



Child Welfare Policy Brief

Developing a Robust Continuum of Care to Support Foster Youth in Family-Based Settings

California Child Advocates for Change is a coalition of California's leading child welfare advocacy organizations that have united to inform conversations about federal foster care reform.

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Introduction

Child welfare systems in California and across the country have undergone dramatic transformations in the past decade as states have successfully reduced the number of children in foster care by focusing on alternatives to removing children from their homes and shortening the lengths of stay for children who do enter foster care. Despite these efforts, hundreds of thousands of children in the U.S. continue to require some time in foster care to ensure their safety.

As the size of the foster care population has decreased over the past decade, many states, including California, have undertaken comprehensive efforts to improve the quality of the foster care systems they administer. Ensuring foster children and youth grow up in families, rather than in congregate care, has been a critical and laudable focus of these reform efforts. However, as child welfare systems strive to reduce congregate care utilization, they must create an adequate infrastructure to meet the needs of youth in family-based placements, including youth who require more intensive services or supports to heal and thrive. For example, efforts must focus on recruiting, retaining, and supporting high-quality caregivers; developing specialized foster homes for youth with serious emotional, behavioral, or mental health needs; equalizing supports, services, and funding for relative caregivers; and ensuring foster children and youth do not need to “fail up” to a congregate care setting in order to receive the services they may need to heal from trauma.

As Congress considers child welfare system reform proposals focused on incentivizing family-based placements for foster youth, it should ensure that any changes in federal policy and funding support, not undermine, state efforts to improve the adaptability and quality of the foster care system and its ability to meet the needs of foster youth across the continuum.

Deinstitutionalization and the Transition to Community-Based Care

Over the past decade there has been a growing prioritization of policies aimed at placing foster youth in the least restrictive, most family-like settings possible, in recognition of the fact that children have better outcomes when raised in families as opposed to institutions.¹ As a result of this increased focus on supporting foster children in home-based settings, the total number of children placed in congregate care settings decreased nationally by 37 percent from 2004 to 2013.² Moreover, congregate care reductions have occurred at a greater rate than reductions to the total foster care population, resulting in a decrease in the percentage of children placed in congregate care relative to the total foster care population.³ Child welfare systems have also made strides in reducing the number of children under age 12 who are placed in congregate care settings.⁴



Making sure foster youth grow up in families has been a critical focus of reform

Many of the youth who remain in congregate care today have more complex needs than their peers in traditional family-based settings. For example, data indicates that youth placed in congregate care settings have nearly twice the rate of clinical problems as youth in traditional foster care placements,⁵ and they are almost three times more likely to have a mental health diagnosis than children placed in other settings.⁶ They are also predominantly older and have significantly higher levels of internalizing and externalizing behaviors than children placed in traditional foster care placements.⁷ However, it is also important to recognize that children and youth in congregate care are not a homogenous group,⁸ and some youth may still reside in group homes for reasons other than a specialized behavioral or mental health need. This may be particularly true for teenagers, for whom there is a serious shortage of foster homes in some jurisdictions, and for youth with juvenile delinquency involvement, as group homes may be used as an alternative to placement in a more restrictive setting (such as a locked juvenile facility).⁹

Developing Alternative Community-Based Placements

As states strive to further reduce utilization of congregate care, they must invest in recruiting, retaining, and supporting caregivers capable of meeting the needs of foster children and youth with varying special needs and trauma histories.¹⁰ This is no small feat as recruitment and retention of families able to provide high-quality care has been a persistent challenge nationally. Many foster parents quit fostering in the first 12 months and cite a lack of agency or caseworker support, difficulty with a child's behavior, and/or inadequate services for the children in their care as reasons why they stop fostering.¹¹ Inadequate financial support for family-based placements also negatively impacts foster parent recruitment and retention. Foster care payment rates in most states do not cover the actual costs foster parents incur while caring for the children and youth placed with them.¹²

Greater engagement and support of relative (also referred to as “kin” or “kinship”) caregivers will be critical to efforts to recruit more family-based homes for foster children and youth. Relative placements have been shown to promote stability and connection to community, and youth placed with relatives often have fewer placement changes, more frequent contact with birth parents and siblings, and fewer negative emotions about their time in foster care.¹³

