

# EXCEPTIONAL PLACEMENT REPORT & RECOMMENDATIONS



Washington State Department of  
**CHILDREN, YOUTH & FAMILIES**



## Washington State Department of **CHILDREN, YOUTH & FAMILIES**

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## Priority Recommendations

This report outlines system and practice enhancements to address exceptional placements. While we view practice changes as equally impactful, we prioritize here for quick reference the system recommendations that require executive leadership support and intervention. Additional details are contained in the report.

### Behavioral Health

- Partner with the Health Care Authority (HCA) to advocate for funding to develop 25 additional Children's Long-term Inpatient Program (CLIP) beds specifically for dependent children and youth.
- Develop a Service Level Agreement (SLA) with HCA to outline an escalation process specific to partnering to keep children and youth out of the child welfare system where they are discharging from behavioral health facilities and are not victims of child abuse or neglect.
- Implement BRS Intensive Mental Health Services (BRS IMH, aka BRS+). The procurement for this contract is in process, and it is anticipated that contracts will be executed by the end of March 2021.
- Implement Treatment Foster Care Initiative for dependent youth with high mental health needs (awaiting/stepping down from CLIP, transitioning back from out of state, etc.). These 15 beds will come online gradually between January 2021 and October 2022.
- Partner with DSHS to advance recommendations of the interagency children's mental health workgroup. Recommendations include a continuum of treatment programs: a Residential Crisis Stabilization Program, inpatient residence and a Habilitative Mental Health (HMH) unit within CLIP.
- Establish regional DCYF child welfare mental health liaisons in each region.

### Developmental Disabilities

- Seek expansion of current case planning statute to require Developmental Disabilities Administration (DDA) to participate in case planning and resource development for youth.
- Support DDA in requesting funding to develop resources for placement of non-dependent children and youth, for those children and youth who are not victims of child abuse or neglect, and for those dependent youth who require long term care or treatment related to their intellectual disability.
- Develop an SLA similar to that mentioned above for behavioral health.

### Local Juvenile Courts/Detention

- Work with local jurisdictions/county detention to enter into a Memorandum of Understanding (MOU) with DCYF that addresses the release of non-dependent youth to adults when there is no allegation of child abuse or neglect and youth are released or there is a plan to release them, and parents are refusing to pick them up or engage in planning for discharge.

### Relative Search/Placement/Support

- Continue work on statutory expansion of the definition of "relative" in RCW 74.15.020(2) to include suitable others, which would widen the availability of placement resources with whom children and youth have a connection.

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## Workgroup Participants

The following table outlines workgroup participant names, roles and locations. With their informed input, this report and ensuing recommendations were made possible.

Exceptional Placement Workgroup Members		
Name	Title	Location
Jami Belieu	Area Administrator – Adoptions	DCYF Region 3
Hieu Dang	Area Administrator	DCYF Region 6
MaShelle Hess	Program Manager – Guardianship	DCYF Headquarters Child Welfare Programs
Renee Kincaid	Supervisor – After Hours	DCYF Region 1
Doug Klinman	Researcher/Data Analyst	DCYF Headquarters OIAA
Erik Larson	Supervisor – Home Finders	DCYF Region 1
Kira Lewis	Area Administrator	DCYF Region 6
Jennifer Marshall	Area Administrator – Adoptions	DCYF Region 4
Jennifer Martin	Supervisor – After Hours	DCYF Region 2
Nastacia O’Neal	Supervisor – After Hours	DCYF Region 4
Betsy Rodgers	Area Administrator – Centralized Services	DCYF Region 5
Kevin Sharp-Smith	Area Administrator	DCYF Region 2
Wendy Skarra	Program Manager –Systems Integration/Mental Health	DCYF Headquarters Child Welfare Programs
Annie Taylor	Supervisor	DCYF Region 3
Anita Teeter	Program Administrator	DCYF Region 5
Hannahlyn Van Veen	Area Administrator – Centralized Services	DCYF Region 3
Codie Veitenheimer	Program Manager – Foster Parent Recruitment	DCYF Headquarters Licensing Division

## Introduction

DCYF has continued to have an increasing number of children and youth experiencing exceptional placements, including hotel and office stays, and night-to-night foster care placements. While the number of children and youth who experience exceptional placements is small as a percentage of the overall number of children and youth in out-of-home care, these children and youth frequently present with complex needs that are not easily met and require significant resources.

In a descriptive analysis of available data related to hotel stays between January 2016 and June 2019, Dr. Doug Klinman, DCYF OIAA, identified the most frequently occurring characteristics for children and youth experiencing hotel stays as verbal/physical abuse by the child (aggressive behavior), mental health needs and oppositional defiant disorder/oppositional behavior. In his review of the data, he also found that, in general, children and youth who were verbally/physically aggressive and/or have mental health issues were at an increased likelihood for more hotel stays. The available data that identified child characteristics has some

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limitations as the identified need was based on the caseworker's perception of need and the presenting problem for the child. Data reflects that children and youth experiencing exceptional placements have high behavioral needs.

