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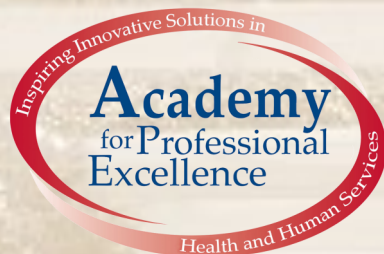
Literature Review: 23-Hour Assessment Centers

Anita Harbert, Ph.D.
Executive Director
Academy for Professional Excellence

Jennifer Tucker-Tatlow, MSW
Director
Academy for Professional Excellence

Prepared by:
Chelsea Payne, MSW Student (San Diego State University)

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6505 Alvarado Road, Suite 107
San Diego, CA 92120
<http://theacademy.sdsu.edu>



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INTRODUCTION TO 23-HOUR ASSESSMENT CENTERS

In 2012, about 250,000 children entered foster care in the United States (U.S. Department of Health and Human Services, 2013). Research shows children in foster care have a higher risk of mental health problems, developmental delays, and physical health issues (Landsverk, Burns, Stambaugh & Rolls Reutz, 2006; Bruskas, 2008). Transitioning out of their homes and into foster care can make children fearful, anxious, confused, and worried. Recently, with a greater understanding of the trauma experienced by children exposed to maltreatment, a push for trauma-informed practice has led to a shift in the way treatment is delivered to these vulnerable youth (“Reducing the Trauma” 2009; Layne et al., 2011).

When it is decided a child will be removed from the custody of his or her parents, a child may be transported directly from his or her home to a new place of residence if an appropriate placement is available immediately. However, many times the social worker assigned to a case needs more time to determine the best placement for the child. A common practice has been for police officers and social workers working on a case to keep the child in an administrative office, or emergency shelter, while decisions are being made about the child’s placement.

In the last 15 years, 23-Hour Assessment Centers (hereafter referred to as Assessment Centers) have been created to provide a temporary placement for children to be taken to after being removed from their homes. Children are allowed to stay at these centers for no more than 23 hours (and 59 minutes). At Assessment Centers, a child is placed with childcare workers who provide proper care to the child while the social worker can meet with other professionals, caregivers, and even perhaps the child herself to decide and search for the best out-of-home placement. Assessment Centers allow time for health assessments, rest, crisis intervention, and other needs addressed in this report. This allows the child’s needs to be at the forefront of the efforts, taking into account his or her immediate physical and mental health needs, medical issues, and comfort needs prior to placing the child. This also gives the placement team more time to potentially locate appropriate relatives who can care for the child. Placement with relatives is a best practice in child welfare out-of-home placements, with research showing that children who are placed with relatives have better developmental, mental health, and placement stability outcomes (Winokur, Holtan, & Valentine, 2009).

Literature on the trauma children experience prior to removal from their homes is prevalent, however research on the trauma experienced during the removal process and before initial out-of-home placement is limited (Winter, 2012). This is the transitional period during which Assessment Centers serve children. The time from the removal to the out-of-home placement leaves a period of uneasiness for the child and while the trauma from removal cannot be thwarted, reducing the traumatic experience for the child can be attempted (Office of Juvenile Justice and Delinquency Prevention, 2014). Children who enter Assessment Centers are assessed by professionals experienced in working with youth in the child welfare system.

Existing literature on the subject of 23-Hour Assessment Centers could not be located in any peer-reviewed journal articles, yet literature is available on the best practices for children in out-of-home care. A review of the literature on this population in regards to the application of children in Assessment Centers will be presented along with any implications for 23-Hour Assessment Centers’ practices, policies, and future research. Since California’s Assessment Centers vary from county to county, this report will also review the policies and procedures of different counties, along with a review of the promising practices they have implemented within their centers.

PURPOSE

Since Assessment Centers are a relatively new practice in child welfare services, they have not received much attention in research. There is no standard operational definition of a 23-Hour Assessment Center, as practices vary among counties. An examination of the available research, literature, policies, procedures, and practices pertaining to Assessment Centers is needed to inform the development of new facilities or the refinement of existing centers practices to most efficiently and effectively serve these children during their critical transition period.

METHODS

The methodology used in this review to locate literature on the topic came from a comprehensive search of: scholarly journals and peer-reviewed articles (through the San Diego State University Library online journal databases and Google Scholar search engine); select internet resources; published county policies and procedures; county reports, assessments and audits; online newspapers, books, and personal communications (via e-mail correspondence and phone interviews). Counties in California that have implemented 23-Hour Assessment Centers were contacted first-hand to gain additional information and resources for inclusion in the review.

REASONS FOR THE DEVELOPMENT OF ASSESSMENT CENTERS

- There is a philosophical ideology about children in foster care and the move toward putting them in a family, home-like environment as soon as possible, as opposed to “institutional” or “congregate” care. The push toward kinship care as a first option, followed by foster families, allows children to be in a home, rather than in a group home or residential facility. Congregate care has, in some research, shown to have worse outcomes for children compared to non-congregate care, and can also be more costly¹ (“Rightsizing Congregate Care,” 2010).
- Assessment Centers put a time restriction, less than 24 hours, for a child to be in the child-friendly, but group setting, after which ideally the child is moved to a home-like setting like kinship or foster family care. In counties where Assessment Centers are not available, it is not unlikely for a child to reside in a temporary group shelter for 30 days or more before being placed in a more ideal home-like setting.
- Providing assessments for behavioral and medical issues initially after removal (occurring on-site at Assessment Centers or in clinics very close to Assessment Centers) can help children to be placed in an appropriate out-of-home placement setting that best meets their individualized needs. The benefits of such assessments can be identifying critical behavioral and health information which social workers can provide to the foster parents for a better transition and understanding of a child’s particular needs. Assessments can also help guide the social worker in the identification of a placement that includes foster parents who have experience/ training with children who have behavioral or medical needs.
 - Prior to the development of Assessment Centers foster parents spoke out about the disconnect they felt with the child welfare system regarding whether a child has a medical or behavioral issue that they should be made aware of prior to taking the child into their home. Assessment Centers allow for social workers to communicate

¹ While the move is toward family care, there are circumstances when congregate facilities may be more appropriate for children with specific needs.

to foster placements about the well-being of the child and as a result foster parents have felt more supported through improved communication and more thorough assessments of each foster child (Michael, 2006).

- By having mental health professionals present at the Assessment Center who are trained in using a trauma-reducing model of treatment, and staff who have been trained and have experience with children removed from their homes, children can be in an environment that better understands and caters to their needs during a critical transition period. (See Appendix A for “Trauma-Informed Care for Children Exposed to Violence-Tips for Agencies and Staff Working with Youth”)
- Foster parents have voiced in the past that children come to them unprepared or unkempt. Assessment Centers allow for children to better prepare for a foster home placement, physically, mentally, and emotionally (Michael, 2006).
 - Assessment Centers can serve as an orientation to the new experiences the child will encounter, something that has been recommended to be helpful for transitioning children (Bruskas, 2008).
 - Some social workers have anecdotally stated that children leaving an Assessment Center have shown to be “calmer and more communicative” (“Alameda Self-Assessment,” 2009, p.75).

ASSESSMENT CENTERS SHARE THE FOLLOWING CHARACTERISTICS:

- 23-Hour Assessment Centers are not licensed as residential facilities (thus the 23 hour time limit) and cannot keep children in their care for more than 24 hours in compliance with Community Care Licensing Division Regulations-Title 22, Div. 12.
- After being removed from their homes due to allegations of abuse and/or neglect (also in some instances following removal from juvenile detention or transfer from one foster care facility to another), Assessment Centers exist to provide a trauma-reducing, child-friendly, home-like setting for children to feel safe and comfortable in while awaiting a more permanent placement.
- Assessment Centers provide children with appropriate health assessments, hygienic, comfort, and nutritional needs (see objectives below).
- Assessment Centers allow children to be supervised by qualified professionals while the placement team (i.e. social worker, members of TDM team) work to find a placement within 23 hours (technically before 23 hours and 59 minutes) of their entry into the facility.
- 23-Hour Assessment Center may be used interchangeably with the following terms:
 - Receiving Center
 - Assessment Center

CWS/CMS

In a California Department of Social Services All County Information Notice (2006) the following information clarified 23-Hour Assessment Center’s data recording protocol:

“A child’s visit to a 23-hour assessment center should be recorded as a non-foster care placement in the CWS/CMS application. It should be recorded in the Placement Management Section as a non-foster care placement. Placements that are less than 24

hours should not be counted statistically. By entering this as a non-foster care placement it will prevent CWS/CMS from erroneously counting this as a foster care placement.”

