California Alliance of Child and Family Services

Short-Term Residential Therapeutic Program (STRTP) Member Task Force

STRTP Policy and Practice Recommendations

Recommendations to Improve a Critical Component of Care for Foster Youth

February 2021

California Alliance of Child and Family Services

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About the Task Force

The California Alliance of Child and Family Services ("California Alliance") Short-Term Residential Therapeutic Program (STRTP) Member Task Force includes agencies representing STRTP licensed programs ranging from 12 beds to over 100, from multiple 6-bed houses in the community to campus-based facilities. The goal of the Task Force is to improve youth outcomes by identifying barriers to effective service delivery / best practice and making policy and practice recommendations that address these challenges.

Acknowledgements

This document is the culmination of collaboration across California Alliance committees, including the STRTP Member Task Force, the Residential and Juvenile Justice Committee, the Mental Health Committee, and the Education Committee. The membership of the STRTP Task Force is listed below.

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YOUTH EXPERIENCE

"At most places that I went to, there was at least a couple of staff that genuinely cared. Some of my fondest memories were just that one staff or that two staff that taught me a lot of things... I think that was the life saver, the people that really do care. That's what it is all about. I mean you can have all these protocols but it's all about the people that care."

-Youth in STRTP Care

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Executive Summary

The California Alliance of Child and Family Services Short-Term Residential Therapeutic Program (STRTP) Member Task Force includes agencies representing STRTP licensed programs ranging from 12 beds to over 100, from multiple 6-bed houses in the community to campus-based facilities. The goal of the Task Force is to improve youth outcomes by identifying barriers to effective service delivery / best practice and making policy and practice recommendations that address these challenges.

RECOMMENDATIONS

1. Adequately fund STRTP mental health services.
2. Correct flaws in the STRTP care and supervision rate.
3. Align STRTP regulations across Department of Social Services and Department of Health Care Services.
4. Change hiring criteria and professionalize the role of STRTP direct care staff.
5. Add and fund STRTP aftercare services.
6. Work with the California Department of Education to address the educational needs of STRTP youth.

Background

The Continuum of Care Reform (CCR), signed into law in January 2017 as AB403, sought to transform foster care in California by strengthening and elevating family-based care. As part of CCR, group homes would be replaced with Short-Term Residential Therapeutic Programs (STRTP) intended to serve children and youth whose challenging behaviors and significant emotional and developmental needs created barriers to placement in family-based care. This new STRTP license category required providers to obtain national accreditation, meet Department of Health Care Services (DHCS) mental health standards, procure a contract with a County Mental Health Plan (MHP), and implement trauma-informed care.

STRTPs were quickly overwhelmed by a licensing and compliance focus and a glaring lack of coordination between the Department of Social Services (DSS) and DHCS – the two departments overseeing the implementation of this level of care. This uncoordinated approach has resulted in:

- regulations that are redundant, conflicting, and in some cases superfluous,
- regulation and funding methods that compartmentalize the mental health and "care and supervision" components of integrated 24/7 treatment,
- minimal direction to placing agencies (counties) regarding the type and intensity of mental health services indicated for youth in STRTP,
- failure to conform the mental health contracting conditions that differ significantly across counties,
- flawed assumptions about occupancy rates and mental health revenue, resulting in financially under-resourced STRTPs,
- lack of consideration for the critical role of education in a short-term residential treatment setting, and
- complete disregard of financial resources and regulatory direction to fund and facilitate aftercare and transitions as a critical component of STRTPs.

The above challenges result from a lack of partnering across State agencies in a manner that supports the critical role of STRTPs. As a result, rather than directly benefitting youth in care, added requirements have compelled providers to invest in sophisticated accounting, billing, human resources and compliance activities to meet new regulatory obligations, maintain national accreditation standards, assure compliance with duplicative documentation requirements and idiosyncratic county contract elements, and manage increased staff turnover. This lack of coordination across State agencies also flies in the face of the Integrated Core Practice Model, which promotes shared values and standards of practice across providers, including STRTPs, who serve youth in care. To remove these barriers and enable STRTPs to maximize treatment effectiveness and outcomes, the following recommendations must be implemented.

1. Adequately fund STRTP mental health services

Youth referred to STRTP have typically experienced multiple and complex trauma. These are youth who have survived severe neglect, physical, sexual, and emotional abuse; have endured traumatic separations from parents and caregivers; and have faced reenactments of these tumultuous growing up experiences through numerous changes in caregivers, placements, and helping professionals. Their behavioral presentations include serious patterns of attempts to harm themselves and others, severe and unmanaged mental health symptoms, many psychiatric hospitalizations, and substantial impairments in their abilities to function across life domains (e.g., challenges completing daily self-care, regulating emotions, building and maintaining relationships with peers and adults, accessing education, and remaining safe in the community).

Treatment of this complex trauma requires an integrated, multidisciplinary approach encompassing significant relationship investment, trust-building, and commitment to trauma-informed approaches. Part of this approach includes provision of Specialty Mental Health Services (SMHS). Counties contract for "outpatient" SMHS and pay STRTP providers through a cost reimbursement mechanism that uses units of service as the billing methodology. Reimbursement is for staff time and the billing unit is each minute of service delivered/documented. However, allowable rates for a minute of service differ widely from service to service and from county to county. Further, despite the high-level needs of youth served in STRTPs, there have been no minimum expectations established regarding type, frequency, and intensity of SMHS youth in an STRTP should receive.

A recent survey of eight STRTP providers (previously RCL-14s) with 433 licensed beds shows that on average each youth is provided 471 minutes weekly of billable mental health services (7 hours, 52 minutes) with an average minute rate of $3.50. Applying this unit rate to the average number of minutes provided to each youth each week yields an average monthly cost of $7,138 (471 minutes per week x $3.50 x 4.33 avg weeks in a month) or an average daily rate of $238. In licensed group homes, the commercial insurance industry funds these comparable "outpatient" services (e.g., partial hospitalization programs) using a "fee for service" methodology that involves reduced documentation requirements and daily funding rates ranging from $500 to $750. As compared to an STRTP, these differences in daily rates are enormous.

The higher rates and reduced documentation burden in commercial insurance funded programs allow providers to maintain lower staff to client ratios, smaller clinical caseloads, increased focus on direct service delivery, and additional funding for program extras (e.g., IT improvements/upgrades, supplemental therapeutic supplies and activities). Generally speaking, as compared to youth who access treatment services via commercial insurance, youth in the Medicaid public insurance system have higher rates of exposure to adverse childhood experiences, are disproportionately Black, Indigenous, People of Color (BIPOC), and have fewer relational resources in terms of involved family and other permanent, natural supports. This glaring disparity is a consequence of systemic racism in the health and foster care systems and results in inequitable access to services for youth and families. It is our shared responsibility as stakeholders in youth systems of care to collaboratively partner to eradicate these systemic injustices, including ensuring adequate funding to provide the robust treatment services that youth served in STRTPs both need and deserve. Specifically, this means State direction to County Mental Health Plans regarding the type and range of services needed by youth as well as an established minimum monthly rate of $7,138 per youth, per month for mental health services.

2. Correct flaws in the STRTP care and supervision rate

Although essential, billable clinical services alone are not sufficient for the comprehensive healing of complex trauma. Individual therapy offered a few times each week, or even a more intensive delivery of an array of

specialty mental health services (e.g., therapy, rehabilitation, case management, crisis intervention), is not antidote enough for the 24/7 unpredictability, chaos, and inconsistency that many youth with complex trauma have faced in their histories and have come to anticipate in the present. Instead, youth with complex trauma need round-the-clock, integrated care that includes repeated exposure to predictable, reliably regulating, and relational experiences that through repetition begin to heal the brain.

Among residential care providers, the therapeutic residence where this around-the-clock care occurs is often referred to as the "milieu" and can be thought of as a major therapeutic intervention in an STRTP. In the milieu, direct care staff assist youth in following daily schedules that parallel the structure and consistency of a family home environment by providing routine and predictability which serve to calm and regulate the brains of youth who have become accustomed to chaos and instability. As such, treatment is dosed in increments of a 24-hour day where the way a youth is greeted in the morning, asked about their school day, or comforted in the middle of the night, are critical aspects of treatment and as important – maybe more important – to their healing as is a therapy session with their individual clinician.

Despite the importance of the milieu in effective treatment, the STRTP rate built in 2016-17 made two critical assumptions that effectively reduced the rate and adversely impacted STRTP providers' ability to maximize milieu treatment. The first assumption concerns occupancy versus licensed capacity. Using methodology from the historical group home rate structure, DSS developed costs for a program that included new staffing ratios, indirect and child specific costs, and overhead. This cost pool was then divided by licensed capacity to get a per month, per youth, care and supervision rate. Recognizing that providers do not operate at full licensed capacity, a 90% occupancy was assumed effectively raising the bed rate by 10% to cover 100% of the costs. In addition to the occupancy assumption, DSS also assumed that mental health billing could bring additional financial support to the milieu and reduced the rate by $1,026 per month in the 2016-17 model.

Neither of these assumptions have been realized. STRTPs tend to operate at less than 90% capacity for both safety and clinical reasons and cannot cover costs with a lower census. Additionally, county mental health contracts do not include services or billing by direct care staff. Consequently, the established rate underfunds the care and supervision component by approximately 15%. It is critical that the STRTP care and supervision rates be revised to assume placement at 85% of licensed bed capacity and that the assumption that county mental health contracts supplement the milieu should be jettisoned. This would result in a care and supervision rate of $15,919 per month.

3. Align STRTP regulations across Departments

Contracting with a County Mental Health Plan is a requirement and enables an STRTP to bill and receive payment for the SMHS provided to youth who meet medical necessity criteria, and virtually all youth do. This process alone requires providers to meet burdensome documentation requirements, but when combined with DSS licensing regulations as well as standards of national accreditation, providers are burdened with documentation requirements and compliance activities that are demanding of staff time and do not directly benefit client care. Among many examples, the Client Treatment Plan developed for each youth is but one instance of duplicative regulatory requirements as it is in addition to and overlaps with the Needs and Services Plan required by DSS. Additionally, the mandated daily mental health note serves no other documentation purpose and duplicates daily logs maintained by milieu staff.

4. Change hiring criteria and professionalize milieu staff

Because the residential milieu is only as effective as the staff who provide direct care and supervision, STRTP hiring criteria and training requirements should be reexamined. The direct care staff role must be professionalized, which

means prioritizing competencies and retention rather than emphasizing educational qualifications that may not translate directly into skillfulness in serving young people. Only then will it be possible to conceptualize this important task – to care for our state's most vulnerable youth – as a vocation or life's work, rather than a steppingstone to other career opportunities. This systemic shift is an essential step in increasing staff retention to minimize STRTP youth exposure to repeated experiences of interpersonal inconsistency and loss.

An example of a competency-based approach to child and youth care work is the work of the Child & Youth Care Certification Board (CYCCB), an international organization whose mission is to advance the profession of direct care youth work. Certification is rigorous, requiring course work, a written exam, peer recommendations, supervisor assessment, and a portfolio. Research shows that certified workers are 2.7 times more likely to be high performers than uncertified workers and a high degree of internal reliability across practice settings has been established.

5. Add and fund STRTP aftercare services

As an STRTP expectation, the therapeutic benefits of the milieu as well as ongoing access to mental health services should be extended into the next placement. Such aftercare services facilitate generalization of new self-regulatory and interpersonal skills and promote permanency and stability across relationships and living situations. Additionally, coordinated, deliberate attention to youth transitional experiences heals past experiences of unexpected, unpredictable, and otherwise traumatic relational losses. Adequate funding should cover this critical transitional support.

6. Address the educational needs of STRTP youth

Just as STRTP referred youth have experienced multiple moves in their living situations, they have also been repeatedly uprooted and re-enrolled across educational settings. Their school histories are replete with stories of negative peer relationships, truancy, academic difficulties, and disciplinary problems. Typically, they have not stayed long enough in a school for their educational needs to be assessed or addressed.