Relatives care for almost a third of the children in foster care today and represent a steadily increasing share of our home-based foster care placements.¹⁴ However, relatives often receive less funding and fewer supports and services as compared to non-relative caregivers. In fact, across the country, the majority of relative foster parents do not receive any foster care benefits due to state licensing laws that allow relatives to be licensed under different standards than non-relatives.¹⁵ Instead, many of these families rely on Temporary Assistance for Needy Families (TANF) benefits, which often provide funding well below the rate of foster care payments and are not reflective of the actual costs associated with raising a child.¹⁶

Further, the lack of financial support provided to relative foster families is not compensated for by an increase in services or other supports. To the contrary, kinship families are far less likely to receive supportive services, including training, access to support groups, or respite care.¹⁷ This lack of support creates significant barriers for kin caregivers, who on average are older, more likely to be single, and have lower incomes than non-related foster parents.¹⁸ Providing equal funding, supports, and services to relative caregivers is essential if states are serious about reducing reliance on group care and connecting children to families.

The Need to Expand High-Quality, Community-Based Mental and Behavioral Health Services

As states work to reduce congregate care use, they must also ensure there is an adequate supply of high-quality services to help these vulnerable children and youth heal and stabilize in family settings.¹⁹ Historically, most states have struggled to meet the mental health needs of foster children,²⁰ who are at high risk for behavioral and mental health conditions because of the abuse, neglect, and trauma they have experienced.²¹ In fact, when the Children's Bureau conducted its first two rounds of reviews of state child

welfare systems, only a few states received a “Strength” rating for assessing and addressing the mental and behavioral health needs of foster children and youth.²² Common challenges include a lack of early identification and assessment of youth’s emotional and behavioral issues, as well as shortages in the availability of high-quality, child-centered behavioral and mental health services.²³

Meeting the emotional and behavioral health needs of foster children and youth also requires strong collaboration between state child welfare and health care systems. Over the past decade, federal legislation and policy guidance have prompted improved collaboration,²⁴ but more work remains to ensure that these systems work together to provide all foster children and youth with the mental and behavioral health services they need to heal in a family setting.

California’s Reform Efforts

California’s efforts to transform the continuum of care for children and youth in the foster care system can provide valuable lessons to policymakers considering ways that the federal government can help ensure that states are placing children in the least restrictive, most family-like settings possible. Initial reform efforts that more narrowly focused on reducing the use of congregate care have since evolved into a broader re-envisioning of how to structure the array of placements and services to meet the needs of all foster children and youth.

In 2012, California launched the Continuum of Care Reform (CCR) effort which revamps the state’s foster care rate-setting system to better support a continuum of programs, services, and placements with the goal of enabling foster children to grow up in family settings.²⁹ At its core, CCR seeks to improve the quality of the foster care system by eliminating long-term group care utilization and increasing placements in family settings. Two fundamental principles underlying CCR are that: (1) children should not need to change placements to get the funding, services, and supports they need, and (2) congregate care should only be used as a short-term intervention to resolve emotional, behavioral, and mental health issues that prevent foster youth from living safely in a family setting.³⁰ Statewide implementation of CCR begins in 2017, and will occur in stages over multiple years.³¹

The CCR effort has been informed by a number of prior and ongoing reform efforts in California,³² including an earlier demonstration project - known as Residentially Based Services (RBS) - that sought to improve outcomes of foster youth in group homes by testing a short-term residential program model with ongoing, community-based services and supports that continued after the youth transitioned to a family setting.³³ Building upon the lessons learned from this demonstration project, CCR will eliminate non-therapeutic congregate care entirely and transform all remaining group homes into “short-term residential therapeutic programs” that incorporate mental health treatment and other intensive services to address the needs of foster youth.³⁴

DATA SNAPSHOT: CONGREGATE CARE IN CALIFORNIA

Over the last decade, California has had significant success in reducing its reliance on congregate care, with the number of children placed in congregate care settings decreasing by 45 percent from 2006 to 2016.²⁵ Similar to national trends,²⁶ reductions in congregate care use in California have outpaced reductions in the total foster care population, with the percentage of California foster children placed in congregate care settings declining from 12.4 to 8.5 percent.²⁷ Approximately 91 percent of California youth living in congregate care settings today are age 12 or older, and 72 percent are age 15 or older.²⁸

As implementation begins, California will face the dual challenge of providing effective residential programs for a high-need population without returning to an overreliance on long-term residential placement. CCR is designed to meet this challenge by not only providing more intensive and effective treatment to foster youth in congregate care settings, but also providing additional supports and services to parents, relatives, and foster parents to help children and youth stabilize and thrive in a family setting whenever possible.