GOALS OF 23-HOUR ASSESSMENT CENTERS²:

- Provide a temporary place for children to stay while a permanent placement is found (Kinship/Relative, Foster Family, Group Home).
- Utilize the mental health and medical professionals at the Assessment Center and their evaluation of the child’s well-being in determining the most appropriate placement.
- Reduce the trauma of removal by meeting the objectives listed below.

OBJECTIVES OF AN ASSESSMENT CENTER²:

- Provide children with a mental health screening upon admission to the center including:
 - Referring to further mental health treatment if needed.
- Provide children with a health screening upon admission to the center including:
 - Referring to further medical treatment if needed.
- Supply meals to the children during their stay.
- Provide clean beds for children to sleep.
- Provide age-appropriate activities for children such as games, toys, play structures, and other activities.
- Provide an orientation or share knowledge about the transition children will experience when leaving the facility.

CRITICAL ISSUES ADDRESSED IN THIS REVIEW

There are critical issues associated with managing Assessment Centers that will be discussed in this report. These critical issues derive from an analysis of policies, procedures, and literature pertaining to Assessment Centers.

- Mental health and medical/physical health screenings are critical in knowing what services the child may need in their out-of-home care setting, including placing the child with a placement that may have training or experience with children of a certain need.
- Creating a safe, comfortable, child-friendly environment that includes the following:
 - Child care workers who can provide safe and engaging supervision.
 - Trauma reduction through appropriate interactions with children.
 - Understanding that children may have mental health or physical health problems that affect their behaviors.
- Ensuring that children’s experiences at the Assessment Center are appropriate and that children exit the Assessment Center feeling prepared for their next step, as much as possible.
- Utilizing child-centered practice can be valuable in gaining a better understanding of a child’s perspective during this transitional period.
- Recommendations for implementing orientation to foster care practices at Assessment Centers are discussed.

² Taken from an analysis of various counties 23-Hour Assessment Center’s policies and procedures.

- Placement within 23 hours is critical to adhere to regulations imposed on 23-Hour Assessment Centers. Implications for this issue are discussed.

COLLABORATION WITH COMMUNITY RESOURCES

It should be noted that Assessment Centers are a collaborative effort that includes multiple service providers. Some collaborations are between county departments, while other partnerships are with private, non-profit agencies. Since Assessment Centers utilize an array of resources (mental health and medical assessments, shelter, child care, food services, etc.) the collaborations depend on the availability of resources within a given community.

CALIFORNIA COUNTIES ASSESSMENT CENTER OVERVIEW

The following provides a basic overview of California Counties' 23-Hour Assessment Centers that were reviewed for the purposes of this report along with collaborations they have made to deliver services at their sites.

Alameda County Assessment Center (ACAC)

The ACAC is a 23-Hour Assessment Center staffed and managed by a private non-profit children's community psychology clinic, West Coast Children's Clinic, contracted by the Alameda County Social Services Agency. Using a comprehensive service delivery model, ACAC collaborates with Alameda County Health Care Services, Alameda County Behavioral Health Care Services Agency, West Coast Children's Clinic, and the Alameda County Social Services Agency. (F. Battles, personal communication, September 20, 2013; "Alameda Self-Assessment," 2012)

Costa County Harmony House and Monterey County Cherish

Contra Costa Harmony House and Monterey County Cherish are two 23-Hour Assessment Centers which are both run separately by Aspiranet, a non-profit organization contracted by each County to staff and manage each assessment center in collaboration with each County's Department of Child and Family Services, Behavioral Health, and Public Health/ Visiting Nurse Association. Both Assessment Centers have similar procedures due to both being run by Aspiranet, however differences due to different county regulations are discussed further in the review (Aspiranet, 2010; D. Garner, personal communication, February 6, 2014).

Santa Clara County Receiving, Assessment, and Intake Center (RAIC)

The Assessment and Intake Center and Receiving Center are co-located at the same location but provide different functions, both staffed and run by the Department of Child and Family Services and make up the Receiving, Assessment, and Intake Center. The "Assessment and Intake Center" performs the initial intake of children, including identifying emergency satellite home placement search for all non-dependent children, and interviewing children for potential relative placements. The Assessment and Intake Center's mental health social workers can assess the child's need for mental health or medical treatment, and refer the child to any additional resources they may need. The "Receiving Center" portion of the facility is where children are admitted to if a placement is not found immediately (J. Hubbs, personal communication, January 21, 2014; "DFCS Online Policies," 2013)

Los Angeles County Children's Welcome Center

LA County Children's Welcome Center opened in November 2012 and serves children under 12 years old. The Children's Welcome Center is a collaboration between the Department of Children and Family Services, and the County departments of Public Health, Mental Health, and Health Services. It is located at Los Angeles County USC Medical Center ("DCFS Winter Newsletter," 2013).

Orange County- Orangewood Children and Family Center

First Step Assessment Center opened in 2003 and is co-located with an emergency licensed group home, both created by Orangewood Children's Foundation and donated back to the County to provide safe and trauma-reducing temporary and more long-term placement for children removed from their homes. Information and literature was limited for Orangewood's First Step Assessment Center and thus, this Assessment Center will not be expanded on in this report. However, it should be noted that First Step Assessment Center's co-location with a licensed group home allows for children to be admitted to the group home facility, should no other placement be located. Although this option comes after all other placement options are exhausted, it serves as a means for the center to ensure that compliance with the 23 hour time regulation ("Orangewood Children's Home," 2009).

San Diego County-23 Hour Assessment Center

Housed at San Diego Polinsky Center (licensed group home) is their 23-Hour Assessment Center which opened in 2006. As with Orangewood Assessment Center described above, San Diego's 23-Hour Assessment Center had limited information and literature available. There will not be an expansion of policy and procedures for this Assessment Center in this report. Similar to Orangewood, San Diego's Assessment Center is located with a licensed group home which allows for the placement team to choose as an option for placement, given that all other options have been considered and are not available within the 23-hour timeframe ("Polinsky Children's Center," 2012).

CREATING A COMFORTABLE ENVIRONMENT FOR CHILDREN

Food

Food services are available at each Assessment Center reviewed for this report. Food services are provided by different sources, ranging from partnerships such as the hospital cafeteria where the center is located, to school districts nearby, to Assessment Center staff purchasing food from the market. Food services will depend on the availability of resources within a community and a center's financial budget and aim to provide health food options for children.

Child Friendly Atmosphere

All 23-Hour Assessment Centers make some effort to accommodate children with age-appropriate toys, games, video games, books, play structures, movies, and arts and crafts. Many of these are donated by the community, other are purchased items, but nonetheless seek to create an environment that makes children feel comfortable and occupied.

Staffing

Staff at Assessment Centers play a critical role in the child's experience during those 23 hours. Staff at each Assessment Center contacted for this report had experience in child care at the minimum. Some child care workers are also social workers, but not all. Many have years of expertise in child care settings and are trained in topics that help them interact and reduce trauma of children at each Assessment Center. Under each specific County's heading "Staff Training" will give more detail as to what each Assessment does to train their staff on topics that benefit the children they serve.

HEALTH CARE NEEDS OF CHILDREN IN OUT-OF-HOME CARE

Children who are removed from their homes due to maltreatment are at greater risk for elevated stress due to the removal process, maltreatment, being separated from their family, or a combination of factors (Jensen, Hunter Romanelli, Pecora & Ortiz, 2009). Children in out-of-home-care have shown higher rates of physical and emotional problems, developmental problems, mental health issues, all which, for children removed from their homes, should be addressed in their health care assessments (Jensen et al., 2009). As children enter the care of the state there are obligations to be met related to their safety, permanence, and well-being. Growing research on children's well-being in regards to their health as they enter the child welfare system shows that there is a need for comprehensive medical and mental health assessment and care (Jensen et al., 2009). Implications for Assessment Center practices will be discussed below.