Youth histories of complex trauma and their resulting significant social, emotional, and behavioral needs necessitate special supports to ensure youth can access and benefit from their education, regardless of eligibility for special education services, though most would meet that criteria. Consideration for an appropriate and beneficial educational experience should be a part of the referral and initial assessment processes and must be incorporated into STRTP treatment.

Conclusion

The Continuum of Care Reform effort – sometimes called a "once in a generation" reform – launched in 2017 with laudable goals, has fallen far short of its target to successfully restructure STRTPs to maximally benefit the highest needs youth in the foster care system – those exhibiting the long-term effects of chronic chaos, repeated loss, multiple disruptions of critical developmental anchors (home and school).

Without correcting the flaws embedded in the current regulatory and fiscal supports along with the need for department collaboration at both the state and county levels, STRTPs will continue to struggle with realities of the extreme needs of youth being served and will never be the critically important resource anticipated in CCR. Ultimately, STRTPs will respond by shifting their beds to other payers or closing, but the biggest consequence of inaction will be to the youth who most need these integrated services.

STRTP Policy and Practice Recommendations

Recommendations to Improve a Critical Component of Care for Foster Youth

Background

The Continuum of Care Reform

A key provision of AB403 – the Continuum of Care Reform (CCR) – was to transform group homes into residential treatment programs. This transformation required major shifts in the licensing and regulatory standards for group care providers. Agencies could continue to operate as congregate care settings only if they met the higher standards imposed by a new licensing category: Short-Term Residential Therapeutic Program (STRTP). Upgrades, intended to be supported by a higher monthly rate for care and supervision, included increased staff training and qualifications and requirements to:

- achieve national accreditation by The Joint Commission, Council on Accreditation (COA), or the Commission on Accreditation of Rehabilitation Facilities (CARF),
- meet Department of Health Care Services (DHCS) Medi-Cal and STRTP mental health program certification standards,
- procure a mental health contract with a County Mental Health Plan (MHP), and
- implement trauma-informed care.

Driving these requirements was an expectation that STRTPs be reserved only for those children and youth having such challenging behaviors and significant emotional and developmental needs that they could not live safely in family-based care. Healing and recovery – a major premise of CCR – would require integrated and sophisticated 24-hour treatment.

Lack of Integrated State Direction and Support

However, the aspirations of CCR – the commitment to innovation, the invitation to adaptability and flexibility – were quickly overwhelmed by a licensing and compliance focus. Albeit necessary in the long-run, technical and regulatory obligations of each State Department having a role in implementing this massive reform effort – the Department of Social Services (DSS) and the Department of Health Care Services (DHCS) – were addressed with urgency and, apparently, with minimal regard for the burdens that might be placed on providers by overlapping, redundant, and in some cases superfluous requirements.

Some examples of what was left behind in this regulatory rush include:

- A lack of specificity about the type and scope of mental health services for youth in an STRTP.
- The arbitrary demarcation between the care and supervision and the mental health components of STRTP interventions.
- The overlooked role of educating youth in a short-term residential treatment setting and integrating the educational services with the mental health and care and supervision components of an STRTP.
- The inconsistency and overlapping regulatory requirements of DHCS and DSS.
- The unwarranted assumptions about blended funding and county mental health contracts being realistic fiscal supports for the care and supervision component of STRTPs.
- Significantly different county-by-county contracting details and conditions for mental health services.

Ironically, this disintegration between State Departments and their policy, regulatory, and funding functions flies in the face of the Integrated Core Practice Model (*see box*) and the articulated "shared values . . . and standards of practice expected from those serving California's children, youth and families" at all levels of care including STRTPs.

Integrated Core Practice Model (ICPM)

Released in 2018, in support of the Continuum of Care Reform (CCR) . . . the ICPM is an articulation of the shared values, core components, and standards of practice expected from those serving California's children, youth, and families and provides practical guidance and direction in the delivery of timely, effective, and collaborative services. Additionally, the ICPM helps create a culturally relevant and trauma-informed systems of care that strengthens the voice and choice of the child, youth, and family and builds consensus around their strengths and needs in service planning and delivery. The practice of working together as a team is at the heart of ICPM and central to the implementation of family-centered practice and CCR.

An additional irony of this well-intended initiative is that the higher care and supervision rates and required mental health contracts aimed at increasing clinical services and upgrading youth care qualifications, have instead been consumed by STRTP provider investments in sophisticated accounting, billing, human resources and compliance activities to meet new regulatory obligations, maintain national accreditation standards, assure compliance with duplicative documentation requirements, and manage increased staff turnover.

Complicated and Contradictory County Mental Health Contracts

A major component of STRTP implementation was that providers would be required to contract with County Mental Health Plans (MHP) enabling them to deliver mental health services funded by the Medicaid mandates of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. However, many newly licensed STRTPs have no previous experience with such contracts and have not had a relationship with a County Mental Health Department. Adding clinical services via a county mental health contract left many providers facing a steep learning curve. New and unfamiliar activities include hiring appropriately credentialed staff, crafting treatment plans to meet the significant needs of youth in care, delivering clinical services, developing documentation protocols, learning billing procedures, managing cashflow, and implementing quality assurance practices. Exacerbating this learning curve is the fact that DHCS has offered no guidance to either counties or providers about the range, type and intensity of mental health services that should be available to youth in an STRTP.

Moreover, each county imposes its own contracting conditions that differ widely from what other counties may require, for example, credentialing standards and provider scope of practice. County contracts often

add burdensome training and educational obligations and increase documentation standards beyond those contained in Medicaid Manuals and the California State Plan. Other contracting discrepancies among counties include significant differences in which services can be provided, county maximum unit rates for the same service, contract financial limits, and settlement protocols. These contracting requirements have buried providers in administrative burdens that decrease the time and limit the resources agencies have available to directly deliver services to meet the needs of youth with the highest needs in the system. Further, these requirements perpetuate systemic disintegration through which youth in an STRTP can quickly become "those kids" or "your kids" rather than "our kids" collectively.

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STRTP Provider Experience

An artifact of CCR's successful efforts to close group homes and move as many youth as possible into community-based settings is that youth with extreme needs who previously had been dispersed into all levels of congregate care settings around the state are now concentrated into a shrinking number of STRTPs.

Demonstrating the increased collective acuity of youth in STRTPs are the results of a survey conducted in November of 2019 of 47 member agencies of the California Alliance of Child & Family Services (CACFS) with a provisional or permanent STRTP license covering 1,638 beds (See *Attachment A* for full survey results):

- 45 referrals per month on average.
- Across the 47 STRTPs surveyed, an average of 13 counties are represented in the program census.
- Compared to the year prior to STRTP licensure (year varies across agencies):
  - Lengths of stay decreased 23% as a direct result of runaways, psychiatric hospitalizations, and need for a higher level of care.
  - Graduations or discharges to lower levels of care or kin/family decreased by 38%.
  - Staff turnover increased by 8%.
  - Workers compensation claims increased by 32%.

The table below from the November 2019 survey shows the percent increase in incidents pre- and post-STRTP licensure. This data demonstrates the increased concentration of high acuity youth funneled into STRTPs rather than being served across a wider range of RCL 10-14 group homes across the state.

Incident Per 1,000 Bed Days	% Increase
Elopement/Runaway	56%
Physical Assault on Peer	47%
Property Damage *(Significant Incident Reports do not capture cost of damage and repairs, which has increased up to 300% post-STRTP licensure)*	38%
Self-Injurious Behavior	14%
Physical Assault on Staff	11%
Staff Response	
Psychiatric Hold Written	50%
Restraint (Physical Hold)	23%
Law Enforcement Involvement	10%

Through calendar year 2020 at least three high-profile programs with 197 licensed beds – 12% of those included in the survey – have closed for reasons identified above as well as the inability to staff the programs appropriately, maintain an occupancy rate that works financially, along with the difficulty of educating youth in an STRTP and the cost of supervision during school hours – an issue that predates the current global pandemic.

Youth Profile

STRTP Placements

The STRTP is often described as "one step below" psychiatric hospitalization, which illustrates not only the level of intervention required, but also, as noted above, the corresponding acuity of the youth served. These are youth who in their young lives have endured neglect, physical, sexual, and emotional abuse at the hands of adults; have suffered traumatic separations from parents and caregivers; and have faced reenactments of these tumultuous growing up experiences through multiple changes in caregivers, placements, and helping professionals.

Their behavioral presentations include serious patterns of attempts to harm themselves and others (in some cases violent assaults on peers and adults), severe and unmanaged mental health symptoms, multiple psychiatric hospitalizations, and substantial impairments in their abilities to function across life domains (e.g., challenges to complete daily self-care, regulate emotions, build and maintain relationships with peers and adults, access education, and remain safe in the community without institutional care supports).

The experience of multiple traumas inevitably shapes youths' views of themselves, their strategies for fulfilling unmet needs, their expectations about personal relationships, and their world. As a result, it is difficult, if not impossible, to describe youth served in STRTPs without discussing complex trauma.

Complex Trauma

Complex trauma is a term used to describe both cause and effect. As a cause, complex trauma is a constellation of risk factors involving repeated interpersonal trauma by caregivers early in life. As an effect, complex trauma is the disruption that occurs post-exposure to traumatic experiences, including dysregulation across emotional, behavioral, interpersonal, physiological, and cognitive functioning (Cook et al., 2005). The effects of complex trauma may appear as externalizing behavior challenges (e.g., aggression, substance use/abuse, self-harm, etc.) and can also manifest in internalizing behaviors and risks (e.g., sensory deficits, attachment/lack of trust, somatic dysregulation, etc.).

The current psychiatric diagnostic classification system does not have an adequate category to capture the full range of difficulties that youth with complex trauma experience. Therefore, while a narrowly defined

PTSD diagnosis is often used, it rarely captures the full extent of the developmental impact of multiple and chronic trauma exposure. Other diagnoses commonly given to children with complex trauma histories include Depression, Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Conduct Disorder, Generalized Anxiety Disorder, Separation Anxiety Disorder, and Reactive Attachment Disorder. Although each of these diagnoses captures an aspect of the traumatized youth's presentation, in isolation these diagnoses typically do not represent the whole picture of the youth's experience.

The treatment that flows from these diagnoses often focuses on the specific – typically externalized – behavior identified, rather than on the core deficits that underlie the presentation of complexly traumatized youth. Consequently, treatment is often symptom-focused, disintegrated from other aspects of the youth's life, and does not generalize across settings.

Treatment Integration

Conversely, when assessed and addressed competently, complex trauma treatment requires an integrated, multidisciplinary approach encompassing significant relationship investment, trust-building, and commitment to trauma-informed approaches. More specifically, integrated treatment means that therapeutic interventions are not limited to Specialty Mental Health Services funded by county mental health contracts. Rather, treatment is dosed in increments of a 24-hour day where the way a youth is greeted in the morning, asked about their school day, or comforted in the middle of the night after a nightmare, are critical aspects of treatment and as important – maybe more important – to their healing as is a therapy session with their individual clinician.

Integrated treatment is dosed in increments of a 24-hour day, where the way a youth is greeted in the morning, asked about their school day, or comforted in the middle of the night after a nightmare, are critical aspects of treatment and as important – maybe more important – to their healing as a therapy session.

As noted, youth with complex trauma are likely to present with difficulties or deficits related to their attachments and relationships, emotions, cognitions, behaviors, physical health, and self-concept (Peterson, 2018). Since these interpersonal and psychological challenges and needs are likely to be pervasive – occurring across life domains and settings – it follows that interventions must be comprehensive, ubiquitous, and integrated. Treatment at the STRTP level of care must be provided throughout the day and in every setting, accounting for youth mental health needs, relationship needs, daily living needs, cultural needs, and educational needs.

