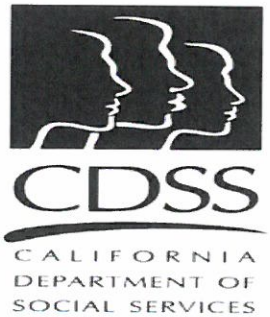
California Child and Family Services Review

Annual SIP Progress Report

2012 – 2017

SUBMITTED BY: GLENN COUNTY HUMAN RESOURCE AGENCY



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GLENN COUNTY HUMAN RESOURCE AGENCY
2013 ANNUAL REPORT

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Glenn County
SIP Progress Report
Cover Sheet

California's Child and Family Services Review System Improvement Plan	
County:	Glenn
Responsible County Child Welfare	Glenn County Human Resource Agency
Period of Plan:	October 21, 2012 – October 20, 2017
Period of Outcome Data:	**Quarter ending:** July 2013
Date Submitted:	November 22, 2013

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Submitted by each agency for the children under its care	
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Name:	Scott Gruendl
Signature:	
Submitted by:	**Glenn County Chief Probation Officer**
Name:	Brandon Thompson
Signature:	

INTRODUCTION

This is Glenn County's annual update of the fourth cycle of participation in the quality improvement program to measure outcomes in the areas of safety, permanence and well being for children in the Child Welfare System. This is also the annual report of the first cycle of integrating the CAPIT/CBCAP/PSSF Plan into the System Improvement Plan (SIP) and moving from a three-year plan to a five-year plan. The County completed the assessment process in collaboration with community and prevention partners to develop a countywide continuum of care.

Glenn County Human Resource Agency (HRA) continues to evolve toward a Learning Organization. The process must become intrinsic to the culture of the agency and is progressing one step at a time along with other changes. In January 2013, the director position of HRA was permanently reclassified and merged with the County Health Services director position. Scott Gruendl had served as part-time director of both agencies for the three previous years. The administrative units of both agencies are also in the process of merging to become the Glenn County Health and Human Services Agency under the direction of Mr. Gruendl. Some employees are already cross-training under the direction of Health and Human Services Agency Deputy Director, Cecilia Hutsell.

During the year being reviewed, staffing moves, leaves and new hires slowed some of strategies being implemented. One social worker was on medical leave for several months and another on maternity leave. One social worker left Glenn County to work closer to home in Sacramento and another left to follow a spouse who got a job out of the area. Two positions were filled along with a position that had been frozen, opening the door for three new social work staff to be trained. The next year will present some challenges and opportunities as key staff retire and as the two public agencies contemplate and plan how to best accomplish a merge while improving services to the citizens of Glenn County. Budgetary issues, mandated requirements and staff changes will necessitate approaching problems more comprehensively in terms of practice. This is already happening as we revise and improve our goals and activities.

During the last year, Glenn County Child Welfare Services (CWS) has focused on three areas; *No Recurrence of Maltreatment*, *Social Worker Visits* and *Reentry to Foster Care*. Glenn County

has made progress on the measures of *No Recurrence of Maltreatment* and *Social Worker Visits*. Reentry to Foster Care continues to remain significantly higher than the National Goal.

Glenn County Probation has focused on making improvement in *Exit Outcomes for Youth Aging-Out of Foster Care*.

STAKEHOLDER PARTICIPATION

The Quality Assurance Team, a sub-committee of the Children's Interagency Coordinating Council (CICC), provides review, input, brainstorming and solutions for outcome improvement. This team is comprised primarily of CWS staff, County mental health staff and in-house community partners providing Differential Response. The committee reviews quarterly county data, services, service gaps and needs and reports back to the general membership of the CICC. The CICC initiated two Round Table Discussions this year as a provocative forum to brainstorm solutions to issues related to child abuse and to avoid duplication of services. The Quality Assurance Team will continue to examine system-level performance indicators and outcome-level data. The CICC has a broad representation of county service providers including tribes and parent partners.

In addition, outcome data is reviewed quarterly at the Blue Ribbon Commission (BRC) meeting. In addition to the juvenile court judge and attorneys, this group has key members from departments and agencies who interact with child welfare families (mental health, adoption, public health, CASA, Community Action, CICC, etc.) and includes youth who are active in the California Youth Connection (CYC). This team initially incorporated SIP goals that involved the court as part of the BRC process. This entity has not yet developed new goals. The team receives an update on quarterly reports but has not developed strategies for improvement. New goals for the commission will be reviewed from presentation of this annual report at the next quarterly meeting.

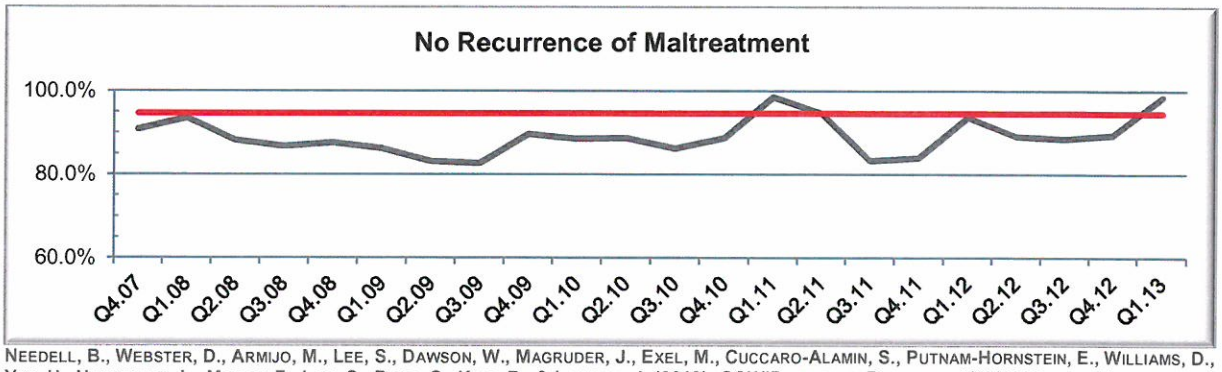
SIP NARRATIVE

CURRENT PERFORMANCE TOWARDS SIP IMPROVEMENT GOALS

Glenn County selected four (4) measures to focus on during the 2012-2017 SIP cycle. The measures selected by CWS are: (S1.1) No Recurrence of Maltreatment; (C1.4) Reentry Following Reunification; and (2F) Timely Monthly Caseworker Visits. The measure selected by Probation is: (8A) Exit Outcomes for Youth Aging-Out of Foster Care. The county's performance for this first year of the five-year SIP cycle is reviewed here. The baseline data reported in *Quarter 4 of 2011* was used for the SIP being reviewed. Baseline data will be compared with the most current data release available for each measure using Report Publication: *July2013. Data Extract: Q1 2013. Agency: Child Welfare.*

S1.1 – No Recurrence of Maltreatment

	Quarter	Look Back Time Period	Percent
Baseline Performance	Q4-2011	Jan. 1, 2011 – June 30, 2011	84.0%
Current Performance	Q1-2013	April 1, 2013 – Sept. 31, 2013	98.4%
National Standard			*94.6%*



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In addition to the baseline data from the beginning of this five year SIP, the chart above reflects five years of data to provide a long-term perspective. This allows a better understanding of trends

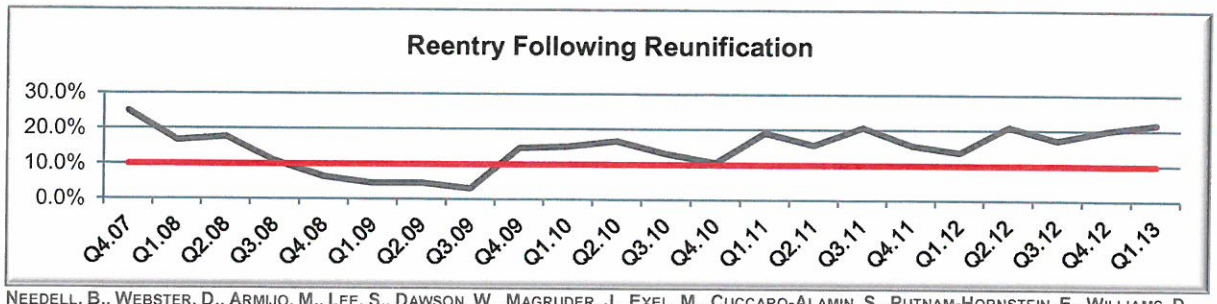
or patterns that may exist from quarter to quarter. The baseline data period for this measure is based on the first quarter and looks back at the six-month period January 2011 through June 2011. The comparison data period is from the fourth quarter and looks back at the six month period April 2012 through September 2012. Glenn County comparison data shows improvement in this measure, with the county's performance exceeding the national standard by 3.8 percentage points in the most current available data set. Although performance fluctuates slightly each quarter, Glenn has shown consistent improvement in each quarter when compared to the baseline data period.