In a report by the Government Accountability Office (2009), *Foster Care State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children's Care*, ten states were assessed for their practices in providing health care needs to children entering out of home care. California was cited as being one of the states that does not have a policy on the initial screening of children entering out-of-home care, but instead that a comprehensive examination of their medical, mental health, and dental health is to be performed within 14-30 days of the child's entry into foster care. Other states use a two-part assessment process of an initial assessment from twenty-four hours to seven days and a comprehensive assessment to follow.

According to a set of standards developed by Child Welfare League of America and American Academy of Child and Adolescent Psychiatry (2007) on best practices for providing mental health services to children, the first step is to assess them within the first 72 hours of foster care placement. Understanding their mental health and physical health state upon entry into an Assessment Center can contribute to proper placements (i.e. placing the child with a family or facility who is experienced or trained with the child's needs).

AACAP/CWLA Policy Statement on Mental Health and Use of Alcohol and Drugs, Screening and Assessment of Children in Foster Care (2003)

Key findings:

(pertaining to practices relevant to 23-Hour Assessment Centers)

- Children removed from their homes due to abuse and/or neglect from their caregivers have been shown to have urgent mental health needs and are also at risk for abusing alcohol and other substances.
- Mental health and AOD (Alcohol and Other Drugs) screenings should be provided in a timely manner-*within 24 hours of coming into the care of child welfare services*. Mental

health and AOD screenings and assessments should be performed as part of the child's health examination into care.

- Mental health and AOD assessments should be performed by mental health professionals trained in the developmental and mental health and use of alcohol and other drugs needs of children in foster care.
- Appropriate training regarding the screening protocol should be administered to the professional performing the assessment and readily accessible consultation should be available if needed.
- Assessments and tools should be culturally competent and delivered in a culturally sensitive manner.
- For children who have been removed from their families, their mental health screening should evaluate the internalized and externalized levels of distress they are experiencing due to the separation and trauma of removal.
- Coping strategies and strengths should be included in the assessment.
- The outcomes of the mental health and AOD assessments should contribute to determining the most appropriate placement for the child.

Implications of Research for 23-Hour Assessment Centers:

- Timely assessment of children's health should begin at their initial entry into out-of-home care. An initial assessment allows for information to be collected and services to be considered at entry, providing more comprehensive health assessments. Establishing a baseline measurement at entry to 23-Hour Assessment Centers can help in monitoring children's progress and development.
- Proper communication and coordination of health assessment outcomes to children's social workers and any other healthcare providers will lead to more efficient and coordinated continuity of care.
- Collaboration: Child welfare agencies that partner with mental health agencies can better provide children with qualified mental health practitioners trained in evidence-based interventions (Jensen et al., 2009).

Behavioral Health Assessment Practices at 23-Hour Assessment Centers

Children who are removed from their homes and taken to an Assessment Center to stay for up to 23 hours, have the availability of behavioral health assessments. Each Assessment Center researched for this report is equipped to perform behavioral health assessments and to determine whether a child is in need of additional behavioral health support. While sometimes the provision of assessments depends on the staffing of individuals equipped to perform these assessments, other times it will depend on a recommendation from the case social worker for the assessment to occur.

Recommended areas to be included in assessment (Jensen et al., 2009):

- Acute risk to themselves or others.
- Suicidality.
- Running away from placement.
- Social functioning.
- Psychotic symptoms.

- Substance abuse.
- Need for crisis intervention.
- Assessment for strengths.
- Coping mechanisms.

If acute needs are recognized, referring the child to a mental health provider for treatment as soon as possible is recommended. The mental health provider and case worker should be in communication in order to allow for the more appropriate placement for the child as well as for the coordination of further care (Jensen et al., 2009).

Child behavioral health issues are one of the most powerful predictors of placement instability and are a significant reason why children are asked to be removed from a foster care placement (Northern California Training Academy, 2008). Thus understanding a child's behavioral health status can prepare foster placements for understanding and being proactive to a child's behavioral and mental health state (Jensen et al., 2009), possibly leading to a decrease in such removals.

If a child requires immediate medical attention:

If a child presents with an obvious and immediate need, the social worker transporting the child to the Assessment Center should first take the child to an emergency room for immediate treatment.

Behavioral Health Assessment Practices by County

- *Alameda County's Assessment Center* is managed by West Coast Children's Clinic which operates the STAT (Screening, Stabilization, and Transition) program. Children brought to the Assessment Center are screened and assessed by a trained social worker, counselor, or psychologist who screens the child through informal observation, supportive play, and conversation in order to gather information useful to aid in the most appropriate placement as well as determining if the child needs additional mental health care ("West Coast Children's Clinic," 2012).
 - STAT clinicians will help transition children into their more permanent placement if needed by providing counseling and assistance to the child and family for up to 30 days after leaving the Assessment Center ("West Coast Children's Clinic," 2012)
 - STAT team can also serve as a liaison to additional community resources for the child and their family and/or foster placement ("West Coast Children's Clinic," 2012).
- *Contra Costa County's Harmony House* has a partnership with Contra Costa County Department of Behavioral Health which provides behavioral health assessments as requested by the case social worker or Assessment Center staff (D. Garner, personal communication, February 6, 2014).
- *Los Angeles County Children's Welcome Center*, located on the grounds of a hospital, has a partnership with a health clinic located in the hospital, called the Violence Intervention Program (VIP) Community-Based Assessment and Treatment Center (CATC), where children are taken to before entry into the Children's Welcome Center. If it is recommended

by the social worker, or if the child is presenting with an obvious need, a behavioral health assessment is performed at the VIP clinic (J. Chandler, personal communication, February 5, 2014).

- *Monterey County Cherish Receiving Center* has a partnership with Monterey County Behavioral Health who provide mental health screenings to children as requested by case social worker or Assessment Center Staff (D. Garner, personal communication, February 6, 2014).
- *Santa Clara Receiving, Assessment, and Intake Center (RAIC)* has mental health social workers that perform initial mental health assessments and who are trained in evaluating the mental health of children to determine if any further mental health interventions are needed. If additional mental health services are deemed necessary, the child can be seen by a mental health professional within the 23 hour time period. All mental health assessments are documented and shared with the case social worker and additional members of the placement team to determine the best placement for the child.
 - For more challenging cases, social workers at the RAIC can also contact EMQ (Eastfield Ming Quang) Receiving Center Stabilization Team. Individuals from EMQ Families First treatment program respond to crisis situations and children needing additional behavioral intervention support. The EMQ team consisting of family specialists, clinicians, and other professionals who work collaboratively with the child's placement team to find a placement that will fit a child who is presenting serious emotional or behavioral problems. The EMQ team will stay with the child's case for up to 60 days, stabilizing him throughout the placement process and working with the caregiver to provide resources, safety planning, and support. ("DFCS Online Policies," 2013; "EMQ Families First," 2014; M. Pani, personal communication, February 14, 2014)
 - EMQ also provides the service of Professional Parent placement, which includes placements with foster parents that have been trained by EMQ to parent at-risk youth and who will accept children with identified behavioral health problems. These placements are short-term (60 days or less) while permanent placements are located. ("EMQ families first," 2014; M. Pani, personal communication, February 14, 2014)

Medical Assessment Practices by County

Each Assessment Center performs a brief medical evaluation to determine if the child has medical needs that need to be attended to while at their stay at the Assessment Center, or in their immediate placement. This information is given to the placement team and social worker as part of the criteria to determine the best placement for the child.

- *Alameda County Assessment Center* assesses each child by having the assigned Public Health Nurse or mid-level practitioner (nurse practitioner or physician's assistant) screen and assess the child entering the Assessment Center (F. Battles, personal communication, September 20, 2013).
- *Contra Costa County Harmony House* staffs a Public Health Nurse to perform medical assessments (Aspiranet, 2010).

