Child Protective Systems Oversight Committee

Annual Report 2015

An annual report to the Sacramento County Board of Supervisors from the Sacramento County Children's Coalition, Child Protective Systems Oversight Committee.

Acknowledgements

The Sacramento County Child Protective Systems Oversight Committee[1] (Oversight Committee) of the Sacramento County Children's Coalition studies and monitors the state of the child protective systems in Sacramento County at the behest of the County Board of Supervisors addressing issues identified in reviews of critical incidents (death and near death occurrences) and/or a review of organizational issues and practices within the general child protective system.

All of the information outlined in this report is general and does not purport to be related to any particular case, person, or occurrence. A Sacramento County Superior Court order prohibits members of the Oversight Committee from disclosing specific confidential case information.

The Oversight Committee wishes to thank the Sacramento County Department of Health and Human Services (DHHS) and Child Protective Services (CPS) staff, especially Dr. Sherri Heller and Michelle Callejas for being responsive to the inquiries made by the Oversight Committee, and their willingness to make continual improvements. Thank you to Abigail Nosce for the technical assistance she provided in putting this report together and her support to the Oversight Committee. The collaborative culture between DHHS, CPS and the Oversight Committee is essential for the improvement of the safety of children and families in our community.

[1] See Appendix A for members of the Oversight Committee.

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History and Role of the Child Protective Systems Oversight Committee

The Sacramento County Children's Coalition was established by the Board of Supervisors in 1994. It is charged with assessing community needs, and evaluating existing services relating to the health and wellbeing of children. By resolution of the Board of Supervisors, the Children's Coalition is responsible for, among other things, providing community oversight of the County's child protective systems through the Coalition's Child Protective Systems Oversight Committee.

In January 1996, the County Executive appointed the Critical Case Investigation Committee (CCIC) and charged it with examining and evaluating the child protection system in the context of its nexus to the homicide of Adrian Conway. Its primary purpose was to examine the Conway case to evaluate the efforts of all service providers, including Department of Health and Human Services (DHHS), Family Preservation and Child Protection Division.

In May of 1996, the CCIC issued its final report. It recommended establishment of, within an existing community advisory group, the function of "community oversight of child protective services, including preparation of an annual report to the Board of Supervisors on outcomes and effectiveness of the system along with recommendation for policy and program changes." It identified a nonexclusive list of areas which the annual report should address:

- Findings from the Child Death Review committee and assessment of impacts on the child protection system;
- Overall statistics and program analysis;
- A quality assurance review of at least one operational unit in the child welfare system;
- Comparison of outcomes for children with other communities in the state and nation;
- Identification of exemplary programs and practices with recommended application to the County;
- Report on community satisfaction with the child protections system; and
- Review and report on progress on recommendations contained in the CCIC's report.

In July 1996, the Board of Supervisors approved DHHS' recommendation that the Board of Supervisors establish the Children's Coalition as the oversight body called for by the CCIC, now called the Child Protective Systems Oversight Committee (Oversight Committee).

The Bylaws of the Children's Coalition define the duties of the Oversight Committee. The Oversight Committee is responsible for performing community review of critical child protective services cases, culminating in an annual report, which includes outcomes and effectiveness of the system with recommendations for policy or program changes. The report may include review of progress on the recommendations contained in the CCIC report and other items identified in the 1996 CCIC report. It must be approved by the Children's Coalition which presents the report to the Board of Supervisors.

The Oversight Committee is not limited to oversight of the Child Protective Services (CPS) Division. It can, in its discretion, expand its inquiry to the County's child protective services system generally, including service providers under contract with the County. Such an examination would necessarily be more systemic in character as access to an individual's records would be limited based upon a spectrum of confidentiality laws. The Juvenile Court order allows access only to those records that fall within the purview of Welfare and Institutions Code section 827, i.e., records related to dependency proceedings. Ultimately, the decision as to the focus and extent of its oversight functions rests within the exclusive determination of the Oversight Committee, subject to any limitations in the Coalition Bylaws or Board of Supervisors action.

During this past year, it has come to the attention of the Oversight Committee in discussion with County Counsel that the committee comes under the auspices of the Brown Act; therefore a new webpage, accessible through the Children's Coalition website has been created which includes meeting agendas and approved minutes. (http://www.dhhs.saccounty.net/Admin/childrenscoalition/Pages/ChildrensCoalition_Home.aspx) As a result of this, Oversight Committee meetings are open to interested members of the community.

Annual Report 2015

I. Introduction

The Child Protective "Systems" Oversight Committee is not limited to just reviewing the Division of Child Protective Services (CPS); however, this year's report does focus on CPS; but in addition, focuses on Extended Foster Care (EFC/AB12).

As a result of last year's recommendations, CPS was given additional resources to start-up the Quality Improvement Committee, as well as other positions to enable work to be done on Policies and Procedures (P&Ps). The Oversight Committee has observed progress in these areas and wishes to thank the Board of Supervisors for their support.

For this Report, the Oversight Committee focused on the following:

- 2015 Presentations to the Oversight Committee, of which there were many
- Follow up on the recommendations that were made in the 2014 Report (there were actually 13 recommendations)
- Critical Incidents review through the Critical Incidents Subcommittee (eight were reviewed for this report), including four recommendations
- Systems Review Subcommittee did an extensive overview of the Extended Foster Care (EFC or AB 12) program which led to four recommendations

In addition, there were three other recommendations, bringing the total to 11. One of these recommendations was that all dependents of CPS need the same level of intervention/attention that is being afforded to the Commercially Sexually Exploited Children (CSEC) population; and another was that the Board of Supervisors support technical solutions that would support the operations of CPS (These include software programs for more structured online storage and for the organization of Policies and Procedures (P&Ps) and making P&Ps available via mobile devices with the ability for staff to participate in online interactive trainings. Currently, this is not possible.).

The challenges CPS faces are immense, and these are exacerbated with an inadequate number of positions. For example, you will see later in this report that the Emergency Response/Informal Supervision (ER/IS) Program is in need of 43 additional positions (Permanency (PP) is in need of 50 additional positions) in order to be aligned with National Standards of Excellence. Also, you will see that the Public Health Nurse support, which is greatly needed, is severely under-supported.

It is the consensus of the Oversight Committee that after nearly 20 years of reviewing dozens of cases of Critical Incidents that chronic underfunding of support services is one of the main reasons – but not the only reason – that these Critical Incidents continue to occur. Included among the problems associated with this understaffing are the inability for Social Workers (SWs) to adequately communicate and collaborate with collaterals (for example, the medical field, Law Enforcement and schools), make adequate assessments, which includes review of Child Welfare

Services/Case Management System (CWS/CMS)[2], etc. – all of which have led to critical thinking errors. We have found that critical thinking errors have accounted for a majority of these many Critical Incidents.

It is an opinion of the Critical Incidents Subcommittee that Sacramento County as an entire community does not have "zero tolerance" for child abuse/neglect deaths – by this we mean that there is not an overarching government commitment to the prevention of these deaths, and that the responsibility for prevention appears to be relegated only to CPS and not shared with medical or psychological providers, or all the many other county and city agencies (including Law Enforcement and Court Services) that interact in the lives of families. Children are more than just a subset of the population – they are our community's future. Please refer to Section IV. for further discussion regarding the above statements.

[2] The CWS/CMS is a statewide tool that supports an effective Child Welfare System of services. The CWS/CMS improves the lives of children and families by giving service workers information to improve case work services and freeing them from repetitive tasks; provides policy makers with information to design and manage services; and fulfill State and Federal legislative intent.

II. 2015 Presentations to the Oversight Committee

The Oversight Committee received updates and presentations over the course of this reporting period as a result of concerns they had expressed. The information received provided updates on the recommendations from last year's Annual Report, and helped inform the recommendations stated in this report. The below section does not include information that can be found in "Appendix C: Data and Reports Received from CPS", which includes CPS' updates to the 2014 recommendations.

A. July 2015

CPS Update: Michelle Callejas

1. AB 12[3] (Extended Foster Care) Implementation – Starting January, 2016 the non-minor dependents in the program will start aging out (turn 21 years of age)
2. Crossover Youth[4] – Update on the work being done with this population
3. Title IV-E – Prevention and Permanency programs are being funded by the Title IV-E Waiver[5]
4. General Updates

B. August 2015

CPS Continuous Quality Improvement (CQI) Update: Mindy Yamasaki

1. CQI Unit Update
2. Training Update – Implementation of Safety Organized Practice[6] (SOP) and California Common Core Curricula (CORE) 3.0[7]
3. Data Requests – Baseline data for Title IV-E and development of a data dashboard
4. Policy and Procedure (P&P) Task Force – Development and plan
5. Child and Family Services Reviews (CFSRs)[8] – What it is and how it is implemented
6. Quality Assurance (QA) Tools – Expanding beyond compliance and focusing on outcomes
7. Quality Improvement Committee (QIC) Update

C. September 2015

Commercially Sexually Exploited Children (CSEC)[9] Presentation: Judge Stacy Boulware Eurie, Michelle Callejas, Michael Shores

CPS Update: Michelle Callejas

[3] The California Assembly Bill that allows foster care for eligible youth to extend beyond age 18 up to age 21.
[4] The population of youth that has contact with both the child welfare and juvenile justice systems.
[5] See Appendix E for definition and information.
[6] Integrated approach to engagement, critical thinking and safety in child welfare. See Appendix E for more information.
[7] Standardized curricula for California's newly hired CPS Supervisors and Social workers. See Appendix E for more information.
[8] Periodic reviews conducted by the U.S. Department of Health and Human Services' Children's Bureau. See Appendix E for more information.
[9] Any child under the age of 18 years old that is used for the purpose of exploitation through sexual servitude (prostitution), regardless of the absence of economic leverage, manipulation, fraud, coercion, threats, force and violence.

Oversight Recommendation: All dependents of CPS need the same level of intervention/attention that is being afforded to the CSEC population.

D. January 2016

CPS Update: Michelle Callejas, Marian Kubiak

1. Staffing, Retention and Recruitment
2. Policies and Procedures
3. CSEC Program Update
4. Extended Foster Care (EFC)
    a. *EFC Outcome Preliminary Report and Outcomes for Non-minor Dependents Child Welfare Youth Exiting Foster Care Quarterly Statistical Report for July – September 2015* was presented and discussed. A success story was shared.
    b. After a full year's worth of data is collected, CPS will perform analysis and develop outcome measures based on the findings.
    c. CPS will create a dashboard around EFC program data which will include Sacramento County, State, and like-county performance. Once data is obtained, Sacramento County can meet with other counties to learn about best practices.

