Northern California Training Academy

Reaching Out

CURRENT ISSUES FOR CHILD WELFARE PRACTICE IN RURAL COMMUNITIES

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What's Inside

The Journey toward Well-Being

By Susan Brooks and Nancy Hafer, Northern California Training Academy

Well-being. The words are said again and again, and while there is a newfound energy regarding the topic, it continues to leave many shaking their heads. The wealth of information and reports which have been issued on how to address the well-being of children and youth in foster care is staggering. And, of course, Katie A. and other initiatives have brought new attention and vigor to the conversation statewide and locally, most of which address specific aspects of well-being. And yet, with all of the attention on well-being, it remains an elusive and ill-defined topic with little clarity on the who, what, when, where, why and how. Who is responsible? And given the enormity of the topic, how can it be addressed?

We know that obtaining safety and even permanency for the children and youth who enter foster care is not enough. The negative impacts of the trauma that lead children into care must be comprehensively mitigated to allow children and youth to grow into healthy adults. It is not enough to do no further harm; at entry into foster care children are already at risk for a reduced quality of life that extends well after their transition to adulthood[1]. We must build a system in which foster children are offered the best services, best supports and best environments/relationships which can lessen the impact of the trauma that brought them into foster care.

No one agency can be completely responsible for ensuring the well-being of children and youth, which is often where the conversation is stalemated. Nevertheless, this challenge cannot be the end of the conversation. The current trend is that while not solely responsible for ensuring overall well-being, child welfare agencies do carry the burden of leadership in terms of coordinating and collaborating with other agencies to make sure children and youth are provided with services and supports. With collaborative and trauma-informed systems in place, well-being may prove an ever-more obtainable outcome.

This issue of *Reaching Out* is dedicated to making sense of the information we have about well-being—focusing in particular on mental, behavioral and social health and cognitive functioning. Our intent with this issue is to integrate the plethora of information available and provide a synthesis of what the best thinking is about the topic and some of the practices used to address it.

As a foundation, we use the framework provided in the ACYF Information Memorandum, 12-04, "Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services" *(see chart on page 30)*. As noted in the IM (page 2), the Administration for Children Youth and Families has called for increased attention to the topic of well-being, suggesting that addressing well-being is the logical next step for child welfare.

The system is moving in the right direction in recognizing and addressing well-being, and while implementation remains on the shoulders of the child welfare professional, the call for community collaboration does make the lofty goals seem more attainable; indeed, it is a call for all villagers to rally around our most vulnerable children and youth, and it's about time.

[1] *Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. American Journal of Preventive Medicine. 1998;14(4):245–258.*

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CONTINUING AND PROFESSIONAL EDUCATION

Well-Being: A Communal Effort

Based on an interview with David Sanders, Ph.D., Executive Vice President of Systems Improvement, Casey Family Programs
By Jason Borucki, Northern California Training Academy

Considering the difficulty of merely defining well-being, it should come as no surprise that the child welfare system has struggled to address it as a measurable and obtainable outcome. Part of this may have to do with the fact that no one agency can ensure the well-being of children in care, and many child welfare professionals are so overwhelmed by their workload that there is little or no time for them to address anything beyond safety.

In 2003, Dr. David Sanders inherited a similarly overwhelmed system when he took over as the director of operations for the Los Angeles County Department of Children and Family Services. When he began, there were more than 30,000 children in placement in his jurisdiction, with nearly 20,000 of them on an essentially long-term foster care order.

"What this created was a system of perpetual crisis," said Sanders in a recent interview with the Northern California Training Academy. "Most of the kids didn't have families, and we weren't doing anything to get them in families, so workers were continually dealing in crisis."

With workers having no time to focus on moving children towards permanency, it was clear something needed to change.

"It was really important to say, 'we've got to deal with these 20,000 kids who are going to linger in care until they're 18 unless we do something different.'"

A key to taking the system out of crisis was emphasizing the importance of freeing up workers to think beyond safety.

"We defined the role of what child protective services should be expected to improve for children in areas of safety and permanency," said Sanders, "but I think the other piece that ended up being quite helpful was saying, 'We do have to be a partner in other areas; we can't work in isolation.'"

This new approach was exemplified in the creation of the Los Angeles Education Coordinating Council, chaired at the time by the chief judge of the Juvenile Court and the chair of the Los Angeles Unified School District in a joint effort.

"We recognized that the child welfare agency was a critical partner in improving educational outcomes for children who were served in foster care," said Sanders. "I think it was really important to say we had a role in improving well-being, even if not the lead role in every instance."

By focusing beyond safety and collaborating with community partners to move youth toward greater well-being, Los Angeles County successfully reduced the foster care population. As a result, workers had more time and resources available to dedicate to those youth and families who needed the most assistance.

Now the executive vice president of Systems Improvement at Casey Family Programs, Sanders applies his experience from his time as a child welfare administrator to improving outcomes for youth nationally. He is currently a part of Casey's 2020 initiative, which aims to safely reduce the number of children in foster care by 50 percent by 2020 and reinvest related savings back into the families the system serves.

While 2020 is still quite far off and there will always be obstacles to overcome in any systemized solution, Sanders believes the potential for better outcomes is there.

"Workers in child welfare agencies are overwhelmed to say the least," he said, "and very rarely is there time, for example, to make sure children are getting to appropriate child care or school. But people want to do a good job. If we can think of ways to free them up and create an environment where that can happen, they will do it."

Responding and Intervening along the Child Welfare Continuum

Adapted with permission from the ACF Children's Bureau's ACYF-CB-IM-12-04

Focusing child welfare on improving social and emotional well-being requires careful consideration of how services are structured and delivered throughout the system. For example, a child welfare system with a focus on social and emotional well-being might be characterized by the following:

- Assessment tools used with children receiving child welfare services are reviewed to ensure they are valid, reliable and sensitive enough to distinguish trauma and mental health symptoms
- Children are screened for trauma when their cases are opened
- In-home caregivers receive services that have been demonstrated to improve parenting capacities and children's social-emotional functioning
- Child welfare staff and foster parents receive ongoing training on issues related to trauma and mental health challenges that are common among the children and youth being served by the system
- Assessments take place at regular and scheduled intervals to determine whether services being delivered to children and youth are improving social and emotional functioning
- Independent living and transitional living programs implement programs to support youth's development of self-regulation and positive relation skills

As child welfare systems continue to improve and refine their work to promote safety and permanency for children, a strengthened focus on the social and emotional well-being of children who have experienced maltreatment is the logical next step in reforming the child welfare system. Children who have been abused or neglected have significant social-emotional, behavioral and/or mental health challenges requiring attention, and treating them with a trauma-focused and evidence-based approach can improve outcomes throughout child welfare. Most importantly, it will enable children who have experienced maltreatment to look forward to bright, healthy futures.

Defining Terms

CAPP: Stands for California Partners for Permanency, a multi-site federal demonstration project focused on implementing a practice model that effectively addresses disparities in outcomes and supports positive permanency outcomes for all children and families with a targeted effort to help those children and youth who are in care the longest and experience the worst outcomes. The California effort focuses on African-American and Native-American children who are over-represented in the state's child welfare system and for whom it has been the most challenging to find loving and permanent homes.

Child well-being: A state in which children's physical, developmental, cognitive, emotional and behavioral functioning is healthy; they are able to develop skills and capacities; they grow and mature appropriately with age; and they can engage in positive social interactions (American Public Human Services Association, aphsa.org).

Fostering Connections After 18: Also known as AB 12, extends foster care to age 21, allowing youth to receive support while they attend school, obtain employment and otherwise strive to become self-sufficient. Extensive information on AB 12 and Extended Foster Care can be found in our Fall 2012 issue of *Reaching Out.*

Katie A.: Short for Katie A. et al v. Bonta et al, which refers to a class action lawsuit filed in federal district court in 2002 concerning the availability of intensive mental health services to children in California who are either in foster care or at imminent risk of coming into care. (childsworld.ca.gov)

Safety-organized practice: A child welfare approach informed by a variety of best and evidence-informed practices and focused on the safety of the child within the family system. Safety-organized practice brings a common language and framework for enhanced critical thinking and judgment on the part of all involved with a family in the pursuit of a balanced, complete picture of child welfare issues.

Trauma-informed care: When every part of a human services program's organization, management and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services (Substance Abuse and Mental Health Services Administration, samhsa.gov).

Wraparound: A planning process that values the engagement of the child and his/her family in a manner that shifts from a problem-focused view of issues to building on individual strengths to improve family and child well-being. The process is used to engage the family as they identify their own needs and create methods and a plan to meet those needs (childsworld.ca.gov).

Adolescent Well-Being

By Chris Downs

I recently asked several Seattle-area adolescents what it meant to them to "be well" or to be "doing well." Being popular, staying healthy, having a lot of Facebook friends and Twitter followers, dancing Gangnam Style, getting along with parents, and making good grades were just some of the varied responses. There was no consistent response on what it meant to "be well."

Well-being, much like love, wisdom, empathy and similar terms, means different things to different people, and yet we can usually agree when we see someone who seems to be doing well or not doing well.

In child welfare, we often make well-being assessments of foster youth based on a constellation of factors. If a youth struggles in school or shows signs of drug abuse, for instance, we might determine that the youth is not doing well. Conversely, if a youth brings home good school grades, talks about future career goals or gets along well with others, we might conclude that the youth is doing well. However, correlations between our perceptions of adolescent well-being and adolescent self-perceptions are notoriously poor. How many times have you concluded that a teen was doing well only to find out the opposite was true?

As a developmental psychologist, I have studied adolescent well-being, independent living, social competence and thriving for more than 30 years. Despite our or adolescents' own assessments of well-being, both the published literature and practice wisdom point to six indicators of high functioning (or well-being) among adolescents.

- Hope for the Future. Adolescents (and adults for that matter) who can describe an optimistic future populated with concrete goals are far more likely to evidence well-being on a host of parameters, including social relationships, school work and health.
- A Devoted Adult. Most of us in child welfare have had this permanency mantra drilled into us, but it turns out this one is accurate: young people who can identify one high-functioning and consistently available adult in their lives are, in fact, more likely to be better off as young adults.
- Social Connectedness. While some adolescents need more friends than others, the literature is very clear that youth need some degree of social connectedness with their community, friendship circle, neighborhood, mentors or other groups. Socially isolated adolescents tend to have much poorer outcomes in early adulthood than adolescents who can name at least one friend they have had for six months or more, an ongoing mentor, a caring teacher and/or a trusted sibling.
- "Bouncebackability." Virtually all adolescents face challenges, and foster youth often face more than their share. A clear predictor of future well-being is something I call "bouncebackability." This is the ability to return to a healthy or emotionally balanced state following a challenging or traumatic event. This is not the same thing as "resilience," which tends to be a basic personality trait associated with youth who—despite all odds—seem to do well.

- Language and behavior of "I Can." Struggling youth often use the language of pessimism and blaming. Phrases such as "I can't do it!" "The world is crap," or "Why can't they fix it?" are frequent. All adolescents use these types of expressions from time to time, but when they become part of daily language they are evidence of a sense of pessimism and (often) entitlement. When these statements are accompanied by ineffective behaviors, the youth generally fails. These adolescents don't tend to do as well as those adolescents who use the language of "I can," "I will," and "I do." Adolescents who use such language tend to elicit positive environmental reactions to themselves.
- Measured Trust. Most of the youth with whom we work in child welfare come from neglecting or abusive homes, and many of them have learned to distrust adults. Youth who tend to succeed as young adults are those who have an ability to trust others by having those others earn their trust. Of some note, these adolescents tend to learn how to trust themselves and significant others (e.g., siblings) first and then trust unknown others, such as new girl/boy friends, classmates and others later on.