Dr. Klinman's descriptive analysis is consistent with the findings of DSHS Research and Data Analysis (RDA), who used FamLink and Integrated Client Database (ICDB) data to develop a profile of youth with at least one night in a placement exception during January 2019 to June 2019. Their analysis found that risk factors including criminal justice involvement, past runaway, suicide or self-harm, disability-related medical coverage, mental health diagnosis, substance use disorder, co-occurring substance use and mental health, pervasive developmental disorder and multiple mental health and/or developmental diagnoses were at least twice as prevalent in youth with a placement exception when compared to the rest of the out-of-home population. While the data reflects that children and youth who experience exceptional placements have a variety of complex needs, we are unable to ascertain from available data whether they entered care due to these needs without allegations of abuse or neglect, or whether they entered out-of-home care due to abuse or neglect.

To comprehensively address the increasing problem of exceptional placements including hotel stays, office stays and night-to-night foster care placements for children and youth, a statewide workgroup was formed to review available data and provide their experience and expertise to more clearly frame the problem and develop proposed solutions.

The workgroup meetings occurred every other week from Oct. 19, 2020, to Dec. 2, 2020. The recommendations were reviewed by the workgroup and their feedback has been incorporated into this final report. The recommendations fall into two categories, systemic issues that require multi-agency commitment and partnership to resolve, and practice issues and recommendations which can be managed internally and implemented in partnership between Field Operations and Child Welfare Programs. We have also included other work that is currently planned or in process.

## Recommendations

### Partnering with Child and Family Serving Systems

The following recommendations are considered complex and high priority. They involve other child and youth-serving systems. Support from the Executive Leadership Team will be needed to move these items forward and may include statutory language changes. The recommendations will assist with developing resources and supports for children and youth who are dependent due to child abuse or neglect, as well as to strengthen the structure to keep children at home with their families without child welfare involvement when it is safe to do so. Families should not have to access the child welfare system in order to get needed treatment and supports for their child.

#### Behavioral Health

- Partner with the Health Care Authority (HCA) to advocate for the appropriation of funds to develop additional placement and care solutions to meet a spectrum of behavioral health needs for children and youth. Funding should specifically target an increase in Children's Long-term Inpatient Program

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(CLIP) beds and related resources including placement alternatives and supports for children and youth awaiting CLIP placements or transitioning from CLIP to a less restrictive placement. While we believe it is important to partner with HCA, the core responsibility for meeting the behavioral health needs of children and youth, regardless of their involvement with child welfare, should remain with the behavioral health system.

- An assessment of youth need and behavioral health resources completed by Wendy Skarra, DCYF Child Welfare Programs Systems Integration/Mental Health program manager, identified a need for 25 additional CLIP beds specifically to meet the needs of our dependent children and youth (Attachment A).
- Develop a Service Level Agreement (SLA) with HCA to outline an escalation process for discharges for youth with complex needs from behavioral health facilities specific to partnering to keep children and youth who are not victims of child abuse or neglect out of the child welfare system. The SLA should also address children and youth with complex behavioral health needs who are exiting a short-term hospital stay or require intensive outpatient treatment rather than inpatient behavioral health. Delineate concrete agency roles and responsibilities. The success of this process will be dependent upon leadership agreement and commitment to the roles and responsibilities.
  - For example, if a youth is discharging from a CLIP facility and there are no allegations of child abuse or neglect, but discharge planning is stalled due to lack of parental engagement, DCYF would be able to partner with HCA to develop alternate plans but DCYF would not assume responsibility for the case planning or the placement of the youth.
- Partner with Coordinated Care and HCA to develop a plan for seamless continuity of care via telehealth while children or youth are experiencing placement instability. It is anticipated that this can be accomplished at the program level and should not require additional resources. If barriers are identified that require statutory or contract changes and agreement cannot be reached, leadership action may be needed.
  - Currently, if children or youth are experiencing placement instability or are temporarily placed out of the area, they are unable to consistently access behavioral health from a provider they were seeing before their placement disruption. Telehealth opportunities for engagement and treatment with their provider will support stability and transition to a stable placement.
- Establish regional DCYF child welfare mental health liaisons. Funding will be needed in order to implement this recommendation. The regional behavioral health liaisons would be responsible for building solid relationships with the local behavioral health agencies and hospitals, establishing local escalation processes consistent with the SLA, providing consultation to field operations staff, participating in shared planning meetings and local behavioral health cross-systems collaboration meetings, and advocating for local behavioral health serving agencies to meet the needs of DCYF involved children and youth.
  - Currently, lead or liaison functions in many areas of child welfare are “other duties as assigned.” Based on the significant impact of trauma on children and youth involved in the child welfare system and the complex nature of their needs, it is recommended that these be

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dedicated positions. Funding, consistent job descriptions and training will be needed for these positions. These positions would work closely with the Child Welfare Programs Systems Integration and Foster Care Health program managers and could also serve as the liaisons with the Developmental Disabilities Administration (DDA) to better support integration of planning and problem-solving.