However, it should also be noted that over the past two years Glenn's performance in this area comes closest to meeting/exceeding the national standard in the first quarter of each year, with performance declining slightly in subsequent quarters of the year. This is consistent with the fact that data for the first quarter period is looking back during a time when school is not in session for three months of the six-month period. When comparing the first quarter of 2012 (baseline) with the first quarter of 2013, performance improved from the baseline of 84% to 93.7% and is indicative of an upward trend. More current data pulled from SafeMeasures® for the period ending December 2012 shows Glenn at 95.1%, or 1.5 percentage points above the national standard (Children's Research Center SafeMeasures® Data. Glenn, CFSR Measure S1.1: No Recurrence of Maltreatment, 7/1/12 to 12/31/12. Retrieved: September 25, 2013 from Children's Research Center Website. URL:https://www.safemeasures.org/ca).

Glenn County appreciates the upward trend. It acknowledges the hard work being done and indicates the changes being made are starting to reduce maltreatment of some kids in Glenn County.

C1.4 – Reentry Following Reunification

	Quarter	Look Back Time Period	Percent
Baseline Performance	Q4-2011	Jan. 1, 2010 – Dec. 31, 2010	15.6%
Current Performance	Q1-2013	April 1, 2011 – March 31, 2012	21.7%
National Standard			*9.9%*



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Reentry Following Reunification is an outcome that Glenn has struggled with for a number of years, only meeting the state's benchmark/national standard in 2007 when performance for January through December of 2007 was 3% for reentry within 12 months and 6.1% for reentry within 24 months. Current performance data shown in the table above is from the 12-month period from April 2011 through March 2012. This includes one quarter report from the baseline report used to develop the five year SIP.

More recent data from SafeMeasures®, representing the period from July 2011 through June 2012, shows Glenn County at 22.7% for this measure, which misses the benchmark by 12.8 percentage points. However, small samples consistently affect Glenn's ability to achieve the national standard. The 12.8 percentage point differential equates to only three children. The trend for this measure is moving away from the desired goal and is indicative of families that have reunified based on achieving temporary stability, with a subsequent recurrence of the underlying issues that ultimately led to re-involvement with CWS. Glenn County will continue to work on this outcome and identified strategies in this area. Developing and implementing a *risk* matrix to determine the most common issues that lead to post-reunification reentry and analyzing the most successful tactics to combat these occurrences is one of the strategies that is in process.

A preliminary review of data from August 2012 through August 2013 on all cases that reentered foster care during that thirteen-month period indicated two types of reentry. One was those children who reentered within twelve months of reunification and the other was children that reentered after more than twelve months of being reunified.

Thirteen children from seven families reentered care within twelve months of being reunified during the period from August 2012 through August 2013. Seven of the thirteen children (54%) had two placement episodes, five of the thirteen children (38%) had three placement episodes, and one child had four placement episodes (6%). One youth who had three placement episodes had been adopted as a young child, making it likely that this youth will experience more than

three episodes before achieving permanency. Eight of the thirteen children (61.5%) reentered care within two to five months, while five of the thirteen reentered care between seven and eleven months. The children ranged in age from 0-5 years (six children), 6-12 years (three children) and 13-18 years (four youth) indicating that reentry for this cohort was initially very young children and teenagers secondly. Time to reentry of care did not seem to be affected by the age of the child.

Ten children from seven families reentered care more than 12 months after being reunited. Six of the ten children (60%) had two placement episodes and four had three episodes (40%). Six of the ten children reentered care within 2-3 years of being reunited. Three of the ten children reentered care within four to five years and one reentered after eight years. The children ranged in age from 0-3 years (three children), 6-12 years (four children) and 13-16 years (three children) indicating that age is likely not a significant factor among the reasons for reentry.

Glenn County is just starting to get a picture of the demographics of children who have multiple placement episodes after reuniting with their parent(s). Substance abuse and\or mental health issues of the parents and of the older youth appear to be compelling reasons that children reenter care. During the next year continued analysis and development of a matrix to use at first entry will help Glenn County identify families that need more intense services to increase their stability with reunification. The matrix will be developed using key issues associated with re-entry to foster care as well as factors specific to the families who have reentered care in Glenn County.

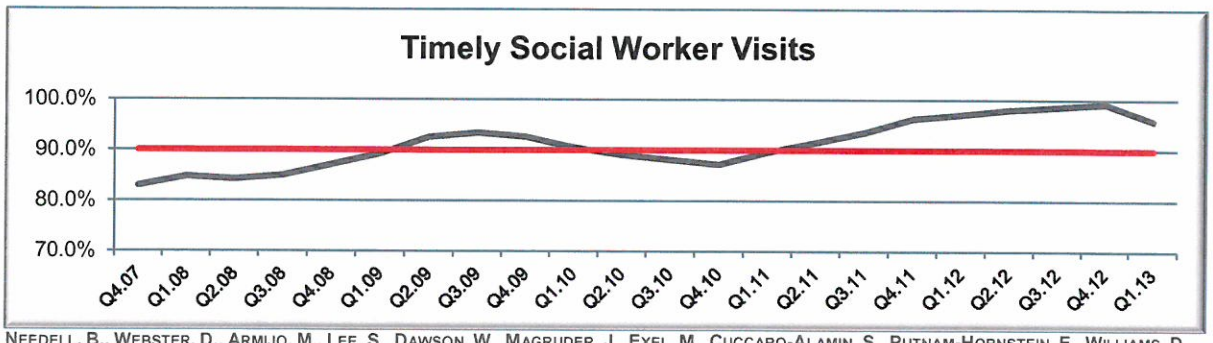
Key predictors of reentry to foster care include children with behavioral or health issues; placement in non-relative foster care; placement instability; parental mental illness and substance abuse; poverty; parental ambivalence about reunification; family coherence at the time of separation; and previous failed reunification attempts. Services and supports needed to reduce the likelihood that children will reenter care include the following: family engagement where the family has a voice in identifying needs and developing the case plan; strong caseworker-client alliances; team-based decision making with the goal of sustaining the family-child relationships; providing empathy, respectful information and education; and instilling within the family the perception that their issues and unique situation are understood. Providing concrete services and supports, like transportation and in-home services, early in a case have been shown to increase engagement. (Predicting and Minimizing the Recurrence of Maltreatment: Literature Review,

Ryan D. Honomichl, PhD & Susan Brooks, MSW, UC Davis Human Services Northern California Training Academy, August 2009.)

Effective parent-child visitation has been identified as one the greatest predictors of successful family reunification and preventing reentry. Encouraging a foster parent/birth-parent healthy and supportive relationship is one method identified as having some success. Visitations that allow parent's participation in the child's life, like attending doctor appointments and sporting or school events, are factors that contribute to stronger reunification. Visit coaching, where the parents meet with the parenting coach before and after a visit to help the parent understand the child's needs and to validate their feelings of guilt, anger and sadness, increase the parent connectedness to the child. These methods combined with the regular parent education classes have been shown to be much more effective than just parenting classes alone. (Predicting and Minimizing the Recurrence of Maltreatment: Literature Review, Ryan D. Honomichl, PhD & Susan Brooks, MSW, UC Davis Human Services Northern California Training Academy, August 2009.)

