Context: Foster care utilization in California

- 1999: 117,162
- 2012: 59,725
- 2018: 62,307
Context: Residential care utilization for foster care in California

- 2003: 11,077
- 2018: 4,793
Residential care utilization for foster care after CCR (projected)
What is CCR?

Continuum of Care Reform:
“A comprehensive approach to improving the experience and outcomes of children and youth in foster care.”
# California’s history of foster care reform

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>SB 933 (Thompson) Foster Care Reform</td>
<td></td>
<td>CDSS led stakeholder workgroups</td>
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<tr>
<td>2003</td>
<td>Child Welfare Redesign</td>
<td></td>
<td>Internal CDSS process</td>
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<tr>
<td>2004</td>
<td>Alliance convenes stakeholder group on roles for residential care</td>
<td>Jan. 2015</td>
<td>Governor’s 2015-16 Budget Proposal: <em>California’s Child Welfare Continuum of Care Reform</em> report</td>
</tr>
<tr>
<td>2007</td>
<td>California Alliance vs. Allenby and Ault (Wagner)</td>
<td>Oct. 2015</td>
<td>AB 403 (Stone; statutes of 2015): CCR implementation</td>
</tr>
</tbody>
</table>
Important consideration

• Education placements per IEPs were never considered during CCR planning

• Education was invited to and did participate to some degree in CCR planning. Education is much more involved in CCR implementation.
CCR’s vision

• All children live with a committed, permanent and nurturing family with strong community connections
• Services and supports should be individualized and coordinated across systems and children shouldn’t need to change placement to get services
• When needed, congregate care is a short-term, high quality, intensive intervention that is just one part of a continuum of care available for children and nonminor dependents
• Effective accountability and transparency drives continuous quality improvement for state, county, and providers
To accomplish this...

- **Group homes**, as *placements*, go away
- **Short Term Residential Therapeutic Programs**, as *interventions*, are created
- **Foster families**, pre-adoptive and kin care families with separate and duplicative licensing and certification processes, go away
- **Resource families** are created using a single RFA approval process

Theoretically, needed individualized Social Services & Support and Behavioral Health Treatment and Therapies are available to all foster children and youth independent of where and with whom they live.
CCR creates 2 levels of care

1. Home-based family care
   - Kin care
   - NREFM care
   - County licensed foster family homes
   - FFA certified foster homes
   - Pre-adoptive families

2. Short-Term Residential Therapeutic Program

   **Goal:** Home-based family care for all children and youth in foster care; permanent families for children exiting foster care.
### Old vs. CCR

#### Levels of Service

<table>
<thead>
<tr>
<th>Home-based family care</th>
<th>Old system</th>
<th>CCR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• 5 foster care payment levels based on <strong>age</strong> of child</td>
<td>• 4 Levels of Care (LOC) payments based on <strong>expectations</strong> of resource family/needs of child</td>
</tr>
<tr>
<td></td>
<td>• 3 Intensive Treatment Foster Care (ITFC) levels based on child’s care and service need (FFA only)</td>
<td>• 1 Intensive Services Foster Care (ISFC) level</td>
</tr>
<tr>
<td></td>
<td>• Therapeutic Foster Care (TFC) as mental health option</td>
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</tr>
<tr>
<td></td>
<td>• Access to MH services required</td>
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</tr>
<tr>
<td>Residential care</td>
<td>• 14 group home Rate Classification Levels (RCL) based on staffing</td>
<td>• STRTP only</td>
</tr>
<tr>
<td></td>
<td>• Some group homes provided mental health services</td>
<td>• Group home licensing category remains but may not be used for foster care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provision of integrated mental health services required</td>
</tr>
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</table>
Placement in STRTPs

- Children and youth will be placed in STRTPs only when they have needs and challenges that cannot safely be met in a home-based family setting.
- Placement in STRTPs will be short-term, only until a youth’s needs and challenges can be safely met in a home-based family setting.
Placement eligibility for STRTP

