

**The Katie A. Advisory Panel  
Report to the Court  
Second Reporting Period of 2012  
December 15, 2012**

**The Katie A. Advisory Panel  
c/o 428 East Jefferson Street  
Montgomery, AL 36104  
(334) 264-8300**

Marty Beyer  
Paul Vincent  
Edward Walker

## **Table of Contents**

<b>Executive Summary</b>	<b>Page 3</b>
<b>I. Introduction</b>	<b>Page 8</b>
<b>II. Background</b>	<b>Page 8</b>
<b>III. Panel Activities Since the Last Report</b>	<b>Page 10</b>
<b>IV. Current Implementation Plan Status</b>	<b>Page 10</b>
<b>V. Panel Analysis of Strategic Plan Implementation</b>	<b>Page 37</b>
<b>VI. Panel Recommendations</b>	<b>Page 43</b>
<b>VII. Glossary of Terms</b>	<b>Page 46</b>
<b>VIII. Appendix</b>	<b>Page 48</b>

# **Executive Summary**

## **System Progress**

### ***Multidisciplinary Assessment Teams (MAT)***

The Department reports that in June 2012, 100% of all eligible newly detained children were referred for a MAT, up from 98% reported in the past Panel Report. The Department is still working to meet its goal of completing MAT assessments within 45 days of referral, with 60% completed within 45 days. By 60 days from referral, 90% of referrals are completed.

### ***Medical Hubs***

For the most recent reporting period, 86% of newly detained children were referred to a Medical Hub for initial examination. In the previous Panel Report the Panel reported that 82% of newly detained children had been referred to a Hub.

### ***Mental Health Screening***

Almost 99% of children needing MH screens were screened, totaling 24,747 children. Seventy-two percent of children screened were found positive for MH follow-up and 98.9% of those children, totaling 17,288, were referred for mental health services. Of this 17,288 children, 97.6% received a mental health service activity (assessment, treatment, case management and consultation). This reflects continued progress in the identification of children needing mental health services.

### ***Coaching***

The County has expanded its coaching efforts for both DCFS and DMH staff. New offices have been added to the coaching initiative that began in Compton and DMH is providing training on a variety of relevant topics to mental health staff.

### ***Wraparound***

At the Panel's suggestion, the County conducted a Qualitative Service Review of Wraparound cases County-wide. The Panel joined as reviewers in this ambitious effort. This review was skillfully managed by DCFS and DMH staff and yielded valuable information about the strengths and challenges in Wraparound in Los Angeles County.

### ***Young Children in Group Homes***

In the past year the County has responded to concerns raised by the Panel about a rising number of children 0-12 years old being placed in group homes. In February 2011 there were 179 children under 13 placed in group homes. Due to diligent efforts by the County, the number has been reduced to 109 children, a significant achievement. The County continues to attend to reducing this number further.

## **System Challenges**

### ***Treatment Foster Care (TFC)***

The County reports that it had 91 certified TFC beds in September 2012. This compares to 80 certified TFC beds available in September 2011. The Corrective Action Plan (CAP) issued by the court requires the County to expand TFC to 300 beds, a goal toward which the County is making only gradual progress. While there are complex barriers to growth of the TFC program, including systemic rate limitations and the complexity of the needs of children referred, the lack of sufficient TFC beds continues to require concerted effort by the County to meet the CAP goal. The Panel hopes that the recent rate increase approved by the Legislature in July 2012, in concert with ongoing County strategies, will enable the County to accelerate its recruitment of homes.

### ***Wraparound***

The implementation and growth of Wraparound has been an important and valuable feature of Katie A. implementation. The recent Qualitative Service Review of Wraparound cases revealed a number of strengths of Wraparound involvement in the lives of the 20 youth and their families who were reviewed. Each case had a functioning team and most children had therapists. Wraparound was being effective in supporting the youth at home or helping transition them to a new placement or school. Families were highly engaged in the process and had a meaningful voice in planning.

The challenges found in the review include Wraparound teams often having little participation by the DCFS CSW, uneven identification of needs for children and youth and poor permanency prospects for at least a third of the children and youth. In some cases, while a therapist may have been serving the youth, they were not involved in the Wraparound team, limiting the clinical focus of interventions. A particular concern was the lack of consistent attention to the trauma experience of the youth, which because unaddressed trauma was often affecting the youths' well-being, limited the long-term effectiveness of the Wraparound intervention.

### ***Expansion of Intensive Home-Based Mental Health Services***

While there has been an expansion of some intensive home-based mental health services, many children only receive conventional office based mental health supports, even though a home based service might be more effective. The County is moving forward with a plan to pilot a contract for provision of flexible and responsive home-based mental health services, which could prove to be a model for a County-wide approach. However, this initiative has not yet begun and until enough is learned from it to implement a broader service development strategy, the expansion of home-based mental health services will be slow. The Panel strongly encourages use of an intense implementation strategy related to home-based mental health services which can hasten the creation of needed services and supports.

## ***Strengthening Front-Line Practice Through Training and Coaching***

The Panel continues to have concerns that training is relatively brief and at a largely conceptual level rather than being focused on the skills of practice. The Panel also has concerns about the County's coaching capacity. Coaches are spread thin and have limited to give sufficient hands-on individual coaching to each CSW and supervisor.

The QSR results to date highlight continuing practice challenges among DCFS offices. Where core practice is concerned, Voice and Choice (family involvement in planning), Assessment, Teaming and Planning need considerable improvement County-wide. As a result of the limited performance in these areas, the indicators of Permanency, Family Functioning (parenting adequacy), Emotional Well-Being and Service and Supports also need significant improvement. Training and coaching are the way the County can improve practice in these important areas. This slow pace of improvement is common in systems undertaking such an initiative and performance doesn't improve until there is enough central office leadership and support, skill-based training and intensive coaching and responsive services to raise the skill level staff and meet the needs of families.

In the next six months the Panel would like assess the County's coaching capacity, attending to the number of coaches, the time spent in coaching, the capability of coaches and their impact on the practice of CSWs.

### **Panel Recommendations**

1. **Treatment Foster Care** Continue to expand the number of children who are successful in TFC.
2. **Young Children in Group Care** Continue to reduce the number of children 12 and under in group care by providing intensive services so they can be stable and successful in family-based settings. While case decision-making plays an important role in whether or not young children are placed in group care, the lack of appropriate intensive home-based services is at the core of the challenges faced by the County regarding reducing its group care population. Until the array of intensive home based services becomes sufficiently larger and more robust, children will continue to be inappropriately placed in group care because there are not enough adequate alternatives.

The Panel recommends a follow-up examination of the combination of services and the intensity of services for children and supports for caretakers that were provided to both the young children who were diverted away from group care and those who were transitioned out of group care during the summer and fall, 2012. There is much to learn from this success about IHBS, teams, effective services, the identification of children's needs and provision of supports to caretakers that is applicable to other Katie A. class members. Now that this way of thinking has been effective with this population, a similar process is necessary for children who have their first placement disruption so that services are promptly intensified to meet the child's needs and support for caretakers to prevent another change in placement.

The Panel also recommends that the County speed up the process of connecting Wrap providers with cases of newly detained youth for whom it is difficult to find appropriate placements. The current time taken for review and approval can interfere with prompt Wrap intervention.

3. **Intensive Home-Based Services** It is vital for the County to quickly expand the service array, including the pilot to develop a contract provider to deliver these services. It is also incumbent on the State to ensure that its Documentation and Claiming Manual provides the flexibility and responsiveness needed to permit providers to fully implement the State Katie A. Settlement. In the interim, every effort should be made to speed up the implementation of the pilot IHBS contract.

4. **Strengthen Front Line Practice** The QSR process is effective in identifying the strengths and challenges of practice model implementation. The areas the Panel identifies as most critical are listed below.

- Teamwork must be improved by engaging CSWs, therapists, school personnel, community supports and the family's natural supports. School staff participation in CFT meetings may increase if meetings are convened at the end of the school day at school. Similarly, where clinicians cannot easily attend team meetings, schedule some team meetings at clinicians' offices. A team meeting in the family's home may also serve as the CSW's monthly family visit.
- More training and coaching on identifying underlying needs should be provided, particularly trauma-related needs so that all participants in child and family teams—including CSWs, therapists and school staff - improve their practice. More training on improved teamwork, assessment and understanding, innovative, individualized services, and long-term view is also necessary. Since LA County has a shared practice model and a shared change process, shared training and coaching for DCFS, DMH and providers should be developed. The Panel recommends that coaches be developed further through training in teaming, identifying needs, and tailoring supports and services (and including families' natural supports in the process) to enable coaches to strengthen mentoring at the case level.
- Tailoring unique supports and services to build on child and family strengths and meet needs is essential. Arranging trauma-responsive care that fits the child and family is not easy but is an important part of individualized services. The child's therapist not only provides treatment to the child and guidance to caregivers and family but also clarifies how TBS and others will meet the child's underlying needs.
- Inclusion of a family's natural supports is necessary, particularly when connections and supports do not exist already. Plans to develop meaningful connections and supports and repairing damaged connections are essential functions of the child and family team to promote legal and relational permanency. Alternatives must be developed in the event that the hoped-for permanent connection does not work out. The use of Family Finding is a critical need for youth who have not achieved legal permanency.

## 5. Wraparound

The Panel makes the following recommendations based on the Wraparound QSR.

- The Panel recommends that the County set clear expectations for CSW attendance at Child and Family Team meetings (even if attending every meeting is not practical) and hold staff accountable for participation.
- Amend Wrap contracts to ensure that Wrap teams fully integrate clinical practitioners into Wraparound team meetings and the Wraparound process. Where independent clinicians are already connected to youth, offer phone participation as an option if actual attendance at Child and Family Team meetings isn't feasible.
- Develop a formal curriculum for Wraparound providers addressing trauma needs and trauma response, other underlying needs and the involvement of informal supports (beyond the parent partner's role).
- The Panel has inquired previously about the significant number of youth who do not successfully "graduate" from the program. The Panel recommends a County study of the reasons for this pattern and follow-up discussions.

**Katie A. Advisory Panel  
Report to the Court  
Second Reporting Period of 2012  
December 15, 2012**

**I. Introduction**

The following Report to the Court outlines the County's progress toward achieving the objectives of the Settlement Agreement, includes a description of its compliance with the current Joint DCFS/DMH Plan, Corrective Action Plan and the Strategic Plan.

**II. Background**

The Los Angeles County Department of Children and Family Services (DCFS) and the plaintiffs in Katie A., et al. v. Diane Bonta, et al., entered into a Settlement Agreement in May, 2003. The Agreement was described as a "novel and innovative resolution" of the claims of the plaintiff class against the County and DCFS and it was approved by the Court and became effective in July 2003.

The Agreement (Paragraph 6) imposes responsibility on DCFS for assuring that the members of the class:

- a. promptly receive necessary, individualized mental health services in their own home, a family setting or the most homelike setting appropriate to their needs;
- b. receive the care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
- c. be afforded stability in their placements whenever possible, since multiple placements are harmful to children and are disruptive of family contact, mental health treatment and the provision of other services; and
- d. receive care and services consistent with good child welfare and mental health practice and the requirements of federal and state law.

To achieve these four objectives, DCFS committed to implement a series of strategies and steps to improve the status of the plaintiff class. They include the following (Paragraph 7):

- immediately address the service and permanence needs of the five named plaintiffs;
- improve the consistency of DCFS decision making through the implementation of Structured Decision Making;
- expand Wraparound Services;
- implement Team Decision Making at significant decision points for a child and his/her family;
- expand the use of Family Group Decision Making;
- ensure that the needs of members of the class for mental health services are identified and that such services are provided to them;
- enhance permanency planning, increase placement stability and provide more individualized, community-based emergency and other foster care services to foster children, thereby reducing dependence on MacLaren Children's Center (MCC). The County further agrees to surrender its license for MCC and to not operate MCC for the residential care of children and youth under 19 (e.g., as a transitional shelter care facility as defined by Health & Saf., Code, § 1502.3). The net County cost, which is currently appropriated to support MCC shall continue to be appropriated to the DCFS budget in order to implement all of the plans listed in this Paragraph 7.

The parties to the Settlement also agreed to the selection of an Advisory Panel to provide guidance and advice to the Department regarding strategies to achieve the objectives of the Agreement and to monitor and evaluate the implementation of its requirements. Specifically, the Settlement Agreement directs (Paragraph 15) that the Panel:

- advise and assist the County in the development and implementation of the plans adopted pursuant to Paragraph 7;
- determine whether the County plans are reasonably calculated to ensure that the County meets the objectives set forth in Paragraph 6;
- determine whether the County has carried out the plans;
- monitor the County's implementation of these plans; and
- determine whether the County has met the objectives set forth in Paragraph 6 and implemented the plans set forth in Paragraph 7.

Additionally, the Settlement directs that:

In the event that the Advisory Panel discovers state policies or funding mechanisms that impede the County's accomplishment of the goals of the agreement, the Advisory Panel will identify those barriers and make recommendations for change.

The Department prepared a Joint DCFS/DMH Mental Health Plan to describe its strategy for implementing the provisions of the settlement agreement. The Panel and plaintiffs identified issues in the Plan they believed needed additional attention and in a subsequent

court hearing, plaintiffs and defendants proposed submitting a joint finding of facts that would identify areas of agreement and disagreement. The court issued an order directing the County to revise its plan and submit the revision for review. That Corrective Action Plan was completed and provided to the Court. In subsequent discussions with the Panel, the County concluded that additional strategies were necessary to achieve the objectives for the plaintiff class and committed to developing an overarching Strategic Plan that would address remaining system design needs. The County has now completed its Strategic Plan and received County Board approval for implementation.

### **III. Panel Activities Since the Last Report**

The Panel has met in Los Angeles during this reporting period, a regular Panel meeting during June 2012, as participants in a week-long qualitative review of a sample of Wraparound cases in July and discussed at the September 2012 Panel meeting.

### **IV. Current Implementation Plan Status**

#### **DMH Staffing**

The Department of Mental Health (DMH) Child Welfare Division was recently allocated two new Psychiatric Social Worker II positions to support implementation of the County’s Treatment Foster Care program, bringing the total number of DMH staff devoted to supporting the Katie A. effort to 319. Staffing includes support for countywide implementation as well as Service Area support for administration and co-located staffing within the DCFS Regional Offices.

<b>LOCATION</b>	<b>MENTAL HEALTH POSITIONS</b>
Child Welfare Division	50
D-Rate	12
Service Area 1	29
Service Area 2	24
Service Area 3	34
Service Area 4	17
Service Area 5	4
Service Area 6	84
Service Area 7	39
Service Area 8	23
MHSA	3
<b>TOTAL</b>	<b>319</b>

#### **Additional staffing for the DMH ACCESS Hotline**

DMH has transferred this position to the DMH Child Welfare Division to support activities related to the Quality Service Review process and Coaching related to the Core Practice Model.

## Selection by DMH and DCFS of Selected Performance Indicators to be Tracked

There is agreement between the parties about the outcome indicators to be tracked.

## Development of Multidisciplinary Assessment Teams (MAT)

The County reports the following status of MAT implementation.

In June 2012, one-hundred percent of all eligible newly detained children Countywide were referred to a MAT assessment. This compares to a ninety-eight percent referral rate reported in the prior Panel Report. From July 2011 through June 2012, there were 5,772 MAT referrals and 4,713 MAT assessments completed. Of those referred, approximately twenty percent were not completed. Ten percent were in the process of being completed and another 10 percent were cancelled after referral for numerous reasons described in detail below.

<b>Table 1: MAT Compliance</b>	<b>MAT Eligible</b>	<b>MAT Referred</b>	<b>Percent</b>
SPA 1	27	27	100 %
SPA 2	56	56	100 %
SPA 3	74	74	100 %
SPA 4	32	32	100 %
SPA 5	12	12	100 %
SPA 6	104	104	100 %
SPA 7	78	78	100 %
SPA 8	97	97	100 %
<b>Total number of DCFS MAT referrals:</b>	<b>480</b>	<b>480</b>	<b>100 %</b>

From July 2011 through June 2012, the average timeline from MAT referral acceptance to completion of the final Summary of Findings (SOF) report was 45 days, which is the expected timeline for completion. Approximately 60 percent were completed in 45 days or less, 77 percent were completed by the 50<sup>th</sup> day and 90 percent were completed by the 60<sup>th</sup> day

As indicated above, approximately 20 percent of children referred to MAT did not have completed assessments as of the end of the Fiscal Year (2011-12). Of this 20 percent, 10 percent of children were in the process of receiving a MAT assessment, so those could not be counted as complete at the time FY data was collected. The remaining ten percent were initially referred to MAT, but did not have completed assessments due to the following “MAT Cancellation Reasons:”

- Children are returned home soon after the MAT referral and are no longer

MAT eligible.

- Children are referred to MAT but they have private insurance and are therefore no longer MAT eligible.
- Children who run away are not available to complete the assessment. These children are referred for mental health services when they return from AWOL but many of them do not receive the MAT assessment.
- Children who are in psychiatric hospitals or juvenile detention have billing and access issues that prevent the completion the MAT process.
- Children move out of county or state.
- Children lose Medi-cal eligibility after referral.

To further clarify, when children become MAT ineligible and need mental health services, they are referred to DMH co-located staff for an assessment. Indigent and privately insured families are also referred for mental health services, as needed. Another consideration is families and youth have the right to refuse mental health services even when children are screened positive for mental health needs.

From January 2012 through July 2012, DMH MAT Coordinators submitted a total of 110 MAT Quality Assurance (QA) Checklists and 94 MAT Children's Social Worker (CSW) Interview Surveys. Overall, 95 percent of the Quality Improvement (QI) Checklist's 8 domain ratings were positive and 94 percent of the MAT CSW Interview Survey's seven domain ratings were positive. Areas rated positive on the MAT QA included efforts to engage families, caregivers, relatives and community partners in the MAT process, the identification of the child's underlying needs and the recognition of child trauma. Areas rated positive on the MAT QI checklist included the usefulness of the Summary of Findings (SOF) report facilitating plan development for the family, the resourcefulness of the MAT assessors and the improved communication between the CSW and the MAT assessor. Areas that presented as challenging included assessors continuing to have difficulty recognizing the signs of trauma in children under the age of 3, the quality of teaming among the Child and Family Team, the utilization of the families' formal and informal supports systems and building upon the child and family's functional strengths during the SOF meetings.

In addition, DMH has conducted site visits to multiple MAT provider agencies to offer technical assistance and support regarding billing and documentation concerns. The MAT agencies have been receptive to this and, as a result, there has been improved communication between DMH and the MAT agencies.

Additionally, there has been progress in the identification of underlying needs by the MAT assessors; particularly in the area of distinguishing needs from services. Extensive training was provided to the MAT assessors in the local service areas, to assist them in improving their ability to identify the underlying needs of the children and families being assessed. Service Areas are using their monthly MAT provider meetings to practice coming up with well articulated needs and strengths using vignettes and case examples. Considerable progress has been demonstrated in the SOF reports as a result of these trainings.

DMH continues to provide trainings to further assist MAT providers with improving the quality of their SOF reports. The following trainings have been offered at the provider level:

- Presentation for MAT providers on identification of underlying needs by Marty Beyer;
- MAT Documentation training for managers and QA staff;
- Bridging the Gaps (Identification of Typical Versus Atypical Behaviors for 0-5);
- Fetal Alcohol Spectrum Disorder – recognizing the signs;
- Core Practice Model Training; and
- Ages and Stages Questionnaire – (Developmental screening for 0-5).

Other forums that have been carried out to improve the overall MAT process include the MAT Best Practices Workgroup. This workgroup convenes quarterly and provides an arena for identifying and addressing problematic system issues. Three subgroups were developed from the Best Practices Workgroup including: Medi-Cal documentation subgroup; a subgroup devoted to improving the SOF meetings; and a subgroup focused on improving the identification of underlying needs. Additionally, a sub-workgroup has recently been formed to streamline the SOF report and to improve its compatibility with Core Practice Model principles.

### **Implementation of the DMH Behavioral Health Information System (IBHIS)**

DMH reports that it has implemented an aggressive planning and testing process to design and bring up an information system that will integrate clinical, administrative and fiscal data, working toward a production date in mid-2013. DMH states that it continues to be on track with the implementation of this new system as reported in the last update described below.

#### **INTEGRATED BEHAVIORAL HEALTH INFORMATION SYSTEM (IBHIS)**

**Description:** Implement a Commercial-off-the-Shelf (COTS) behavioral health information system that provides clinical, administrative and financial functionality. The IBHIS shall include an Electronic Health Record and conform to the Mental Health Services Act Information Technology (IT) Plan Guidelines.

**Status:** DMH selected the Avatar system from Netsmart, Inc. (Netsmart) as the result of an RFP process. The Board of Supervisors approved an Agreement with Netsmart on October 18, 2011. Work with Vendor began in November 2011; the project team is currently engaged in planning and discovery work that will lead to decision-making about how the system will be configured for DMH. The target date for first production use of IBHIS is mid-2013.

Critical Future  
Policy Issues:

**Workforce Issues:** An electronic health record (EHR) with integrated administrative and financial functionality will create a work environment in which nearly all DMH employees will need to be computer literate. Computer literacy is not universal in DMH, although nearly so now with the implementation of e-timekeeping. “Opting out” of using the IBHIS to do assigned work will not be possible; so substantial training may be required. Existing job specifications may need to be modified, and potentially union MOUs, in order to make computer literacy and use of an information system a requirement for most existing job classifications.

**Contract Providers:** Approximately half of all DMH clients receive services delivered through contract providers of mental health services. The contract providers currently have direct access to DMH’s computer system, but under the IBHIS, they will not. They will, instead, exchange information with DMH electronically. Initially the content of this exchange will be only slightly expanded from the current focus on health care claims, but may eventually include substantial portions of the consumer health record. This is a major change for most contract providers. The LA County DMH MHSA IT Plan includes the use of MHSA funds to facilitate this transition for contract providers.

**Consumer Access to Healthcare Information:** The Avatar system includes a client portal. This will allow DMH clients to securely access selected portions of their healthcare record from any location in which they have access to the Internet.

Key Future  
Milestones:  
Fiscal/Financial  
Information:

Initial Production Use – June 2013

IBHIS expenses are projected at approximately \$11 million in FY 11-12.

