

Shasta County System Improvement Plan – 2007/2009
Children and Family Services / Probation Department

System Improvement Plan
October 1, 2007 – September 30, 2009

Executive Summary

As part of the California Child and Family Services Review (C-CFSR), the California Department of Social Services requires every county's Children and Family Services (CFS) and Probation Department to produce a System Improvement Plan (SIP). The purpose of the SIP is to identify specific services – with timelines and measurable benchmarks – to help improve the safety, permanency, and well-being of CFS dependent children and probation wards that are in county care because of abuse or neglect or may be at risk of coming into county care.

During the first three years of the C-CFSR (FY04/05 – FY06/07), the SIP was produced annually and reported on the county's performance measures for the various Outcome/Systemic Factors that affected child safety, permanency, and well-being. These measures provided a statistical basis to evaluate programs – such as Differential Response or Family Team Meetings – and determine if the programs were having an affect on the Outcome/Systemic Factors.

Beginning this year, the State's methodology of analyzing performance measures is undergoing a conversion to a more detailed and improved model. Because of this transition period, the State is requiring the County to produce a two-year SIP. This document, therefore, will provide benchmarks and frame our programs through September of 2009.

Shasta County's SIP 2007/2009 is based upon:

- The County Self-Assessment (CSA) – The Board of Supervisors approved the CSA in July 2007. This document was a comprehensive analysis on how the CFS and Probation systems performed in improving the safety, permanency, and well-being of dependent children and wards. The CSA informs and structures the SIP and its updates.
- Peer Quality Case Review (PQCR) – In the fall of 2006, social worker and probation peers from other counties met with Shasta County child welfare and probation staff to evaluate specific cases and practices to determine improvement options. The resulting report also guides this SIP.
- System Improvement Plan Implementation Committee – Beginning in 2004, Shasta County child welfare staff and Probation staff, community stakeholders and nonprofit organizations, met monthly to examine data and practices of ongoing SIP services and to make recommendations on continuous quality improvements.

The C-CFSR deals with three primary measures. The safety measures are designed to reflect the effectiveness of efforts to protect children from abuse or neglect. The permanency measures are designed to reflect the time and proportion of children reunified with parents, the number of foster care placements for children, the length of time a child is in foster care, length of time to adoption, and the rate that children re-enter foster care after they have returned home or other permanent care arrangements have been made. The well-being measures are designed to reflect the degree to which children in foster care retain relationships with the family and extended communities with whom they are associated at the time of their removal from their parents, reflect the placement environment, and represent the transition to independence for transitional age youth.

The SIP 2007/2009 will guide service-delivery in six (6) specific areas to work toward improvements in the safety, permanency and well-being of children in Shasta County:

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1. Differential Response (Safety): Expands the response capacity of Children and Family Services (CFS) to reports of child abuse and neglect. CFS has partnered with the Shasta County Child Abuse Prevention Coordinating Council to provide peer Parent Partners for services to families when there is low risk for child removal.
2. Timely 10-Day Response (Safety): Measures the percentage of referrals where face-to-face contact with a child occurs, or is attempted, within the regulatory time frames (where a determination is made that the abuse or neglect allegations indicate possible significant danger to the child).
3. Substance Abuse Counseling (Safety/Permanency): This service has been added to CFS to screen, assess, make referrals, case-manage, and monitor family members that are suspected/confirmed as having alcohol and/or drug involvement in an effort to decrease the recurrence of maltreatment of children.
4. Family Team Meetings (Safety, Permanency): This service involves families currently within, or at risk of becoming involved with, the child welfare or juvenile probation systems. A team decision-making approach is used with families and their support systems as partners to define family strengths, needs and goals. This service also assists families to identify helpful local services and resources. Shasta County Probation will also utilize this service, as appropriate, to improve safety and permanency outcomes for probation wards.
5. High Risk Team (Permanency): This service was developed in response to requests from foster and adoptive parents. A specialized case manager and high-risk team focus on early identification of high-risk children. They work closely with care providers and social workers to access needed services. Shasta County Probation will also utilize this program to improve permanency outcomes for probation wards.
6. The Relative/NREFM (Non-Related Extended Family Member) Liaison (Permanency/Well-being): This program was initiated to meet the identified need of Relative/NREFM caregivers in accessing information and in navigating the child welfare system. Shasta County Probation will also utilize this program to improve permanency and well-being outcomes for probation wards.

The **SIP** 2007/2009 report includes the following for each of the service-areas:

1. Outcome/System Factors. These are specific outcome areas where services and programs can have a measurable impact: No Recurrence of Maltreatment, Timely Response, Reentry Following Reunification, Multiple Foster Care Placements, and Multiple Care Placements in Least Restrictive Settings
2. The County's Current Performance for the Outcome/System Factors
3. Improvement Goals
4. Strategies and Strategy Rationales
5. Milestones, Timeframes and Assigned Staff/Agencies

The **SIP** 2007/2009 will guide service delivery, including contracted services, to ensure improvements in the safety, permanency and well-being of children in Shasta County. Children and Family Services and Probation are committed to a continuous focus on improving the lives of the community's children and families through this review process.

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I. SIP Narrative

1. Identify Local Planning Bodies

The Shasta County Children and Family Services (CFS) – part of the Health and Human Services Agency, Social Services Branch – and the Probation Department have been fortunate to have a large network of partners from government, nonprofit and community-based organizations, foster parents, concerned citizens, and other stakeholders to collaborate with in crafting community-inspired responses to child-welfare issues of safety, permanency and well-being. **Highlighted** participants were directly involved in this SIP report. All listed participants were included in the County Self-Assessment with the understanding that the SIP would contain the service-specific aspects:

Amber Middleton, CFS - Supervisor
Art Alvarado, Division Director
Betty Madison, County Office of Education
Brad Seiser, CFS – Program Manager
Carla Clark, Shasta Head Start
Christine O’Neill, CFS – Program Analyst
Dena Persell, LMFT, Counselor
Dianne Moty, Family Services Agency
Eddie McAllister, Community Advocate
Fred Castagna, Shasta Lake Parks & Recreation
Gayle Hermann, Probation/Chief Fiscal Officer
Glenda Berger, CFS – Social Worker
Ida Riggins, Redding Rancheria
Janine Swain, California Youth Connection
Jane Work, HHSA – Branch Director
Jantina Thompson, CFS - Supervisor
John Barry, Public Health
Judy Kruse, Far Northern Regional Center
Kathy Hupal, CFS - Supervisor
Laurie Bell, CFS – Program Analyst
Linda Barba, Eligibility
Linda Lafferty, LMFT/Counselor
Lisa Goza, Independent Living Program
Lori Steele, Mental Health
Margaret Jenson, Acorn Community Center
Martha McCoy-Nagel, NorthValleyCathSoc.Svc
Maxine Wayda, Mental Health/Clinical Div.Chief
Melissa Olson, CFS - Supervisor
Michelle Erickson, Anderson Partnership for
Healthy Children
Mickey Harris Shasta Cnty Foster Parents Assoc.
Muffy Berryhill, First 5 Shasta
Nora Hendrix, CFS - Supervisor
Paul Werner, Shasta FICS
Raelene MacDowell, Foster/Adopt Parent
Ron Abke, CFS – Supervisor
Sherri McLaughlin, Foster/Adopt Parent
Susan Alvarez, Pitt River Tribal Government
Susan Morris-Wilson, Health Improve.Partnrship
Tammy Baker, Parent Leadership Task Force
Tom Taylor, CFS – Program Manager
Traci Baker, Foster/Adopt Parent

Anna Diaz, Child Abuse Prevention Council
Barbara Howell, HHSA-Deputy Director
Betty Futrell, Child Abuse Prevention Council
Brian Richart, Chief Probation Officer
Charlie Menoher, Youth Viol. Preven. Council
Crystal Adams, Youth and Family Programs
Dennis Kessinger, CFS – Program Analyst
Doug Carney, Redding Police Department
Faye Lee, Shasta County CalWORKs
Gary Montgomery, CFS – Social Worker
Gina Collier, Anderson Police Department
Holly Hetzel, Drug Endangered Children
Jacqueline Dunn, CFS - Supervisor
Jane Wilson, CFS – Program Manager
Janet Stortz, CFS - Supervisor
Jeannie Spurr, New Directions to Hope
John Simmons, CFS - Supervisor
Karen Alvord, Lilliput Children’s Services
Kimberley Hawkins, Mercy Medical Center
Leanne Link, HHSA – Branch Director
Linda Dickerson, Shasta Cnty Women’s Refuge
Linda Parks, CalWORKs
Lori Bridgeford, Youth and Family Programs
Lynne Jones, Clinical Division Chief; CFS P.M.
Marta McKenzie, HHSA - Director
Matt Grigsby, CFS – Analyst/Help Desk
Melissa Field, CFS – Analyst/Help Desk
Michael Schweitzer, CFS – Social Worker
Michelle Johnson, HHSA
Vanessa Proctor, Youth and Family Programs
Monique Taylor, FaithWORKS/Francis Court
Nancy Bolen, CFS – Program Manager
Pam Lewis, Anderson Parks and Recreation
Rachelle Neal, Child Abuse Prev. Council
Reid McKellar, Counselor
Sheri Wiggins, Foster/Adopt Parent
Steve Lucarelli, Visions of the Cross
Susan Hacking, Mental Health
Sue Longee, HHSA
Terry McCauley, Public Health
Tom Wright, Counselor
Trish Harmon, True North/Grassroots

2. Share Findings that Support Qualitative Change

The six (6) specific service-delivery program areas discussed in this SIP resulted from an ongoing evaluation of our data outcomes/measures *and* from collaborative discussions with a broad range of stakeholders. Each committee/group routinely discussed quantitative data from computer systems and manual client counts and qualitative practices such as customer service, family assessment, service delivery, case planning and other aspects of improving services to children and families. Examples include:

- **SIP Implementation Committee**: Starting in 2004, a group of child welfare experts has held monthly meetings to analyze – in detail – the outcome/measures identified in the 2004 CSA and subsequent SIP plans. This was both a data intensive view of performance – from both the UC Berkeley and SafeMeasures reports – as well as a qualitative evaluation – based on real-world case experience – of how alterations in programs and procedures could improve in the outcomes/measures.

The monthly participants include social workers, social worker supervisors, program managers, program analysts, a probation officer, a foster/adoptive parent, and nonprofit organizations such as Shasta County Child Abuse Prevention Coordinating Council and Youth and Family Programs.