2F - Timely Monthly Social Worker Visits

	Quarter	Look Back Time Period	Percent
Baseline Performance	Q4-2011	Jan. 1, 2010 – Dec. 31, 2010	96.3%
Current Performance	Q1-2013	April 1, 2011 – March 31, 2012	95.8%
Desired Standard			*<90%*



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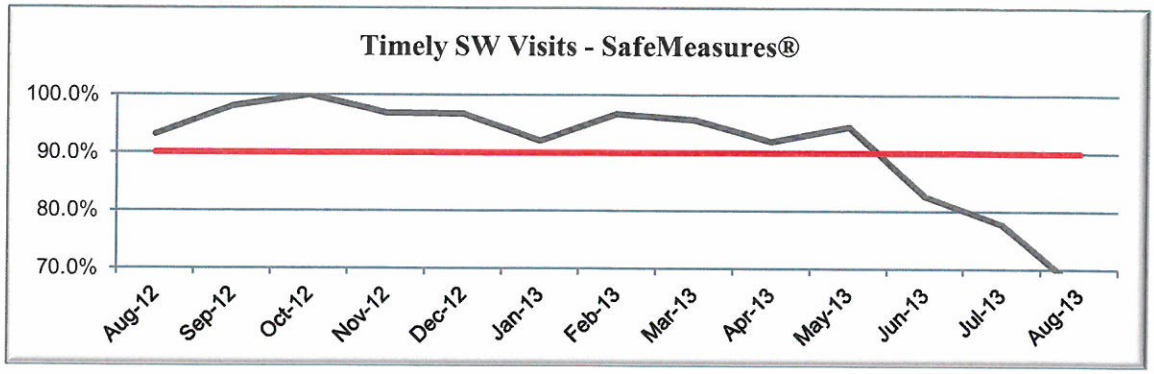
The chart above from UC Berkeley data, representing the time period from 2007 through March 2013, indicates that Glenn County has had some difficulty in past years meeting the desired standard of timely completion of 90% of all required contacts.



More recent data from SafeMeasures® indicates the County has met or exceeded the benchmark in all but the most recent three months of calendar year 2013 (Children's Research Center Safemeasures® Data. Glenn, AB636 Measure 2F: Social Worker Contacts, and August 2013. Retrieved September 25, 2013 from Children's Research Center Website. URL: https://www.safemeasures.org/ca). This is indicative of data lag, where the contact occurs in the appropriate month but is not recorded timely after occurrence. The data currently lags by one quarter (three months) and it appears that the lag is consistently attributable to certain staff members.

Glenn County will work more closely with these staff to determine the reasons for the lag in data input and find ways to assist these staff in timely entry of contact data.

STATUS OF STRATEGIES

No Recurrence of Maltreatment Update

Strategy 1: Increase Family Engagement in Differential Response Services

DR services have been provided by the Prevention, Intervention and Education (PIE) Unit comprised of Community Action and AmeriCorps staff under the supervision of the CICC Coordinator. This in-house unit was created to work with families at risk of abuse on a voluntary basis utilizing a diverse staff. The PIE unit has offered a number of services in addition to DR including the following: PSSF, ILP, Foster Care Licensing, relative home approvals, parent education class coordination, multi-disciplinary team organization (MDT) and child abuse prevention activities. A DR brochure was completed in November 2012 by the PIE Unit and given to twenty-eight families accepting PIE services.

English-speaking families were provided letters, handouts and educational materials in addition to case management services. Four Spanish-speaking families were not provided this service because of the lack of Spanish-speaking staff and translated program materials. The PIE staff referred these families to other community providers who serve Spanish-speakers.

Not having Spanish-speaking staff or translators working in the program resulted in a barrier to PIE services for those families where Spanish is the preferred language. Brochures and other information will be translated into Spanish and resource information in Spanish will continue to be sought and provided to Spanish speaking families whenever possible, ensuring that families will continue to receive service information in their desired language.

PIE staff was trained in Safety Organized Practice (SOP) family meeting facilitation in October of 2012 along with a group of CWS social workers and their supervisor. During this last year the PIE staff participated in a number of SOP meetings conducted by social workers for CWS cases as part of PSSF services. They were unable to facilitate SOP meetings due to the need to develop their team and improve processes, procedures and communication between their unit and CWS units. Their engagement skills were greatly increased in eliciting family voice; they used using scaling questions and focused on helping families understand the concepts of safety, danger and complicating factors.

Policy and procedures were developed as a joint effort with the CWS manger, supervisors and CICC Coordinator as lead for the PIE team. This provides clear guidelines for PIE and social work staff to define roles and processes for team members when working together. PIE staff, serving as child and family advocates, facilitated Team Decision Making (TDM) meetings by setting up the meetings for those families at risk of entering foster care. Staff ensured that the family identified who would attend the TDM meeting on their behalf and provided transportation to the meeting. They ensured completion of the county Universal Release of Information (URI) forms. The TDM meeting practices afford staff a decision making role at the meeting. These practices ensured that the family voice was heard and acknowledged and helped staff to advocate that the family be served outside of the CWS system whenever a safe plan could be developed. This activity significantly promoted engagement for clients who received these services.

Nurturing Parent Program (NPP) pre-assessments (AAPI) have been completed on all DR cases. The assessment results are given to the parent(s). The parent(s) are referred to a Nurturing Parent Program based on the age of the focus child. The assessment is used to examine the areas needing improvement. This action step is ongoing and will continue for any case accepting services from the PIE Unit.

Differential Response has significantly been improved this last fiscal year and its benefits as a practice are starting to be reflected in *Recurrence of Maltreatment* outcome data. During the year, regular MDT-type meetings were held every other week between CWS emergency response staff and PIE staff to review CWS referrals going to the PIE Unit for differential response and to review staff progress regarding the families PIE was serving. The Child Abuse Treatment (CHAT) Program staff began participating in those meetings as well, with the goal of increasing timely access to mental health services and to provide progress reports on those being served. The CHAT Program accepts all county mental health referrals. The CHAT therapist screens for needed counseling services and the program serves families who do not have Medi-Cal. The CHAT Program refers Medi-Cal clients to County mental health services. The therapist also provides crisis intervention services as needed. CHAT also provides short-term crisis intervention for Medi-Cal clients when they cannot be served immediately through mental health. The therapist also attends TDM meetings for families at risk of entering foster care. Establishing a single point of entry for all mental health referrals is improving access to mental health services and communication between prevention services, CWS and mental health.

Facilitated by a CWS Supervisor and the CICC Coordinator, MDT meetings between CWS, schools, law enforcement and other service providers were improved and expanded to two meetings a month (instead of one) and to two communities, Willows and Orland (instead of just in Willows). This allows greater attendance from the schools and from law enforcement. PIE staff who provide DR services now attend MDT meetings, enabling them to intervene with families prior to a CWS referral and to receive and provide updates about families they are serving. A new strategy will be added to the matrix to reflect this change.

As part of the Continuous Quality Improvement (CQI) process, a Business Objects report was created that identifies all referrals within a month, type of abuse, their dispositions, the assigned CWS worker and risk designations (path 1, 2 or 3). These reports are used

during the bi-weekly meetings to triage new referrals, share information, assess progress and brainstorm ideas to improve services. During this meeting cases are staffed to insure the team is updated on services provided, changes within families, share new information, whether someone who agreed to services has decided to decline, to preventive duplication of services, and to determine whether a new referral should be generated and to assure timely access to mental health services.

Differential Response funding was slated to be eliminated this next fiscal year due to the need to decrease funds in this area to cover rising costs in foster care and adoption assistance payments. Through coordinated efforts, PIE staff will be able to continue services, although staff has been reduced by one FTE. While DR services may be decreased, they will continue through the AmeriCorps program's *family support aide* and one part-time Community Action *child and family advocate* staff serving in the PIE unit. In addition, the Public Health Nurse will work with the ER staff on new referrals involving children ages 0-5 that can be deferred to the community for services. The nurse will visit families with the investigating social worker, complete the Ages and Stages assessment, attend SOP and TDM meetings, consult on medical issues, provide health information and refer children and new mothers to appropriate services.

Continued evaluation is part of the ongoing quarterly CQI process. Aggregate data for the AAPI assessments has not been compiled as there is no post test comparison being completed by PIE staff. This strategy will be removed due to the lack of comparison data and the data likely not being helpful at the aggregate level.