A \$51,660,413 million allocation in the DMH MHSA IT Plan is being applied to IBHIS initial costs. Additional funding comes from the DMH IT budget as obsolete systems to be replaced by IBHIS are no longer updated and finally shut down.

Stated costs do not include support for the contract providers’ transition to EDI, which is supported with \$23 million in funding through DMH MHSA IT Plan.

### ***Innovative County Information Sharing Initiative***

As described in the Panel’s last report, in April 2012 the Department of Mental Health (DMH) began sharing mental health information on children receiving mental health services with the Department of Children and Family Services (DCFS). This was motivated in part by the County’s concern about a lack of coordination and teamwork in casework practice, as revealed by the qualitative review process. The County reports that DMH Information Alerts are sent

every week via email to Children's Social Workers (CSWs) and Supervising Children's Social Workers (SCSWs). The information, derived from the DMH Integrated System (IS), is being shared for the purpose of coordinating the care of children with open DCFS cases who are receiving mental health services. The alerts, which include provider agency names, phone numbers, and the type and dates of services, are expected to improve communication between social workers and mental health service providers.

The County has now assessed the utilization of this process in a survey of a sample of staff and reports the following findings.

The results below are from a sample of 112 CSWs and SCSWs from all 19 DCFS regional offices informally surveyed by Service Linkage Specialists (SLS) about the utility of this information sharing. In addition to conducting this informal survey, the SLS informed the CSWs and SCSWs that they would be asked to complete a formal survey in early September. The informal survey provided the following results as reported by the County:

- 100 percent of SCSWs/CSWs report receiving weekly alerts (96 percent said yes and 4 percent said they sometimes receive weekly alerts).
- 81 percent of SCSW/CSWs report that the alerts are helpful.
- 79 percent of SCSWs and CSWs report opening the alerts; 13 percent do not open the alerts; and 8 percent sometimes open the alerts.
- 42 percent of SCSWs/CSWs report the content of the alerts is correct, 18 percent report the information is incorrect; 21 percent report that the information is sometimes correct; and 19 percent don't know.
- 73 percent of SCSWs/CSWs report the alerts are helpful in coordination of care and treatment for the children; 22 percent report the alerts are not helpful (mainly because they already have the information); and 5 percent report the alerts are sometimes helpful.
- 38 percent of SCSWs/CSWs report having follow-up conversations with the service providers listed in the alerts; 39 percent do not follow-up with providers listed; and 23 percent sometimes follow-up with providers.
- 39 percent of SCSWs/CSWs replied that the alerts were incomplete or incorrect.

The Department's assessment of these findings produced the following analysis.

The results indicate that, while 81percent of those surveyed think the alerts are helpful, only 38 percent report following-up with service providers. The Department anticipates this percentage will improve as more regional offices participate in a Quality Services Review (QSR), receive coaching on utilizing the approach, and use the principles of the CPM in their daily work. In this way they will have a better understanding of the importance of teaming to ensure children are receiving the right services at the right intensity.

The information in the alerts comes from the DMH Information System, which depends on contracted providers' billing to identify types and frequency of services. DMH and DCFS will work together to further investigate this matter and work to ensure the accuracy of the information provided to DCFS SCSWs/CSWs.

**Completion of an Internal Qualitative Assessment of Service Provision and Client Outcomes**

The County continues its implementation of the Qualitative Service Review process, which satisfies this provision. This Panel report includes Qualitative Service Review findings since the last report in a subsequent section of this report.

**Training for Staff Providing Intensive In-Home Services to Children Needing Mental Health Services**

The County reports the following status of its intensive home-based mental health service training.

DMH has convened an Intensive Home - Based Services (IHBS)/Intensive Care Coordination (ICC) Workgroup composed of representatives from DMH, DCFS, and community providers to review the Settlement Agreement in the Katie A. State case related to these service models and to propose how these services might be expanded in Los Angeles County.

The workgroup proposes to begin the first phase of ICC and IHBS implementation with Wraparound providers in addition to a pilot project targeting expanding Field Capable Clinical Service provision to Emergency Response Command Post (ERCP), Children Awaiting Placement centers, Emergency Shelter Care, and clients who are discharging from psychiatric hospitalizations to ensure that they receive ICC and IHBS services. The training required for the implementation of ICC and IHBS will include: training of the Medi-Cal Documentation and Claiming manual as provided by the State Department of Health Care Services; specific ICC and IHBS applied training, technical assistance, and consultation provided by Tim Penrod of Arizona; and, Los Angeles County specific billing guidelines as provided by DMH’s Quality Assurance Division.

The Panel has regularly asked for detail about the training of mental health in a variety of approaches integral to Katie A. implementation and the DMH practice Model. In response to the Panel’s inquiries, the County has provided the following table which outlines the scope of evidence-based Trauma based training provided to clinicians.

Evidence Based Practices for Trauma	EBP	AGE Range	Estimated Number Trained
	Alternatives for Families: Cognitive Behavioral Therapy	6-15	25

	Child Parent Psychotherapy	0-6	360
	Cognitive Behavioral Intervention for Trauma in Schools	10-15	128
	Cognitive Behavior Therapy (CBT) for Trauma	18+	30
	Managing and Adapting Practice - Traumatic Stress	2-18	1400
	Mental Health Integration Program - Trauma	18-60	250
	Prolonged Exposure for PTSD	18-70	60
	Seeking Safety	13-60	1100
	Trauma Focused Cognitive Behavioral Therapy	3-18	1500
	<b>Approximate number of trained clinicians:</b>		<b>4853</b>

### Expansion of Funding

According to the County, the FY 2010-11 Katie A. budget closed with \$16.2 million in net County cost savings, an amount slightly higher than projected in the last report. The budget closed with \$22 million in net County cost savings in 2009-2010. The savings were primarily due to vacant Wraparound slots. As done with prior year savings, the Chief Executive Office (CEO) has rolled the FY 2010-11 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2011-12 and FY 2012-13 in support of the incremental rollout of the Strategic Plan. The County reports that most of the current savings occurred due to a slower roll-out than projected.

The County states that based on the draft Katie A. PFU document, the savings for FY 2012-13 Final Adopted Budget is \$9.64 M after the inclusion of \$4.1 M, funded with prior year savings, in the Supplemental Changes. The breakdown for the \$4.1 M is as follows:

#### Breakdown for \$4.1 M in Katie A. funds

<b>Katie A.</b>	<b>Appropriation</b>
Plaintiff Fees	\$84,000
Panel	\$200,000
County Counsel	\$76,000
Medical Hubs	<u>\$2,372,000</u>
Total	\$2,732,000
Increase in DMH Employee Benefits	\$791,000
DMH and DCFS positions to support Treatment Foster Care program development	
2 PSW IIs (DMH)	\$228,000
1 CSA I (DCFS)	<u>\$139,000</u>

Total	\$367,000
Ambulance Cost	\$227,000
<b>Total</b>	<b>\$4,117,000</b>

DMH is in the process of amending the contracts of 15 Wraparound providers by a total of \$6,468,469 to increase Wraparound capacity for fiscal year 2012-2013 by an additional 225 slots and bringing the total Wraparound EPSDT allocation countywide to \$51,620,300.

### **Expansion of Staff Resources for Multidisciplinary Medical Hubs**

The County continues report progress toward its goal that 100 percent of the newly detained children are referred to a Medical Hub for the Initial Medical Examination. For the period of October 2011 to September 2012, and as of September 26, 2012, 86 percent of newly detained children were referred to a Medical Hub for this required medical examination. This compares with 82 percent referred at the time of the last Panel report.

The County adds the following information to its update on progress on Hub implementation.

Towards the County achieving the goal, the DCFS Procedural Guide, Utilization of the Medical Hubs, was revised in July 2012. The delay in revising the Procedural Guide was caused by union inquiries on workload issues that required review and resolution. The revised policy clarifies that the CSW who detains the child will be responsible for submitting the Medical Hub Referral Form. In addition, the revised Procedural Guide provides instructions for DCFS staff to include a recommendation in the Detention Report for the Court to order medical services at the Hub. Further, the revised Procedural Guide includes instructions to DCFS staff on required steps to take when the medical exam results and appointment notification statuses are received through the DCFS interface with the Department of Health Services' E-mHub System. These revisions contribute to more effective and efficient use of the Hubs and ensure that the recommendations from the Hub providers are addressed.

In addition to revising the Procedural Guide, the DCFS Child Welfare Health Services (CWHS) Section implemented in April 2012, a progress report titled, "Tracking Newly Detained Children Referred to the Medical Hubs" for the Regional Administrators/Assistant Regional Administrators on monthly basis that provides the current percentage of children referred to the Medical Hubs. The report has been well received by DCFS managers as a tool to monitor each office's percentages of referrals to the Hubs from their respective office including any need for improvements. Further, in September 2012, the CWHS Section initiated training to the DCFS regional CSWs and their SCSWs to ensure proper completion of the required Hub Referral Form and interface with Hub personnel. Also, DCFS continues to collaborate with the Medical Hubs through the establishment of a pilot that provided for additional out-stationed CSWs to serve all the Medical Hubs, including after hours at the 24/7 LAC+USC Medical Center Hub and Children's Hospital, Los Angeles, the private sector Hub. These out-stationed CSWs are significantly contributing to the efficiency of DCFS making referrals to the Hubs and to the work flow/operations of the Hubs.

Moreover, through collaborative review by DCFS, DHS and DMH, and as discussed with the Hub Medical Directors, a decision was made for the Medical Hubs beginning in October 2012, to discontinue the completion and submission of the Mental Health Screening Tools (MHST) on children whom they serve. The rationale is that currently DCFS has strong policy that addresses the completion of the MHSTs for children by CSWs along with a strong protocol to refer children for an assessment as needed. Although use of the MHSTs was discontinued, the Medical Hubs continue to team with DCFS through use of a protocol on who to contact at DCFS when mental health concerns are demonstrated or noted by Hub personnel when serving a child through the medical examination.

### **Expansion of Team Decision Making (TDM) Capacity Sufficient to Meet the Needs of the Plaintiff Class**

The County reports that for calendar year 2012, there are a total of 12,313 TDM meetings held. This compares to 15,497 TDM meetings held in 2011. The Department currently has eighty-three TDM facilitator items filled and three vacant items. Of the eighty-three positions, fourteen are Permanency Planning Conference (PPC) facilitators responsible for facilitating the Resource Management Process (RMP) and PPC TDM meetings and there are two Pregnant and Parenting Teen (PPT) conference facilitators. By calendar year, the County has completed TDM meetings as follows:

Calendar Year 2010: 16,602 TDM meetings completed

Calendar Year 2011: 15,497 TDM meetings completed

Calendar Year 2012- 1<sup>st</sup> Quarter: 4,242 TDM meetings completed; 2<sup>nd</sup> Quarter: 4158 completed;  
3<sup>rd</sup> Quarter: 3753

### **Implementation of the DMH Mental Health Screening Tool, Coordinated Services Action Team (CSAT) and Referral Tracking System**

The County reported the following performance related to the revised mental health screening tool and associated rollout.

#### **Number of Children Screened - (of a total of 28,917 children):**

- 25,020 children required a screen, (28,917 children minus those currently receiving mental health services, in a closed case, who ran away, or were abducted);
- 24,747 (98.89 percent) children were screened.
- 278 (1.11 percent) screens are showing pending.

- 18,041 (72.90 percent) of those children screened (24,747) were determined to be in potential need of mental health services (received positive screens).

Screening Compliance – (of the 24,747 children screened):

- 18,041 (72.90 percent) children screened positive of those children requiring screens (25,025);
- 6,706 (27.10 percent) children screened negative of those children requiring screens (25,025);

Acuity Determination (18,041) children screened positive):

- 14 (0.08 percent) children were determined to have acute needs;
- 406 (2.25 percent) children were determined to have urgent needs;
- 17,067 (94.60 percent) children were determined to have routine needs;
- 554 (3.07 percent) children's acuity level was pending determination and/or data entry.

Number of Children Referred for Mental Health Services:

- 18,041 children could be referred to mental health services minus children for whom consent was declined, whose case was closed, who ran away, or who were abducted.
- 17,288 (98.93 percent) children were referred for mental health services.

The following chart provides a breakdown of timeliness from screening to referral for FY 2011-2012 as of September 28, 2012).

Acuity	Number of children/number of days from positive screening to referral for mental health services												Total
	0-3 Days	%	4-7 Days	%	8-13 Days	%	14-20 Days	%	21-30 Days	%	31 Days or more	%	
Acute	11	78.57%	1	7.14 %	1	7.14%	0	0	1	7.14 %	0	0	14
Urgent	332	81.77%	44	10.84%	11	2.71%	9	2.22%	0	0	10	2.46%	406
Routine	10,311	61.92%	2,764	16.60%	1,490	8.95%	825	4.95%	583	3.50%	677	4.07%	16,650
<b>Total Referred</b>	<b>10,654</b>	<b>62.41%</b>	<b>2,809</b>	<b>15.45%</b>	<b>1,502</b>	<b>8.80%</b>	<b>834</b>	<b>4.89%</b>	<b>584</b>	<b>3.42%</b>	<b>688</b>	<b>4.03%</b>	<b>17,070</b>

for MHS

The County plans to address the lesser timeliness for routine referrals as follows:

- The regional CSAT staff will work closely with each unit SCSW to ensure CSWs submit referral packets to CSAT without delay. CSAT staff will regularly review the “pending referral report” on a weekly basis and alert SCSWs/CSWs when any incomplete referral packets are received. Incomplete referral packets (due to missing consents or other required documents) account for the delays of many routine referrals. CSAT staff will determine which children are privately insured and follow up with CSWs to ensure those children receive mental health services.
- CSAT central management is working to develop a user-friendly web-based referral form where demographic and family information is automatically filled-in. The form that is currently in use requires the CSW to complete a separate form for every child; a time consuming task.

Referrals to mental health services are sometimes delayed due to children running away or parents’ refusal to provide consent. As more CSWs are coached and utilizing the Core Practice Model, it is hoped that a decrease in runaway behavior will occur and family engagement will improve. CSAT central management anticipates fewer delays as the partnerships with children and parents improve.

**Children Receiving a Mental Health Service Activity:**

- Of 17,288 children referred for mental health services: 16,878 (97.63 percent) children began receiving mental health service activities such as assessment, treatment, case management and consultation.

**Number of Days from Screening to Start of Service):**

- Average of 6 days from case opening/case plan update to mental health screening;
- Average of 4 days from receipt of a positive screen to a referral for mental health services;
- Average of 2 days from referral to the start of mental health service activities.

The Panel asked for timeliness data on the receipt (vs. referral) of mental health services. The following table reflects that performance, which is also positive, especially for children with acute or urgent needs in FY 2011-2012.

Acuity	Number of children/number of days from positive screening to receipt of a mental health activity												Total
	0-3 Days	%	4-7 Days	%	8-13 Days	%	14- 20 Days	%	21- 30 Days	%	31 Days or More	%	
Acute	14	100.00%											14
Urgent	402	99.01%	3	0.74%			1	0.25%					406
Routine	13,518	82.14%	858	5.21%	945	5.74%	578	3.51%	307	1.87%	252	1.53%	16,458
<b>Total</b>	<b>13,934</b>	<b>82.56%</b>	<b>861</b>	<b>5.10%</b>	<b>945</b>	<b>5.60%</b>	<b>579</b>	<b>3.43%</b>	<b>307</b>	<b>1.82%</b>	<b>252</b>	<b>1.49%</b>	<b>16,878</b>

**MH  
Activity  
Received**

The County continues to show improvement in implementing the screening process and promptly referring children for mental health services.

### Expansion of Mental Health Services

#### *Treatment Foster Care (TFC)*

According to the County, as of September 30, 2012 there were a total of 77 youth receiving Treatment Foster Care (TFC) services. At this same point in time, TFC had 91 certified beds with 4 youth in the process of being placed, and ten vacancies. The utilization rate is 85 percent. If adjusted for the four youths pending placement, the utilization rate is 89 percent.

#### *TFC Trends per Fiscal Year*

	FY 08-09	FY 09-10	FY 10-11	FY 11-12
Number of youth placed into TFC homes during FY	26	30	68	62
Number of youth who transitioned out during FY	14	27	36	49
Youth who moved to Higher Level of Care (GH, Hosp)	9 of 14 (64%)	12 of 27 (44%)	17 of 36 (47%)	14 of 49 (29%)
Youth who moved to a Lower Level of Care (HOP, LG)	5 of 14 (36%)	15 of 27 (55%)	19 of 36 (53%)	35 of 49 (71%)
Total Youth who received TFC services during FY	30	41	81	95

The County reports the following detail about their ongoing implementation efforts.

The County sees improvements in outcome trends since the beginning of TFC implementation. Over the past four fiscal years, a total of 188 youth have received TFC services. In addition to identifying the ratio of youth who transitioned to higher and lower levels of care, as indicated above, TFC administration has determined that youth stability in lower level care (LLC) settings (i.e. home of parent, legal guardian, relative and/or foster home) after TFC discharge would also provide valuable information regarding programmatic performance. As such, TFC administration has identified where youth who graduated from TFC were placed 6, 12 and 18 months after their discharge date to determine if they in fact remained at a LLC. The following chart illustrates these findings:

	FY 08-09	FY 09-10	FY 10-11	FY 11-12
<b>% Remaining LLC after 6 Months</b>	100%	80%	84%	N/A
<b>% Remaining LLC after 12 Months</b>	40%	73%	79%	N/A
<b>% Remaining LLC after 18 Months</b>	40%	87%	100%	N/A

As indicated above, the program has seen great improvements in the number of youth graduating to LLC settings and remaining in those settings. Outcomes for those graduates in fiscal year 2011-12 are not yet available.

The success of TFC is also evidenced by those youth who remain stable in their TFC placements as this is a successful step toward permanency, pro-social stability, and as a result, present the County with a significant annual fiscal savings.

County Update on TFC: Since the December 2011 Panel Retreat where TFC recruitment strategies were of central concern, the County has made significant TFC investments to enhance TFC recruitment and retention efforts. The activities consist of the following:

The County continued to participate on the two state workgroups which are examining various elements of TFC, including rate setting, contracting, service provision, and evaluation since October 2011. The County will continue to do so through December 2012 when a statewide implementation plan is expected to be developed and a documentation manual produced. Since the last report, Los Angeles County TFC administration has participated in the development of a statewide Intensive Treatment Foster Care (ITFC) manual of service delivery and a matrix identifying and describing all allowable mental health activities within the scope of TFC service delivery. Currently, the activity of the work groups have slowed as the focus has been temporarily turned to best practices in the implementation of the exit conditions identified in the Katie A. settlement agreement.

March 27, 2012, a proposal from the California Alliance of Child and Family Services was submitted to the State Department of Social Services for an interim increase in AFDC-Foster Care Rates for the existing model of ITFC programs pending

implementation of the Katie A. State Settlement Agreement and the re-evaluation of the ITFC program model. The proposal recommends increasing the California Necessities Index (CNI) not previously provided to ITFC foster parents that would increase their stipend to \$2,168/month and the overall FFA rate by roughly 11 percent. A recommendation was submitted to the Governor to increase the ITFC monthly rates. On June 27, 2012 the Governor included in the State Budget for FY 2012-13 an increase for ITFC providers and it included a mandatory minimum monthly payment to ITFC foster parents of \$2100 that roughly equaled the suggested increase. The rate officially went into effect on July 1, 2012.

The County has agreed to add three additional positions to support the expansion of the TFC programs in the FY 2012-13 budget. Two Psychiatric Social Workers and one Children's Services Administrator were requested to help with on-going recruitment efforts, facilitate provider meetings, collaborate with regional staff, provide on-going training and support to the Foster Family Agencies (FFA), and participate in qualitative program evaluation reviews. These positions are being finalized and should be filled by January 1, 2013. The need for additional positions has been learned after several years of program development and a better understanding of the time and support needed from the County to assist FFA agencies with recruitment and provision of quality services.

On February 17, 2012, DCFS, DMH and 12 FFAs hosted a foster parent recognition, training, and recruitment event. The goal was to offer support and training to existing TFC caregivers to help sustain existing homes. Each caregiver was encouraged to bring individuals interested in becoming a TFC caregiver. Approximately 22 potential new caregivers were invited and another event is planned for February 2013.

TFC, DMH, and DCFS staff are working with several faith-based organizations to expand recruitment efforts. This work has included e-mails, phone calls and presentations to organizations whose membership include clergy and other religious leaders.

In December 2011, the TFC administrative team and the DCFS Placement and Recruitment Unit (PRU) began an ongoing partnership to expand its support, marketing and targeted recruitment efforts for TFC. This partnership has generated a number of interested prospective foster parents. From March 2012 until September 2012 nearly 800 prospective foster parents were identified. With the expected 6 percent penetration rate, TFC anticipates 48 new certified homes this fiscal year.

TFC recruitment activities will be included in the PRU budget for the upcoming fiscal year. Activities completed to date include (1) technical assistance in mailings, radio advertisements, event planning, development of brochures and novelty items for distribution; (2) inclusion of TFC materials at all PRU ongoing events, orientations, dedicated website, social media and community outreach; (3) screening all calls coming into the PRU hotline for interest in TFC program.

## *Training and Coaching*

The Panel continues to view training and coaching as a foundational element in the County's Practice Model implementation. Coaching began in Compton, then Pomona, and has now begun to occur in Torrance and Wateridge. The coaching process has developed into an approach designed for each office. According to the County, coaching involves collaboration among the DCFS and DMH coaches who are in the office three days each week. The regional administrators and lead supervisors meet biweekly to guide the coaching. The process begins with training on the shared Core Practice Model for the participating two or three units in the office. The coaches meet weekly with the SCSWs, guiding them in how to coach workers in the 23 practice behaviors that are part of the practice model. Coaches have one or two individual sessions with each worker, plus going out with workers, plus group coaching with their units assist in TDMs and Child and Family Team meetings. Over time, the SCSWs assume the coaching role and the coaches begin the process again with other units in the office. The County provided the following summary of its recent training and coaching supports.

As of August 2012, the external coaches from DCFS, DMH and Los Angeles Training Consortium (LATC) have participated in a training series of Children's Institute, Inc (CII) for Integrating Child Welfare Trauma Training into the Core Practice Model (CPM) sessions for the coaching roll-out.