The following sections will detail STRTP supports related to (a) mental health services, (b) therapeutic residential services, (c) educational services, (d) barriers to providing services, and (e) recommendations to address identified barriers.

Mental Health Services

Specialty Mental Health Services (SMHS)

A primary reason youth are referred to an STRTP is to ensure access to the type and intensity of Specialty Mental Health Services (SMHS) necessary to address the barrier behaviors preventing the youth from living in family-based care in the community. Most Medi-Cal eligible youth, including foster youth, are able to live

in the community and can benefit from mental health services that can be addressed by a network of providers contracted with commercial insurance managed care organizations or the fee-for-service Medi-Cal system, depending on their county.

On the other hand, given their histories of complex trauma and severe emotional and behavioral issues, youth placed in an STRTP have "severe" mental health conditions which qualify for treatment via SMHS under the domain of County Mental Health Plans (MHP). Contracting with an MHP – which STRTPs are required to do – enables an STRTP to bill for and receive payment for the mental health services provided.

County Mental Health Contracts

Mental health services delivered under an MHP contract with an STRTP provider are driven by the unique needs of each youth and are incorporated into the client plan. These needs are determined based on the outcome of a mental health assessment which is conducted upon the youth's admission to the STRTP and is required to establish medical necessity at the residential care level.

To qualify for Specialty Mental Health Services youth must meet three medical necessity criteria which due to their exposure to complex trauma and resulting social, emotional, and behavioral challenges virtually all youth referred to an STRTP do. These include:

- Diagnostic criteria – the youth must be diagnosed with a current ICD 10 diagnosis,
- Impairment criteria – the youth must have a significant impairment, or probability of deterioration in an important area of life functioning which will impede appropriate developmental progress, or the probability that the youth will not progress developmentally as individually appropriate, and
- Intervention criteria – the planned interventions are expected to address the youth's functional impairment to correct or ameliorate the condition.

The client plan based on this initial assessment and developed for each youth specifies measurable goals, a detailed description of the interventions to be provided, and the proposed frequencies and durations of the interventions.

Note, however, that this detailed client plan is:

1. in addition to and overlaps with the Needs and Services Plan required by DSS,
2. constrained by the restrictions imposed by a county mental health contract such as what services are included (or not) in the contract, limitations on "dosing," i.e., units of service allowed, unit rate maximums, provider scope of practice limitations, overall contract amounts, and
3. limited by EPSDT requirements which, under the above-described impairment and intervention criteria, do not allow for permanency-specific, social services-oriented goals – causing further systemic disintegration of goals, plans, and supports for youth in STRTPs.

The STRTP specialty mental health services listed below are also often limited by county contracts though they are included in California's mental health plan, are mandated by federal law when they are found to be medically necessary, and are essential for treating youth with complex trauma.

- **Medication Support** specific for psychiatric evaluation and medication management but often disallowed for the time nurses provide instruction in the use, risks, and benefits of the medication, and check for side effects.

- **Crisis Intervention** is often restricted in an STRTP despite the fact that youth needing the STRTP level of care are much more likely to require crisis intervention and despite the acknowledgement that similar services, when received in the community, would qualify as a billable, reimbursable service.
- **Intensive Care Coordination (ICC)** is limited even as a stronger emphasis should be placed on coordination of care as well as developing transition and aftercare plans and case management follow-up on Child and Family Team (CFT) recommendations. ICC was previously limited to 90 days prior to discharge from a residential program; however, by Katie A litigation, that limit was removed prior to the implementation of AB403.
- **Peer Supports** delivered by Youth Advocates and Parent Partners are often excluded from county contracts, but when available, can enhance treatment effects for youth who may be apprehensive to engage in usual methods of mental health care.
- **Therapeutic Behavioral Services (TBS)** are often not allowed by counties; however, when delivered proactively in the STRTP these individualized supports can help to facilitate stabilization, support relationship development, and reduce crisis episodes, especially in the initial phases of treatment.
- **Rehabilitation Services** as noted above, are one of the highest-frequency and most generalizable services provided in an STRTP, though some counties do not allow individual or group rehabilitation services.
- **Collateral Services** which can, for example, be used for "expanded" Family Finding efforts that assist youth in developing and managing relationships with found family members who may become a resource. Many counties have narrow definitions of collateral and/or what services can be provided to collateral resources.

STRTP Provider Experience

The SMHS clinical services delivered as part of the STRTP intervention are dosed as an "outpatient service" and reimbursable by Medi-Cal through county contracts. Services are billed by the minute of staff-time when delivered within the scope of practice of the staff member.

A survey of eight STRTP providers (see table below) with 433 licensed beds was conducted in the fall of 2020 and shows that, on average, each youth is provided 471 minutes weekly of billable mental health services (7 hours and 52 minutes). However, it should be noted that this number does not reflect the total amount of services each youth receives since outpatient mental health services are billed by staff time rather than by the amount of time youth are receiving treatment. To illustrate: when billing for group services staff must divide their time by the number of youth participating in the group – six youth in a group lasting an hour would require staff leading the group to bill 10 minutes for each youth (60 minutes of staff time/6 youth participants = 10 minutes of billable service time per youth). Meanwhile, the actual time each youth spends participating in that group is 60 minutes.

Average Hours Per Week Per Youth of Mental Health Services				
Mental Health Services	**Average Minutes Billed**	**Average Hours Billed**	**Average Hours Received by Youth**	**Percent Received**
Individual Therapy	80	1 hr, 21 min	1 hr, 21 min	8%
Group Therapy	44	44 min	4 hrs, 23 min	26%
Family Therapy	25	25 min	25 min	2%
Collateral Services	24	24 min	24 min	2%
Individual Rehab	126	2 hrs, 6 min	2 hrs, 6 min	12%
Group Rehab	66	1 hr, 6 min	6 hrs, 37 min	39%
Targeted Case Management	25	25 min	25 min	2%
Intensive Case Coordination	39	39 min	39 min	4%
Crisis Intervention	16	16 min	16 min	2%
Medication Management	26	26 min	26 min	3%
TOTALS	**471**	**7 hrs, 52 min**	**17 hours**	**100%**

Note that most "received" services – 10 of the 17 hours per week – are delivered in groups (group therapy and group rehabilitation). Also note that consistent with the discussion about the importance of the milieu in the next section, rehabilitation services – individual and group – constitute 51% of all mental health services received by each youth (almost nine hours a week).

Rehabilitation services are focused on supporting youth to develop new skills or improve/restore an existing skillset necessary for appropriate developmental functioning. Areas of intervention may include functional, social, communication, or daily living skills with the purpose of enhancing self-sufficiency or self-regulation. These services include adjunctive therapies such as art, music, and physical activities requiring cooperation, appropriate exchange of information, and a broad range of interpersonal skills. These rehabilitative interventions, provided across settings and life domains, are critical approaches in meeting the above-described holistic, integrated treatment needs of complexly traumatized youth.

Two other agencies participating in this survey have day rehabilitative programs – a bundled mental health service supported by a daily rate. These day rehabilitative programs are between 4.5 and 4.8 hours per day and delivered either five or six days a week. The weekly average hours of these bundled mental health service are between 22 and 30 hours. In addition, these programs bill another three hours weekly of unbundled mental health outside of day rehabilitative hours. Total mental health services in these programs span 25 to 33 hours a week. Note that this bundled approach simply structures more "billable" mental health time into each day. It does not mean that these agencies provide more treatment services than those using an unbundled approach.

A caution in interpreting these results: the agencies included in this survey are former RCL-14s who garnered their STRTP license with existing mental health contracts that had been in place for years. This is not the case with many of the group homes that have transitioned or are transitioning to STRTP status and

may be shouldering additional stress on their organizational systems due to lack of prior experience or under-resourced existing administrative infrastructure.

Also worthy of note and as stated previously – the range of billable mental health services in an STRTP is entirely dependent on contracts with the Counties that place youth or on Counties required to fund mental health services because of presumptive transfer. County contracts vary widely. As noted above some do not allow Crisis Intervention services to be billed by an STRTP. Others authorize Medication Support to be billed only by psychiatrists, not nurses who educate youth about the benefits and risks of medication and check for side effects as they dispense psychotropic medication. Others preclude billing for collateral services and case management. In addition, county contract maximums restrict the amount of services that youth in an STRTP can receive. Consequently, it is fair to say that the specialty mental health services a youth receives is more based on the contract with the county than the needs of the individual youth.

Cost of Mental Health Services

Counties contract for specialty mental health services and pay through a cost reimbursement mechanism that uses units of service as the billing methodology. For the wide variety of outpatient services displayed in the table above, reimbursement is for staff time and the billing unit is each minute of service delivered and documented. Aside from the fact that this is a cumbersome and anachronistic billing methodology, the allowable rates for a minute of service differ widely from service to service and from county to county. In the case of provider experience described above, an average minute rate is $3.50. Applying this unit rate to the average number of minutes provided to each youth each week yields an average monthly cost of $7,138 (471 minutes per week x $3.50 x 4.33 avg weeks in a month). Translating this to a daily rate results in $238 per day.

As noted, a critical feature of county mental health contracts is that they are cost reimbursed. Unit rates must be supported by actual costs incurred by the provider. At year-end counties settle with providers based on the cost pool for mental health services which is then divided by the total units/minutes provided to calculate the actual unit/minute rate. From this perspective, unit rates can be viewed as a proxy for costs and wide variation exists across counties regarding the costs that counties will fund and the value counties place on STRTP services. The $3.50 unit rate (average of $238 per day) reflects the cost of mental health services of providers who are on the mature end of the developmental continuum in their conversion to STRTP and provision of intensive treatment services.

Cost Comparisons

To contextualize the cost of the mental health component of STRTPs, it is informative to consider how lookalike residential services are funded by commercial insurance carriers where payments are structured as a bundled service with a single, all-inclusive daily rate. Although the services provided within each of these residential treatment programs are similar, the rates are vastly different, with commercial insurance being as much as double an STRTP when combining mental health reimbursements with care and supervision rates ($1,200/day vs. $600/day). This is an alarming affront to parity and especially concerning given state and national requirements for equal treatment of mental health conditions and substance use disorders in insurance plans.

Because STRTP mental health services are funded by EPSDT Medi-Cal as outpatient rather than inpatient services, it is also important to consider comparable commercial insurance funded outpatient services: Partial Hospitalization and Intensive Outpatient Programs. Note that, as is the case for commercial

insurance-funded residential treatment, these are fee-for-service programs with a daily bundled rate rather than a cost-reimbursement financing structure.

1. **Partial Hospitalization Program (PHP)**. PHP programs generally operate five to six hours per day, five to six days per week. They are equivalent to day treatment programs in SMHS Medi-Cal, though they include the analogous unbundled services provided by STRTPs described above (e.g., group therapy and group rehabilitation, individual and family therapy, adjunctive services such as therapeutic recreation and art therapy, case management, medication support, etc.). Depending on the insurance carrier, daily rates for PHPs range from $600 to $750.
2. **Intensive Outpatient Program (IOP)**. IOP programs are similar to PHP but at reduced hours and reduced days – typically three hours per day, three days per week. Daily rates for IOP range between $350 to $500.

When compared to the $238 STRTP average daily rate deduced above, the commercial insurance-funded daily outpatient rates exceed STRTP rates by up $500 per day. Further, the commercial insurance fee for service system involves far fewer documentation requirements. The higher rates and reduced documentation burden in commercial insurance funded programs allow providers to maintain lower staff to client ratios, smaller clinical caseloads, increased focused on direct service delivery, and additional funding for program extras (e.g., IT improvements/upgrades, supplemental therapeutic supplies and activities).

Generally speaking, as compared to youth who access treatment services via commercial insurance, youth in the Medicaid public insurance system have higher rates of exposure to adverse childhood experiences, are disproportionately Black, Indigenous, People of Color (BIPOC), and have fewer relational resources in terms of involved family and other permanent, natural supports (Marrast, Himmelstein, & Woolhandler, 2016). This glaring disparity is a consequence of systemic racism in the health and foster care systems and results in inequitable access to services for youth and families.