Additionally, there is evidence that all of the following signal positive functioning, or well-being, among adolescents:

- Respect for oneself and for others, especially older adults
- An attitude of abundance rather than scarcity
- An understanding that to love others, one must first love oneself
- Having reasonably good personal and social boundaries
- Maintaining adequate life skills and money management skills
- Being able to articulate a global purpose of life or spirituality

While we may not agree on the definition, well-being is something we generally know when we see it, and there are solid indicators of well-being among adolescents. As child welfare professionals, we can guide adolescents toward these indicators by engaging with them on their future goals, asking them about adults who are important to them, encouraging social connectivity, facilitating how rapidly they bounce back after challenges, encouraging the use of "I can" language, and helping identify others in whom they can build trust. All of these will promote overall well-being in the long run and set up the youth for a happier young adulthood.

"Correlations between our perceptions of adolescent well-being and adolescent self-perceptions are notoriously poor. How many times have you concluded that a teen was doing well only to find out the opposite was true?"

Katie A.: Nuts and Bolts

By Joanne Brown and Betty Hanna

According to the National Survey of Child and Adolescent Well-Being (NSCAW), between one-half and three-fourths of the children entering foster care exhibit behavior or social competency problems that warrant mental health services, a number substantially higher than in the general population. Some studies show that more than half of children in foster care may experience at least one or more mental disorders. Among that group, research shows as many as 63 percent are victims of neglect. The importance of early identification is amplified for children involved with child welfare services, as research has shown nearly one half of children who are investigated for maltreatment experience a clinical-level need for mental health services, and yet only one fourth of these children actually receive specialty mental health care in the 12 months preceding the investigation (Burns et al., 2004).

With these challenges in mind, it should come as no surprise that many states have struggled to administer adequate mental health services to at-risk and foster care children. California has been no exception. This struggle was exposed most publically on July 18, 2002, when the *Katie A. et al. v. Diana Bonta et al.* lawsuit was filed seeking to make Wraparound services and Therapeutic Foster Care available to all child welfare children by having these services covered under Medicaid.

What is now simply referred to as Katie A. started when five named plaintiff's (National Center for Youth Law, Western Center on Law & Poverty, Protection & Advocacy, Bazelon Center for Mental Health, the ACLU of Southern California, along with the law firm of Heller Ehrman LLP) filed a federal class action lawsuit against the director of the California Department of Health Care Services (DHCS), the director of the California Department of Social Services (CDSS), the Los Angeles County Department of Children and Family Services (DCFS), and the DCFS director. Importantly, DHCS administers Medi-Cal, California's Medicaid program, while CDSS supervises and monitors child welfare services in the state.

The lawsuit alleged that DCFS failed to assess children in care for mental health needs and provide adequate mental health services. Additionally, the attorneys alleged that DCFS had been relying too heavily on congregate care and that placements for children needing these services were too often disrupted due to inadequacies in the system. The court certified the class to include all children with an open case in child welfare services who had or may have had mental health needs.

In 2003, the parties entered into a settlement agreement. Implementation was not consistent, however, and in 2005 the court ordered the agreement to be replaced by a five-year strategic plan that required significant fiscal and structural changes within DCFS and between DCFS and public and private child service providers. In December 2011, with significant progress made by Los Angeles County, the court agreed to dismiss the case and accepted a new settlement agreement.

The current Katie A. settlement agreement is structured around a set of objectives which require DCFS to develop a fiscal system to deliver an array of mental health services for children in their care, facilitate their delivery and specify how they are delivered. This system is required to be 1) coordinated, 2) comprehensive and 3) community-based.

Class members in the Katie A. lawsuit are defined as children who:

- are in foster care or are at imminent risk of foster care placement; and
- have a mental illness or condition that has been documented; or, had an assessment already been conducted, would have been documented; and
- need individualized mental health services, including but not limited to: professionally acceptable assessments, behavioral support and case management services, family support, crisis support, Therapeutic

Foster Care, and other medically necessary services in the home or in the home-like setting to treat or ameliorate their illness or condition.

To clarify, children in this class are not limited to those in foster care and group care. They may also include children living with their parents or relatives or in any variety of placements.

The agreement also recognizes specific subclasses of children entitled to more attention/resources. This subclass includes children and youth who are full scope Medi-Cal eligible, meet medical necessity, have an open child welfare services case and meet either of the following criteria:

1. Currently in or being considered for: Wraparound, Therapeutic Foster Care or other intensive services; therapeutic behavioral services; specialized care rate due to behavioral needs or crisis stabilization/ intervention; or
2. Currently in or being considered for a group home (RCL 10 or above) psychiatric hospitalization or 24-hour mental health treatment facility; or has experienced three or more placements within 24 months due to behavioral health needs.

The parties agreed that for these services to be delivered in a way that would most benefit the class and targeted subclass members, state and county level staff would have to work together in new ways, requiring the development of a collaborative service delivery system to work practices across both agencies. To implement and monitor ongoing collaboration, the parties adopted what was called the Katie A. Core Practice Model, which has been developed by experts working with Los Angeles County.
Now in the early phase of implementation, the Katie A. Core Practice Model (CPM) provides hope, fiscal support and a strategy as a first step to get foster children the mental health assessments and services needed to achieve greater levels of functioning. The CPM takes into account important practice aspects such as client-centered engagement strategies, cultural humility and trauma-informed practice. There is still much work to be done, but there is no doubt that Katie A. is a big step toward meeting the significant challenge of making mental health services easily accessible to every child who needs it.

U.S. Department of Health and Human Services, Administration on Children, Youth and Families (2007). Child Maltreatment 2005. Washington, DC: U.S. Government Printing Office.

Implementation Methods to Accomplish Katie A. Objectives

By Lynn M. Thull, Ph.D., Senior Policy Advocate, Mental Health Policy and Practice Improvement

- CDHCS develops and disseminates a Medi-Cal Mental Health Documentation Manual (the settlement agreement identifies required chapters in the manual)
- Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS), defined in Chapter 5 and Appendix D of the Medi-Cal Manual, will be provided to the subclass
- The negotiation workgroup will determine to what extent activities and/ or components of Therapeutic Foster Care (TFC) are covered under the Medicaid Act, and amend the state plan to cover TFC services if appropriate
- CDHCS and CDSS will establish a shared management structure, and will develop and endorse practice tools, training curriculum, practice improvement protocols and quality control systems
- CDSS and CDHCS will clarify and provide guidance on state and federal laws as needed. This includes ongoing technical assistance, audit compliance, and "encouraging" local policy and regulatory discretion/variations
- A Data and Quality Task Force will be established

The Katie A. Core Practice Model

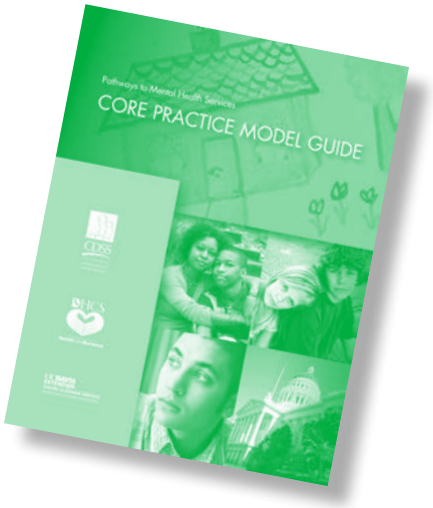
This article is a compilation of information provided in the federal court judgment on the Katie A. case, filed on 12/5/11

At the heart of the Katie A. settlement is the agreement that all aspects of implementation be built around a common core of values and principles called the Core Practice Model (CPM). This shared vision and mission will result in statewide consistency and a high level of individualized service to children in care (and their families) from entry to exit from the program.

The CPM coalesces many evidence-based practices and ideas and essentially should sound very familiar to child welfare professionals. Social workers are directed to "engage children and families" and work in teams rather than in isolation, or in "silos."

The core set of principles and values are:

- Services are needs-driven, strengths-based and family-focused from the first conversation with or about the family
- Services are individualized and tailored to the strengths and needs of each child and family
- A multi-agency collaborative approach grounded in a strong community base is the basis for the strongest delivery
- Services incorporate a blend of formal and informal resources designed to assist families with successful transitions that ensure long-term success
- Services are culturally competent and respectful of the culture of the children and their families
- Services and supports are provided in the child and family's community
- Children are first and foremost protected from abuse and neglect and maintained safely in their own homes.
- Children have permanency and stability in their living situations



The CPM uses six key practice components that are organized and delivered in the context of an overall family plan. These six components are:

Engagement: Engaging families is the foundation of building trusting and mutually beneficial relationships between family members, team members and service providers.

Teaming: The Child and Family Team (CFT) is the primary vehicle for delivering services. The CFT brings together significant, caring individuals, both professionals and partners, to work with and support the child and family.

Assessing: Information gathering and assessing needs includes gathering and evaluating information about the child's and family's strengths and underlying needs. Assessing also includes determining the capability, willingness and availability of resources for achieving the safety, permanency and well-being of children.

Service Planning and Intervention: Service planning is the practice of tailoring supports and services unique to each child and family to address their unmet needs. The plan specifies the goals, roles, strategies, resources and timeframes for coordinated implementation of supports and services for the child, family and caregivers.

Monitoring and Adapting: Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed.

Transition: The successful transition away from formal supports can occur when informal supports are in place and providing the support and activities needed to ensure long-term stability. This is the same direction workers are required to follow from the Fostering Connections to Success Act (2008) and AB 12, which in many ways are the logical extensions of the Foster Care Independence Act of 1999 (Chaffe Act).

The Katie A. settlement provides an exciting opportunity for California state and local agencies, service providers, community groups and families to work together to provide a new level of individualized, intensive, coordinated mental health services to children and their families. This new model, consisting as it does of sound core practices, will likely serve as model for other states to follow.

What Katie A. means for child welfare professionals

Because the Katie A. CPM requires services to be individualized and the provision and impact of those services to be tracked, child welfare professionals can expect case plans to rely more heavily on assessment. Case plans cannot be static and must be responsive to identified strengths and needs. Katie. A. also reinforces the expectation that the case plan reflects a multidisciplinary process and engagement with a wider range of providers. Additional child welfare worker training on testing, assessment and best practices when referring to services should be expected. With these requirements in place, team meetings will likely focus on how well services are being delivered rather than, for instance, whether the parent is participating—working as a team with family members and providers is a core principle, stressing the use of informal supports by families.

In addition to more strongly emphasizing best practices already in place, the CPM will require emphasis on more specific and individualized services to ensure the child's overall well-being. More scrutiny by court and attorneys on legal foundation for removal, including reasonable efforts, can be expected. The court will want to know whether the safety plan reflects active familiarity with services and an intention to strengthen the placement at home; or show that even with such services, allowing the child to remain in the home would be contrary to his/her welfare.

While the idea of assessment plus centralized funding may not be new, Katie A. will very likely elevate the standard for reasonable efforts. For this reason, despite the temptation to consider this as just "another new thing" that may not materialize, the child welfare professional might instead embrace the CPM and think of it as an acceleration of where we have been trying to go for the past two decades combined with a real-life model of system-of-care thinking.