III. Follow up on 2014 Recommendations

The information for this section was obtained from CPS Deputy Director Michelle Callejas and other members of the CPS organization. The Oversight Committee received a written report from CPS as a response to 2014 Recommendations (see Appendix C). The full text of the 2014 Recommendations can be found in Appendix B.

A. Recommendation: Complete P&Ps within designated timeframe.

Findings:

CPS has continued to contract with Resource Development Associates (RDA) to assist the Department with the process of developing and implementing policies and procedures (P&Ps). A P&P taskforce was created to write the updated P&Ps. However, in January 2015, due to staffing needs in Court Services (CS), the P&P staff was re-assigned to assist with stabilizing the CS program. As of today's date, the P&P Taskforce has resumed, has completed and trained staff on two policies, and there are 21 policies currently under revision. No timeframe has been communicated to complete the remaining P&Ps. The Board of Supervisors provided the resources necessary to implement this recommendation.

Plan:

The Oversight Committee will ask CPS to report out at least twice over the next year on the completion of this recommendation.

B. Recommendation: Permanency and Court Services are fully staffed with experienced Social Workers.

Findings:

CPS has made efforts and progress to fill the vacant positions, as evidenced by the following information received:

- A total of 37 Social Work staff were hired across the Division
- Currently, there are 36.6 Social Worker (SW) vacancies across the agency – a reduction from last year
- Specific to Court Services there are currently three vacancies
- There are less than 10 vacancies in Permanency and there are plans to fill these from a recent hiring pool

Plan:

The Oversight Committee will ask CPS to report out at least twice over the next year on the implementation of this recommendation.

C. Recommendation: Prioritize and fully resource the CQI process through staffing, training and data systems so that it becomes an ongoing and integrated part of CPS.

Findings:

As a result of the Oversight Committee's recommendations, positions were created with resources provided by the Board of Supervisors to support the CQI process. Interviews for the positions were conducted and qualified staff were identified, however, they were reassigned to other areas of the system in critical need. After the critical need was addressed, five of the six CQI related positions throughout the Division were then staffed.

Plan:

The Oversight Committee will ask CPS to report out at least twice over the next year on how the CQI process is going. There are currently two positions on the CQI Committee for Oversight Committee members. One is currently filled and the plan is to have the second position filled this year.

D. Recommendation: As part of the QIC, develop a proactive plan for measurements to be put in place so that changes made can be measured to determine whether that change resulted in the intended improvement.

Findings:

A plan for measurement has been developed. However, the Oversight Committee's investigation did not find answers to the question of whether there is a feedback loop in place to operationally implement the recommendations from the QIC and report back about how and if the changes resulted in the intended improvement.

Plan:

The Oversight Committee will ask CPS to report out over the next year on how this process is going, hopefully with some concrete examples.

E. Recommendation: Support the creating of a CPS Training and Staff Development Unit dedicated to training, technical assistance, case reviews, P&Ps, and lessons learned from QIC.

Findings:

The CPS Training and Staff Development Unit has been created and implemented. The committee would like to commend the actions of the Board of Supervisors in funding this critical part of the CPS system. As a result of this, CPS was able to hire additional staff, including a dedicated County Counsel.

Plan:

The Oversight Committee will ask CPS to report out over the next year on how this process is going.

F. Recommendation: Implement recommendations and changes initiated as a result of the QIC and CI subcommittee case reviews.

Findings:

A matrix is currently being formulated dealing with implementation of approved recommendations, but this matrix has not been completed as of the date of this report.

Plan:

The Oversight Committee will ask CPS to report out over the next year on the progress of the proposed matrix. The Critical Incidents Subcommittee will review the progress and the content of this matrix over the coming year.

G. Recommendation: Establish a consistent ongoing means for intentional interagency coordination of County departments such as Department of Human Assistance (DHA), Probation, and DHHS (including CPS, Behavioral Health Services (BHS), In-Home Supportive Services and Public Health (PH)).

Findings:

CPS provided multiple examples of their collaboration with other agencies such as the establishment of a CSEC Steering Committee, collaboration on a Crossover Youth Practice Model, coordination of services for housing needs, partnership with Division of Public Health for Public Health Nurse (PHNs) services, participation in the Sacramento Child Abuse and Neglect (SCAN) and Medical Neglect and Review (MNR) teams, and collaboration with Behavioral Health. See Appendix C for full details.

Plan:

The Oversight Committee will seek input on how these collaborations are going over the next year, and will hopefully gain some good examples.

H. Recommendation: Continue to refine improvements within the CPS Call Center by decreasing wait times, consistent use of SDM hotline tools, and reviewing "evaluated out" dispositions.

Findings:

CPS has reported exploring ways to improve services and operations at the Hotline, however the Oversight Committee would like to obtain specific detail on the effectiveness of the changes put in place to address wait times, dropped calls, evaluated out referrals, and Structured Decision Making compliance.

Plan:

The Oversight Committee will ask CPS to report out over the next year on the progress of this recommendation.

I. Implement Critical Incidents Subcommittee recommendations

There were five recommendations made by the CI Subcommittee in the 2014 Annual Report: 1) creation of a Domestic Violence (DV) protocol; 2) ongoing staff training on dispositions; 3) consideration of all CPS history when evaluating a case; 4) evaluating the child holistically,

considering the risk of harm to a child when developing Safety Plans, including risks associated with drug use, mental health, and domestic violence; 5) progressive intervention and consequences for parents.

For CPS' response to these recommendations, see Appendix C.

Findings:

There has been some progress such as training for ER Field SWs on considering all CPS history when evaluating a case; this training was completed on January 31, 2016. There is still a lot of work to be done in these areas, however. Most of the work currently being done in these areas is in the "being updated" or "work in progress" stage.

Plan:

The Oversight Committee and the CI Subcommittee will ask CPS to report on the progress of these recommendations over the next year.

IV. Critical Incidents Subcommittee Report

The Critical Incident Subcommittee of the Oversight Committee meets monthly to examine child maltreatment, death and near death situations. This review covers incidents that occurred in Sacramento County from April 2015 to February 2016. The purpose of this report is to identify system issues that in addressing would lead to improved outcomes for children. This information can be used by Sacramento County as well as the partners in the child protective system to improve practice, avoid repeating mistakes of the past and make recommendations for changes in available resources. Since the inception of the Oversight Committee, these reports have documented repetitive issues that needed to be addressed and have identified future needs that would help address these issues.

The Critical Incident Subcommittee reviewed eight cases. These cases included review of Quality Assurance Reports and Memos prepared by DHHS in response to the death/near death of a child due to maltreatment which are reported to the State, and information from the Quality Improvement Committee established last year in 2015. Each case reviewed and discussed was examined to determine whether or not CPS's responses prior to the death or critical incident were adequately investigated. The ages of the children ranged from 11 days to 10 years.

It is an opinion of the Critical Incidents Subcommittee that Sacramento County as an entire community does not have "zero tolerance" for child abuse/neglect deaths – by this we mean that there is not an overarching government commitment to the prevention of these deaths, and that the responsibility for prevention appears to be relegated only to CPS and not shared with medical or psychological providers, or all the many other county and city agencies that interact in the lives of families. Children are more than just a subset of the population – they are our community's future. It is therefore imperative that all agencies consider how every decision they make may possibly either improve or degrade child safety, and they should be working together to identify children at risk. This community-wide commitment appears lacking in Sacramento County. We recognize that a continued lack of adequate attention and resources means these deaths and critical incidents will continue to happen. The Board of Supervisors may want to consider modeling child abuse prevention awareness by considering undertaking an initiative such as the "#1 Question, Is it good for children?"[10], wherein elected officials, business leaders, and community members ask the question of every decision they consider. These types of initiatives have been used in jurisdictions (open the link in footnote 10) across the nation to improve the lives of their children. The lack of consequences for the underlying causes of maltreatment, such as abuse of drugs and alcohol has not been adequately recognized or addressed.

Other concerns that have been raised in the past and continue to be problematic are:

A. The importance of collateral contacts between CPS, pediatricians, schools, Mental Health providers, Law Enforcement and others involved in the life of a child and family. In some cases, this was insufficient or lacking. For example, in one case, a mental health clinician treating a distraught mother did not recognize the risk to the child and alert CPS. This was

[10] Public policy campaign led by Prevent Child Abuse West Virginia. https://number1question.wordpress.com/

not the only incident. In another case, CPS was not alerted when a high risk parent was admitted on a psychiatric hold, leaving her child with her boyfriend – who subsequently murdered the child.

Similarly, Law Enforcement did not appear to consider the potential risk to a toddler in a home with numerous marijuana plants, or ascertain the whereabouts of a child in a home they frequented because of the mother's violent outbursts. The subsequent harm to children in those homes were not surprising, given the warning signs; but Law Enforcement can only appropriately respond to those warning signs if given the training and clear direction that they must consider the impending risk posed to children in the household and alert CPS accordingly.

In other cases it was the CPS worker who made insufficient collaboration attempts. In one case, a SW made it clear to all household members that a child was not to be in a dangerous section of the property. This "Safety Plan" did not appear to be shared with numerous collaborating providers on the case. In a case involving a medically compromised child, the SW did not consult with any health provider before closing the case. We understand that CPS has formed a training program to reinforce expectations to the workers; however, we worry that added training will not address the issue of workloads too high to allow adequate time to think critically or conduct in-depth collaborations.

Insufficient collaboration and the narrow delegation of child safety to CPS is a continuing concern of the Oversight Committee. It is our understanding that DHHS has conducted an "in it together" training series for CPS and Mental Health providers[11]. While we commend this effort, we also recognize the need for Law Enforcement, hospitals, clinics and other providers who are outside the DHHS system to likewise commit to improving their focus on child safety. With parents that are involved in Mental Health treatment and Law Enforcement, it seems imperative that both systems look at the broader issues, such as where the children are and who is watching them when the adult issues are being addressed. When a parent is incapacitated by drugs, illness (mental or physical), or arrest, Law Enforcement and Health/Mental Health providers need to notify CPS as to the whereabouts of the children of that parent so that follow up can be done to assure the safety of the children.

B. There is a need for significant "Safety Plans" and follow up. Added to that is having consequences when adults do not follow the "Safety Plan", such as not doing drug testing. In two cases, families that had failed to follow "Safety Plans" were only admonished. In one of those cases, the family was adamant against receiving services or drug testing, and because of the lack of intermediate services the investigation was closed with several small children in the home. This is a repeated concern of the Critical Incidents Subcommittee. It is our understanding that CPS recently finalized a "Safety Plan" policy and has completed training on the subject[12]. We hope to see improvement in this area. There needs to be more concern about the impact of drugs, including alcohol and marijuana, on children in their environment and the risk for secondary effects. This, too, has been a concern in the past.

[11] This information was obtained from CPS.
[12] This information was obtained from CPS.