However, as noted above, in California as in many other states, there is a critical shortage of foster parents, especially foster parents willing to accept older youth and those with more complex needs.³⁵ The success of CCR will depend on building an array of alternative placements for youth who today are placed in or are at risk of placement in congregate care. This will require both an overall increase in the number of foster homes and the development of specialized foster homes that can support youth with specific challenges and needs.³⁶ Simply reducing the use of congregate care without developing effective alternatives runs the risk that many of these youth will be thrust into environments where their caretakers may not have the skills, capacity, or training to meet their needs. This would likely result in increased placement disruptions, runaway behaviors, and long-term negative outcomes such as homelessness and incarceration.³⁷

In attempting such an ambitious reform in the face of a serious foster parent shortage, California is in the midst of making revolutionary changes to its foster care rate system in order to ensure that families are equipped with the resources to successfully care for children with wide-ranging needs. Beginning in January 2017, California will replace the existing foster family home rates with a new home-based family care rate that will include four levels of care. Rather than being slotted into a rate based on arbitrary factors unrelated to the child's needs (such as the placement type, the age of the child, or whether the child is placed with a relative or non-relative caregiver), the new rate system will be based on an assessment of the child, and will be available across all family placements.³⁸

California has also begun to invest substantial funding in foster parent recruitment and retention, and CCR increases training and support to improve foster parents' ability to provide a caring environment for youth.³⁹ Similar state and federal investments will be needed to safely and responsibly reduce the use of congregate care across the country.

While creating a child-centered family rate system that is tied to the needs of the child, not the child's placement type, and investing substantially in recruitment and retention efforts are a good start, California will also need to fully equalize the services and supports available to children across all placement types. Current state statute requires nonprofit Foster Family Agencies (FFAs), which recruit and support primarily non-relative foster parents, to provide a robust array of core services to children and families as a condition of licensure.⁴⁰ California's reform effort will remain incomplete, however, until the state finds ways to ensure that all foster families, including relatives, have access to these core services for the children and youth in their care regardless of whether the home is an FFA or county-supervised placement.

CCR's success will also depend on ensuring that all children have access to intensive, community-based mental health treatment wherever they live. Prior to CCR, California had launched a statewide initiative to improve access to mental health services for foster youth and prevent institutionalizations.⁴¹ Continuing this progress and expanding access nationwide is a key element of reducing congregate care use and helping children and youth heal from trauma.⁴²

While more work remains to ensure CCR realizes its full promise, California has developed a comprehensive framework for meeting the needs of children and youth in foster care, and the state's experience planning and implementing CCR can and should inform Congress as it leads conversations about federal foster care policy and financing reform.

Conclusion

Advocates and elected officials in California and in Washington, D.C., share a number of guiding policy priorities for the child welfare system, including keeping children with their families whenever possible and placing children who must spend some time in foster care in the least restrictive, most family-like setting. California's experience underscores the need for a nuanced approach to federal child welfare reform. A one-size-fits-all federal approach would risk undermining states' efforts to improve the ability of their child welfare systems to respond appropriately to the diversity of experiences and needs among the nation's more than 415,000 foster children.

For example, proposals that would place arbitrary time limits on federal funding for congregate care can impact the ability of states to effectively serve children and youth with significant mental and behavioral health challenges, who may take longer to stabilize and heal. Similarly, proposals to defund group homes without making concrete investments in alternative family placements could result in serious unintended consequences, such as foster children bouncing from home to home, becoming homeless, getting arrested, or worse.

The federal government should support states in developing a range of strategies to reduce group care, including increased funding and access to supportive services for kinship caregivers, better foster parent recruitment and retention, development of specialized foster homes, and improved access to community-based mental and behavioral health services and other supports for foster children and youth wherever they are placed.