### Developmental Disabilities

- Strengthen processes for Developmental Disabilities Administration (DDA) eligible youth, who are turning 18, to access needed services and placement resources upon turning 18. This includes requirements for DDA to participate in case planning and resource development for youth. Currently, there is a statutory requirement (RCW 74.13.341) for DCYF to invite representatives from the Division of Behavioral Health Recovery (DBHR), Economic Services Administration (ESA), Juvenile Rehabilitation (JR) and DDA, to the youth's shared planning meeting to develop the transition plan. However, there is no corresponding requirement for DDA or other agencies to participate in the meeting.
- Request legislative support for accountability measures for DDA to identify and/or develop resources for placement of non-dependent children and youth, for those children and youth who are not victims of child abuse or neglect, and for those dependent youth who require long term care or treatment related to their intellectual disability.
- Develop collaborative processes (similar to what is outlined in the behavioral health section above) to include the development of an SLA specific to establishing an escalation and decision-making process for children and youth with complex needs and partnering to keep children and youth who are not victims of child abuse or neglect, out of the child welfare system.

### Local Juvenile Courts/Detention

- Approach local jurisdictions/county detention to enter into a Memorandum of Understanding (MOU) with DCYF that addresses the release of non-dependent youth to adults when there is no allegation of child abuse or neglect and youth are released or there is a plan to release them and parents are refusing to pick them up or engage in planning for discharge. Ultimately these would be local agreements between the DCYF region or office and the local juvenile court/detention. Previous efforts have failed to establish consistent agreements statewide.
  - Revisiting the previously developed statewide MOU template could be a place to start (Attachment B).
  - Spokane and Richland have local MOUs that could also be used to inform the development of a current statewide template.

### Practice/Service Items

The following recommendations are low-cost or no-cost recommendations that can be implemented in partnership between Field Operations and Child Welfare Programs and may require policy and guidance revisions. The strategies proposed below can be implemented to be used at the time a child or youth is experiencing an exceptional placement, but also can be implemented for dependent children and youth to

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stabilize placements and prevent disruptions by supporting the appropriate level and access to needed services and resources.

### Shared Planning Meetings

- Hold shared planning meetings (including FTDMs) whether the child or youth is available or not (e.g., missing from care youth). This allows the caseworker to develop a plan for appropriate service referrals/connections and supports to placement once identified, which should reduce the lag time for supports being put in place and streamline approval processes for placements.
- Invite the appropriate experts to shared planning meetings depending on the specific child or youth's needs and circumstances. For example, if the meeting involves a child or youth with significant behavioral health challenges, the regional mental health liaison and the regional medical consultant in addition to any community-based or contracted provider should be invited to provide input and feedback to the plan.
- Participate in shared planning meetings held by external partners when there is no open DCYF case to prevent children and youth who are not victims of child abuse or neglect from entering the system. This could be addressed through the agreements referenced in the Partnering with Child and Family Serving Systems section and integrated into practice.
- Strengthen the practice of placement stabilization FTDMs to identify services and supports needed to stabilize children and youth in their current placements and prevent placement disruptions.
- Establish and maintain consistent protocols for staffing children and youth experiencing exceptional placements.

### Case Consultations

- Utilize regional medical consultants to review the medical chart to include psychotropic medications and provide recommendations. No additional resources or contract changes are needed for this.
- The Foster Care Assessment Program (FCAP) contract through Harborview can be accessed for consultations on cases involving children or youth with complex behavioral health, behaviors and/or medical issues.
  - Region 4 has accessed FCAP for consultations for some of their youth involved in exceptional placements, and this is reported to have been helpful.
  - We are assessing program capacity and structure to determine if this is a service that could be used in a more formalized way when children or youth are experiencing exceptional placements.
  - This contract had been identified for budget reductions. Shifting how the program is used or seeking to expand capacity for this specific service may result in a recommendation not to reduce the contract.
- Refer all youth with complex behavioral health, behaviors and/or medical issues to care coordination through Coordinated Care. The assigned care manager can assist the caseworker and caregivers in accessing the appropriate types and levels of care for the youth. In addition to addressing an

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immediate crisis, care coordination can serve to strengthen preventive processes by helping to ensure they receive needed services in a timely way.

- Regional mental health liaisons (if established), can consult on an ongoing basis to ensure the needs of the child or youth are being met and to strategize ways to break down barriers to accessing services.

#### Relative Search/Placement/Support

- Establish QA/CQI processes for following up on relative search information to include training and technical assistance for vetting potential placement, permanency and support resources.
- Continue to work on statutory expansion of the definition of “relative” in RCW 74.15.020(2) to include suitable others, which would widen the availability of placement resources with whom children and youth have a connection. This work will require conversations with DSHS and DCYF’s Licensing Division, as both would be impacted.
  - Broadening the definition for relative will allow the Licensing Division to use Non-Safety waivers for suitable other placements, providing more kinship caregivers the ability to become licensed. This will improve the overall licensing experience and access to financial and other supports for a wider pool of placement options for children and youth while maintaining important familial/kin connections.
  - Expanding the definition of relative is anticipated to positively impact children and families of color which could address disparate outcomes. It may also expand options for short-term voluntary placements which could keep children and youth from further penetration into the child welfare system when only a brief placement is needed while services are put in place.
- Identify staff in each Region with access to relative search databases and establish a referral process/form for staff to send a referral to the identified regional lead.

#### Support Services

- Establish a single case aide contract that could be used by independent case aide providers or Child Placing Agencies (CPA). There are currently three different case-aide contracts to provide support to state-licensed foster homes. These contracts are underutilized in certain areas due to an inability to retain and staff the program sufficiently, the primary concerns being lack of financial compensation for case aide staff. Efforts are being made to provide additional case aide support to state-licensed foster homes that private agency foster homes receive.

