#) to "create a long-term plan for how children and youth in foster care receive health care services (physical health, mental health, substance use disorder treatment, social services, and oral health) and as an opportunity for stakeholders to provide feedback on ways to improve the current system of care for children and youth in" and transitioning out of foster care. We applaud the engagement of providers, youth, and families in this workgroup.

When 80% of foster youth present with significant mental health needs²⁶, it is imperative that the behavioral health and child welfare systems function seamlessly to minimize fiscal barriers that keep children from accessing necessary care in the right place, in the right dose, and in a timely manner.

²⁴ From California's Dept. of Health Care Services: In accordance with the requirements in Section 1905(r) of the Social Security Act and Title 42 Code of Federal Regulations (CFR) Section 441.50 et seq., the Department of Health Care Services (DHCS) is responsible for providing full-scope Medi-Cal beneficiaries under the age of 21 with a comprehensive, high-quality array of preventive (such as screening), diagnostic, and treatment services under Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT). These services are covered without cost.

²⁵ <https://lao.ca.gov/handouts/socservices/2018/Mental-Health-Services-Overview.pdf>

²⁶ <https://www.ncsl.org/research/human-services/mental-health-and-foster-care.aspx>



CA Alliance recommendations on minimizing fiscal barriers:

- 1) Urge the US Congress and the Centers for Medicare and Medicaid Services (CMS) to **issue guidance clarifying that Qualified Residential Treatment Programs or QRTPs (STRTPs in CA) are not Institutes for Mental Disease** and should be an exception to the IMD exclusion outlined in the Social Security Act, section 1905(a)(B). The Medicaid IMD exclusion prohibits the use of federal Medicaid financing for care provided to most residential treatment facilities with more than 16 beds. Currently, CMS has placed the burden on states to determine if a facility qualifies as IMDs. With over 1100 youth in California likely impacted, it is imperative that federal advocacy take place to ensure that an exception is made for these facilities. This could mean, at a minimum, an additional \$48 million annually in state and local dollars required to support these facilities if no exemption is obtained. The CA Alliance has developed a [set of recommendations](#) related to the QRTP/IMD issue.
- 2) **Develop fiscal incentives to place children and youth at the clinically recommended level of care necessary**, and disincentivize the practice of simply identifying an available bed. This would ensure that youth get the right service at the right time in the right amount, rather than having to “fail up” through levels of care.
- 3) **Increase access to care** by using CalAIM’s process to remove diagnosis as a qualifying requirement for services. There is significant stakeholder support for establishing [automatic behavioral health eligibility](#) for child-welfare involved youth based on the presumption that, to warrant social services intervention, they have“(pg. 2) experienced a significant enough degree of trauma” meet CalAIM’s standard for medical necessity.
- 4) **Develop a statewide fiscal structure for youth placed out-of-county in STRTPs and other high-end services.** The current Medi-Cal laws dictating the provision of specialty mental health services to foster youth who experience cross-county placement changes are built upon the presumptive transfer of responsibility, which automatically places the financial burden on the receiving county. To alleviate this undue burden, particularly on smaller counties, we must establish a statewide system where Medi-Cal dollars follow the child across jurisdictions.

Regulatory and statutory. Instead of advancing the vision of CCR, regulatory barriers and legislative changes have created a compliance-oriented culture that punishes professionals who are motivated to ensure children are connected with quality services that meet their treatment needs.

A paramount systemic issue is that STRTPs must meet no less than 5 sets of governing regulations, contractual, and accreditation requirements: state CCL and DHCS licensing regulations, Medi-Cal certification requirements (often for more than one county), individual county mental health contract requirements (often for more than one county), and Joint Commission (JCAHO), Council on Accreditation (COA), or the Commission on Accreditation of Rehabilitation Facilities (CARF). These multiple (and at times contradictory and overlapping) requirements result in significant administrative burdens that divert capacity away from providing client care to focus on documentation. The redundancies in these various requirements must be identified and minimized in order to maximize both the fiscal and the outcome return on our investment.

Because California facilities with the level of controlled environment that many foster and probation youth require, our kids have historically been sent out of state. While keeping young people in the least restrictive environment is critical, the regulatory limitations placed on STRTPs and other facilities reduces the placement options when youth present with serious behavioral issues. For example,



regulations limit a facility's ability to utilize delayed egress²⁷ or perimeter barriers²⁸ to safeguard against youth running away. These types of options are available in facilities certified by the Department of Developmental Services (DDS), but not through DSS' Community Care Licensing regulations.

Ongoing efforts, [legislative and regulatory](#), to reduce law enforcement involvement in residential facilities prevents STRTPs from reaching out even when a crisis situation presents a risk to the safety of residents or staff. As such, these well-intentioned regulations have inadvertently limited STRTPs' ability to admit, or continue serving, youth with histories of significant aggressive behavior. State and local efforts to reduce the number of secure facilities that work with youth in the juvenile justice system have not attended to best practices recommendations in juvenile justice reform. As a result, STRTPs are pressured to admit youth that they are ill-equipped to effectively treat.