A new strategy is being added this year to reduce maltreatment and support the loss of some differential response services by expanding Voluntary Family Maintenance (VFM) services to include a more intensive program for those higher risk referrals that would have been referred to the PIE Unit for DR services. These will include families in the high to moderate range who are willing to accept help. Formal supervision cases will begin services within 30 days after receiving SOP case planning meetings and identifying a harm and danger statement. They will receive weekly social worker contact and be given specific tasks to complete each week. Every two weeks, social workers will meet with the ER supervisor to determine whether to continue with intensive services, step services down to information supervision or promote the case to court ordered services. Policy and procedures will be written for the formal supervision activities.

Strategy 2: Implement Safety Organized Practice (SOP) in Glenn County CWS

In November 2012, Glenn County completed a UCD readiness and needs assessment for implementation of Safety Organized Practice (SOP). Glenn County adopted an approach of implementation that pairs classroom training with a mentoring program that uses a *practice liaison* performing on-site coaching and in-the-field practice opportunities. This practice, combined with Structured Decision Making (SDM) assessments, assists with the integration of safety and risk assessment with effective family engagement tools and processes.

From November 2012 to June 2013, CWS supervisors met monthly with a UCD *Practice Liaison*, Brad Seiser, to develop and refine training needs and practice goals. Both the Emergency Response (ER) and On-Going Units received mini trainings from the liaison. He shadowed social workers in the field to provide coaching with SOP practice components. The liaison demonstrated SOP mappings using Glenn County families and attended some SOP family meetings. He provided feedback about the meetings using an SOP perspective; he modeled the method by asking four questions: What are we worried about? What's working well? What needs to change? What can we do better next time? He met with individuals to discuss their personal goals of using SOP and help the two units develop unit goals. The liaison met with the Program Manager three times during the contract term. He provided consultation on training needs, progress within the units and case reviews. He provided training materials specific to the subject under discussion.

A procedural guide is continuing to be developed as more staff are trained and mentored and processes are refined. Having one of the two SOP trained social workers out on medical leave for a number of months slowed the process down in the ER Unit. Staff is in various processes of utilizing SOP tools and activities with new referrals including table mappings to discern harm and danger in the process of investigations, using the *3 Houses* tool and completion of training in SOP Foundations and Facilitation of SOP meetings. Staffing moves from the ER Unit to the On-Going Unit has led to faster implementation of SOP at the back end of cases. One SOP champion social worker created an SOP binder and some forms that are being used and tested by others. This worker was *trained as the trainer* for SOP meeting facilitation. Other workers had started co-facilitating SOP meetings but this has slowed due to the training social worker's resignation from Glenn

County and the difficulties inherent when social workers attempt to fulfill both the role of assigned caseworker and SOP meeting facilitator.

SOP implementation is an ongoing effort and Glenn will continue to meet monthly with the liaison. Needs analysis and implementation is continuous as part of the SOP processes. The practice liaison model of training and support is helpful to a small county. It is hands-on; it is a necessary support in implementing a new practice. The liaison scheduled individual time with social workers who asked for individual coaching. This allowed the meeting time for the individual session to fit the social worker's schedule and not the other way around. County Mental Health staff who attended SOP meetings embraced the practice. County Mental Health will send three coordinators to training in the fall for the SOP foundation courses and then to learn the SOP meeting facilitation processes and skills. The Glenn County Collaborative Leadership team implementing Katie A-identified services sees this as a method to engage families needing intensive mental health treatment.

New Strategy 3: Expand Voluntary Family Maintenance to include more intense services.

Voluntary Family Maintenance (VFM) services will be expanded to include a more intensive program for those referrals that would have been routed to the PIE Program for differential services. These will include families in the high to moderate risk range but who are willing to accept help. Formal supervision cases will begin services within 30 days after receiving SOP case planning meetings and identifying a harm and danger statement. They will receive weekly social worker contact and be given specific tasks to complete each week. Every two weeks, social workers will meet with the ER supervisor to determine whether to continue with intensive services, step services down to information supervision or promote the case to court ordered services. Policy and procedures will be written for the formal supervision activities.

Timely Social Worker Visits with Child Strategy Update

Strategy 1: Maintain face-to-face contact with child at least once each month.

The measurement for this outcome has changed from 2C to a new report methodology 2F-Timely monthly caseworker visits (out of home). The report analysis follows the federal methodology to measure the compliance rate for case worker visits with children.

The rate is equal to the percentage of children requiring a caseworker contact who received the contact in a timely manner. The monthly reporting period is based on a client (not case) level.

Written policy, procedures and expectations were completed and provided to all social workers regarding monthly social worker contact. SafeMeasures® reports were used monthly to monitor contact compliance with social workers. Workload, social worker/supervisor schedules, training new workers and new initiatives were barriers to consistent staffing with individual social workers. Clear and specific visit expectations are written into case plans. Organizing visitation schedules was not found to be a problem as Glenn County has a high compliance with monthly contacts, and in fact, contacts typically occur more frequently than monthly with many families. The issue is getting the information entered timely into the CWS system as there is a two- to three-month lag in completing contact entries. Social workers are evaluated annually on timely contact entry and specific goals are set for improvement in this area for individual social workers.

Having all social worker staff at an MSW level has greatly improved the type of work being done with families. However, getting comprehensive data components entered into CWS/CMS is problematic without a mobile solution. When social workers return to the office after visits, they are often required to attend to family crises and interventions, placement disruptions and client/child visitation schedule changes. Entering contacts then gets postponed, especially during times of staff changes, increases in new cases, having multiple court reports due and having to cover the intake line for staff who are sick or needing personal time-off. Ever more stringent mandates requiring additional data entry for social workers impacts the social worker's time. This means that many of the contact entries are completed in overtime status. Glenn County will continue to monitor and assist with improving the data entry process to be timely.

Reentry Following Reunification Strategy Update

Strategy 1: Implement back-end Safety Organized Practice (SOP) in the On-going Unit

Safety Organized Practice training and coaching was implemented with the on-going unit through development of a training strategy for staff. The unit continues to proceed with this new practice in an organized fashion to assist social workers in attaining competence and confidence in action, self-reflection, self correction and use of new SOP skills and

strategies. Glenn County has completed the early phase with the on-going unit in building rapport, developing needs assessments and initial goal setting, reflection and supportive feedback both at the group and individual levels. Four of the six workers in the on-going unit have completed these early phases of training and coaching with the UCD Practice Liaison assigned to the County. This includes trainings and coaching in *safety mapping*, *family meeting facilitation* and developing *harm and danger statements*. Two new workers will start the process and begin the initial phases during the next year. The next phase consist of similar steps that continue building rapport, goal setting, debriefing and feedback with the practice liaison.

Development of a procedural guide and/or best practice tool is in the process of being refined as completion of the various phases and staff turnover set the pace for implementation. The unit has just started utilizing SDM assessments with safety mapping, meeting the objective of implementation in September 2013. This has not yet been established as a routine practice at three months after the detention of children ages 3 and younger. This action step is being revised to focus on ensuring all cases with children 0-5 years of age have a safety mapping to utilize with the SDM Family Strength and Needs Assessment prior to Disposition. This effort, conducted at critical points in a case, will help to determine the potential time to reunification, progress in services, protective capacity and available support system.

Review of the cases that reentered care indicated that various SDM assessments were not completed consistently throughout the life of the cases and prior to reunification. This may be due to staff focusing on SOP activities, with a concurrent decrease in using the SDM assessment as a decision tool. This appeared to be true for both the early referral part of the cases and then again during the phases of reunification, family maintenance and case closure. New workers who are not as familiar with SDM tools and their use have been confused about SOP being a decision making tool, which it is not. A new activity for this strategy will be to review regular SDM compliance activities and ensure that decisions are being made utilizing SDM assessments in the context of an SOP practice. The Quality Assurance Team will review SDM compliance quarterly, while the social worker supervisors will review it prior to approval of various decisions in a case.

Strategy 2: Increase parent support network.

The Parent's Anonymous group has been incorporated as a sub-committee of the CICC under the name of *Parent Partners*. The group has been slow to develop due to the need for training for both the family advocate and the parent facilitator. After training occurred, program and recruitment materials were developed, forms were created and a referral process implemented. Meetings began in the spring of 2013 with consistent attendance by a few parents. Peak attendance reached eight parents at one meeting so far. The group is developing a strategy to recruit new parents and have requested that CWS make parent attendance mandatory for a minimum of four sessions for cases new to CWS. The goal for this has been extended and realigned with the development of the program. The group has agreed to participate as stakeholders to provide feedback to the Children's Services and PIE Units.