This glaring disparity is a consequence of systemic racism in the health and foster care systems and results in inequitable access to services for youth and families. It is our shared responsibility to collaboratively partner to eradicate these systemic injustices.

It is our shared responsibility as stakeholders in youth systems of care to collaboratively partner to eradicate these systemic injustices, including ensuring adequate funding to provide the robust treatment services that youth served in STRTPs both need and deserve. Specifically, this means State direction to County Mental Health Plans regarding the type and range of services needed by youth as well as an established minimum monthly rate of $7,138 per youth, per month for mental health services.

Beyond Specialty Mental Health

Billable clinical services alone are not sufficient for the comprehensive healing of complex trauma. It can be argued that the STRTP therapist and other mental health program staff deliver experiences of environmental and interpersonal safety via clinical interventions, provided a few hours each day, dosed throughout the youth's week. However, interpersonal neuroscience research (Perry & Szalavtiz, 2006; Siegel, 2020; summarized below) establishes that these experiences must be provided with greater consistency and across the youth's life experiences to be maximally effective. This finding highlights the importance of routine and repetition in therapeutic healing as "the brain changes in response to patterned,

repetitive experiences: the more you repeat something, the more engrained it becomes" (Perry and Szalavitz, 2006, p. 245).

Given the constant state of arousal, vigilance, and fear that traumatic experiences have produced in complexly traumatized youth, the direct care staff who provide around-the-clock care and supervision are primary, paramount, and the key to providing the interventions that promote physical and relational safety. Stated simply, when relationship is the cause of trauma and distress, relationship must also be part of the cure (John, 2016; Perry & Szalavitz, 2006; Siegel, 2015). This leads us to the importance of the therapeutic milieu.

The Therapeutic Milieu

Role of the Therapeutic Milieu

Among residential care providers, the therapeutic residence is often referred to as the "milieu". Milieu is a French word that refers to the social environment of an individual. Youth referred for STRTP intervention have typically come from a social environment marked by chronic stress, chaos, physical danger, and a lack of interpersonal safety. A therapeutic milieu, on the other hand, is the opposite of a toxic social environment. It provides for repeated, predictable, interpersonally supportive experiences with caring and treatment-savvy adults. In STRTPs the therapeutic milieu is an intervention where direct care staff assist youth in following daily schedules that provide routine, structure, and predictability. Consistency in routine is especially important for young people who have experienced complex trauma, as it "provides them with a sense of security, knowing what is happening and what to expect" (Barton, 2012, p. 149). This may include daily activities such as meal preparation and clean-up, laundry, room care, and homework. Although task-oriented, the consistency and reliability of these daily routines serves to calm and regulate the brains of young people who have become accustomed to chaos and unpredictability, who have had to learn to be hypervigilant to subtle cues of threat or danger in their living space.

Practically speaking this means that when young people have experienced pervasive and repeated disruption and danger in their homes and families, "outpatient" mental health services delivered within an STRTP are not sufficient to address a youth's reluctance to bathe or dress when they wake up in the morning, the outburst that ensues when asked by a teacher to write about a family holiday, the threat perceived when a well-intended coach places a hand on the youth's shoulder, and the terror experienced when awakened in the middle of the night after a nightmare about their abuser.

Therapists have an important and integral role in helping youth learn to cope with, understand, and integrate these experiences, but rarely is it the therapist who is present at all hours of the day and night to guide the young person through these moments. Instead, it is the direct care worker who develops enough rapport to be trusted to "guard" the bathroom door against a feared breach, to hold space for the painful

wounds uncovered by a school assignment, and to offer comfort to tuck the young person back into bed at night. It is not the therapist's office where the bulk of these repeated, profound, and reparative experiences occur, but within the young person's daily living and relational environment. Through this process, a home and interpersonal landscape that a youth has historically experienced as dangerous and unpredictable, can gradually be experienced as safe, consistent, and reliable. And so, the therapeutic milieu in the STRTP is not a "time-filler between psychotherapy sessions" nor is it only a "provider of life necessities such as eating, sleeping, and recreation." Instead, "the milieu can be thought of as the major impact that the institution has on the child" (Trieschman, Whittaker, Brendtro, 2010, p. 2-3).

It follows that individual therapy offered a few times each week, or even a more intensive delivery of an array of specialty mental health services (e.g., therapy, rehabilitation, case management, crisis intervention), is not antidote enough for the 24/7 unpredictability, chaos, and inconsistency that many youth with complex trauma have faced in their histories and have come to anticipate in the present. Instead, young people with complex trauma need repeated exposure to "predictable, reliably regulating, and relational experiences…that provide a touchpoint and, through repetition, become 'how [young people] do things in day-to-day life" (Elson, et al., 2020, p. 3).

Another important component of the STRTP therapeutic milieu is relational engagement or community. In a typical family home, this may be likened to an after-school "How was your day?" check-in, dinner-time conversation, or chats on the couch during weekend downtime. In the STRTP environment, these points of connection may be one-on-one or in group settings and may involve interactions between the young people and adult caregivers or youth and their peers. Group gatherings may be utilized to make announcements or share accomplishments and celebrations, establish connection and community, assist in meeting youth's needs, prepare youth for transitions (e.g., to school, to activities, to bedtime), and debrief important events or activities to promote reflection and learning.

The forced delineation between the "care and supervision" and the "mental health" sides of the STRTP that parallel state and federal funding streams, unduly disintegrates the comprehensive, integrated, 24/7 care that young people in STRTP need and deserve.

Overall, the STRTP living space is not merely the housing component of a residential therapeutic intervention or a "platform" where therapeutic interventions are provided, rather, the therapeutic milieu is the restorative intervention that provides around-the-clock opportunities to model, teach, and coach relevant skills (e.g., self-care or daily living skills, social skills, coping skills, independent living skills) as well as engage the youth in reparative relationships, interactions, and experiences designed to support youth development, healing, and growth. As such, the forced delineation between the "care and supervision" and the "mental health" sides of the STRTP that parallel state and federal funding streams (e.g., Department of Social Services, Department of Health Care Services), unduly disintegrates the comprehensive and integrated, 24/7 care that young people in STRTP need and deserve.

Milieu Staff Characteristics and Competencies

As a therapeutic intervention, the residential milieu is only as effective as the staff who provide direct care and supervision to the young people in an STRTP. This calls for the professionalization of the direct care staff role, including prioritizing child and youth care competencies rather than educational qualifications or certifications that may not translate directly into skillfulness in serving young people.

As an example, one competency-based approach to child and youth care work is evident in the work of the Child & Youth Care Certification Board (CYCCB), an international organization whose mission is to advance the profession of direct care youth work. Recognized in states in the Midwest and East Coast as well as Canada and several European Countries, the certification incorporates a curriculum now taught at several colleges and universities, some of which culminate in the earning of a graduate degree *(see Attachment B).* Requirements are grounded in a body of knowledge and skills focused on five domains, including:

- Professionalism
- Cultural & Human Diversity
- Applied Human Development
- Relationship & Communication
- Developmental Practice Methods

Certification is rigorous, requiring course work, a written exam, peer recommendations, supervisor assessment, and a portfolio. Most importantly, research shows that certified workers are 2.7 times more likely to be high performers than uncertified workers (Curry et al., 2013). It demonstrates a high degree of internal reliability across practice settings and was incorporated into the Council on Accreditation standards in 2017. Additionally, Freeman and Garfat (2014) identified 25 characteristics of "relational youth care" in three skill sets – Being, Interpreting and Doing (*see Attachment C*).

Although it is unrealistic to expect all milieu staff upon employment to possess this certification, the approach may serve as a model for competency-based standards for training and professional development. Further, demonstration of these competencies would be less dependent on educational experience, which systemically narrows the pool of candidates eligible for a direct care staff role, unduly excluding those with lived experience or other diverse backgrounds who may have much to offer youth in care such as character and competence. Additionally, those with college degrees may often utilize this employment experience as a stepping-stone to other career opportunities rather than viewing the important youth care worker role as a vocation. Afterall, we know from the young people themselves that "you can have all these protocols, but it's all about the people that care" (Anonymous youth in STRTP level of care, August 2020).

Cost of Milieu/Care and Supervision

The quality and effectiveness of the residential living environment is directly related to staff qualifications and training and to having sufficient milieu staff to provide for consistent, predictable, structured daily routines that meet the individualized needs of STRTP youth. Currently under-resourced, the STRTP care and supervision component of treatment must be adequately funded to maximize treatment effects and shorten lengths of stay.

The primary cost driver in an STRTP is staff, typically accounting for 60% to 70% of all costs. Community Care Licensing requires a staffing ratio of one staff to every four youth between the hours of 7:00am and

10:00pm and one staff to every six youth from 10:00pm to 7:00am. Factoring out paid-time when direct care staff are unavailable – holidays, vacation and sick time, training, supervision, and meetings – results in 85% of each full-time employee's (FTE) work year for direct care and supervision. Assuming a 40-hour work week, this means that to have one staff "on the floor" at all times – 24/7, 365 days a year – will require 5.2 FTEs. Applying this computation to CCL required staffing ratios in a 12-bed program results in the need for slightly more than 14 staff to cover the work week and meet mandated ratios.

Productive Staff Hours	
2080	hours in a year (subtract the following)
80	holiday hours
144	vacation hours (120 hours)/ sick (24 hours)
40	required annual training
48	supervision & meetings
1768	hours available for work
85%	percentage of work hours in a year

But that does not tell the whole story. In an STRTP, more staff are needed to fill-in – for staff training, staff meetings, medical appointments, court hearings, school refusals/suspensions, CFT meetings, crisis management situations, one-on-one supervision needs, overnight support, and a supervisor. In this 12-bed program example, at least four more staff are needed yielding a total of 18 FTEs or 1.5 FTE to each licensed bed.

This formulation can be applied to STRTP programs of any size – a 24-bed program will require a minimum of 36 FTEs, a 60-bed program a minimum of 90 FTEs and so on. However, agencies report that even this formula-based level of staffing is a bare minimum and that most elect to hire enough staff that equate to between 1.75 and 2.0 FTEs per licensed bed to ensure quality care and supervision. It is also important to note that the aforementioned does not include other support positions such as clerical staff, STRTP administrators, etc.

The STRTP rate built in 2016-17 made two critical assumptions that effectively reduced the rate and adversely impacted STRTP providers' ability to maximize treatment in the milieu (See *Attachment D)*.

The first assumption concerns occupancy versus licensed capacity. Using methodology from the historical group home rate structure, DSS developed costs for an STRTP that included new staffing ratios, indirect and child specific costs, and overhead. This cost pool was then divided by licensed capacity to determine a per month, per youth, care and supervision rate sometimes referred to as the "bed rate". Recognizing that, for a variety of reasons described below, providers do not consistently operate at 100% of licensed capacity, a 90% occupancy was assumed. This effectively raised the bed rate by 10% to cover 100% of the costs. For example, if actual costs are assumed to be $15,000 per youth, per month, in a 10-bed program where 90% occupancy equals 9 youth, the bed rate would be calculated at approximately $16,667 per youth ($15,000 x 10-bed capacity = $150,000 / 9 youth = $16,667) to account for program beds that are unoccupied for periods of time.

The second assumption was that STRTPs would use EPSDT mental health billing to supplement care and supervision. Specifically, that a significant amount of service provided in the residential setting would comprise specialty mental health services and should rightly be paid for with EPSDT Medi-Cal, not foster care funding. The fact that DHCS and the County Behavioral Health Directors Association (CBHDA) participated minimally in the STRTP staffing and funding design discussions left this key funding assumption unchallenged and a part of the final STRTP rate structure. Consequently, the care and supervision rate was discounted by the amount of EPSDT assumed to be billable by direct care staff in the milieu.