• The child must meet at least one of the following conditions:

1. Has been assessed as meeting the medical necessity criteria for Medi-Cal specialty mental health services (SMHS), OR
2. Has been assessed as seriously emotionally disturbed as defined in WIC Section 5600.3(a), OR
3. Has been assessed as requiring the level of services provided by the STRTP program in order to meet his/her behavioral and therapeutic needs
Foster care placement decisions today

Juvenile Court issues placement order

Caseworker selects placement

Youth placed

If RCL 14, IPC reviews for eligibility
How will CCR ensure youth get what they need, when they need it?

**Standardized assessment - CANS**
- will determine each child’s need for:
  - care & supervision
  - services & support.
- CANS will be used by both CWS and MH ⇒ 1 functional assessment per child

**Child and Family Teams**
- using the CANS assessment,
- will recommend to the caseworker where and with whom a child will live; and
- the services and support the child, caregiver, birth family, kin, and permanency family will receive
- in order to ensure the child’s safety and well-being while achieving permanency.
Placement decisions under CCR

Child & Family Team makes recommendations re: placement

Juvenile Court issues placement order

Caseworker selects placement

Youth placed in STRTP

If STRTP, Interagency Placement Committee affirms youth needs STRTP & placement meets needs

WIC 11462.01(h)(3)(A-B)

WIC 11462.01(h)
STRTP components

- Child and family team-based planning
- Environmental interventions that establish a safe, stable, and structured living situation.
- Intensive treatment interventions that facilitate the rapid movement of children or youth toward connection or reconnection with home, school, and community.
- Permanency-focused parallel, pre-discharge community-based interventions that help youth, family and community members prepare for connection or reconnection.

Upon request of county placing agency:

- Follow-up, post-discharge support and services provided as needed after youth have exited the residential component and returned to family, school and community.
Core Services

• STRTPs and FFAs are required to provide or provide for trauma-informed, culturally relevant Core Services:
  – Specialty mental health services
  – Transition services
  – Education, physical, behavioral, mental health, extracurricular supports
  – Transition to adulthood services
  – Permanency support services
  – Indian Child Services
What are the medical necessity criteria for SMHS for children?

1. Have a qualifying diagnosis (DSM) AND
2. Have either:
   – A significant impairment in an important area of life functioning; OR
   – A significant probability of deterioration in an important area of life functioning; OR
   – A reasonable probability a child will not progress developmentally as individually appropriate.

AND...

3. Must meet each of the following intervention criteria:
   A. Focus of the proposed intervention is to address the identified condition; AND,
   B. Expectation is that proposed intervention will:
      — Significantly diminish impairment; OR
      — Prevent significant deterioration in important area of life functioning; OR
      — Allow child to progress developmentally as individually appropriate.
Specialty mental health services

Rehabilitation SMHS
- Mental Health Services
  - Assessment
  - Plan development
  - Rehabilitation
  - Collateral
    - Individual or group therapy
- Crisis intervention
- Crisis stabilization
- Day treatment intensive services
- Day rehabilitation
- Medication support
- Targeted case management

Unplanned services

Day treatment

EPSDT SMHS
- Therapeutic Behavioral Services (TBS)
- Katie A. specialized services
  - Intensive Care Coordination (ICC)
  - Intensive Home-Based Services (IHBS)
  - Therapeutic Family Care (TFC)
At a minimum, STRTPs must:

1. Be Medi-Cal Certified to provide the following SMHS as medically necessary
   a. Mental Health Services
   b. Crisis Intervention
   c. Medication Support
   d. Targeted Case Management

2. Provide or provide access to other mental health services based on individual need
Bottom line

• STRTPs will maintain and have in good standing a mental health program approval, Medi-Cal certification and contract for Medi-Cal specialty mental health services (SMHS)

• STRTPs will maintain the level of care and services necessary to meet the needs of the children and youth in their care
Are STRTPs “medical model” programs