Strategy 3: Develop an Alternative Family Court intensive treatment services in Glenn County for service provision to targeted families at risk of reentering care.

This was a lofty strategy conceived without the right understanding of the needed support to carry it off. Too many barriers exist to change the judicial system in Glenn County at this time. It is sufficient that the Blue Ribbon Commission continues to meet and develop goals in line with the identified outcome goals of the SIP and to work on collaborative relationships. The dependency court experience in Glenn County is very amicable among all parties; social workers efforts are appreciated, parents are treated respectfully and children and older youth are engaged in the process. Glenn County dependency court is often referred to as one of the best courts to work in by the public defenders. As a small community the workload is heavy with two judges to serve the entire county. The funding is insufficient and the culture impervious to change. There is support from the local court for change but it cannot occur without the resources to sustain it. While the action steps for most of this strategy were not accomplished, the county did begin the process to develop a matrix to assess new cases for families most at risk of reentry.

Demographics were collected on children who reentered care over the last year. In addition, case data was compiled on all children who reentered care over the last five years. This data is currently being assessed for consistency and timeliness of the use of SDM tools, time between foster care episodes, reasons for entry and reentry including parent or child's mental health and drug/alcohol issues. In October of 2012, Glenn began

identifying all referrals where Alcohol and Other Drug (AOD) issues were present at the time of the referral investigation and also in families referred through the Glenn Tehama Interagency Narcotics Task Force. Business Objects reports were developed to assist in the assessment and are being used to identify these referrals and cross-check with families whose children reentered foster care. Glenn is hoping to complete this assessment by the end of year. New strategies have been added toward this effort.

Exit Outcomes for Youth Aging-Out of Foster Care Strategy Update

Strategy 1: Improve utilization of resources within Probation to provide services to youth transitioning to adulthood.

Casey Life Skills Assessments have been conducted for youth in foster care who are close to aging-out and also for all youth in Juvenile Hall. Probation has had two youth enter foster care this year and both have completed assessments. The assessments continue to be used by the ILP coordinator and probation officer to help develop goals for each youth's Transitional Independent Living Plan (TILP). Staff working with the Foster Youth Services (FYS) Program, operated by the Office of Education, are conducting the assessments under the guidance of the Probation Department. FYS staff are well positioned to interface with youth as they are involved with the California Youth Connection. One of the two staff was herself a former probation foster youth. As such, she was able to connect with youth at their level and as someone who has *walked in their shoes*.

Cross-training of Probation, CWS and ILP staff has not yet occurred because of staffing issues discussed earlier in this narrative. The timeframe for this action step has been moved forward to begin January 2014.

The development of the procedural manual to help guide Probation Officers as they deal with youth is scheduled to begin November 2014 and is still on-track with that timeframe.

Strategy 2: Develop at least one Lifelong Connection for every child before they leave foster care.

After a youth is 16 years old or older, the ILP coordinator will conduct an *Emancipation Meeting* for youth with a foster care plan of Planned Permanent Living Arrangement. The process of this meeting requires the youth to identify and invite to the meeting at least one lifelong connection. The meeting facilitates a development of a TILP and transition to independent living or extended foster care.

BARRIERS TO IMPLEMENTATION

2011 realignment shifted the cost sharing of CWS activities between State General funds and county allocations to a *pooled* fund from which all CWS expenses are covered using realignment tax dollars. Rising costs in foster care due to an increase in foster care rates, the number of group home placements and adoption assistance cases, have a negative impact on county funds as they eat into funds used for non-mandated prevention efforts. In the last twelve months, foster care costs and adoption assistance payments have increased by 55.4% while caseloads have increased by only 9.1% (please see Attachment 1, Changes in Caseload and County Share of Cost), resulting in the need to reduce the DR program funding and develop alternative means of providing differential response services.

Staff shifts and changes continue to impact implementation of new activities. Making decisions without information about client's mental health has been a huge barrier to making good decisions. It is not enough to know that the client attended counseling or groups. Making decisions about reunification without fundamental information about a client's mental and emotional functioning is not helpful. The merging of Human Resource Agency with Health Services Agency and creating processes where staff members from both departments are working toward similar goals should significantly improve the social workers ability to make the best decisions with the family.

Glenn County is identified as a Wraparound county utilizing a public partnership model but has failed to implement the Wraparound Program. Glenn County has a Wraparound Plan approved by the Department of Social Services but has not been able to complete an MOU between social services and mental health. There are many reasons for this despite the will of the leaders to recognize the need for this type of intervention. Key leadership at the director, deputy director and program manager levels of both departments retired prior to implementation. The learning curve for new leadership, a low group home rate and other program mandates decreased the impetus of implementing Wraparound services. Consequently, group home rates have significantly increased over the last two years making initiation of the program compelling. While the will to implement is strong, the Katie A settlement mandate is taking precedent over implementation of this program. Glenn County is planning on returning to a solution to this once Katie A services are established.

OTHER SUCCESSES/PROMISING PRACTICES

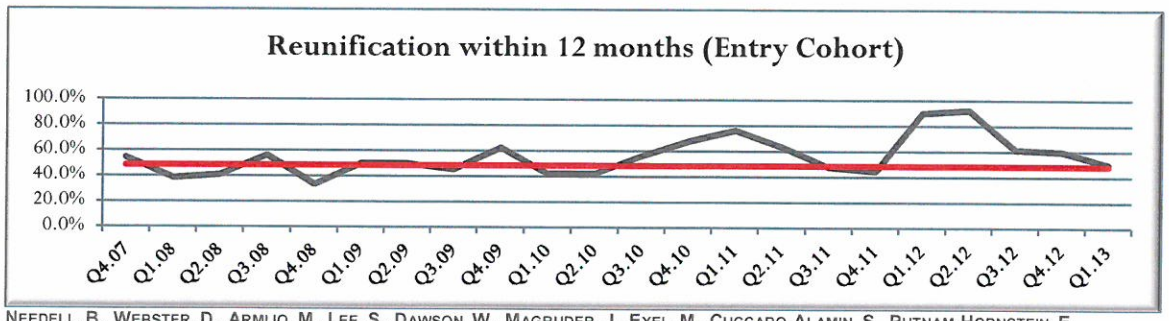
Glenn County continues to move forward with Safety Organized Practice which takes time to implement and is rolled out in phases. Glenn County Mental Health is also implementing pieces of the SOP practice in collaboration with CWS and as a strategy to engage Katie A identified families in intensive in-home mental health services. Management from both agencies are involved in assessment, development, implementation and training of these services. Regularly scheduled planning meetings are ongoing. A needs assessment and implementation plan has been accepted by the state oversight team. Glenn County applied for and received acceptance to be early implementers for this initiative in a Learning Collaborative process that involves regional convening with other small counties. County management staff attended a training and web conference, and will attend a Learning Collaborative kick-off meeting in October in Sacramento. Glenn County has identified the subclass cases to receive the more intense services in collaboration with CWS staff and Mental Health staff. CWS staff will be trained in early October. The first quarterly report is due in mid-October.

Glenn County's Program Manager is involved in the Continuous Quality Improvement (CQI) Advisory Group which includes CDSS-Outcomes & Accountability, UC Davis, University of Chicago, UC Berkeley and county partners to provide guidance around CQI training and support services. The goals are to develop agency cultures that value the CQI processes, teach counties how to develop and test CQI improvement hypothesis and demonstrate the ability to improve the foundational administrative structures necessary to implement and sustain a quality CQI process. The skills to use data to change systems and improve outcomes for children and families are greatly needed by counties to maintain a system of continuous quality improvement which supports the County's SIP.

The Katie A mandates and the establishment of a Health and Human Services Agency holds great promise in improving outcomes for both recurrence of maltreatment and reentry to foster care. These collaborative efforts promote effective teams for serving families with children with high mental health needs in their home. Having the mental health staff join in the SOP activities should improve safety, permanency and well being by serving more families in their homes and providing more intense services.