- *Los Angeles County Children's Welcome Center* assesses each child before entry into the Assessment Center by having the child visit the VIP CATC clinic for a medical clearance (J. Chandler, personal communication, February 5, 2014).
- *Monterey County Cherish Receiving Center* staffs a VNA (Visiting Nurse Association) nurse to perform a health assessment. The nurse coordinates any additional medical care the child may need before or after placement ("Cherish Agreement," 2010; D. Garner, personal communication, February 6, 2014).
- *Santa Clara County RAIC* has a healthcare specialist assistant (HSA) who can perform the initial medical assessment. If the HSA determines that further assistance is needed, an on-call nurse or teleworking nurse can be available ("DFCS Online Policies," 2013).
 - Santa Clara County's RAIC is located in the same building as Santa Clara County Health and Hospital System's Valley Medical Center and employs a full-time pediatrician who can perform comprehensive medical assessments (Leung & Medina, 2012).

TRANSITIONING INTO CARE

Understanding and supporting young children's transitions into state care: Schlossberg's transition framework and child-centered practice (Winter, 2012).

A qualitative study in the UK focused on the experience of children transitioning to state care to compliment research of children before removal from their homes, and after placement into state care. The study highlights 'child-centered' care as being social work practice that focuses on the experiences perceived by children in their initial transition to out-of-home care. These perceptions and experiences are analyzed in the context of Schlossberg's Transition Framework, which used in applied direct practice with individuals, can be used to conceptualize and understand the process and impact of transition.

Key findings:

- Schlossberg's model is comprised of three parts: approaching transitions, taking stock of coping resources, and taking charge (See Appendix B for details). It is intended to assess a person's ability to successfully navigate a transition and can be used for clinician's assessing a child's ability to navigate a transition in foster care.
- Goodman added that an assessment of the type, context, and degree of impact of the transition all play into the experience felt by the individual.
- There is a distinct difference between listening to children and acting upon the input they give. This is linked to personal, professional, and organizational biases that may exist regarding the reliability and validity of the input given by a child regarding their experience and whether that experience can and should impact policy and practice.
- Winter suggests that the quality of relationships between social workers and children should outweigh the caseload/output.
- Although the article focuses on one qualitative case study, Winter suggests that this one case shows the complexity of the experience of a child transitioning and that further research should give serious consideration to the valuable input of child-centered care in regards to transitions, not only theoretically and conceptually, but in practice and policy terms.

Implications for 23-Hour Assessment Centers:

- Twenty-three hour Assessment Centers are the first stop in the transition children experience when being removed from their homes. Child-centered care in these facilities could translate into changes in assessment practices, adding more focus on the experience of the child's transition.
- The use of Schlossberg's transition framework can aid child care workers and those who perform assessments in understanding the experience of the child's transition.
- With social services' move toward evidence-based practices, a deeper look into the child's experience and perception of the Assessment Centers can provide valuable insight into the effectiveness and value of an Assessment Center.

PLACEMENT

Timely placement in out-of-home care after children are brought to an Assessment Center is a main priority, and one that must be attended to, especially with time regulations imposed on all Assessment Centers. Individual practices used by each county to meet the time requirements are listed under the heading "Placement" in the individual county sections. However, first a critical issue for all counties is what to do when placements are not found within the allotted time limit.

23-Hour Assessment Center Overstays

Since 23-Hour Assessment Centers do not operate as residential child care facilities, they must place children in an out-of-home care placement within 23 hours and 59 minutes, in order to stay compliant with California Department of Social Services Code of Regulations, Title 22. Due to confounding factors meeting this time limit can be challenging for particular cases. Recently two counties' Assessment Centers in California, Santa Clara and Los Angeles, were cited for non-compliance with these regulations. The literature on this subject discusses reasons for children staying over 24 hours, and resulting organizational and practice changes recommended to help alleviate this problem.

Reasons for Overstays:

Santa Clara RAIC ("Management Audit," 2013)

- Challenges in locating or lack of appropriate, available placements (65%)
- Foster parents unable to arrive before 24 hours (19%)
- Child requiring more medical clearance or significant medical attention (16%)

Los Angeles County Children's Welcome Center

Unlike Santa Clara County, a breakdown of specific reasons for overstays could not be located for Los Angeles, but in an article in Southern California Public Radio (Palta, 2013c) *Los Angeles County* indicated that overstays often occur because even after comprehensive searches, there are not enough placements available for these children. In addition, while traditionally the county's foster care system has struggled with a shortage of homes for children who are older and with medical and mental health needs, more recently workers noticed a shift, suddenly, there's a shortage of beds for the system's babies and toddlers. Some of this may be related to a Los Angeles County policy change requiring that new foster parents be certified as adoptive parents as well. In addition, placements taking in younger children do incur additional financial implications such as paying for diapers/formula and a lack of resources for foster parents who also need to pay for daycare services (Villacorte, 2013).

Practices to Prevent Overstays at Assessment Centers

The goal of 23-Hour Assessment Centers is that children are placed quickly but appropriately; however, it is not realistic that this can always be the case. Options gathered from various sources on practices that have been implemented in order to be compliant with placing children within the timeframe are:

- Placing a child in an emergency shelter, residential shelter, or group home.
- Utilizing Team Decision Making (TDM) models to find the best placement in a timely manner.
- Calling foster parents who have agreed to take a child to have them pick up the child earlier, or have the social worker transport the child earlier.
- Contracting with additional foster family agencies to accept children on a 24/7 basis.
- Ongoing recruitment of additional foster families.
- Assessing and evaluating organization structure of placement services to ensure the most efficient utilization of placement search teams are in place.

Practice Changes Being Explored and/or Implemented:

Santa Clara County

The County of Santa Clara has since begun to make changes in its organization and procedures as to address this issue and become compliant with child care center regulations (“Management Audit,” 2013). Please see “Other Notable Findings” for Santa Clara County for an expanding description of changes from the Management Audit.

Los Angeles County

Los Angeles County Department of Children and Family Services is fully aware of the overstay issue and has created changes to try to solve it (Palta, 2013a).

Possible changes being made include:

- Contracting with 13 foster agencies to provide intake services 24 hours per day (Palta, 2013a).
- Recruiting more foster families (an ongoing effort).
- Working with the state to raise monthly stipends for foster parents who take in small children (Palta & Foshay, 2013).
- It was confirmed via personal communication (J. Chandler, February 5, 2014) that Los Angeles County is currently working toward licensure as a child care facility.

Notable County Practices: Contra Costa and Monterey County have a protocol in place should a child near the 23 hour time limit. At 20 hours of a child being in the Assessment Center, the center staff will call the social work supervisor of the case, and division supervisor if necessary. At 23 hours, center staff will contact the Director of Children and Family Services to ensure compliance with center regulations of children not residing for over 24 hours (A. McGee, personal communication, February 12, 2013). Similarly Santa Clara County has a protocol when children may not be placed in time, including: when kids reach 14 hours, an email alert is sent out to the County and Department Directors, with a follow-up email every two hours to ask for assistance or leads for placement (E. Carbajal, personal communication, February 12, 2014).

FOSTER CARE ORIENTATION

According to Bruskas (2008), children in foster care do not receive a proper orientation to the new world they are entering when they first come under the care of Child Welfare Services. Key findings from his article, Children in Foster Care: a vulnerable population at risk.

- Child in foster care are deprived of a proper orientation like one would receive when starting a new job or school.
- Children start asking “why” about new situations, foster care being no different. However, because of the complex feelings they have like anxiety and fear, they may not be able to formulate questions for what is happening, or know who to address them to.
- Giving children a time and space to ask questions, affirms their value and important role in the process.
- Education about their environment can help children understand the process and their emotions better, which can lead to a decrease in the negative emotions they are experiencing like sadness, uncertainty, and loss.
- The article also gives recommendations on how to administer foster care orientation to children in a way that allows outcomes to be measured:
- Making the orientation age/grade appropriate.
- Discussing common terms children may hear in foster care, as well as common processes children may go through.
- Utilizing a holistic rating scale, orientation administrators will be able to understand what parts children are not understanding correctly and then can focus more carefully on those areas.

Application of Research to 23-Hour Assessment Centers

For many children Assessment Centers are their only stop between home and foster care, thus the Assessment Center would be the appropriate place to administer such an orientation. Children could have time for open questions to the child care/ social workers at the Assessment Center. Orientation at Assessment Centers could be integrated with trauma-reducing models of care, behavioral assessments, and general conversations between the children and the care workers.

- Contra Costa and Monterey County’s Aspiranet staff have an informal orientation process in which they discuss with the children what the process is that they are going through in regards to foster care and the experiences they may have. See “Staff Roles” subheading under Contra Costa and Monterey County.