- **Peer Quality Case Review**: The POCR occurred in the fall of 2006 and involved extensive and deep-level analyses of select cases dealing with, for CFS, ‘reentry into foster care’ for the purpose of a qualitative assessment of social work practices. The Probation Department looked at ‘placement stability’ for its sex-offender population. Expert social worker and probation peers from Butte, Glenn, Orange, Sutter, Fresno, Los Angeles, and Trinity counties as well as local experts met with case-carrying social workers, probation officers, and supervisors to assess best practices. The resulting qualitative report was used to provide guidance for this SIP.
- **County Self-Assessment**: The CSA occurred in the spring and early summer of 2007 and involved a broad base of community stakeholders and child welfare professionals (see above listing). The data collection (quantitative and qualitative) included email surveys, town hall meetings, internal focus groups, and consultation with child welfare practitioners to provide an assessment of progress over the first three years of the C-CFSR and what areas that should be addressed in the upcoming three years. The report provided the report card of practices and helped to frame areas for concentrated efforts. This report was weighted on quantitative analyses and, in conjunction with the POCR to provide comprehensive guidance for this SIP.

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II. SIP Plan Components

System Improvement Plan – Differential Response

Outcome/Systemic Factor:
No Recurrence Of Maltreatment (S1.1)

County's Current Performance:

No Recurrence Of Maltreatment (S1.1)
This safety measure reflects the percentage of children who were victims of a substantiated or indicated child maltreatment allegation within the first 6 months of a specified time period for whom there was no additional substantiated maltreatment allegation during the subsequent 6 months.

Measure number	Measure description	Most recent start date	Most recent end date	Most recent numerator	Most recent denominator	Most recent performance	Direction?	Percent change
S1.1	No Recurrence Of Maltreatment	01/01/06	12/31/06	217	246	88.2	No	-1.7%

Measure number	Measure description	Baseline start date	Baseline end date	Baseline performance	Most recent start date	Most recent end date	Most recent performance	Percent change	Estimated # of children affected
S1.1	No Recurrence Of Maltreatment	07/01/02	06/30/03	89.7	01/01/06	12/31/06	88.2	-1.7%	-4

Improvement Goal 1.0
Reduce the recurrence of abuse/neglect as measured by the number of subsequent substantiated/inconclusive re-referrals occurring within 6 months.

Strategy 1. 1 Engage the community to partner with Children and Family Services to develop alternative responses to end the abuse of children in Shasta County.	Strategy Rationale Primary prevention in the community and early intervention with referred families will result in a reduction of abuse/neglect in the future because minor problems will be addressed before they become major ones.
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Milestone	1.1.1 Efforts to identify new service providers and community based organizations to provide services to our Path 1 and Path 2 families will be ongoing.	Timeframe	1 – 24 months (10/31/07 – 09/30/09)	Assigned to	Shasta County Child Abuse Prevention Coordinating Council, Community Parent Partners, Parents, CFS Intake Supervisor, CFS Social Workers, CFS Program Manager.
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	1.1.2 Develop and implement a media campaign, including a Newsletter, to increase community awareness of the Differential Response program. Convey a better understanding of what the program is about to obtain greater community participation.		1 – 24 months (10/31/07 – 09/30/09) Newsletter 1, 6, 12, & 18 months (10/31/07, 03/31/08, 09/30/08, 03/31/09)		Shasta County Child Abuse Prevention Coordinating Council, Community Parent Partners, CFS Intake Supervisor, CFS Social Workers, CFS Program Manager, HSA Public Relations.
Strategy 1. 2 Path 1 and Path 2 families requesting services will be assessed and referred to relevant community based organizations for resources and services.			Strategy Rationale Early intervention with referred families will result in a reduction of abuse/neglect in the future because minor problems will be addressed before they become major ones. A thorough assessment of family's needs/strengths will lead to more appropriate referrals and services.		
Milestone	1.2.1 The Community Parent Partners will provide an initial assessment then identify and coordinate services for Path 1 and Path 2 families.	Timeframe	1 – 24 months (10/31/07 – 09/30/09)	Assigned to	Shasta County Child Abuse Prevention Coordinating Council, Community Parent Partners, CFS Intake Supervisor, CFS Program Manager.
	1.2.2 All new and existing Community Parent Partners will be trained in case management and assessment.		1 – 24 months (10/31/07 – 09/30/09)		Shasta County Child Abuse Prevention Coordinating Council, CFS Training Coordinator.
Strategy 1. 3 Appropriate Path 1 families referred to Children and Family Services (CFS) will receive a Community Parent Partner response. Moderate-risk Path 2 families referred to Children and Family Services (CFS) will receive a joint CFS and Community Parent Partner response or will receive a Community Parent Partner response once the referral is closed. (Initially identified Path 3 families where the issues are resolved, children are not taken into custody, and no case is opened could be downgraded to moderate risk Path 2 and fall into this strategy as well.)			Strategy Rationale Community partner involvement in Path 1 and moderate-risk Path 2 referrals will increase family willingness to address safety and risk issues.		
Milestone	1.3.1 Guideline and procedures implemented for joint CFS and Community Parent Partner Differential Response.	Timeframe	1 month (10/31/07)	Assigned to	CFS Intake Supervisors, CFS Social Workers, CFS Program Manager, Shasta County Child Abuse Prevention Coordinating Council, Community Parent Partners.
	1.3.2 Automated monthly data reports generated from the SCCAPCC Differential Response services database that identifies all participating CBOs, and the level of engagement, participation and satisfaction of CFS Path 1 and Path 2 clients. New data fields added, as necessary.		1 – 24 months (10/31/07 – 09/30/09)		Shasta County Child Abuse Prevention Coordinating Council.

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	<p>1.3.3 Data reports of 1.3.2, including client satisfaction survey results, reviewed and analyzed on a monthly basis to assess efficiency and effectiveness of Differential Response program processes.</p>		1 – 24 months (10/31/07 – 09/30/09)		Shasta County Child Abuse Prevention Coordinating Council, CFS Intake Supervisors, CFS Social Workers, CFS Program Manager, CFS Analyst.
	<p>1.3.4 Results shared with other Counties and States through the Children’s Welfare Directors Association regional meetings, the Child Abuse Prevention Council regional meetings, and Differential Response technical conferences.</p>		1 – 24 months (10/31/07 – 09/30/09)		CFS Program Manager, CFS Intake Supervisors, CFS Social Workers, Shasta County Child Abuse Prevention Coordinating Council, Community Parent Partners.
<p>Strategy 1.4 Maintain and continue to develop funding sources.</p>			<p>Strategy Rationale Funding and incentives are needed for community-based organizations to provide resources and services to the clients.</p>		
Milestone	<p>1.4.1 Conduct annual educational brainstorming / planning meeting with DSS Administration & Fiscal to explore funding options to sustain the Differential Response program.</p>	Timeframe	3 & 15 months (12/31/07 & 12/31/08)	Assigned to	Shasta County Child Abuse Prevention Coordinating Council, Community Parent Partners, Parents, CFS Intake Supervisors, CFS Program Manager, CFS Social Workers, CFS Analyst, DSS Administration/Fiscal.
	<p>1.4.2 Research to continue on how other counties and states fund services/resources.</p>		1 – 24 months (10/31/07 – 09/30/09)		CFS Program Manager, Shasta County Child Abuse Prevention Coordinating Council.
	<p>1.4.3 Continue to develop and implement plans for obtaining funds for agency and community based organizations.</p>		1 – 24 months (10/31/07 – 09/30/09)		Shasta County Child Abuse Prevention Coordinating Council, CFS Intake Supervisors, CFS Program Manager, CFS Analyst, DSS Administration/Fiscal
<p>Discuss changes in identified systemic factors needed to further support the improvement goals. Implementation of guidelines between agencies and community based organizations that provide procedures for implementation, working relationships, and confidentiality. Implementation of a referral form, release and exchange of information form, and reporting tool for all Differential Response referrals. Funding for caseload levels to permit the assignment of referrals to the three tracks and to reach the SB2030 Optimum Workload levels for delivery of best practice.</p>					

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Describe educational/training needs (including technical assistance) to achieve the improvement goals.

Ongoing training in fairness and equity as well as in the use of the assessment tool and agency expectations to increase consistency in how referrals are assigned to the tracks. Ongoing training of County and community staff on procedures and guidelines for handling differential responses and confidentiality expectations. Training in working collaboratively with community partners for Social Workers. Case management and assessment training for Community Parent Partners.

Identify roles of the other partners in achieving the improvement goals.

Community partners will share the responsibility for follow up and provision of services for families that would otherwise be screened out as not meeting the legal requirements for an investigation and/or services as a result of abuse and neglect. Community partner staff trained on mandated reporting, risk factors, identifying abuse and neglect will help Children and Family Services staff feel confident having referrals responded to by non Children and Family Services staff. Development of Children and Family Services intervention specific resource guide for intake referrals. Continue to make resource lists available for families identifying resources they may need.

Identify any regulatory or statutory changes needed to support the accomplishment of the improvement goals.

A Child Welfare Services/Case Management System (CWS/CMS) tracking system for Differential Response with appropriate funding for the amount of work involved. Continued enhanced and flexible funding to support the early intervention activities to which families are referred. Regulatory/law changes to support the implementation of Differential Response and the sharing of information, training, and resources.

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System Improvement Plan – 10-Day Response

Outcome/Systemic Factor: Timely Response (10-Day Response Compliance)										
County's Current Performance: Timely Response (10-Day Response Compliance) (2B) This measure computes the percentage of cases in which face-to-face contact with a child occurs, or is attempted, within the regulatory time frames in those situations in which a determination is made that the abuse or neglect allegations indicate significant danger to the child (10-day response).										
Measure number	Measure description	Most recent start date	Most recent end date	Most recent numerator	Most recent denominator	Most recent performance	Direction?	Percent change		
2B	Timely Response (10-Day Response Compliance)	Q4 2006	Q4 2006	290	321	90.3	Yes	15.6%		
Measure number	Measure description	Baseline start date	Baseline end date	Baseline performance	Most recent start date	Most recent end date	Most recent performance	Percent change	Estimated # of children affected	
2B	Timely Response (10-Day Response Compliance)	Q2 2003	Q2 2003	78.1	Q4 2006	Q4 2006	90.3	15.6%	39	
Improvement Goal 1.0 Increase the percentage of timely Supervisor assignment and timely Social Worker response to and documentation in CWS/CMS of child abuse/neglect 10-Day referrals. Obtain and maintain stable County performance to at least 90% compliance.										
Strategy 1. 1 Monitor, communicate, and publicize within CFS the agency expectation to consistently meet the 90% compliance level and current level of operation.					Strategy Rationale Intake Supervisors will monitor and communicate on an individual basis with each worker in their units. Intake Supervisors/Social Workers will communicate with Law Enforcement. Documented and posted group performance will raise awareness of performance within the agency. The above will heighten the level of awareness of the requirement to meet agency expectation of timely Social Worker response to and documentation in CWS/CMS of child abuse/neglect 10-Day referrals.					