In addition, over 25 DCFS Internal Affairs staff were trained on the basics of the CPM on August 29, 2012. Additionally, the DCFS Public Health Nurses (PHN) were provided with a similar training on October 11, 2012 at Burton Chase Park.

Both DCFS and DMH participated in the consultations with the Federal California Partnership for Permanency (CAPP) Technical Assistance (TA) Team, during which the crucial role of Implementation Teams was reviewed in helping support and sustain practice change. The CAPP TA staff also acknowledged the importance of merging Katie A. Practice Principles with the 23 CAPP Practice Behaviors, so that staff are not confused or led to believe that they are being asked to follow two different practice models.

In preparation for the coaching roll-out for the Pomona, Torrance and Wateridge DCFS offices, DMH staff and mental health providers were offered office-based trainings on Core Practice Model (CPM) and coaching overviews were provided as early as April 2012 and are provided ongoing, as needed.

For the Pomona office, the following trainings were provided to mental health providers:

- On April 11, 2012, eight MAT providers were trained;
- On April 16, 2012, 15 children's mental health providers were trained;
- On May 23, 2012, seven outpatient mental health providers were trained;
- On September 11, 2012, DMH Service Area (SA) 3 Wraparound Administration, MAT administration, co-located supervisors and staff from

the Pomona, Covina, Pasadena and El Monte offices were trained on the CPM.

On April 10, 2012, the Pomona DCFS office along with SA 3 DMH staff held their coaching kick off. Two DCFS units and four mental health providers were selected for the first phase of the coaching roll-out. In addition to the selection process, Pomona developed their local implementation team meeting, which includes representation from the DCFS Pomona office, DCFS Quality Improvement (QI) Section, DMH SA 3 Administration, coaches and participation from a parent and youth advocate. The members of the local implementation team are the drivers that ensure implementation of the CPM via coaching and training.

The next two Implementation Units for the DCFS Pomona office have also been selected and started in-depth coaching on October 2, 2012. They include and Emergency Response (ER) Unit, as well as an additional Continuing Services Unit. On September 25, 2012 the Pomona office introduced two additional units to the coaching process while DMH prepared three additional MAT providers.

For the Torrance office, the following trainings were provided to mental health providers:

- On April 5, 2012, 10 MAT providers were trained;
- On June 5, 2012 and June 7, 2012, an overview was provided on CPM and Coaching to DCFS Torrance staff, DMH co-located staff and DMH contract providers and community partners.

On June 26, 2012, the Torrance DCFS office along with SA 8 DMH staff held their coaching kick off. Two DCFS units and the DMH co-located staff were selected for the first phase of the coaching roll-out. The Torrance implementation team includes representation from DCFS staff, DMH and DCFS coaches, and a community partner. Currently, the implementation team is discussing ways to strategically include mental health providers into the multiple coaching opportunities taking place in SA 8.

Weekly Torrance coaching implementation meetings are occurring and have concluded that an intensive training for Torrance Team Decision Making (TDM) facilitators about Child and Family Team (CFT) meetings will be very helpful. The Department continues to move toward CFTs as the vehicle that is used across all offices to meet and plan with families about strengths, underlying needs, and teams that can assist them. An initial session is planned for October 11, followed by a more intensive training on November 8, 2012.

Wateridge had an initial coaching training for the DCFS implementation units and co-located DMH staff on September 19. This was followed by a “Coaching Launch” that was held on September 27, 2012.

DCFS and DMH staff were instructed on the “3-2-1” Model for Coaching to help them understand the process of coaching that is now rolling out in their office. In a nutshell,

the “3-2-1” model is constructed so that a neophyte coach has coaching modeled for them three times. They then co-coach with their mentor for two additional sessions, and finally fly solo, with an additional coach present, to assess their skill level and check for coaching fidelity. The “3-2-1” process is intensive and includes extensive case coaching and de-briefs before and after each coaching opportunity.

On the mental health side for the Wateridge office, DMH contract providers who service the Compton office also service the Wateridge office. Therefore, the 15 mental health providers who participated in the Compton office coaching roll-out will continue participating in the Wateridge roll-out. These providers were trained in February 2012 and have participated in coaching opportunities via the Compton coaching roll-out.

DMH and DCFS have also been working on the development of a three-year plan. There has been consensus on the specific trainings that both departments and the mental health provider will need to participate in. The Departments continue to work on an implementation plan to roll-out the trainings. The five core trainings include: CPM Overview, Trauma Responsive Practice, Identifying Underlying Needs, Teaming and Cultural Awareness and Humility.

Finally, DCFS and DMH are working on developing an ongoing support group for the DMH and DCFS coaches who are exposed to vicarious trauma on a daily basis as they work with challenging families and sometimes resistant staff and community providers as we transition to conducting strength-needs based CFTs with families.

Both Departments and the Panel members recognize the importance of providing support and continued professional development for the coaches. Planning is underway to develop additional coaching capacity that would provide for three to four coaches for each DCFS office and 24 coaches for DMH providers. This will help ensure that the CPM takes hold, and is consistently implemented across all the life domains of families involved in the child welfare system. It is essential that FCS and DMH not have less than this staffing for coaching.

### **Expansion of Wraparound by 500 Slots**

The County reports that as of June 30, 2012, cumulatively 3,732 children have been enrolled in Tier II Wraparound, compared with 2,813 children in December 2011. In addition, the County has provided the following summary of its first Wraparound Qualitative Service Review. A complete copy of the full report on the Wraparound review can be found in the Appendix.

This year, Wraparound underwent its first “Wraparound only” Quality Service Review (QSR). The Wrap cases were selected using a quasi random method from the population of open Wraparound Tier II cases within each of the 19 DCFS offices to ensure that each of the 19 DCFS offices and 20 different Wraparound providers were sampled. An agency servicing a catchment area was aligned with each office and then the cases were randomly selected to control for a representation of cases from each office and the requisite number of Wrap agencies. Backup cases were also randomly selected because of the likelihood that not all families would consent to or be available

for the review. Last minute cancellations by families meant that Tier II Wraparound cases were included from 16 of the 19 DCFS offices with four offices having two randomly selected cases.<sup>1</sup> Out of the 34 Wrap agencies, 19 were represented in the sample.

The QSR identified several strengths (teamwork, engagement, interventions) and identified several needs. The specific needs identified: ensure CSW and therapist participation on the team, involvement of informal community resources and team agreement on long term view.

Los Angeles County DCFS and DMH are working closely with the Katie A Panel to develop a report that will communicate the findings, but also to identify program and system opportunities for growth.

On September 12<sup>th</sup>, Dr. Marty Beyer (Panel member and one of the designers and co-authors of the report), Dr. Angela Shields, Brian Bruker and Dr. Michael Rauso presented the QSR findings to invited DCFS, DMH and Wraparound providers. There was an opportunity for the audience to reflect on the findings and also elaborate on some of the strengths and needs.

The QSR Wraparound report was also shared with the larger Wraparound provider community and Wraparound ISC teams on September 4<sup>th</sup>.

## **Mental Health Services for Children in D-Rate and FFA Settings**

At the request of the Katie A. Panel, the County conducted an analysis of the mental health services provided to children and youth in D-Rate and FFA placements. The County summary follows.

We were particularly interested to identify the more intensive services provided to this population either through enrollee based programs or particular service models/arrays. In part, we wanted to see how these programs/services compared to the concepts of Intensive Care Coordination and Intensive Home Based Services that are contained in the Katie A. State Case Settlement Agreement (2011).

More specifically, this analysis examined youth who were in D-Rate and FFA homes on January 31, 2011 and the mental health services they received six months prior or post this date. Of particular interest were the intensive mental health services provided to this population. Intensive services are defined as enrollee and non-enrollee based program services that include Wraparound and Full Service Partnership (FSP) in addition to service arrays under Comprehensive Children's Services Program (CCSP), Field Capable Clinical Services (FCCS) and other mental health services, such as Therapeutic Behavioral Services (TBS) consistent with the principles of Intensive Home Based Services (IHBS) model. The programs and models that we have identified as "intensive

---

<sup>1</sup> Belvedere, Compton, El Monte, Glendora, Lancaster, Metro North, Pasadena, San Fernando Valley, Santa Clarita, Santa Fe Springs, South County, Torrance, Vermont, Wateridge, West LA, and West San Fernando Valley.

services” are those service arrays that we might expect to be consistent in offering the intensity of services that is provided in IHBS, as defined for this analysis. Please note that IHBS is not a program but an array of services, which we believe is consistent with the IHBS and ICC service elements outlined in the Katie A. State Case Settlement Agreement.

Using these parameters, we found that there were 1,391 youth in D-Rate placements and 4,312 youth in FFA placements. We examined the frequency, type and location of mental health services provided to these youth during the identified time frame. Comparisons were made between intensive service approaches and non-intensive services, e.g., those mental health services not captured in one of the seven mental health service categories named above.

We expected that these more intensive service programs and service arrays provided a higher frequency of services, a more robust mix of services, and often would be provided in the home or a suitable home-like setting. In short, the expectation was that these programs and services would be more in line with the kinds of services and supports identified in the County and State Katie A. Settlement Agreements.

We found that 89 percent of the children and youth placed in D-Rate homes received mental health services (both intensive and non-intensive) compared to 70 percent of the children and youth in FFAs. Of children and youth in D-Rate placements, 37 percent received intensive services with the IHBS array and Wraparound being most commonly provided. The least common intensive service modality for children and youth in D-Rate homes was TFC with less than 1 percent of this population receiving this service model. (It should be noted that TFC services are only available to children/youth placed in FFAs.)

By comparison, 25 percent of the children and youth in FFAs received intensive services with, again, the most common service vehicles being our IHBS array and Wraparound. The least common intensive service model provided to children and youth in FFAs was FSP-Transitional Aged Youth (TAY), with less than 1 percent of this population receiving this service model. Non-intensive mental health services were provided to 63 percent of the D-Rate population and 75 percent of the FFA population over this period of time. Children and youth that received mental health services while placed in D-Rate or FFA homes, more often than not received non-intensive mental health services.

Prior to data analysis, our hypothesis was that those programs/models that were included in the “intensive services” would be closely in line with the concept of ICC and IHBS that are contained in the Katie A. State Case Settlement Agreement (2011). While some of the programs and models that we have identified as “intensive services” seem to provide the depth of services similar to those that are provided in IHBS (e.g. TFC and Wraparound), other programs and models that we have included in this category, have not provided the intensity of services originally hypothesized (e.g. CCSP and FCCS).

Overall, based on this data, clients in the more intensive service models received more intensive services than youth that received non-intensive services, evidenced by youth receiving a greater frequency of services, services typically geared toward improving daily living skills and access to community resources, as well as, receiving a greater proportion of services in their home and community. Finally, it is important to note that a significant number of children and youth receive an intensive level of a service array that is consistent with the Katie A. State and County cases while not being enrolled in one of the County's intensive service models.

The Panel asked the County to provide information about intensive and non-intensive mental health services for a more recent population of Katie A. class members and they are preparing a new analysis.

### **Caseload/Workload Reduction**

The County reports that the DCFS total out-of-home caseload has increased from 15,191 (January 2012) to 15,547 (August 2012). According to the County, the individual CSW generic caseload average in August 2012 was 28.37, an increase of 1.99 children per social worker since January 2012 caseloads of 26.38. The ER caseloads depict an increase of (.86) in number of referrals from January 2012 (15.80) to August 2012 (16.66).

For purposes of comparison, in its August 2010 report the Panel found that the generic caseload was 24.94 cases. The ER caseload was 19.72. So while the ER caseload has gone down since that period, the generic caseload has gone up which is concerning during a time when caseworkers are being expected, as part of the Core Practice Model, to implement a strengths/needs based approach, including convening family meetings.

The County also noted the following strategies.

The Director has begun the process to implement the Department's Strategic Plan, asking Department leaders and managers to sign up to volunteer as Objective Team Leaders for each of the Strategic Plan's 50 Objectives. Objective Team Leaders will receive training on project management and will be tasked with pulling together small Action Teams to develop Action Plans. The Director is interested in participation from across the Department on these Action Teams and within the next few weeks, will send an email to all staff identifying Objective Team Leaders and soliciting staff participation on Objective Action teams. The Director of Program Development and Strategic Initiatives is currently researching tracking tools so that the Objective Team Leaders can better manage each of the objectives and there is a centralized source to track progress, prepare status reports, etc.

The Department plans to address caseload reduction through its Strategic Plan with the following objectives directly aimed at reducing caseload:

**I.1.1** By December 2014, implement the CPM Department-wide

**I.1.2** By December 2014, implement coaching and mentoring Department-wide

**I.1.3** By December 2013, expand and enhance existing prevention/aftercare services to reduce the number of children and youth entering, re-entering and/or experiencing extended associations with the County’s health and human services systems

**I.1.5** By July 2013, increase “reunification within 12 months” from 64.5 percent to 70 percent

**I.1.7** By December 2013, implement the Countywide [youth] self-sufficiency plan, coordinating DCFS efforts to better serve TAY with a wide array of programs and initiatives run by allied departments

**I.4.1** By July 2014, CFTs will create a plan that addresses permanency options for every child/family by the third month of case opening

**I.4.2** By December 2013, ensure relevant contracted services include outcomes which assist and support shortened timelines to permanence

**I.4.3** By December 2013, reduce the percentage of youth in care three years or longer by 10 percent

**I.4.4** By July 2013, increase the percentage of children adopted within 24 months from 24.2 percent to 28 percent

**I.5.2** By December 2012, explore the use of Resource Centers appropriate to each geographical area to support families and prevent entry into the system

**I.5.3** By December 2012, each regional office will have a community advisory body, including representatives of involved faith-based organizations, to develop a resource matrix and network to provide differential response services, teenage socialization, parenting and visitation centers for DCFS children and families

**I.5.4** By July 2013, implement the Parents in Partnership program in each office to offer support and mentoring to parents whose children have been placed in out-of-home care and assist with reunification

**I.5.5** By July 2013, develop and outreach and training model for communities and partners that increases their ability to provide services that improve safety, permanency and well-being of children and families and monitor the provision of these services for efficacy

**II.1.1** By December 2012, complete a Caseload Equity Analysis and seek approval from the Board of Supervisors, Union and CEO

**II.1.2** By July 2013, achieve a 3 percent reduction in the number of employees on Leaves of Absence (LOA) by implementing enhancements to the Department’s Return to Work (RTW) programs, such as quarterly RTW Coordinator’s meetings and an educational campaign about the RTW program

**II.1.3** By December 2013, develop a plan for targeted hiring of staff with a 3-year commitment for offices which are understaffed and provide incentives for current staff

**III.4.2** By December 2012, as part of the Re-Organized Management Structure’s implementation, redeploy resources to meet caseload equity goals

**III.4.4** By July 2013, secure a Title IV-E Waiver for Los Angeles County with favorable conditions

## **Young Children in Group Homes**

The Panel noticed that the number of young children in group homes was rising during past reporting periods and voiced its concerns to the County. Ultimately the Panel made a series of recommendations to the County on reducing the numbers of children in group care, including the

proposal to forbid the placement of children 8 and younger for being placed in group care. The county concurred with Panel recommendations and on its own raised the age threshold, limiting placement to age 12. The following is the County's report on its commendable progress in this area.

The issue of young children in group home settings has been an area of increased concern for the County. By the end of 2009, there were 100 children ages 0-12 years in group homes, by the end of 2010, there were 163 children 0-12 in group homes and by the end of February 2011, there were 179 children in group homes ages 0-12 years. As a result of this rising population of young children in group homes, the DCFS Director issued a memo that instructed staff to obtain the Director's approval prior to placing a child 0-8 years in a group home. Effective April 2012, this mandate was extended to children 0-12 years old for whom group home placement is sought.

As of October 2012, there were a total of 109 children ages 0-12 in group homes, a declining trend that leads the County to expect further declines in this population over the next several months. In order to admit a youth 0-12 to a group home, senior managers join with the CSW and the Resource Management Division Chief and a representative from the Medical Director's office to explore alternate placements and supports that could be utilized (including emergency Wraparound and TBS services) to effectively support the youth in a lower level of care. Several children have been diverted from group home care in this manner.

The children 0-12 years who are placed in a group home must have their cases reviewed every four months by Resource Management Specialist who utilize the Child and Adolescent Needs and Strengths (CANS) tool for the purpose of planning what services and supports need to exist in order to allow a child to move to a lower level of care. This intensive review of children 0-12 in group care has also contributed to the significant decline in this population.

The County reports that its Residentially Based Services Demonstration Project (RBS) is also showing success in transitioning young children out of group care. The program is based on the recognition that emotionally disturbed young children are placed in residential facilities because their needs are so difficult for parents, foster parents, relatives, outpatient providers and schools to meet. They often have multiple placements because of the necessity for periodic intense support that may not be available quickly enough. In recent months, RBS has shown noteworthy success with several children. For example, a nine-year old was removed with his three older siblings when he was 5 years old. He lived in seven foster homes until he was placed at a residential treatment center. In RBS, he was part of the Boy Scouts, received trauma treatment and had regular behavior support in school. The RBS team worked to make it possible for his adult cousin to gain approval for his placement in her home, with intensive support services after he was able to move to a lower level of care.

**GROUP HOME REPORTS FOR CHILDREN 0 TO 12  
BY OFFICE LOCATIONS  
FOR THE MONTH OF OCTOBER 2012**

<b>OFFICE NAME</b>	<b>TOTAL CHILDREN</b>
Asian Pac / Am Indian	3
Belvedere	4
Compton	9
El Monte	3
Glendora	7
Lancaster	6
Medical Case Management (MCM)	1
Metro North	3
Palmdale	3
Pasadena	11
Pomona	5
S F Springs	3
San Fernando Valley	5
Santa Clarita	5
South County	9
Torrance	3
Vermont Corridor	7
Wateridge	15
West LA	2
West San Fernando Valley	5
<b>TOTAL</b>	<b>109</b>

**Qualitative Service Review (QSR)**

The County has continued to implement the QSR process at a rapid pace. County QSR staff have fostered responsiveness to the feedback provided by the process in local offices and have expanded the number of trained reviewers, including adding staff with a variety of roles. Both DCFS and DMH staff are the core of the review work force and opportunities to observe (shadow) cases reviews have been offered to a variety of stakeholders. The Panel members have served as reviewers in many of the QSRs and have seen outstanding reviews firsthand. The County has provided the following update on its progress.

QSRs have been completed in 18 DCFS offices, in which 210 cases have been randomly selected and reviewed. An average of nine children, youth, caregivers, family members, service providers and other professionals per case have been interviewed. The results were fairly consistent across the 18 offices reviewed – Belvedere, Santa Fe Springs, Compton, Vermont Corridor, Wateridge, Lancaster, Palmdale, Pomona, Glendale, El Monte, Pasadena, San Fernando Valley, Santa Clarita and West San Fernando Valley, West Los Angeles, Torrance, and South County. A QSR Baseline Cycle Report is scheduled to be issued by December 31, 2012. A special county-wide study of Wraparound services using the QSR evaluation methodology was also completed and the Report is contained in the Appendix.

The new QSR Review cycle scheduled to resume during the first week in December 2012, within the DCFS Belvedere Regional Office. The QSR schedule through the first quarter of calendar year 2013 is provided below:

Belvedere	December 3-6, 2012
Santa Fe Springs	January 23/24 & 28/29, 2012
Compton	March 12, 2012
Vermont Corridor	April 8-11, 2012

The QSR assesses both current outcomes for children and families (which it describes as Child and Family Status) and the system’s Practice Performance. This occurs by utilizing a pair of trained reviewers who review each case in the sample by reading the case file and interviewing all of the major participants in the child’s case over a two-day period. These interviews include the child and parents, substitute caregiver where applicable, all providers and in some cases, attorneys. Using a structured protocol, the team assesses status and performance indicators to be able to determine facts such as:

Child and Family Status

- Is the child safe?
- Is the child stable?
- Is the child making progress toward permanency?
- Is the child making progress emotionally and behaviorally?
- Is the child succeeding in school?
- Is the child healthy?
- Are the child’s parents making progress toward acquiring necessary parenting skills and capacity?

Practice Performance

- Are the child and family meaningfully engaged and involved in case decision making (called Voice and Choice)?
- Is there a functional team made up of appropriate participants?
- Does the team understand the child and family’s strengths and needs?
- Is there a functional and individualized plan?

Are necessary services available to implement the plan?  
Does the plan change when family circumstances change?

These indicators are scored and scores are aggregated across the cases reviewed in each office producing a table reflecting overall scores. A written case story about each case is also produced to provide context to the scores. It is important to recognize that some indicators should be considered as having greater importance than others. Regarding Child and Family Status Indicators, Permanency and Family Functioning, for example, are vitally important. If children do not achieve permanency their future outcomes are more likely to be poor. If families (parents) do not gain or regain the ability to meet their children's needs, the likelihood of permanency achievement is poor. Stability and Emotional Well-Being are also critical status indicators. Both are also closely linked and relevant to permanency achievement. Safety is an obvious vital indicator: however it usually scores high due to the fact that once a case is opened immediate attention is given to child safety and where significant unmanaged threats are present the child is removed.

Under Practice Performance, Family Engagement, Teaming, and the Assessment of Underlying Needs are considered the most important indicators. The County has to achieve a performance level of 70 percent acceptability for each of these three indicators to meet exit conditions.

Like systems in other states measuring their performance against the QSR, initial baseline scores are always generally low among the most critical indicators due to the high standard of performance necessary to achieve an acceptable score. Over time as the County fully implements its practice model and the strategic plan, experience has shown that its performance should improve. The QSR Exit Standard is stated as follows:

## QUALITY SERVICE REVIEW

**Description:** Regional offices will exit individually by meeting the passing standards for both the Child and Family Status indicators and the System Performance indicators (85 percent of cases with overall score of acceptable respectively and 70 percent acceptable score on Family Engagement, Teamwork and Planning). Once the targets have been reached, at the next review cycle the regional office must not score lower than 75 percent respectively on the overall Child and Family Status and System Performance indicators, and no lower than 65 percent on a subset of System Performance indicators respectively (engagement, teamwork, and assessment). The County will continue the QSR process for at least one year following exit and will post scores on a dedicated Katie A. website.