#### Additional Recommendations/Work in Progress

There are additional activities and recommendations at an agency and system level that may positively impact the frequency of exceptional placements for children and youth. These include:

**BRS Intensive Mental Health Services (BRS IMH, aka BRS+) contract:** The procurement for this contract is in process, and it is anticipated that contracts will be executed by the end of March 2021. These facility-based placements will have a more intensive mental health focus than current BRS placement resources and will expand the continuum of youth we are able to serve.

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**Treatment Foster Care Initiative:** Short-term (90-day) planned placements for dependent youth with high mental health needs who are awaiting CLIP or stepping down from CLIP. The 15 beds will be funded through a SAMHSA grant held by HCA. If the outcomes are positive, additional funding will be pursued for expansion.

**Children's Mental Health Workgroup:** As a result of an interagency workgroup, support needs were identified for youth who require residential behavioral health treatment and also have an intellectual disability. A continuum of treatment programs has been recommended, including a Residential Crisis Stabilization Program, inpatient residence and a Habilitative Mental Health (HMH) unit within CLIP. To meet the needs of children and youth and reduce exceptional placements, these resources would have to be available and accessible to families not involved in the child welfare system as well as for our dependent children and youth (Attachment C).

**Permanency from Day 1 (PFD1) Grant:** Facilitated permanency planning meeting (PPM) strategy, ensuring the needs of children and youth are identified and met, kin placements are identified and explored and caregivers are supported are critical elements of permanency planning. Strengthening PPM through the facilitated meetings will help to identify appropriate placement resources, stabilize children and youth to prevent placement disruptions, and improve youth engagement in the planning process.

**BRS/CPA Executive Leadership Work Group:** Child Welfare Programs, Field Operations and Licensing leadership have convened a workgroup with the executive leadership of BRS providers and CPAs. The group has produced preliminary recommendations to address both exceptional placements and the wider service continuum. A stronger continuum with fewer service gaps will help address exceptional placements, and providers have been active in discussing ideas and system needs. Recommendations include ideas such as assessment beds, expanded case aide support and more collaborative planning (Attachment D).

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# DCYF – CLIP Bed Increase Proposal

**Goal:** to identify rationale via data for adding more CLIP beds for DCYF dependent youth

### CLIP Capacity information:

- CLIP is the most intensive inpatient psychiatric treatment available to WA State residents, ages 5-18 years of age.
- CLIP is funded by Federal and State Medicaid dollars through DSHS and HCA/DBHR. Private insurance and other income sources can be billed if applicable.
- There are five programs and a total of 84 beds across Washington State.
  - Child Study and Treatment Center (CSTC), Lakewood (\$1000/day; 47 beds; 3 cottages)
  - Sunstone Youth Treatment Center (Navos), Burien (\$840/day; 10 beds)
  - Pearl Street Center, Tacoma (\$840/day; 12 beds)
  - Tamarack Center, Spokane (\$840/day; 16 beds)
  - Two Rivers Landing, Yakima (\$840/day; 16 beds)
- The current budget for the 84 CLIP beds is: pending HCA response.
- Average length of stay: 9 months

### Data request:

- Kids needing a CLIP bed who went out of state
- Kids in exceptional placements who need a CLIP bed
- Kids discharging from inpatient levels of care to DCYF, that actually need a CLIP bed

### DCYF Sources of data:

1. **Out-of-State tracking sheet**
  - a. **Out of State youth data as of 12-8-20:**
    - i. **Current # out-of-state youth: 12 total**
      1. **Current MH diagnosis: 12/12**
      2. **History of inpatient BH hospitalization: 10/12**
      3. **History of CLIP treatment: 2/11**
      4. **CLIP application submitted: 1/11**
      5. **Currently on CLIP waitlist: 1/11**
  - b. Out of State youth by history: 15-30 individuals at any given time.
2. **Exceptional Placements- AIRS Monthly Summary Report** (example October 2020 report)
  - a. AIRS incidents in October 2020 include:
    - i. There were **264 exceptional placements** (hotel and office stays) for the month of **October**.
    - ii. There were **198 exceptional placements** (hotel and office stays) for the month of **September**.
    - iii. **Forty-five (45) different children** spent nights in hotels or DCYF offices during the month of October.
    - iv. Of the 264 exceptional placements, there were one hundred-twenty-three (123) DCYF office stays.

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Wendy Skarra, Systems Integration/Mental Health Program

- b. **DCYF Youth on Exceptional Placement by history: 30-40 unduplicated individuals per month use an exceptional placement.**
- 3. **CLIP-DCYF-HCA monthly check-in meeting** with Lisa Daniels (Statewide CLIP Coordinator), LaRessa Fourre (DBHR CLIP Administrator) and Mandy Huber (DBHR CLIP Administrator).
  - a. Meeting on 12-2-20: Currently one dependent youth on the CLIP waitlist at this point in time.
  - b. **DCYF youth on CLIP Wait List by history: 4-14 individuals at any given time (over the last 3 years)**
- 4. **Treatment Foster Care Initiative Beds** (TFCI Beds coming January 2022)
  - a. **As of 12-7-20: 4 total referrals, and 3 out of the 4 would be better served by CLIP.**