C. More resources are needed for CPS workers, particularly to aid with assessing the well-being of children under the age of five. There are currently far too few Public Health Nurses (PHN) to assist CPS[13], as well as too few PHNs to provide services to families in the community and decrease the need for CPS intervention in the first place. This committee was informed that the current PHN staff can only intervene with certain sick or medically compromised children and do not have the staff to go out on home visits wherein health concerns are suspected but not yet identified or have not yet hit a critical threshold[14]. This means that the PHNs cannot do the necessary prevention and early intervention work. Due to staffing and budgetary limitations for the cases that the PHNs can take on, they currently must close their involvement when the case is stabilized and cannot provide ongoing monitoring after intervention.

D. There are two SWs assigned specifically to work with medically neglected children in CPS. These two SWs have special training and expertise in dealing with medically neglected/fragile children. Their lighter caseload reflects the extra time that needs to be devoted to these very difficult cases. There is a need for more SWs to be assigned to this area, but resources currently are not available to do this. CPS currently has a Medical Neglect Review Team. Any SW, including the two assigned specifically to work with medically neglected children, can consult with them regarding a particular case.[13]

E. There is a major concern as it relates to staffing and retention within CPS. Vacant positions within CPS and the shortage of SWs as well as the retention of the SWs within the department have put CPS in a vulnerable position. This year CPS was in a constant triage position at one point in Court Services and other departments; the CPS leadership had to attempt to get staffing to cover various growing requirements and workloads. The inability to retain workers caused more staffing issues as the veteran workers began to experience workload burn out from ballooning case counts. When workers inherit cases from workers who leave, they must spend critical time familiarizing themselves with the new families and triaging the new cases along with the old. This constant re-adjustment could easily result in critical thinking errors as well as other errors.

Per the Child Welfare League of America (CWLA) Caseloads Standards, it is recommended that the maximum new cases per month per Emergency Response (ER) SW should not exceed 12; the recommended Supervisor to SW ratio should be 1:5; and the maximum new caseload in Permanency (PP) should be 20. Also, the SB2030 Case Load Recommendation Study that was conducted in the late 1990's states that new cases per month per ER SW should not exceed 10-13; for Family Maintenance (FM) SWs it should not exceed 11-14; for Family Reunification (FR) SWs it should not exceed 12-16; and for PP SWs (which includes FR) it should not exceed 14-20. In Sacramento, the average new cases per month per ER SW is 19, this according to CPS[15].

[13] Currently there are only 4.5 PHNs available for home visits in ER/IS and Hearts for Kids (H4K) programs. See Appendix D for details.
[14] This information was obtained from CPS.
[15] See Appendix E for more information regarding ER and PP staffing.

The reasons the ER and other SW caseloads are so high are due to the following:

1. Vacancies: There is a Vacancy Rate (VR) that has averaged 11% over the last three years due to staff quitting, retiring, etc. It has been suggested in the past that CPS over-hire to reduce this rate.[16]
2. Unavailability Rate (UR): Currently this rate is close to 50% due to maternity leave, illness, writing detention reports, training, etc. Training and the constant updating of new policies and procedures is a major component of the UR.
3. Too few positions are allocated. Even if the VR and UR could be reduced (which would be very difficult with the current culture of Sacramento County to underfund CPS, as well as internal, Court, State and Federal requirements imposed on CPS) the workload would still be unacceptable with the current CPS resource allocation.

The Oversight Committee continues to see some of the same issues from year to year. CPS management has been addressing many of these issues, and has moved towards becoming a "learning environment" within the organization by instituting a significantly improved quality improvement process for critical case reviews. However, it is difficult to change the culture of the organization when SWs are overburdened with cases and the department is chronically understaffed.[17]

[16] This information was obtained from CPS.
[17] See "Recommendations" section of this report for the recommendations from this committee.

V. Systems Subcommittee Report – Overview of Extended Foster Care System (AB12)

The CPS Systems Subcommittee researched the implementation of the Extended Foster Care System (EFC or AB 12) in order to inform the Board of Supervisors of the current status of this program. We quickly identified that there are many changing provisions and approaches to meeting the needs of this distinct population. Some of the information gathered was through interviews with SWs, Eligibility Workers, foster care youth, and attorneys representing the youth in dependency court. This report is not intended to be a full investigation into EFC, but to advise the Board of Supervisors of a recently mandated program and give some initial impressions.

A. Introduction[18]

The California Fostering Connections to Success Act was signed into law September 30, 2010 through Assembly Bill (AB) 12 and became effective January 1, 2012. The bill and subsequent legislation allowed foster care for eligible youth to extend beyond age 18 up to age 21. Eligible foster youth are designated as "non-minor dependents" (NMDs). This legislation also recognized the importance of family and permanency for NMDs by extending payment benefits and transitional support services for the Adoption Assistance Program (AAP) and the Kinship Guardianship Assistance Payment (Kin-GAP) Program. There have been numerous statute and policy directives subsequent to the original legislation as implementation guidance.

B. Goals and Benefits

- Foster youth will be able to maintain a safety net of support while experiencing independence in a secure and supervised living environment.
- Provides youth extended time as "non-minor dependents" to obtain educational and employment training opportunities which assist youth in becoming better prepared for successful transition into adulthood and self-sufficiency[19].

C. Some Facts

- In the first year of implementation Sacramento County experienced a participation rate of 95%. It was anticipated that only 60% would participate in Extended Foster Care. This resulted in creating a special department for these NMDs comprised of 12 SWs.[20]
- Funding for extended foster care comes from Federal and non-Federal Funds. For Federal placements the sharing ratio is 50% Federal Title IVE funding and 50% Non-Federal Funding which is a combination of 2011 Realignment, 1990/91 Realignment and General Fund. The Non-Federal placements are 100% Non-Federal which are also a combination of 2011 Realignment, 1990/91 Realignment and General Fund. In Fiscal Year 2014-15

[18] Independent Living Program Policy Unit "After 18 Program Fact Sheet".
[19] See Appendix D for information regarding basic eligibility requirements, foster placement options, AAP and Kin-GAP extended benefits after age 18, and additional information.
[20] According to CPS.

the Non-Federal (local) costs were $7,819,811. These Non-Federal costs are funded with a combination of 2011 Realignment, 1990/91 Realignment and General Fund. [21]

- Rates paid by the County depend on the placement of the NMD:[22]
  - Supervised Independent Living Placement (SILP) is $859 per month (the infant supplement for a custodial parent is $411 per month)
  - Foster Home or Relative/Non-related Extended Family Member (NREFM) is $859 per month, plus special needs for infant supplement. Special needs can range from $107 to $751 per month
  - Dual agency rate (NMDs that are CPS and Regional Center clients) is $2,265 per month
  - Group Home Rate Classifications Level (RCL) rates vary from $7,746 to $10,130 per month
  - Transitional Housing Placement Plus Foster Care (THP+FC), single or remote site, is $3,007 per month. The host family model receives $2,393 per month.
- Placement by Type:[23]
  - Supervised Independent Living 53.1%
  - Foster Family Agency (FFA) 23.0%
  - Guardian 16.7%
  - Group Home 5.6%
  - Relative/Non-Related Extended Family Member (NREFM) 1.2%
  - County Foster Home 0.5%
- See Appendix G, Section A for data received from CPS

D. Recorded Outcomes

Outcomes measures by the County are required to be submitted to the State on a quarterly basis, indicating data at point of discharge from EFC services. Our outcomes research was limited to analyzing the available data representing three quarters (April through December 2015; we were unable to obtain fourth quarter data as of the time of this report). Outcome data measures growth toward independent functioning and stability.

Outcome data is collected through a report completed by the SW at the point of termination from the EFC program.

- Most leave EFC between the ages of 20-21.
- Statewide 14% are custodial parents at time of termination; compared to 32% in Sacramento County.
- Subsequent data submitted by Sacramento County CPS has shown a sharp reduction in the percentage of parenting EFC youth. It is their opinion the parenting rate is 20-25%.

[21] According to Department of Human Assistance Financial Management.
[22] According to Statewide Foster Care Rates.
[23] According to CPS CWS/CMS.

- Youth who, by virtue of EFC, were able to complete high school or equivalency before leaving foster care were 60% statewide and 70% in Sacramento County.
- Youth who enrolled in college during EFC was 25% both statewide and in Sacramento County. None of the NMDs from Sacramento County graduated college, and less than 1% statewide did so.
- 43% of the Sacramento County foster care youth leaving foster care stated that they intend to enroll in college during the next semester.
- Youth who enrolled in and completed on-the-job training, a certificate program, or vocational training was less than 1% statewide, but 24% in Sacramento County.
- Youth that obtained either full or part-time employment at point of leaving foster care was 44% statewide and 57% for Sacramento County.
- Youth who have made arrangements to rent their own housing or to pay rent to or share rent with another person is 40% statewide and 62% in Sacramento County.
- 97% of Sacramento County youth stated that they have at least one connection to a caring, committed adult who can provide a safe, stable relationship, guidance and emotional support to the youth.
- 32% of Sacramento County youth are custodial parents at the time of termination of EFC services.
- See Appendix G, Section B for further Outcomes Data

E. Interviews

The Subcommittee interviewed two attorneys, seven EFC SWs, two eligibility workers, and nine youth. While this is admittedly a very small sample, there was a lot of commonality in the responses. Six of the nine youth lived in one residence that had onsite staff that worked with them daily in pursuit of their independence. A common theme emerged from the six female former foster youth, some receiving extended foster care funding and some employed and paying out of their earnings. They found value in having a structured environment where there were rules and high expectations. They found safety in the rules because they believed having those rules protected them from getting involved with the wrong people and kept them focused on becoming independent. They identified the house manager as their primary source of assistance in meeting their goals and reported marginal contact and direction from SWs, Probations Officers, etc. One had a caseworker from a THP+FC provider and received assistance and support from that person. The interviews with the other three female NMDs were consistent with the above and they indicated they value living in a safe environment and rules set by the SW to continue eligibility. One of the youth indicated they wish the program continued to age 25. All were participating in work or school and were meeting with their SW.

The Transitional Independent Living Plan (TILP) is the foundation by which the SWs/Probation Officers agree with the NMD that they have a plan towards independence, which meets the eligibility requirements for the EFC program. SWs and attorneys agree that many NMDs do not take this document or the process to complete the document seriously. They have difficulty coming up with their own goals and the SW is left to accept whatever

goals they state regardless of the reasonableness. For example, a goal may be to get a car; however, the youth is not able to identify a process by which they will get a driver's license, purchase the car, and get insurance. They neither have the capability, nor are they willing to learn. This deficiency may be seen in court as an incomplete and insufficient document. The SWs believe *they* are accountable for the lack of specificity, as opposed to the NMD.