Overall Score

Passing Score: 85% Passing Score: 85%

The following tables reflect the performance of the each of the 14 offices reviewed.

### Child and Family Status Indicators Percent of Cases Scoring Acceptable

Office	Safety	Stability	Perma- nency	Living Arrange- ments	Health	Emotional Well-Being	Learning & Develop- ment	Family Function- ing	Caregiver Function- ing	Family Connec- tions	Overall Status
<b>Belvedere</b>	100	92	22	100	100	54	77	73	100	N/A	<b>85%</b>
<b>Santa Fe Springs</b>	100	71	60	86	93	64	79	40	100	71	<b>71%</b>
<b>Compton</b>	100	85	62	85	100	54	77	64	88	56	<b>77%</b>
<b>Vermont Corridor</b>	100	86	43	93	93	64	79	36	80	67	<b>86%</b>
<b>Wateridge</b>	100	71	64	93	100	57	64	60	100	50	<b>93%</b>
<b>Lancaster</b>	100	91	64	100	100	100	82	83	100	60	<b>100%</b>
<b>Palmdale</b>	100	83	50	100	100	83	83	33	100	82	<b>92%</b>
<b>Pomona</b>	100	75	50	100	100	75	92	78	75	100	<b>92%</b>
<b>Glendora</b>	100	83	58	92	83	75	92	63	100	67	<b>83%</b>
<b>El Monte</b>	100	86	79	93	100	93	93	73	100	70	<b>93%</b>
<b>Pasadena</b>	100	83	67	100	100	83	100	67	100	60	<b>92%</b>
<b>San Fernando Valley</b>	92	75	58	92	92	83	75	56	100	67	<b>92%</b>
<b>Santa Clarita</b>	92	92	67	100	100	58	83	63	100	67	<b>92%</b>
<b>West SFV</b>											
<b>Metro North</b>	100	64	54	100	100	73	73	67	100	67	<b>100%</b>
<b>WLA</b>	92	75	67	92	92	75	67	40	100	63	<b>83%</b>
<b>Torrance</b>	100	90	70	100	90	70	80	86	100	89	<b>100%</b>
<b>South County</b>	100	58	42	100	100	33	58	80	89	90	<b>75%</b>
<b>Overall</b>	99	80	57	95	97	70	80	61	96	71	<b>88%</b>

### Practice Performance Indicators Percent of Cases Scoring Acceptable

Office	Engage- ment	Voice & Choice	Team- work	Assess- ment	Long- Term View	Planning	Supports & Services	Intervention Adequacy	Tracking & Adjustment	Overall Practice
<b>Belvedere</b>	46	31	8	45	23	38	62	38	31	<b>31%</b>
<b>Santa Fe Springs</b>	79	64	29	52	36	36	57	43	36	<b>36%</b>

<b>Compton</b>	38	46	0	59	23	23	69	54	46	<b>31%</b>
<b>Vermont</b>	36	36	7	30	36	14	57	43	14	<b>21%</b>
<b>Corridor</b>										
<b>Wateridge</b>	43	43	0	32	21	14	43	21	21	<b>14%</b>
<b>Lancaster</b>	36	55	36	51	45	45	64	55	45	<b>45%</b>
<b>Palmdale</b>	50	50	33	52	50	58	67	58	58	<b>50%</b>
<b>Pomona</b>	58	58	8	35	25	42	67	50	50	<b>42%</b>
<b>Glendora</b>	58	50	25	52	58	42	67	58	50	<b>50%</b>
<b>El Monte</b>	79	64	29	50	71	64	79	79	64	<b>71%</b>
<b>Pasadena</b>	58	42	0	33	42	50	50	42	50	<b>50%</b>
<b>San</b>	67	50	8	67	42	42	50	50	50	<b>50%</b>
<b>Fernando</b>										
<b>Valley</b>										
<b>Santa</b>	75	58	25	75	58	50	75	50	58	<b>58%</b>
<b>Clarita</b>										
<b>West SFV</b>										
<b>Metro</b>	64	55	27	64	36	55	91	73	55	<b>64%</b>
<b>North</b>										
<b>WLA</b>	83	75	17	67	33	50	67	67	58	<b>75%</b>
<b>Torrance</b>	90	60	30	50	40	60	100	70	50	<b>80%</b>
<b>South County</b>	75	50	25	75	25	33	75	42	37	<b>42%</b>
<b>Overall</b>	60	52	18	50	39	41	66	52	45	<b>47%</b>

Through training and coaching and the awareness created by the first round of QSR, the County anticipates that the second QSR in each office will find improved practice and child and family status, and hopefully engagement and teamwork will be closer to the required 70%.

### Exit Criteria

The County Board concurred with the County's proposal for exit conditions and the Court subsequently approved them.

## V. Panel Analysis of Strategic Plan Implementation

The County has made strides in collaboration between DCFS and DMH, defining their shared practice model, developing shared training and coaching for staff to have strengths/needs-based trauma-responsive practice and implement Child and Family Teams, including Wraparound and other mental health providers in this process, and utilizing QSR to assess progress toward this practice in cases throughout the County. Prominent themes in the past six months have been:

- Achieving a depth of understanding of the practice the county must achieve (and which will comply with Katie A).
- Ensuring underlying needs - trauma-related, developmental and other needs - are the focus rather than just the child's behavior. Additionally, assuring that these needs are a focus of the team at every point from assessment to service design and to ongoing supports after the case closes - by every person involved in the case.

- Clarifying what effective teamwork on all cases means: (a) every important person in the case getting together as a group in person in order to have a shared understanding of the child's needs, what the caretaker and parent require to meet those needs and designing unique services and supports to meet those needs and support caretaker and family; (b) for some cases a provider may convene the team (e.g. Wraparound or a residential program), but for many the CSW or SCSW will convene the team; and (c) using the team to build enduring supports for a positive long-term view for the child and family after the case closes.
- Establishing the long-term view as measure of success of cases, rather than the case plan, case closure or other short-term indicators and having everyone involved with the case—not just the caseworker—recognizing their responsibility for achieving continuing success of the child and family being able to meet the child's needs or independently maintain services and supports to meet those needs.
- Defining what sufficient intensity of services is in order to meet the child's needs, support the caretaker and family, and prevent placement disruptions or moves of the child into more restrictive care. Almost all children, including those with severe emotional problems, can live successfully and with stability in family homes with sufficiently intensive services which for some children may cost as much and be similar to the services they would receive in residential care. Figuring out what intensity - from once weekly outpatient therapy to daily therapeutic services in home and school - is sufficient to prevent deteriorated behavior in the child and making sure that intensity is implemented by providers (this has been a major challenge).

### **Intensive Home-Based Service Development**

The County is very hopeful that the implementation of the State Katie A. Case will assist in the expansion of intensive home-based services. However, both the County and the Panel have concerns about the recent State draft of its Documentation and Claiming Manual pursuant to the State settlement. In our opinion it does not go far enough in providing a clear vision of an intensive home-based service delivery system or sufficient detail, examples and authority for confident claiming by providers. Nor does the current State budget authorization provide a net increase for counties in implementing IHBS or Therapeutic Foster Care. The County and the Panel intend to raise these concerns with the State as part of the public comment process.

In the interim, Wraparound continues to grow and Treatment Foster Care is making slow progress, although far short of its goal of three hundred beds. The County's plan to pilot a form of flexible intensive home-based services with a single provider could be a useful model, but that process is not near implementation.

DMH is currently in the process of issuing a selective solicitation to identify a small number of mental health providers to implement intensive field capable clinical services consistent with the definitions of ICC and IHBS. These services will be targeted to children and youth who have had involvement with or who are at risk of psychiatric hospitalization, Emergency Response Command Post, or the Urgent Care Center and will provide a countywide presence. It is

anticipated that this project will be implemented in February or March of 2013 and will serve as an important learning lab for ICC and IHBS implementation more broadly.

## **Wraparound**

In FY 2010-11, Wraparound in Los Angeles County provided support to 4,248 children and their families, a 40% increase from the previous year. Tier II Wraparound was launched in 2009. In the past year, total Tier II enrollment increased from 966 to 2,031 (Tier I enrollment increased from 2,068 to 2,217). The monthly Wraparound case rate for Tier II children is \$1,250 and \$4,184 for Tier I.

At the time of the Wrap QSR, there were about 1,300 open Tier II Wraparound cases in 34 different contract agencies throughout the County: ALMA (27), Amanecer (15), Aviva (57), Bienvenidos (31), Children's Bureau (27), Child & Family Center (16), Child & Family Guidance Center (10), Children's Institute (78), Childnet (22), D'Veal (27), EMQ (29), Five Acres (37), Florence Crittenton (112), Foothill (31), Gateways (14), Hathaway-Sycamore (76), HELP Group (42), Hillside (17), HVG-Bayfront (16), IMCE (36), LA Child Guidance (16), Masada (9), Olive Crest (15), Penny Lane (88), PIC (25), St. Anne's (18), SCHR (9), Starview (169), SFVCMHC (34), San Gabriel (30), SSG (56), Tarzana (16), Vista Del Mar (48), and Village Family Services (45). Of the Tier II cases, 51% were male and 49% were female. The average age of Tier II children was 13 (the average age of Tier I children was 15). Tier II children were 62% Hispanic, 27% African American and 8% Caucasian. At the time of their enrollment in Wraparound, 70% of Tier II children were either at home or with a relative and 30% were in a foster home, group home or juvenile detention. At the time of graduation, 84% were at home, placed with a relative or living independently. The average length of stay for Tier II children who graduated was 12 months; 77% of Tier II children had no out-of-home placements during the 12-month period after Wraparound graduation.

In the Wrap QSR completed in the summer, 2012, each of the 20 cases was reviewed by a team of two reviewers who did a day and a half of interviews and scored the protocol together. The Wrap QSR was a remarkable collaborative process of designing and implementing the review: a total of 28 reviewers were involved in the 20 Wrap cases reviewed: DCFS QSR staff (11), DMH QSR staff (3), DCFS Wraparound staff (4), DMH Wraparound staff (1), other DMH (4), other DCFS (2), and Katie A. Panel (3); the Katie A. Panel members reviewed a total of 8 cases. An average of 10 individuals were interviewed in each case review, usually including the DCFS CSW, child, caregiver, parent(s) if different from caregiver, Wrap Facilitator, Wrap Parent Partner, Wrap Child and Family Specialist, and some therapists; school was on vacation but some school staff were interviewed. Of the 20 cases in the sample, the children were 5-18 years old and 11 children were living in their birth home, 6 in a foster family home, 2 in a kinship care home, and 1 with a legal guardian while participating in Wraparound.

The Wraparound QSR of 20 cases demonstrated the power of intensive home-based services. Most of the reviewed children had complex mental health needs and many traumatic experiences, often with long histories of DCFS involvement. In all 20 cases, there was a functioning team with child, parent/caregiver, and Wraparound Facilitator, Wraparound Parent Partner and usually Wraparound Child and Family Specialist. Most children had therapists. In most cases,

Wraparound was able to build on child and family strengths to get services quickly in place to support the child at home or in making a transition to a new home and/or school.

The Panel and County identified the following areas needing improvement in Wraparound practice.

- Teamwork Issues: Despite the strong Wraparound teams functioning in most of the cases, CSWs, therapists, and the family's natural supports were not involved in most teams.
- Understanding Underlying Needs: In many of the reviewed cases, the child's needs listed in the Wraparound Plan of Care were primarily the child's behaviors and the parent/caretaker's concrete needs (such as housing, employment, transportation, and advocacy support) and assisting the parent/caretaker in managing the child's behaviors. Half the 20 reviewed cases got a low score on Learning and Development because their needs in school and/or their disabilities were not adequately understood. The reviewers found little attention to underlying needs as described in the DCFS/DMH Core Practice Model.
- Trauma Treatment: In five of the reviewed cases, TF-CBT was being provided. In 11 of the 20 reviewed cases, the reviewers specifically noted that it was understandable that Wrap had a behavior focus at the outset, but that the children had needs requiring trauma treatment that was not being provided (although most of the children were seeing a therapist) and the parents/caregivers were not receiving sufficient guidance about how to respond to the children's trauma-related needs. Often in these cases, the reviewers found that the child's needs were poorly understood by the team.
- Long-Term View. Only four of the 20 reviewed cases received scores of 5 or 6 on Long-Term View. In eight of the reviewed cases, the reviewers expressed concern that planning for transition to the future had not been adequate. Lack of community networks was identified as one of the problems in transition planning. Ideally, the team should have enough community supports to support the family when Wraparound plans for graduation. Weak informal supports were described above under teamwork, but for some children and families their absence significantly compromised the future.

The QSR found that LA Wraparound engaged families and provided concentrated supports so children remained in family homes. This is a significant achievement with children with complex mental health and school needs, often with long DCFS histories. However, in many of the reviewed cases, Wraparound did not appear to be functioning as an *intensive mental health intervention*. Trauma-related needs are not in most Plans of Care and most therapists are not providing trauma-related, clinical guidance to the teams, so it is not surprising that only half have emotional well-being in the acceptable range.

After the draft Wrap QSR report was prepared a large group of Wrap providers and DCFS and DMH staff discussed the findings and worked together on a lengthy list of recommendations. The Panel has included key suggestions from the Wrap QSR in the recommendations section of this report.

## **Overall County QSR Performance**

Under Child and Family Status, the County scored relatively high on important indicators like Safety, Health, Learning and Development and Living Arrangements. As with systems in other states utilizing the QSR, scores for Permanency at 57 percent acceptability and Family Functioning at 61 percent acceptability lag considerably behind other indicator scores. Based on the experience elsewhere, scores on Permanency and Family Functioning are not likely to improve until the Practice Performance indicators on Family Engagement, Teamwork and Assessment improve.

Practice Performance indicators continue to need considerable attention and training/coaching resources if performance is to rise beyond current levels. Nationally, the Practice Performance indicators are slow to improve, as they are dependent on the intensity and quality of practice model implementation, which is a slow process. Areas needing the most attention are Child and Family Engagement at 60 percent acceptability, Teamwork at 18 percent acceptability, Assessment at 50 percent acceptability and Planning at 41 percent acceptability.

## **Trauma Responsive Care**

In addition to the intensity of services, DCFS and DMH have made a clear commitment to trauma-responsive services. Most children in care and almost all Katie A class members have experienced abuse and/or loss and/or disrupted caregiving and/or exposure to violence and are at risk of anxiety, depression, problems regulating their emotions, relationship difficulties and aggression. To understand a child's trauma-related needs requires looking behind the difficult behaviors associated with these symptoms. It is crucial that family, caregivers and other adults understand that trauma is behind these symptoms and how to respond to the children's trauma-related needs to assist in trauma recovery. Achieving services and supports to families that meet the trauma-related needs of children requires numerous simultaneous steps in many different areas:

- The practice model describes the importance of (a) identifying a child's trauma-related needs and (b) arranging trauma-responsive care not only treatment for the child but also guidance for parents and foster parents in how to respond to the child's trauma-related needs
- There is training in how to identify a child's trauma-related needs
- There is coaching in recognizing a child's trauma-related needs
- MAT assessors are improving in their inclusion of trauma-related needs in their Summary of Findings
- DMH has contracted for training for thousands of therapists in several evidence-based methods of treating trauma so trauma treatment is available for children in all parts of the County

It is difficult to determine how effective these efforts have been in meeting class members' needs. The Wrap QSR indicated that for many of the reviewed cases trauma-related needs were not

identified and only a few children were receiving trauma treatment. The key ingredient of guidance for caregivers and families about how to respond to trauma-related needs appeared absent in most of the cases. Perhaps doing a study of class members receiving trauma treatment and the change in trauma-related symptoms and behaviors is necessary. This could conceivably be added on to the QSR with several questions to ask therapists and caretakers, but the QSR is already a lengthy process.

### **Evidence Based Trauma Practices (EBPs)**

The County provided the Panel with a summary of training provided to practitioners. The Panel requested that additional information about the training be provided, as outlined below and DMH is currently in the process of responding to this request.

- A summary of each of the EBPs that are being used with Katie A class members.
- A description of what the training entailed for each EBP being used with class members.
- Whether there are 4,853 different clinicians working with class members, or whether a smaller number received training in several different modalities of trauma treatment
- The number of clinicians trained in the EBPs for trauma who have actually used the EBP with a Katie A class member and/or provided caretaker/parent trauma responsive guidance.
- The type of setting in which the clinicians trained in EBPs are serving class members (outpatient clinic offices, in the home, in the school)

### **Children and Youth Placed in D-Rate and FFA Settings**

At the Panel's request, the County provided information about mental health services provided to children in D-Rate and FFA Settings, a copy of which is found in the Appendix. That report generated other questions about the pattern of service delivery that the County is answering.

- Conclusions from the finding that 38% of Wrap and 34% of IHBS/TBS were provided in the home (a third of Wrap and 38% of IHBS/TBS were provided in the office).
- Target for how much of Wrap and IHBS should be provided in-home. If in-home and in office do not include counseling provided to children in school, important practice questions would be: (a) is guidance being provided to school staff in conjunction with the in-school counseling; and (b) if the therapist does not go to the home, when and where do they provide guidance to the caretaker? What is the County's plan for training and coaching necessary to achieve practice goals for therapy in the home?

The non-intensive services collateral rate (18%) is about the same as Wrap, 21% and IHBS, 20%. If collateral is where guidance to caretakers and parents is captured, it seems surprisingly low for a DCFS population referred for behavior problems that lead to placement disruption.

- Conclusions from the finding that in IHBS 15% of the service is individual, 20% is collateral and all the rest is other; in Wrap 17% of the service is individual, 21% is collateral and all the rest is other.
- The setting of the clinicians providing these services--separating clinicians working outpatient clinics from those working in agencies serving class members through Wrap is necessary to understand what this information means.
- This data is from 8/10-7/11. Are you pulling this data regularly? How difficult would it be to do this analysis with 2012 data?

### **Young Children in Group Homes**

DCFS made the decision to prevent children age 12 and under from entering group care by requiring high level sign-off for each placement and putting in place a process for determining what combination of intensive services could meet the child's needs in a family home. DMH collaborated with DCFS in identifying mental health services not only to prevent entry into group care but to support the transition of young children from group care into Treatment Foster Care or Wraparound in a foster home or with family. These efforts produced a dramatically smaller number of young children in group care.

## **VI. Panel Recommendations**

**1. Treatment Foster Care** Continue to expand the number of children who are successful in TFC.

**2. Young Children in Group Care** Continue to reduce the number of children 12 and under in group care by providing intensive services so they can be stable and successful in family-based settings. While case decision-making plays an important role in whether or not young children are placed in group care, the lack of appropriate intensive home-based services is at the core of the challenges faced by the County regarding reducing its group care population. Until the array of intensive home based services becomes sufficiently larger and more robust, children will continue to be inappropriately placed in group care because there are not enough adequate alternatives.

The Panel recommends a follow-up examination of the combination of services and the intensity of services for children and supports for caretakers that were provided to both the young children who were diverted away from group care and those who were transitioned out of group care during the summer and fall, 2012. There is much to learn from this success about IHBS, teams, effective services, the identification of children's needs and provision of supports to caretakers that is applicable to other Katie A. class members. Now that this way of thinking has been effective with this population, a similar process is necessary for children who have their first placement disruption so that services are promptly intensified to meet the child's needs and support for caretakers to prevent another change in placement.

The Panel also recommends that the County speed up the process of connecting Wrap providers with cases of newly detained youth for whom it is difficult to find appropriate placements. The current time taken for review and approval can interfere with prompt Wrap intervention.

**3. Intensive Home-Based Services** It is vital for the County to quickly expand the service array, including the pilot to develop a contract provider to deliver these services. It is also incumbent on the State to ensure that its Documentation and Claiming Manual provides the flexibility and responsiveness needed to permit providers to fully implement the State Katie A. Settlement. In the interim, every effort should be made to speed up the implementation of the pilot IHBS contract.

**4. Strengthen Front Line Practice** The QSR process is effective in identifying the strengths and challenges of practice model implementation. The areas the Panel identifies as most critical are listed below.

- Teamwork must be improved by engaging CSWs, therapists, school personnel, community supports and the family's natural supports. School staff participation in CFT meetings may increase if meetings are convened at the end of the school day at school. Similarly, where clinicians cannot easily attend team meetings, schedule some team meetings at clinicians' offices. A team meeting in the family's home may also serve as the CSW's monthly family visit.
- More training and coaching on identifying underlying needs should be provided, particularly trauma-related needs so that all participants in child and family teams—including CSWs, therapists and school staff - improve their practice. More training on improved teamwork, assessment and understanding, innovative, individualized services, and long-term view is also necessary. Since LA County has a shared practice model and a shared change process, shared training and coaching for DCFS, DMH and providers should be developed. The Panel recommends that coaches be developed further through training in teaming, identifying needs, and tailoring supports and services (and including families' natural supports in the process) to enable coaches to strengthen mentoring at the case level.
- Tailoring unique supports and services to build on child and family strengths and meet needs is essential. Arranging trauma-responsive care that fits the child and family is not easy but is an important part of individualized services. The child's therapist not only provides treatment to the child and guidance to caregivers and family but also clarifies how TBS and others will meet the child's underlying needs.
- Inclusion of a family's natural supports is necessary, particularly when connections and supports do not exist already. Plans to develop meaningful connections and supports and repairing damaged connections are essential functions of the child and family team to promote legal and relational permanency. Alternatives must be developed in the event that the hoped-for permanent connection does not work out. The use of Family Finding is a critical need for youth who have not achieved legal permanency.

## **5. Wraparound**

The Panel makes the following recommendations based on the Wraparound QSR.

- The Panel recommends that the County set clear expectations for CSW attendance at Child and Family Team meetings (even if attending every meeting is not practical) and hold staff accountable for participation.
- Amend Wrap contracts to ensure that Wrap teams fully integrate clinical practitioners into Wraparound team meetings and the Wraparound process. Where independent clinicians are already connected to youth, offer phone participation as an option if actual attendance at Child and Family Team meetings isn't feasible.
- Develop a formal curriculum for Wraparound providers addressing trauma needs and trauma response, other underlying needs and the involvement of informal supports (beyond the parent partner's role).
- The Panel has inquired previously about the significant number of youth who do not successfully "graduate" from the program. The Panel recommends a County study of the reasons for this pattern and follow-up discussions.