ASSESSMENT CENTERS BY COUNTY

The following sections are organized by each individual County Assessment Center and summarize the practices, policies and procedures including information on:

- An Overview of the Assessment Center
- Behavioral Health and Physical Health Assessment (and developmental health if applicable)
- Staff Roles
- Staff Training
- Placement
- Other Notable Findings

ALAMEDA COUNTY COUNTY ASSESSMENT CENTER (ACAC)

(Sources: "West Coast Children's Clinic," 2012; "Alameda Self-Assessment," 2009; "STAT Support Counselor," 2014; Baldovinos, 2009; Walker, 2012; F. Battles, personal communication, September 20, 2013)

Serves ages 0-18

Capacity: 10 children

Ratio: 1:3

The ACAC receives children who are new to foster care or are changing foster placements.

Behavioral Health and Physical Health Assessment

- Behavioral health assessments are performed by West Coast Children's Clinic who staffs the Assessment Center and assesses children through their Screening, Stabilization, and Transition (STAT) program. The clinician who performs the assessment is either a licensed social worker, counselor, or psychologist. They are assessing the child for risk for harm, crisis level, and need for additional services. The clinician communicates the child's needs to the case worker who can use the information to find an appropriate placement and to assist foster parents in best meeting the needs of the child. The trained clinicians use informal observation, supportive play, and conversation to assess the child ("West Coast Children's Clinic," 2012).
 - If a child needs additional support transitioning to their placement, the STAT clinician can work with the child for up to 30 days in their placement.
- Each child receives a physical health assessment performed by a Public Health Nurse or mid-level practitioner (F. Battles, personal communication, September 20, 2013).

Staff Roles

- The West Coast Children's Clinic staffs the Assessment Center with STAT Support and Relief Counselors, STAT Clinicians, STAT Support Counselor Supervisor, STAT Assistant Program Director, Alameda County Social Services staff, and a public health nurse.
- STAT Support/Relief Counselors are in charge of the basic supervision and care for the children at the Assessment Center including, but not limited to ("STAT Support Counselor," 2014):
 - Contributing to the multidisciplinary team's comprehensive assessment of children in the center by observing behavior, emotional, and psychological states and communicating and documenting information appropriately.
 - Providing support to children by setting clear boundaries, utilizing positive and negative consequences, understanding developmental differences in communicating with children, and maintaining a respectful, healthy interaction.
 - Aiding in crisis intervention services (along with other Assessment Center Staff);
 - Conducting intakes of children including: orientation to the Assessment Center, inventory of belongings, and brief health screening if a nurse is not available.
 - Assuring children basic needs (eating, bathing, sleeping) are met, along with providing the child with age appropriate activities while maintaining a clean and safe environment where children can be monitored at all times.

Staff Training

Information regarding the specifics of staff training could not be located.

Placement

- Alameda County's Placement Unit has placed staff at the Assessment Center in order to aid social workers on site in located placements ("Alameda Self-Assessment," 2009)
- Alameda County's Placement Unit also works offsite at County offices on placement efforts.
- As in other counties, Alameda County found that placing children age 0-6 is difficult due to the cost of day care for this age group and the limited financial resources foster parents receive. In FY 2009-2010, Alameda County was able to provide day care through funding under Title IV-E waiver reinvestment funds (Baldovinos, 2009).

Other Notable Findings

Alameda County's Assessment Center employs two advocates from MISSEY, a community-based organization providing services to sexually exploited youth, to work with youth who enter the center. MISSEY advocates provide education and treatment interventions to youth over the age of 11 in order to teach them about warning signs of sexual exploitations, along with characteristics of healthy relationships, self-esteem, and sexual health. Advocates can also work with sexually exploited youth to move beyond education to evidence-based interventions for treatment (Walker, 2012).

CONTRA COSTA HARMONY HOUSE/ MONTEREY COUNTY CHERISH RECEIVING CENTER

(Sources: Aspiranet, 2010; "Cherish Agreement," 2010; Michael, 2006; D. Garner, personal communication, February 6, 2014; A. McGee, personal communication, February 12 2014)

Capacity: 10 children at each center

Ratio: 1:3

Ages: 0-18

Aspiranet, a private non-profit organization, staffs and manages the Contra Costa Harmony House and Monterey County Cherish Receiving Center.

Behavioral Health, Physical Health, & Developmental Assessments

Contra Costa Harmony House and Monterey Cherish Receiving Center run differently in regards to their mental health and physical health assessments.

- Monterey County Cherish has a partnership with Visiting Nurses Association and with County Behavioral Health. Nurses from VNA provide medical screenings and the County provides mental health screenings. The VNA provides screenings to nearly every child that enters the facility. Due to staffing and financial issues of County Behavioral Health, while it is preferred that every child receives a mental health assessment, it is not guaranteed that each child does. However if the assessment is specifically requested by the social worker or Aspiranet staff for a particular child because of an apparent need, County Behavioral Health will find a way to ensure the assessment occurs (Aspiranet, 2010; D. Garner, personal communication, February 6, 2014).
 - At the Monterey County Cherish Receiving Center a nurse from the Visiting Nurse Association conducts a health screening, basic dental screening, and reports any

- needs to the social worker to better inform foster parents of health needs. Monterey County Behavioral Health screening provides any crisis counseling to children due to the trauma of removal, as needed, and communicates this information to the social workers for placement and any other follow-up referral the child may need (“Cherish Agreement,” 2010; Aspiranet, 2010).
- Contra Costa has a partnership with County Behavioral Health who provides a mental health counselor who goes to the center based on whether the social worker or Aspiranet staff recommends an immediate mental health screening for a child. The Assessment Center also collaborates with County Public Health through the Child Health and Disability Prevention Program (CHDP) which staffs the Assessment Center with a nurse from 1pm-5pm, and who can come out if a medical screening is needed outside of those hours. The nurse assesses children’s health needs and makes referrals for any other additional treatment (A. McGee, personal communication, February 12, 2013).
 - For high-risk youth, please see Appendix C for information on Monterey County Cherish Receiving Center’s procedure for admitting high risk youth.

Staff Roles

Aspiranet staff are in charge of getting the children clean and fed, as well as checking for and treating head lice, and proceeding to care for any other needs, especially keeping them comfortable, entertained, and safe (Aspiranet, 2010). Developmental assessments can be performed by County Behavioral Health, and Aspiranet staff are currently being trained in using the Ages and Stages model for developmental assessments (D. Garner, personal communication, February 6, 2014).

One of the duties of the Aspiranet staff is to orient the child to their placement following the Assessment Center. The representative from the Assessment Center stated that the more information they know about the placement the better (i.e. if the child is going with a relative, foster family, or group home, and what that experience might be like). Preparing a child for his/her next step includes talking to the child about what he knows about where he is going, and explaining any details the child may not be knowledgeable about. Strategies for how this is done vary depending on the age of the child in order to make the conversation appropriate and well understood. For younger children it may be during play, while with older children it may be over meal time. Garner stated that orienting children to their next step validates their feelings, and many times allows them to come back to her staff with more questions and better communication (D. Garner, personal communication, February 6, 2014).

Staff Training

Aspiranet staff come from a variety of education backgrounds, yet all staff members have previous child care experience. Aspiranet provides ongoing training through classes and webinars to child care staff including, but not limited to, the following topics (D. Garner, personal communication, February 6, 2014):

- Crisis prevention and interventions.
- Behavior interventions.
- Trauma-informed care.
- Child development.
- Health and nutrition.

- Blood borne pathogens.
- Documentation.
- Child abuse reporting laws.

Contra Costa Harmony House also has bilingual staff members (Spanish/English speaking) (A. McGee, personal communication, February 12, 2013).

Aspiranet's representative stated it is the staff's interactions with the children that provide a comforting environment, high quality of care and the ability to attend to the children's needs (D. Garner, personal communication, February 6, 2014).