Footnotes

1. Dozier, M., Kobak, R., Sagi-Schwartz, A., Shaffer, C., van IJzendoorn, M., Kaufman, J., O'Connor, T., Scott, S., Smetana, J., Zeanah, C. (2014). "Consensus Statement on Group Care for Children and Adolescents." *American Journal of Orthopsychiatry* 84 (3), 219-225. <https://www.apa.org/pubs/journals/features/ort-0000005.pdf>
2. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. "A National Look at the Use of Congregate Care in Child Welfare." (2015). <http://www.acf.hhs.gov/programs/cb/resource/congregate-care-brief>
3. In 2004, 18 percent of children in foster care were placed in congregate care settings, compared to 14 percent of children in foster care in 2013. *Ibid.*, 5.
4. Between 2010 and 2013, the median percentage of children entering foster care under the age of 12 who were placed in group homes or institutions decreased by 11.1 percent (from 4.5 to 4.0 percent). U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2016). "Child Welfare Outcomes 2010-2013: Report to Congress, Executive Summary." <http://www.acf.hhs.gov/programs/cb/resource/cwo-10-13>
5. Chadwick Center and Chapin Hall. (2016). "Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare." San Diego, CA & Chicago, IL: Collaborating at the intersection of Research and Policy. http://www.chapinhall.org/sites/default/files/effective%20reduction%20of%20congregate%20care_0.pdf
6. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. "A National Look at the Use of Congregate Care in Child Welfare." (2015).
7. Chadwick Center and Chapin Hall. (2016). "Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare."
8. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. "A National Look at the Use of Congregate Care in Child Welfare." (May 2015). p. 17.
9. While probation-supervised foster youth account for approximately six percent of the overall foster care population in California, they comprise nearly 35 percent of the foster youth population placed in group homes. Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., King, B., Rezvani, G., Wagstaff, K., Sandoval, A., Yee, H., Xiong, B, Benton, C., Tobler, A., & Romero, R. (2016). "CCWIP reports." Retrieved 5/26/2016, from University of California at Berkeley California Child Welfare Indicators Project website. URL: http://cssr.berkeley.edu/ucb_childwelfare. See also UCLA. (2015). "Resource Family Recruitment in Los Angeles County, Insights & Pathways Forward." p. 1, 43 (noting particularly acute need for homes for older children and children with severe emotional and behavioral concerns). http://lacdfs.org/aboutus/documents/ResourceFamilyRecruitment_LAC.pdf
10. Chadwick Center and Chapin Hall. (2016). "Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare." p. 10 (noting that to avert congregate placements and/or transition youth from these settings, states must substantially increase the capacity to provide home-based placements especially for older youth and specialized populations of youth).
11. UCLA. (2015). "Resource Family Recruitment in Los Angeles County, Insights & Pathways Forward." p. 1. See also Walsh, Wendy A., Mattingly, Marybeth J. (2014). "Related Foster Parents Less Likely to Receive Support Services Compared with Nonrelative Foster Parents." Carsey Research, National Issue Brief 74, p. 2. <http://scholars.unh.edu/cgi/viewcontent.cgi?article=1216&context=carsey>, and Center for the Study of Social Policy. "Policy Matters: Setting and Measuring Benchmarks for State Policies," April 2009, p. 72, <http://www.cssp.org/publications/public-policy/PROMOTING-CHILD-SAFETY-PERMANENCE-AND-WELL-BEING.pdf>
12. Center for the Study of Social Policy. "Policy Matters: Setting and Measuring Benchmarks for State Policies." p. 72.
13. Northern CA Training Academy. (2009). "Fostering Family Connections: Pursuing Permanence for Children and Youth in Foster Care." See also The Annie E. Casey Foundation. (2012). "Stepping Up for Kids: What Government and Communities Should Do to Support Kinship Families." KidsCount Policy Report.
14. Twenty-nine percent of children in foster care on September 30, 2014, were placed in relative foster family homes compared to 23 percent on September 30, 2003. Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2014 data and FY 2003 data. <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/afcars>
15. Mauldon, J., Spielman, R., Sogar, C., and Stagner, M. (2012). "TANF Child-Only Cases: Who Are They? What Policies Affect Them? What is Being Done?" Chapin Hall, University of Chicago. p. 76 – 77. <http://www.chapinhall.org/sites/default/files/TANF%20Child-Only%20Cases%20-%20The%20Report%201-25-2013.pdf> ("Despite the federal subsidy for IV-E placements, states may not always maximize their efforts to draw down the federal contribution. States are permitted to pay less than the full foster-care (IV-E) rates to a relative caregiver who is unlicensed or partially licensed, even when a child is IV-E eligible. As foster care payments have become much more generous than TANF payments, the fiscal incentives for states to rely on TANF to support maltreated children have grown. In 17 states the one-child TANF benefits as of 2010 were so low that they fell below 38 percent of the foster care rate, with 38 percent representing the typical state share of an IV-E foster-care payment.")
16. *Ibid.*, p. xii.
17. Walsh, W., Mattingly, M. (2014). "Related Foster Parents Less Likely to Receive Support Services Compared with Nonrelative Foster Parent." Carsey Research, National Issue Brief 74, p. 2. <http://scholars.unh.edu/cgi/viewcontent.cgi?article=1216&context=carsey>.