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Milestone	1.1.1 Maintain the Referral Assignment Log to include the Referral Receipt Date. Reassign referrals that are identified as in danger of noncompliance to other Social Workers.	Timeframe	1 – 24 months (10/31/07 – 09/30/09)	Assigned to	CFS Intake Supervisors.
	1.1.2 When an Intake social worker does not come back into work, Supervisor will open caseload and look for 10-Day referrals needing response on that or the subsequent day. Reassign referrals that are identified as in danger of noncompliance to other Social Workers.		1 – 24 months (10/31/07 – 09/30/09)		CFS Intake Supervisors.
	1.1.3 Continue to educate and train Social Workers on the correct documentation of 10-Day referrals in CWS/CMS.		1 – 24 months (10/31/07 – 09/30/09)		CFS Intake Supervisors.
	1.1.4 Continue to educate Law Enforcement about our regulatory need to respond within 10 days to referrals designated as requiring a 10-Day response.		1 – 24 months (10/31/07 – 09/30/09)		CFS Intake Supervisors, Social Workers.
	1.1.5 Add a third Phone Screener position to develop a Screening Unit to better handle the fluctuating workload, cover vacations and unexpected absences, and eliminate delays in getting the referrals to the assigning Intake Supervisor.		3 months (12/31//07)		CFS Intake Supervisors.
Milestone	1.1.6 Establish and implement a standard of 3 calendar days or less for referrals to remain in the Screening Unit prior to moving to the assigning Intake Supervisor and a standard of same or next day assignment, by Intake Supervisor, of referrals to Social Workers.	Timeframe	1 – 24 months (10/31/07 – 09/30/09)	Assigned to	CFS Intake Supervisors, CFS Phone Screener Unit.
	1.1.7 Assign a third Social Worker to the Sexual Abuse Investigation Team to target 10-Day compliance.		3 months (12/31/07)		CFS Intake Supervisors.
	1.1.8 Weekly, distribute to Intake Supervisors individual worker caseload referral reports and reports that monitor individual worker workload, 10-Day compliance performance, and 10-day referrals that need documentation in CWS/CMS.		1 – 24 months (10/31/07 – 09/30/09)		CFS Analyst.
	1.1.9 Graphically display current agency performance. Display prominently. Develop a mural strategy to draw attention to graph and performance level.		Data 1 – 24 months (10/31/07 – 9/30/09) Mural 3 months (12/31/07)		CFS Intake Supervisors, CFS Program Manager, CFS Analyst.

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	<p>1.1.10 Use reports in 1.1.8 and 1.1.9 to monitor 10-Day referral response compliance level to assure performance remains at or above 90%.</p>		<p>1 – 24 months (10/31/07 – 09/30/09)</p>	<p>CFS Intake Supervisors, CFS Program Manager, CFS Analyst.</p>
<p>Discuss changes in identified systemic factors needed to further support the improvement goals. Weekly tracking could lead to more timely inputting of contact data.</p>				
<p>Describe educational/training needs (including technical assistance) to achieve the improvement goals. Education of Law Enforcement, education/training of correct CWS/CMS documentation, time management, priority setting.</p>				
<p>Identify roles of the other partners in achieving the improvement goals. Expanded community responsibility and collaboration in the increased delivery of intervention and prevention services will allow for CFS to concentrate more efficiently on tracks that require CFS involvement.</p>				
<p>Identify any regulatory or statutory changes needed to support the accomplishment of the improvement goals. Allow the first response that is done by a community agency to count towards the 10-Day response timeline if CFS follows up with a contact within a 21-day timeframe.</p>				

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System Improvement Plan – Substance Abuse Counselor

Outcome/Systemic Factor(s): No Recurrence Of Maltreatment (S1.1)
Reentry Following Reunification (C1.4)

County's Current Performance:

No Recurrence of Maltreatment (S1.1)

This safety measure reflects the percentage of children who were victims of a substantiated or indicated child maltreatment allegation within the first 6 months of a specified time period for whom there was no additional substantiated maltreatment allegation during the subsequent 6 months.

Measure number	Measure description	Most recent start date	Most recent end date	Most recent numerator	Most recent denominator	Most recent performance	Direction?	Percent change
S1.1	No Recurrence Of Maltreatment	01/01/06	12/31/06	217	246	88.2	No	-1.7%

Measure number	Measure description	Baseline start date	Baseline end date	Baseline performance	Most recent start date	Most recent end date	Most recent performance	Percent change	Estimated # of children affected
S1.1	No Recurrence Of Maltreatment	07/01/02	06/30/03	89.7	01/01/06	12/31/06	88.2	-1.7%	-4

Reentry Following Reunification (C1.4)

This measure computes the percentage of children reentering foster care within 12 months of a reunification discharge.

Measure number	Measure description	Most recent start date	Most recent end date	Most recent numerator	Most recent denominator	Most recent performance	Direction?	Percent change
C1.4	Reentry Following Reunification (Exit Cohort)	01/01/05	12/31/05	16	195	8.2	Yes	-32.7%

Measure number	Measure description	Baseline start date	Baseline end date	Baseline performance	Most recent start date	Most recent end date	Most recent performance	Percent change	Estimated # of children affected
C1.4	Reentry Following Reunification (Exit Cohort)	07/01/01	06/30/02	12.2	01/01/05	12/31/05	8.2	-32.7%	-8

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Improvement Goal 1.0					
Decrease the recurrence of maltreatment and/or abuse/neglect of children, as well as re-entry to foster care, through the elimination or mitigation of alcohol and/or other drug use that may be impairing their (caregivers) ability to parent their children.					
Strategy 1.1			Strategy Rationale		
The proposed strategy is the Alcohol and Other Drug (AOD) Substance Abuse Counselor on assignment at Child and Family Services to act as a liaison between the Behavioral Health Team (BHT) at CalWORKs, the Alcohol and Drug Programs Division, and Social Services – Children and Family Services.			The Substance Abuse Counselor screens, assesses, makes referrals, case-manages, and monitors cases that are suspected of having alcohol and/or drug involvement. Case consultation and crisis intervention are also provided.		
Milestone	1.1.1 Screening and Assessment. Conduct Substance Abuse screening on all clients referred by CFS staff. Conduct and/or arrange assessments for clients.	Timeframe	1 – 24 months (10/31/07 – 9/30/09)	Assigned to	Substance Abuse Counselor, Social Workers
	1.1.2 Individual/Family Case Management. Provide direct services to clients as needed. Take warm handoff from CFS Social Worker. Follow-up on client attendance at treatment program to ensure enrollment and participation. Schedule client appointments at treatment facilities.		1 – 24 months (10/31/07 – 9/30/09)		Substance Abuse Counselor, Social Workers
Milestone	1.1.3 Consultation. Attend community meetings (client present) at CFS. Represent CalWORKs BHT and treatment program when needed at case staffings. Provide feedback to CFS staff by researching client treatment and treatment options. Distribute Assessment Summaries and Status Reports from the treatment programs. Provide consultation to mental health, social work, probation, and family violence staff.	Timeframe	1 – 24 months (10/31/07 – 9/30/09)	Assigned to	Substance Abuse Counselor, Mental Health Staff, Social Workers, Probation staff, Domestic Violence counselors/staff.
	1.1.4 Collaboration. Represents Shasta County Alcohol and Drug Programs at weekly Multi-Disciplinary Team meetings. Attend Service Unity Meeting Voluntary staffing. Provide Perinatal Substance Abuse/HIV Infant Program Foster Care Training quarterly.		1 – 24 months (10/31/07 – 9/30/09)		Substance Abuse Counselor, MDTs, SUM Team, Training Coordinator

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Strategy 1.2 The Alcohol and Other Drug (AOD) Substance Abuse Counselor on assignment at Children and Family Services will participate in planning and implementation of transitional activities for parents reunifying with children, including reassessment of risks, provision for after care services and linking to support services.		Strategy Rationale Emphasis on parent’s connections to the AOD counselor at time of reunification will help them maintain recovery and increase stability of the reunification.		
Milestone	1.2.1 Provide support services to parents during the transition period for children that are being unified with their families.		1 – 24 months (10/31/07 – 09/30/09)	Substance Abuse Counselor, Social Workers
	1.2.2 Participate in reunification transition and planning activities for identified families.		1 – 24 months (10/31/07 – 09/30/09)	Substance Abuse Counselor, Social Workers, Supervisors, Mental Health Staff
	1.2.3 Reassess each identified client for risk focus factors, identify needed support services, and provide a warm handoff, connecting parents to appropriate and available resources.		1 – 24 months (10/31/07 – 09/30/09)	Substance Abuse Counselor, Social Workers
	1.2.4 Provide aftercare services to identified clients as needed on relapse prevention and recovery support.		1 – 24 months (10/31/07 – 09/30/09)	Substance Abuse Counselor, Supervisors, Social Workers
	1.2.5 Report to social workers on additional services needed as they appear.		1 – 24 months (10/31/07 – 09/30/09)	Substance Abuse Counselor, Social Workers
Discuss changes in identified systemic factors needed to further support the improvement goals. Funding for caseload levels to reach the SB2030 Optimum Workload levels for delivery of best practice.				
Describe educational/training needs (including technical assistance) to achieve the improvement goals. On the policy level the agency must make a commitment to strengths-based work.				
Identify roles of the other partners in achieving the improvement goals. The Substance Abuse Counselor provides, locates, coordinates and monitors necessary and appropriate services and treatment for parents/families with child protection involvement.				
Identify any regulatory or statutory changes needed to support the accomplishment of the improvement goals. Flexible funding and continued CWS Outcome Improvement Project funds are necessary to sustain this project.				