Katie A. and the kids

The Core Child Welfare Practice Principles of Katie A. guarantee that children in care will have their specific needs met by adults who are committed to helping them live a normal life as much and as soon as possible. If these principles are properly implemented, children can expect to see several improvements to the ways in which their individual needs are met. Some of these improvements will include the following:

- More children will receive services in their home, often with direct involvement of their parents, relatives or other caregivers
- Services, rather than referrals to services, will be offered, and those services will be monitored to make sure they are accessible and used, whether that means making sure that transportation is available or subsidized, or that appointments fit in with the other demands on the child and caregivers
- Case plans will link services rather than overlap
- Children and/or parents, caregivers and attorneys will more closely monitor the day-to-day impact on the child's overall well-being
- Counselors will not be replaced or services interrupted or terminated without a timely transition
- Family members will be expected to participate in helping the child and caregivers meet the child's needs and help advance permanency
- Children will be entitled to expect more connection rather than less; will experience more stability in their daily routine; and will enjoy more opportunities to play and learn, rather than experiencing the frustration of opposite circumstances too common in our work

Sobering Statistics from the National Survey of Child and Adolescent Well-Being

Researchers conducting the National Survey of Child and Adolescent Well-Being (NSCAW) continue to report findings that demonstrate the well-being adversities children involved in child welfare face.

According to the Alliance for Children and Families, the NSCAW is the first national study to examine child and family well-being outcomes in relation to their experience in the child welfare system and to family characteristics, community environment and other factors. Its data is drawn from nationally available firsthand reports from children, parents and other caregivers, as well as reports from caseworks, teachers and data from administrative records.

Among many findings, the NSCAW reported that:

- More than half of adolescents reported for maltreatment are at risk for an emotional or behavioral problem, and a substantial proportion exhibit other risk factors, including poor social skills, grade repetition, substance use disorder, running away, having made a court appearance for an offense (delinquency, running away, truancy or other offenses), and (among adolescent girls) having been pregnant.
- One third to one half of children meeting clinical symptom criteria did not receive any specialty services in the past 18 months.
- Psychotropic medications were used alone, in absence of any other service, by a larger percentage of children living out of home (9.4 percent) than children living in-home (1.8 percent).
- Children with unsubstantiated reports of abuse or neglect experience the same risk of negative outcomes as children with substantiated reports.
- Children reported for maltreatment have a high risk of experiencing developmental problems, cognitive problems, behavioral/emotional problems or substance use disorders, regardless of whether they were placed in out-of-home care, remained in-home with receipt of services or remained in-home without services.
- Compared to adults nationally, in-home caregivers in NSCAW have much higher rates of substance abuse, intimate partner violence and major depression

The survey, which has run from 1997 to 2013, draws data from two cohorts of children sampled in 1999 and 2008, respectively. Survey follow-ups for the second cohort are currently underway.

For more information on the National Survey of Child and Adolescent Well-Being, visit http://www.acf.hhs.gov/programs/opre/research/project/national-survey-of-child-and-adolescent-well-being-nscaw

Education Statistics

By grade 11, only 1 in 5 foster youth is proficient in English. Only 1 in 20 is proficient in math.

– Frerer, K., Sosenko, L., Pellegrin, N., Zakharenkov, A., Horowitz, J., & Patton, M. (2011). Ready to Succeed: An exploration of secondary and postsecondary educational outcomes for foster children in California. (Four County Study)

Approximately 75 percent of foster youth perform below grade level standards, and by third grade 80 percent have had to repeat a grade in school.

– Education of Foster Youth in California Report. California Legislative Analyst Office. (2009).

Less than half (49 percent) of foster youth complete high school or receive their GED.

– Exit Outcomes for Youth Aging Out of Foster Care Quarterly Statistical Report, October-December 2009. (Statewide Data) UC Berkeley: Center for Social Services Research

The Over-prescription of Psychotropic Medications

By Nancy Hafer, Northern California Training Academy

There has been a dramatic increase in the use of antipsychotic medication among children and adolescents over the past two decades. For children in foster care, the increase has been substantially and alarmingly steeper. According to the National Survey of Child and Adolescent Well-Being (NSCAW), as many as 41 percent of children in foster care who took any psychotropic medication received three or more psychotropics within the same month, a level of use that requires screening, assessment and close monitoring by a physician.

In an Information Memorandum by the Administration for Children and Families issued in 2012, the use of psychotropic medications in the child welfare system was described as, "too many, too much, too young." Essentially, children are prescribed too many different psychotropic medications and too much medication at too young an age.

The following factors may play a role in these patterns of psychotropic medication use among foster children:

- Insufficient state oversight and monitoring of psychotropic medication use
- Gaps in coordination and continuity of medical and mental health care across public health and social service systems involved with affected children and their families
- Provider shortages, especially of board-eligible and board-certified child and adolescent psychiatrists, in some geographic areas (i.e.., rural areas)
- A lack of access to effective non-pharmacological treatments in outpatient settings

Fortunately, states are now required to include a psychotropic medication oversight plan in their State Child and Family Service Plans. Recommended components of those plans include:

1. Screening, assessment and treatment planning for the unique mental health needs of children entering out-of-home care;
2. Mechanism(s) for providing informed consent with respect to medication use;
3. System(s) for monitoring medication use, both at the child and population levels;
4. Access to child and adolescent psychiatric consultation, at both the child and systems level; and
5. Access to and dissemination of up-to-date information on evidence-based approaches (both pharmacological and non-pharmacological) for addressing the needs of these children.

When used appropriately, antipsychotic medications may provide a legitimate treatment option for some children in foster care. However, it is generally recommended that prescription of antipsychotic medications be closely monitored, especially when they are prescribed for more than two years and when they are used without a diagnosis of schizophrenia, bipolar disorder or psychosis.

Stambaugh, L.F., Leslie, L.K., Ringeisen, H., Smith, K., & Hodgkin, D. (2012). Psychotropic medication use by children in child welfare. OPRE Report #2012-33, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Available at: National Data Archive on Child Abuse and Neglect (NDACAN), Cornell University, ndacan@cornell.edu

Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services (ACYF). (2012). Information memorandum: Promoting the safe, appropriate, and effective use of psychotropic medication for children in foster care (ACYF-CB-IM-12-03). Washington, DC: Author.

Screening Tools for Developmental, Social-Emotional, Trauma and Mental Health Issues

By Nancy Hafer and Holly Hatton, UC Davis Extension

It is estimated that between 12-18 percent of U.S. children have disabilities; however, many of children's special needs are not identified until they enter kindergarten or later.

Universal screening of children entering child welfare services can increase the likelihood that children's developmental concerns and other special needs are identified at the earliest possible time, maximizing opportunities for early intervention. Amendments to the Child Abuse Prevention and Treatment Act (CAPTA) and the Individuals with Disabilities in Education Act (IDEA) now require improved coordination between child welfare and early intervention to ensure that maltreated children with developmental needs, such as speech and fine motor problems, receive early intervention services. One way to achieve the goal of improving coordination between child welfare and early intervention in each county's child welfare system is implementing a universal screening tool, such as Ages and Stage and/or the Child and Adolescent Needs and Strengths Assessment (CANS).

Ages and Stages

The Ages and Stages[1] Questionnaire (ASQ-3) and the Ages and Stages Social-Emotional Questionnaire (ASQ-SE) are empirically valid, reliable and culturally sensitive tools to screen infants and young children for developmental delays during the first 5 years of life.

The ASQ-3 screens children in the following developmental domains: communication, gross motor, fine motor, problem solving, and personal-social. Any area of concern indicated by the ASQ should be followed up by a more comprehensive developmental assessment.

The ASQ-SE focuses specifically on social-emotional development and allows professionals to quickly recognize young children at risk for social and emotional difficulties, identify behaviors of concern to caregivers, and identify need for further assessment.

In a recent study results revealed that children systematically assessed with the ASQ-3 between the ages of 4 months and 61 months doubled the detection rates of developmental delays for children entering the foster care system. Thus implementing systematic Ages and Stages screening for children between the ages of three and five years is expected to lead to increased detection of developmental disabilities and receipt of needed early intervention services for this vulnerable population.

Child and Adolescent Needs and Strengths Assessment–Mental Health (CANS-MH)

CANS-MH is a functional assessment of the child and caregivers' needs and strengths and is widely used in child services fields. There is one version for children ages 0-5 years and another for children up to 17 years. The CANS-MH was developed in collaboration with several states' child services systems, with the intent of creating a common assessment tool across systems (mental health and addictions, child welfare, juvenile justice, Medicaid and education). It is currently being used in 27 states.

Information from the CANS-MH is intended to support decisions at multiple levels: direct services, supervision, program management and system management, with the primary objectives of permanency, safety and improved quality of life. It is generally conducted after initial intake for children with mental, emotional and/or behavioral health needs, mental retardation/developmental disabilities, and juvenile justice involvement. It provides information regarding the service needs of the child and their family for use during the development of the individual plan of care.

Some advantages to using CANS are that it relates directly to DSM-IV diagnostic categories; measures strengths in addition to problems or concerns; can be completed by case workers; and provides a flexible framework for gathering information.

CANS tools and supporting documents are posted at: http://ibhas.in.gov/mainDocuments.aspx

To see a comprehensive review of mental health screening and assessment tools, please visit http://humanservices.ucdavis.edu/academy/pdf/FINAL2MentalHealthLitReview.pdf.

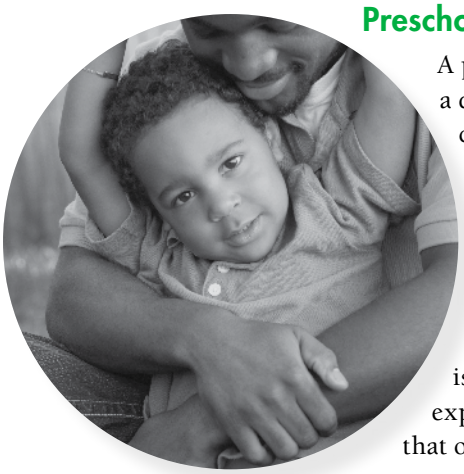
[1] *J. Squires, L. Potter, and D. Bricker. Publisher: Paul H. Brookes Publishing Company*

Developmental Differences in Children's Response to Trauma

Excerpted from the Chadwick Trauma-Informed Systems Project: Creating trauma-informed child welfare systems: A guide for administrators (2nd ed.)

Infants and toddlers

A child exposed to trauma in early childhood can have a difficult time in coping with loss, although it may not be as easy to identify as in other age groups. This has the potential to hinder a child's normal development[1]. An infant or young child is at particularly high risk of later mental health problems because the ability to manage emotions and use coping skills is not fully developed. The infant or young child may also be overwhelmed by events that an older child may not view as traumatic.



Preschool children

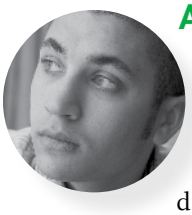
A preschool child often has a difficult time adjusting to change and loss. The child often feels helpless and powerless and is unable to protect himself/herself[2]. Research has shown that a preschool child exposed to interparental violence is at a greater risk of the exposure causing harm than that of an older child[3].

It is also common for a preschool child with traumatic stress symptoms to show regressive behaviors. This means he/she might appear to lose skills or behaviors that had been previously mastered (e.g., bladder control) or that he/she might revert to behaviors that had been previously outgrown (e.g., thumb sucking). Similarly, a traumatized preschool child often becomes clingy and may be unwilling to separate from familiar adults, including teachers.