18. Northern CA Training Academy. (2009). "Fostering Family Connections: Pursuing Permanence for Children and Youth in Foster Care."
19. Chadwick Center and Chapin Hall (2016). "Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare." p. 11. ("To step-down youth who have benefited from congregate care, especially residential treatment, to a community-based home-like setting may require a combination of intensive evidence-based or evidence-supported treatments and support services to stabilize placements before disruption. To support some of the high-need children and youth in home-like settings, state may need to allow more frequent (more than once a week) clinical contracts; expanded use of follow-up services in the home in combination with center-based therapy; day treatment or therapeutic day care; direct clinical care for caregivers; or clinical contracts for a longer duration than current reimbursement rules allow...")
20. Children's Bureau (2014). "Child and Family Services Reviews: Factsheet for Mental Health Professionals." <http://www.acf.hhs.gov/programs/cb/resource/cfsr-fact-sheet-mental-health-professionals>. See also GAO (2012). "Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care." <http://www.gao.gov/assets/660/650716.pdf>
21. Szilagyi, M., et al. (2015). "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care." American Academy of Pediatrics. 136,(4) (noting that up to 80% of children in foster care enter with a significant mental health need). <http://pediatrics.aappublications.org/content/136/4/e1131>. See also Pecora, P., et al. (2009). "Mental Health Services for Children Placed in Foster Care: An Overview of Current Challenges." Child Welfare. 88(1): 5-26. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3061347/>
22. Children's Bureau (2014). "Child and Family Services Reviews: Factsheet for Mental Health Professionals."
23. Pecora, P., et al. (2009). "Mental Health Services for Children Placed in Foster Care: An Overview of Current Challenges." (noting the lack of comprehensive mental health screenings of children entering out-of-home care, the need for more thorough identification of youth emotional and behavioral deficits, and insufficient access to high-quality mental health services. See also Szilagyi, M. et al. (2015). "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care." (noting there is a shortage of mental health professionals with the appropriate training in trauma-focused therapies and that funding is insufficient to ensure that all children who could benefit from these services can access them). See also GAO. (2015) "Foster Care: HHS Could Do More to Support States' Efforts to Keep Children in Family-Based Care." <http://www.gao.gov/products/GAO-16-85>
24. Zlotnik, S., et al. "Improving Child Well-Being: Strengthening Collaboration Between the Child Welfare and Health Care Systems." (2014). p. 2-3. (Describing federal legislation and policy guidance over the past decade promoting increased coordination and collaboration). http://policylab.chop.edu/sites/default/files/pdf/publications/Improving_Child_Well-Being_By_Strengthening_Collaboration.pdf
25. Webster, D., et al. (2016). CCWIP reports. (Data includes all children in foster care 0-21, including probation-supervised foster youth. Congregate care totals include any child or youth residing in a group or shelter setting. As of January 1, 2016, 5,682 youth resided in a congregate care setting compared to 10,330 youth on January 1, 2006.)
26. Nationally, congregate care reductions occurred at an even greater rate than reductions to the total foster care population (decrease of 37 percent versus 21 percent from 2004 to 2013). As a result of these reductions, 14 percent of children in foster care were placed in congregate care settings in 2013 compared to 18 percent of the foster care population in 2004. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. "A National Look at the Use of Congregate Care in Child Welfare."
27. Webster, D., et al. (2016). CCWIP reports.
28. Ibid.
29. The Continuum of Care Reform effort was initiated by statute. Specifically, it requires that "[t]he State Department of Social Services shall establish, in consultation with county welfare departments and other stakeholders, as appropriate, a working group to develop recommended revisions to the current rate-setting system, services, and programs serving children and families in the continuum of AFDC-FC eligible placement settings including, at a minimum, all programs provided by foster family agencies and group homes including those providing residentially based services." See California Welfare and Institutions Code 11461.2(b).
30. California Department of Social Services. "Fact Sheet: What is the Continuum of Care Reform?" <http://www.cdss.ca.gov/ccr/>
31. Ibid.
32. California Child Welfare Co-Investment Partnership. (2015). "Who is Caring for California Children in Foster Care?" Insights, IX. http://co-invest.org/home/wp-content/uploads/insights_volume9.pdf (Describing other programs that CCR builds upon including the Residentially Based Services Demonstration Project, Approved Relative Caregiver program, Resource Family Approval Program, Quality Parenting Initiative, and Kinship Support Services Program, among others). See also California Department of Social Services. Continuum of Care Reform. "Fact Sheet: What is the Continuum of Care Reform?"
33. In 2007, California authorized a 5-year pilot demonstration project, known as the Residentially Based Services (RBS) Reform Effort. <http://www.childsworld.ca.gov/PG2119.htm>
34. Foster Care, Assembly Bill 403 (2015) http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0401-0450/ab_403_bill_20151011_chaptered.pdf; Foster Care, Assembly Bill 1997 (2016) http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1951-2000/ab_1997_bill_20160405_amended_asm_v98.pdf
35. UCLA. (2015). "Resource Family Recruitment in Los Angeles County, Insights & Pathways Forward." p. 1, 43. ("In California, the need for resource families has been particularly acute for older children and children with severe emotional and behavioral concerns.")