Shasta County System Improvement Plan – 2007/2009
Children and Family Services / Probation Department

System Improvement Plan – Family Team Meetings

Outcome/Systemic Factor(s): No Recurrence Of Maltreatment (S1.1)
Reentry Following Reunification (C1.4)

County's Current Performance:

No Recurrence of Maltreatment (S1.1)

This safety measure reflects the percentage of children who were victims of a substantiated or indicated child maltreatment allegation within the first 6 months of a specified time period for whom there was no additional substantiated maltreatment allegation during the subsequent 6 months.

Measure number	Measure description	Most recent start date	Most recent end date	Most recent numerator	Most recent denominator	Most recent performance	Direction?	Percent change
S1.1	No Recurrence Of Maltreatment	01/01/06	12/31/06	217	246	88.2	No	-1.7%

Measure number	Measure description	Baseline start date	Baseline end date	Baseline performance	Most recent start date	Most recent end date	Most recent performance	Percent change	Estimated # of children affected
S1.1	No Recurrence Of Maltreatment	07/01/02	06/30/03	89.7	01/01/06	12/31/06	88.2	-1.7%	-4

Reentry Following Reunification (C1.4)

This measure computes the percentage of children reentering foster care within 12 months of a reunification discharge.

Measure number	Measure description	Most recent start date	Most recent end date	Most recent numerator	Most recent denominator	Most recent performance	Direction?	Percent change
C1.4	Reentry Following Reunification (Exit Cohort)	01/01/05	12/31/05	16	195	8.2	Yes	-32.7%

Measure number	Measure description	Baseline start date	Baseline end date	Baseline performance	Most recent start date	Most recent end date	Most recent performance	Percent change	Estimated # of children affected
C1.4	Reentry Following Reunification (Exit Cohort)	07/01/01	06/30/02	12.2	01/01/05	12/31/05	8.2	-32.7%	-8

Improvement Goal 1.0 Continue to increase community participation with Children and Family Services or juvenile probation systems by tailoring services to a family's individual needs and strengths.

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Strategy 1. 1 Continue to increase family and community involvement by the tailoring of services to a family’s individual needs and strengths through the continued development and expansion of the Family Team Meeting (FTM) program, particularly by the Probation Department.		Strategy Rationale Family Team Meetings (FTM) are a team decision-making approach that works with families as partners to define family strengths, needs, goals, and to identify helpful services and resources. FTMs lead to more involvement of “family” members, community, and personal support people and services that can help the family change so that further incidents of abuse and/or neglect are minimized.			
Milestone	1.1.1 Develop and apply practice of utilizing FTMs for the assessment of current and future child safety of families referred to Children and Family Services.	Timeframe	1 - 3 months (10/31/07 – 12/31/07)	Assigned to	Case-carrying social worker, Probation Officer(s) and contracted FTM provider.
	1.1.2 Establish and utilize 241.1 protocols for Probation FTMs when terminating ward placement.		1 - 3 months (10/31/07 – 12/31/07)		Probation Officer(s) and contracted FTM provider.
	1.1.3 Develop protocols for CFS dependent youth who commit their first crime.		1 – 6 months (10/31/07 – 03/31/08)		Case-carrying social worker, Probation Officer(s) and contracted FTM provider.
	1.1.4 Develop protocols for probation wards in placement and apply FTMs for transition.		1 – 6 months (10/31/07 – 03/31/08)		Probation Officer(s) and contracted FTM provider.
Strategy 1. 2 Continue to integrate into the agency’s training and operating practice the culturally and ethnically appropriate CFS Guideline and Procedures and ensure adequate training to CFS and Probation staff on the family involvement in the case-planning process and strength-based FTMs.		Strategy Rationale The written Guidelines and Procedures help CFS and Probation deal with conflicting priorities and provide additional guidance and strength-based approaches for culturally and ethnically diverse clients. Initial and ongoing training is an important component to institutionalize this process, as well as the 40-Developmental Assets philosophy.			
Milestone	1.2.1. The existing FTM Guidelines and Procedures will be reviewed by Mid-Managers and Program Analysts to ensure they are culturally and ethnically appropriate. Consultation with community stakeholders will be included.	Timeframe	1 – 6 months (10/31/07 – 03/31/08)	Assigned to	Mid-Managers, Probation staff, Program Analyst(s).
	1.2.2 CFS and Probation Supervisors will include in their staff supervision time with social workers and probation officers to train on the use of FTM Guidelines and Procedures in relation agency expectations for culturally/ethnically diverse clients.		1 – 6 months (10/31/07 – 03/31/08)		CFS and Probation Training Supervisors, Supervisors
	1.2.3 FTM procedures and client handouts will be translated in languages as identified by County guidelines.		1 – 6 months (10/31/07 – 03/31/08)		Program Analyst(s) and contracted FTM provider.
Strategy 1. 3 Continue to refine measurements and data tracking methods on Family Team Meetings for Children and Family Services dependents and probation wards to determine longitudinal outcomes and client/extended family participation rates.		Strategy Rationale An effective Family Team Meeting program will help to reduce recidivism and re-entry and increase placement stability and parent/youth participation in the case planning process. Collection and analysis of data will be used to assess perceived and objective effectiveness.			

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Milestone	1.3.1 Track number of Family Team Meetings, all participants, ongoing use of Family Team Meetings, and stage in case when Family Team Meetings occur. Also track individual client family recidivism and re-entry.	Timeframe	Quarterly – 12/31/07, 03/31/08, 06/30/08, 09/30/08, 12/31/08, 03/31/09, 06/30/09	Assigned to	CFS Program Analyst(s), Probation staff, and FTM contracted provider.
	1.3.2 Track, on a quarterly basis, the number of CFS and Probation client families as compared to the number of CFS and Probation client families with Family Team Meetings held to monitor agency acceptance of Family Team Meeting program.		Quarterly – 12/31/07, 03/31/08, 06/30/08, 09/30/08, 12/31/08, 03/31/09, 06/30/09		CFS Program Analyst(s), Probation staff, and FTM contracted provider.
	1.3.3 Develop, conduct, and track results of satisfaction survey administered to all Family Team Meeting program participants. Data will also be collected on perceived effectiveness.		Quarterly – 12/31/07, 03/31/08, 06/30/08, 09/30/08, 12/31/08, 03/31/09, 06/30/09		CFS Program Analyst(s), Probation staff, and FTM contracted provider.
Strategy 1.4 Continue to develop funding sources.			Strategy Rationale Funding and incentives are needed for community-based organizations to provide resources and services to the clients.		
Milestone	1.4.1 Collaboration of CFS and Probation fiscal staff working with CFS Program and Probation Officer(s) and FTM contracted provider to plan for ongoing funding sources.	Timeframe	1 - 12 months (10/31/07 – 09/30/08)	Assigned to	CFS Program Analyst(s), Probation staff, CFS/Probation fiscal representatives, and FTM contracted provider.
	1.4.2 Research how other counties, states, or nonprofit organizations acquire ongoing funding for FTM services/resources.		1 - 3 months (10/31/07 – 12/31/07)		CFS Program Analyst(s), Probation staff, CFS/Probation fiscal representatives, and FTM contracted provider.
	1.4.3 Funding sources located and applications created for obtaining funds for CFS and Probation and community-based organizations.		1 - 12 months (10/31/07 – 09/30/08)		CFS Program Analyst(s), Probation staff, CFS/Probation fiscal representatives, and FTM contracted provider.
Discuss changes in identified systemic factors needed to further support the improvement goals. We need a good Quality Control/Assurance system. We need more funding for community agencies to offer more individualized services. Caseloads consistent with SB2030 recommendations are necessary to afford Social Workers time for an effective implementation of the labor-intensive Family Team meeting process. Awareness of cultural issues and cultural diversity must be taken into consideration and, if appropriate, incorporated into every decision making process.					
Describe educational/training needs (including technical assistance) to achieve the improvement goals. Community partners will have to have solid training in identifying families that need to be referred back to CFS. Training will be needed in conducting Family Team meetings for Social Workers and community partners. On the policy level the agency must continue to make a commitment to strengths-based work a part of the agency culture.					
Identify roles of the other partners in achieving the improvement goals. Community partners and CFS must be willing and able to work together on a pilot project even if there is not additional funding available. Together we need to work through communication and confidentiality issues.					
Identify any regulatory or statutory changes needed to support the accomplishment of the improvement goals. Flexible funding and continued CWS Outcome Improvement Project funds will be necessary to sustain the pilot project. Funding for additional Social Workers and support staff will be needed. UC Davis trainings should be open to all community partners.					

Shasta County System Improvement Plan – 2007/2009
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System Improvement Plan – High Risk Team Meetings

Outcome/Systemic Factor: Multiple Foster Care Placements (C4.1.2.3)

County's Current Performance:
Placement Stability (C4.1.2.3)

For all children in child welfare supervised foster care for (8 days to 12 months) or (12 to 24 months) or (more than 24 months), what percent had no more than two placements?

Measure number	Measure description	Most recent start date	Most recent end date	Most recent numerator	Most recent denominator	Most recent performance	Direction?	Percent change
C4.1	Placement Stability (8 Days To 12 Months In Care)	01/01/06	12/31/06	225	277	81.2	No	-6.1%
C4.2	Placement Stability (12 To 24 Months In Care)	01/01/06	12/31/06	160	225	71.1	Yes	8.1%
C4.3	Placement Stability (At Least 24 Months In Care)	01/01/06	12/31/06	67	234	28.6	No	-27.9%

Measure number	Measure description	Baseline start date	Baseline end date	Baseline performance	Most recent start date	Most recent end date	Most recent performance	Percent change	Estimated # of children affected
C4.1	Placement Stability (8 Days To 12 Months In Care)	07/01/02	06/30/03	86.5	01/01/06	12/31/06	81.2	-6.1%	-15
C4.2	Placement Stability (12 To 24 Months In Care)	07/01/02	06/30/03	65.8	01/01/06	12/31/06	71.1	8.1%	12
C4.3	Placement Stability (At Least 24 Months In Care)	07/01/02	06/30/03	39.7	01/01/06	12/31/06	28.6	-27.9%	-26

Improvement Goal 1.0: Reduce placement disruption, multiple foster care placements, and reentry into foster care of high-risk children. These high-risk children are placed in FFAs or county foster homes (at Special Care Rates) due to a combination of physical, emotional/behavioral and/or developmental challenges.

Strategy 1. 1 Continue to develop and support the specialized high-risk team case-manager who identifies high-risk children from multiple system entry points. This case manager facilitates, assesses, coordinates and tracks high-risk children to support foster and adoptive parents to minimize placement disruption. This case manager will be assigned to the High-Risk Services Team.