OUTCOME MEASURES NOT MEETING STATE/NATIONAL STANDARDS

C1.3 – Reunification Within 12 Months (Entry Cohort)



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., MASON, F., LOU, C., PENG, C., KING, B., & LAWSON, J. (2013). *CCWIP REPORTS*. RETRIEVED 9/25/2013, FROM UNIVERSITY OF CALIFORNIA AT BERKELEY CALIFORNIA CHILD WELFARE INDICATORS PROJECT WEBSITE. URL: <HTTP://CSSR.BERKELEY.EDU/UCB_CHILDWELFARE>

Glenn County performs relatively well in this measure, meeting or exceeding the national standard most of the time in the past five data periods. Glenn fell below the national standard in 8 of 22 quarters over the last five years. Since calendar year 2010, Glenn has been consistent in exceeding the national standard, falling below 48.4% from September through December 2010 (or two quarters). However, Glenn did not meet the national standard in these two quarters by only 1.2 percentage points in September and by 4 percentage points in December. When equating these differentials to actual cases, it appears that one additional child reunifying would have exceeded the national standard in both instances. Again, small sample sizes mean that a single child can make the difference between Glenn's ability to meet the national standard or not. Of greater concern is more recent data from SafeMeasures®, which indicates 31.8% of children were reunified for the six-month period January through June 2012, or 16.6 percentage points below the national goal (Children's Research Center SafeMeasures® Data. Glenn, CFSR Measure C1.3: Reunification within 12 Months. 1/1/12 to 6/30/12. Retrieved September 25, 2013 from Children's Research Center Website. URL: https://www.safemeasures.org/ca).

Strategies that assist with improved Reentry to Foster Care outcomes also assist with timely reunification. In addition, to affect timely reunification Glenn County will use two activities to improve this measure. Implementation of Ice Breaker meetings between the parent and the foster parent is a promising practice developed in the Casey Family-to-Family model. Glenn County has wanted to implement this activity in the past but due to other activities it was never implemented. Glenn County has participated in the Quality Parenting Initiative (QPI),

developing principals and goals to be more supportive of this kind of activity. Another activity will be to develop the Nurturing Parenting in-home supportive coaching for cases in need of more intensive services. This will be treatment level coaching from the team serving the family.

STATE AND FEDERALLY MANDATED CHILD WELFARE/PROBATION INITIATIVES

Glenn has not participated in any of the state and federally mandated Child Welfare-Probation Placement initiatives like Title IV-E Waiver Capped Allocation Project (CAP). Our county reviews such initiatives and conducts a cost-benefit analysis to determine the feasibility and gain in their undertaking. In general, the county has found that limited funding resources and the intensive mandates of the programs do not make it feasible for our county to participate in such efforts.

S 1.1 - NO RECURRENCE OF MALTREATMENT

Strategy 1: *Increase family engagement in Differential Response Services*	☐ ***CAPIT*** ☐ ***CBCAP*** ☐ ***PSSF*** ☒ ***N/A***	***Applicable Outcome Measure(s) and/or Systemic Factor(s):*** ***S1.1 No Recurrence of Maltreatment***
Action Steps:	***Timeframe:***	***Person Responsible:***
A. ~~Develop~~ Update PIE brochure for DR Program	*~~November 2012 – January 2013~~* *January 2014*	*CICC Coordinator*
B. ~~Provide~~ Update written information to families describing ~~DR~~ PIE services in English and Spanish.	*~~Jan 2012 – November 2017~~* *January 2014*	*~~CWS Staff, PIE staff~~* *CICC Coordinator* *CWS Program Manager*
C. ~~Train DR staff in family meeting facilitation.~~	*~~November 2012 – November 2013~~* *Completed*	*~~CICC Coordinator~~*
D. ~~Develop policy and procedures for family team meeting facilitation with DR services.~~	*~~November 2012 – November 2013~~* *Completed*	*~~CICC Coordinator~~* *~~CWS Program Manager~~* *~~CWS Supervisors~~*
E. Implement Family Team Meetings in DR Program for families at risk of foster care placement.	*~~November 2013 – March 2014~~* *Continuous*	*PIE Staff* *CWS Staff*
F. PIE staff to complete Nurturing Parent Pre-test on all DR cases.	*~~November 2012 – October 2017~~* *Continuous*	*CICC Coordinator, PIE staff*
G. Evaluate recurrence of maltreatment outcome.	*Quarterly* *December 2012 – December 2017*	*Quality Assurance Team*

~~*H. Evaluate aggregate data using Nurturing Parent Pre- and Post-test changes.*~~	~~*Annually*~~ ~~*November 2013 – November 2017*~~	~~*Quality Assurance Team*~~

Strategy 1a: *Involve Community Partners to identify families at risk of abuse and provide services.*	☐ ***CAPIT*** ☐ ***CBCAP*** ☐ ***CBCAP*** ☒ ***N/A***	***Applicable Outcome Measure(s) and/or Systemic Factor(s):*** ***S1.1 No Recurrence of Maltreatment***

Action Steps:	***Timeframe:***	***Person Responsible:***
A. Use County MDT meetings to problem solve and refer families for services.	*One in each community monthly through 2013-2014*	*CICC Coordinator* *CWS Supervisor*
B. Use collaborative leadership team of staff from CWS, PIE and Mental Health to review referrals, provide status of services updates.	*Every two weeks.*	*CWS Supervisors* *CICC Coordinator*
C. The Public Health Nurse will work the ER staff on new referrals involving children 0-5 that can be deferred to the community for services. The nurse will visit families with the investigating social worker, complete Ages and Stages assessment, attend SOP meetings, consult on medical issues, provide health information and refer children and new mothers to appropriate services.	*October 2013 – September 2017*	*CWS Program Manger* *CWS ER Supervisor*

Strategy 2: *Implement Safety Organized Practice (SOP) in Glenn County CWS*	☐ ***CAPIT*** ☐ ***CBCAP*** ☐ ***PSSF*** ☒ ***N/A***	***Applicable Outcome Measure(s) and/or Systemic Factor(s):*** ***S1.1 No Recurrence of Maltreatment***
Action Steps:	***Timeframe:***	***Person Responsible:***
A. ~~Complete~~ Continue development of ~~UC Davis~~ needs analysis and implementation ~~preparedness~~ for SOP.	*~~November 2012 – May 2013~~* *November 2013 – October 2014*	*CWS Program Manager, ER Supervisor, Ongoing Supervisor*
B. Continue to meet with assigned UC Davis Practice Liaison to discuss training strategy for new CWS staff and ~~begin~~ continue staff trainings in safety mapping, ~~word and picture processes~~3 Houses and Harm and Danger Statements.	*~~May 2013 – May 2014~~* *November 2013 – October 2014*	*CWS Program Manager* *CWS Supervisors* *UC Davis Practice Liaison*
C. Continue to develop procedural guide and/or best practice tool for using SOP for various activities and stages of a referral and case.	*~~June 2013 – August 2013~~* *November 2013 –October 2014*	*CWS Program Manager* *ER Supervisor* *Ongoing Supervisor*
D. Continue implementation of ~~Implement~~ SOP in the ER Unit by training new staff and refining current practice, plans and goals. CWS staff will utilize TDM/Safety Mapping meetings, 3 Houses, and Harm and Danger Statements in the intake and referral investigation process.	*September 2013 – November 2014*	*Program Manager, ER Supervisor, UC Davis Practice Liaison*

E. *Review regular SDM compliance activities and ensure that decisions are being made utilizing SDM assessments in the context of an SOP practice.*	*October 2013 – October 2017*	*CWS ER Unit Supervisor* *CWS Program Manager*
F. *Evaluate strategy by assessing Recurrence of Maltreatment outcome and SDM compliance in an SOP Context*	*~~Annually~~ Quarterly* *November 2014 – November 2017*	*Quality Assurance Team*