<b>Data Analysis &amp; Recommendation</b>
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**Target populations:**

- 1. Out of state individuals
  - a. Current #: 12 individuals
  - b. Average # by history: ~23 individuals
- 2. Exceptional placements
  - a. Current # unique individuals for October 2020: 45
  - b. Average # by history: 35 individuals
- 3. CLIP waitlist
  - a. Current #: 1 individual
  - b. Average # by history: ~9 individuals

**Potential Increase with Multiple System Efforts:**

- 1. TFCI Grant (ETA 2021): 15 beds
- 2. Additional CLIP-CSTC beds (ETA 2021): ~15 beds
- 3. BRS-MH (mental health) beds (ETA 2021): ~20 beds

**Total Estimates:**

- 1. Current DCYF estimate of individuals in need of CLIP-like services:  $12 + 1 = 13$ 
  - a. Average by history:  $23 + 9 = 32$  individuals
- 2. Current DCYF dependent children/youth in need of placement (with MH supports): 45 individuals
  - a. Average by history: 35 individuals
- 3. Number of potential beds added by utilizing both DCYF and DBHR contracted beds in 2021:  $15 + 15 + 20 = 50$  beds
- 4. Estimate of current number of DCYF dependent children/youth in need of CLIP or placement (with MH supports):  $23 + 35 = 58$

**Narrative:**

The data in the above draft proposal details the populations of concern (out of state, exceptional placements, CLIP waitlist) that would likely benefit in a CLIP bed. However, it has been identified that there is a CLIP bed shortage across Washington State, greatly limiting the long-term BH inpatient treatment options for these youth. As these are youth who have likely exhausted the outpatient behavioral health system, juvenile detention, BRS, foster homes, and even other inpatient

behavioral health and SUD systems, adding additional CLIP beds across Washington state will provide the long-term treatment options that are indicated for these high-risk, vulnerable youth populations.

Using data from the Health Care Authority (HCA/DBHR) and DCYF, the data shown in the proposal represent estimates of the current needs and potential future resources. There is a potential of an increase in BH treatment or treatment-like beds (TFCI, CSTC, BRS-MH) by 50 in 2021, between the DCYF and HCA/CLIP systems. This is a combination of DCYF and HCA/CLIP resources. As of 12-9-20, using current and historical data, there are approximately 58 youth in need of a behavioral treatment bed (that are placed either out of state, in an exceptional placement, or on a waitlist). Should the additional 50 beds come to fruition, that may potentially serve 50 of these current youth in need. However, seeing that the TFCI beds are a combination of foster care and mental health services for up to 90 days only, and CLIP beds are intensive long-term behavioral health beds, I would recommend to add an additional **25 CLIP** beds across the state in order to better meet DCYF dependent children and youth's needs.

For questions, please contact Wendy Skarra, Systems Integration/Mental Health Program Manager at: [Wendy.skarra@dcyf.wa.gov](mailto:Wendy.skarra@dcyf.wa.gov)

# Attachment B

## AGREEMENT BETWEEN COUNTY JUVENILE COURTS (CJC) AND THE DSHS CHILDREN'S ADMINISTRATION (CA)

**XXXX 2016**

This agreement is intended to provide guidance to staff in both organizations on cooperative working strategies for shared youth.

For the purposes of this agreement, County Juvenile Courts (CJC) will include Juvenile Court staff, detention staff or other staff independent of Juvenile Court that are responsible for the detention of youth. This MOU does not include King County.

RCW 13.40.040 (5) 13.40.050 (7) states: "A juvenile may be released only to a responsible adult or the department of social and health services". However, these statutes do not provide CA the legal authority to take custody of a youth directly from detention. The youth must be placed in protective custody by Law Enforcement (LE) per RCW's 43.185C.260, 13.34.050, 26.44.050 or 26.44.056 (2). LE may transfer custody to CA per RCW 43.185C.265.

Both CA and CJC recognize the importance of ensuring best efforts are made to safely release a youth from detention to a responsible adult and all such efforts, when possible, should occur during normal business hours.

### **I. Definitions:**

- A. **At Risk Youth (ARY), Child In Need of Services (CHINS) and Abuse and Neglect** definitions can be found in RCW 13.32A.030.
- B. **Dependent Child:** Under RCW 13.34.030, Dependent Child means any child who:
  - 1. Has been abandoned;
  - 2. Is abused or neglected as defined in Chapter 26.44 RCW by a person legally responsible for the care of the child;
  - 3. Has no parent, guardian, or custodian capable of adequately caring for the child, such that the child is in circumstances which constitute a danger of substantial damage to the child's psychological or physical development; or
  - 4. Is receiving extended foster care services as authorized by RCW 74.13.031.
  - 5. Court ordered into the care and custody of Children's Administration or a recognized Tribe.
- C. **Non-Dependent** : a child or youth not court ordered in the care and custody of Children's Administration or recognized Tribe (see dependency)

- D. **Responsible Adult:** Statute does not define responsible adult. For the purpose of this agreement responsible adult means:
1. Any adult who is the youth's legal guardian;  
OR
  2. Any adult identified by the legal guardian who can pick up or receive the youth from detention
- E. **Voluntary Placement Agreement (VPA):** A time-limited written agreement between the department and a child's parent or legal guardian authorizing a short-term placement of the child WA C388-25-0050.