Placement

Team Decision Making (TDM) takes place at the Contra Costa County Children & Family Services office with community members, foster parents, family/relatives of the child, and any other parties who can contribute to a collective decision on where to best place the child. In Monterey and Contra Costa counties, children older than 12 can attend their TDM meetings in order to provide input on what they believe is their most appropriate placement (D. Garner, personal communication, February 6, 2014). However, TDM scheduling is in the hands of the social worker to plan and coordinate when a child can participate (A. McGee, personal communication, February 12, 2013)

If a placement is not found within the 24 hour time constraint, the social worker picks the child up and takes him/her to an emergency foster home. Cherish Receiving Center and Harmony House's representative stated that it is completely against their policy to keep children past the 24 hour limit, and thus will utilize emergency foster facilities as an option when no placement is located (D. Garner, personal communication, February 6, 2014).

At 20 hours of a child being in the Assessment Center, the center staff will call the social work supervisor of the case, and division supervisor if necessary. At 23 hours, center staff will contact the Director of Family and Children's Services to ensure compliance with center regulations of children not residing for over 24 hours (A. McGee, personal communication, February 12, 2013).

Other Notable Findings

- Contra Costa is the first 23-Hour Assessment Center to open in California in 1997 (Michael, 2006), and with years to develop and refine practices and policies for the facility, it has shown great strides in improving the way the Assessment Center is run. According to A. McGee (personal communication, February 12, 2014), surrounding counties have visited Harmony House Receiving Center for site visits in order to learn more, and possibly replicate their practices. McGee also stated that for other counties interested in contacting the center for more information, they are welcome to do so. McGee also stated that because of their outstanding relationship with Contra Costa County of Children and Family Services, the Assessment Center has support from directors to social workers who understand the purpose of the Center and work collaboratively to ensure that children are well cared for within the 23 hour time limit.

LOS ANGELES COUNTY CHILDREN’S WELCOME CENTER

(Sources: “Management Audit,” 2013; “DCFS Winter Newsletter,” 2013; Therolf, 2012; Palta, 2013; Villacorte, 2013; Department of Children and Family Services, 2013; Violence Intervention Program, 2014; J. Chandler, personal communication, February 5, 2014)

Capacity: 11-20 beds (“Management Audit,” 2013)

Ratio: 1:10 children; however the CWC typically staffs their center with a lower ratio in order to provide increased levels of supervision to the children.

Ages: 0-11

Los Angeles County Children’s Welcome Center (CWC) is the newest 23-Hour Assessment Center to be developed, opening in 2012.

The CWC evolved out of a need for children to be placed somewhere other than the Emergency Response Command Post. Younger children became the first priority with the development of the Children’s Welcome Center. A Youth Welcome Center for children age 12+ is expected to open across the street from the Children’s Welcome Center in 2014 (J. Chandler, personal communication, February 5, 2014). Currently, youth age 12+ are taken to the Emergency Response Command Post. With the expansion of care for foster youth, a question of where to house older children 18+ is being considered.

Los Angeles County has been cited previously for children staying over 24 hours at the Assessment Center. This issue is discussed further under “23-Hour Assessment Center Overstays.” The County is working toward becoming licensed as to allow children to stay longer than 24 hours, if needed, and working on other practices to inform this issue.

Behavioral Health & Physical Health Screenings

Upon entrance to LA County’s CWC children are first taken to the Violence Intervention Program (VIP) Community-Based Assessment and Treatment Center (CATC) where they are assessed for physical health related issues. If issues come up, they can be taken by their social worker to the Emergency Room located in the hospital for further evaluations. Mental health evaluations are completed in the VIP clinic if the child presents with a mental health emergency or if the requested by the social worker for evaluation. After assessments are completed in VIP clinic, children are taken to the CWC (J. Chandler, personal communication, February 5, 2014).

From VIP’s CATC, these are the services offered (Violence Intervention Program, 2014):

- Forensic evaluations including photo-documentation and evidence collection
- Comprehensive medical evaluation and treatment including follow-up care.
- STD and pregnancy prophylaxis.
- Forensic interviews with a trained psychologist.
- Coordination with law enforcement, courts, and social services.
- Well-child physicals and immunizations for children in foster care.
- Vision and hearing screening.
- Same-day/next-day sick visits for children in foster care.
- Developmental screening and referrals.

- Nutritional evaluations.
- Health and parenting education.
- Dental screening and referrals.
- Mental health intake screening.
- Case management and advocacy services.
- 24-hour crisis intervention.
- On-site Department of Children and Family Service workers.
- Court consultation.
- Subspecialty consultations and services through LAC+USC Medical Center.

VIP's CATC are open 24 hours a day, 7 days a week to serve children at all times of the day.

Staff Roles

Staffing of the CWC consists of a partnership with a non-profit organization called Mexican American Opportunity Foundation who staff child care workers at the center. In addition, a social worker supervisor, who has experience working with youth in child welfare services is always on site (J. Chandler, personal communication, February 5, 2014).

Staff Training

Currently, it is still being decided what type of additional training to require of the child care workers, since while they are trained in working with children, they do not typically have training to work with youth in the child welfare system including those with trauma/maltreatment histories (J. Chandler, personal communication, February 5, 2014).

Placement

A placement search team immediately begins looking for placement for a child when they are removed from their home. An issue with such a large county is having enough placement options available for the number of children that are in need. A shortage of placement options has led the county's Placement and Recruitment Unit to recruit more qualified foster families to take in children. As of November 2013, the department had added 75 in the previous 6 months (Palta, 2013c) and as of August of 2013, Director Philip Browning stated that the department was entering contracts with private, non-profit foster agencies who would be willing to take in children 24 hours a day. Many efforts have already been put in place, or are in the process of being put in place to address the high volume of children that Los Angeles County serves (Therolf, 2013).

Other Notable Findings

With the CWC located on the grounds of the hospital, the center utilizes the food services from the hospitals dining facilities. The CWC representative stated that they are currently in the process of changing the food options that the hospital offers because of the preferences observed by the children. The CWC also tries to make sure that the food they receive from the hospital has fruits and vegetables and other healthy options (J. Chandler, personal communication, February 5, 2014).

With its location on the LAC-USC hospital grounds, the CWC can also utilize hospital security if needed, and in any emergency, there is a panic button that alerts emergency services/ police if pressed (J. Chandler, personal communication, February 5, 2014).

SANTA CLARA COUNTY RECEIVING, ASSESSMENT AND INTAKE CENTER

(Sources: Tondreau & Blockie, 2013; “Interagency Collaboration,” 2013; Leung & Medina, 2012; “DFCS Online Policies,” 2013; “Management Audit,” 2013; “Receiving Center Site Visit” , 2013; “Receiving Center Update,” 2013; “Management Audit Committee,” 2012; J. Hubbs, personal communication, January 21, 2014; E. Carbajal, personal communication, February 12, 2014)

Capacity: 8 beds available for sleeping

Ratio: No defined ratio, a total of 2 staff present at all time in the Assessment Center

Ages: 0-18

Santa Clara County’s Receiving, Assessment, and Intake Center (RAIC) was developed after closing a residential facility due to budget cuts and moving to serving only as a receiving point for child removed from their home or foster placement.

Santa Clara Department of Family and Children’s Services has an online Policies and Procedures Handbook that outlines the following policies and procedures as they pertain to the 23-Hour Assessment Center (“DFCS Online Policies,” 2013):

- Chapter 1-10: Assessment and Intake Center (AIC): Staffing and Functions
 - Overview
 - Hours of Operation
 - Goal to Limit Placements
 - Staffing
 - Staff Responsibilities
 - Medical and Mental Health Screening
- Chapter 1-11: Receiving Center
 - Overview
 - DCFS Policy on Receiving Center Intakes
 - The Facility
 - Services Available at the Receiving Center
 - Receiving Center Staff Responsibilities
 - Child’s Right to Make and Receiving Phone Calls
- Chapter 2-9: Intake at the Assessment and Intake Center (AIC)
 - Overview
 - Initial Evaluations
 - ER Social Worker Responsibilities
 - AIC Social Worker’s Role in Joint Response Protocol
 - RAIC Social Worker Responsibilities
 - AIC Creating New Referrals in CWS/CMS
 - Placement Authority over Children at the Receiving Center

- Juvenile Contact Report (JCR)
- Receiving Center Admission for Placement Disruptions
- Circumstances that do not Meet the Criteria for Child Welfare Services

Additional Chapters include:

- Chapter 4-5: Family Finding Resources
- Chapter 6-3 Emergency Satellite Home (ESH) Placements

This easily accessible resource makes understanding the policies, procedures, roles and responsibilities of the staff and department clear. This was the only formal policy and procedures handbook/manual of its kind to be located online for a 23-Hour Assessment Center.