Elementary school-aged children

An elementary school-aged child can more fully understand the meaning of a traumatic event, and this can result in feelings of depression, fear, anxiety, emotional "flatness," anger or feelings of failure and/or guilt[4]. Behaviors that an elementary school-aged child with traumatic stress symptoms may exhibit include:

- Anti-social and/or aggressive behavior
- Sadness and crying
- Poor concentration and other behaviors commonly seen in attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)
- Irritability
- Fear of personal harm, or other anxieties and fears (e.g., fear of the dark)
- Nightmares and/or sleep disruption
- Bedwetting
- Eating difficulties
- Attention-seeking behaviors
- Trauma themes in play/art/conversation



Adolescents

An adolescent with traumatic stress will tend to place more importance on peer groups, to rebel against authority, and to feel immune from physical danger. His/her distress, coupled with age-appropriate feelings of immortality, may motivate him/her to experiment with high-risk behaviors such as substance use, promiscuous sexual behavior or other at-risk behaviors such as driving at high speed or picking fights[5]. An adolescent may also:

- Feel extreme guilt after failing to prevent injury to or loss of loved ones
- Fantasize about revenge against those who may have caused the trauma
- Be reluctant to discuss his/her feelings or even deny any emotional reactions to the trauma, in part because an adolescent will typically feel a very strong need to fit in with his/her peers
- Show traumatic responses similar to those seen in adults, including flashbacks, nightmares, emotional numbing, avoidance of reminders of the trauma, depression, suicidal thoughts and difficulties with peer relationships[4]

Continued...

In addition, an adolescent with traumatic stress symptoms may begin to exhibit:

- Delinquent and/or self-destructive behaviors
- Changes in school performance
- Detachment and denial
- Shame about feeling afraid and vulnerable
- Abrupt changes in or abandonment of former friendships
- Pseudomature actions, such as getting pregnant, leaving school, or getting married

[1] *Ghosh Ippen, C., & Lieberman, A. F. (2008). Infancy and early childhood. In G. Reyes, J. Elhai, & J.Ford (Eds.), Encyclopedia of psychological trauma (pp. 345-353). New York: Wiley & Sons. Hartnett, M. A., Leathers, S., Falconnier, L., & Testa, M. (1999). Placement stability study. Urbana, IL: Children and Family Research Center.*

[2] *De Young, A. C., Kenardy, J. A., & Cobham, V. E. (2011). Trauma in early childhood: A neglected population. Clinical Child and Family Psychology Review, 14(3), 231-250.*

[3] *Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. Journal of Consulting and Clinical Psychology, 71(2), 339-352.*

[4] *Briggs-Gowan, M. J., Carter, A. S., Clark, R., Augustyn, M., McCarthy, K. J., & Ford, J. D. (2010). Exposure to potentially traumatic events in early childhood: Differential links to emergent psychopathology. Journal of Child Psychology and Psychiatry, 51(10), 1132-1140.*

[5] *Substance Abuse Mental Health Services Administration (SAMHSA). (2002). Mental health: A report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Retrieved from http://store.samhsa.gov/product/Mental-Health-A-Report-of-the-Surgeon-General-Full-Report/SG-RPT*

"Shifting the System" to Promote Social and Emotional Well-Being

Adapted with permission from the ACF Children's Bureau's ACYF-CB-IM-12-04

There are many ways that child welfare systems can begin to embed a focus on social and emotional well-being. A few specific examples are listed below.

Services

- Conduct high quality and regular trauma screenings and functional assessments of children, youth and families to determine exposure to and impacts of maltreatment and other forms of complex interpersonal trauma.
- Deliver evidence-based and evidence-informed interventions for the treatment of trauma and mental health disorders.
- Consider restructuring services that are the sole responsibility of child welfare.
- Develop a workforce strategy that supports an emphasis on promoting social and emotional well-being

Workforce

- Build the capacity of child welfare and mental health systems' staff to understand, install, implement and sustain evidence-based practices. This includes: using research to identify effective interventions that improve outcomes for the population; developing an awareness of principles of evidence-based practice among staff at all levels; and reorganizing infrastructure to support implementation fidelity.
- Train staff to more effectively serve specific populations of children and youth and specific populations of prospective foster and adoptive families served by the child welfare system.
- Provide training on the impact of maltreatment, trauma and the social and emotional well-being of children who have been abused or neglected.
- Train courts on the core components of social and emotional well-being and trauma and effective screening, assessment and intervention approaches that can improve functioning.

System

- Examine current spending to understand where resources can be shifted to support evidence-based programs and practice.
- Measure outcomes, not service; specifically, measure how young people are doing behaviorally, socially and emotionally and track whether or not they are improving in these areas as they receive services.

Integrating Data Across Systems as a Tool for Measuring Child Well-Being

California Performance Indicators Project

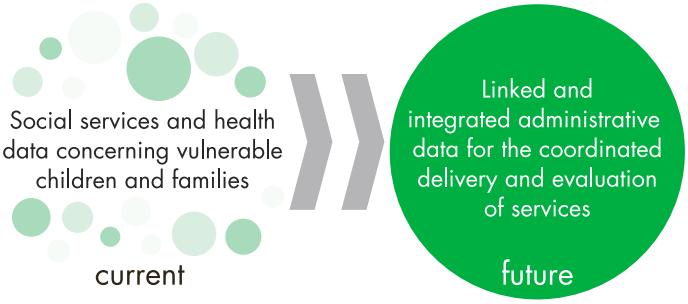
By Emily Putnam-Hornstein, Ph.D., School of Social Work, University of Southern California; Daniel Webster, Ph.D., Center for Social Services Research, UC Berkeley; and Barbara Needell, Ph.D., Center for Social Services Research, UC Berkeley

It is a public policy axiom that one must be able to both define and then measure what one ultimately hopes to track, manage and improve. Although researchers have long argued for the concept of quality improvements to the child welfare system guided by performance measures, the development of well-being outcome measures poses two key challenges. On the definitional side, the concept of "well-being" is inherently more ambiguous and therefore encompassing; on the measurement side, difficulties lie with the scope and reach of data elements recorded in administrative child welfare data systems.

Most state child welfare data systems were designed to collect information on a narrow set of short-term case management data elements; information concerning child well-being (e.g., educational achievement, mental health) is infrequently captured, or is recorded at only a single point in time. This is problematic because a large body of research points to a high prevalence of often severe and pre-existing health, mental health and educational problems among maltreated children. Although some researchers and advocates have pointed to negative child outcomes following involvement with the child welfare system as evidence that the system is failing, this is generally an oversimplification that stretches far beyond available data. The fact is that these are incredibly vulnerable children, whose outcomes may be improved by effective child welfare interventions, but who may still have worse outcomes relative to other non-maltreated children. Any attempt to measure the child welfare system's success in attending to child well-being must reflect dynamic measures that incorporate baseline health and well-being risk profiles for children, data that are not typically available in child welfare data systems—at either the point of entry, or the time of exit.

So where do we go from here? One approach would be to establish federal mandates specifying changes to the data elements captured by state child welfare data systems, but this would be accompanied by significant costs, take years to implement, and even the most expansive list of seemingly relevant data elements today may be obsolete in a few years.

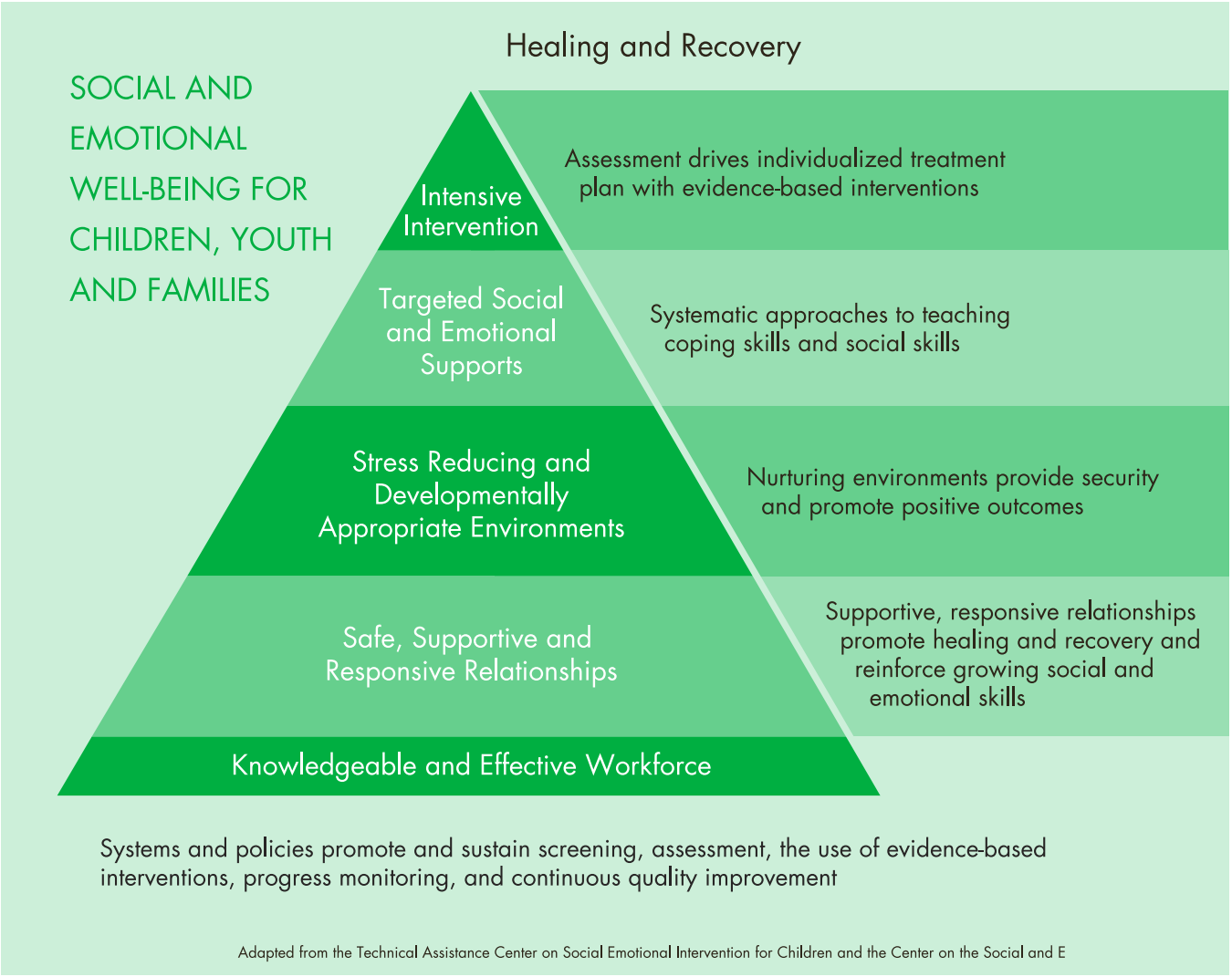
The best tools for assessing the children's health, mental health and education—core components of child well-being—should be determined by the systems that deliver those services. If we want to track the child welfare system's success in triaging children into appropriate mental health services that improve child functioning, we should use mental health data, not duplicate its collection in child welfare data systems. Likewise, if we want to track the educational progress of children involved in the child welfare system, we should use data already collected by our schools.



Information contained in any one agency's data system is, inevitably, incomplete from the perspective of a given child. Fortunately, technological advances make it both possible and eminently feasible to link data concerning individual children across child welfare, education, health, mental health and other systems.

We believe that investments in the expanded use and integration of administrative data across agencies will significantly enhance capacity for the measurement of child well-being. While technology and resources pose minimal barriers relative to the larger hurdles of politics, proprietary data questions and confidentiality concerns, these too can be overcome. If we are truly serious about measuring child well-being, we must find ways to move from data silos to integrated data systems.

U.S. Department of Health and Human Services, Administration on Children Youth and Families. (April 17, 2012). Information Memorandum Re: Promoting Social and Emotional Well-being for Children and Youth Receiving Child Welfare Services. http://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf



California Partners for Permanency: A Comprehensive and Culturally Responsive Approach to Practice and System-Level Change

Youth, Families, African American and Tribal Community Representatives

California Partners for Permanency (CAPP) is one of six projects nationwide funded through the Permanency Innovations Initiative (PII), a multi-site federal demonstration project designed to improve permanency outcomes among children in foster care who have the most serious barriers to permanency.