The impact of this oversight, which reduced the care and supervision monthly rate, continues to hamper the ability of STRTPs to deliver the range, quality, and quantity of services needed by youth.

The impact of this oversight, which reduced the care and supervision monthly rate, continues to hamper the ability of STRTPs to deliver the range, quality, and quantity of services needed by youth placed for intensive 24/7 treatment interventions. Further, the assumption that direct care staff should be expected to complete additional documentation, particularly documentation that must meet EPSDT standards, would result in more time away from their critical role in providing healing interactions to youth.

Additionally, there are other costs apparently not considered in developing the STRTP rate. For example, family visits. Ongoing contacts between the youth and their families are an essential part of treatment for giving youth hope and for guiding aftercare planning and preparation. Often families need help with transportation and overnight housing, especially for youth in STRTPs hours away from their counties of origin. These costs add up quickly and should be the responsibility of county placing agencies. Instead, these costs are often absorbed in good faith by STRTPs as part of delivering quality care and treatment.

Occupancy vs. Capacity

As noted above, STRTPs are overwhelmed with the acuity of youth referred which has led to more significant and dangerous incidents, higher staff and youth turnover, and most importantly poorer outcomes. Consequently, as noted above, staffing ratios typically exceed CCL staff to youth ratio requirements. Hiring extra staff is one way of managing and effectively treating STRTP youth. Another way used by most STRTPs is to reduce occupancy – the number of youth in placement versus the licensed capacity. This approach is used to manage safety concerns, staffing shortages, staff morale and retention issues, and to improve outcomes. The STRTP provider survey (*Attachment A*) reveals that STRTPs have closed for use 17% of licensed beds resulting in an average occupancy rate closer to 80% to 85% of available capacity for child welfare and probation youth for the following reasons:

- **Single rooms** – most STRTP programs are set-up for two youth to a room. However, for safety reasons more and more youth referred to STRTPs require a room to themselves.
- **One-on-ones** – not infrequently youth admitted into an STRP require one-on-one staffing. Though a good solution as a way of assisting youth to adjust to a new placement and assure safety, one-on-one staffing takes direct care staff away from regular duties, reducing the number of staff available for the remaining youth.
- **Staff morale and retention** – STRTP direct care and clinical staff routinely experience vicarious trauma because of their work caring for young people who have survived complex trauma. Administrators are keenly aware of the need to provide care for the caregivers. One demonstrable way of providing this kind of support is to reduce occupancy by delaying an admission. When there is minimal time between a discharge and admission, the perception of direct care staff can be that administration is concerned primarily about the financial bottom-line, which can create cynicism and lead to higher turnover. Conversely, after a period of particularly intense service delivery with high-risk youth, reduced program occupancy provides a way to allow staff time to pause and reflect, reenergize, and be intentional in preparing for new admissions.

Transitions and Aftercare

Successful outcomes require careful transition planning coupled with strong aftercare supports. A key element in positive transitions from congregate care to the community is continuity of care – assuring that important relationships developed during the STRTP experience continue through a transition home or to a community setting. Movement from place to place for most youth in STRTPs has been a wrenching disruption and a substantial contributor to the trauma they have experienced in the foster care system. Without strong supports in place, moving youth from an STRTP that has helped them reduce barrier behaviors, gain self-regulatory and interpersonal skills, make academic progress, and strengthen relationships with family/kin is likely to result in a significant set-back.

Transitional supports must be funded if STRTP treatment gains are to be solidified and permanency in the community is to be long-lasting.

The Residentially Based Services Reform Project launched in 2010-11 in four California Counties with 10 participating group homes (Haye & Franz, 2013) found that:

- Having the same staff move with the family between the residential program and the community is a key component to successful transitions.
- Starting parallel community-based activities while youth are still in the residential program is important to making a smooth transition.
- When families are 'held' by the same team that they've built relationships with during residential treatment and through transitions into the community, crisis stabilization is more effective.

Transitional supports must be funded if STRTP treatment gains are to be solidified and permanency in the community is to be realized. This will mean back-filling direct care staff who, due to their significant relationships with a youth and family, are assigned to provide support through the discharge process and into aftercare. This temporary loss of direct care staff from the residential program while supporting the transition, must be managed by reduced occupancy levels or increased staffing levels. Further, in order to implement thoughtful, well-planned transitions, days or even weeks may be required to support a youth's transition out of an STRTP, which may result in prolonged program vacancies and/or requests to hold open placements for an incoming youth.

Educating Youth in an STRTP

When youth are placed in an STRTP, all aspects of their life have been disrupted. At the top of that list is their educational placement. Given that education is key to a productive and successful adulthood and that youth are typically expected to spend a large percentage of their week in the school setting, it is imperative that the STRTP model of care also addresses and accounts for the educational needs of youth in a way that ensures they are maintaining their skills and educational trajectory forward.

Lack of Educational Evaluations

Just as STRTP referred youth have experienced multiple moves in their living situations, they have also been uprooted and re-enrolled in different educational settings time and again. Their school histories are replete with stories of bullying, negative peer relationships, truancy, poor academic performance, and disciplinary

problems. In many situations, youth have not stayed long enough in a school for their individual needs to be identified. Though some have been referred for special education assessments, often youth have moved before the assessment can be initiated let alone completed.

Their histories of complex trauma and resulting significant social, emotional, and behavioral needs call for special supports to access and benefit from their education, regardless of their eligibility for special education. As a result, it is logical to conclude that the supports and services available to youth in residential treatment should be an integral component of their educational experience as well. And, given the short-term and intensive treatment focus of an STRTP, placement in a local, comprehensive public school without supports is typically contraindicated. At the very least, consideration for an appropriate and beneficial educational placement should be a part of the referral process.

School of Origin Issues

Current policy encourages youth placed in an STRTP to remain in their "school of origin" – defined as school at time of entry into foster care or any school attended within the last 15 months with which the student has a connection – or to attend public schools in the local geography in which the STRTP is located. In practice, this is often not possible and results in several challenges, including:

- School of origin may be miles away from the STRTP and may have become an aversive setting, which argues for a different school experience altogether.
- Many STRTP placements are out-of-county with school of origin in another part of the state.
- All too frequently, STRTP youth have changed schools so many times there is no school of origin.
- Typically, and understandably, STRTP youth do not want to attend a new public school where they know no one and are significantly behind academically.
- Efforts to place STRTP youth in a comprehensive school setting often results in runaways, suspensions, or school refusal due to the youth's needs outweighing the resources available.
- STRTP youth need Educational Rights Holders (ERH) who know them, know their school histories and academic progress, who understand their circumstances and can work with the STRTP and school having jurisdiction to find the best educational environment for them.
- Traditional public schools typically do not have the resources and are overwhelmed by the needs of STRTP youth; consequently, mental health symptoms are treated as disciplinary problems and absences/truancies are not followed up on by schools, (e.g., public school staff frequently call STRTP staff to pick up a youth or to provide support in a classroom; STRTP youth are often suspended from public school campuses; referrals to a School Attendance Review Board (SARB) rarely happen).
- Data shows that many youth in an STRTP would, upon assessment, qualify for special education services, but their unique circumstances have prevented them from staying in or attending a school for a long enough period to complete an educational assessment.
- STRTPs must provide unfunded care and supervision during school hours when youth refuse school or are suspended and remain in the residential program.

Current law requires that priority enrollment for a newly admitted STRTP youth should be to a local public school whenever possible. However, incomplete school records and minimal educational information accompanying the STRTP placement, leaves the local school with the daunting task of determining appropriate class placement. This can result in yet another negative school experience for the youth.

To adequately plan for, integrate and meet the educational needs of STRTP youth, the California Department of Education should be integrated with DSS and DHCS into STRTP regulations and oversight. At the local level, Local Education Agencies (LEAs) serving students in STRTPs must be willing to create positive educational experiences that successfully integrate with the mental health and care and supervision components of the STRTP. This must be the case regardless of whether the youth has been assessed for special education or has an Individual Education Program (IEP).

To adequately plan for, integrate, and meet the educational needs of STRTP youth, the California Department of Education should be integrated with DSS and DHCS into STRTP regulations and oversight.

The supports needed by an STRTP youth or group of youth could be provided in the public school setting with appropriate assistance and clinical input. Or, on the other hand, alternative school arrangements could be offered including delivering educational services in the STRTP. In addition, the cost of supporting this critical component of a youth's time in an STRTP must be considered. Direct care staff will be / are required to provide supervision during school hours when youth are in residence for any reason. School funding currently includes a supplement to Special Education Local Plan Areas (SELPAs) for the number of licensed group home beds in their catchment area. In 2015-16 this funding was between $16,000 to $24,000 per bed per year, some of which should be shared with STRTPs to assist in implementing educational services and supports for youth in care.

The attached table (*Attachment E*) displays various educational options – many of which require additional staffing on the part of STRTP. Financial support for this additional supervision time was not considered in the design of STRTPs.

Barriers to Service

It must be noted that the California Department of Social Services, responsible for the implementation of CCR, has been responsive to concerns raised by both providers and placing agencies. Many of the barriers described in this paper are a function of other State agencies not partnering in a straightforward manner to assist in fully implementing CCR and supporting the role of STRTPs. The resulting barriers to effective treatment have been described throughout this paper and are summarized below.

1. The lack of specificity about what type and quantity of mental health services should be available in residential treatment for youth with extreme needs. This left counties on their own to determine the range and intensity of mental health services for each STRTP.

2. County contract differences such as the limits placed on contract maximums, the types and range of services allowed regardless of treatment plans, discrepancies around provider credentialing and

scope of practice definitions, drastically different unit rates for the same service, and contract settlement approaches.

3. The overlapping, conflicting and redundant regulations promulgated separately by DHCS and DSS without acknowledging the other's requirements or considering national accreditation standards which STRTPs must also meet. For example, two separate and overlapping client plans are required. Mental health daily notes are required by DHCS even though services are documented when they are delivered, and STRTPs use daily notes in the milieu that describe a youth's day and behavior – an important communication tool across staff and shifts that could be in lieu of a daily mental health note.

4. Incorporating into the hiring requirements for direct care staff a bachelor's degree while minimizing the value of experience and ignoring the importance of competency-based training such as CYC certification as more effective ways of assuring quality treatment in the milieu.

5. Related to Item #4 is the failure to provide guidance and support around the qualifications, training, and cost of professionalizing direct care staff.

6. The lack of acknowledgement about the acuity level of youth and the impact of concentrating into STRTPs the youth with the most extreme needs which affects the ability to maintain the 90% occupancy assumed in the care and supervision rate structure.

7. The fallacious assumption that DHCS and CBHDA would support the use of EPSDT funds to augment the STRTP milieu resulting in diminished financial resources for care and supervision.

8. Inadequate resources to support transitions from STRTP to the community and family, resulting in a discontinuity of care and a failure to capitalize on significant therapeutic relationships developed in the STRTP that can provide ongoing support.

9. The failure to work with the California Department of Education to assure that education has a central place in the treatment of youth with complex needs and that appropriate educational options are incorporated into an integrated and seamless set of services. The default educational placements into local public schools ill-equipped to address the mental health issues of these youth and to meet their corresponding educational needs is not working.

Recommendations

1. Adequately fund STRTP mental health services

First and foremost, implement CalAIM and the recommendations of the Foster Care Mental Health Taskforce of the Child Welfare Council. Beyond that, consider funding STRTP mental health services in one of three ways – (1) identify and bundle a set of services that are delivered each day and establish a daily rate for that bundle, (2) expand the current method of billing an array of "outpatient" services by staff time, or (3) use a hybrid model that incorporates both. Conceptually, these approaches are all "outpatient" services that are bolted onto STRTP care and supervision funding with a State-set monthly rate. Regardless of the option, based on the survey results described above, the minimum monthly rate per youth should be $7,138.