Behavioral Health and Physical Health Assessment

(See page 11 for an expanded description)

- It is not required that each child who enters the RAIC receive a behavioral health assessment. If it is requested by the social worker, or if the child presents with an obvious need for assessment, a clinician will assess the child at the RAIC (J. Hubbs, personal communication, January 21, 2014)
- Social Worker IIIs are able to perform a behavioral health assessment, after which, if needed, they can request that further assessment may be needed ("Management Audit," 2013).
- Each child who enters into the RAIC receives a minimum physical health clearance assessment by a healthcare specialist assistant who can contact an on-call nurse who can respond in person, or via teleconference for consult. A medical clinic is co-located in the same building as the RAIC which allows for a more in-depth assessment if needed ("DFCS Online Policies," 2013).

Staff Roles

Social workers in the assessment and intake portion of the RAIC are responsible for processing intake data and paperwork for all admits (children who physically enter the Receiving center awaiting placement) and intakes (children who a placement is located for directly after being removed by DCFS).

Other duties include ("DFCS Online Policies," 2013):

- Performing initial behavioral health assessments and referring the child for comprehensive care, if needed.
- Interviewing the child about potential relative placements.
- Reviewing the child's personal rights.
- Reviewing the process and rules of the RAIC.
- Introducing the child to Counselors in the Receiving Center.
- Inputting records in CWS/CMS.

Counselors in the Receiving Center are responsible for caring for the children's well-being during their time at the RAIC which includes assisting them with age-appropriate activities, making sure they are comfortable, allowing them to sleep and eat when they need to, and providing a safe and trauma-reducing environment for them to await placement (J. Hubbs, personal communication, January 21, 2014).

Staff Training

- Social workers who work in the RAIC are trained according to State standards for Child Welfare training.
- Counselors who work in the Receiving Center do not receive the same required training as social workers. Hubbs (personal communication, January 21, 2014) spoke of having staff development trainings. Counselors have thorough child care experience and many bring years of child care expertise to the RAIC.
 - Staff in the Receiving Center receive training in various topics such as: CPR, first aid, behavioral management, child development, and safety issues (E. Carbajal, personal communication, February 12, 2014). A majority of the staff have worked for 10 or more years at the Children's Shelter (the county-run shelter that closed previous to the opening of the RAIC).

Placement

- Social workers in the Assessment and Intake Center are responsible for placing all children who are non-dependents (prior to entering the RAIC did not have an open case with DFCS) into their out-of-home placements (J. Hubbs, personal communication, January 21, 2014).
- The Family and Permanency Bureau's Placement Unit is responsible for locating placements for all dependent children ("Management Audit," 2013).

Other Notable Findings

In a Management Audit of the Department of Family and Children's Services (2013), the department was assessed in a number of areas, several pertaining to the RAIC. Responses to the Management Audit are also included.

- Santa Clara County RAIC is one of two counties that has been cited for being non-compliance with licensing regulations. The RAIC has had overstay, resulting from not placing the child within 24 hours. The details of these overstay, as well as implications for future practice at the RAIC, as recommended by the Management Audit Department (2013) are discussed in the section "Overstay at 23-Hour Assessment Centers."
- The audit team recommended the following staff and organizational changes be made in the RAIC ("Management Audit," 2013):
 - Convert Children's Counselor positions to Social Worker I positions in order to give greater responsibility to counselors, who at the time of the audit, only performed child care duties. With a move to Social Worker I position³, the RAIC is recommended to employ 11 Social Worker I positions who can assist case-carrying social workers in other duties (i.e. placement), especially in times of low capacity at the center.
 - The response from Santa Clara Social Services Agency was they partially agreed, and all 17 counselor positions should be reclassified in order to provide more support for case-carrying social workers. A draft staffing needs assessment was scheduled to be reviewed in December 2013 ("Management Audit Committee," 2012).

³ Social Worker Is require graduation from an accredited college or university, however, "[qualifying experience] may be substituted for a maximum of two years of the required education on a year-for-year basis when lower division general education requirements with an emphasis in the human services curriculum are met." The audit team believes that many Counselors who work at the RAIC could qualify as a Social Worker I by using their experience in lieu of a degree ("Management Audit", 2013).

- Currently, they are working to move forward with this, but reclassification has not happened yet (E. Carbajal, personal communication, February 12, 2014).
- Realigning DFCS Bureaus to put the management of the RAIC and recruitment and placement functions under one manager in order to make more timely, coordinated, and appropriate placements.
 - The response from Santa Clara Social Services Agency was that they agree that a new Bureau including Receiving, Recruitment, and Placement should be created and managed by one manager to ensure improved coordination of services. However, at this point in time they are not under one Bureau (E. Carbajal, personal communication, February 12, 2014)
- By making the above changes, the audit team calculated a net savings to the department of \$547,042, as well as additional support to high case carrying social workers, and less likelihood of overstays at the RAIC due to more timely and efficient placements.

Location Safety Issues

Safety at the RAIC has been on the forefront of the critique and inspection done on the Assessment Center. In a site visit report performed on the RAIC in January 2013, issues were brought up in regards to safety (“Receiving Center Site Visit,” 2013. “Receiving Center Update,” 2013):

- Since youth cannot be prevented from leaving the facility, concern has been raised in regards to the safety of the surrounding neighborhood of the RAIC. Police reports show levels of crime in the area that are concerning and indicate the potential for incidents involving the youth from the RAIC to occur.
 - Many cosmetic and aesthetic issues were addressed after the initial inspection including: the removal of an unlocked dumpster outside of the facility, medical equipment removed from the site, standing water removed from the site, and debris cleaned from the perimeter. The Juvenile Justice Commission reported being satisfied with these changes.
- A recommendation made during the site visit was to immediately begin planning to find a facility that is a safer, state of the art Receiving, Intake, and Assessment Center and that all other recommendations for the current RAIC are to be viewed as interim. As of March 2013, DFCS reported that while there are plans for the development of a new facility, no date has been set.

IMPLICATIONS FOR FUTURE RESEARCH

- Overall, 23-Hour Assessment Centers present with a significant gap in literature and research, partly because the facilities are fairly new and there is no consensus on a single best approach. While county documents are somewhat prevalent (some counties more than others), what is missing is peer reviewed literature, or evaluative studies on the efficacy of Assessment Centers. After researching the details of Assessment Centers, it is clear that this time period of transition for children is critical and can be very traumatic. The need for research in this area is crucial, especially when the outcomes deal with the well-being of our children in the child welfare system.
- The literature presented in this review allow for a better understanding of the scope of literature available, and for Assessment Center management and other professionals to learn from practices and policies of other centers to inform their own practice.

- Evaluation are a critical part of practice in social services. Understanding the effect of services on a population allows social service professionals to ensure that the programs being delivered are backed with evidence proving effectiveness. Assessment Centers and its population can benefit from evaluative studies. Evaluations that can benefit 23-Hour Assessment Centers include:
 - Needs assessments in areas without Assessment Centers and the feasibility to create one.
 - Process evaluations to evaluate the implementation of practices and policies at Assessment Centers currently in place.
 - Outcome evaluations to determine what effect Assessment Centers are having on children utilizing them. Understanding the benefit to children in qualitative and quantitative terms can help shape practices and policies.
 - Comparison studies between counties with Assessment Centers and counties that operate with only emergency shelter or foster care to evaluation effectiveness of Centers.
 - Satisfaction surveys in the form of qualitative interviews with youth to evaluate their perspective on Assessment Centers (e.g. what was most/least helpful) could help inform and refine practices.
- Although Assessment Center policies and procedures vary based on county and the level of collaboration a center has with the other community providers/ agencies, what is lacking are best practices for this specific transitional period.
 - Best practices, specifically standardized screenings for Mental Health and Physical Health, could help ensure that children in child welfare are receiving quality care. As discussed before, while California does not have a policy on initial mental health screenings (not comprehensive assessments) for children removed from their home, if all counties used a reliable and valid screening tool, it could aid in evaluative efforts on a larger scale, not to mention would create a more universal protocol for Assessment Centers in general.
- A cost effectiveness analysis of each county's Assessment Centers, as well as for counties without Assessment Centers but interested in creating one, would allow for county agencies to see the fiscal impact of developing an Assessment Center, or for keeping an existing one open.