## **VII. Glossary of Terms**

ADHD – Attention deficit hyperactivity disorder

CASSP – Child and Adolescent Service System Program, a federal initiative

Child and Family Team (CFT) – A team consisting of the child and family, their informal supports, professionals and others that regularly meet face-to-face to assess, plan, coordinate, implement and adjust the services and supports provided.

Comprehensive Children’s Services Program (CSSP) – Services and supports including a combination of intensive case management and access to several evidence-based treatment practices, including Functional Family Therapy, Trauma-Focused Cognitive Behavior Therapy and Incredible Years.

Coordinated Services Action Teams (CSAT) – A process to coordinate structure and streamline existing programs and resources to expedite mental health assessments and service linkage.

D-Rate – Special rate for a certified foster home for children with severe emotional problems.

DMH – Department of Mental Health

EPSDT – Early Periodic Screening, Diagnosis and Treatment (a process enabling children to get Medicaid support for services, including mental health and developmental services)

ER – Emergency response

FFA – Foster family agency (there are about 13,000 FFA beds in over 60 FFAs and about 7,000 beds in county foster homes)

Full Service Partnership (FSP) – An approach to mental health services that is strength-based, individualized, child and family driven, coordinated and flexible in response to child and family needs.

FGDM – Family Group Decision Making

FM – Family maintenance services, provided for families with children living at home.

Hub – Six regional sites where children will receive a comprehensive medical evaluation, mental health screening and referral for services.

IEP – Individual Education Plan

Intensive Home-Based Mental Health Services (IHBS) – Definition needed

MAT – Multi-Disciplinary Assessment Team

PTSD – Post-traumatic stress disorder

RCL – Rate Classification Level (levels of group home care, with RCL 14 being considered residential treatment; about 2,332 children are in 83 group homes)

RPRT – Regional Permanency Review Teams

TAY – Transitional Age Youth

## **VIII. Appendix**



**Mental Health Services  
for Children and Youth in  
D-Rate and FFA  
Placements**

**June 2012**

## INTRODUCTION

At the request of the Katie A. Panel, we conducted an analysis of the mental health services provided to children and youth in D-Rate and FFA placements. We were particularly interested to identify the more intensive services provided to this population either through enrollee based programs or particular service models/arrays. In part, we wanted to see how these programs/services compared to the concepts of Intensive Care Coordination and Intensive Home Based Services that are contained in the Katie A. State Case Settlement Agreement (2011).

More specifically, this analysis examined youth who were in D-Rate and FFA homes on January 31, 2011 and the mental health services they received six months prior or post this date. Of particular interest were the intensive mental health services provided to this population. Intensive services are defined as enrollee and non-enrollee based program services that include Wraparound and Full Service Partnership (FSP) in addition to service arrays under Comprehensive Children's Services Program (CCSP), Field Capable Clinical Services (FCCS) and other mental health services, such as Therapeutic Behavioral Services (TBS) consistent with the principles of Intensive Home Based Services (IHBS) model. The programs and models that we have identified as "intensive services" are those service arrays that we might expect to be consistent in offering the intensity of services that is provided in IHBS, as defined for this analysis. Please note that Intensive Home-Based Services is not a program but an array of services which we believe is consistent with the IHBS and ICC service elements outlined in the Katie A. State Case Settlement Agreement.

Using these parameters, we found that there were 1,391 youth in D-Rate placements and 4,312 youth in FFA placements. This report will examine the frequency, type and location of mental health services provided to these youth during the identified time frame. Comparisons will be made between intensive service approaches and non-intensive services, e.g., those mental health services not captured in one of the seven mental health service categories named above. Please see addendum for a specific definition of these programs and services.

We would expect that these more intensive service programs and service arrays would provide a higher frequency of services, a more robust mix of services, and often be provided in the home or a suitable home-like setting. In short, these programs and services would be more in line with the kinds of services and supports identified in the County and State Katie A. Settlement Agreements.

## Methodology

The D-Rate/FFA report details mental health services received by children (at least four years of age) in a D-Rate or FFA placement. For the current report, the child was categorized as D-Rate or FFA, when in such a placement as of January 31, 2011. Data was provided in collaboration with the Department of Children and Family Services. Once the placement cohorts were established, children were placed in cross sectional cohorts by mental health program enrollment. This cross sectional analysis is made possible by the weekly Katie A client match which occurs between the Department of Children and Family Services and the Department of Mental Health. This match allows for each respective Department to identify clients with concomitant cases.

Enrollment is utilized in the reporting to establish a period of time within the study period to calculate frequency and intensity of services. This is accomplished by summarizing service types, durations, and costs between the enrollment and disenrollment dates by client. Clients may have received additional services not included in the report due to the service delivery date being outside of the enrollment period. For example, they may have terminated Wraparound services shortly after the beginning of the time period or initiated such services just prior to the end of the study period. The study period for the D-Rate/FFA report was August 1, 2010 through July 31, 2011. The study period allowed DMH staff to examine and summarize services rendered during this time period. DMH was particularly interested to identify the more intensive services provided to this population. It is important to note that some of the programs in this analysis had a small number of youth enrolled and this should be considered when comparing the results across programs.

Client enrollment was determined using the following sources:

<b>Mental Health Enrollment Categories</b>	<b>Source</b>	<b>Criteria where applicable</b>
Comprehensive Children's Services Program (CCSP)	DMH - Child Welfare Division Enrollment Roster	Clients were enrolled in CCSP, receiving some combination of Functional Family Therapy (FFT), Incredible Years (IY) or Trauma-Focused Cognitive Behavior Therapy (TF-CBT).
Field Capable Clinical Services	Integrated System	Clients with at least one FCCS service (plan id 2,058, 2,078) during the study period (08/2010-07/2011) and age 4 and over
Full Service Partnership - Child	FSP Authorization System	Clients were authorized and Enrolled in the Full Service Partnership
Full Service Partnership - TAY	FSP Authorization System	Clients were authorized and Enrolled in the Full Service Partnership
Intensive Home-Based Services	Integrated System	Clients who have received IHBS type services defined as: at least 8 face-to-face visits within a month (a minimum of 4 visits need to be Rehabilitation Services received at home), and at least 2 occurrence of Targeted Case Management, and at least 2 occurrences of Team Conference/Case Consultation
Treatment Foster Care	DMH - Child Welfare Division Roster	Children and Youth enrolled in ITFC or MTFC programs
Wraparound	DCFS - BIS	Children enrolled in either Tier I or Tier II Wraparound

Lastly services compiled during the study period were grouped by type of procedure and categorized in one of the following groups:

<b>Service Type Categories</b>
Collateral
Individual
Individual Rehabilitation
Medication Support
Other Treatment
Targeted Case Management
Team Consultation

## **Mental Health Services for Children and Youth in D-Rate and FFA Placements Chart and Graph Breakdown**

### **Table 1:**

These charts are a breakdown of the number of children that received mental health services from August 1, 2010 to July 31, 2011. There were 1,232 (89%) children and youth in D-Rate homes and 2,998 (70%) children and youth in FFAs that received mental health services during this time period. These charts also show a breakdown of the number of children between various age ranges in these homes. The majority of children and youth at these placements were at least age 14.

### **Table 1D:**

For D-Rate placements, the majority of youth were placed in a D-Rate/Guardian Home, while D-Rate/Relative Home was used less than any of the other D-Rate homes.

### **Table 2A:**

This chart shows the number of children and youth in D-Rate homes that received intensive services during this time period. TFC, FSP-TAY and CCSP had 2, 6 and 10 children and youth, respectively enrolled in their programs. Most of the children and youth in D-Rate homes received Intensive Home-Based Services and/or Wraparound. These small numbers should be considered when making comparisons across programs. The average cost per child is highest in the Wraparound and FSP-TAY programs. While the number of youth served in Intensive Home Based Services was similar to the number served in Wraparound, the total amount of charges incurred was drastically lower with the average cost per child around \$12, 000 as compared to an average Wraparound cost of almost \$19,000.

### **Table 2B:**

This chart shows the number of children and youth in FFA homes that received intensive services during this time period. There were only 8 children and youth enrolled in FSP-TAY, while the majority received Intensive Home-Based Services and/or Wraparound during this time period. The average service cost was highest for Treatment Foster, followed by Wraparound and Full Service Partnership (Child).

### **Table 3A:**

This chart is a breakdown of the types of services provided for children and youth that received Non Intensive Services in D-Rate homes. It also includes the total charges for these services. Over half of the charges for non-intensive services are associated with individual therapy. For children and youth in D-Rate placements, there were also significant costs for individual rehabilitation and medication support.

### **Table 3B:**

This chart is a breakdown of the types of services provided for children and youth that received Non-Intensive Services in FFA placements. It also includes the total charges for these services. Over 65% of the costs associated with non-intensive services for youth in FFAs is associated with individual therapy.

**Graph 1:**

This graph shows the frequency of services provided for each program for children and youth in D-Rate and FFA placements. Children and youth enrolled in TFC, Wraparound and FSP-Child (D-Rate), had higher frequencies of service, on average, than children and youth in CCSP, Field Capable Services, FSP-TAY or FSP-Child (FFA).

**Graph 2:**

This graph shows the frequency of services provided for Intensive Home-Based Services and Non-Intensive Services for children and youth in D-Rate and FFA placements. Children and youth enrolled in Intensive Home-Based Services received a higher frequency of services than children and youth that received Non-Intensive Services.

**Graph 3:**

This graph shows, on average, the services that children and youth received during this time period. Overall, children and youth received more Individual Therapy than any other service type. On average, children and youth enrolled in TFC, Wraparound and FSP – TAY (FFA) received Individual Rehabilitation more than children and youth in other programs. In addition, there was a greater percentage of Team Consultation being provided for children and youth enrolled in Wraparound than in other programs.

**Graph 4:**

This graph shows, on average, the services that children and youth received for Intensive Home-Based Services and Non-Intensive Services during this time period. TBS is the largest component of services provided in the Intensive Home-Based category while Individual Rehabilitation is the primary modality of service provided for children and youth in Non-Intensive Services. Intensive Home-Based services also tend to provide more Team Consultation than Non-Intensive Services while children and youth in the Non-Intensive Services received more Medication Support, on average, than those in the Intensive Home-Based Services category.

**Graph 5**

This graph is a breakdown of the location of services by each program/category. The graph shows that FCCS, FSP-TAY, FSP-Child, Wraparound and IHBS provided the highest amount of services in the home and community. This graph does not provide the breakdown of the types of services being provided in the office (e.g., note writing, team consultation, Medication Support, phone contact, etc.).



**Los Angeles County - Department of Mental Health  
Children in D-Rate and FFA Placement on 01/31/2011 receiving  
Mental Health Services 6 months prior or post placement report**



**Table 1A**

Placement Type	Number of Children in Placement	Number of Children Receiving Mental Health Services	Percentage of Children Receiving Mental Health Services*	Number of Children Matched by DataFlux Match**	Number of Children Not Matched by DataFlux Match***
D-Rate	1,391	1,232	89%	1,353	38
Foster Family Agency Certified Home	4,312	2,998	70%	3,893	419

**Table 1B**

Placement Type	Number of Children Receiving Intensive Services	Number of Children Receiving Non-Intensive Services	Number of Children Receiving Mental Health Services
D-Rate	455	777	1,232
Foster Family Agency Certified Home	745	2,253	2,998

**Table 1C**

Placement Type	Number of Children age 4-8 yrs at placement +	Number of Children age 9-13 yrs at placement +	Number of Children age 14+ yrs at placement +	Total Children
D-Rate	139	441	811	1,391
Foster Family Agency Certified Home	1,465	1,055	1,792	4,312

**Table 1D**

Placement Type / Facility Type	Number of Children age 4-8 yrs at placement +	Number of Children age 9-13 yrs at placement +	Number of Children age 14+ yrs at placement +	Total Children
D-Rate / Foster Family Home	46	111	243	400
D-Rate / Guardian Home	46	233	426	705
D-Rate / Small Home	0	93	136	229
D-Rate / Relative Home	47	4	6	57
FFA / FFA Certified Home	1,465	1,055	1,792	4,312

\*Percentage derived from Number of Children receiving Mental Health Services compared to Number of Children in Placement.

\*\*Numbers derived from client match conducted by DMH - BI using Feb 2012 data.

\*\*\*Numbers derived from clients not matched by DMH - BI using Feb 2012 data.  
+Age calculated at January 31, 2011 while child was in placement



**Los Angeles County - Department of Mental Health  
Children in D-Rate and FFA Placement on 01/31/2011 receiving  
Mental Health Services 6 months prior or post placement report**



**Table 2A**

<b>D-Rate</b>				
<b>Intensive Services</b>	<b>Number of Children*</b>	<b>Total Charges</b>	<b>Total Charges %</b>	<b>Average Cost Per Child</b>
Comprehensive Children's Services Program	10	\$ 65,296.88	0.7%	\$ 6,529.69
Field Capable Clinical Services	46	\$ 253,969.20	2.8%	\$ 5,521.07
Full Service Partnership - Child	53	\$ 749,668.13	8.4%	\$ 14,144.68
Full Service Partnership - TAY	6	\$ 102,884.85	1.2%	\$ 17,147.48
Intensive Home-Based Services	255	\$ 3,039,479.14	34.0%	\$ 11,919.53
Treatment Foster Care	2	\$ 6,212.34	0.1%	\$ 3,106.17
Wraparound	250	\$ 4,727,065.02	52.8%	\$ 18,908.26
<b>Totals</b>		<b>\$ 8,944,575.56</b>	<b>100.0%</b>	

**Table 2B**

<b>Foster Family Agency Certified Home</b>				
<b>Intensive Services</b>	<b>Number of Children*</b>	<b>Total Charges</b>	<b>Total Charges %</b>	<b>Average Cost Per Child</b>
Comprehensive Children's Services Program	59	\$ 294,591.43	3.0%	\$ 4,993.08
Field Capable Clinical Services	74	\$ 252,395.23	2.5%	\$ 3,410.75
Full Service Partnership - Child	62	\$ 831,471.29	8.3%	\$ 13,410.83
Full Service Partnership - TAY	8	\$ 44,001.85	0.4%	\$ 5,500.23
Intensive Home-Based Services	360	\$ 3,138,646.87	31.4%	\$ 8,718.46
Treatment Foster Care	52	\$ 990,238.46	9.9%	\$ 19,043.05
Wraparound	280	\$ 4,434,514.24	44.4%	\$ 15,837.55
<b>Totals</b>		<b>\$ 9,985,859.37</b>	<b>100.0%</b>	

\*Children may have overlapping enrollment periods and summary of child counts does not reflect unique children in placement.

\*\* See Definitions for Program descriptions



**Los Angeles County - Department of Mental Health  
Children in D-Rate and FFA Placement on 01/31/2011 receiving  
Mental Health Services 6 months prior or post placement report**



**Table 3A**

<b>D-Rate</b>			
<b>Non-Intensive Services - Service Type Category**</b>	<b>Number of Children*</b>	<b>Total Charges</b>	<b>Total Charges %</b>
Collateral	604	\$ 507,433.38	9.1%
Individual	697	\$ 3,068,387.49	55.0%
Individual Rehabilitation	220	\$ 603,314.54	10.8%
MedicationSupport	509	\$ 684,716.95	12.3%
Targeted Case Management	225	\$ 324,117.39	5.8%
Team Consultation	385	\$ 161,038.75	2.9%
Other Treatment	430	\$ 229,557.88	4.1%
<b>Totals</b>		<b>\$ 5,578,566.38</b>	<b>100.0%</b>

**Table 3B**

<b>Foster Family Agency Certified Home</b>			
<b>Non-Intensive Services - Service Type Category**</b>	<b>Number of Children*</b>	<b>Total Charges</b>	<b>Total Charges %</b>
Collateral	1718	\$ 1,280,574.13	10.1%
Individual	2159	\$ 8,291,763.11	65.6%
Individual Rehabilitation	463	\$ 864,427.61	6.8%
MedicationSupport	355	\$ 412,708.35	3.3%
Targeted Case Management	927	\$ 778,785.85	6.2%
Team Consultation	908	\$ 310,987.77	2.5%
Other Treatment	1590	\$ 705,381.91	5.6%
<b>Totals</b>		<b>\$ 12,644,628.73</b>	<b>100.0%</b>

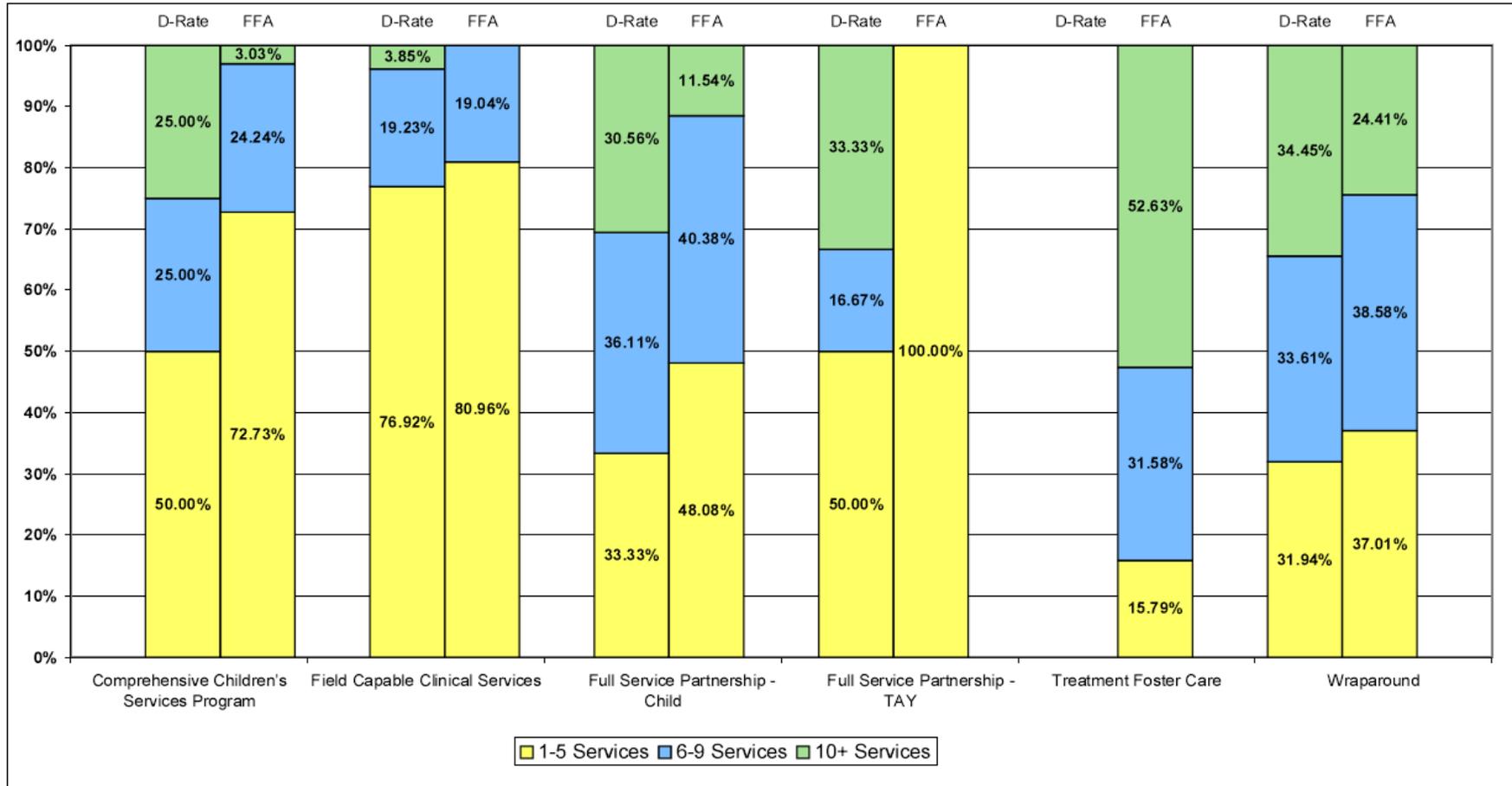
\*Children may have overlapping enrollment periods and summary of child counts does not reflect unique children in placement.