## **II. Children Covered by Interstate Compact on Juveniles**

If the youth is from out-of-state, CJCD staff will use the INTERSTATE COMPACT ON JUVENILES (RCW 13.24.10) to return the child to the appropriate state. CJCD staff will make efforts to plan with the other state for the return of the youth.

## **III. Dependent Youth**

- A. Picking up and placing a youth who is a dependent of the State of Washington and placed in detention, will, upon release, be the responsibility of CA.
1. CJC will notify CA assigned workers of dependent youth entering detention, as soon as possible. If CA worker is not available, leave a message and if urgent contact their Supervisor or the local DCFS office reception.
  2. CJC will communicate with the CA worker regarding the status of the criminal charges and the anticipated release date and time.
  3. CJC will inform the CASA/GAL (if assigned) and the CA worker as soon as possible, in advance of any movement. If a youth is moved in an emergency, CJCD will inform the CA worker on the next business day after the move.
  4. If the youth has an identified placement resource the CA worker will arrange with the caregiver to pick up the youth on a specified date and time from detention.
  5. The CA worker will contact the CJC and provide the following information:
    - a. Name of caregiver picking youth up
    - b. Contact information for the Caregiver
    - c. Date and time the Caregiver will pick youth up from Detention.
  6. If the caregivers do not pick up the youth on the agreed upon date and time, CJC will contact the caregiver. If unable to contact the Caregiver CJC will call the assigned CA worker and the CA worker will provide an estimated time of arrival or a mutually agreed upon time to pick up the youth during business hours.
  7. If the youth is not picked up at the agreed upon date and time by the CA worker and it is not during normal business hours, CJC will call CA Central Intake at 1-800-422-7517.

8. CA Central Intake will notify the local Afterhours staff. Afterhours staff will contact CJC staff, providing estimated time of arrival to pick up the youth, or a mutually agreed upon date and time.

#### **IV. Non-Dependent Youth**

CJC and CA recognize there are times when a non-dependent youth cannot release to a responsible adult and need to be taken into protective custody with Law Enforcement and custody transferred to CA. CJC and CA also recognize best efforts shall be made to ensure this occurs during normal business hours.

- A. CJC staff will exhaust all release options with responsible adults for the youth, prior to the date and time of release from detention. CJC will make efforts to:
  1. Contact legal guardians, verify a specific date and time to pick up the youth from detention
  2. Inform the legal guardians they can identify other responsible adults who can pick up or receive the youth from detention.
  3. Obtain names and contact information for other responsible adults as alternative options for the release of a youth
  4. Obtain information on the legal guardians place of employment to include address
- B. If the legal guardian is unable or unwilling to pick up the youth from detention and no other responsible adults are options or the legal guardian or other responsible adult constitute imminent danger to the youth if released (RCW's 43.185C.260, 13.34.050, 26.44.050), CJC staff will inform the legal guardian that CPS will be notified and it will be reported that the youth's legal guardian are unwilling or unable to pick them up from juvenile detention or pose an imminent danger to the youth.
- C. In cases where all attempts by CJC fail to release a youth to a responsible adult. and the youth can no longer stay in detention:
  1. CJC staff should contact the local CA DCFS office during business hours to complete an intake
  2. CJC staff will, if known, provide, the following information to CA intake:
    - a. Identifying information; full names, addresses, telephone numbers any family, relatives, responsible adults;
    - b. Legal guardians place of employment and address;
    - c. The youth's name, DOB and school information;
    - d. Active efforts to facilitate the youth's release, including any attempt or contacts made with potential responsible adults which failed
    - e. If the responsible adult poses imminent danger to the youth and what those identified dangers are.
    - f. Behavioral concerns, including any physically aggressive or sexually aggressive behaviors or other behaviors that may put caregivers or other youth at risk;



- g. Special health or safety concerns pertaining to the youth or to others with whom the youth may have contact;
- h. Legal status, adjudications, Charges, court ordered conditions, and if applicable probation officer name and contact information;
- 3. CA staff will assess the youth and families service need and if needed, provide placement prevention services to the youth and family
- 4. CA staff, if appropriate, will conduct family and relative search attempting to locate responsible adults
- 5. If all attempts by CA fail to produce a responsible adult a youth can release too. CA staff will contact CJC staff and coordinate placing the youth into protective custody with Law Enforcement. CA and CJC staff will agree to a date and time for this to occur, during normal business hours
- 6. Once the youth is into protective custody with Law Enforcement, CA will work with Law Enforcement to transfer custody to CA
- 7. Once CA has custody, CA will find appropriate temporary placement for the youth.

D. In cases where all attempts have failed during normal business hours.

- 1. CJC staff will contact CA Central Intake (1-800-422-7517).
- 2. CJC staff will communicate all necessary case information and efforts made to identify a responsible adult (listed in C2 above).
- 3. CA Central Intake will:
  - a. Take all the appropriate and needed information from CJC staff
  - b. Contact the local CA Afterhours staff, informing them of the situation, providing all the information from CJC and the CJC contact information.
- 4. CA Afterhours Staff will:
  - a. Will make all efforts to identify a responsible adult.
  - b. If no release options can be identified, CA staff and CJC staff will coordinate placing the youth into protective custody with Law Enforcement
  - c. Once Law Enforcement has taken youth into protective custody, CA will work with Law Enforcement to transfer custody to CA
  - d. Once CA has custody, CA will find safe and appropriate temporary placement for the youth.