F. Findings[24]

1. **The level of participation in the TILP by the NMD is not connected to eligibility for payment in that the law and court process reinforces keeping the NMD eligible.** The threshold for ineligibility is if the SW cannot find the NMD or the NMD does not make himself/herself accessible to the SW. The court determines when EFC services will stop. The threshold for eligibility is low in that the NMD can continue to state they are "removing barriers to employment", which was intended by the State to bridge gaps in participation and eligibility. The court can order a trial if the NMD disputes the termination of services. If services are terminated, the NMD can reenroll at any time. NMDs are not held accountable and they receive a foster care payment regardless of progress toward independent living, including education.

2. **THP+FC is viewed as a resource to the NMD in order to provide more structure and operationalize the TILP.** The rate paid to the THP+FC provider is $3,007. The youth receives $1,475. The provider secures housing and provides case management services to assist the NMDs in meeting their goals. Absent a supportive housing environment, the NMDs living on their own in SILP settings struggle to cover all their expenses, and move frequently due to landlord or roommate conflicts.

3. **Obstacles to success include a shortage of housing, lack of support to Regional Center clients by the Regional Center system, and the lack of quality mental health services.** The mental health system is seen as deficient in providing clinicians of adequate experience and high incidence of turnover causing a lack of consistency in service. It is reported that NMDs are reluctant to engage in mental health services based on past experience.

[24] See "Recommendations" section of this report for the recommendations from this committee.

VI. CPS Oversight Committee Recommendations

As a result of the observations documented in this report, the Oversight Committee recommends the following:

From the Critical Incidents Subcommittee

1. That the Board of Supervisors develop a countywide commitment to encourage other departments – such as Law Enforcement, Mental Health, hospitals, and the courts –to become more aware and responsive to how their decisions impact the safety of children and the work of CPS, and collaborate better with CPS and each other (perhaps forming a Blue Ribbon Commission to address this issue).
2. That the Board of Supervisors support and encourage CPS management's efforts to improve employee retention, particularly around the issues of high caseloads and employee morale. What this support means is that there need to be more SW positions allocated to the CPS department.
3. That the Board of Supervisors request CPS to ensure that stronger drug and alcohol policies are put in place, that CPS workers have the resources needed to evaluate caretaker substance abuse (training, ready access to testing, consultative support, etc.), and that caretaker substance abuse is elevated to high risk when formulating the "Safety Plans".
4. That the Board of Supervisors review funding for Public Health Nurses and provide the necessary funding to the Division of Public Health to increase the number of PHNs dedicated to both child maltreatment intervention (in collaboration with CPS) and prevention (field nursing).

From the Systems Review Subcommittee

Regarding the Extended Foster Care program:

5. There needs to be more accountability and more structure for the NMDs, incorporating input from SWs, attorneys and providers.
6. There is a need for increased coordination and collaboration among attorneys, SWs, Probation Officers, the Regional Center System and Mental Health.
7. There are several community agencies, individual, and corporate donors that are committed to assist former foster youth. Much could be gained by convening all interested stakeholders to hold an annual resource fair that all NMDs should be required to attend in order to identify the available resources.
8. There needs to be a far more structured approach to the initial process for NMDs with accountability measures implemented. It is our understanding that there is now a special dependency court for NMDs which creates far more consistency, court activity and follow up with the assigned judge. This is a big step towards accountability and consistency in the message to the NMD.

Other

9. All dependents of CPS need the same level of intervention/attention that is being afforded to the Commercially Sexually Exploited Children (CSEC) population.
10. The BOS support technical solutions that would support the operations of CPS. These include software programs for more structured online storage and for the organization of Policies and Procedures (P&Ps). Also, we recommend making P&Ps available via mobile devices and the ability for staff to participate in online interactive trainings. Currently, this is not possible.
11. That CPS complete their work on Policies and Procedures and submit a timeline to the CPS Oversight Committee.

VII. 2016 Work Plan

- Review CPS' responses and results of recommendations from 2014 (13 recommendations) and 2015 (11 recommendations) Annual Reports
- Continue to review Critical Incidents
- Follow up on AB12 research (including data on the number of EFC youth Sacramento County has served since 2012; and nearly 2 years' worth of exit data would be available)
- Reach out to the Child Death Review Team for more collaboration
- Possibly look at resources in City and County Law Enforcement agencies (e.g., number of detectives assigned to the Child Abuse Division and their caseloads)
- Receive presentations at CPS Oversight Committee meetings, including quarterly report-outs by Division of CPS
- See if Sacramento County has made a more significant commitment to the prevention of child deaths and critical incidents (see Recommendation 1)
- Possibly review the work of the Medical Neglect Review Team within the Division of CPS
- Other issues that may present themselves in the next year

Appendix A: CPS Oversight Committee Membership

Roy Alexander, LCSW
CEO
Sacramento Children's Home

Karen Alvord, LCSW, MBA
CEO
Lilliput Children's Services

Michele Bell, MA
Permanency Supervisor
Department of Health and Human Services, Children's Protective Services

Jane Claar, MSC, PPS
Coordinator, Child Welfare Attendance
Twin Rivers Unified School District

Joni Edison, MSW
Program Manager, Foster Care Eligibility
Department of Human Assistance

Sister Jeanne Felion, SSS
Executive Director
Stanford Settlement Neighborhood Center

Holly Ferreriae, MSW
Emergency Response Social Worker
Department of Health and Human Services, Children's Protective Services

Maynard A. Johnston, MD, FAAP
Retired

Sgt. Aaron Marino
Sacramento County Sheriff's Department, Child Abuse Bureau

Dr. Virginia E. Maulfair
Sacramento CASA Volunteer

Chris Ore
Supervising Deputy District Attorney
Sacramento District Attorney's Office, Special Assault and Child Abuse Unit

Sharon Rea Zone, LCSW
Infant Mental Health Program Manager
U.C. Davis C.A.A.R.E. Center, U.C. Davis Children's Hospital

Appendix B: Annual Report 2014 Recommendations (Full Text)

A. Complete the Policies and Procedures (P&P) process within the timeframe designated. The Oversight Committee commends CPS for seeking external expertise in revising their P&Ps. However, this important effort needs to be fully realized in a timely manner so Social Workers have clear policies and procedures to guide their practice in ensuring children are safe.

B. Due to the particular complexity of Court Services, as part of the Court Stability Plan, CPS should ensure that Court Services is fully staffed with experienced Social Workers.

C. *Prioritize and fully resource the Continuous Quality Improvement (CQI) process through staffing, training, and data systems, so that it becomes an ongoing and integrated part of CPS, despite the pull to respond to other pressing issues.

D. As part of the Quality Improvement Committee (QIC), develop a proactive plan for measurement to be put in place so that changes made can be measured to determine whether that change resulted in intended improvement. The QIC staff, and other identified staff throughout the Division, should have specific training in the evaluation of continuous quality improvement and be able to guide the group in designing clear and objective ways of measuring the outcome of the recommendations resulting from critical incident reviews. Significant and thoughtful investment is needed to answer the following question, "How will we know that a change is an improvement to help keep children safe?"

E. *Support the creation of a CPS Training and Staff Development Unit dedicated to training, technical assistance, case reviews, Policies & Procedures, and lessons learned from QIC. The Training Unit should include a staff accountability component to ensure staff are getting training they need and are demonstrating improvement in knowledge and skills. Additionally, a Deputy County Counsel should be assigned to the Training Unit to contribute to and support improved Social Worker skills and practice including but not limited to: training on accuracy of dispositions, establishing fact patterns to get to the correct disposition, preparing court reports, reviewing policies and procedures to ensure alignment with regulations and legal requirements, and to review new legislation and regulations to inform practice and policy changes. As part of the training plan, CPS should continue to do case reviews with Social Workers and Supervisors as an effective form of training.

F. Implement the recommendations and changes initiated as a result of the QIC and Critical Incident Subcommittee case reviews.

G. Establish a consistent ongoing means for intentional interagency coordination of County departments that intersect in the lives of families and children. Coordinated interagency communication between Department of Human Assistance including government aide and domestic violence; Probation; Department of Health and Human Services including Child Protective Services, Behavioral Health, In-Home Supportive Services, and Public Health will decrease fragmentation and improve service delivery.

*Were able to be implemented due to Board of Supervisors support.

H. Continue to refine improvements within the CPS Call Center such as:

1. Explore data driven innovative strategies to reduce wait times through expanding successful models being implemented;
2. Improve the consistent use of SDM hotline tools for consistency in response times; and
3. Review “evaluated out” dispositions to ensure accurate dispositions and address any training issues that may improve more accurate dispositions.

Critical Incidents Subcommittee 2014 Recommendations

There were five recommendations made by the CI Subcommittee in the 2014 Annual Report: 1) creation of a Domestic Violence (DV) protocol; 2) ongoing staff training on dispositions; 3) consideration of all CPS history when evaluating a case; 4) evaluating the child holistically, considering the risk of harm to a child when developing Safety Plans, including risks associated with drug use, mental health, and domestic violence; 5) progressive intervention and consequences for parents.

Appendix C: Data and Reports Received from CPS

CPS Updates on 2014 Annual Report Recommendations

A. Complete P&Ps within designated time frame

The Department continues to contract with Resource Development Associates (RDA) to provide consultation services related to the implementation of an effective and sustainable process for developing policies and procedures. In January 2015, CPS had to temporarily shift staff resources to address critical needs in the Court Services program. In December 2015, the 8-member (part-time) P&P Taskforce resumed. Additional writers and subject matter experts (SMEs) are assigned as needed to write policies, with oversight by the Taskforce. Two policies have been completed and disseminated, and training provided to division-wide staff. An additional 21 policies are currently under revision. Once completed, they will be presented to various stakeholders to give feedback prior to finalization.

In partnership with RDA, the P&P Taskforce has accomplished the following to date:

- Developed organizational infrastructure to support P&P review and revisions
- Created a policy domain categorization to prioritize the revision process
- Created the *P&P Development and Revision Policy* instructional guide
- Implemented effective approaches to dissemination and training
- Standardized and implemented tools (including instructional guides):
    - Master policy template
    - Policy review checklist
    - Staff policy review tool
    - Training template
    - Training materials review tool
    - Pre/post test template
    - Training evaluation template

Next steps – policies will continue to be developed, rewritten, disseminated, and trained. Software programs are being assessed to provide a more structured online storage and organization of P&Ps, and to make P&Ps available via mobile devices and to allow staff to participate in online interactive trainings. These technical solutions will be dependent on funding for the software and technical support.