CA Alliance recommendations on addressing regulatory barriers

- 1) **Allow for delayed egress and/or perimeter barriers for facilities serving youth with complex needs.** This is an approach that has been utilized in developmental services facilities, and statute exists that could be adopted for foster care populations needing this level of care.
- 2) **Measure progress based on outcomes, not simply law enforcement involvement.** Currently the only "performance measure" that CDSS posts on its website for STRTPs is the number of law enforcement contacts the STRTP generates. This does not in any way reflect a program's effectiveness. In fact, a program that is proactive and wants to ensure safety of all youth and staff will more readily contact law enforcement rather than use restraint to intervene in a crisis. Additionally, calls made to report runaways, which often need to occur several times for follow-up purposes, are each counted as a new incident, resulting in programs that transparently report all contact as being considered to be relying on law enforcement to "solve" a behavioral challenge rather than intervening in a trauma-informed and clinically appropriate manner.

In fact, these programs may be of the highest quality and are therefore working to ensure responsible reporting to their local police. More effective measures must be used to assess a program's effectiveness, such as movement towards reunification, scores on the Child and Adolescent Needs and Strengths (CANS) and monthly progress in the program.

Realizing California's Vision for Healthier Children and Youth

To create a true system of care for foster and probation youth under FFPSA, statewide consistency in service delivery is crucial. California's vision for reforming the continuum of care requires strategic and sustainable funding all levels of care to strengthen interventions provided within the continuum. This requires deep investments in programs and services, not a cost neutral approach. It requires state, local, and provider leaders to evaluate the gaps in services array and collaborate to develop funding mechanisms that can truly support all youths' needs. Further, community-based services are key to holistically supporting these young people and their families. The Behavioral Health Committee of the [Child Welfare Council](#) developed a set of [recommendations](#) for creating and sustaining a full continuum of services for children and youth that serves as a framework.

²⁷ Delayed egress is a door locking system that allows the user to set a lag time (usually 15 to 30 seconds) between when the exit bar is engaged and when the lock releases; allowing for security to confirm that the person is authorized to leave the facility.

²⁸ Perimeter doors automatically lock from the outside and alarm when the door is propped open; preventing unauthorized entry and exit.



As we attempt to overcome the myriad challenges to supporting the health and well-being of California's most vulnerable youth, the **Governor's 2021-22 Budget and the [Children & Youth Behavioral Health Initiative](#)** should serve as key pillar. It provides funding and a vision to increase greater support at all levels of behavioral health system to ensure that children and youth get the right care when they need it, where they need it, and at the right level of service that is clinically appropriate. The Children and Youth Behavioral Health Initiative Act (\$4.4 billion over 5 years) is intended to transform California's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs. The state budget for 21-22 includes the following key components of the Initiative:

- a) Establishes a behavioral health services and supports virtual platform and requires DHCS to procure and oversee a vendor to establish and maintain the platform that integrates screenings, application-based supports, and direct services to children and youth (\$747.9 million).
- b) Authorizes DHCS, or its contracted vendor, to award competitive grants for school-linked partnership, capacity, and infrastructure to support implementation of behavioral health services in schools. Defines entities eligible to receive these grants to include counties, city mental health authorities, tribal entities, local educational agencies, institutions of higher education, publicly funded childcare and preschools, health care service plans, community-based organizations, and behavioral health providers (\$550 million).
- c) Requires DHCS to make incentive payments to qualifying Medi-Cal managed care plans to implement interventions that increase access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for children in publicly funded childcare, preschool, and schools with grades TK-12 (\$400 million).
- d) Requires DHCS to develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to children and youth 25 years of age or younger at a school site).
- e) Requires DHCS to develop and select evidence-based interventions and community-defined promising practices to improve outcomes for children and youth with, or at high risk for, behavioral health conditions (\$429 million).
- f) Requires DHCS to target funding to qualified entities serving individuals 25 years of age and younger through the Behavioral Health Continuum Infrastructure Program (also established through this budget) (\$310 million).
- g) Requires implementation of a comprehensive and culturally and linguistically proficient, public education and social change campaign (\$100 million); and
- h) Requires investments in behavioral health workforce, education, and training, including a multiyear plan to launch and implement a statewide school behavioral health counselor system (\$448 million).

This initiative reflects just how important the needs of California's children and youth are to both the Administration and the Legislature. However, all the various investments in children and youth behavioral health programs and services must address the specific needs of children, youth, and their families if they are to be successful in reducing the impact of trauma, poverty, and most recently the impact of COVID-19. In addition to these investments, parents, youth, state leaders, policymakers,



counties, and community-based organizations must address the gaps in the Continuum of Care Reform effort and develop strategies for improving outcomes for children and youth, as early as possible, and before they become involved in public systems. And for those families that still need additional supports and services through our public systems, we need to ensure that the services are focused on children and youth remaining close to home, returning to family as early as possible.