## **V. Disputes**

If a dispute takes place regarding the release of a youth from Detention who is a dependent or a non-dependent the following process shall occur during normal business hours:

- 1. CA and CJC staff shall work to resolve release issues. If no resolution is possible, the dispute shall be referred to supervisory staff.
- 2. CA and CJC supervisors or designees will work to resolve release issues. If no resolution is possible, the dispute shall be referred to the CA Regional Administrator or designee and the CJC Administrator or designee. (CA Office phone numbers Attachment A, CJC Detention phone numbers Attachment B)

3. If not during normal business hours, CA Central Intake (1-800-422-7517) may be called to request the on call Supervisor or Area Administrator's contact information.
4. Local disputes should be communicated to the CJC and CA statewide leads for this agreement.
5. These disputes will be reviewed as part of the 24 month review process. Any identified gaps, barriers, or local problems will be discussed and if possible addressed in the updated agreement.

## **VI. Training**

CA and CJC agree to disseminate, inform and educate local DCFS, court and detention staff regarding this agreement. This includes others such as but not limited to law enforcement, judges and any others identified.

## **VII: Review**

This agreement remains in effect until revised. If both parties agree, review and revision can occur anytime, but no later than 24 months from the date the agreement was signed.

\_\_\_\_\_  
WAJCA President

\_\_\_\_\_  
Jennifer Strus; Assistant  
DSHS Children's Administration

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## Attachment C

### HCA Summary of Recommendations for Children with Intellectual Disabilities with Intensive Behavioral Health Needs

Youth with intellectual/developmental disabilities (I/DD) their families and caregivers face many barriers to receiving appropriate and available services. These services include lack of residential treatment service options, intensive behavioral health services, crisis intervention/stabilization, short and long-term supports, and treatments to avoid major crises that result in negative impacts to their lives. Workgroups have identified specific recommendations to improve and increase services to these vulnerable youth.

Currently, there are a number of youth with I/DD receiving intensive behavioral health services out-of- state, some of which may have co-occurring mental health diagnoses. Long-term Inpatient treatment as well as residential treatment related to youth with autism, is currently not available in the State of Washington for children who have severe cognitive impairments or need significant assistance with ADL's. There are also a number of children, who have been treated in acute inpatient settings like Seattle Children's Psychiatry and Behavioral Medicine Unit (PBMU), Sacred Heart Children's hospital and in hospital emergency rooms awaiting residential treatment services.

HCA has identified children and youth requiring medically necessary residential behavioral health treatment with a diagnosis of I/DD (currently, as reported by DDA, eighteen youth are receiving out of state treatment, with another thirty either seeking out of state treatment and/or in crisis). There are approximately five youth identified in acute care hospitals. There are currently thirteen children enrolled with DDA receiving treatment at Children's Long-term Inpatient Program (CLIP). Of those thirteen, four have been identified as potentially in need of a long-term residential treatment setting. As reported by DCYF there are fourteen youth in the foster care system receiving out of state treatment for their complex behavioral support needs, five of whom have an intellectual/developmental disability.

These children have intensive behavioral support needs and exhibit behaviors so challenging that parents often struggle to maintain the family's safety. Examples of such behaviors include: self-injurious behavior resulting in soft tissue damage, physical aggression towards others, property destruction and elopement without antecedent. Many times, families will call 911 in crisis and the child is then taken to the emergency room. Depending on the situation, the child may or may not be admitted due to whether the child meets inpatient level of care criteria, and if so, whether there is bed capacity for admission. Families often feel it is no longer safe for the youth to be at home, and the youth is left waiting for appropriate treatment options to be identified. Resources are explored, and due to the absence of facilities that specialize in the treatment of co-occurring mental health and I/DD for children in WA, children are being treated out-of-state. This is a lengthy and arduous process.

HCA Summary of Recommendations for Children with  
Intellectual Disabilities  
with Intensive Behavioral Health Needs

Recommendations are as follows:

Establish a state staffed drop-in Residential Crisis Stabilization Program (RCSP) (modeled after the one in Hawaii) which is accompanied with a state staffed Inpatient/Residence Designated Living Facility:

- A) An RCSP provides twenty-four (24) hour per day, seven (7) days per week treatment and supervision of youth, who are between six (6) and eighteen (18) years of age and have a minimum IQ of fifty-five (55), in a safe and therapeutic environment. This program is designed to help youth experiencing a crisis who do not meet inpatient acute hospital or free-standing psychiatric hospital admission criteria and has no wrong door for the referral to service. The RCSP provides youth with a structured setting for a short-term stay (up to 30 days). The program includes recreational activities, therapeutic interventions, access to medication management, and tutoring/support with school assignments.
- B) A designated inpatient residence for children with intensive behavior conditions related to Intellectual or Developmental Disabilities, who are too young or require too high a level of care and support to be placed in another DDA-type facility and requiring twenty-four (24) hour supervision and a milieu, which provides a strong foundation of intensive behavior support, well-grounded in ABA principles.
- C) Create Habilitative Mental Health (HMH) Unit residing within CLIP, specifically for children with I/DD expanding the scope of the CLIP by offering a habilitative program while receiving inpatient behavioral health treatment in a secure setting. This program would replicate the services available in the State Hospitals for adults who have disabilities.