Strategy Rationale High-risk children, because of severe medical and/or emotional/behavioral and/or developmental issues, suffer a far higher rate of placement disruptions, multiple foster care placements, and reentry into foster care. Early identification and intensive case-management is necessary to prevent these disruptions and to increase stability and the likelihood of permanency. Due to the emotional impacts and stresses on foster and adoptive parents when caring for high-risk children, a single point-of-contact provides tools, strategies, support and access to specialized services.

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Milestone	1.1.1 The High-Risk Coordinator will continue to work with the foster parent/adoptive parent, the case carrying social workers and, the biological parent when applicable, to create a team that will support the foster parent through the creation and implementation of a individualized, intensive service package that will support the child's needs as the child moves through foster care. If the child is reunified or moves into another permanent situation such as adoption, then the case manager will work to pass the service plan to the family and to a community based team, creating continuity of care, to reduce the risk of the child re-entering the system.	Timeframe	1 – 24 months (10/31/07-09/30/09)	Assigned to	CFS High-Risk Coordinator, Treatment Supervisor, High Risk Services Team, CFS Program Manager and Interagency Partners. * (See page 21 for listing of Interagency Partners.)
	1.1.2 High-Risk Services Team committee to continue to meet on a periodic basis to assess programmatic results by the monitoring and tracking of client demographic, attendance, and other quantitative and qualitative dynamics. Data tracking measures and tools will be refined and modified based on ongoing evaluation.		1 – 24 months (10/31/07-9/30/09)		CFS Program Analyst(s), CFS High-Risk Coordinator, Treatment Supervisor, High Risk Services Team, CFS Program Manager and Interagency Partners*.
	1.1.3 Continue to develop and refine referral processes and all associated forms developed for social worker utilization of High Risk Services Team.		1 – 24 months (10/31/07-09/30/09)		CFS High-Risk Coordinator, Treatment Supervisor, High Risk Services Team, CFS Program Manager and Interagency Partners*.
	1.1.4 Provide training to all CFS social workers, interagency staff, Probation officers, community partners, county foster homes and Family Foster Homes on the High-Risk Team.	Timeframe	6 – 12 months (03/1/08 – 09/30/08)	Assigned to	CFS Training Supervisor, CFS High-Risk Coordinator, Treatment Supervisor, High Risk Services Team, CFS Program Manager and Interagency Partners*.
Strategy 1. 2 Continue to refine and evolve the guidelines and procedures for the High-Risk Team Case Manager and the High-Risk Services Team.		Strategy Rationale As the program is an integral part of CFS and Probation operations, the refinement and clarity of the Guidelines and Procedures is important to address operational and programmatic changes that benefit the clients. Dissemination of the Guidelines and Procedures will provide standard agency expectations in helping workers deal with conflicting priorities.			
Milestone	1.2.1 Guidelines and Procedures to be placed on the regular High-Risk Services Team Agenda for discussion and modification as necessary.	Timeframe	Quarterly – 12/31/07, 03/31/08, 06/30/08, 09/30/08, 12/31/08, 03/31/09, 06/30/09	Assigned to	CFS High-Risk Coordinator, Treatment Supervisor, High Risk Services Team, and CFS Program Manager.

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<p>1.2.2 As Guidelines and Procedures are refined, CFS and Probation Staff will receive updates on the agency expectations.</p>	<p>1 – 24 months (10/01/07-9/30/09)</p>	<p>CFS Training Supervisor, CFS High-Risk Coordinator, Treatment Supervisor, High Risk Services Team, CFS Program Manager, and Interagency Partners*.</p>
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Improvement Goal 2.0 Provide check-in and basic informational support for families to improve timely, consistent access for High-Risk Services and provide office support for and for improved data and client usage reporting by utilizing Family Workers.

<p>Strategy 2.1 Enhance services to clients/families by providing additional levels of direct logistical and informational support.</p>	<p>Strategy Rationale Clients/families who utilize High-Risk Services may miss scheduled meetings or fail to obtain necessary information due to lack of available child-care and/or the procedural realities of accessing services such as check-in, necessary paperwork, and related documentation.</p>
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Milestone	<p>2.1.1 Determine funding sources and scope of work for Family Workers assisting the High-Risk Services program.</p>	Timeframe	<p>1 – 6 months (10/31/07-03/31/08)</p>	Assigned to	<p>CFS High-Risk Coordinator, CFS Program Analyst(s), and CFS Program Manager</p>
	<p>2.1.2 Develop Guidelines and Procedures on the use of Family Workers to provide “check-in” services for front-office work for clients/families accessing High-Risk Services and for client usage and data tracking to support analytical work on outcomes/measures.</p>		<p>6 – 9 months (04/1/08-06/30/08)</p>		<p>CFS Training Supervisor, CFS High-Risk Coordinator, Treatment Supervisor, High Risk Services Team, CFS Program Manager, and Interagency Partners.</p>
	<p>2.1.3 Develop appropriate child-care services coordinated by Family Workers for clients/families accessing High-Risk Services.</p>		<p>6 – 9 months (04/1/08-06/30/08)</p>		<p>CFS Training Supervisor, CFS High-Risk Coordinator, Treatment Supervisor, High Risk Services Team, CFS Program Manager, and Interagency Partners.</p>

Improvement Goal 3.0 Create a support team for post-adoption families to provide technical support.

<p>Strategy 3.1 To assist post-adoptive families in accessing High-Risk Services Team support to provide placement stability and avoid possible reentry into foster care of High-Risk dependents and wards.</p>	<p>Strategy Rationale Post-adoptive families with High-Risk youth face additional challenges in maintaining the child in the home. By providing High-Risk Services post-adoptive support and structure, reentry into foster care and multiple placements will be reduced.</p>
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Milestone		Timeframe		Assigned to	
	3.1.1 Research and assist in the development of applying High-Risk Team services to the post-adoption cohort of clients. Determine applicability and funding source(s).		1 – 24 months (10/31/07-09/30/09)		CFS Program Analyst(s), CFS High-Risk Coordinator, Treatment Supervisor, High Risk Services Team, and CFS Program Manager.
	3.1.2 Develop appropriate protocols to be included in the Guidelines and Procedures.		1 – 3 months (10/31/07-12/31/07)		CFS Training Supervisor, CFS High-Risk Coordinator, County Adoptions, Treatment Supervisor, High Risk Services Team, CFS Program Manager, and Interagency Partners*.
	3.1.3 Implement and promote a post-adoption focused High-Risk Services element and provide training to CFS and Probation staff who may have contact with post-adoptive families.		6 – 12 months (03/1/08-09/30/08)		CFS Training Supervisor, CFS High-Risk Coordinator, County Adoptions, Treatment Supervisor, High Risk Services Team, CFS Program Manager, and Interagency Partners*.
<p>Discuss changes in identified systemic factors needed to further support the improvement goals. The current service gap for high-risk children results from being assigned to a regular case-carrying social worker already carrying a large caseload and who is limited in being able to deliver intensive and targeted services immediately or in a comprehensive and inclusive manner. Also, the need to have a statistically valid tracking system to address outcomes/measures that can be accessed on-demand within the existing computer systems is needed for supervisory and operational management.</p>					
<p>Describe educational/training needs (including technical assistance) to achieve the improvement goals. Ongoing training of staff, foster parent and adoptive parents, and CFS and Probation staff on the implementation and utilization of the High-Risk Services program.</p>					
<p>Identify roles of the other partners in achieving the improvement goals. A foster parent may need a specialized advocate to assist them with high-risk child issues and access to needed services. This would then empower a foster or adoptive parent to provide focused services and reduce the likelihood of a placement disruption.</p>					
<p>Identify any regulatory or statutory changes needed to support the accomplishment of the improvement goals. . Continuation of the CWS Outcome Improvement Funding and funding augmentation and/or identifying and acquiring other sustainable funding streams to maintain the High-Risk Services program.</p>					

* Interagency Partners include, but are not limited to, Mental Health Clinician, County Educational Specialist, Alcohol and Other Drug (AOD) Counselor, and Public Health personnel.

Shasta County System Improvement Plan – 2007/2009
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System Improvement Plan – **Relative/NREFM** (Non-Related Extended Family Member)

Outcome/Systemic Factor(s): Multiple Foster Care Placements (C4.1.2.3)
Multiple Care Placements in Least Restrictive Settings (4B)

County's Current Performance:

Placement Stability (C4.1.2.3)

For all children in child welfare supervised foster care for (8 days to 12 months) or (12 to 24 months) or (more than 24 months), what percent had no more than two placements?

Measure number	Measure description	Most recent start date	Most recent end date	Most recent numerator	Most recent denominator	Most recent performance	Direction?	Percent change
C4.1	Placement Stability (8 Days To 12 Months In Care)	01/01/06	12/31/06	225	277	81.2	No	-6.1%
C4.2	Placement Stability (12 To 24 Months In Care)	01/01/06	12/31/06	160	225	71.1	Yes	8.1%
C4.3	Placement Stability (At Least 24 Months In Care)	01/01/06	12/31/06	67	234	28.6	No	-27.9%

Measure number	Measure description	Baseline start date	Baseline end date	Baseline performance	Most recent start date	Most recent end date	Most recent performance	Percent change	Estimated # of children affected
C4.1	Placement Stability (8 Days To 12 Months In Care)	07/01/02	06/30/03	86.5	01/01/06	12/31/06	81.2	-6.1%	-15
C4.2	Placement Stability (12 To 24 Months In Care)	07/01/02	06/30/03	65.8	01/01/06	12/31/06	71.1	8.1%	12
C4.3	Placement Stability (At Least 24 Months In Care)	07/01/02	06/30/03	39.7	01/01/06	12/31/06	28.6	-27.9%	-26

County's Current Performance:

Foster Care Placement in Least Restrictive Settings (4B)

This measure reflects the percent of children placed in each type of foster care setting. For all children who entered child welfare supervised foster care for the first time (and stayed at least five days) during the 12-month study period, what percent were in relative home, foster home, FFA, group home or other placements?

What percent of children in child welfare supervised foster care were in relative home, non-related extended family member home, foster home, FFA, group home or other placement at a specified point in time?