36. Chadwick Center and Chapin Hall. (2016). "Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare." p. 10. ("If congregate care placements are to be averted, it will be necessary to substantially increase the capacity to provide home-based placements, especially for youth entering child welfare at ages older than 11 years old. This capacity development must be pursued strategically in order to ensure foster parents are appropriately prepared to meet the needs of older youth as well as other specialized populations being diverted for transitioning from congregate care, such as children and youth with sexual behavior problems and those with chronic medical needs.")
37. Ibid. ("In principle, any effort to reduce the use of and support for congregate care must be paired with steps to establish the infrastructure to meet the needs of children now in group placements who will be served in more home settings. Failure to do so may result in a host of unintended consequences, including the increased disruption of foster and kin placements, higher demands on hospital emergency rooms and psychiatric hospitalizations, and increased use of more restrictive juvenile justice settings (Ainsworth & Hanson, 2005).")
38. California Department of Social Services 2016 May Revision Local Assistance, p. 113-119. <http://www.cdss.ca.gov/cdssweb/entres/localassistanceest/May2016/EstimateMethodologies.pdf>
39. California's Child Welfare Continuum of Care Reform, California Department of Social Services. January 2015. http://www.cdss.ca.gov/cdssweb/entres/pdf/CCR_LegislativeReport.pdf, p. 12 – 16 (describing investments California made prior to implementation of CCR to begin reduction in use of congregate care including the Approved Relative Caregiver Funding Option Program, Quality Parenting Initiative, Katie A. Settlement Agreement, Resource Family Approval, and the Residentially-Based Services Demonstration Project); State Budget 2015-16. Department of Social Services, Continuum of Care Reform (providing \$17.8 million in general fund dollars to create the Foster Parent Recruitment, Retention and Support Funding).
40. Calif. Welf. & Inst. Code §§ 11462, 11463.
41. This was the result of a lawsuit, *Katie A. v. Bonta*, which was filed in federal district court in 2002 and settled in 2011. <http://www.childsworld.ca.gov/PG3346.htm>
42. Integrating Mental Health Services, Continuum of Care Reform, California Department of Social Services, <http://www.cdss.ca.gov/ccr/> See also Chapin Hall & Chadwick Center. (2016). "Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare." p. 11