Bundled Services. With appropriate daily rates – approximating what is available in commercial insurance PHPs – both Day Treatment Intensive and Day Rehabilitative Services (often called habilitative for children since we are not "rehabilitating" them) can serve as a "bundled" billable service for STRTPs. The daily rate is based on youth attendance rather than staff time. Day services have been out of favor with DHCS and County Behavioral Health Departments for at least a decade, however, allowing these options would be an important step toward reducing burdensome documentation obligations now required for "unbundled" services that are billed by the minute of staff time. At least one important condition would need to be considered in tailoring day "bundled" services for STRTPs. The daily rate would need to consider the billing requirements of client attendance versus staff time. This becomes a concern as youth are unable to attend because of other priorities including court and medical appointments.

Unbundled Services. The alternative to day services is what exists currently – outpatient mental health services billed by the minute of staff time. Given the extreme needs of youth in an STRTP, these services should be as robust and intensive as those needs demand. Already described in this document is the necessity for DHCS to be more prescriptive in providing direction to providers and counties regarding the range and scope of services to which youth with complex trauma should have access. This includes requiring that (1) the full range of outpatient mental health services described on page 7 are accessible to all youth in an STRTP regardless of county of origin or county of service and (2) counties should be held accountable to EPSDT mandates to which each youth is entitled as is necessary to address the mental health conditions included in a youth's treatment plan. Implementation of these recommendations would ensure that youth are not systematically disallowed access to certain service types or amounts based on the variations in MHP practices.

Hybrid Services (preferred option). A hybrid approach would have as its core the bundled day treatment/rehabilitative services described above supplemented by unbundled services outside of a day program. These supplemental services would be necessary when a youth misses day programing because of medical/court appointments, employment, extracurricular activities or other treatment activities taking place during day treatment/rehabilitation hours and/or when services are delivered to youth and families outside of day treatment/habilitation hours, e.g., family therapy session at night to accommodate the working schedules of the youth's parents/caregivers. As noted, two STRTPs – one in San Diego County and one in Los Angeles County – are using this model.

2. Correct flaws in the care and supervision rate

The corrections needed have been described in the section on the "Cost of Milieu Services." One correction that can help address the expense of competency-based training and credentialing of direct care staff would be to recalibrate the STRTP care and supervision rate by assuming 85% occupancy instead of the 90% used for establishing the current monthly rate (see *Attachment D*). Ironically, reducing the occupancy adjustment in calculating the monthly rate will have the paradoxical effect of increasing occupancy in STRTPs as they are able to increase direct care staff compensation, increase training and other efforts to professionalize direct care, and reduce turnover.

A second correction would be to jettison the EPSDT downward rate adjustment of 8% which has never been actualized to support the costs of care and supervision. These two corrections will not only enable providers to cover the true cost of care but will also provide for competency-based training as described above as well as recognize the costs of California's increasing minimum wage requirements. These two corrections would yield a FY 2020-21 monthly STRTP rate of $15,919.

STRTP Original Rate Methodology						
Basic Rate Includes Personnel (51%) and Non-Personnel Costs (49%) as of Jan 2017			Amounts adjusted for CNI-based COLAs for:			
			2017-18	2018-19	2019-20	2020-21
			3.84%	3.96%	4.15%	3.72%
	Basic Rate = 11,770		$12,222	$12, 706	$13,233	$13,726
	ADJUSTMENTS	Effective January 1, 2017				
+	~~Occupancy Adjustment to reflect 90% average occupancy~~	~~$ 1,177~~	~~$ 1,222~~	~~$ 1,271~~	~~$ 1,323~~	~~$ 1,373~~
+	Occupancy Adjustment to reflect 85% average occupancy	$ 1,766	$ 1,833	$ 1,906	$ 1,985	$ 2,059
+	Training Adjustment to reflect requirement for 40 hours annual training	$ 115	$ 120	$ 125	$ 130	$ 135
	AFDC RATE FOR STRTPS (no EPSDT Adjustment)	$ 13,063	$ 14,175	$ 14,736	$ 15,348	$ 15,919
-	~~EPSDT Adjustment assuming 30% of the time for "Day Shift" staff and supervisors plus Administrative overhead at 20% for that time, will be billed to EPSDT and not paid by the AFDC FC rate~~	~~$ (1,026)~~	~~$ (1,066)~~	~~$(1,108)~~	~~$(1,154)~~	~~$(1,197)~~
~~AFDC FC Rate for STRTPs @ 90 % occupancy~~		~~$ 12,036~~	~~$ 12,498~~	~~$ 12,993~~	~~$ 13,532~~	$ 14,035

Rate with 85% occupancy and without EPSDT adjustment

Current rate with occupancy (90%) and EPSDT adjustments

*reduced occupancy adjustment from 90% to 85%
*deleted EPSDT adjustment

3. Align STRTP regulations across departments

To support an integrated model of mental health services and the therapeutic milieu as a seamless and comprehensive STRTP treatment intervention, licensing and regulatory requirements should be unified into a single set of standards. The most glaring examples of duplication are:

- **Client plans** – two are now required, one by DSS and another by DHCS. There is significant redundancy in these plans and within the ICPM, the Katie A settlement, as well as AB2083 requirements, these two plans could easily be combined into a single plan.
- **Daily notes** – DHCS requires a daily mental health note for each youth in an STRTP unrelated to service delivery or payment. DSS documentation is also required and should be deemed to meet this burdensome and duplicative requirement.

The alignment of licensing and regulatory mandates would establish consistent standards of care between payors, would reduce redundancies that overburden providers, and, most importantly, would enable STRTPs to deliver robust services to which the State's most vulnerable youth have access. Such an approach would integrate physical, emotional, and mental health services seamlessly across a 24/7 treatment environment.

Further, this alignment of regulations should acknowledge the programmatic assurances inherent in the requirement that STRTPs attain national accreditation by one of three national accrediting bodies. Such accreditation means that STRTPs meet the highest standards set by the health care and social services industries with policies and procedures in place that achieve best practice. State Departments should require their regulatory staff to be familiar with these standards as they develop and revise regulations and evaluate STRTPs for both certification and quality assurance.

4. Change hiring criteria and professionalize milieu staff

Given the important role of direct care staff in managing the therapeutic environment, in providing treatment-oriented interventions, and in responding to daily crisis, consider adopting a competency-based approach to staffing qualifications in lieu of the current bachelor's degree requirement. As an example, STRTPs may be required to demonstrate Child and Youth Care (CYC) Certification for a certain percentage of direct care staff (understanding that certification can take over a year), and for all supervisory level staff. Given the additional training and supervision requirements this will likely mean adding staff to provide for care and supervision while their colleagues who are pursuing this certification are "off the floor" in training and supervision. Over time, the benefits to the program – lower turnover, more skilled staff, more effective treatment for the youth -- would more than offset the additional cost.

5. Add and fund aftercare services

As an expectation of an STRTP intervention, the therapeutic benefits of the milieu as well as ongoing access to mental health services should bridge the youth's transition to the family and community. Such aftercare services facilitate generalization of new self-regulatory and interpersonal skills and promote permanency and stability across relationships and living situations. Additionally, coordinated, deliberate attention to youth transitional experiences heals past experiences of unexpected, unpredictable, and otherwise traumatic relational losses. Adequate funding should cover this critical transitional support.

6. Address the educational needs of STRTP youth

Youth placed in STRTPs have typically experienced school as an aversive and punitive place – one in which their performance has been impaired by too many school moves, lack of assessments to determine the types of supports they need, and further relational inconsistency, including unfamiliar peer groups. As noted earlier, this may very well be the experience in their school of origin. Providing for alternative, positive educational experiences that can increase attendance and credit recovery while supporting safety and complementing other aspects of STRTP treatment should be aggressively explored. This may include:

- At the time of referral, Interagency Placement Committees (IPCs) should be required to review a youth's educational experience and ask for an educational assessment should that be indicated.
- Crafting special arrangements with local public or charter schools that share Average Daily Attendance (ADA) funding, which could help support the increased staffing requirements of an STRTP as they provide the support needed by youth in placement.

Conclusion

The Continuum of Care Reform effort – sometimes called a "once in a generation" reform – launched in 2017 with laudable goals, has fallen far short of its target to successfully restructure STRTPs to maximally benefit the highest needs youth in the foster care system – those exhibiting the long-term effects of chronic chaos, repeated loss, multiple disruptions of critical developmental anchors (home and school). Overlapping and inconsistent regulations, the lack of direction regarding mental health treatment and reimbursement approaches, the undervalued need for integrated treatment, erroneous funding assumptions that hamper the ability of STRTPs to fully integrate and support the 24/7 therapeutic environment, failure to plan for transitions and aftercare supports, and the neglect of the importance of the educational component of an STRTP have all contributed to a regrettably deficient STRTP rollout.

Without correcting the flaws embedded in the current regulatory and fiscal supports along with the need for department collaboration at both the state and county levels, STRTPs will continue to struggle with realities of the extreme needs of youth being served and will never be the critically important resource anticipated in CCR. Ultimately, STRTPs will respond by shifting their beds to other payers or closing, but the biggest consequence of inaction will be to the youth who most need these integrated services.

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Attachments

Attachment A – California Alliance STRTP Survey

Attachment B – CYC Certification Process

Attachment C – Characteristics of Relational Child and Youth Care

Attachment D – CDSS Rate Methodology for STRTP

Attachment E – Educational Options for STRTP Youth

Attachment A – California Alliance STRTP Survey

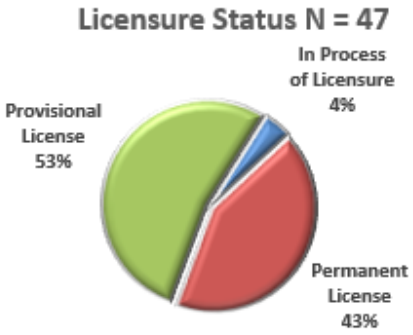
Background & Overview

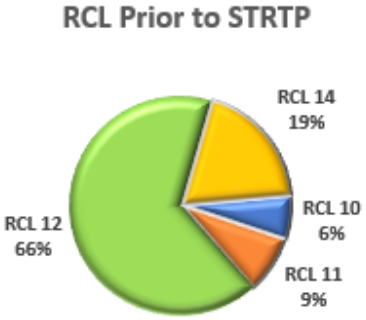
Members of California Alliance Residential Care and Juvenile Justice Committees are developing a set of recommendations to present to state agencies and associated stakeholders regarding how to better support STRTPs in achieving better outcomes. These recommendations are supported by data collected from member agencies with STRTPs. The survey was initiated January 27, 2020. Forty-nine agencies responded (N=49). Below are the results.

Licensure & Bed Capacity

Provisional Licensure: Earliest Date; 7/24/2017 Latest Date; 12/13/2019

Permanent Licensure: Earliest Date; 1/1/2018 Latest Date; 12/21/2019





Total Pre-STRTP Licensed Bed Capacity: 1,733 (N= 47)
Two agencies have closed their STRTP programs.