B. Permanency and Court Services are fully staffed with experienced Social Workers

We have made significant progress in this area. A team of in-program Planners has focused specifically on this are for the last year. A total of 37 social work staff across the Division were hired from the initial pool of 45 applicants from the first hiring day faire, and have since participated in both program and Division training as a cohort. Staff members in this cohort are approaching the end of the training period and have recently been assigned cases. The cohort approach was replicated after the initial round of Court Services hiring in 2015 in which we brought on nine social workers.

All provided positive feedback about being in a cohort versus being hired individually and placed throughout the division. Of the nine that started, only one has left the agency. With the cohort approach, we are also providing comprehensive training, exposure to various practices and interventions of the agency, and delaying assignment of cases to ensure they are ready to serve clients.

As of the writing of this report, per our position control data, we have 36.6 Social Worker vacancies across the agency. Specific to Court Services we currently have only three vacancies which is significant growth as last year we faced a 100% turnover rate. To further support staff we began the utilization of on call social worker staff that can support the work when case volume gets to high levels. Permanency staff vacancies also decreased and as of the writing of this report, there are less than 10 vacancies and there are plans to fill from a recent hiring pool. Although we have been able to fill a significant number of positions from the previously mentioned efforts, some of the vacancies across the entire division may be attributed to recent promotions and delays in hiring due to resources being focused on training the incoming staff. To fill vacancies across the division, a second mass hiring day was held in March 2016 and 30 social work candidates were interviewed. Candidates selected as a result of the March 2016 hiring day are being utilized to fill some of the 36.6 identified vacancies. Our short term goal is to reach a point where we are hiring and training in cohorts concurrently so that there is a continuous flow of staff into programs. Program planners will continue this focus until we can transition this model to Program Administration.

Ongoing strategies for staff recruitment include: continuing with mass hiring days; outreach to local and surrounding universities via both in-person recruitment and job postings; Job announcements at Berkeley's California Social Work Education Center (CALSWEC); exchanging information with other counties regarding staff retention and recruitment practices; concurrent hiring and training; continuing with cohort training as this has proven to be a successful model that provides support to incoming staff; assigning peer trainers to incoming staff; assignment of cases in accordance with new staff skill development and allowing time for adjustments as needed.

C. Prioritize and fully resource the CQI process through staffing, training and data systems so that it becomes an ongoing and integrated part of CPS

Five of the six CQI related positions throughout the department have been filled. The hiring process is underway for one vacant position, a Human Services Specialist in Program Administration. CQI staff resources in Program Administration returned from the reassignment to stabilize the Court Services Program and reported to their regular posts in August 2015. Since returning, four staff from Program Administration (PA) and two staff from Emergency Response and Permanency were certified to complete 25 case reviews per quarter for the CFSR process. The staff has completed the mandatory certification process which spans a period of eight weeks. These qualitative case reviews are an important way to gather data about the "how" and the "why" questions associated with CQI. Beginning April 1, 2016, two PA Program Planners are solely dedicated to perform the case reviews to ensure that the County completes the federal requirement of 25 case reviews per quarter. The case level data compliments the quantitative data obtained through systems such as the California Child Welfare Indicators Project, Safe Measures and Business Objects reports. California is currently using the Administration for Children and Families' (ACF) Onsite Review Instrument (OSRI) for review of all cases.

In addition, since returning from the temporarily reassignment in Court Services, Program Administration's CQI staff has been performing CQI related data analysis and reports:

- CQI-PDSA Reentry Quantitative Study
- Katie A. Compliance Reports
- Referral Duration Report
- Permanency 2+ Years Report
- Permanency Outcomes
- Commercially Sexually Exploited Children Data Collection & Report
- Crossover Youth Practice Model Data Collection
- Data Reports and validation in response to State Auditor's requests
- Measure 2F Report (Out of Home F2F Visits) FY 14/15 Comparisons to Current Month
- Psychotropic Medication Reconciliation Report
- Group Home Placements
- Foster Parent Recruitment Retention Support
- Quarterly Dashboard for Outcome Indicators
- CEO Compliance Monitoring Board
- Data Book
- Ad Hoc Reports as requested

D. As part of the QIC, develop a proactive plan for measurement to be put in place so that changes made can be measured to determine whether that change resulted in intended improvement

A plan for measurement seeking to effectively answer the question, "How do we know the implemented change improves child safety," has been developed. PA staff developed a root cause matrix categorizing recommendations made by the QIC into themes: 1) Assessment/Critical Thinking; 2) Engagement; 3) Intervention; and 4) Partnering with Community. The underlying goal of all recommendations included in the four themes is to increase child safety. PA staff identified outcome measures, available on the California Child Welfare Indicators Project (UC Berkeley) website, to be used to monitor the Department's performance in improving child safety over time. The outcome measures identified are S2 Recurrence of maltreatment and P4 Re-entry to foster care within 12 months. PA staff will also use information obtained through the SOP Case File Review process to measure change in the organizational culture involving child and family engagement.

On October 28, 2015, the CPS Executive Management Team attended a CQI training sponsored by the Casey Foundation. The training was intended to develop a common language and understanding about CQI systems and prioritize Sacramento County's CQI development and implementation efforts. All CPS members of the QIC were included. A draft of the proposed CQI-PDSA Reentry Study was presented at the training by PA CQI staff to obtain feedback.

E. Support the creating and a CPS Training and Staff Development Unit dedicated to training, technical assistance, case reviews, P&Ps, and lessons learned from QIC

The plan is for the CPS Hiring and Staff Development Unit to be housed within Program Administration. It will be managed by one Program Planner and staffed with three Specialists and two support staff. In March 2016, a new Program Specialist was hired to assist with coordinating and facilitating trainings for new hires as well as existing staff. Two additional Program Specialist positions were recently advertised to increase capacity. These specialists will develop curriculum, create training plans and provide induction training to new hires. Each Division was allocated an additional Program Specialist, whose role will be to provide program specific training to new hires and existing staff. In February 2016, County Counsel was hired to provide legal training and review training materials to ensure accuracy with legal mandates. The dedicated County Counsel has already attended many of the new hire trainings and provided clarification regarding legal questions. She also provided two days of legal mandates training to ensure accuracy and consistency of information to our new social workers.

The following are additional training updates:

CORE 3.0

- CPS is working with the Northern California Training Academy on implementing CORE 3.0 for new staff which will be rolled out in January 2017. CORE 3.0 is the new mandatory training for all social workers.
- Cohorts of workers will be provided on-line training, classroom training, skill-based activities, and field supervision.
- Social Workers must attend within the first year of being hired.
- A modified version of Common Core 3.0 (Common Core 2.5) is being provided prior to full implementation of Common Core 3.0 in 2017. Sacramento County currently has five staff attending the modified version, which includes a portion of online learning as well as the field-based learning activities for the Assessment block. We have several supervisors and Program Specialists who are certified Field Advisors and can provide the supervision required. We will continue to send supervisors and specialists to the Coaching Institute and Field Advisor training in order to increase our capacity.

Structured Decision Making (SDM) 3.0

- Updated and implemented in November 2015.
- A major change to SDM 3.0 is that the family strengths and needs has become more trauma-based which required the retraining of all staff.
- Seven staff at the supervisory level or above attended SDM Train the Trainer and are responsible for training staff across the division.
- A total of 15 sessions were held to train all supervisors and social workers during October - November 2015.

Policy and Procedures

Staff Development is responsible for coordinating trainings for identified policies and procedures and will work closely with the subject matter experts during this process. Once a policy has been approved, a team of trainers is appointed to provide the training. Generally the lead trainer will be the writer and/or subject matter expert. Additional trainers will be selected from program and staff

development. The team will be responsible for developing the PowerPoint and handouts as well as creating interactive exercises to reinforce learning. Pre and post tests may be administered to measure what level of learning has occurred.

Adult Mental Health Providers – to consider the children

In partnership with the Northern California Training Academy and CPS staff, training has been completed for Behavioral Health (BH) staff and community partners. Training was conducted for 365 BH staff between February-October 2015. Those who attended found the interactive case scenarios to be beneficial to understanding the connection between adults with mental health issues caring for children, and the need to do a deeper assessment. The training curriculum will be adjusted to make it relevant for CPS staff.

Lessons learned from QIC

PA staff has taken the lessons learned from QIC and developed two CQI-PDSA studies focused on Disposition and Re-entry to get baseline data, test assumptions to better assess systemic issues, and develop strategies to create targeted interventions. Once the studies are completed, CQI staff will partner with the Training Unit to develop any necessary training.

The following activities informed the training needed for staff as our agency moves to full implementation of the Safety Organized Practice (SOP):

SOP Coaching

- Sacramento County has contracted with UC Davis and three coaches have been hired
- All coaches met with respective programs/bureaus by January 31, 2016 and have scheduled individual supervisory coaching meetings which commenced in February 2016
- Coaches are assigned by programs and will spend 25 hours per month with each respective supervisory team
- Supervisory meetings will entail development of individual coaching plans
- SOP Steering Committee is in the process of developing tools to measure effectiveness of coaching

SOP Case Reviews

- In conjunction with UC Davis, completed a statistical sampling of case reviews and Social Worker interviews to establish a baseline of SOP practice
- Baseline information was obtained from UC Davis in March 2016
- SOP Steering Committee is in the process of developing tools (documentation guidelines/forms/etc.) to start tracking progress and use of SOP
- A two day SOP Foundational training for all social workers and supervisors began in March 2016 and is scheduled to conclude in June 2016
- Completion of advanced SOP trainings will be will be determined based on the needs of each program

F. Implement recommendations and changes initiated as a result of the QIC and Critical Incidents (CI) subcommittee case reviews

As highlighted in the Child Protective Systems Oversight Committee 2014 Annual Report, a matrix aimed at capturing implemented recommendations has been developed (QIC Recommendation Matrix). The matrix has been used as a mechanism to list and demonstrate the activities, initiated within CPS, aimed at making system wide improvements to increase child safety. Child Protective Services has effectively captured recommendations made by the QIC and the Critical Incident Subcommittee and established action items which seek to address the root causes which may have contributed to fatalities or near fatalities.