CAPP's focus is on implementing a practice model that effectively addresses disparities in outcomes and supports positive permanency outcomes for all children and families with a targeted effort to help those children and youth who are in care the longest and experience the worst outcomes.

CAPP acknowledges the fundamental relationship between community and tribal involvement and partnership and the successful implementation of a child and family practice model that reduces long term foster care for the most impacted families. In addition, there is a clear recognition that practice and system changes are inextricably linked and true partnerships are needed to understand how the day-to-day actions and interactions of child welfare and the broader system of services and supports for children and families must change so that all children remain connected to their families and to cultural, community and tribal supports that address their underlying needs.

With the technical support and assistance of the Center for the Study of Social Policy, and with significant input and guidance from local community and Tribal partners, CAPP sites have been conducting local system reviews to better understand the systemic barriers that undermine achieving optimal permanency outcomes for children and families. This comprehensive focus on identifying and addressing key systemic barriers to permanency has guided the development of the CAPP Child and Family Practice Model. Key findings and how they are addressed by the four front-line practices in the Child and Family Practice Model are illustrated in the following chart.

Systemic Issues	CAPP Child and Family Practice Model: Front-Line Practice Approach
1. Weak and Insufficient Engagement Practices • Social workers, lawyers, judges and other practitioners are not effectively organized in ways that prioritize supports and enhance engagement and support of families, youth and caregivers. • There are inadequate systems of accountability and support for a culturally-sensitive and respectful, strength-based approach with families.	1. Exploration & Engagement Five practice behaviors support effective Exploration and Engagement with families and involve skillful use of appreciative inquiry, honest and respectful interactions with families, and actively listening to and learning from families so that their strengths, perspectives and underlying needs become central in the work of child welfare agencies and partners.
2. Lack of Family Voice and Urgent Sustained Permanency Focus • There are too few opportunities for family and youth voices in decision making and information from the family, their caregivers and Tribes is limited or missing in assessments, reports, or other critical decision points. • Staff, resources and partnerships are not organized to maximize opportunities for safe and timely permanency, resulting in an inadequate and irregular focus on permanency for children, particularly older youth.	2. Power of Family Six practice behaviors recognize and support the Power of Family and involve seeking out, strengthening, affirming and incorporating the voice of the child and family in all casework and documentation. The family is actively involved in assessing, finding solutions, planning and decisions about their lives. There is linkage to and coordination with formal and informal advocates and peer supports (parent partners, attorneys, CASA's, community and tribal representatives, cultural brokers, etc.)
3. Lack of Relevant, Timely, Well-Coordinated Services • Lack of system coordination and meaningful involvement of families, communities and Tribes to effectively identify and address underlying family needs. • Poor systems of accountability to determine families receive services with progress tracked and case plans adjusted/cases closed.	3. Circle of Support There are seven practice behaviors that establish, bring together and support a child and family team or Circle of Support. The team includes natural family and cultural/community supports and is facilitated in critical thinking and discussion about child safety, family and cultural strengths, underlying needs and the roles team members will play over time, including post-permanency, to ensure child safety and family support
4. Lack of Accurate Understanding of Family Strengths and Needs • Problematic administrative protocols and practices that do not focus on strengths and underlying needs of families; casework tools and processes do not take into account personal histories of trauma, the trauma of child welfare interventions on parents and child and historical trauma. • Inadequate resources to support parents/caregivers in their ability to heal and parent children.	4. Healing Trauma Five practice behaviors focus on Healing Trauma and involve partnerships with families and their communities and Tribes to understand and meet the underlying needs of children and their families. These practices identify, advocate for and support use of culturally sensitive and trauma-informed supports and services to address child safety, cultural relationships and health, wholeness, healing, recovery and well-being of the child and fam

The Child and Family Practice Model is a comprehensive and culturally responsive approach to both practice and system level change. Outreach and involvement of communities and tribes has laid the foundation for local partnerships that are guiding development of system solutions and promoting accountability in implementing and evaluating the Practice Model in 4 California counties: Fresno, Humboldt, Los Angeles (Pomona, Torrance and Wateridge offices) and Santa Clara.

To learn more about our work, visit www.reducefostercarenow.org or contact Karen Gunderson, CAPP Project Director, (916) 651-7395 or karen.gunderson@dss.ca.gov.

Well-Being and the Title IV-E Waiver

Based on an interview with David Sanders, Ph.D., Executive Vice President of Systems Improvement, Casey Family Programs
By Jason Borucki, Northern California Training Academy

For Casey Family Programs Executive Vice President of Systems Improvement David Sanders, the federal administration's work on the Title IV-E waiver goes a long way to clarify what exactly is meant by well-being in the child welfare system.

"The notion of appropriate development for children and families, the impact of trauma, and thinking about the role the child welfare system plays in trying to mitigate trauma, seems an appropriate definition of well-being," said Sanders in a recent interview. "Unless trauma in families and children is dealt with, it will be difficult to safely reduce the foster care population."

The Title IV-E waiver is a funding program that offers jurisdictions an alternative to linking federal funding to the number of foster children currently in care. With this system in place, a jurisdiction neither loses funding when its foster population goes down, nor receives increased funds if it goes up, but instead receives a set annual amount. This system can serve as an incentive to moving foster children toward permanency so that funds can be applied toward optimizing services for those still in care, whereas under the traditional system there is arguably less financial incentive to finding a placement for children in care.

With the initial wave of Title IV-E waivers expiring and results mixed, Sanders and Casey Family Programs have been strong supporters of the re-authorization of waiver ability and have been heavily involved with both the legislative branch process and now the executive branch process that is currently in place.

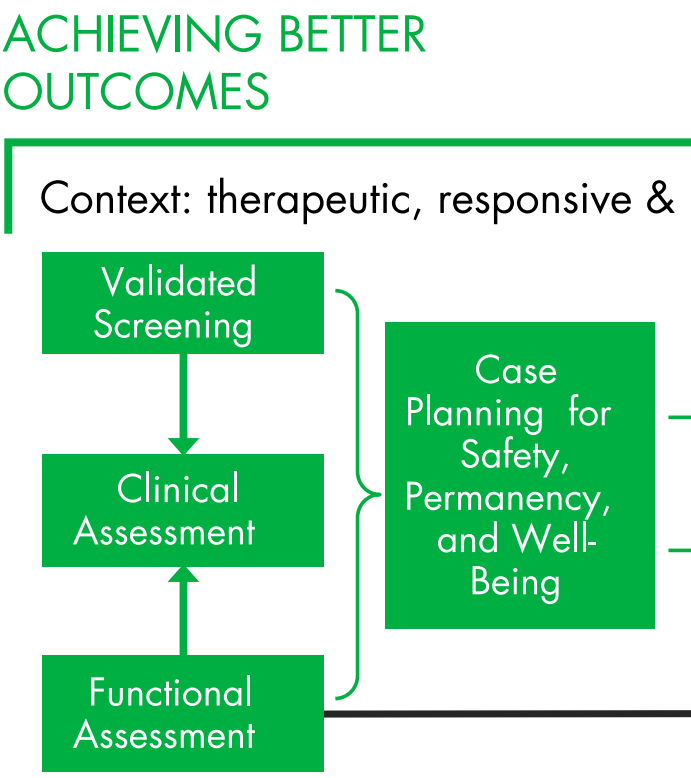
"While working with the administration, it became clear that the overall need to improve positive outcomes for children beyond the traditional notions of safety and permanency was an important element for Congress," said Sanders. "The administration's instructions emphasized greater focus on going beyond permanency and safety to where children were actually better off as a result of the intervention of the child welfare agency."

One of the obstacles to meeting the administration's challenge was a lack of mechanism in place for assessing well-being for children in terms of appropriate child development. In an attempt to fill this gap, the administration is challenging jurisdictions approved for the waiver to implement some kind of screening and assessment tools on an ongoing basis to assess overall functioning for children. This will require waiver states to show how children are doing.

Additionally, the new waiver recipients are being required to look beyond safety and permanency by utilizing developmentally appropriate evidence-based practices to demonstrate what treatment strategy was used and how that treatment helped the children and family address the trauma that impacted them.

Nine states have approved plans to use the new waiver, with more than 16 expressing interest for the future. In California, Alameda and Los Angeles counties are currently using the waiver, with 19 additional counties having submitted letters of intent to participate in the extension if one is granted.

While the verdict is still out as to whether the Title IV-E waiver is effective, the new waivers clearly demonstrate an increased focus on addressing well-being as a definable, measurable and obtainable outcome.



Placer County Spotlight: A System of Care County

If the Katie A. Core Practice Model sounds somewhat similar to the System of Care Model, that's because it is.

The Katie A. Core Practice Model (CPM) directs child welfare professionals to engage children and families and work in teams rather than in isolation. During safety planning, strength-based and needs-based planning is emphasized, as well as testing more directly the child welfare professional's substantive knowledge of and communication with family resources.

By comparison, SAMHSA.gov states that Systems of Care are:

- Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
- Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes and relationships at the community level.
- Culturally and linguistically competent, with agencies, programs and services that reflect the cultural, racial, ethnic and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

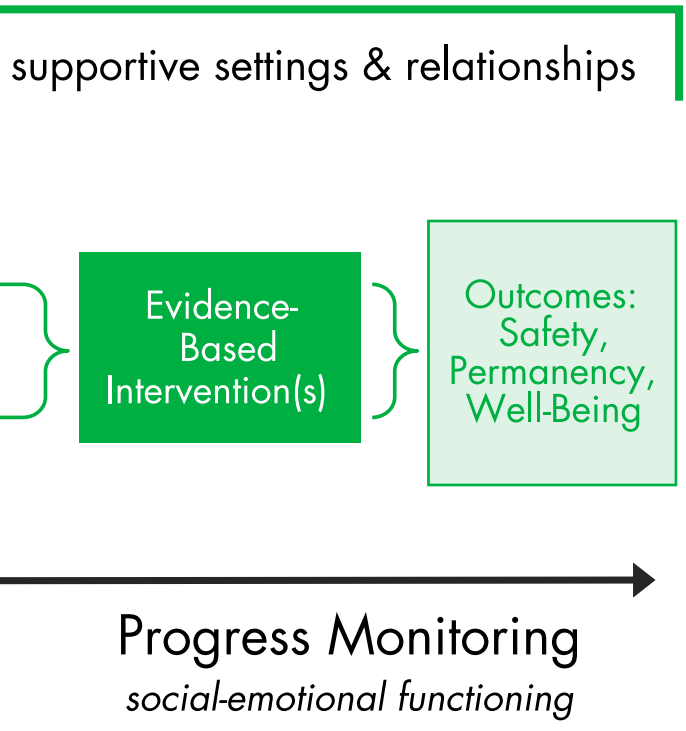
Although they are described almost identically, the System of Care Model and the CPM are not one in the same. Joanne Brown, a retired Superior Court Commissioner from Alameda County, probably summarizes the relationship between the models best when she writes that the CPM is essentially "a real-life model of system-of-care thinking."

With this in mind, it stands to reason that counties already utilizing the System of Care Model will have much less difficulty implementing the CPM. In Placer County, for instance, rather than scrambling to create integrated services to implement the CPM, one of the bigger challenges may be the tweaking and/or renaming of services already offered to fit definitions specified in Katie A. legislation. This is because System of Care not only predates the CPM, but it also predates the Katie A. lawsuit itself by more than a decade. Furthermore, System of Care anticipates and actively seeks to prevent the systemic shortcomings that lead to lawsuits such as Katie A.