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Measure number	Measure description	Most recent start date	Most recent end date	Most recent numerator	Most recent denominator	Most recent performance	Direction?	Percent change
4B	Least Restrictive (Entries First Plc.: Relative)	01/01/06	12/31/06	17	267	6.4	N.A.	-29.3%
4B	Least Restrictive (Entries First Plc.: Foster Home)	01/01/06	12/31/06	159	267	59.6	N.A.	-16.9%
4B	Least Restrictive (Entries First Plc.: FFA)	01/01/06	12/31/06	72	267	27.0	N.A.	87.1%
4B	Least Restrictive (Entries First Plc.: Group/Shelter)	01/01/06	12/31/06	3	267	1.1	N.A.	-50.1%
4B	Least Restrictive (Entries First Plc.: Other)	01/01/06	12/31/06	16	267	6.0	N.A.	121.7%
4B	Least Restrictive (PIT Placement: Relative)	01/01/07	01/01/07	145	568	25.5	N.A.	34.4%
4B	Least Restrictive (PIT Placement: Foster Home)	01/01/07	01/01/07	113	568	19.9	N.A.	-27.4%
4B	Least Restrictive (PIT Placement: FFA)	01/01/07	01/01/07	146	568	25.7	N.A.	16.6%
4B	Least Restrictive (PIT Placement: Group/Shelter)	01/01/07	01/01/07	27	568	4.8	N.A.	-14.4%
4B	Least Restrictive (PIT Placement: Other)	01/01/07	01/01/07	137	568	24.1	N.A.	-7.2%

Measure number	Measure description	Baseline start date	Baseline end date	Baseline performance	Most recent start date	Most recent end date	Most recent performance	Percent change	Estimated # of children affected
4B	Least Restrictive (Entries First Plc.: Relative)	07/01/02	06/30/03	9.0	01/01/06	12/31/06	6.4	-29.3%	-7
4B	Least Restrictive (Entries First Plc.: Foster Home)	07/01/02	06/30/03	71.6	01/01/06	12/31/06	59.6	-16.9%	-32
4B	Least Restrictive (Entries First Plc.: FFA)	07/01/02	06/30/03	14.4	01/01/06	12/31/06	27.0	87.1%	34
4B	Least Restrictive (Entries First Plc.: Group/Shelter)	07/01/02	06/30/03	2.3	01/01/06	12/31/06	1.1	-50.1%	-3
4B	Least Restrictive (Entries First Plc.: Other)	07/01/02	06/30/03	2.7	01/01/06	12/31/06	6.0	121.7%	9
4B	Least Restrictive (PIT Placement: Relative)	07/01/03	07/01/03	19.0	01/01/07	01/01/07	25.5	34.4%	37
4B	Least Restrictive (PIT Placement: Foster Home)	07/01/03	07/01/03	27.4	01/01/07	01/01/07	19.9	-27.4%	-43
4B	Least Restrictive (PIT Placement: FFA)	07/01/03	07/01/03	22.0	01/01/07	01/01/07	25.7	16.6%	21
4B	Least Restrictive (PIT Placement: Group/Shelter)	07/01/03	07/01/03	5.6	01/01/07	01/01/07	4.8	-14.4%	-5
4B	Least Restrictive (PIT Placement: Other)	07/01/03	07/01/03	26.0	01/01/07	01/01/07	24.1	-7.2%	-11

Improvement Goal 1.0 Increase the placement stability of children in placement (target number is no more than 2 placements per child).	
Strategy 1. 1 Determine the causes of multiple moves, analyze and recommend what can be changed, then develop a plan for change. This involves both CFS and Probation staff.	Strategy Rationale Analysis of the reasons for placement changes may reveal patterns that can be mitigated or reversed through further social worker education and Relative/NREFM (Non-Related Extended Family Member) liaison support.

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Milestone	1.1.1 Produce a report with details of all moves for all placement types (including emergency intake) and distribute to supervisors for analysis.	Timeframe	1 – 3 months (10/31-07 to 12/31/07)	Assigned to	Program Analyst
	1.1.2 Determine cause for each move.		1 – 6 months (10/31/07 to 03/31/08)		Social Worker Supervisors, Social Workers, and Probation Officers.
	1.1.3 Analyze statistics and make recommendations on changes that can be made to reduce moves.		1 - 6 months (10/31/07 to 03/31/08)		Program Managers, Supervisors, Relative/NREFM Liaison, Program Analyst
	1.1.4 Review reasons why children were removed from relatives and NREFM and make suggestions on how this can be prevented in the future.		1 – 6 months (10/31/07 to 03/31/08)		Relative/NREFM Liaison and Licensing Supervisor.
	1.1.5 Implement changes, including implementation of 'family finding' protocols to search for family members who can provide stability and support and/or additional options for placement for youth.		1 - 24 months (10/31/07 to 09/30/09)		Program Managers, Supervisors, Program Analyst

Improvement Goal 2.0 Increase the number of available Relative/NREFM caregivers, and increase the percentage of Relative/NREFM placements and connect Relative/NREFM Liaison to child /family in relative/NREFM placement for support.

Strategy 2. 1 Place more children in relative/NREFM and FFH homes early on and facilitate and enhance the access these families have to services and resources.

Strategy Rationale Kinship (relative/NREFM) families caring for dependant children have historically been underserved in terms of receiving support and training to assist them in dealing with the complexity of the child welfare system, the Juvenile Court, and in many cases the special needs of the children in their care. This can cause disproportional changes in relative/NREFM placement.

Milestone	2.1.1 Determine supervisor/social worker training/awareness on the relative/NREFM preference and its importance on department performance (possible front-end emphasis).	Timeframe	1 – 4 months (10/01/07 to 01/31/08)	Assigned to	Program Managers, Supervisors, Relative NREFM Liaison, Training Supervisor
	2.1.2 Develop agency philosophy/expectations regarding placement preferences and recommend process changes.		1 – 6 months (01/01/08 to 6/30/08)		Program Managers, Program Analyst
	2.1.3 Develop philosophy on more thorough front-end relative assessment to increase stability of first placement.		1 – 6 months (01/01/08 to 6/30/08)		Program Managers and Supervisors

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2.1.4 Review reasons why children were removed from relatives and NREFM and make suggestions on how this can be prevented in the future.		1 – 12 months (10/31/07 – 10/31/08)	Relative/NREFM Liaison and Licensing Supervisor
2.1.5 Develop training and awareness program and train social workers.		1 – 12 months (10/31/07 to 10/31/08)	Program Managers, Training Manager, Relative/NREFM Liaison
2.1.6 Ongoing liaison work to support relative/NRFEM caregivers to help maintain placements, including referral to Relative/NREFM Liaison for help with possible initial placement.		1 – 24 months (10/31/07 to 09/30/09)	Relative/NREFM Liaison
Discuss changes in identified systemic factors needed to further support the improvement goals. Agency expectation of Social Worker staff to utilize and promote to families the Relative/NREFM Liaison. Social Workers to promote Relative/NRFEM placement starting with first placement after intake.			
Describe educational/training needs (including technical assistance) to achieve the improvement goals. Expanded education of Social Worker staff on utilization and promotion to families of the Relative/NREFM Liaison and identify Relative/NRFEM sooner.			
Identify roles of the other partners in achieving the improvement goals. Expanded community responsibility and collaboration in the increased support of Relative/NREFM caregivers.			
Identify any regulatory or statutory changes needed to support the accomplishment of the improvement goals. Streamline and simplify the Relative Home Approval process, develop a philosophy for intake.			

Attachment A – From Shasta County’s 2007 County Self-Assessment (pages 93-104)
 (Per instructions, this Attachment is not included in the 25 page maximum limit.)

SECTION V. SUMMARY ASSESSMENT

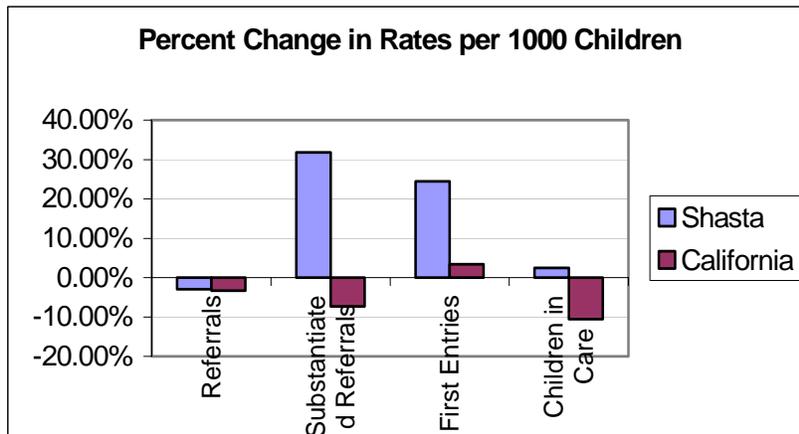
A. Summary of System Strengths and Areas Needing Improvement

Shasta County is one of California’s medium sized rural northern counties. Its population has increased faster than average and experiences higher poverty and unemployment than the state average.

Summary: Percent Change in Rates per 1000 Children

From the April 2004 Quarterly Outcome and Accountability County Data Report to the April 2007 report:

- The rate of children in referrals has decreased by 2.97% for Shasta County from 74.0 per 1,000 to 71.8. This rate has remained higher than the California average rate of 51.2 per 1,000 children with a decreasing trend for California of 3.28% during the same time period.
- The rate in referrals that had substantiated allegations has increased by 31.76% for Shasta County from 14.8 per 1,000 in 2002 to 19.5 in 2005, and has remained higher than the California average rate of 11.8 with a decreasing trend of 7.32%
- The rate of children entering a child welfare supervised placement episode has increased by 24.44% for Shasta County from 4.5 per 1000 in 2002 to 5.6 in 2005 and has remained higher than the California average of 2.9 per 1000 with an increasing trend of 3.45%
- The rate of children in child welfare supervised foster care has increased by 2.42% for Shasta County from 12.4 per 1000 in 2003 to 12.7 in 2006, and has also remained higher than the California average rate of 8 per 1,000 with a decreasing trend of 10.59%.



Participation Rates	Study Period	Shasta Percent Change	California Percent Change
Referrals	2002 to 2005	-2.97%	-3.28%
Substantiated Referrals	2002 to 2005	31.76%	-7.32%

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First Entries	2002 to 2005	24.44%	3.45%
Children in Care	2003 to 2006	2.42%	-10.59%

County specific demographic factors that impact abuse, neglect and reunification rates are: high unemployment rates, low vacancy rates for low income housing (less than one percent), extremely high divorce rates, high rates of substance abuse and addiction and a high number of transient families.