\*\* See Appendix A for Procedures included under each Service Type Category



## Los Angeles County - Department of Mental Health

### Graph 1: D-Rate and FFA Service Frequency in January 2011, Comparison by Service



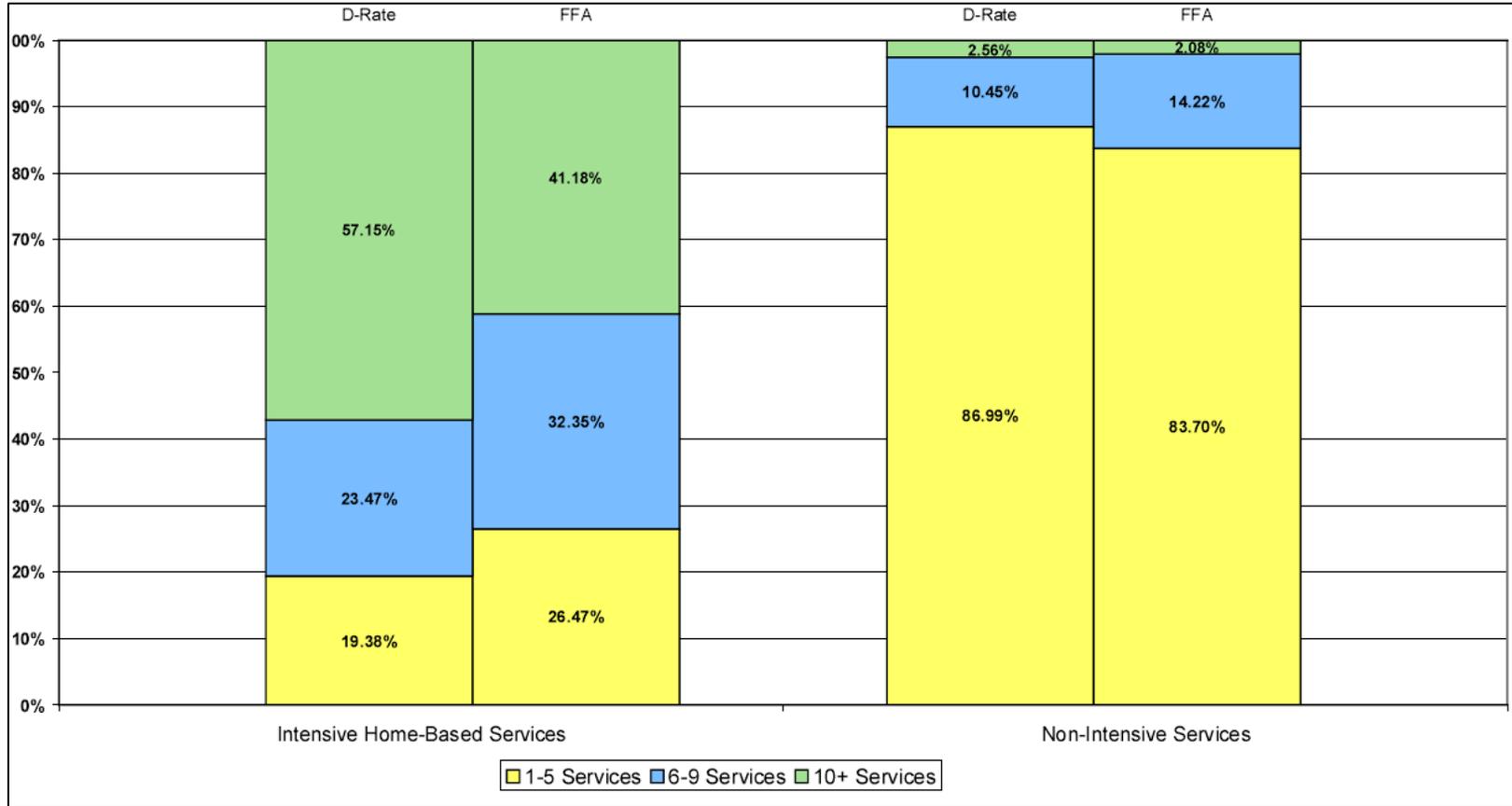
ce Frequency Category: The number of services provided to an individual client receiving Intensive Services in a single month.

Service Frequency Distribution: An average monthly percentage of clients in each Service Frequency Category within an individual Intensive Service.

Servi



**Los Angeles County - Department of Mental Health**  
**Graph 2: D-Rate and FFA Service Frequency in January 2011, Comparison by Service**

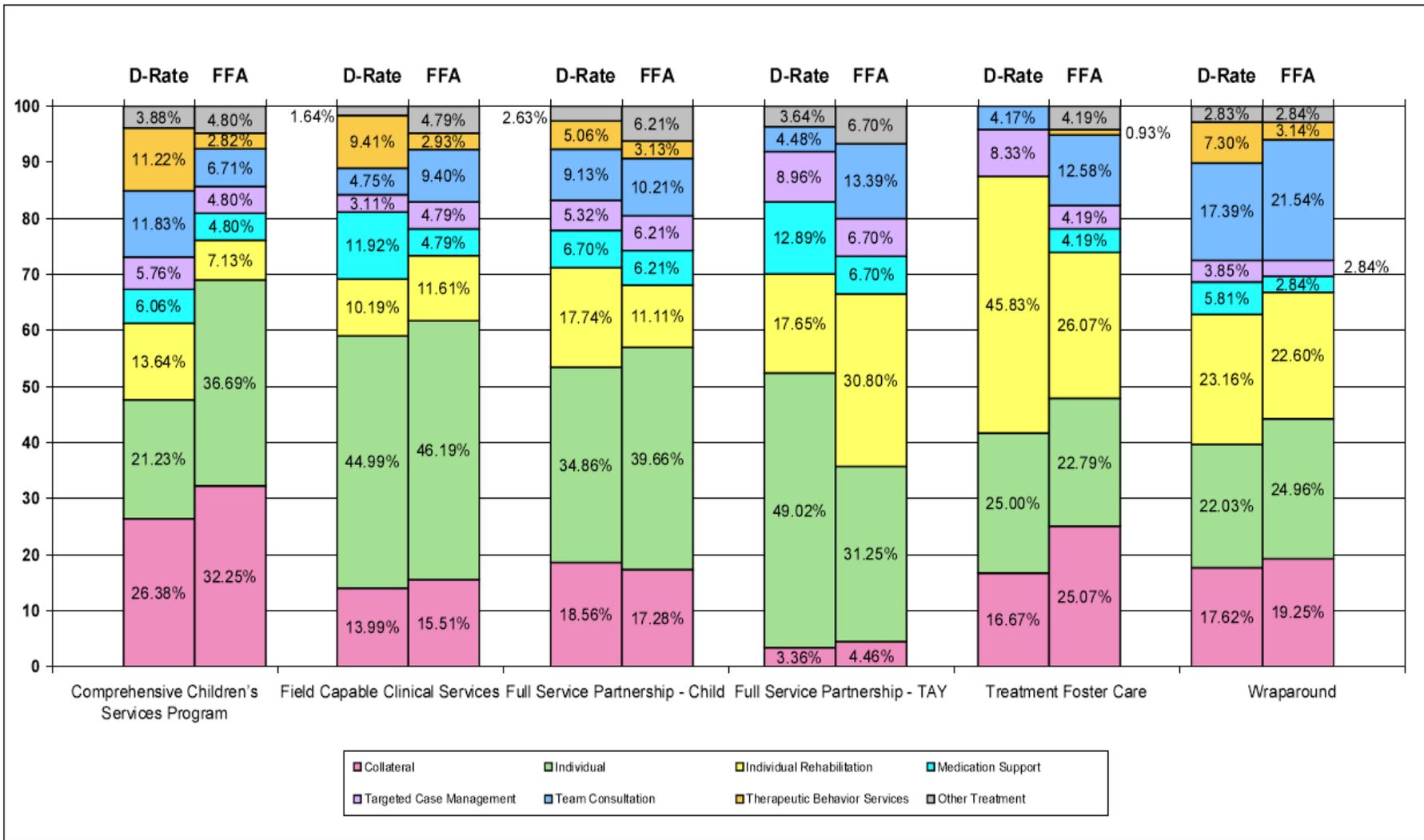


Service Frequency Category: The number of services provided to an individual client receiving Intensive Services in a single month.

Service Frequency Distribution: An average monthly percentage of clients in each Service Frequency Category within an individual Intensive Service.



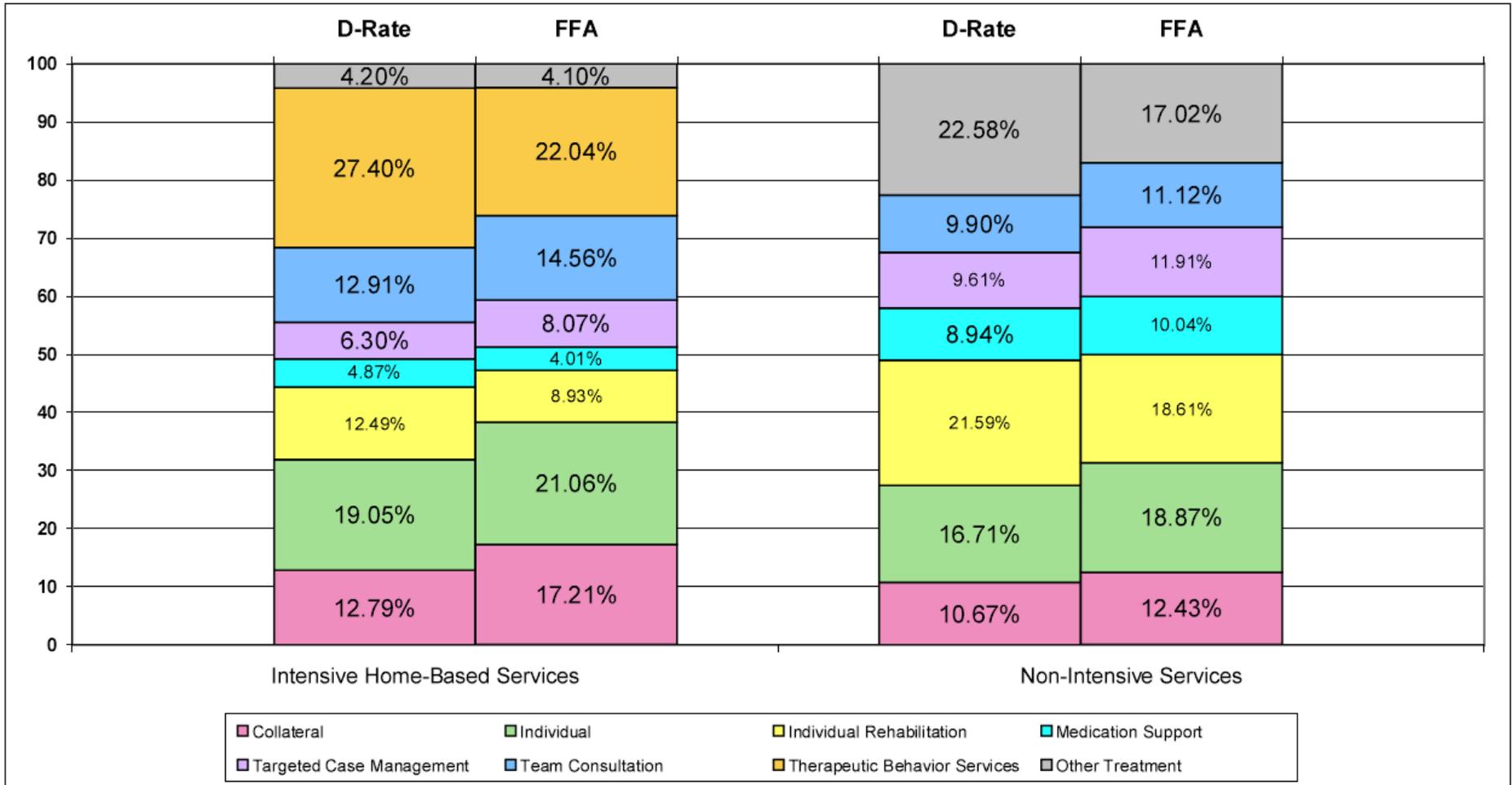
### Los Angeles County - Department of Mental Health Graph 3: D-Rate and FFA Average Client Services Mix



\* Numbers derived from averaging individual client's Service Type received for the time period 08/2010-07/2011 \*\* See Appendix A for Procedures included under each Service Type Category



Los Angeles County - Department of Mental Health  
 Graph 4: D-Rate and FFA Average Client Services Mix

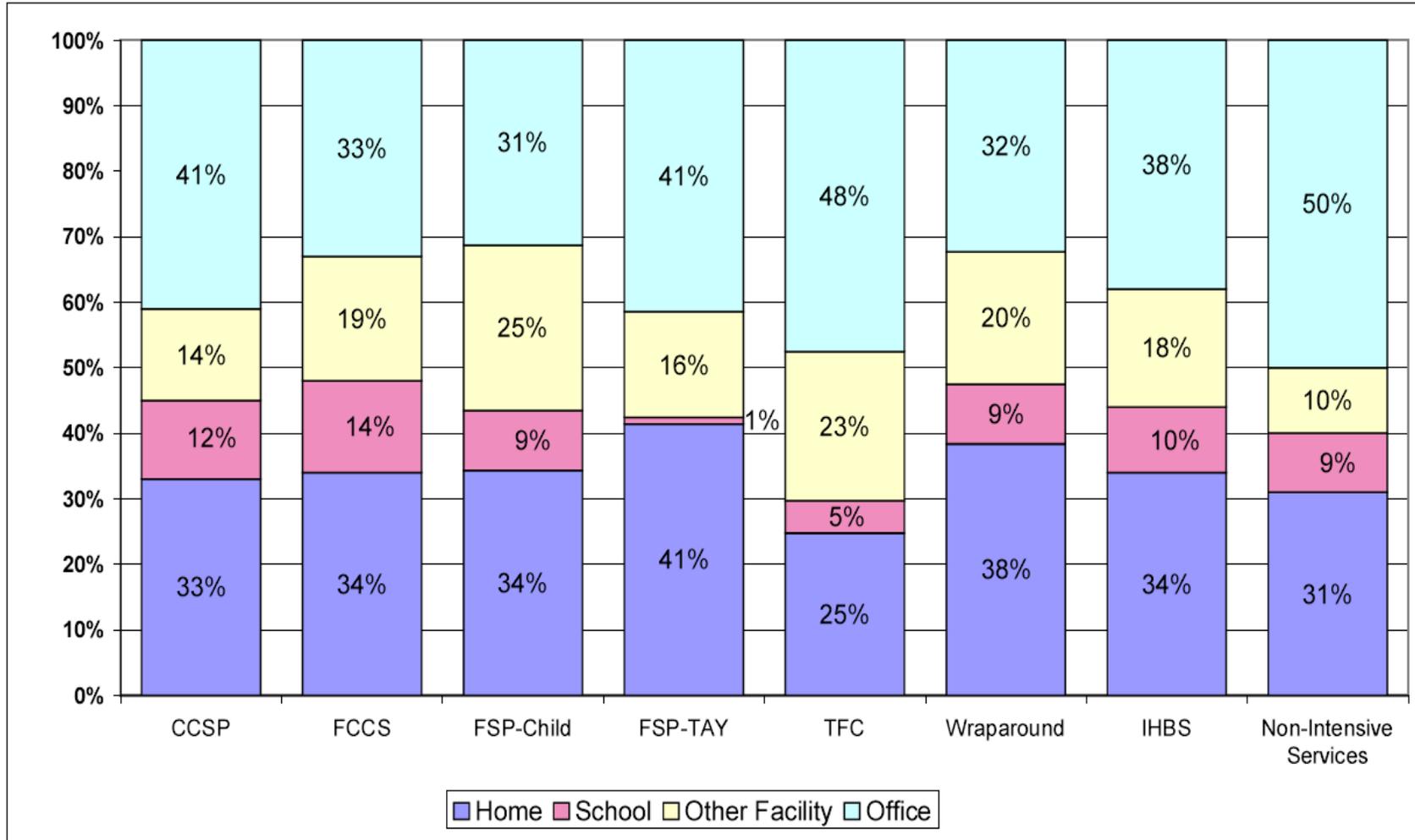


\* Numbers derived from averaging individual client's Service Type received for the time period 08/2010-07/2011

\*\* See Appendix A for Procedures included under each Service Type Category



Los Angeles County - Department of Mental Health  
Graph 5: D-Rate and FFA Location of Service In January 2011, Comparison by Service Location



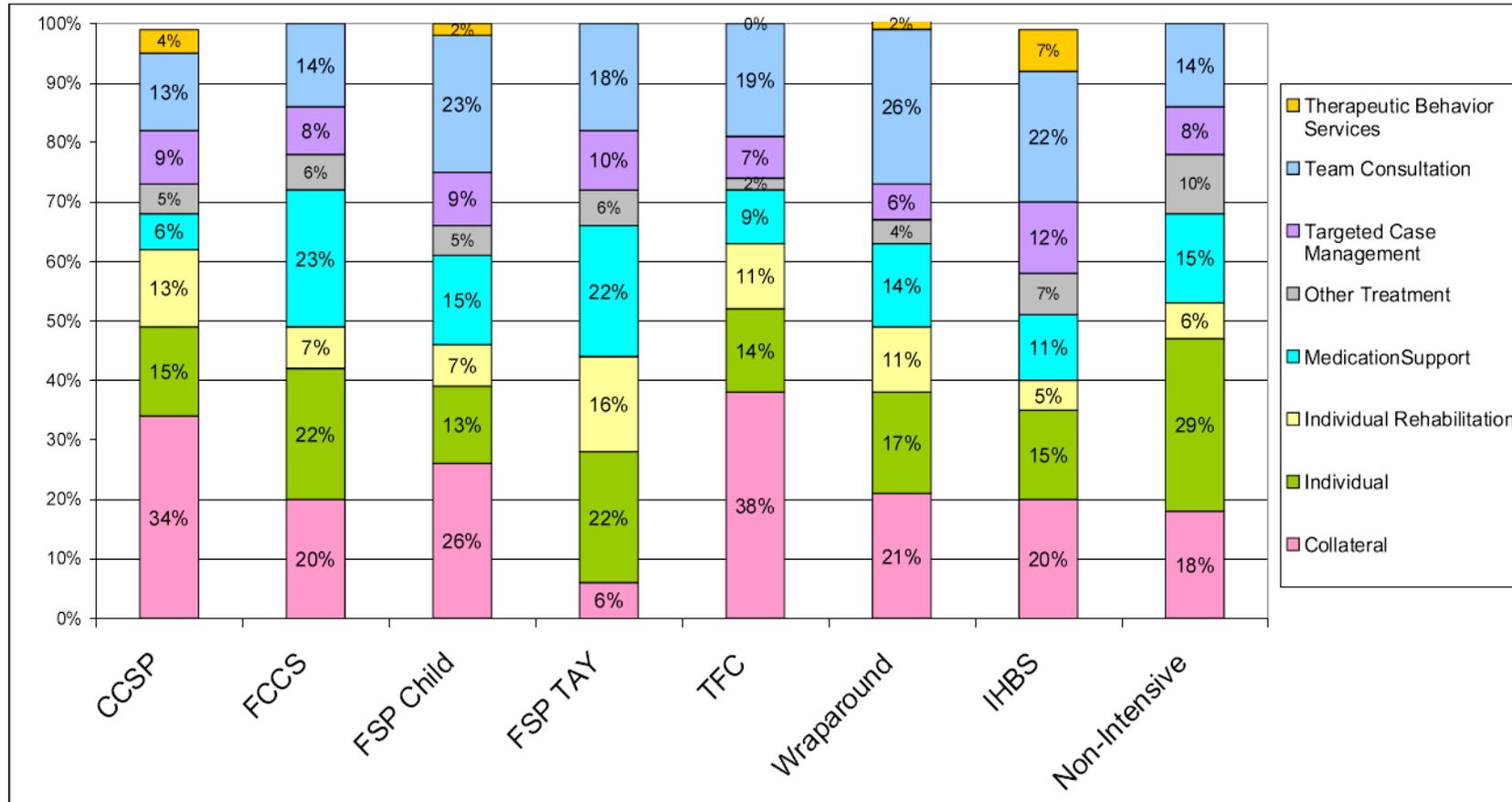
\* Service Location: An average amount of services provided in the various locations

\*\* See Appendix A for description of Office and Other Facility



## Los Angeles County - Department of Mental Health

### Graph 6: D-Rate and FFA Office Location Breakout by Service Mix



\* Breakout of top 5 services provided in the Office Service Location  
 Please refer to Graph 5 of the June 2012 D-Rate FFA Placements Report

## SUMMARY OF FINDINGS

This section is a summary of the mental health services provided to youth in D-Rate and FFA placements.

We found that 89% of the children and youth placed in D-Rate homes received mental health services (both intensive and non-intensive) compared to 70% of the children and youth in FFAs. Thirty-seven percent of children and youth in D-Rate placements received intensive services with the Intensive Home-Based Services array and Wraparound being most commonly provided. The least common intensive service modality for children and youth in D-Rate homes was Treatment Foster Care with less than 1% of this population receiving this service model. (It should be noted that TFC services are only available to children/youth placed in FFAs.)

By comparison, 25% of the children and youth in FFAs received intensive services with, again, the most common service vehicles being our Intensive Home-Based Services array and Wraparound. The least common intensive service model provided to children and youth in FFAs was FSP-TAY, with less than 1% of this population receiving this service model.

Non-Intensive mental health services were provided to 63% of the D-Rate population and 75% of the FFA population over this period of time. Children and youth that received mental health services while placed in D-Rate or FFA homes, more often than not received non-intensive mental health services.

Prior to data analysis, our hypothesis was that those programs/models that were included in the "intensive services" would be closely in line with the concept of Intensive Care Coordination and Intensive Home-Based Services that are contained in the Katie A. State Case Settlement Agreement (2011). While some of the programs and models that we have identified as "intensive services" seem to provide the depth of services similar to those that are provided in IHBS (e.g., TFC and Wraparound), other programs and models that we have included in this category, have not provided the intensity of services originally hypothesized (e.g., CCSP and FCCS).

### Service Frequency

When analyzing the frequency of services youth received while in D-Rate and FFA placements, youth in the more intensive service programs consistently received a greater frequency of services than youth that were engaged in Non-Intensive Services. In particular, Wraparound, Treatment Foster Care (FFA), FSP-Child, and Intensive Home-Based Services had more than half the youth in their respective programs receive six or more services in a given month. More specifically, Treatment Foster Care and Intensive Home-Based Services (D-

Rate) had more than 50% of youth receive ten or more services in a given month.

Not surprisingly, for D-Rate homes, some of the most intensive service models carried the highest costs - Wraparound followed by FSP-Child and Intensive Home-Based Services. While FSP-TAY (D-Rate) did not provide a high frequency of services, it had one of the highest service costs. For FFAs, some of the most intensive service models also carried some of the highest costs – Treatment Foster Care followed by Wraparound and FSP-Child. The least costly “intensive” programs were the Children’s Comprehensive Services Program and Field Capable Clinical Services.

In comparison, youth not receiving intensive services, the “Non-Intensive group”, had more than 80% of youth receive less than six services in a given month. Over half the costs of these non-intensive services was associated with individual therapy.

### Service Type

This analysis also examined the various types of mental health services offered to youth in D-Rate homes and FFAs such as Individual Therapy, Collateral, Individual Rehabilitation, Medication Support, Targeted Case Management, Team Consultation, Therapeutic Behavior Services and Other Treatment. For the purpose of this report, we have identified support services that may be a greater indicator of intensive services being provided such as Targeted Case Management, Rehabilitation Services, and Therapeutic Behavioral Services.

Essentially, Targeted Case Management are services that a family might need to assist in accessing resources aimed at helping the youth build the necessary skills to function successfully in the home and community. Rehabilitation services, on the other hand, are services aimed at improving, maintaining, or restoring daily living, social and leisure activities. Within the “intensive” programs, ample use of Rehabilitation and Targeted Case Management was made by Wraparound, Treatment Foster Care, and just to a lesser extent by Full Service Partnership Programs. We also see that in some instances these intensive service models are augmented with Therapeutic Behavioral Services, which include within them Targeted Case Management and Rehabilitation elements.