G. Establish a consistent ongoing means for intentional interagency coordination of County departments such as Department of Human Assistance (DHA), Probation, and DHHS (including CPS, Behavioral Health Services (BHS), In-Home Supportive Services and Public Health (PH))

The Division is making great strides in strengthening partnerships and coordinating services across systems. All agencies involved strongly believe that ongoing communication and coordination of care is critical to promoting better outcomes for the children and families we serve. Below are some of the efforts on which we have been focused:

Commercially Sexually Exploited Youth

In early 2015, CPS and several system and community providers established a Commercially Sexually Exploited Children (CSEC) Steering Committee. The committee was formed in response to new legislation that clarified that children and youth that are victims of sexual exploitation, may fall under the jurisdiction of child welfare. The CSEC Steering Committee was comprised of various members including the Presiding Judge of the Juvenile Court, CPS, Probation, BHS, Public Health, Sacramento Sheriff's Department, Sacramento Police Department, the offices of the District Attorney and Public Defender, Sacramento County Offices of Education (SCOE), Sacramento City Unified School District, County Counsel, Children's Law Center and several community partners who specialize in serving victims of sexual exploitation. The Steering Committee worked hard with the facilitation of WestCoast Children's Clinic to complete CSEC Protocols focused on a multi-disciplinary approach to provide victim-centered and trauma informed responses across systems to meet the needs of children and youth who have been commercially sexually exploited. Several agencies, including CPS, began piloting the Commercial Sexual Exploitation Identification Tool (CSE-IT) to strengthen efforts to better identify who are being or at risk of being sexually exploited. In September of 2015, the Protocols were signed by all parties and CPS began piloting them. There is much work to do with our system partners in coordinating this effort but all are committed to working together to improve services and outcomes to this very vulnerable population.

Crossover Youth Practice Model

CPS has also been part of a strong cross-systems partnership focused on implementation of the Crossover Youth Practice Model (CYPM), which is a model developed by the Center for Juvenile Justice Reform at Georgetown University. The CYPM is focused on preventing youth in child welfare from "crossing over" to juvenile justice. The Executive Committee members include the Presiding Judge of the Juvenile Court, Assistant Chief Probation Officer, CPS Director, BHS Director, Assistant County Counsel, SCOE Assistant Superintendent, and CPS, Probation and BHS executive managers. We are developing protocols that would delineate roles and responsibilities to strengthen collaboration, coordination and provision of services. The work has already led to identification of gaps, strategies that can be adopted, and opportunities to better serve these youth.

CPS will begin training regarding various aspects of the protocol in June with implementation to begin October 1, 2016.

Housing

CPS has formed partnerships and coordination of services that are focused on housing. Housing is a significant need in our community in general but also for the children and families that come to the attention of CPS. Lack of housing is a stressor we see in conducting investigations and it can also be a major barrier to timely reunification. CPS is working on coordinating resources with the Department of Human Assistance, Sacramento Housing and Redevelopment Agency, Sacramento Steps Forward, and exploring partnerships with various housing providers in town.

Public Health

CPS and the Division of Public Health have been working closely together to think "outside the box" and identify strategies to leverage resources to better support the needs of our youth. This reporting period we focused on a key area of need directly related to the health, safety and well-being of children and youth: co-locating nursing staff from our Centralized Placement Unit (CPSU) in the space we lease from the Children's Receiving Home. Staff at CPSU identified a need for youth to have access to on-site nursing services for those that were either entering care via a new protective custody or youth who were returning to care from runaway status. Due to a shortage of funding for Public Health Nurses (PHN), we adopted a new strategy of utilizing an existing PHN registry of nurses. This has first and foremost provided youth with direct on-site medical assessment, and further supports staff with identifying whether a youth needs ongoing medical care. The registry nurses have also been able to assist with medications and provide information that we can pass on to the caregivers when we secure a placement for the child. The below identifies further successes of the PHN and CPS partnership and collaborative efforts:

- Appropriately triage children entering care with a medical condition, including assessment of the need for further medical treatment
- Education of staff and foster parents on medication regimen
- Education of staff and foster parents regarding proper care of a child with a complex health condition
- Development of protocols for medication administration
- Professional consultation with medical providers regarding children's medical needs
- Administer treatment for communicable diseases
- Monitor a child's condition while at CPSU
- Prepare discharge summaries for children

Sacramento Child Abuse and Neglect Team

The Sacramento Child Abuse and Neglect (SCAN) team is comprised of representatives from local hospitals, CPS and Law Enforcement. The team is led by Dr. Vickers from the Sutter Bear clinic and includes other physicians and Social Workers from UC Davis, Kaiser and Mercy. Law Enforcement representatives include Sacramento Police Departments, Sacramento Sheriff's Department, and other local jurisdictions when they are needed. A CPS representative and a Social Worker from the CPS

Special Assault and Forensic Evaluation (SAFE) Center also participate. The team meets two times monthly at the Sutter Bear clinic.

The purpose of the team is to review reports of child abuse and neglect that originated from medical providers, school systems, and others, that were made to law enforcement and/or CPS. The reviews are to address gaps in health care and CPS or law enforcement service delivery. If there is an issue with the case, the team will discuss next steps and assign follow-up to one of the team members. The follow-up item will then be discussed at the next meeting. CPS representatives follow-up with Social Workers who have had a referral or case reviewed to deliver medical and/or law enforcement information. This collaboration ensures consistent service delivery to each child and family that comes through the medical system with a child abuse or neglect issue.

Medical Neglect and Review Team

The Medical Neglect Review Team (MNRT) consists of CPS, Public Health, Senior and Adult Services, California Children's Services and California Alta Regional Services. The team may include the treating physician or nurse and a representative from the Department of Human Assistance and any other provider with the family, as needed. The team is led by CPS and meets as needed.

The primary purpose of the MNRT is to help Social Workers resolve issues involving difficult medical neglect or chronic/complex medical conditions and to ensure that the child's medical needs are met. The MNRT can provide the Social Worker with relevant questions to ask the family about the child's on-going service needs, identifies additional investigative needs, identifies medical resources for the family and coordinates any medical needs and follow-up needed for the family. The MNRT promotes coordination between agencies and identifies services gaps and breakdowns, with recommendations for next steps, ensuring consistent medical care for the child.

H. Continue to refine improvements within the CPS Call Center by decreasing wait times, consistent use of SDM hotline tools, and reviewing "evaluated out" dispositions

CPS continues to explore ways to improve services and operations at the Hotline:

- Attempted to decrease wait times by doing the following:
  - Adding staff to the Hotline
  - Hiring staff to fill behind vacancies quickly – the Hotline is fully staffed without vacancies at this time
  - Increased supervisory oversight of the Call Center to triage calls timely and efficiently
  - Working with IT to obtain data that will inform decision making regarding resources at the Hotline
  - Hold time at the Hotline is a recurring agenda item on the weekly supervisory team meeting with discussions focused on possible solutions
- Consistent use of SDM Hotline Tools
  - Supervisory oversight is utilized when approving referrals generated
  - SDM Coordinator attends supervisory meetings to discuss proper usage of the tools
- Reviewing "evaluated out" dispositions

- Monthly Peer Review is conducted in order to review the work of peer Supervisors to ensure appropriate decisions are being made
- A Program Specialist reviews all "evaluate out" referrals following the downgraded decision from field Supervisors
- Major incidents are reviewed and staff is interviewed as part of the comprehensive process
- Case discussions are conducted to include all of the Hotline staff to create an on-going learning environment for all staff

I. Implement Critical Incident Committee recommendations related to:

1. Domestic Violence (DV) protocol

   Two trainings for all Emergency Response (ER) staff have taken place in collaboration with A Community for Peace (ACFP), and the current DV protocol/field tool was provided in the trainings. Every new Social Worker in CPS is provided the training as well. The DV protocol is a tool that contains questions to ask and risk factors to assess while in the field. ER staff received the second round of DV trainings in November and December 2015. Permanency services needs the second round of training, which is a continuation of the first training, but includes additional topics such as the effect of trauma on children, how to recognize abuser tactics, and how to engage adult DV victims in safety planning. One barrier is that we have not gone back to evaluate how this training has impacted our practice or conducted a qualitative review. As we continue to build our staff in Program Administration, this issue will be addressed.

2. Ongoing training on dispositions

   Disposition training is provided as part of the induction training for new Social Workers. Disposition Decisions Trees have been developed for all allegations (physical abuse, sexual abuse, emotional abuse, and neglect) to guide Emergency Response (ER) Social Workers in concluding referrals with the correct disposition based on all information gathered during an investigation. ER Social Workers were trained on the Disposition Decision Trees in 2015.

3. Consideration of all CPS history

   Training for ER field Social Workers on this practice was completed by 1/31/16. For ER Intake, the ER Program Manager and Division Manager worked on the process for reviewing history when new calls come in, how to document, etc. The Referral Intake document has been updated to prompt hotline workers to include prior CPS history that is relevant to the current allegations on the referral document. ER Program Planner trained to the ER Documentation guidelines at ER Bureau meetings in November/December 2014, which included reviewing CPS history and factors to consider when conducting an investigation and assessment. New ER Social Workers are also trained to this as part of their induction training. ER Program Managers conducted a random sample of ER referrals, and this area was considered as part of the QA review. Findings were discussed with the Social Worker and Supervisor and corrective actions taken as needed.

4. Evaluate child holistically, considering risk of harm to child when developing Safety Plans, including risks associated with 1) parental drug use, 2) mental health, and 3) domestic violence

   These were identified as the KEY 3 RISK factors to look for in referrals. These factors were added to the ER documentation guidelines, with a requirement that Social Workers staff these referrals with their Supervisor prior to conducting their investigation. Also, ER social workers complete Mental Health screenings on open cases and all children who present with behavioral concerns. Safety plan training has been completed for all ER and Permanency Social Workers, which included a review of the Safety Plan and Body Check policies, as well as scenarios, and pre and post testing. Trainings on assessing parental drug abuse, identifying commonly used drugs in Sacramento county, and Alcohol and Other Drug (AOD) resources was provided to ER staff in 2015 and is included in the induction training for new social workers.

5. Progressive intervention and consequences for parents

   Currently the Informal Supervision policy and procedure is being updated, which outlines Social Workers' expectations for referral closure, assessing parental progress, and intervention strategies when faced with parental non-compliance. The ER program managers conduct case reviews prior to closure for all referrals assessed as very high by the SDM risk assessment tool to ensure all safety factors have been addressed and all interventions align with the assessment, and safety threats have been mitigated.

   Program Planners have been conducting case discussion with all ER staff to analyze decision points on cases where a fatality or near fatality occurred. Highlights and discussions involve consideration of all CPS history, dispositions, progressive intervention, safety planning, critical thinking, and decision making. These case discussions are on-going and occur in small-group sessions with a Supervisor and his/her direct reports. Currently, ER staff is on their third round of case discussions and case reviews for Permanency staff will begin in summer of 2016.