To improve outcomes between 2004 and 2007, CFS and Probation jointly developed and implemented an annual SIP that included some new intervention strategies such as:

- Differential Response
- Substance Abuse Counseling
- Family Team Meetings
- High Risk Services Team, and
- Relative/NREFM (Non-Related Extended Family Member) Liaison

Differential Response provides an expanded approach for responding to allegations of child abuse and neglect. This allows for more families to receive needed services before the situation warrants involuntary intervention.

Family Team Meetings provide a means for families and the people they consider to be their support system, CFS, and other service providers to make solid plans regarding the safety, permanence, and well-being of children.

High Risk Services Team addresses the needs of foster and adoptive children who have very serious physical health, mental health, and behavior problems, and assures that they and their caregivers receive the services they need to successfully maintain the placement.

The Relative/NREFM (Non-Related Extended Family Member) Liaison program was initiated to provide support and training to assist these caregivers in dealing with the complexity of the Child Welfare and the Juvenile Court system, and the special needs of their family members. The Relative/NREFM program was implemented to increase the placement stability of children, increase the number of available Relative/NREFM caregivers, and increase the percentage of Relative/NREFM placements.

Additional **Substance Abuse Counseling** services have been added to CFS to screen, assess, make referrals, case-manage, and monitor family members that are suspected/confirmed as having alcohol and/or drug involvement. The goal of these efforts is to decrease the recurrence of maltreatment associated with substance abusing parents.

The County has demonstrated a strong commitment to address the needs of children, parents, and care providers. In June 2000, CFS reorganized to become an integrated, collocated, multi-agency service-delivery system. Working together as a team, CFS, Probation, Mental Health, Public Health, Drug and Alcohol Program, Shasta County Office of Education, and community based organizations share the responsibility for the

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children they serve. The team assesses strengths and needs and provides comprehensive services to each identified family and child.

Specialized units have been formed to provide:

- 1) Intensive services for high-risk families where children are maintained in the home
- 2) Voluntary services for families willing to accept and participate in services
- 3) Intensive services for children who require higher-level placements

Shasta County currently utilizes a structured series of case staffing policies to foster good social work through periodic team review prior to major decision points. This provides uniform standards of decision-making on behalf of children and families. These teams and committees include:

- 1) A review at Intake to determine whether to remove a child from the home, whether to provide voluntary or court ordered services, and types of service referrals needed.
- 2) MDT meetings each time a recommendation is made to the Juvenile Court (usually every six months).
- 3) Service Unity Meetings for voluntary cases receiving services from CFS and CalWORKs concurrently.
- 4) Concurrent and Permanency Planning MDT ensures that all children are placed in a home that can provide permanence if reunification with a parent is not possible.
- 5) Placement Prevention and Resource Team (PPRT) reviews high-level placement and determines whether the current level of care meets the needs of the child.

Shasta County creative use of contracts has expanded available services for both children and parents. Shasta County is continually looking at new ways to offer services and involve other agencies and community-based organizations in the care of the community's at risk children.

The state and federal governments have selected outcome indicators that measure the nine key outcomes of the Child Welfare Services Redesign.

1. Children are, first and foremost, protected from abuse and neglect.

The system in Shasta County focuses on assessment, investigation and intervention. This approach often uncovers issues and stresses, that when addressed early, can improve family function and reduce the likelihood of a future referral and intervention by CFS. A Differential Response approach that stresses engagement of a family has been implemented and allows low risk families to receive community services when it isn't necessary to open a case in the CFS system.

There are currently data on three measures for recurrence of maltreatment, and the following reflects Shasta County's changes during the period from April 2004 to April 2007.

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- Recurrence of Maltreatment (1A - Federal measure that reflects the percent of children with a substantiated allegation of abuse/neglect within the first six months of the 12-month study period with a subsequent substantiated allegation within six months) decreased by 33.0% for Shasta County;
- Recurrence of Maltreatment (1B - State measure that reflects the percent of children with a substantiated allegation of abuse/neglect during the 12-month study period with a subsequent substantiated allegation within 12 months) decreased by 42.6% for Shasta County;
- Recurrence of Maltreatment (1B - State measure that reflects the percent of children with a *first* substantiated allegation of abuse/neglect during the 12-month study period with a subsequent substantiated allegation within 12 months) decreased by 47.1% for Shasta County.

Once families enter the system, many additional services are available, but when they leave, funding and services often end, making it hard for families to sustain the changes and growth they have achieved. More can be done to engage the extended family in the support of the identified family, in order to realize or sustain the desired positive changes.

2. Children are maintained safely in their homes whenever possible and appropriate.

The State and Federal measures look at children and families that have been referred to the CWS system and at how CFS responds to the needs of those children and families. Recurrence of Abuse/Neglect in Homes Where Children Were Not Removed (2A - State measure that reflects the percent of children with an inconclusive or substantiated allegation of abuse/neglect during the 12-month study period who were not removed and had a subsequent substantiated allegation within 12 months) increased by 1.3% for Shasta County as compared to decreasing by 7.9% for California.

Face-to-face contacts are stressed between Social Workers, parents and children. The County has worked to ensure consistent data entry in the Child Welfare Services Case Management System (CWS/CMS). Timely Social Worker Visits With Child (2C - State process measure that reflects the percent of children determined to require an in-person monthly Social Worker visit that receive the visit) increased 16.4% for Shasta County. The State benchmark for this measure is greater than 90%. As of the April 2007 Quarterly Outcome and Accountability County Data Report, Shasta County had reached 96.4%.

As of the April 2007 Quarterly Outcome and Accountability County Data Report, Child Abuse/Neglect Referrals with a Timely Immediate Response (2B - *State process measure reflects the percent of child abuse and neglect referrals that require an immediate in-person investigation where face-to-face contact with a child occurred, or was attempted, within the regulatory time frame*) was at 94.4%. Child Abuse/Neglect Referrals with a Timely 10-Day Response (2B) has increased by 4.8% for Shasta County and as of the

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April 2007 report was at 83.3%. The State benchmark for both the 2B-Immediate and 2B-10-Day response measure is greater than 90%. Staffing shortages and workload interfere with the County's ability to meet these standards.

3. Children have permanency and stability in their living situations without increasing reentry to foster care.

This is a very complex area as it looks at the provision of services to families with children out-of-home and time to reunification, the stability of the placement of the child while in care, recurrence of abuse or neglect and the time to permanence of adoption.

From the April 2004 Quarterly Outcome and Accountability County Data Report to the April 2007 report, Length of Time to Exit Foster Care to Reunification (*3E - Federal measure that reflects the percent of children reunified from child welfare supervised foster care during the 12-month study period that had been in care for less than 12 months*) decreased by 4.6% for Shasta County. The Federal benchmark for this measure is greater than 76.2%. As of the April 2007 report Shasta County was at 68.2% and the California average was 70.9%.

Length of Time to Exit Foster Care to Reunification (*3A - State measure that reflects the percent of children who entered foster care for the first time and stayed at least five days during the 12-month study period that were reunified within 12 months*) has decreased by 15.4% for Shasta County. There are many factors impacting these numbers. While the collocated, multi agency delivery of services to families has had a positive impact on service delivery and parent success, the following issues have had a negative impact:

- 1) The County has experienced a trend of more complex and serious cases entering the system that require extensive long-term services to resolve. Greater numbers of parents are seen with more significant impairment as a result of substance abuse and mental illness, and higher numbers are hospitalized or incarcerated.
- 2) A family's involvement with services can be impaired by cases that are subject to lengthy court continuances. The family's focus is on the legal process rather than areas in which the family needs to change. This adversarial start can stress the family's relationship with the Social Worker and service providers and delay positive changes within the family.
- 3) The child's needs also play a role at the time to reunification. Older youth and children with emotional or behavior problems can necessitate longer and higher level placements to address their issues. As more complex families enter the system, their children tend to have more complex needs as evidenced by an increase in higher-level placements.

From the April 2004 Quarterly Outcome and Accountability County Data Report to the April 2007 report, Rate of Foster Care Re-Entry (*3F - Federal measure that reflects the percent of children who entered child welfare supervised foster care during the 12-month study period that were subsequent entries within 12 months of a prior exit*) increased by 18.8% for Shasta County. The Federal benchmark for this measure is less than 8.6%. As

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of the April 2007 report Shasta County was at 12.0% and the California average was 10.8%. Rate of Foster Care Re-Entry (*3G - State measure that reflects the percent of children who entered child welfare supervised foster care for the first time and stayed at least five days during the 12-month study period and were reunified within 12 months of entry, that re-entered foster care within 12 months of reunification*) has increased by 46.0% for Shasta County.

The following factors may contribute to Shasta County's high rate:

- 1) The drug of choice in the Shasta County is Methamphetamine and relapse rates are extremely high for this drug.
- 2) Chronic neglect, mental illness, and other lifestyles are difficult to change and sustain without continued services and support.
- 3) Often a family's use of services declines or ends with the termination of court involvement. This may be due to the family no longer having the motivation to continue services without the motivation and support provided by CFS.
- 4) Emotional and behavioral problems of children can resurface and destabilize the family once they are returned home. This is especially true if previous support systems are no longer available or are not utilized by the family.

Shasta County performed rather well on the outcomes that measure the stability of placement for children in care. From the April 2004 Quarterly Outcome and Accountability County Data Report to the April 2007 report, Multiple Foster Care Placements (*3B - Federal measure that reflects the percent of children in child welfare supervised foster care for less than 12 months during the 12-month study period that had no more than two placements*) decreased by 3.2% for Shasta County. The Federal benchmark for this measure is greater than 86.7%.

As of the April 2007 report Shasta County was at 86.8% and the California average was 84.6%. Multiple Foster Care Placements (*3C - State measure that reflects the percent of children who entered child welfare supervised foster care for the first time (and stayed at least five days) during the 12-month study period, and were in care for 12 months, that had no more than two placements*) has increased by 1.4% for Shasta County. Some factors that contribute to the number of placement changes a child may experience during their first year in care include:

- 1) Identification of a relative that may apply and be approved for placement after the initial placement has been made.
- 2) ICWA status being confirmed and a Native American home found.
- 3) A non-custodial parent being located and requesting that the child be placed with them.
- 4) Some children may begin to show behavior or emotional issues that require higher-level placements.
- 5) With a chronic shortage of homes, ideal matching of children and foster homes is not always possible and a child.