Of course, children and youth who received our Intensive Home Based Services model received significant amounts of Targeted Case Management, Rehabilitation and Therapeutic Behavioral Services.

Interestingly, children and youth who did not receive intensive services had a significant portion of their treatment provided through Rehabilitative Services and Targeted Case Management.

Overall, the data shows that although youth in some of the intensive services, such as Treatment Foster Care and Wraparound, were provided a greater

amount of Rehabilitation services when compared with Non-Intensive Services, youth in the Non-Intensive Services received more Targeted Case Management.

While some of the intensive services provided more in-depth services to youth through models/service arrays such as TFC, Wraparound and Intensive Home-Based Services, others are lacking in providing the array of services that are expected in an intensive service.

### Service Location

For the purpose of this analysis, service location was divided into four categories; services provided in the youth's home, services provided in the youth's school, services provided in the office and services provided in any other facility (group home, emergency room, psychiatric residential treatment center, unlisted facility, etc.). When compared to the more intensive programs and services, Non-Intensive Services were provided, on average, more frequently in the office. Further analysis might be beneficial to gain a more complete understanding of the specific types of services being offered in the various locations.

Overall, based on this data, clients in the more intensive service models received more intensive services than youth that received Non-Intensive Services, evidenced by youth receiving a greater frequency of services, services typically geared toward improving daily living skills and access to community resources, as well as, receiving a greater proportion of services in their home and community. Finally, it is important to note that a significant number of children and youth receive an intensive level of a service array that is consistent with the Katie A. State and County cases while not being enrolled in one of the County's intensive service models.

# APPENDIX

## DEFINITIONS

**D-Rate** – DCFS client found to be in a D-Rate level placement on January 31, 2011

**FFA** – DCFS client found to be in a Foster Family Agency placement on January 31, 2011

**Intensive Services:** Client found to be a concomitant client of DCFS and DMH. Client is also receiving one of the following Intensive Services:

- **Comprehensive Children’s Services Program** – CCSP provides 24/7 intensive case management for children ages 3-17, as well as access to one or more of the following EBPs\*\*:
  - Incredible Years (IY)
  - Trauma Focused Cognitive Behavioral Therapy (TFCBT)
  - Functional Family Therapy (FFT)
  
- **Field Capable Clinical Services** - The FCCS program is designed to provide services to individuals who are isolated, unwilling or unable to access traditional mental health outpatient services due to location/distance barriers, physical disabilities, or because of the stigma associated with receiving clinic-based services.
  
- **MHSA Full Service Partnership – Child** - The FSP program is for children ages 0-15 and their families who would benefit from, and are interested in participating in, a program designed to address the total needs of a family whose child (and possibly other family members) is experiencing significant emotional, psychological or behavioral problems that are interfering with their wellbeing. The FSP program provides comprehensive, intensive mental health services for children and their families in their homes and communities. \*\*
  
- **MHSA Full Service Partnership – Transition Age Youth (TAY)** - The FSP Program is designed for Transition Age Youth ages 16-25 who could benefit from and are interested in participating in a program that can help address emotional, housing, physical health, transportation, and other needs that will help them function independently in the community. The FSP program provides comprehensive, intensive mental health services for individuals in their homes and communities. \*\*

- **Intensive Home-Based Services** – A client is considered to be receiving intensive home-based services if
  1. The client has received Therapeutic Behavioral Services during the study period, or
  2. For any 30-day period, intensive home-based services are defined as receiving the following:
    - At least 8 face-to-face visits (a minimum of 4 visits need to be Rehabilitation Services received at home), and
    - At least 2 occurrence of Targeted Case Management, and
    - At least 2 occurrences of Team Conference/Case Consultation
  
- **Treatment Foster Care (TFC)** - provides a cost-effective individualized treatment alternative to children and youth whose psychosocial and/or behavioral needs cannot be met in their current home setting. Due to the severity of needs, these youth would be at risk for more restrictive placement settings in the absence of a TFC home. TFC provides individualized Intensive Home Based Services and Intensive Care Coordination where children learn and practice appropriate behavioral and social skills in a supportive, home-like environment, generally in their own community and close to their own family and school. TFC foster parents are professionally trained caregivers who are supported by their Foster Family Agency TFC team 24 hours per day.
  
- **Wraparound** - Wraparound is an integrated, strength-based, family and community centered approach designed to stabilize children into long-term and permanent settings with the support of specialized comprehensive services. It includes a commitment to create a Child and Family Team to develop and implement uniquely tailored Plans of Care that include the strategies, services and supports to provide “whatever it takes” to address the needs of the child and family in order to maintain the child in a safe, nurturing, permanent community-based setting. \*\*
  
- **Non-Intensive Services** - Client found to be a concomitant client of DCFS and DMH who is not receiving one of the following mental health programs: CCSP, FCCS, FSP, TFC, Wraparound and IHBS, but may be receiving other mental health services provided by Los Angeles County Department of Mental Health.

\*\* Source of definitions - <http://lacdcfs.org/katieA/LOG/>

<b>Service Type</b>	<b>Code</b>	<b>Procedure Description</b>
Collateral	90887	Collateral
Individual	H2011	Crisis Intervention
	S9484	Crisis Stabilization in ER
	90847	Family Therapy with Client
	H0046	Indiv Ther minimum 0-19
	90804	Indiv Ther minimum 20
	90806	Indiv Therapy 45-74 min
	90808	Indiv Therapy 75+ min
	90802	Interactive Psych Diag
	90810	Play Therapy minimum 20
	90812	Play Therapy 45-74 min
	90814	Play Therapy 75+ min
	90801	Psych Diagnostic Serv
	90805	Ther-E&M minimum 20
	90807	Ther-Eval&Man 45-74 min
	90809	Ther-Eval&Man 75+ min
Individual Rehabilitation	H2025	Emp Maintenance Support
	H2015	Indiv/Gp Rehab
Medication Support	M0064	Brief Med Visit
	H2010	Indiv/Gp Rehab Med
	90862	Indiv Medication
	H0033	Oral Medication Administration
Targeted Case Management	T1017	Targeted Case Management
Team Consultation	G9007	Case Conference Attendance
	99361	Case Consult to 59 min
	99362	Case Consult 60 min or more
	H0032	Team Plan Development
Therapeutic Behavior Services	H2019	Therapeutic Behavior Serv

<b>Service Type</b>	<b>Code</b>	<b>Procedure Description</b>
Other Treatment	0101	Acute Hosp-Admin Day
	0100	Acute General Hospital - PDP
	H0002	Behavioral Health Screening
	H2012	Day Rehabilitation, Full Day
	99261	E&M Consult Follow - low
	99255	E&M Consult New IP 110+
	99243	E&M Consult OP 40-59 min
	99244	E&M Consult OP 60-79 min
	99245	E&M Consult OP 80+ min
	90853	Group Therapy
	0183	IMD Pass Day
	90857	Interactive Gp Therapy
	90849	Multi-fam Gp Therapy
	90889	No Contact – Report Writing
	06057	PG Administration
	H2013	Psychiatric Health Fac
	96101	Psych Testing by psych or psychol
	96102	Psych Testing by technician
	90885	Record Review
	H0019	Semi-Supervised Living

### Service Location

<b>Service Location</b>	<b>Description</b>
Other Facility	Assisted Living Facility
	Custodial Care Facility
	Emergency Room - Hospital
	Group Home
	Homeless Shelter
	Inpatient Hospital
	Inpatient Psychiatric Facility
	Nursing Facility - with STP
	Other Unlisted Facility
	Outpatient Hospital
	Prison/Correctional Facility
	Psychiatric Residential Treatment Center
	Residential Substance Abuse Treatment Facility
	Skilled Nursing Facility - w/o STP
	State or Local Public Health Clinic
	Temporary Lodging
	Urgent Care
	Office
Community Mental Health Center	

## Panel-DCFS-DMH WRAP QSR REVIEW FINDINGS

In July 2012 the Quality Improvement Section of the Los Angeles County Department of Children and Family Services (DCFS), with the collaboration of the Los Angeles County Department of Mental Health (DMH) and Katie A. Panel, conducted a Quality Service Review (QSR) of 20 children in Wraparound Tier II. Wraparound is an integrated, multi-agency, community-based process of ensuring that children thrive in permanent homes with informal supports. Los Angeles County has provided Wraparound to families and their children with multiple needs since 1998.

QSR is an innovative case review process designed to stimulate change to improve practice performance by evaluating key outcomes for children and families. Unlike an audit that is compliance-based and focused on the individual, QSR centers on opportunities for practice development system wide. QSR specifically measures the quality of interactions between all parties of the child welfare system; DCFS, DMH, Wraparound, community service providers, the legal system, etc. with the family and their informal supports. The QSR process provides a “big picture” view of case practice that recognizes the unique role and involvement of not only the Wraparound team, but all other key players that are significant to the children and families reviewed.

### LA County Wraparound<sup>2</sup>

In FY 2010-11, Wraparound in Los Angeles County provided support to 4,248 children and their families, a 40% increase from the previous year. Tier II Wraparound was launched in 2009. Tier II children have an open DCFS case, full scope Medi-Cal, and a mental health need or behaviors that place them or others at risk of harm. The monthly Wraparound case rate for Tier II children is \$1,250 (compared to \$4,184 for Tier I). In the past year, total Tier II enrollment increased from 966 to 2,031 (Tier I enrollment increased from 2,068 to 2,217). At the time of the Wrap QSR, there were about 1,300 open Tier II Wraparound cases in 34 different contract agencies throughout the County.<sup>3</sup> Of the Tier II cases, 51% were male and 49% were female. The average age of Tier II children was 13 (the average age of Tier I children was 15). Tier II children were 62% Hispanic, 27% African American and 8% Caucasian. At the time of their enrollment in Wraparound, 70% of Tier II children were either at home or with a relative and 30% were in a foster home, group home or juvenile detention. At the time of graduation, 84% were at home, placed with a relative or living independently. The average length of stay for Tier II children who graduated was 12 months; 77% of Tier II children had no out-of-home placements during the 12-month period after Wraparound graduation. The three largest diagnostic categories for children in Tier II Wraparound were Disruptive Disorder (30%), Mood Disorder (26%), and Anxiety Disorder (11%); 21% had no mental health diagnosis at referral. Tier II graduates averaged a 55% decrease in the Child and Adolescent Functional Assessment Scale (CAFAS) scores (99 to 45). Of Tier II children, 404 graduated in 2011 and 317 were disenrolled; 60% of the disenrollments were

---

<sup>2</sup> Data is from the February, 2012, Wraparound 2011 Annual Report.

<sup>3</sup> The providers and the number of Tier II children being served at the time of the review were: ALMA (27), Amanecer (15), Aviva (57), Bienvenidos (31), Children’s Bureau (27), Child & Family Center (16), Child & Family Guidance Center (10), Children’s Institute (78), Childnet (22), D’Veal (27), EMQ (29), Five Acres (37), Florence Crittenton (112), Foothill (31), Gateways (14), Hathaway-Sycamore (76), HELP Group (42), Hillside (17), HVG-Bayfront (16), IMCE (36), LA Child Guidance (16), Masada (9), Olive Crest (15), Penny Lane (88), PIC (25), St. Anne’s (18), SCHR (9), Starview (169), SFVCMHC (34), San Gabriel (30), SSG (56), Tarzana (16), Vista Del Mar (48), and Village Family Services (45).

because of early termination of court jurisdiction or move to another area and 40% were an unsuccessful outcome (usually the family chose not to continue).

### Selection of the 20 Reviewed Cases

For the Wrap QSR, review cases were selected using a quasi random method from the population of open Wraparound Tier II cases within each of the 18 DCFS offices to ensure that each of the 18 DCFS offices and 20 different Wraparound providers were sampled. An agency servicing a catchment area was aligned with each office and then the cases were randomly selected to control for a representation of cases from each office and the requisite number of Wrap agencies. Backup cases were also randomly selected because of the likelihood that not all families would consent to or be available for the review. Last minute cancellations by families meant that Tier II Wraparound cases were included from 16 of the 18 DCFS offices with four offices having two randomly selected cases.<sup>4</sup> Nineteen of the 34 Wrap Agencies were represented in the sample.

### The QSR Method

The review was conducted utilizing the QSR Protocol developed by Human Systems Outcomes, Inc., and refined specifically for Los Angeles County DCFS by a team of staff from DCFS, DMH and other stakeholders. QSRs using the protocol have been completed in all the DCFS offices (see baseline data at the end of this report). The protocol provides a specific set of indicators to examine the status of the child and parent/caregiver and to analyze the responsiveness and effectiveness of practice. Both status and practice indicators are scored using a six-point Likert scale. Score of 6 is considered an optimal (most favorable) score, and score of 1 is adverse (poor). Scores of 6 and 5 are considered “Optimal” and “Good” respectively and require maintenance; scores of 4 and 3 are considered “Fair” and “Marginal” and require refinement, and scores of 2 and 1 are considered “Poor” and “Adverse” and require improvement. Scores in the range of 6, 5, and 4 are considered “Acceptable”, and scores in the range of 3, 2, and 1 are considered “Unacceptable”.<sup>5</sup>

The indicators are scored by the reviewers using varying time parameters, focusing on events that have already occurred and/or on recent processes that have been and are continuing to occur at the time of review. The QSR Protocol provides ten qualitative indicators for measuring the current status of a focus child and the child’s parent and/or caregiver. Status is usually determined for the most recent 30-day period, unless stated otherwise in the indicator. Status indicators measure Safety; Stability; Permanency; Living Arrangement, Health/Physical Wellbeing; Emotional Wellbeing; Learning and Development; Family Functioning; Caregiver Functioning; and Family Connections.

Practice indicators measure the extent to which core practice functions are applied successfully by practitioners and others who serve as members of the child and family team, including the youth/family’s informal supports. The timeframe for reviewing practice performance is the past 90 days. Practice indicators measure Engagement; Voice; Teamwork; Assessment-Child; Assessment-Family;

---

<sup>4</sup> Belvedere, Compton, El Monte, Glendora, Lancaster, Metro North, Pasadena, San Fernando Valley, Santa Clarita, Santa Fe Springs, South County, Torrance, Vermont, Wateridge, West LA, and West San Fernando Valley.

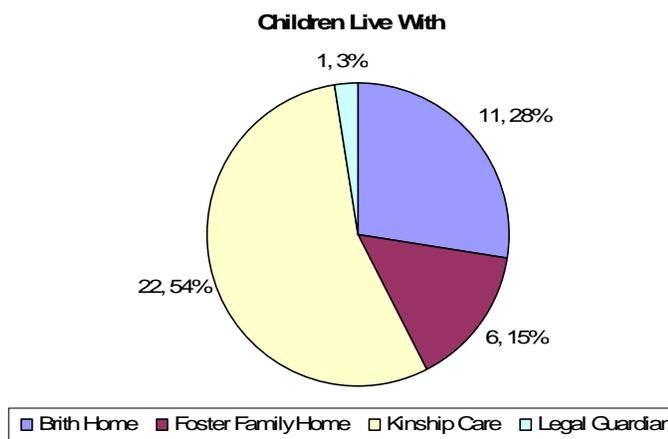
<sup>5</sup> For a detailed description of the indicator ratings, please see Appendix 2.

Assessment-Caregiver; Long Term View; Planning; Supports and Services; Intervention Adequacy and Tracking and Adjustment.<sup>6</sup>

Each of the 20 cases was reviewed by a team of two reviewers who did a day and a half of interviews and scored the protocol together.<sup>7</sup> An average of 10 individuals were interviewed in each case review (a range of 7-13 interviews were done, usually including the DCFS CSW, child, caregiver, parent(s) if different from caregiver, Wrap Facilitator, Wrap Parent Partner, Wrap Child and Family Specialist, and some therapists; school was on vacation but some school staff were interviewed). In addition to giving feedback at the end of the review to the CSW and SCSW and presenting a case description attended by Wraparound providers, DCFS, DMH and the Panel, each team also prepared a 6-8 page detailed review summary, completed a Wraparound-specific questionnaire and submitted their scoring sheet.<sup>8</sup>

### Overview of the 20 Review Cases

Of the 20 cases in the sample, 11 children were living in their birth home, 6 in a foster family home, 2 in a kinship care home, and 1 with a legal guardian while participating in Wraparound.

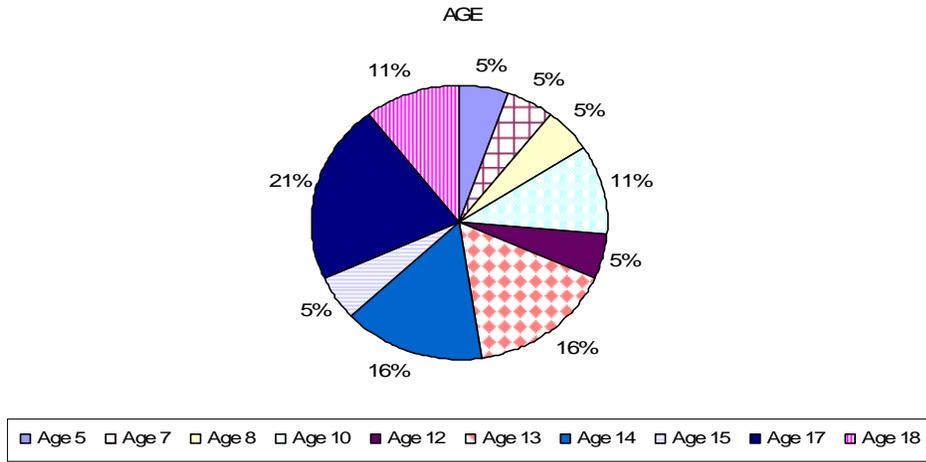


Of the 20 cases, 14 were male and 6 were female. The 20 cases ranged from 5-18 years old: 5 (1), 7 (1), 8 (1), 10 (2), 12 (1), 13 (3), 14 (3), 15 (1), 16 (1), 17 (4), and 18 (2).

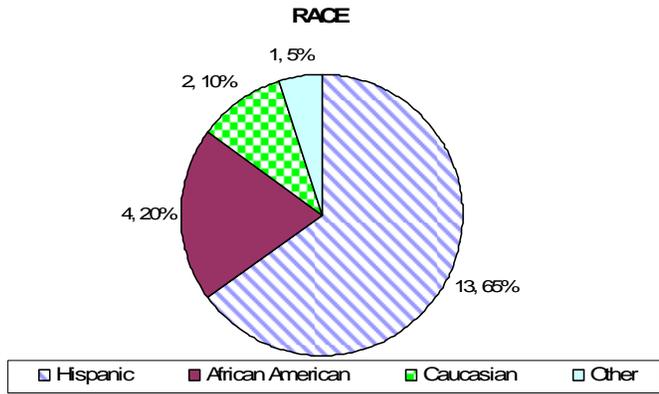
<sup>6</sup> For a detailed description of status and practice indicators see Appendix 1.

<sup>7</sup> The Wrap QSR was a remarkable collaborative process of designing and implementing the review: a total of 28 reviewers were involved in the 20 Wrap cases reviewed: DCFS QSR staff (11), DMH QSR staff (3), DCFS Wraparound staff (4), DMH Wraparound staff (1), other DMH (4), other DCFS (2), and Katie A. Panel (3); the Katie A. Panel members reviewed a total of 8 cases. There were 11 cases involving Spanish-language interviews and translators were used for 9 of those cases.

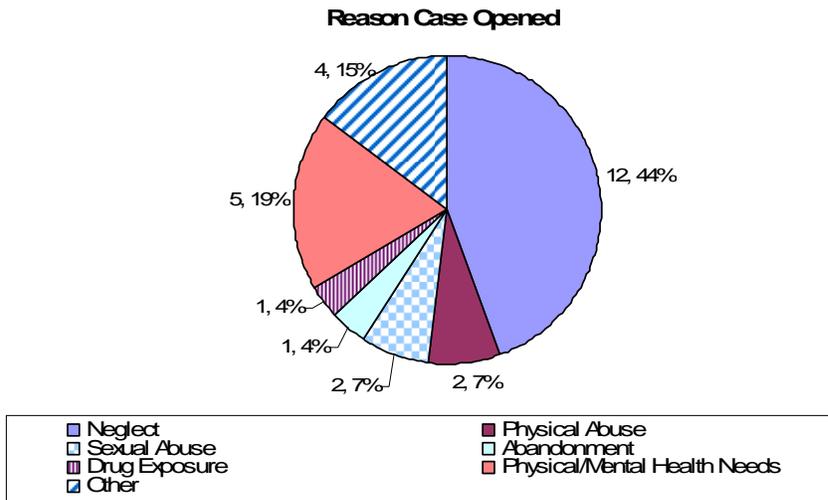
<sup>8</sup> Doing this first-ever multi-office, multi-provider countywide QSR was a monumental undertaking. The reviewers are grateful for the generosity of families, Wraparound providers, and DCFS and DMH interviewees—without their stories, practice and outcomes cannot be improved. We are also appreciative of the time and patience of the DCFS and DMH QSR staff and the DCFS and DMH Wraparound staff in arranging the complicated logistics of 193 interviews by 28 reviewers in 16 DCFS offices and 19 Wraparound providers.



Of the 20 cases, 13 were Hispanic, 4 were African American, 2 were Caucasian and 1 was other.

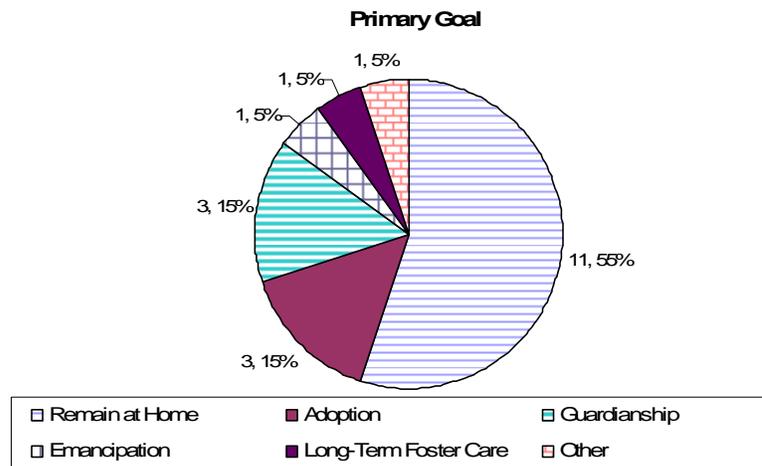


Of the 20 cases, 12 were open for neglect, 2 for physical abuse, 2 for sexual abuse, 1 for abandonment, 1 for drug exposure as a newborn, 5 for physical or mental health needs of the child, and 4 for other reasons.