Appendix D: Public Health Nurses Assigned to CPS

1.0 FTE – Permanency Services
4.5 FTE – Emergency Response/Permanency Services
2.5 FTE – HEARTS for Kids Program (Medical clearance exams, funded by First 5 Sacramento, for children ages 0-5 placed in protective custody)

PHN by Program Who Complete Home Visits (HV)	Current Approved PHN Positions	Current PHN HV Vacancies	Current PHN HV on leave	Current PHN Available for HV Referral Assignment	PHN HV Referrals from April 2015 to April 2016	Additional Consultation with ER/IS Social Workers on Investigations and Open Cases	PHN HV Referrals Unable to be Assigned due to Staffing Ratios(*)
ER/IS	4.5	1.5	1.0	2.0	215	315	N/A
H4K	3.5	0.0	1.0	2.5	667	N/A	183

(*) Best Practice for a home visiting PHN is to maintain a caseload of 15-20 (depending upon the severity of medical condition/medical complications)
In the grid above there are listed the two programs in which Public Health Nurses (PHN) take home visitation referrals. Since April 2015 through April 2016 the Emergency Response/Informal Supervision (ER/IS) Program PHN's have received 215 referrals for home visitation and completed 315 consultations which include but are not limited to consulting with ER/IS Social Workers regarding medical concerns on open investigations, obtaining medical documents, attending Team Decisions Making (TDM) Meetings (when medical concerns are noted), as well as participation in the Medical Neglect Review Team. Additionally, for the last 6 months the ER/IS PHN's have been covering home visitation referrals in the Permanency Hearts 4 Kids (H4K) Program whenever possible. Since April 2015 through April 2016 the H4K PHN's have received 667 referrals and even with the assistance from ER/IS PHN's there were 183 referrals that could not be assigned.

In addition, there are 10.8 FTE PHN positions approved for CPS and their assignments are:

2.0 FTE – Child Health and Disability Prevention (CHDP) Program Court
1.0 FTE – Oversight Nurse
1.0 FTE – CPS Courts
5.8 FTE – Foster Care Program

Total: 17.8 FTE

Appendix E: CPS Social Worker Assignments in Emergency Response (ER) and Permanency (PP)

ER Current referral numbers are 19 per month.

Current number of Fulltime ER Field Workers	ER Field Social Worker Availability for Referral Assignment(*)	ER Field Social Workers Available	Current Average Referrals a Month	Referrals Received per Fulltime ER Field Social Worker
94	54%	50	966	19
Number of Fulltime ER Field Social Worker if all Vacancies are Filled	ER Field Social Worker Availability for Referral Assignment(*)	ER Field Social Worker Available	Current Average Referrals a Month	Referrals Received per Fulltime ER Field Social Worker
107	54%	57	966	17
Number of Fulltime ER Field Social Worker Needed to be at 12 Referrals per Worker	ER Field Social Worker Availability for Referral Assignment(*)	ER Field Social Workers Available	Current Average Referrals a Month	Referrals Received per Fulltime ER Field Social Worker
150	54%	81	966	12

The grid above shows the number of fulltime ER Field Social Workers currently (green), the number of fulltime ER Field Social Workers if all current vacancies were filled (Red) and the number of fulltime ER Field Social Workers needed to achieve the recommended referral assignment (blue). The grid shows the current percentage of availability to receive a referral of 54%. (*) The availability is based upon social workers not available for referral assignment due to: vacations, sick leave, writing a Detention Report/Protective Custody Warrant (PCW), Court Hearing, follow up on open investigations, attempts to serve a PCW (locate the child), mandated trainings and/or disciplinary actions.

Current Caseloads for Available Permanency SW = 27.5

Current Open Permanency Cases	Current Number of Available Fulltime Permanency Social Worker	Current Caseload for Available Fulltime Permanency Social Workers	Number of Fulltime Permanency Social Worker with Vacancies Filled	Average Caseload for Fulltime Permanency Social Workers with all Vacancies Filled	Number of Additional Fulltime Permanency SW's Needed to achieve 17 Cases per Worker	Number of Additional Fulltime Permanency SW's Needed to achieve **17** cases per Worker -10% (*)
2078	75.6	27.5	87.6	23.7	37.0	50.0

(*) Average of 10% absenteeism

Appendix F: California Assembly Bill 12 Additional Information

Basic Eligibility Requirements[25]

- At the six month hearing prior to youth turning age 18, the Social Worker/Probation Officer must have a plan to ensure the NMDs meet at least ONE of the following participation criteria:
    1. Working toward completion of high school or equivalent program (e.g. GED); OR
    2. Enrolled in college, community college or a vocational education program; OR
    3. Employed at least 80 hours a month; OR
    4. Participating in a program designed to assist in gaining employment; OR
    5. Unable to do one of the above requirements because of a medical condition.
- Non-minor dependents must sign an agreement to reside in an eligible placement location and agree to work with a Social Worker/Probation Officer to meet the goals outlined in their Transitional Independent Living Case Plan.
- Remaining in foster care after age 18 is voluntary. NMDs can exit at age 18 or at any subsequent time before age 21. Youth who exit at age 18 can re-enter foster care at any time before age 21.
- Tribal youth under county jurisdiction are also eligible to remain in foster care after age Tribes with a Title IV-E agreement with the state or federal government can create their own extended foster care (EFC) program.
- Probation youth who are in a foster care placement are also eligible for EFC.

Foster Placement Options

Eligible placement options for youth after age 18 include:

1. Remain in existing home of a relative or non-related extended family member; licensed foster family home; certified foster family agency home; home of a non-related legal guardian whose guardianship was established by the juvenile court; or group home (NMD may remain in a group home after age 19 only if the criteria for a medical condition is met and the placement is a short-term transition to an appropriate system of care); or
2. THP-Plus Foster Care (THP+FC) – This program has three models: Host Family where the NMD lives with a caring adult who has been selected and approved by the transitional housing provider; Single Site where the NMD lives in an apartment, condominium or single family dwelling rented or leased by the housing provider with an employee(s) living on site; or Remote Site where the NMD lives independently in one of the housing types listed above with regular supervision from the provider; or
3. Supervised Independent Living Placement (SILP) – This placement option allows NMD to live independently in an apartment, house, condominium, room and board arrangement or college dorm, alone or with a roommate(s), while still receiving the supervision of a Social Worker/Probation

[25] Independent Living Program Policy Unit "After 18 Program Fact Sheet".

Officer. The youth may directly receive all or part of the foster care rate pursuant to the mutual agreement.

AAP and Kin-GAP Extended Benefits after Age 18

- For AAP, the initial AAP agreement must have been signed when the child/youth was at least 16 years old.
- For Kin-GAP, the child/youth must have attained 16 years of age before the Kin-GAP negotiated agreement payments commenced.
- Both AAP and Kin-GAP youth must meet at least one of the participation criteria listed above.

Additional information

- Youth who are custodial parents have the same rights to participate in foster care after age 18 as all other youth.
- Youth who are consumers of Regional Center services can continue to receive dual agency and supplemental rates.
- Youth who meet the eligibly requirements to receive Supplemental Security Income (SSI) may be eligible to receive both at the same time.

Appendix G: Data Received from CPS Relating to EFC

A.

Extended Foster Care Outcome
Preliminary Report
1/19/15

The Extended Foster Care (EFC) program was implemented in Sacramento County on January 1, 2012 in accordance with AB 12 – Foster Youth Connections Act. Since the program began, 402 youth have exited the program. General demographic information for those that have exited are listed below. In addition, we have provided some outcome data that has been captured since April 1, 2015. This information is collected quarterly and the data below reflects two quarters covering the time period between April 1, 2015 and September 30, 2015. October 1, 2015 to December 31, 2015 is being pulled now and should be available in early February 2016.

General Demographics of Youth that exited

Ethnicity	
White	159
Black	184
Latino	39
Asian/Pacific Islander	13
Native American	7
Total	402

Age at Exit	
18	84
19	83
20	30
21	205
Total	402

Gender	
Male	207
Female	195
Total	402

Placement at Exit*	
Relative/NREFM	17
Foster Family Home	7
FFA	62
Group Home	54
THP+FC	45
SILP	216
Court Specified Home	1
Total	402

Number of Youth Parenting	
Male	9
Female	75
Total	84

*The placement at exit data reflects the placement type the youth resided in prior to exiting the Extended Foster Care program. The categories are defined as follows:

- Relative/NREFM – placed with a family member or non related extended family member
- Foster Family Home – county licensed foster family home
- FFA – foster home licensed through a foster family agency monitored by Community Care Licensing
- Group Home – A residential facility that provides foster children with high level services that cannot be offered in a foster family setting.

- THP+FC – Transitional Housing Program _ Foster Care is a program offered by a licensed transitional housing placement provider to provide safe housing for NMDs and assistance in developing the skills needed for transitioning to independent living. The program provides supportive services based on the NMD's TILP and Needs and Services plan as developed by the provider. This program is for NMDs who are not ready for a highly independent type living situation. Sacramento County has three THP+FC providers: AspiraNet, Environmental Alternatives and Lutheran Social Services.
- SILP – Supervised Independent Living Placements are for NMDs who are developmentally ready to live independently or in a less restrictive environment (such as renting a room) with less intensive services from a case manager or caregiver. There is no caregiver or provider to assist the NMDs as with other placement types; therefore, it is important to ensure the NMDs are ready for this type of placement. Examples of SILPS can include apartments (alone or with roommates), single room occupancies (may have shared bathrooms and/or kitchens, renting a room, dorms/ university housing, etc.
- Court Specified Home – This particular court specified home was an Alta Vendorized home

B.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
DATA SYSTEMS AND SURVEY DESIGN BUREAU

Outcomes for Nonminor Dependents Child Welfare Youth Exiting Foster Care Quarterly Statistical Report SOC 405X

DOWNLOAD REPORT FORM FROM:
http://www.cdss.ca.gov/dssdb/
E-MAIL COMPLETED REPORT FORM TO:
admsoc405x@dss.ca.gov
Please keep the file in .xls extension.