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When a child cannot return home and adoption becomes the Permanent Plan, Shasta County CFS has its own Adoptions Unit, which recruits, trains, and approves adoptive parents for eventual placement. The federal measure for adoptions shows that Shasta County is doing well.

From the April 2004 Quarterly Outcome and Accountability County Data Report to the April 2007 report, Length of Time to Exit Foster Care to Adoption (*3D - Federal measure that reflects the percent of children who were adopted from child welfare supervised foster care during the 12-month study period that had been in care for less than 24 months*) has increased by 50.5% for Shasta County. The Federal benchmark for this measure is greater than 32.0%.

As of the April 2007 report Shasta County was at 55.1% and the California average was 30.2%. Length of Time to Exit Foster Care to Adoption (*3A - State measure that reflects the percent of children who entered child welfare supervised foster care for the first time and stayed at least five days during the 12-month study period that were adopted within 24 months*) has increased by 25.2% for Shasta County.

One of the key factors with the County's success in this area is the use of Foster/Adoptive (Fost/Adopt) homes. These are families that are willing to provide foster care and, if needed, become the adoption placement for the children. Considerable effort is given to the recruitment, training, and placement of children into these very special homes. An area still requiring some attention in the Shasta County is earlier Concurrent Planning. Upon entering the Child Welfare Services, each child should have an alternative permanent plan that considers adoption, in case reunification efforts fail and the child is not able to return home to the care of their parents.

4. The family relationships and connections of the children served by the CWS will be preserved, as appropriate.

This standard looks at siblings being placed together, children placed in the least restrictive placement and Native American placements (ICWA compliance).

The County makes every effort to place sibling groups together and will use a Foster Family Agency if foster homes are not available. From the April 2004 Quarterly Outcome and Accountability County Data Report to the April 2007 report, Siblings Placed Together in Foster Care (*4A - State that measure that reflects the percent of children in child welfare supervised foster care on the point-in-time, of those with siblings in care, that were placed with **all** of their siblings*) has increased by 18.3% for Shasta County.

As of the April 2007 report Shasta County was at 56.2% and the California average was 47.4%. Siblings Placed Together in Foster Care (*4A - State measure that reflects the percent of children in child welfare supervised foster care on the point-in-time, of those with siblings in care, that were placed with **some or all** of their siblings*) has increased by

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10.3% for Shasta County. As of the April 2007 report Shasta County was at 73.1% and the California average was 69.0%. Unfortunately, the chronic shortage of foster homes, especially homes that can take a sibling group, presents a major barrier to placing more siblings together.

From the April 2004 Quarterly Outcome and Accountability County Data Report to the April 2007 report: relative placements have decreased by 25.2% for Shasta County and have remained unchanged for California; Foster Home placements have decreased by 10.8% for Shasta County and have increased by 22.3% for California; Foster Family Agency placements have increased by 65.8% for Shasta County and have decreased by 22.4% for California; and Group Home placements have decreased by 63.0% for Shasta County and have increased by 20.0% for California.

Shasta County falls well behind the State in the use of relative foster homes. This may be the result of burnout of relatives who have tried to help parents in the past, out-of-county or out-of-state relatives who cannot be used due to transportation issues required visitation, parents not providing sufficient relative information, Social Workers not having access to sophisticated web-based child welfare search tools and some delays in obtaining approvals. CFS has established Family Team Meeting protocols to capture better relative information and is in the process of contracting with a firm specializing in child welfare search methods that will lead to improved permanency and stability for children, as family connections are essential to the child's development. More data is needed to assess these complex issues. The County's rate of group home placement use is significantly lower than the state average. This can be partly credited to the interagency collaboration used by the Placement Prevention Resource Team (PPRT) to ensure that the child's needs are met, to monitor needs and progress, and that children are moved to a lower level of care when ready.

From the April 2004 Quarterly Outcome and Accountability County Data Report to the April 2007 report for Shasta County, placements for ICWA eligible children: in relative homes have increased by 39.1%; in non-relative Indian family homes have decreased by 60.0%; and in non-relative non Indian family homes have increased by 4.6%.

Native American children present additional legal consideration in the form of ICWA regulations. Every effort is made to follow the law and to work with the tribe the child is affiliated with. More effort needs to be given to developing better ties to the Native American population in the County and recruiting Native American foster homes.

5. Children receive services adequate to their physical, emotional and mental health needs.

An important goal of the Shasta County's existing collocated integrated service-delivery approach, as described earlier, is to provide the best possible services to children and their families. Collocated Mental Health and Public Health staffs play an important role in meeting the physical and emotional treatment needs of the children within the system. In the last year CFS developed and implemented a High Risk Team Meeting and Case

Manager Program as a mechanism for providing intensive case management services to caregivers who are having severe difficulty in caring for their special needs children. These meetings use a collaborative approach of multiple disciplines to create a plan for meeting the needs of the child and foster parent that could include gaining access to specialized services. The program is too new to have valid data, however, there appears to be less placement disruptions and foster parents report feeling supported and empowered in meeting the needs of these children.

CFS has Structured Decision Making and this tool is used in assessing initial intake. The staff is encouraged to work with families from a strength-based perspective but this approach needs greater consistency of use at select decision-making points.

6. Children receive services appropriate to their educational needs.

Shasta County Office of Education (SCOE) is one of the partners working in the CFS office. They have the specific responsibility of assessing each child's education needs and to assist the staff and caretakers in making sure that a child is in the appropriate educational placement and, if needed, receiving the services as defined in their IEP. Since these children have experienced frequent school moves, SCOE staff help locate school records and work with the schools to understand the issues facing the child.

7. Families have enhanced capacity to provide for their children's needs.

The enhanced services provided by the collocated CFS as described above have helped families focus on issues and increase their capacity to care for themselves and their children. In addition, a number of programs have been started and maintained to meet the specific needs of families and children.

The implementation of Differential Response has expanded the ability of child welfare to respond to reports of child abuse and neglect by providing a broader set of responses for working with families at the first signs of trouble. In addition, Differential Response provides a meaningful family engagement to ensure that needed changes are recognized and addressed, and expanded community partnerships provide needed services to families. The comprehensive countywide system of community-based family resource services of the Differential Response program are designed to prevent child abuse by working directly with the families that have issues not serious enough for Children and Family Services intervention but who are in need or crisis with issues that could escalate to abuse or neglect if not addressed.

The Family Team Meeting program facilitates a team decision-making approach that works with families as partners to define strengths, needs and goals, and to identify helpful services and resources. Family Team Meetings have led to more involvement of family members, community and personal support people, and services that can help the family change so that further incidents of abuse and/or neglect are minimized.

The Parent Education Program was started to provide very basic parenting skills to families with issues of abuse and neglect. This program has been incorporated into the

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Parenting Center program where parents can visit their children who are in out-of-home-care. This center provides a home like setting where staff are trained to supervise and support parent/child visits. One of their primary tasks is to help reinforce good parenting skills as taught in the parent education program.

8. Youth emancipating from foster care are prepared to transition to adulthood.

From the April 2004 Quarterly Outcome and Accountability County Data Report to the April 2007 report, Children Transitioning to Self-Sufficient Adulthood (*8A - State measure that reflects the number of foster children eligible for Independent Living Services who receive appropriate educational and training, and/or achieve employment or economic self-sufficiency*) has shown improvement in all categories for Shasta County. High School Diploma has increased by 147.4%; Enrolled in College/Higher Education increased by 100.0%; Received ILP Service increased by 13.1%; Completed Vocational Training increased by 33.3%; and Employed or other means of support increased by 61.3%.

Shasta County contracts with Youth and Family Programs (Y&F) for the provision of Independent Living Program (ILP) services. Shasta College provides the Independent Living Skills classes for youth. Through a cooperative effort CFS, Y&F and Shasta College attempt to prepare youth for their future as independent adults. This arrangement is continually being assessed in an effort to improve outcomes for youth.

Through this cooperative effort the county has developed a Transitional Housing program and a relationship with the Housing Authority to help youth find, maintain, and pay for appropriate and affordable housing. More work is needed to encourage the youth to participate in this program and to encourage care providers to support the youth in this process.

9. Additional systemic factors identified as part of the review process.

Court – Shasta County considers the Juvenile Dependency Court a great asset in working with parents and children in the Child Welfare Services. The Judge, County Counsel, private contracted attorneys, and courtroom staff are all committed to meeting the needs of parents while still protecting children and working with CFS to provide appropriate services in meeting the needs of parents and children. There are areas that warrant improvement including, timely completion of court reports and addendums by Social Workers and establishing a closer working relationship and partnership with all the Court's stakeholders. This could be accomplished through regular meetings that focus beyond the legal issues, but on keeping the Court and all the attorneys abreast of CFS outcome data, CFS practice initiatives, challenges and successes.

Through increased communication and further education of these stakeholders, the court stakeholders can better understand the role they might play in having families be successful with the CFS system. With so many new Social Workers and supervisors, joint

education is needed between the courts and CFS staff regarding the benefits of Family Team Meetings.

B. Areas for further exploration through the Peer Quality Case Review

Shasta County participated in an extensive PQCR process in November 2006 to examine the issue of re-entry of children into foster care. Out of the PQCR, both CFS and Probation obtained peer-reviewed recommendations in the areas of systemic issues, training needs, system and policy changes, state technical assistance, and resource issues. (See page 69 for a listing of the recommendations.)

The next PQCR will take place in FY 09/10. In the months leading up to the next PQCR, CFS and Probation will examine both quantitative data elements from the quarterly reports and listen to the qualitative assessments of Social Worker and collaborative staff to determine specific areas of practice that needs improved outcomes for children and families.

C. Conclusion

The County Self-Assessment document reflects how children in the CFS and Probation systems did in 2004, and in the years following that initial self-assessment through April 2007. Over half of the specific outcome measurements have shown demonstrable improvement, and of those not showing improvement, declines have been slight. While many improvements in outcomes for children have been made in the three years, CFS will continue to apply this information as well as the PQCR recommendations toward completion of the 2007 SIP in the coming months.

The 2007 SIP will guide service delivery including contracted services for the next three years in an effort to ensure improvements in safety, permanency and well-being of children in Shasta County. CFS is committed to a continuous focus on improving the lives of the community's children and families through this process.

On July 17, 2007, the Shasta County Board of Supervisors approved and authorized the Social Services Branch Director, Jane Work, and the Chief Probation Officer, Brian Richart, to sign and submit the County Self-Assessment to the California Department of Social Services.