NEW FOR 2013-2014

Strategy 3: *Expand Voluntary Family Maintenance to include more intense services*	☐ ***CAPIT*** ☐ ***CBCAP*** ☐ ***PSSF*** ☒ ***N/A***	***Applicable Outcome Measure(s) and/or Systemic Factor(s):*** ***S1.1 No Recurrence of Maltreatment***
Action Steps:	***Timeframe:***	***Person Responsible:***
D. *Moderate to high risk families will be offered VFM formal supervision services. Requires the parents to be in services within 30 days, have weekly contact with the social worker and specific weekly service tasks.*	*November 2013 – October 2014*	*ER Supervisor*
B. *Families indentified as formal supervision VFM cases will have a harm and danger statement identified and participate in SOP case planning meetings.*	*November 2013 – October 2014*	*CWS ER Supervisor* *UC Davis Practice Liaison*

E. Social workers will staff cases with their supervisor biweekly to assess stepping down to informal supervision of opening a court case.	*November 2013 – October 2014*	*CWS Supervisor*
F. Policy and Procedures for formal supervision services will be written to guide the process.	*November 2013 – October 2014*	*CWS ER Supervisor*

2F – TIMELY SOCIAL WORKER VISITS WITH CHILD

Strategy 3: *Maintain face-to-face contact with child at least once each month*	☐ ***CAPIT*** ☐ ***CBCAP*** ☐ ***PSSF*** ☒ ***N/A***	***Applicable Outcome Measure(s) and/or Systemic Factor(s):*** ***~~2C~~ 2F – Timely Social Worker Visits with Child***
Action Steps:	***Timeframe:***	***Person Responsible:***
A. ~~Develop~~ Train new workers on policy and procedure and expectations for monthly face-to-face visit ~~expectations~~ for social workers.	*~~December 2013 – January 2013~~* *Ongoing – October 2017*	*CWS Manger* *CWS Supervisors*
B. Continue to monitor month-to-month social worker compliance with visits using SafeMeasures® monthly reports during monthly individual case staffing with social workers.	*January 2013 – ~~November~~ October 2017*	*CWS Manager* *CWS Supervisors*
C. Continue to write clear, specific visitation expectations in case plan and verbalize to caregiver and parent.	*January 2013 – ~~November~~ October 2017*	*CWS Supervisors* *CWS Social Workers*
~~D. Provide individual or group training on organizing visit schedule.~~	*~~January 2013 – November 2017~~*	*~~CWS Supervisors~~*
E. Include compliance with month-to-month contacts in social workers' annual evaluation and develop written goals to improve practice.	*January 2013 – ~~November~~ October 2017*	*CWS Supervisors*
F. Evaluate timely Social Worker Visits with Child outcome data.	*Quarterly January 2013 – ~~November~~ October 2017*	*Quality Assurance Team*

C1.4 - REENTRY FOLLOWING REUNIFICATION

Strategy 4: *Implement back-end Safety Organized Practice (SOP) in the Ongoing Unit*	☐ ***CAPIT*** ☐ ***CBCAP*** ☐ ***PSSF*** ☒ ***N/A***	***Applicable Outcome Measure(s) and/or Systemic Factor(s):*** ***C1.4 Reentry Following Reunification***
Action Steps:	***Timeframe:***	***Person Responsible:***
A. Continue to meet with assigned UC Davis Practice Liaison to discuss training strategy for new CWS ongoing staff and ~~begin~~ continue staff trainings in Safety Mapping, Family Meeting Facilitation, 3 Houses tool utilization ~~work and picture processes~~, and Harm and Danger Statements.	*May 2013 – ~~May~~ October 2014*	*CWS Program Manager* *CWS Ongoing Supervisor* *UC Davis Practice Liaison*
B. Develop procedural guide and/or best practice tool for using SOP at various points in time for FR cases.	*June 2013 – ~~August 2013~~ October 2014*	*CWS Program Manager* *CWS Ongoing Supervisor*
C. Implement SOP in ongoing unit.	*September 2013*	*CWS Program Manager* *CWS Ongoing Supervisor*

G. Utilize SDM's family strengths and needs assessments with safety mapping for children ~~three~~ five and younger. Safety mapping meeting will occur ~~three months from detention to disposition to determine potential time to reunification~~ prior to Disposition, 6 month review, 12 month review and 18 month review to determine if services will be sufficient to reunify family, to determine the family's progress in services and to identify the family's support system and protection capacity.	*September 2013 – November 2014*	*CWS Ongoing Unit Supervisor* *UC Davis Practice Liaison* *TDM/Safety Mapping Facilitator*
H. Review regular SDM compliance activities and ensure that decisions are being made utilizing SDM assessments in the context of an SOP practice.	*October 2013 – October 2017*	*CWS Ongoing Unit Supervisor* *CWS Program Manager*
F Evaluate Reentry following Reunification Outcome data and compliance with SDM assessments.	*November 2013 – November 2017 (quarterly)*	*Quality Assurance Team*

Strategy 5: *Increase parent support network*	☐ ***CAPIT*** ☐ ***CBCAP*** ☐ ***PSSF*** ☒ ***N/A***	***Applicable Outcome Measure(s) and/or Systemic Factor(s): C1.4 Reentry Following Reunification***
Action Steps:	***Timeframe:***	***Person Responsible:***
A. Develop a referral process to the Parents Anonymous meeting.	*~~June 2013~~* *December 2013 – August 2014*	*CWS Program Manager* *CWS Supervisors* *Parent Partners*
B. Mandate families to attend four Parents Anonymous Inc. meetings when a new case is opened.	*~~July 2013~~* *March 2014*	*CWS Supervisors* *CWS Social Workers*
C. Conduct parent satisfaction survey with parents prior to each case plan update.	*March 2014 – October 2015*	*Quality Assurance Team*
D. Meet ~~quarterly~~ every six months with Parent Partners to evaluate mandated parent attendance and parent satisfaction.	*~~October 2013~~* *March 2014 – October 2017*	*CWS Program Manager* *CWS Supervisors* *Parent Partners*

Strategy 6: *~~Develop an Alternative Family Court~~ Provide more-intensive and coordinated treatment services in Glenn County ~~for service provision~~ to targeted families at risk of reentering care.*	☐ ***CAPIT*** ☐ ***CBCAP*** ☐ ***PSSF*** ☒ ***N/A***	***Applicable Outcome Measure(s) and/or Systemic Factor(s):*** ***C1.4 Reentry Following Reunification***
Action Steps:	***Timeframe:***	***Person Responsible:***
A. Begin collaboration ~~through the BRC~~ with mental health service providers to identify and develop a model for ~~Alternate Family Court for Glenn County~~ intensive services for identified cases.	~~*January 2013*~~ October 2013 – *December 2014*	~~*Blue Ribbon Commission*~~ *Collaborative Leadership Team* *CWS Program Manager* *CWS Supervisors* *CHAT Child Advocate* *Mental Health staff*
B. Determine implementation timeline for intensive mental health treatment for children/youth in foster care.	~~*June 2013 – August 2013*~~ *October 2013 –January 2014*	~~*Alternative Family Court subcommittee of the BRC.*~~ *Collaborative Leadership Team*
C. Develop policy and procedure for intensive services model of mental health and in-home services.	~~*June 2013 – August 2014*~~ *January 2014 – December 2014*	~~*Alternative Family Court subcommittee of the BRC.*~~ *Collaborative Leadership Team*
D. Identify relevant training strategies for ~~all indentified staff and court personnel~~ collaboration on intensive service provision utilizing a team-based approach.	~~June 2013 – August 2013~~ October 2013 – July 2014	~~*Alternative Family Court subcommittee of the BRC.*~~ *Collaborative Leadership Team*
E. Develop a matrix to identify families most at risk to reenter foster care.	~~*June 2013 –*~~ *August 2013 – December 2013*	~~*Alternative Family Court subcommittee of the BRC.*~~ *Collaborative Leadership Team*

F. Implement ~~Alternative Family Court~~ intensive service collaborative model.	*September 2013 – September 2017*	*CWS Program Manager* *CWS Supervisor* *~~Glenn County Juvenile Court~~*
G. Evaluate results by assessing Reentry Following Reunification Outcome	*September 2013 – September 2017*	*Quality Assurance Team*

C1.3 – REUNIFICATION WITHIN 12 MONTHS (ENTRY COHORT)