• No
• STRTPs are foster care residential placements with integrated mental health services for youth with exceptional needs

If an STRTP has an affiliated NPS, it could be:

• A residential treatment program with integrated mental health services for pupils who need that level of special education service to take advantage of their FAPE
Are STRTPs “medical model” programs

• “Medical model” mental health programs:
  – Assume that psychopathology is the result of one's biology
  – Focus on use of psychopharmacological and neurobiological interventions to arrest disease process
  – Physician is chief of service
  – Direct care staff consists primarily of nurses and other medical personnel with ancillary treatment staff
No arbitrary limit on duration of placement in STRTP

• AB 403 requires:
  – “A child of any age who is placed in a community care facility licensed as a group home for children or a short-term residential treatment center..., shall have a case plan that indicates that placement is for purposes of providing short term, specialized, and intensive treatment for the child..., the case plan specifies the need for, nature of, and anticipated duration of this treatment, and the case plan includes transitioning the child to a less restrictive environment and the projected timeline by which the child will be transitioned to a less restrictive environment. **If the placement is longer than six months, the placement shall be documented ...and shall be approved by the deputy director or director of the county child welfare department.**”
Discharge begins at intake

• The purpose of STRTPs is not to “cure” youth,
• Or to make them successful in residential treatment.
• The purpose is:
  – To prepare youth for their return to family and community, and
  – To prepare families and communities for the youths’ return.
How are STRTPs different from traditional group care?

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<td>Goal for youth is to successfully transition to family and community</td>
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<td>Discharge planning begins when youth is close to “finishing program”</td>
<td>Discharge planning begins before intake</td>
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<tr>
<td>Key decisions are made by caseworker and staff</td>
<td>Key decisions are made by caseworker in collaboration with Child and Family Team</td>
</tr>
<tr>
<td>Services focus on youth-in-residence</td>
<td>Services focus on youth’s return to family and community</td>
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<tr>
<td>Families may visit</td>
<td>Families are sought out and welcomed as integral partners in decision-making and treatment</td>
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<td>Services stop when youth leaves residence</td>
<td>Services and staff can move with youth into community and after d/c from residential component</td>
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## How are STRTPs different from traditional group care with a NPS?

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How is STRTP different from traditional group home care?

• “Group home” as place to live, gives way to “short-term residential therapeutic program” as an intervention or means to get back to family and community.

• It’s the train, not the station.
CCR implementation timeline

**STRTP**
- STRTPs must obtain a mental health program approval and a contract to provide EPSDT specialty mental health services within 1 year of licensure.
- STRTPs must obtain and maintain national accreditation within 24 months of licensure.

**FFA**
- FFAs must obtain and maintain national accreditation within 24 months of licensure.
## Where are we now?

<table>
<thead>
<tr>
<th>STRTP</th>
<th>Capacity</th>
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<tbody>
<tr>
<td>STRTP licenses issued</td>
<td></td>
</tr>
<tr>
<td>Capacity:</td>
<td></td>
</tr>
<tr>
<td>• 36 providers</td>
<td></td>
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<tr>
<td>• 107 facilities</td>
<td></td>
</tr>
<tr>
<td>1,852</td>
<td></td>
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<tr>
<td>STRTP license applications in process</td>
<td></td>
</tr>
<tr>
<td>Capacity:</td>
<td></td>
</tr>
<tr>
<td>• 62 providers</td>
<td></td>
</tr>
<tr>
<td>1,363</td>
<td></td>
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<tr>
<td>Total capacity if all are licensed</td>
<td>3,215</td>
</tr>
<tr>
<td>Total foster youth transitioning to STRTP according to budget projections</td>
<td>2,487</td>
</tr>
<tr>
<td>Total capacity if 75% is available for foster youth</td>
<td>2,411</td>
</tr>
<tr>
<td>Total capacity for youth not in foster care</td>
<td>804</td>
</tr>
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Implications for schools and education?

• Thoughts, questions, discussion
The End