Total Current STRTP Licensed Bed Capacity: 1,638 (N= 44)
Alliance members participating in this survey – approximately 40% of licensed STRTPs in California

Of 1,638 Beds Surveyed:

- 281 are closed for use
- Up to 251 beds are set aside for other placements
- STRTPs are planning to use another 160 beds for other placements

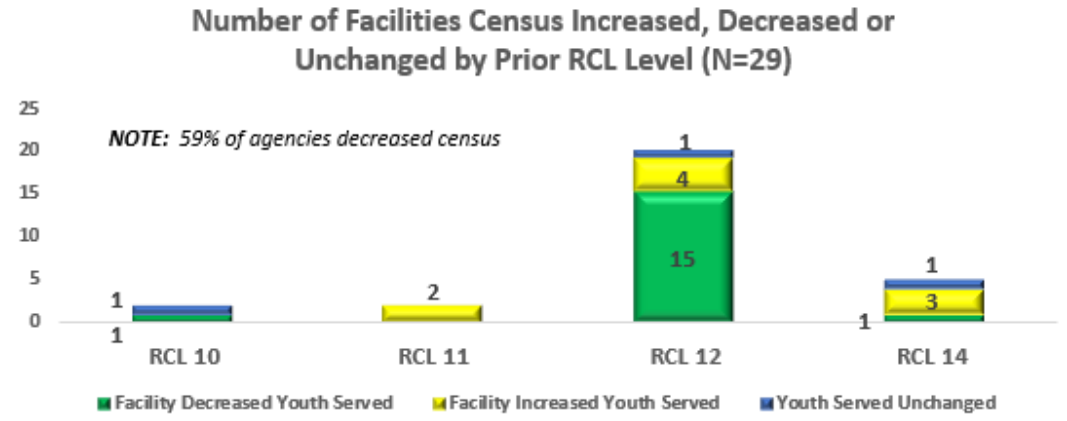
Potentially leaving 946 Alliance member STRTP licensed beds (58 %) available for use by Child Welfare & Probation

Comments from Agency CEOs:

- *We may have to close our program if transition to other funding is unsuccessful.*
- *We will close program in new FY due to inadequate rate. Losing over $1 million per year.*
- *We are contemplating changing program to THP NMD or SILP to provide housing to youth as STRTP youth have a very high acuity level and are difficult to manage.*
- *Funding and staffing make it difficult to be working at full capacity.*

NOTE: *46% of STRTP's are using beds for other placements and 14 agencies are considering bed reduction or closure due to safety issues, funding and staffing. Other placements consist of School Districts, Private Pay, Commercial Insurance and AAP*

Attachment A – California Alliance STRTP Survey

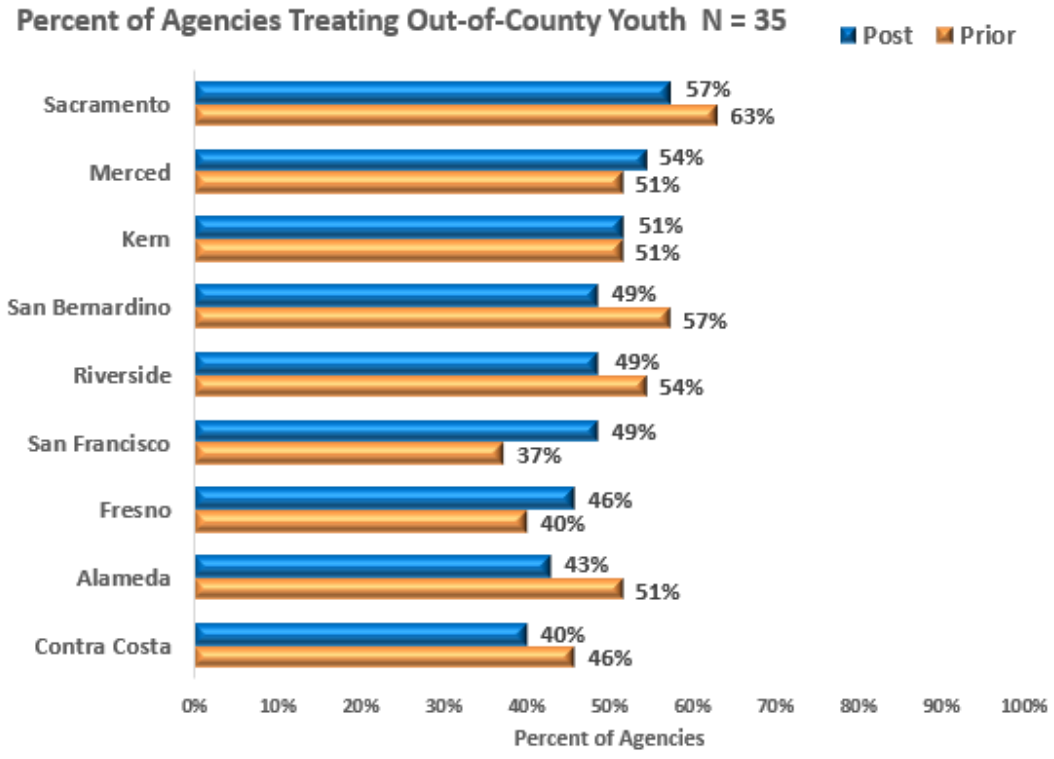


Referrals

Agencies receive an average of 45 referrals per month ranging up to 350. (N= 47). Every County in California has referred at least one youth to member STRTPs

Counties Served

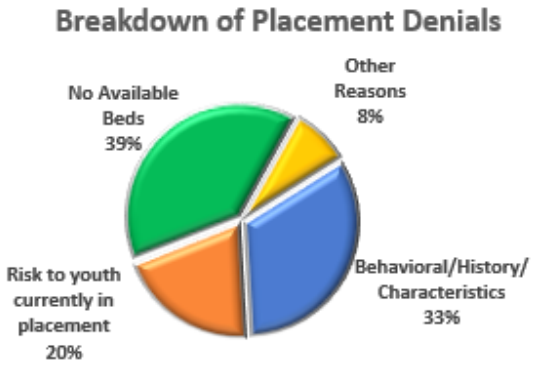
Alliance agencies average placements from 13 counties. Note that prior to- and post-STRTP youth from every California county were served in Alliance agencies. The graph below shows the counties that place the most youth out of county.

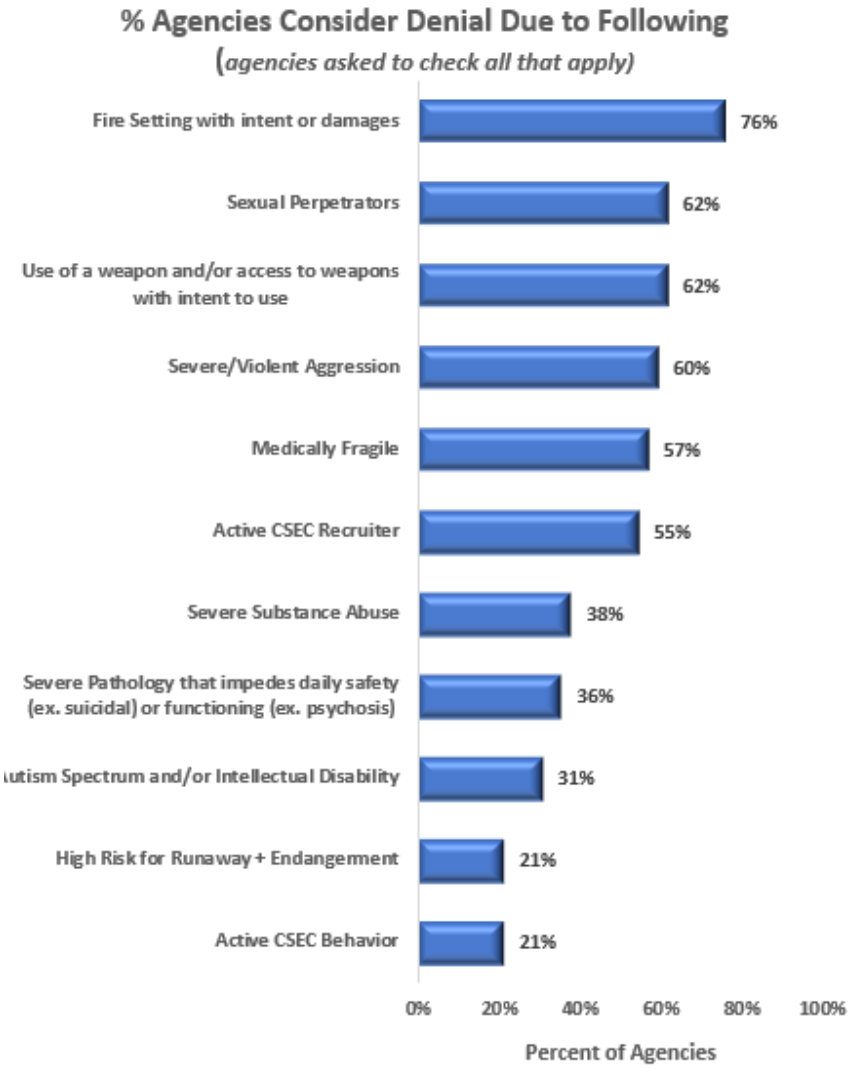


Attachment A – California Alliance STRTP Survey

Reasons for Denial

Agencies do not use blanket denials. Youth are evaluated individually. Denial would depend on severity and frequency of behaviors along with the potential risk to others in placement.
(Overwhelmingly, agencies responded that they are at times unable to place a youth due to behaviors that conflict with youth currently in placement.)





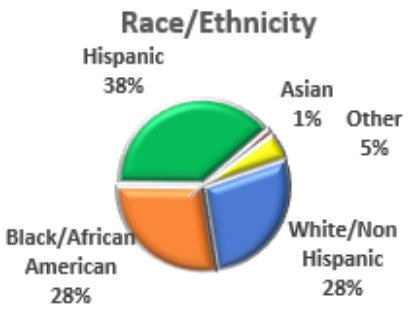
Note: *Agencies are experiencing the impact of "funneling" the highest acuity youth in the system into their programs. In considering referrals, the first obligation is to make certain that a new admission does not jeopardize the safety or progress of youth in their programs.*

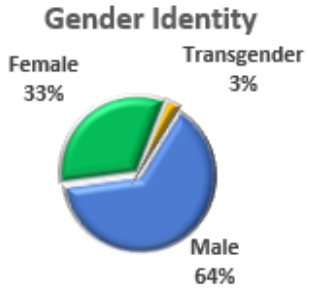
Attachment A – California Alliance STRTP Survey

DEMOGRAPHICS (N=32)

There was only a 1% variation between Pre- & Post STRTP.

Average Age: 15 (Range from 8 to 17)





TYPE OF INCIDENTS & STAFF RESPONSE

Incidents per 1,000 Bed Days (N=30)	Avg % Increase Pre-STRTP vs. Post-STRTP
AWOL/Elopement	56%
Physical Assault on Peer	47%
Property Damage (incident reports) *(SIRs do not capture cost of damage & repairs which has significantly increased up to 300% post STRTP)*	38%
Self-Injurious Behavior	14%
Physical Assault on Staff	11%
Staff Response	
Psychiatric Hold Written	50%
Restraint – (physical hold)	23%
Law Enforcement Involvement	10%

OUTCOMES

Length of Stay (N = 27)	Pre-STRTP	Post-STRTP	Change
Average (days)	246	187	-24%
Median (days)	217	170	-22%

Decrease in length of stay due to youth not completing program as a result of increased AWOLs, psychiatric hospitalizations & need for higher level of care.

Comments from Agency CEOs

- *The STRTP push for shorter lengths of stay does not fit the needs of our youth. The trauma and attachment wounds of these youth requires additional time to build trust and rapport as a foundation for treatment.*
- *High quality intensive treatment is undermined by short term placements.*
- *The primary reason for shorter lengths of stay in our program is the significant increase in unplanned discharges.*
- *We see "bait & switch" placements – placing agencies have a solid "permanency plan" until a youth is placed and then it disappears – leaving the youth hopeless & acting out.*

Attachment A – California Alliance STRTP Survey

Discharge Status (N = 26)	Avg % Change - Pre- to Post-STRTP
Higher Level of Care	41% increase
AWOL/Elopement	12% increase
Lateral Level of Care	3% increase
7/14 day notice	9% decrease
Lower Level Care	19% decrease
Discharged to Kin/Family	19% decrease

Agencies seeing increase in youth re-referred after discharge to a resource family home

IMPACT ON STAFFING (N=27)

- Staff Turnover Ratio has increased 8%
- Workers compensation claims have increased 32% -- *which has a significant impact on personnel costs and remains a component of worker comp rates for three to five years into the future.*

Comments from Agency CEOs

- *It is very difficult to keep high quality staff when they are physically attacked and spit on.*
- *We've seen an increase in group assaults – to include attacking law enforcement. Though police officers arrest them, they don't meet booking criteria at Juvenile Hall and are back in our program three hours later. Staff feel helpless and eventually leave.*
- *We can't pay staff more than they can make at a fast food restaurant.*

Attachment B – CYC Certification Process

"When viewed across the diversity of practice settings, child and youth care is the largest human service profession in the world."