COUNTY NAME	Version	REPORT QUARTER	REPORT YEAR
34 Sacramento	Initial	Jul-Sep	2015

Part A. Outcomes for Nonminor Dependents Child Welfare Youth Exiting Foster Care	Youth Who Exit at Age 18 (A)	NMD Age 18 (B)	NMD Age 19 (C)	NMD Ages 20-21 (D)	Re-Entry NMD Ages 18-21 (E)
1. Youth exiting Foster Care during the quarter (Item 1 includes non-parental youth not included in Items 1a, 1b, 1c and 1d below; AND Item 1 equals the sum of Item 2 plus Item 3)	1	11	6	46	0
a. Of the youth in Item 1, females who are a custodial parent of one child	0	2	1	11	0
b. Of the youth in Item 1, females who are a custodial parent of two or more children	0	0	0	4	0
c Of the youth in Item 1, males who are a custodial parent of one child	0	0	0	2	0
d. Of the youth in Item 1, males who are a custodial parent of two or more children	0	0	0	2	0
2. Youth whose whereabouts are unknown and could not be contacted during the quarter	0	7	2	0	0
3. Youth whose whereabouts are known during the quarter (Item 1 minus Item 2) (Items 4 - 48 below provide information about the youth entered in Item 3)	1	4	4	46	0
Part B. Educational Attainment/Enrollment For Items 4 - 18 select all that apply for each youth. The sum of Items 4 - 18 must be greater than or equal to Item 3.					
4. Youth who completed high school or equivalency (Item 4a plus Item 4b)	0	2	2	37	0
a. Youth who received a high school diploma	0	1	2	36	0
b. Youth who received a General Equivalency Degree (GED)	0	1	0	1	0
5. Youth enrolled in an educational program in order to continue to pursue their high school education (e.g., high school diploma, GED)	0	2	0	2	0
6. Youth who dropped out of high school	1	1	2	8	0
7. Youth who plan to enroll in college during the next available quarter/semester	0	1	1	24	0
8. Youth enrolled in college (Item 8a plus Item 8b)	0	0	0	14	0
a. Youth in a two-year community college	0	0	0	14	0
b. Youth in a four-year college	0	0	0	0	0
9. Youth who attended one year of college	0	1	0	14	0
10. Youth who attended two years of college	0	0	0	11	0
11. Youth who received a college degree	0	0	0	0	0
12. Youth who completed three or more years of college	0	0	0	2	0
13. Youth who dropped out of college	0	1	0	9	0
14. Youth who plan to enroll in on-the-job training, certificate program or vocational education during the next available quarter/semester	0	0	0	3	0
15. Youth enrolled in on-the-job training, certificate program or vocational education	0	0	0	1	0
16. Youth who completed on-the-job-training, certificate program or vocational education (Item 16a plus Item 16b)	0	0	0	24	0
a. Youth who completed on-the-job training	0	0	0	12	0
b. Youth who completed certificate program or vocational education	0	0	0	12	0
17. Youth who dropped out of on-the-job-training, certificate program or vocational education	0	0	0	0	0
18. Youth for whom no information is known about their education	0	0	2	0	0
Part C. Means of Financial Support and/or Other Financial Resources For Items 19 - 31 select all that apply for each youth. The sum of Items 19 - 31 must be greater than or equal to Item 3.					
19. Youth who obtained employment (Item 19a plus Item 19b)	0	1	0	36	0
a. Youth who obtained full-time employment	0	0	0	26	0
b. Youth who obtained part-time employment	0	1	0	10	0
20. Youth enlisted in the military, Job Corps, California Conservation Corps or AmeriCorps	0	0	0	2	0
21. Youth with a savings account	0	1	1	36	0
22. Youth with a checking account	0	0	2	41	0
23. Youth who are receiving or have applied for Supplemental Security Income (SSI)	0	0	2	2	0
24. Youth who have applied for CalWORKs	0	0	2	10	0
25. Youth who have applied for General Assistance/General Relief (GA/GR)	0	0	2	3	0
26. Youth who have applied for CalFresh	0	0	2	29	0
27. Youth who are receiving or have applied for Subsidized Child Care	0	0	0	11	0
28. Youth who are receiving or have applied for Temporary Financial Assistance (Independent Living Program, Emancipated Youth Stipend, other)	0	0	0	1	0
29. Youth who are receiving financial support or assistance from another source other than those listed above	1	0	0	11	0
30. Youth with no means of financial support	0	0	0	1	0
31. Youth for whom no information is known about their financial situation	0	2	3	0	0

SOC 405X (4/15)
Electronic Form Updated 9/18/15

Part D. Housing Arrangements For Items 32 - 40 select only ONE item for each youth. The sum of Items 32 - 40 must be equal to Item 3.	Youth Who Exit at Age 18 (A)	NMD Age 18 (B)	NMD Age 19 (C)	NMD Ages 20-21 (D)	Re-Entry NMD Ages 18-21 (E)
32. Youth who have made arrangements to rent their own housing or to pay rent to or share rent with another person	216 0	217 1	218 3	219 33	220 0
33. Youth who have made arrangements to live free of rent with another individual	221 1	222 0	223 1	224 5	225 0
34. Youth who have made arrangements to live in supportive transitional housing	226 0	227 0	228 0	229 4	230 0
35. Youth who have made arrangements to receive subsidized housing	231 0	232 0	233 0	234 0	235 0
36. Youth who have made arrangements to reside in an emergency shelter	236 0	237 0	238 0	239 0	240 0
37. Youth who have made arrangements to live in a college dorm the next available quarter/semester	241 0	242 0	243 0	244 0	245 0
38. Youth who have made housing arrangements other than those listed above (e.g., military, Job Corps, California Conservation Corps or AmeriCorps)	246 0	247 0	248 0	249 2	250 0
39. Youth who have no housing arrangements	251 0	252 0	253 0	254 0	255 0
40. Youth for whom no information is known about their housing arrangements	256 0	257 3	258 2	259 3	260 0
Part E. Health Care Insurance For Items 41 - 45 select all that apply for each youth. The sum of Items 41 - 45 must be greater than or equal to Item 3.					
41. Youth who have Medi-Cal	261 1	262 4	263 4	264 45	265
42. Youth who have applied for Extended Medi-Cal (must also be counted in Item 41)	266 0	267 1	268 1	269 41	270
43. Youth who have health insurance other than Medi-Cal	271 0	272 0	273 0	274 0	275
44. Youth who do not have health insurance (Medi-Cal or other)	276 0	277 0	278 0	279 0	280
45. Youth for whom no information is known about their health care insurance coverage	281 0	282 0	283 2	284 1	285
Part F. Permanency Connection For Items 46 - 48 select only ONE item for each youth. The sum of Items 46 - 48 must be equal to Item 3.					
46. Youth who reported that they have at least one connection to a caring, committed adult who can provide a safe, stable relationship, guidance and emotional support to the youth	286 1	287 4	288 4	289 46	290
47. Youth who reported that they have no permanency connection	291 0	292 0	293 0	294 0	295
48. Youth for whom no information is known about their permanency connection	296 0	297 0	298 2	299 0	300

Comments

Revised Report Explanation *(Complete if Revised is selected. If Initial is selected this box remains blank)*

CONTACT PERSON	TELEPHONE	EXTENSION	FAX
JOB TITLE/CLASSIFICATION	E-MAIL		DATE SUBMITTED

Appendix H: Additional Information Referenced in Footnotes

Title IV-E Waiver

Under Federal law, Title IV-E of the Social Security Act provides foster care maintenance payments for children placed in out-of-home care. The Child Welfare Demonstration authority provides states with an opportunity to use federal funds more flexibly in order to test innovative approaches to child welfare service delivery and financing. Using this option, states can design and demonstrate a wide range of approaches to reforming child welfare and improving outcomes in the areas of safety, permanency, and well-being. http://www.acf.hhs.gov/programs/cb/programs/child-welfare-waivers

Safety Organized Practice

Safety Organized Practice (SOP) is a collaborative practice approach that emphasizes the importance of teamwork in child welfare. SOP aims to build and strengthen partnerships with the child welfare agency and within a family by involving their informal support networks of friends and family members, and uses strategies and techniques that align with the belief that the partnership between child welfare and the family exists in an effort to find solutions that ensure safety, permanency and well-being for children. SOP is informed by an integration of child welfare practices and approaches including:

- Solution-focused practice
- Signs of Safety
- Structured Decision Making
- Child and family engagement
- Risk and safety assessment research
- Group supervision and interactional supervision
- Appreciative inquiry
- Motivational interviewing
- Consultation and Information Sharing Framework
- Cultural humility
- Trauma-informed practice

https://humanservices.ucdavis.edu/sites/default/files/142198_1.pdf

California Common Core Curricula

California Common Core Curricula (CORE) is standardized curricula for California's newly hired child welfare supervisors and child welfare workers. It was developed through a multi-year statewide collaborative effort and was mandated by California's Program Improvement Plan (PIP) as part of the 2003 federal Child and Family Services Review (CFSR).
http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin05/pdf/I-49_05.pdf

CORE 3.0

Since the initial development of CORE, training has evolved to include more technology and more innovative ways to support transfer of learning and skill development.
http://calswec.berkeley.edu/common-core-30-0

Child and Family Services Reviews

Child and Family Services Reviews (CAFRs) are conducted by the U.S. Department of Health and Human Services' Children's Bureau. They are periodic reviews of state child welfare systems to achieve three goals: ensure conformity with federal child welfare requirements; determine what is actually happening to children and families as they are engaged in child welfare services; assist states in helping children and families achieve positive outcomes. After a CFSR is completed, states develop a Program Improvement Plan (PIP) to address areas in their child welfare services that need improvement. http://www.acf.hhs.gov/programs/cb/monitoring/child-family-services-reviews

Appendix I: Glossary of Acronyms and Abbreviations

AAP – Adoption Assistance Program

AB 12 – California Assembly Bill 12 California Fostering Connections to Success Act (Extended Foster Care)

ACF – Administration for Children and Families

ACFP – A Community for Peace

AOD – Alcohol and Other Drug

BH – Behavioral Health

BHS – Behavioral Health Services

CALSWEC – California Social Work Education Center

CCIC – Critical Case Investigation Committee

CFSR – Child and Family Services Review

CHDP – Child Health and Disability Prevention

CI – Critical Incidents

CORE – California Common Core Curricula

CPS – Child Protective Services (Division)

CPSU – Centralized Placement Unit

CSEC – Commercially Sexually Exploited Children

CSE-IT – Commercial Sexual Exploitation Identification Tool

CWLA – Child Welfare League of America

CWS/CMS – Child Welfare Services/Case Management System

CYPM – Crossover Youth Practice Model

DHA – Department of Human Assistance

DHHS – Department of Health and Human Services

DV – Domestic Violence

EFC – Extended Foster Care

ER – Emergency Response

F2F – Face to Face

FFA – Foster Family Agency

FTE – Full Time Equivalent

H4K – Hearts for Kids

HV – Home Visits

IS – Informal Supervision

Kin-GAP – Kinship Guardianship Assistance Payment

MNRT – Medical Neglect Review Team

NMD – Non-minor Dependent

NREFM – Non-related Extended Family Member

OSRI – Onsite Review Instrument

PA – Program Administration

PH – Public Health

PHN – Public Health Nurse

P&P – Policy and Procedure

PP – Permanency

PDSA – Plan, Do, Study, Act

QA – Quality Assurance

QIC – Quality Improvement Committee

RDA – Resource Development Associates

RCL – Rate Classifications Level

SAFE – Special Assault and Forensic Evaluation (Center)

SCAN – Sacramento Child Abuse and Neglect (Team)

SCOE – Sacramento County Office of Education

SDM – Structured Decision Making

SILP – Supervised Independent Living

SME – Subject Matter Expert

SOP – Safety Organized Practice

SSI – Supplemental Security Income

THP+FC – Transitional Housing Placement Plus Foster Care

TILP – Transitional Independent Living Plan

UR – Unavailability Rate

VR – Vacancy Rate