**Based on available data, there are approximately sixty children whom have been identified in need of behavioral health treatment, and could benefit from one of the treatment models above.**

## Attachment D

Hotel Stays and other placement exceptions are a persistent challenge in Washington. As reported in the recently released 2020 OFCO Annual Report, 220 children spent a combined total of 1,863 nights in hotels or offices. WACF providers are aligned with DCYF in wanting to address this challenge and are well positioned to be able to provide Recommendations and increase the capacity needed to support our children and youth.

**Challenge #1: 68% of hotel stays lasted five days or less, and over half of those only had 1 night hotel stay.**

- Recommendation: Expand Receiving Care Beds to address needs for kids who are only having 1-2 night stays in hotels.

**Challenge #2: Just 43 children made up 75% of all hotel stays. Of those, half were eventually placed in BRS homes.**

- Recommendations:
  - ◆ Prioritize finding the right fit for youth by contracting for assessment beds. Beds would be 30-90 days to provide the flexibility to keep a youth until they find the right fit, and not be hamstrung by arbitrary time frames.
  - ◆ Expand the use of assessment beds to meet the needs of youth. The assessment bed contract should include the flexibility to work not ONLY with youth with higher behavioral needs, but also youth new to care, or simply needing an updated assessment, with some stability while identifying and securing a long-term placement. The financial model would need to be different from the BRS group home rate. We would like to provide a financial model that could support this idea, if DCYF is willing to consider this as a viable option.

**Challenge #3: Youth experiencing hotel stays have higher needs, including Suicidal/Self-harm, Running, Serious Mental Health, Physically Aggressive.**

- Recommendation: Expand capacity of BRS+ and CLIP. Expand the new Therapeutic Foster Care Initiative (TFCI) program/contracts that are rolling out with the YMCA, CYS, and Yakima Farm Workers. It is designed to take kids with higher needs for short-term (90 days) in TFC foster homes.
- Increase funding for EPS beds-beds have been lost and were serving youth that were otherwise in a hotel

**Challenge #4: 30% reduction in foster families taking placements during the pandemic in Region 1**

- Recommendation: Add Case aide support to all regions to help parents with the overwhelming responsibilities of full-time school, family time, their own employment etc. Case aides should be considered post COVID as well. It can help stabilize placement to prevent placement moves

**Challenge #5: 80% of the Hotel stay cases are in region 4 and 6.**

- Recommendations:

- ◆ Look at regions to see what is working in the areas where this is less of an issue. An example would be in region 5 receiving care contracts are widely used, but they aren't used regularly in region 4 and 6.
- ◆ Expand the region 3 case aide program to other regions in order to support foster families to take harder to place youth.
- ◆ Create a strategy for stepping down from group care to BRS foster care. This frees up beds for youth needing a group home placement.

**Challenge #6: Siloed regions and providers prevents us all from the collaborative, creative problem-solving that is needed to address this persistent challenge.**

→ Recommendations:

- ◆ Engage in proactive planning together using shared data. Regular data sharing regarding the needs of youth, capacity, and the areas providers specialize in to identify gaps for youth we don't have enough or any placements.
- ◆ Allow cross-provider communication. Private agencies can often have a better sense of open beds and can discuss the child rather than relying solely on a referral packet. This will also result in quicker placement.

Some of these recommendations will take additional resources, and potentially changes to contracts, however, several suggestions are process changes that can be implemented more immediately. An additional consideration is that 80% of all hotel stays occurred in Regions 4 and 6, and so those regions should be prioritized for implementing or piloting any recommendations.

	Proposed Recommendation	Commitment Needed
Short Term	Engage in proactive planning together using shared data.	<i>Process change:</i> With actionable data and collaborative planning, agencies can increase capacity based on location and agencies that support the types of needs youth need. Some data needs include: <ul style="list-style-type: none"> <li>● What is the capacity in the state (region by region) and what are the needs of kids in need of placement?</li> <li>● Who are the youth being declined?</li> <li>● How do we understand the continuum and where are the open beds?</li> </ul>
	Increase the use of receiving care	<i>Process change:</i> conversation with field staff
	Add Case aide support	funding

	<p>Increase cross-provider communication. Private agencies can often have a better sense of open beds and can discuss the child rather than relying solely on a referral packet. This will also result in quicker placement.</p>	<p><i>Process Change:</i> Allow the opportunity for providers to connect directly. Examples: Allow agencies to reach out to one another, add the phone number of the current provider to the referral packet. Once foster parents get more context it can help move forward with acceptance rather than a decline.</p>
<b>Longer Term</b>	Expand Receiving care	Funding and foster home recruitment for those types of beds
	Prioritize finding the right fit for youth by expanding assessment beds.	Could this cost come from the money spent for hotel costs/other placement alternatives?
	Expand the use of assessment beds to meet the needs of youth.	Same as above
	Expand capacity of BRS+ and CLIP	DCYF releasing RFP December 16th
	Expand EPS capacity	Funding