"If every county had System of Care 20 years ago, there would have been no Katie A. lawsuit," said Richard Knecht, director of Children's System of Care in Placer County.

In Placer, child welfare agencies are already co-located, which allows for much more to get done with fewer resources. Working across systems becomes the culture rather than the mandate, and the result is more comprehensive services for the children and families the system serves.

Counties such as Placer are a few steps ahead in preparing to implement Katie A. Moving forward, it will be interesting to watch and see how System of Care and the Katie A. Core Practice Model continue to inform one another, and how counties already utilizing System of Care handle implementation as compared to those which are just now addressing the integration of services.



The Promise of Integrated Mental Health Services: Katie A.'s Impact on Foster Youth with Special Education Needs

By Fiza Quraishi, Staff Attorney, National Center for Youth Law, and Daniel Senter, Staff Attorney, East Bay Children's Law Offices

Emma is a 14 year-old child in foster care who just exited a mental health hospital stemming from an involuntary psychiatric hold. She is placed into a group home with no therapeutic services. Her social worker says his hands are tied because Emma does not have an Individualized Education Plan (IEP) that would allow her access to a higher-level group home. Emma is re-enrolled in her middle school, but the school puts her on home hospital instruction until it can complete an IEP assessment, in hopes of finding her eligible for a non-public school. Her school does provide weekly therapy, but the therapist she had been seeing for over a year stops seeing her because the school says it needs to bill Medi-Cal for its therapy services. Emma makes no connection with the school therapy intern assigned to her; her mental health declines, resulting in suicide attempts and more hospitalizations, as she continues to sit without peers or services for hours each day with little education access.

Unfortunately, when child welfare service providers work in silos, youth receive disjointed, incomplete and inadequate assistance. The *Katie A. v. Bonta* settlement provides an opportunity to prevent situations like Emma's by requiring intensive individualized, needs-based mental health services that draw upon the collaboration of all service providers in a foster youth's life. Most, if not all, Katie A. class members will be eligible for school-based mental health services through the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Americans with Disabilities Act.

With this comprehensive approach in place:

- Collaboration can occur through formal Child and Family Teams (CFT) for certain youth who are part of the Katie A. subclass, or through more informal teams focused on developing a needs-based plan for services.
- Services that may be provided in the school, such as In-Home Based Mental Health Services (IHBS), can be integrated into the child's case plan, providing an opportunity to align the educational goals of an IEP (or 504 Plan) with the mental health goals developed through the Katie A. case planning process.
- School personnel who know and work with a particular youth can also contribute to the development of a Katie A. case plan. Similarly, if a community-based provider has been working with the child, that person can participate in the school-based meetings (IEPs or 504 planning meetings) as someone with special expertise and knowledge of the child's needs.

In Emma's case, she will now be eligible to receive a formal CFT with a trained facilitator. The CFT can be composed of her social worker and original therapist, as well as any other outside supports the family and team identify. This CFT can implement IHBS for an integrated approach to serving her mental health needs. The team can also consider the importance of the pre-existing therapeutic relationship Emma had with her therapist, and determine how that service might be continued even with the possible addition of the school-based IEP therapeutic services. If Emma did not qualify for the subclass, she would not receive a formal CFT, but this type of needs-based collaboration could still occur within teams that already exist, like a team decision-making (TDM) team.

Had coordinated, individualized services been in place previously, Emma may have avoided home hospital instruction and may have been able to stay in a regular public school. Further, she may have been immediately placed in an appropriate level group home and not been made to wait for an IEP meeting. This could have mitigated her suicidal ideations and anxiety.

Katie A. promises greater availability of intensive, individualized community-based services. Ideally, as local jurisdictions implement the Katie A. settlement, mental health and child welfare agencies will engage school districts and school-based mental health providers to identify barriers to accessing services, like restrictions created by information-sharing laws. Through this increased communication and collaboration, foster youth across the state can start accessing the services they need to successfully transition into self-sufficient adults.

Education Equals Initiative in Sacramento County

Three California counties—Fresno, Orange and Sacramento—have been selected to partner with the Stuart Foundation on the Education Equals Initiative. This five-year grant is aimed at achieving dramatic improvement in educational outcomes for foster youth through foster youth engagement, school stability and academic achievement across the educational continuum.

Foster youth are one of the most academically at-risk populations, often performing significantly worse in school than the general population. The goal of the initiative is to help foster youth in California succeed at levels equal to or greater than the general population through mutual accountability and deliberate coordination between child welfare, the juvenile court and the education system. This five-year goal will require a double-digit improvement of individual foster youth on key educational markers.

There are three core program elements to the initiative:

1. **Education Informed Home Placement:** Clear protocols will be developed to ensure that educational needs of each child will be systemically considered in all home placement decisions.
2. **Systematic Information Gathering:** For every child and youth entering foster care, information about the current educational status will be collected and distributed as appropriate to courts, caregivers and school personnel.
3. **Education Monitoring and Intervention System:** To ensure that the systematic collection of information is translated into action, trained staff will work with the child and the adults in his/her network to ensure that a clear educational case plan focused on progress is developed and followed.

In Sacramento County, Sacramento County Child Protective Services (CPS) is partnering with the Sacramento County Office of Education (SCOE) on this initiative. SCOE plans to target 150 foster youth (CPS clients) who will be divided into three groups of 50: the first group will include foster youth who are doing well in school; the second group will include foster youth who are transitioning into either middle school, high school or back into the home; and the last group will include foster youth who are preparing to graduate from high school and move into post-secondary education. Intensive case managers from SCOE will work with the youth and his/her network to ensure that a clear educational case plan will be developed and followed.

The Education Equals Initiative will be funded for five years, with the first year (2012-2013) being solely devoted to implementation and tools development. CPS is working with both SCOE and the Stuart Foundation to provide information on existing practices, such as inviting educational liaisons to Team Decision Making meetings, considering educational needs when making placement decisions and using Foster Focus to locate appropriate placements. Both agencies are working with the Stuart Foundation to identify current best practices that can be built upon to improve educational outcomes for foster youth.

Additionally, Sacramento County will be working collaboratively with other counties on a standardized Academic Information Report (AIR). This report will be available to social workers to attach to their court report, which will provide comprehensive educational information regarding a child's school stability, academic progress and any educational concerns.

While the first year of Education Equals funding is devoted to implementation, the roll-out phase for case management services to foster youth is targeted for July 2013.

Placement Stability and Trauma-Informed Care

Adapted from the Chadwick Trauma-Informed Systems Project's Creating trauma-informed child welfare systems: A guide for administrators (2nd ed.)

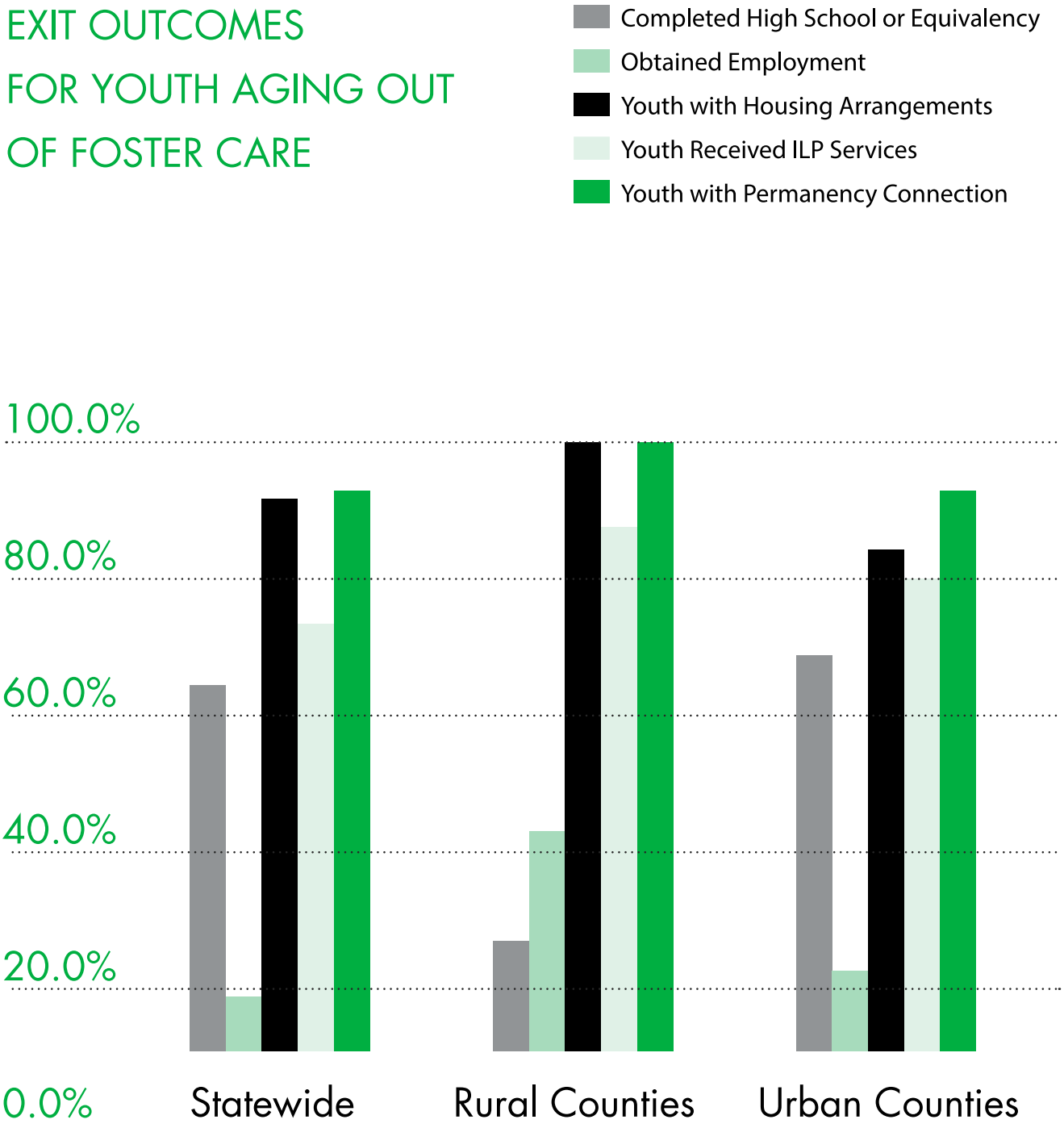
Foster and adoptive parents and residential providers are required to undergo specialized training. However, this training usually does not include much content related to trauma or how to provide trauma-informed caregiving. Resource parents and group home staff are therefore ill-prepared to handle the trauma-related reactions and behaviors exhibited by a traumatized child who enters their home. Well-meaning resource parents often request placement change when they feel unable to give a traumatized child the care he or she needs. Placement disruption is financially costly to the child welfare agency and takes an emotional toll on the child and the resource family. Child welfare systems are likely to continue to have substandard rates of placement stability and permanency if they fail to provide the proper education, training and support to substitute care providers.