Dale Curry, Ph.D.
Kent State University

A commitment to quality

Grounded in a body of knowledge and skills, certification is a tangible display of commitment to quality care for young people and families.

DOMAINS	SUB DOMAINS
PROFESSIONALISM	Awareness of the profession, professional development and behavior, personal development and self care, professional ethics, awareness of laws and regulations, advocacy
CULTURAL AND HUMAN DIVERSITY	Personal awareness and inquiry, integration of cultural awareness in developing respectful and effective relationships and communication, integration of cultural awareness in applying developmental practice methods
APPLIED HUMAN DEVELOPMENT	Contextual-developmental assessment, sensitivity to contextual development in relationships and communication, practice methods that are sensitive to development and context, access resources that support healthy development
RELATIONSHIP AND COMMUNICATION	Interpersonal communication, relationship development, family communication, teamwork and professional communication skills
DEVELOPMENTAL PRACTICE METHODS	Genuine relationships, health and safety, intervention planning, environmental design and maintenance, program and activity planning, activities of daily living, group process, counseling, behavioral guidance, family and caregiver engagement, community engagement

Mattingly, M., Stuart, C. & VanderVen, K. (2010). *Competencies for professional child and youth work practitioners.* Milwaukee, WI: Association for Child and Youth Care Practice.

A comprehensive assessment

The certification process provides individuals with a comprehensive assessment of their professional experience and skills.

1: WRITTEN EXAM

Based on developmental and ecological theory, the exam assesses the ability to apply situational judgment to 75 multiple choice questions from case examples across a variety of practice settings.

The 3 hour exam is available at over 230 proctored sites. Advance registration is required at least 72 hours prior to exam.

$135 exam fee

2: APPLICATION

The application guides candidates in assimilating work history, education, association membership, training, and commitment to ethical practice. Supporting documentation is reviewed to confirm education and training history.

3: PEER REFERENCES

Two written peer references are reviewed and the reference providers are asked to confirm the candidate demonstrates professional character, ethics, and behavior on a consistent basis.

4: SUPERVISOR ASSESSMENT

A written assessment by a current or former supervisor examines the consistency in which the candidate demonstrates 38 specific areas of knowledge and skills on the job.

5: PORTFOLIO

Candidates demonstrate their professional practice through a series of eight reflective essays and activities. Each portfolio is peer reviewed before certification is granted.

Candidates have 6 months from the date of testing to complete parts 2 through 5. A 6 month extension may be requested ($20 administrative fee). After twelve months, retesting is required.

$100 processing fee

CYC-P designation awarded

RENEWAL

Successful candidates retain their certification through demonstration of 30 hours of continuing education and professional engagement every two years.

$50 renewal every two years

Certification contributes to the safety and quality care of children, youth, and families.

It makes business sense for organizations interested in providing high quality services to invest in certification as a part of the professional development of care providers.

In a 2013 qualitative study on the impact of certification, participants reported the following benefits of being certified:

- Establishes a baseline of competence
- Increases motivation and confidence
- Promotes reflective practice
- Demonstrates commitment to child and youth care as a career

Highlights of key research findings

Predictive of higher performance

Certified workers are 2.7 times more likely to be high performing practitioners than uncertified (Curry et al., 2013). The exam itself is predictive of child and youth worker competence/performance on the job across practice settings (Curry et al., 2009).

The major components of CYCCB certification (education, experience, passing score on the exam, completion of certification including the portfolio) are each predictive of CYW performance. Each component progressively predicts performance – an indication of the incremental validity of the certification process (Curry et al., 2013).

Content validity of certification process

The certification process assesses competencies in the Competencies for Professional Child and Youth Work Practitioners, which was developed through a meta-analysis of 87 sets of competencies across North America (Mattingly, Stuart, & VanderVen, 2002, 2010).

To ensure content validity, these competencies guided the development of each assessment component (Curry et al., 2009; Eckles et al., 2009).

Internal reliability and face validity of exam

The exam has a high degree of internal reliability: Cronbach's alpha = .90 and appears to assess one general construct of professional CYW judgment (Curry et al., 2013; Curry et al., 2009; CYCCB 2011).

The exam has a high degree of face validity across practice settings. For example, 90% of practitioners agree that the exam accurately assesses important aspects of CYW and 90% agree that the exam's case examples provide realistic samples of CYW (Curry, et al., 2009).

LEADERSHIP

Strategic leadership is provided by a volunteer board of directors who serve two year terms and are elected by the body of certified practitioners.

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Training Director
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Certification for Child and Youth Care Professionals

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979-764-7306 voice | 979-764-7307 fax
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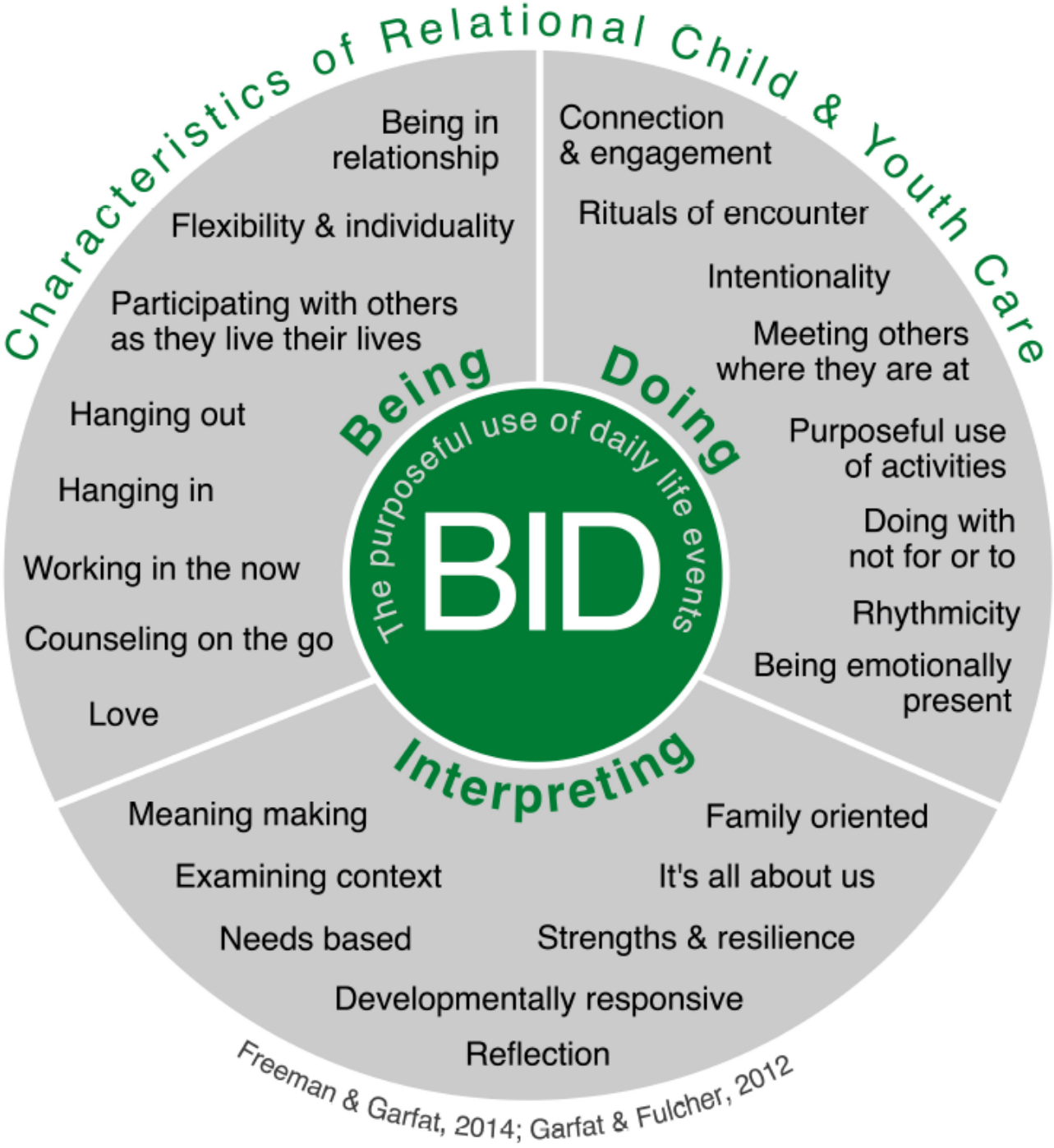
Attachment C – Characteristics of Relational CYC



Attachment D – CDSS Rate Methodology for STRTP

STRTP Residential Care Rate

CDSS Methodology for May 2016 Revision of Governor's Budget for 2016-17 for implementation on January 1, 2017		
3.3:1 Staffing Ratio (Day) and 4.8:1 Staffing Ratio (Night)		
First Day Shift	Second Day Shift	Night Shift
3.7 staff FTEs	3.7 staff FTEs	2.1 staff FTEs
1.4 supervisor FTEs	1.4 supervisor FTEs	1.4 supervisor FTEs
	(9.5 FTEs @ $20.625/hr 4.2 FTEs @ $22.55/hr)	
+	30 % benefits	
	$2,368 staff cost per day	
x	365 days	
	$864,411 per year	
÷	12 months	
	$72,034 per month	
÷	12 children	
	$6,003 Daily Supervision (51%)	
+	$2,354 Admin (20%)	
+	$2,593 Indirect Costs (22%)	
+	$820 Child-Related Costs (7%)	
	$11,770 before adjustments (100%)	
	ADJUSTMENTS	Effective January 1, 2017
+	***Occupancy Adjustment*** *to reflect 90% average occupancy*	**$ 1,177**
+	***Training Adjustment*** *to reflect requirement for 40 hours annual training*	**$ 115**
	Sub-Total TOTAL RESIDENTIAL CARE RATE (before EPSDT Adjustment)	**$ 13,063**
-	***EPSDT Adjustment*** *assuming 30% of the time for "Day Shift" staff and supervisors, plus Administrative overhead @ 20% for that time, will be billed to EPSDT and not paid by the AFDC-FC rate*	**$ (1,026)**
AFDC-FC RATE for STRTPs		$12,036

Attachment E – Educational Options for STRTP Youth

STRTP Education Options

	Traditional Public School							Charter Public School			NPS	
Funding	$$ Public School Collects ADA $$							$$ Charter School Collects ADA $$			$ Public School pays NPS $	
	1	2	3	4	5	6	7*	8	9*	10	11	12
Type of School Placement	General education / classroom	Continuation or community school (go at their own pace)	Special ed placement (resource room, special day class, etc)	Independent Study (student checks in w teacher)	Home/ Hospital (teacher comes to student)	Opportunity Classroom on Public School Campus - STRTP staff	STRTP provides at STRTP & shares ADA	Virtual / Non-classroom based	Hybrid / Non-classroom based & shares ADA	Traditional "seat-based"	Operated by agency w STRTP	Operated by outside entity
Hours of instruction / supervision provided by school	school day	school day	school day	1 hr/wk	1 hr/day	none (by public school)	none (by public school)	Varies	Varies	school day	school day	school day
Additional staffing required by STRTP	none	none	none	STRTP Provides	STRTP Provides	STRTP Provides	STRTP Provides	STRTP Provides	STRTP Provides	none	none (no residential staff)	none

NOTE: School of origin to be considered as best educational option whenever possible

**Preferred option*