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APPENDIX A: TIPS FOR AGENCIES AND STAFF WORKING WITH YOUTH

Trauma Informed Care for Children Exposed to Violence Tips for Agencies and Staff Working with Youth

What happens to youth who have been exposed to violence?

Exposure to violence at home, in the form of child abuse and neglect, or in the community, whether at school or in the neighborhood, can affect young people in profound ways. Youth who have been exposed to violence may drop out of school, run away or become homeless, become involved in the juvenile justice system (regardless of whether it is the reason they come before the courts), abuse drugs or alcohol, or end up with labels like “conduct disorder.” A significant portion of these youth may also go on to act violently against intimate partners or family members. Because exposure to violence is often a hidden problem, adults may deem these youth undeserving of sympathy and view them as willfully bad kids who resist efforts to help them. Read the rest of this tip sheet to find out how youth workers can identify youth exposed to violence and give them the sympathetic care they need.

What are some warning signs?

Some young people react immediately when exposed to violence. For other youth, signs of the exposure appear months, even years later. In addition, young people’s reactions differ in severity and include a range of behaviors. What warning signs appear will depend on the frequency and intensity of the traumatic events.

Youth may have one or more of the following symptoms:

- Physical complaints, such as headaches and stomachaches.
- Constant worry about danger or the safety of loved ones.
- Signs of depression, such as withdrawing from other or no longer enjoying favorite activities.
- Difficulty paying attention in class, concentrating on work, or learning new information.
- Outbursts of anger directed toward others or themselves.
- Refusal to follow rules.
- Use of violence to get what they want.
- Rebellion at home and at school.
- Bullying or aggression toward others.
- Risky behavior such as driving fast or jumping from high places.
- Revenge-seeking.
- Abrupt changes in friends or dating relationships.
- Stereotypical beliefs about males as aggressors and females as victims.

What can youth workers do?

People who work with youth, such as social workers, teachers, coaches, therapists, and shelter staff, can play a critical role in reducing the impact exposure to violence has on youth. First, youth workers can recognize that a lifetime of exposure to violence may be pervasive in young people’s lives. To aid that recognition, youth-serving organizations can inform staff about the

incidence and prevalence of exposure in the community they serve. Second, staff must understand how exposure to violence may be affecting each individual young person. By identifying and addressing young people's exposure to violence and victimization, youth-serving organizations can attempt to break the cycle of violence. Here are some steps organizations and their staff can take to support young people who have been exposed to violence:

Establish protocols to screen for exposure to violence symptoms and mental health needs on an ongoing basis.

Routine screening for possible exposure to violence and its impact on youth is recommended at every phase of youths' involvement with an agency.

Refer youth for comprehensive mental health assessment.

The assessment should evaluate direct victimization or exposure of violence, especially family violence in the home. The assessment will help identify trauma and stressors that might be contributing to a young person's problems. It will also help the agency decide how to intervene. The assessment should result in a plan to provide the services and supports that are needed to help the young person heal.

Plan individualized interventions that take traumatic experiences into consideration.

Youth respond to violence in different ways, depending on their gender, age, and past experiences. Each treatment plan should be individualized, age-appropriate, and tailored to the young person's family history. At the same time, every treatment plan should help the youth (and caregivers) re-establish a normal routine, safety, and predictability. When planning for services, it is important to remember that young people's families may have been exposed to violence, too, and may have their own reactions to trauma. When that's the case, agencies should offer specific plans and supports that help parents address their own needs so they can become a powerful anchor for the youth treatment.

Avoid staff burnout.

Youth workers may also have been exposed to violence, whether on the job or in their personal lives. To be able to effectively respond to their client needs, they should develop their own plans for resolving personal issues and addressing job stress.

Help youth feel safe and in control.

Adolescents may feel embarrassed to talk to adults about what they are going through. Youth workers can help them feel comfortable using some of the following strategies:

- Don't force them to talk if they don't want to.
- Find out what is making them feel unsafe and help them make a safety plan.
- Give straightforward explanations for things that are worrying them.
- Don't downplay their feelings by saying things like "Don't worry" or "Everything will be all right."
- Don't make commitments that you cannot honor.
- Look at their options and suggest concrete steps they can take.
- Help them think of positive ways to keep busy, such as playing sports, going out with friends, or making art or music.

When to seek professional help

If an adolescent is doing any of the following, youth workers should take serious notice and link the young person specialized mental health interventions:

- Being involved in violent dating relationships, either as abuser or victim
- Drinking and using drugs
- Skipping school a lot or dropping out
- Thinking about wanting to die or committing suicide
- Breaking the law or destroying things

(Source: “Safe Start Center,” 2014)

APPENDIX B: TRANSITION FRAMEWORK

Schlossberg's transition framework

- Approaching transitions
 - What is the *context* of the transition (relationship of the individual to the transition and the context in which the transition is occurring)?
 - What *type* of transition is occurring (anticipated, unanticipated or a non-event)?
 - What is the *impact* of the transition on the individual (individual's perception of the impact of the transition on relationships, routines, assumptions and roles)?
- Taking stock of coping resources (potential resources that a person possesses to cope with transitions)
 1. The *situation* variable—What is happening? (the trigger, timing, control, role change, duration, previous experiences of transition, concurrent stress)
 2. The *self* variable—To whom is it happening? Each individual is different in terms of life issues and personality (factors include socio-economic status, age, life stage, gender, psychological resources, outlook, spirituality)
 3. The *support* variable—What help is available? Supports and available options vary for each individual (these could include relationships, family, friends, community/institutional networks)
 4. The *strategies* variable—How does the person cope? People navigate transitions in different ways (Goodman *et al.*, 2006, p. 55)
- Taking charge (strengthening resources)
 - The four variables listed above can be regarded as potential assets and/or liabilities in terms of the likelihood of successful adaptation to the transition (Goodman *et al.*, 2006, p. 55)

(Source: Adapted from Goodman *et al.*, 2006, pp. 32–55; as cited in Winter, 2012)

APPENDIX C: MONTEREY COUNTY CHERISH PROCEDURE FOR ADMITTING HIGH-RISK YOUTH

Monterey County Cherish Procedure for Admitting High-Risk Youth

High Risks and Unusual Circumstances may include:

1. Clients under the influence of drugs or alcohol.
2. Clients who have family and/or friends that know the Cherish location.
3. Clients who exhibit high risk behavior, such as threats, violence, suicidal ideation, gang affiliation, etc.
4. Previous clients with known high risk behaviors.

If it is determined before client 's arrival that the client presents a high risk, then I , Cherish staff will inform Cherish Supervisor.

1. Cherish Supervisor will inform Cherish Director.
2. Cherish Supervisor will inform Cherish on-call staff to be prepared to come in if needed in case of an emergency.
3. Cherish Director and DSES Program Manager will consult to draft a safety plan and inform their respective staff.
4. Nurse and Behavioral Health staff will be contacted.
5. DSES Staff who brings in the high risk youth may stay on- site to assist.
6. Safety plan is put into place.

For clients under the influence: DSES staff will take client to the hospital first for evaluation. Once cleared, client may be brought to site.

If multiple youth are in the center, then

1. Cherish staff will inform Cherish Supervisor.
2. Cherish Supervisor will call in Cherish on-call staff to work.
3. Cherish Supervisor will inform Cherish Director.
4. DSES Staff may choose to stay on-site to assist if approved by the on call County Standby Supervisor, County Standby Supervisor also has option of contacting DSES standby worker to assist.

If youth starts to exhibit high risk behavior:

1. Cherish staff contacts Cherish Supervisor.
2. Cherish Supervisor will:
 - a) go to site to assist
 - b) call Cherish on-call staff in to assist
 - c) call DSES standby in to assist
 - d) call Behavioral Health Staff
 - e) call Cherish Director

In extreme cases, if youth's behavior is beyond control, staff will call 911,

(Source: "Cherish Agreement," 2010)