Recommendations from the Field

- Work with the organizations that provide initial licensing training to resource parents and group home staff to ensure that initial training includes education on trauma and its impact as well as trauma-informed parenting skills
- Work with training entities, state foster parent associations and resource parent support groups to promote ongoing trauma training and skills building for substitute care providers
- Educate substitute care providers about trauma triggers and psychological safety
- Institute policies that include substitute care providers as important members of the child's and family's support team and involve them in team decision-making meetings
- Work to remove administrative barriers to communication and collaboration to ensure that all substitute care providers have the information they need to care for and meet the child's needs
- Provide training to permanency/foster care/kinship/adoption staff on how to support resource parents on trauma issues and how to work with them on secondary traumatic stress reactions and self-care
- Work to enhance family finding efforts
- Ensure adequate support (financial, social and emotional) and services to kinship care givers
- Promote and facilitate positive relationships between birth and resource parents to enhance placement stability; and support the role of the resource parent as a mentor to the birth parent
- Ensure adequate and appropriate respite services to give substitute care providers much-needed breaks
- Enlist extended family members and family friends with whom the child is already familiar as respite providers
- Identify and certify respite caregivers as soon as a child is placed
- Encourage residential care agencies to train their staff in one of the trauma-informed care models, including the Sanctuary Model[1]
- Work with residential providers to reduce or eliminate harsh practices such as seclusion and restraint and encourage them to train staff in trauma-informed alternative methods
- Promote trauma-informed step-up, step-down and Wraparound services at all levels of intervention to ease transitions for youth in out-of-home care

[1] *Bloom, S. L., Creating sanctuary for kids: Helping children to heal from violence. Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations, (2005). 26(1), 57-63.*

EXIT OUTCOMES FOR YOUTH AGING OUT OF FOSTER CARE



Rural Counties: Alpine, Amador, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Sierra, Siskiyou, Tehama, Trinity and Tuolumne

Urban Counties: Butte, El Dorado, Placer, Sacramento, San Joaquin, Shasta, Sutter, Yolo and Yuba

Data from Child Welfare Dynamic Report System Citation: Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Williams, D., Yee, H., Hightower, L., Lou, C., Peng, C., King, B.,& Henry, C. (2013). Child Welfare Services Reports for California. Retrieved 2/19/2013, from University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/ucb_childwelfare

Quality Improvement Project: Improving the Use of Psychotropic Medication Among Children and Youth in Foster Care

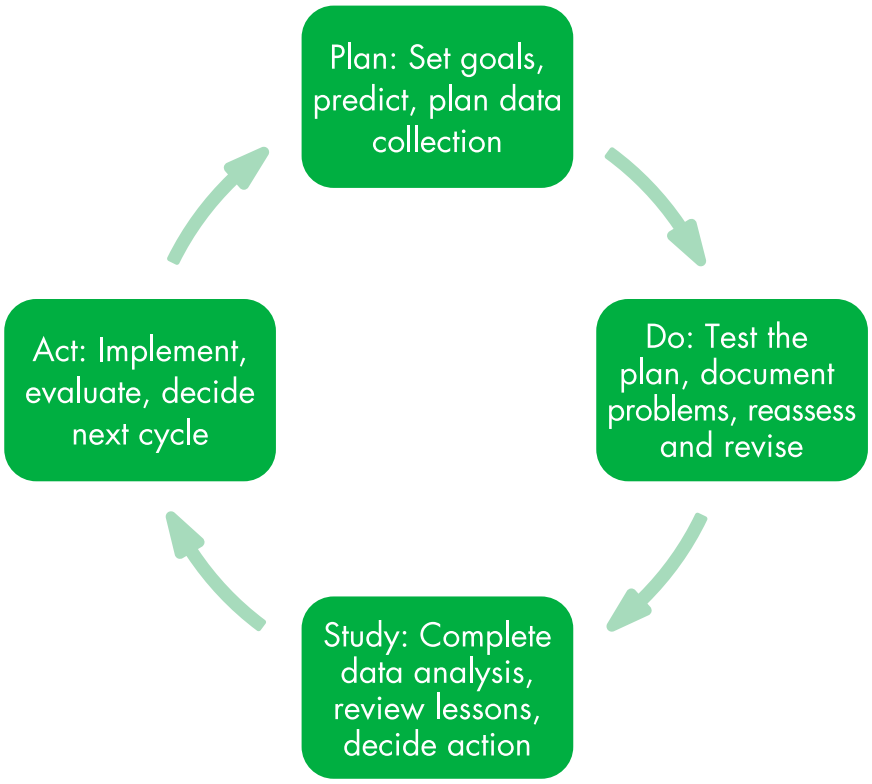
From the Department of Health Care Services and the California Department of Social Services

In 2008, the Department of Health Care Services (DHCS) and the Department of Mental Health (DMH) participated in a 16-state study of antipsychotics and psychotropic medication use in children and adolescents. In the study, each of the 16 states, including California, provided the analysis of four years of data (2004-2007) to identify possible safety and quality issues surrounding antipsychotic use in children and youth. In general, safety and quality issues identified with the California data points to the potentially inappropriate and concurrent use of multiple drugs of the same class, of high doses, and with significant gaps of therapy. The California data in this study identified a disproportionate use of psychotropic drugs in the segment of children and youth in foster care, including:

- Children in foster care are five times more likely to receive psychotropic medications compared to non-foster care children
- Within the foster care children group receiving at least one psychotropic drug, more than half (56.6 percent) were prescribed two or more psychotropic drugs at the same time

To address this concern and improve the use of psychotropic medication among children and youth in foster care, DHCS and CDSS developed the Quality Improvement (QI) Project.

The QI Project will attempt to bring parties together, frame the issue(s), and develop a five-step psychotropic monitoring plan based on the Child and Family Services Improvement and Innovation Act of 2011. These steps include:



1. Screening, Assessment and Treatment

- Comprehensive and coordinated screening process, assessment and treatment planning
- Mechanisms to identify children's mental health and trauma-treatment needs
- Include a psychiatric evaluation, if necessary, to identify needs for psychotropic medication

2. Improving the Effectiveness of the Consent Process: Informed and Shared Decision-Making

- Identify methods for ongoing communication between the prescriber, the child, caregivers, other healthcare providers, child welfare worker and other key stakeholders

3. Effective Monitoring

- Improve the safety and effectiveness of psychotropic medication use in the foster care population through the utilization of best practices
- Reduce the practice of polypharmacy therapy with psychotropic medications in the foster care population

4. Availability of Mental Health Expertise

- Consultation on consent and monitoring issues by a board-certified or board-eligible child and adolescent psychiatrist (agency and individual case levels)

5. Mechanism for Sharing Accurate Data

- Expand collaboration among key stakeholders in this issue, including foster parents, DHCS management, CDSS caseworkers, medical and mental health care providers, and the impacted children and youth

To measure and track improvements, DHCS and CDSS will be utilizing the Model for Improvement Methodology consisting of three fundamental questions and the Plan-Do-Study Act (PDSA) cycle to test and implement changes in real work settings.

The QI Project is currently targeted for implementation by July 2013, with evaluation targeted for July 2014.

LGBTQ Youth and Well-Being

By Chris Downs

I've given lectures, seminars, workshops and keynotes on lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth for many years. Invariably, an adult in the audience will say something like, "I treat all young people alike—my straight kids and my gay kids. There shouldn't be any difference between them."

While the basic sentiment is well-intentioned, the fact is that although LGBTQ adolescents share many hopes, dreams and needs with their non-LGBTQ peers (hopes for their personal futures, needing important adult/parent figures in their lives, wanting good friends, etc.), the opportunities for LGBTQ youth to achieve these basic parameters of well-being are routinely derailed by societal and familial stereotypes and reactions to those youth when they "come out" as LGBTQ.

"Rates of suicides, clinical depression, illegal drug use and STDs were extremely high among LGBT youth whose families had not been at all accepting of their sexual orientation or gender identity."

The nation's oldest LGBT civil rights organization, the Human Rights Campaign, recently published a survey[1] of 10,030 LGBTQ adolescents ages 13-17. When asked what one thing they would like to change in their lives right now, the most frequent responses from heterosexual youth were money problems, debt, and concerns about weight and appearance. LGBTQ youth, on the other hand, indicated a desire for understanding and tolerance, and a better family situation with respect to their being LGBTQ. When asked to describe the biggest problem in their lives right now, heterosexual youth identified classes, exams, grades, choice of college and career, and financial pressures related to going to college, while LGBTQ youth named non-accepting families (26 percent), bullying at school (21 percent) and fear of being "out" (18 percent). They also indicated a constant struggle with the basic discrepancy between what their personal world (family, friends, church, neighbors) has told them they are (i.e., heterosexual with everything that label implies) and what they know to be the truth—they are not heterosexual.

This discrepancy can cause a range of emotions from mild to extreme. More importantly, the reactions of the adolescent's social and familial world can lead to huge differences in long-term well-being. San Francisco State University's Dr. Caitlin Ryan amply documented this in her Family Acceptance Project[2], showing that rates of suicides, clinical depression, illegal drug use and STDs were extremely high among LGBT youth whose families had not been at all accepting of their sexual orientation or gender identity. In contrast, when families were extremely accepting of their LGBTQ youth, rates of these negative outcomes plummeted. For instance, 92 percent of LGBTQ youth whose families were extremely accepting of them saw a future as a happy adult. This is compared with 35 percent of LGBTQ youth whose families were not at all

accepting.

Additional research has amply documented many of the risk factors associated with being an LGBTQ youth in America, including much higher rates of drug consumption (cigarettes, marijuana, cocaine, inhalants, painkillers), bullying, ostracism and assault in school, higher involvement with juvenile justice and substitute care systems, homelessness, depression, and suicide. Rates of LGBTQ youth attempting suicide range from 22-37 percent, depending on the study. For comparison, the rate for heterosexual students is closer to 6 percent. Needless to say, it can be very difficult to be an LGBTQ youth in America.

Many of us look for ways to ameliorate or counterbalance these risk factors, and there are some very promising avenues to consider. One of the most important is a Gay-Straight Alliance (GSA), a school-based, youth-led program that seeks to provide education, community and support for LGBTQ youth. In a recent study in Oregon of more than 31,000 high school students, Hatzenbuehler (2011)[3] found that communities supporting a GSA held substantially lower suicide rates among LGBTQ youth, often as low as the rate for heterosexual students. Other ways to counteract the risk factors include: 1) working to promote family connectedness and acceptance, 2) helping schools to implement and enforce anti-bullying policies, and 3) identifying one or more highly caring adults in the youth's life. Each of these has been demonstrated to significantly lower the risk factors, and especially the risk of suicide.

Another fact to consider when discussing LGBTQ youth well-being is that LGBTQ youth are disproportionately represented in our child welfare systems. The numbers in foster care are systemically elusive, since we tend not to ask or report the sexual orientation or gender identity/expression of our foster youth. For instance, child welfare leaders report that LGBTQ youth clients represent at least 20 percent of older youth in care, while just last year Durso and Gates (2012)[4] reported that 42 percent of host homes, 39 percent of permanent housing programs, 22 percent of independent living programs, and 21 percent of emergency shelter program clients were LGBTQ identified.

Regardless of the discrepancy in numbers, the literature on LGBTQ youth is quite clear. These young people want full, rich and enjoyable lives just like their heterosexual peers. However, communities and families often create challenges based on stereotypes. Those stereotypes can have direct, even lethal, impacts on LGBTQ youth. As child welfare professionals, we must become fully educated about what it is like to be an LGBTQ youth, especially a youth in substitute care. Our job is to provide safe and welcoming support to them so they, like heterosexual youth, can move into adulthood and achieve their goals and dreams.