Strategy 7: *Improve the quality of the parent-child relationship prior to reunification.*	☐ ***CAPIT*** ☐ ***CBCAP*** ☐ ***PSSF*** ☒ ***N/A***	***Applicable Outcome Measure(s) and/or Systemic Factor(s):*** ***C1.3 Reunification within 12 Months (Entry Cohort)***
Action Steps:	***Timeframe:***	***Person Responsible:***
A. Implement Ice Breaker sessions between the foster parent and the parent prior to Disposition.	*January 2014 – October 2017*	*CWS Program Manager* *CWS Supervisors* *CHAT Child & Family Advocate*
B. Provide in-home Nurturing Parent Coaching.	*July 2014 – October 2014*	*Mental Health Staff* *CWS Social Workers*

8A – EXIT OUTCOMES FOR YOUTH AGING OUT OF FOSTER CARE

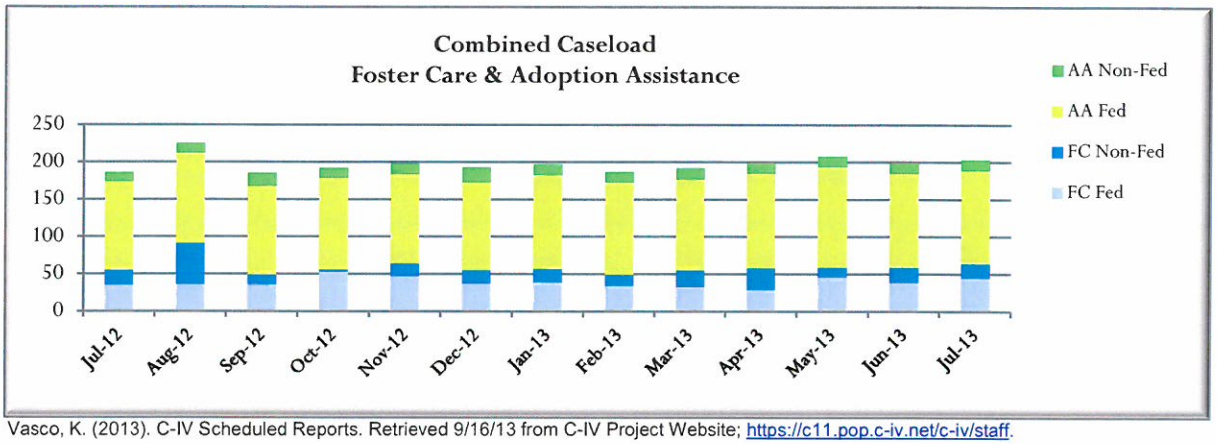
Strategy ~~7~~ 1: *Improve utilization of resources within Probation to provide services to youth transitioning to adulthood*	☐ ***CAPIT*** ☐ ***CBCAP*** ☐ ***PSSF*** ☒ ***N/A***	***Applicable Outcome Measure(s) and/or Systemic Factor(s):*** ***8a – Exit outcomes for youth aging out of foster care***
Action Steps:	***Timeframe:***	***Person Responsible:***
A. Coordinate with ~~Glenn County ILP~~ Foster Youth Services to ensure that all probation minors receive the Casey Life Skills Assessment.	*~~November 2012 – November 2013~~* *November 2013 – October 2017*	*Deputy Probation Officer III*
B. Utilize Life Skills Assessment to develop (with youth) TILP goals and objectives.	*January ~~2013~~ 2014 – November 2017*	*Deputy Probation Officer III*
C. Coordinate with HRA/Social Services to provide cross-training for Probation Officers, ILP and CWS staff on best practice for emancipation aged youth.	*~~May 2013 – May 2015~~* *January 2014 – October 2017*	*CWS Program Manager* *Deputy Chief Probation Officer* *Deputy Probation Officer III*
D. Develop procedural manual for Probation Officers to build knowledge base.	*November 2014 – November 2015*	*Deputy Probation Officer III*
E. Assess youth well being outcome data.	*Quarterly* *November 2012 – November 2017*	*Quality Assurance Team*

Strategy ~~8~~ 2: *Develop at least one Lifelong Connection for every child before they leave foster care.*	☐ ***CAPIT*** ☐ ***CBCAP*** ☐ ***PSSF*** ☒ ***N/A***	***Applicable Outcome Measure(s) and/or Systemic Factor(s):*** ***8a – Exit outcomes for youth aging out of foster care***
Action Steps:	***Timeframe:***	***Person Responsible:***
A. Incorporate the concept of life-long connections into the Probation Procedural Manual.	*November 2014 – November 2015*	*Deputy Probation Officer III*
B. Hold permanency meetings every six months for youth in long-term care and invite individuals the youth identifies as their life-long connection to participate.	*~~November 2012 – November 2013~~* *November 2013 – October 2014*	*Deputy ~~Chief~~ Probation Officer III* *ILP Coordinator*
C. Include visitation schedule in case plan for identified life-long connections.	*~~November 2012 – November 2013~~* *November 2013 – October 2014*	*Deputy ~~Chief~~ Probation Officer III*
D. Assess number of life-long connections for each youth.	*Quarterly* *~~November 2012 – November 2017~~* *January 2014 – October 2017*	*Quality Assurance Team*

Attachment 1

Changes in Caseload and County Share-of-Cost

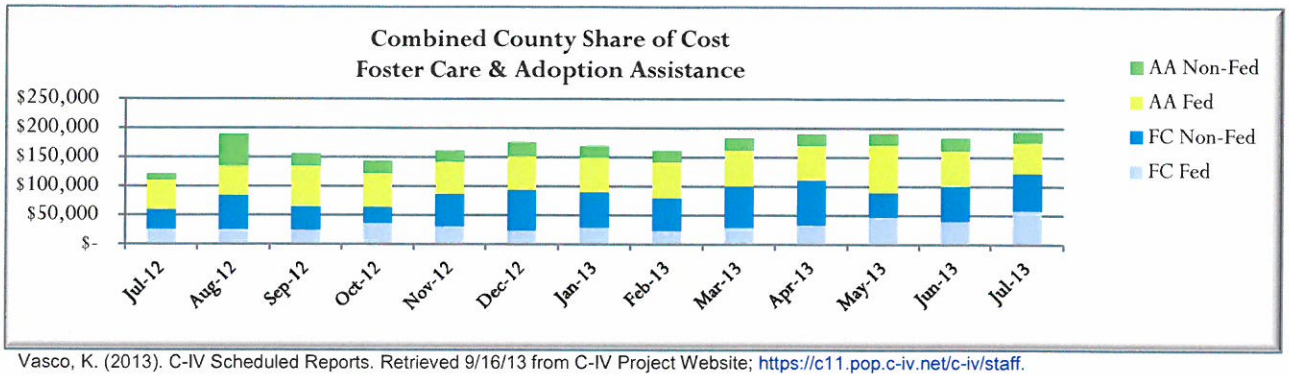
The charts below illustrate changes in the number of federal and non-federal foster care and adoption assistance cases from July 2012 through July 2013, as well as changes in the costs associated with those cases. The chart titled *Combined Caseload* shows the aggregate number of federal and non-federal foster care cases and federal and non-federal adoption assistance cases each month. While caseloads vary slightly each month, the overall trend is relatively flat. A point-in-time comparison between July 2012 and July 2013 reveals a 9.1% increase in the combined number of cases.



Vasco, K. (2013). C-IV Scheduled Reports. Retrieved 9/16/13 from C-IV Project Website; https://c11.pop.c-iv.net/c-iv/staff.

The relatively flat trend in caseloads is sharply contrasted with the trend of consistently rising costs in service delivery for these same cases. Realignment of 2011 effectively eliminated the State share of cost by establishing a funding pool from which all costs must be covered. The chart titled *Combined County Share of Cost* plots the aggregate cost to the county each month of federal and non-federal foster care and adoption assistance cases. The figures are calculated by adding costs that were once covered by the state general fund (formerly known as the "state share") to costs that have always been the responsibility of the county to arrive at a combined county share of cost. Here, the point-in-time comparison between July 2012 and July 2013 shows a staggering 55.4% increase in costs, largely owing to an increase in the number of group home placements. This is concerning for Glenn County, especially when coupled with the realization that this increase equates to a less than 10% increase in caseload, and speaks to the fact that

counties have a very limited ability to control such cost increases if they are to provide a standard of care appropriate to the needs of the child.



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