[1] *Human Rights Campaign: Growing up LGBT in America. Accessible at http://www.hrc.org/files/assets/resources/Growing-Up-LGBT-in-America_Report.pdf*

[2] *Ryan C, Huebner D, Diaz RM et al. Family Rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. Pediatrics 2009; 123:346-52*

[3] *Hatzenbuehler, M. L. (2011). The social environment and suicide attempts in lesbian, gay and bisexual youth. Pediatrics, 127, 896–903. doi:10.1542/peds.2010-3020*

[4] *Durso, L.E., & Gates, G.J. (2012). Serving Our Youth: Findings from a National Survey of Service Providers Working with Lesbian, Gay, Bisexual, and Transgender Youth who are Homeless or At Risk of Becoming Homeless. Los Angeles: The Williams Institute with True Colors Fund and The Palette Fund.*

Legal Update: AB 1856 requires LGBTQ training for foster youth caregivers

In 2012, California saw the passage of AB 1856, a new law that bears directly on LGBTQ youth in foster care. This law requires the "training for an administrator of a group home facility, licensed foster parent, and relative or non-relative extended family member caregiver to include instruction on cultural competency and sensitivity relating to, and best practices for, providing adequate care to lesbian, gay, bisexual and transgender youth in out-of-home care." Agencies will now be required to have basic training on LGBTQ youth.

Casey Life Skills Assessment (CLSA)

With emphasis on well-being projected to grow exponentially in the child welfare system over the next few years, many agencies are scrambling to find appropriate assessment tools to adequately measure it. Interestingly, one assessment tool that addresses youth well-being has been around (and constantly evolving) since the 1980s. Now called the Casey Life Skills Assessment (formerly the Ansell Casey Life Skills Assessment), this free, online youth-centered tool assesses life skills youth need for their well-being, confidence and safety as they navigate high school, postsecondary education, employment and other milestones. Designed to be as free as possible from gender, ethnic and cultural biases, the assessment serves as a measure for youth's confidence in their future and their permanency connections to caring adults.

The CLSA is appropriate for all youth ages 14-21 regardless of living conditions and contains 113 assessment items categorized within eight areas for skills, knowledge and awareness. Youth can complete one area at a time or finish the whole assessment in approximately 30-40 minutes.

While well-being is much too broad to be entirely covered by this assessment, the CLSA nevertheless serves as a solid indicator tool that child welfare service providers can, have and will likely continue to use moving forward in a child welfare environment that is ever-more focused on measuring how children served by the system are doing after exiting care.

For more information on the Casey Life Skills Assessment, visit the official site at www.caseylifeskills.org.

Legal Update: Uninterrupted Scholars Act (2013)

By Joanne Brown, J.D., M.S.W., National Child Welfare Resource Center

In January 2013 President Obama signed into law the Uninterrupted Scholars Act, an amendment to the Family Educational Rights and Privacy Act (FERPA) allowing the "agency caseworker…who has the right to access a student's case plan" access to the child's records. This Act amends an unintended consequence of FERPA, which although designed to protect parents' control over their children's records often created imposing, onerous and often insurmountable barriers to social workers.

The campaign to amend FERPA was initiated by California advocates for foster youth. The Congressional Caucus on Foster Youth solicited input from youth, parents, educators, attorneys, child welfare professionals and advocates for youth across the country, and as a result successfully created an effective bipartisan alliance.

In testimony before Congress, the Caucus detailed the educational challenges children in foster care continue to face despite laws enacted to encourage educational stability, such as the Fostering Connections to Success Act (2008). This amendment will allow agency caseworkers to obtain the information they need to reinforce permanency planning for children and the foundation for successful transition into adulthood for every youth exiting foster care.

"When we enter a situation, believing we already know the answer, we close ourselves off to the possibility that perhaps we really do not know at all."

—Fontes, L. A., (2005). Child abuse and culture: Working with diverse families. Guildford Press: NY.

Recommendations from the Field...

Early Identification of Trauma

Excerpted from the Chadwick Trauma-Informed Systems Project's Creating trauma-informed child welfare systems: A guide for administrators (2nd ed.)

Early identification and intervention techniques (such as those listed below) are critical and can decrease the impact of trauma on a child's development:

- During investigations of suspected child abuse or neglect, assess the child's developmental status, including cognitive, linguistic, gross and fine motor, emotional and social competence along with a full medical history, including any prenatal substance exposure.
- Incorporate expertise in the identification and assessment of young children with serious, trauma-related mental health problems so that a young child may be referred into an existing clinical treatment program that addresses these complex and widely unmet needs. It is also imperative that caregivers receive the mental health assessment and treatment they need in order to be emotionally available to the child. (National Scientific Council on the Developing Child, 2005)
- Ensure that training for child welfare staff, resource parents and other system stakeholders includes information about brain development and how sensitive and responsive caregivers can help mediate stress experienced by a child. (National Scientific Council on the Developing Child, 2005)
- Educate professionals and parents that the quality of care and education a young child receives in a daycare setting (i.e., any place where the young child may spend many hours each day while the parent/caregiver is at work) plays a substantial role in whether, and to what extent, their brains are exposed to elevated stress hormones early in life. (National Scientific Council on the Developing Child, 2005)

National Scientific Council on the Developing Child. (2005). Excessive stress disrupts the architecture of the developing brain: Working paper no. 3. Retrieved from the Center on the Developing Child, Harvard University website: http://developingchild.harvard.edu/resources/reports_and_working_papers/working_papers/wp3/

Addressing Trauma

Excerpted from the Chadwick Trauma-Informed Systems Project's Creating trauma-informed child welfare systems: A guide for administrators (2nd ed.)

The following are some recommended strategies that child-serving administrators may use to effectively address the impact of trauma on the children and families served, as well as well as on the professionals and organizations who work with them:

- Provide forums for training all child welfare staff on types of trauma, reactions to traumatic events, and short- and long-term impact of trauma at the most basic level.
- Consider the full trauma history of the child and family to develop effective, tailored interventions unique to each child and family.
- Recommend and/or provide interventions that comprehensively address the child's needs beyond the initial abuse investigation.
- Attempt to minimize caregiver-child separations whenever safe and possible, and consider alternate strategies for monitoring child safety.
- Minimize separation-related distress by developing systems that allow for liberal visitation when the caregiver is not thought to present an active danger to the child.
- Integrate trauma-informed child welfare into the fabric of existing child welfare practice approaches to avoid the initiative fatigue that workers may experience due to child welfare agencies often integrating new and innovative initiatives into their daily practice.
- Identify staff who can serve as trauma champions within the child welfare agency to provide the voice of trauma throughout supervision, family meetings and group meetings.

WELL-BEING OUTCOME DOMAINS

	General Well-Being Domains		Social and Emotional Well-Being Domains	
	Cognitive Functioning	Physical Health and Development	Emotional/ Behavioral Functioning	Social Functioning
Infancy (0-2)	Language development	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Early Childhood (3-5)	Language development, pre-academic skills (e.g., numeracy), approaches to learning, problem-solving skills	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, self-esteem, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Middle Childhood (6-12)	Academic achievement, school engagement, school attachment, problem-solving skills, decision-making	Normative standards for growth and development, overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competencies, social connections and relationships, social skills, adaptive behavior
Adolescence (13-18)	Academic achievement, school engagement, school attachment, problem solving skills, decision-making	Overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competence, social connections and relationships, social skills, adaptive behavior

Adapted from ACYF Well-Being Framework

RESOURCES

Organizations with Data on Evidence-based and Evidence-informed Interventions

Adapted with permission from the ACF Children's Bureau's ACYF-CB-IM-12-04

In recent years, public and private sector organizations have produced extensive, publically available lists and databases of evidence-based and evidence-informed interventions for improving well-being outcomes for vulnerable children. These include, among others:

- The Agency for Healthcare Research and Quality (ahrq.gov)
- National Child Traumatic Stress Network (nctsn.org)
- National Early Childhood Technical Assistance Center (nectac.org)
- National Registry of Evidence-Based Programs and Practices (nrepp.samhsa.gov)
- The Substance Abuse and Mental Health Services Administration (samhsa.gov)
- U.S. Department of Justice's site crimesolutions.gov

Other Key Resources

ACF Information Memorandum on Social and Emotional Well-Being
http://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx

Chadwick Trauma-Informed Systems Project
http://www.chadwickcenter.org/CTISP/images/CTISPTICWAdminGuide.pdf

Katie A. Web Resources

Katie A. Settlement Agreement Implementation
http://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx

Documents Related to the Katie A Lawsuit
http://www.childsworld.ca.gov/pg1320.htm

National Survey of Child and Adolescent Well-Being
http://www.acf.hhs.gov/programs/opre/research/project/national-survey-of-child-and-adolescent-well-being-nscaw

The Pathways Initiative
http://www.aphsa.org/policy/pathways.asp

Katie A. Q & A

By Joanne Brown, J.D., M.S.W., National Child Welfare Resource Center

Q: Is Katie A. and the Katie A. Core Practice Model another set of requirements; or an elaboration of good practice?

A: Katie A. is not a fundamentally new law or a new practice model, but rather reflects a systematic strategy for responding to the frustration that social workers, courts, providers and families experience in most counties (i.e., not enough mental health services for children in need, multiple and inconsistent eligibility requirements, gaps in continuity of services and interruptions in service based on funding streams).

Q: How does Katie A. impact resources for children and families outside of Los Angeles County?

A: The principles of Katie A. are closely related to federal and California law regarding safety, permanency and well-being and the significant steps we have taken to better meet the needs of children through the Individualized Disability and Education Act (IDEA), the Fostering Connections to Success Act (2008), and AB 12 (Fostering Connections After 18). Katie A., however, will have an impact on the mental health service delivery for all California children. As a result of Katie A., it has been established that all components of in-home based services are reimbursable under Medi-Cal.

Q: How will Katie A. impact child welfare professionals outside of Los Angeles County?

A: Although the State of California was named as a party in Katie A., the specific terms of the settlement agreement apply only to children in Los Angeles County and are not binding on other counties. However, as references for best practices and standards for policy and procedure and local practice, child welfare professionals can anticipate hearing about Katie A. from lawyers and likely from the bench, specifically around early assessment, wraparound services, in-home services, and collaborative case planning.

ANNOUNCEMENTS

Upcoming trainings

Health Care Needs of Children and Youth in CWS
Online: May 1-14, 2013

Psychotropic Medications and Children in Foster Care
Davis: May 22, 2013

Advanced Analytics for Child Welfare Administration
Sacramento: Summer 2013

Introduction to Mental Health
Redding: June 18, 2013

For full course listings visit the Northern California Training Academy's official site at http://www.humanservices.ucdavis.edu/academy.

Summer/Fall Course Catalog will be available on the web July 2013.

We can't publish this newsletter without you.

We received lots of helpful and interesting feedback on our last issue. Please send your comments and any ideas for future issues to me at sbrooks@ucdavis.edu

In Our Next Issue

Look for more articles, research, success stories and resources in our next issue of Reaching Out. The next issue will focus on Supervision and Leadership in the Field of Child Welfare.

Production team:
Staff Writer/Editor: Jason Borucki
Staff Writer: Nancy Hafer
Senior Editor: Kristin Mick
Graphic Designer: Jeff Moore

About the Northern California Training Academy

As part of the Center for Human Services at UC Davis Extension, the Northern California Training Academy provides training, consultation, research and evaluation for 28 Northern California counties. The counties include rural and urban counties with various training challenges for child welfare staff. The focus on integrated training across disciplines is a high priority in the region. This publication is supported by funds from the California Department of Social Services.

About the Center for Human Services

The Center for Human Services at UC Davis Extension began more than 30 years ago as a partnership between the University of California, Davis and state government to address the needs of rural counties in developing skills for their social workers. Through professional training, consultation and research, the Center has grown to serve human services organizations and professionals throughout California and across the nation.

Northern California Training Academy
UC Davis Extension
University of California
1632 Da Vinci Court
Davis, CA 95618

Phone: (530) 757-8725
Fax: (530) 752-6910
Email: academy@ucde.ucdavis.edu
Web: www.humanservices.ucdavis.edu/academy

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