Of the 20 cases, 3 had been open to DCFS less than a year, 7 for 13-18 months, 4 for 19-36 months, 4 for 37-60 months and 2 for more than 60 months. In the 20 cases, the average length of time this CSW had been assigned to the case was 18 months, and the average number of caseworkers assigned to the case was 3. The average size of the caseload carried by the CSWs in the 20 reviewed cases was 30 cases.

The primary goal of the 20 cases was remain at home (11), adoption (3), guardianship (3), emancipation (1), long-term foster care (1), and other (1).



The 20 reviewed children had the following diagnoses (some had more than one): Depression-8 (including Major Depressive Disorder-2); ADHD-7; Anxiety-4; PTSD-2; Pervasive Developmental Disorder-1; Intermittent Explosive Disorder-1; Mood Disorder-1; Enuresis-2; Auditory Processing Disorder-1; and Phonological Disorder-1. Several youth had one or more psychiatric hospitalizations prior to Wraparound involvement.

Of the 20 reviewed children, 12 were not taking psychiatric medications. Eight were prescribed the following psychiatric medications (some were taking more than one): Celexa-1 (SSRI antidepressant); Concerta-1 (ADHD stimulant); Desmopressin-1 (bedwetting); Guanfacine-1 (ADHD nonstimulant); Lexipro-1 (SSRI antidepressant, antianxiety); Prozac-2 (SSRI antidepressant); Risperdal-1 (antipsychotic); Ritalin-1 (ADHD stimulant); Seroquel-1 (antipsychotic); Tenex-1 (bedwetting); and Vyvanse-2 (ADHD stimulant). Five were prescribed 1 psychiatric medication, 2 were prescribed 2 psychiatric medications, and 1 was prescribed 4 psychiatric medications.

### Strengths Of Wraparound

The Wraparound QSR of 20 cases demonstrated the power of these intensive home-based services. Most of the reviewed children had complex mental health needs and many traumatic experiences, often with long histories of DCFS involvement. In all 20 cases, there was a functioning team with child, parent/caregiver, and Wraparound Facilitator, Wraparound Parent Partner and usually Wraparound Child and Family Specialist. Most children had therapists. In most cases, Wraparound was able to build on child and family strengths to get services quickly in place to support the child at home or in making a transition to a new home and/or school. Three brief success stories from the 20 reviewed cases provide a window on Wraparound services:

BB is a 10-year old Latino male living with his mother and three siblings. When BB was 8, he and his 11-year old sister were placed with their father when their mother was arrested with her boyfriend for drug sales and went to jail. Three months later their father had a drunk driving accident with the children in the car and the family was referred for Family Preservation Services. After nine months, BB's father had deteriorated and was not able to keep the children safe. BB and his sister were returned to their mother who was living with relatives and caring for her two youngest children. In addition to the painful breakup of his parents, the loss of his mother, mistreatment by his father, and changes in placement, BB was also affected by his father's rejection after they left his home. Although he was working at grade level in 4<sup>th</sup> grade, BB was easily frustrated and had unmanageable angry behavior at home and school culminating in possible expulsion for stabbing a classmate with a pencil. Wraparound helped BB's mother persuade the school not to expel him. After only three months of Wraparound, the reviewers observed numerous significant improvements, and BB and his mother were enthusiastically participating on the team and in services.

KG is a 7-year old African American male in a relative placement with two of his eight siblings. Since 2007 DCFS received 17 emergency response referrals for this family. The children were removed in 2009 because their father was incarcerated, their mother was abusing substances and the children had inadequate supervision and were exposed to sexual behavior. KG spent the first 8 months in care in an FFA home and then he and two siblings were placed with relatives. He was subsequently removed after being sexually victimized by his older sibling, but KG quickly returned after a safety plan was developed. Their father completed court-ordered programs, but because their mother did not and their parents wanted to stay together, TPR has been filed. His caregivers are identified as an adoptive resource for KG. KG receives TF-CBT once weekly from the Wraparound therapist who also offers conjoint therapy once a month. For awhile KG received TBS, and now the Wraparound Child and Family Specialist provides behavior guidance for KG several times a week. The Parent Partner provides weekly support to the caregivers for KG's behaviors. A year of Wraparound services has helped KG with his aggression, his school behavior has improved, and his work is above grade level.

MB is a 14-year old Latino male living with his mother, adult sister and her daughter in a one-bedroom. His family had 23 referrals to DCFS, and his mother received Voluntary Family Maintenance. On 3/11, his mother asked that MB be removed and he was placed in three foster homes prior to recent reunification. MB has a lengthy trauma history: loss of his father who was deported after he was convicted for sexually abusing MB's half-sister, finding out that his father sexually abused his sister from a court report; the loss of his mentally ill brother whose whereabouts are unknown; removal from his mother; and multiple placements in foster care. The CSW has had the case for five months and everyone agrees she goes above and beyond to help the family. Even though adoption was recommended, when the CSW received the case, she listened to MB and his mother about their desire for reunification. Wraparound has been involved with the family for a year; the Wrap Facilitator and the Child and Family Specialist each meet with the family weekly, and the Parent Partner meets with the mother at least once a week (often several times a week) to help her search for employment, secure funding sources, and improve her parenting skills. MB has had the same therapist for more than a year. He and his mother also participate in conjoint therapy. MB is smart and resilient - having missed most of the 7th grade, he was able to graduate from 8th grade and earn an award from the Board of Supervisors for the Most Improved in school.

In addition to these examples of outstanding engagement of children and families, two reviewed cases received the highest QSR score for teamwork:

CM is a 13-year old Latina female living with her mother and older sister. The DCFS case was opened in 6/10 for emotional abuse by her mother who had become depressed when CM's father left. Voluntary Family Maintenance was initiated, three more referrals for physical and emotional abuse were substantiated, her father could not be found, and CM and her sister were placed in a foster home 40 miles from their mother in 11/10. In 1/11 CM and her sister were placed with relatives closer to their mother. CM became suicidal, and was hospitalized for two weeks for depression. The relationship between the initial CSW and mother was poor, but the CSW referred to Wraparound which had strong positive engagement with mother and children. The Wraparound team supported CM's mother's request for a different CSW.

In the other strong teamwork example, a parent rejected Family Preservation services, but when she met the Wraparound Parent Partner at a TDM, rapport was established. The Wraparound team attributes the ongoing communication within their team and the CSW for the success of this case: "It was just a matter of empowering mother to identify what she needed. As needs were identified, the right people were brought into the team. Having the CSW present at CFT meetings made the greatest impact. The case plan was family driven and the child and his mother really had voice and choice."

#### Improvements In Wraparound Practice Recommended By The QSR Review

Although many of the 20 reviewed Wrap cases showed strong engagement, teamwork, supports and services, the QSR revealed several areas requiring improvement.

#### **Teamwork Issues**

Despite the strong Wraparound teams functioning in most of the cases, there were three weaknesses in the formation of the team: the lack of involvement by CSWs, therapists, and the family's natural supports. The Child and Family Team (CFT) should be comprised of the "right people" as perceived by the child and the family and their supports (informal supports) to provide a safety net and support system (with the right professionals to include therapists and school staff). Building upon the child and family strengths and needs, members of the team have a shared understanding of the outcomes and functional life goals for the family in order to collectively plan services and evaluate results.

Seventeen of the reviewed cases scored between 2 and 4 on teamwork (highest=6). In nine of the cases, the CSW's lack of participation in the Child and Family Team meetings was reported as a major challenge. In eight of the cases, a significant challenge identified by the reviewers was the therapists' lack of participation in the Child and Family team meetings. The absence of a school staff person and a TBS were also noted as problems in several teams. The typical scenario in these cases was that the Wraparound team consisted of child, parent/caretaker, and Wraparound Facilitator, Parent Partner and Child and Family Specialist. Therapists who were not employed by the Wraparound provider apparently never participated in team meetings, but in several cases Wraparound therapists were also absent from the teams or if they participated did not appear to be guiding the team.

"Most communication occurs between the Wrap staff and mother and separately between the Wrap Facilitator and CSW." (GR)

“There is limited sharing of information, and thus people are working in isolation. Some of the key players missing from the team are the CSW, therapist, psychiatrist, informal supports, and the transition coordinator or community worker.” (FR)

“The child’s therapist does not attend team meetings and, as a result, it has been difficult to integrate important information that comes out in the team meetings to establish a productive, trusting relationship with his therapist. It is critical at this point in the child’s life that he gain more understanding of his feelings and that the interventions in therapy address his trauma history and match the child’s short and long term goals. There also needs to be a greater presence and involvement of the CSW or other DCFS staff on the team at this critical time, in order to identify appropriate emancipation services for the youth and family.” (AZ)

“There are critical players missing from the child and family team, and some team members are working in isolation and not communicating and collaborating to develop common goals. To date, the CSW has been unable to attend any Wraparound CFT meetings due to workload issues. It would be important, however, for the CSW to provide her input in solidifying a plan for safe case closure. TBS has attended some CFTs, but the therapist attended only one recent CFT. Although TBS has been working with BM at his school, communication with the teacher has been limited. The teacher reports that no one has given her information on the child and why he requires on-site support. His teacher is also involved in an afterschool program, which provides homework assistance and enrichment activities. The family does not have knowledge of this resource because the teacher has not been engaged. There has been no contact made by anyone on the child and family team with his family’s natural supports.” (BM)

“There has not been an opportunity for all of the various parties to communicate at the same time, to share information, concerns and successes. Teamwork is minimally adequate due to the CSW’s absence from the communications involving the unified team. In addition, though the TBS worker and the child’s therapist remain in communication with the Wraparound Facilitator, they have limited involvement in CFT meetings. Therapist and CSW did not participate in the past five weekly child and family team meetings; TBS participated in one; CFS participated in two. CFTs are usually attended by child, mother, PP and facilitator. The team would benefit from consultation with the child’s therapist to gain a better understanding of the role of trauma in developing appropriate intervention strategies in the Plan of Care.” (BB)

In several additional cases, the reviewers documented poor involvement of the child’s and family’s natural supports in the team:

“Wrap Child and Family Team meetings most often consisted of the professionals on the team, the caregiver and the youth. Occasionally the CSW attended. The other people that were important to the youth, such as her “aunt” who lives across the street, and all the staff she is fond of from each of the programs that she participates in on a regular basis were missing. It is likely that if these informal supports were regular team members, then the transition out of Wrap would not be so problematic.” (IM)

“There is a lack of inclusion of all of the formal and informal supports in the team, and there is no on-going communication amongst everyone important to the family. Usually the child, his mother and the Wrap Facilitator, Parent Partner and Child and Family Specialist participate in team meetings weekly in the home. Informal supports – maternal uncles, cousin, former foster family, and church friends are not

included in the team. Formal supports, such as individual and conjoint therapists, are not a part of the team and are not included in case planning activities. The individual therapist is from a different agency and has not participated in any CFTs and only recently found out there was a Wrap team in place. The child's sister, who is a great source of emotional support for him, has not been positively engaged by the team." (MB)

## **Understanding the Child and Family's Needs**

Assessment and understanding is the degree to which the team has a shared understanding of the child and family's strengths, needs, and underlying issues. What must change for the child and family to have better overall well-being and improved family functioning? Having a better assessment and understanding of the child and family's underlying needs, as well as trauma-related and developmental-related needs will result in better informed intervention efforts.

### **Underlying Needs**

Wraparound practice emphasizes the strengths and needs of the child and family. The Wraparound Plan of Care focuses on the needs of the child and family, and Child and Family Team meetings clarify who can do what to assist in their needs being met. One of the greatest strengths of Wraparound is the rapid focus on needs in the team meetings and initiating services and supports in response to those needs. In one of the success stories described above, the Wraparound Plan of Care listed underlying needs that were similar to the priorities seen by the reviewers:

- BB needs help dealing with anger in a positive way
- BB needs to feel loved and to have a sense of belonging.
- BB needs to control himself in a positive fashion at school.
- BB needs to feel safe in expressing his thoughts and feelings with his family which are part of the reason he often seems not to get along with his sister.
- BB's mother needs to feel respected and appreciated by him.

In many of the reviewed cases, the child's needs listed in the Wraparound Plan of Care were primarily the child's behaviors and the parent/caretaker's concrete needs (such as housing, employment, transportation, and advocacy support) and assisting the parent/caretaker in managing the child's behaviors. The reviewers found little attention to underlying needs as described in the DCFS/DMH Core Practice Model and the training and coaching provided by both agencies. The lack of involvement of therapists in many team meetings and misunderstanding of trauma (described below) contributed to this lack of clarity about underlying needs. The assessment of trauma and underlying needs must occur at the outset and on an ongoing basis to assess the "big picture" situation and dynamic factors that impact the child and family in order to guide intervention. As one Wrap staff person described, "we work on the behavior and the therapist works on emotional issues."

These trauma-related and other underlying needs being missing from the Wrap Plans of Care may account for only two of the 20 reviewed cases receiving the highest scores (one 5 and one 6) on assessment of the child. The following cases exemplify this issue of understanding the child's underlying needs:

FR is an 18-year old Latino male who just graduated from high school and has lived for 14 years in a non-relative foster home with his 19-year old college student sister. FR and his siblings came into

care in 1997 due to physical abuse and lack of supervision by their mother. His two younger siblings were adopted; FR has not seen his mother in three years and has never known his father. Their caregiver had legal guardianship of FR in 2000, but it was terminated in 2011 due to his behavior. Wraparound was initiated in 1/12 when FR was skipping school, breaking household rules and stealing. The current focus of Wraparound has been FR's transition to adulthood, his running away from home, and his arrest for having sexual contact with his 15-year old girlfriend. FR's needs listed in the Wraparound Plan of Care were:

- For FR to make good decisions in the community; avoid stealing, be in school
- For FR to continue respecting his caretaker as the head of household
- For FR to explore his biological family when he's ready
- For FR to work towards emancipation from foster care system
- For FR to process his depression and anxiety in appropriate ways
- For FR to express his needs in appropriate ways
- For FR to comply with his caregiver's house rules and follow daily schedule
- For FR to earn credits to graduate from high school
- For FR to explore colleges and trade schools
- For FR to work part-time
- For FR to develop healthy relationships with peers
- For FR to obtain some work experience

The above list is practical and behavioral. Some "needs" listed may not be needs a teenager would appreciate but instead are demands of adults. Based on the information gathered during the reviews, some underlying needs thought to be missing from the Wrap Plan of Care were identified:

- FR needs to love himself and know that he is worthy of being loved.
- FR needs to feel secure knowing he has somewhere to live no matter what happens.
- FR needs to make sense of his history, particularly the loss of his family, and know that it is not his fault.
- FR needs to learn to trust others.
- FR needs to learn to voice his own opinions and thoughts and not worry about appeasing others.
- FR needs to feel respected as a young adult.
- FR needs to know that he capable of achieving success.

EM is a 14-year old Latina female living with her mother. For nine months since her mother left their father with EM and her sister due to domestic violence, they have been living in her maternal uncle's 2-bedroom apartment with him, his wife, and their three children. In 9/11 EM was hospitalized for an overdose, with a history of cutting and depression, in reaction to her parents' arguments and father's alcohol use and criticism of her. EM and her family were enrolled in Wrap (at the same provider where she and her family had been receiving therapy) in 2/12. In the Wrap Plan of Care, EM's needs were listed as:

- Mom needs to know EM is safe
- Mom and Dad want to get closer to EM
- Mom needs to make sure EM can control her anxiety
- EM says she needs to know how to communicate better
- EM wants to be on a sports team

The reviewers were concerned with the lack of attention to her underlying needs such as:

- EM needs to understand how worried, hurt, angry and powerless she felt when her family had so many problems and how to express these feelings with the people she trusts rather than resorting to cutting herself or harming herself in other ways in order to soothe her anxiety.
- EM needs to learn how she, as the oldest daughter born to mono-lingual, undocumented, Spanish speaking parents will need to act as a cultural navigator for her parents without sacrificing her own emotional well-being in order to “fix” her family.

## Trauma Treatment

In five of the reviewed cases, TF-CBT was being provided. In 11 of the 20 reviewed cases, the reviewers specifically noted that it was understandable that Wrap had a behavior focus at the outset, but that the children had needs requiring trauma treatment that was not being provided (although most of the children were seeing a therapist) and the parents/caregivers were not receiving sufficient guidance about how to respond to the children’s trauma-related needs. Often in these cases, the reviewers found that the child’s needs were poorly understood by the team.

The child in the success story above was originally diagnosed with ADHD, Oppositional-Defiant Disorder, Rule Out Depressive Disorder, and the reviewers concluded: “The therapist reported that his initial impressions of the child’s symptoms seemed likely to be ADHD, but his current belief is that BB is suffering from trauma-related symptoms of depression stemming from numerous life disruptions. There is insufficient knowledge of the child’s underlying feelings that may be driving the child’s’ inappropriate actions. BB has suffered tremendous trauma yet he has not been provided with information or the opportunity to ask questions. BB needs to have a developmentally appropriate understanding of what happened to his family (his mother’s arrest and incarceration) and of his father’s alcohol abuse. BB needs to be able to ask questions openly, express his feelings with his mother and be supported in this process.”

In the case of EM, the 14-year old described above, the reviewers noted the lack of understanding by the team of EM’s trauma-related needs: “EM has had significant traumatic experiences: her parents’ arguments which intensified over the year prior to referral; her half brother’s arrest in the home for marijuana sales; her father’s verbal abuse towards her and her mother, denigrating her; witnessing domestic violence; being upset by her parents pulling her into their arguments; their separation; and EM’s overdose and hospitalization. The effects of these experiences were apparent in her depression, anger and worsening grades in school. The team’s interventions were not driven by the therapist’s insights and the therapist’s work with EM was behaviorally based which appeared to have successfully taught EM some new coping skills, but did not help her or her family gain much insight into her underlying needs. Asked if she thought EM might benefit from doing a trauma narrative, her therapist said she had not considered TF-CBT.

TS is a 15-year old African American male whose D-Rate foster mother describes him as “soaring.” He is the second oldest of 8 children with siblings ranging in age from 7 months to 17 years old. The family has a seven year history of involvement with DCFS due to substance abuse and domestic violence. When TS was 8 and the 6th child in the family was born positive for cocaine, his family

received Voluntary Family Maintenance Services (VFM) for a year and the case was closed in 2006. In 2007, allegations of neglect were filed because the children were not attending school and Family Preservation Services were put in place. In 2008, his mother gave birth to her seventh child, and she and the infant tested positive for cocaine at the time of delivery; their father was in prison. All seven children were removed from their maternal grandmother who was caring for them but was incapacitated by a stroke. The four older boys in the family were placed together in a foster home from November 2008 until September 2011 when TS was asked to move due to angry outbursts. The three girls were initially placed in separate foster homes. Currently, one of the girls has been adopted, one is placed in a RCL 12 group home and one lives with an adult half sister. In 8/11, their mother gave birth to an eighth child who was also placed with their adult half sister whose home TS had been hoping to move into. His foster mother indicated that TS has made significant improvements in his behavior and his school work since coming to live with her approximately six months ago. TS lives within walking distance of his brothers who still live with his former foster mother and he visits often; he also visits his older half sister on weekends. The siblings have rarely been all together since they were detained in 2008. They have little contact with either parent. The Wrap team has focused on TS's "prosocial interpersonal skills" for more than a year. His new therapist wants to address his trauma-related needs. TS's Wrap Plan of Care includes the following needs:

<u>NEED</u>	<u>STRATEGIES</u>	<u>What</u>
<ul style="list-style-type: none"> <li>▪ Be aware of surroundings &amp; ignore peers</li> <li>▪ Earn his own money</li> <li>▪ Be respectful with adults</li> </ul>	<ul style="list-style-type: none"> <li>▪ Get home on time &amp; take the major street only</li> <li>▪ His foster mother will help him get his birth certificate &amp; social security card &amp; apply for a job</li> <li>▪ Express his feelings</li> <li>▪ His CFS &amp; therapist will help him learn coping skills like walking away, deep breaths and counting to 10 to avoid talking back</li> </ul>	<p>t puts the per man ency of this</p>

home at risk are his foster parent and older sister not understanding his unmet trauma-related needs behind his problem behaviors. If the team meeting helped everyone define the unmet trauma-related needs behind his behaviors, then the Plan of Care could specifically state what team members will do to meet each of those needs. The following is an example of how TS's needs could be stated, and the role of his foster mother, sister, CFS and therapist in meeting his needs:

<u>TS'S NEEDS (AGE 15)</u>	<u>SUPPORTS &amp; SERVICES</u>
<ul style="list-style-type: none"> <li>▪ To make peace with not living with family &amp; know his family loves him</li> </ul>	<ul style="list-style-type: none"> <li>▪ Seeing his siblings weekly</li> <li>▪ His therapist helping him make a list of all his losses, grieve them, not blame himself that family cannot provide a home for him &amp; feel lucky to have his foster mother</li> <li>▪ His sister feeling proud of all she does for him</li> <li>▪ His foster mother not feeling hurt by his wish for family</li> </ul>

- To ask for what he wants & calm himself when he doesn't get it right away
- To believe that he is smart & good at music
- To feel he likeable and worthy of friends
- His therapist teaching him self-soothing
- His therapist helping him see why he gets so anxious when things are not in his control
- His therapist teaching his foster mother & sister what triggers his anxiety & how to help him calm himself
- His foster mother helping him get a job
- His therapist & CFS helping him change his self-talk
- His CFS recognizing accomplishments & guiding his foster mother, sister & teachers praising his talents
- His foster mother and CFS looking for singing instruction or other musical opportunities with him & considering an arts high school
- His therapist & CFS helping him change his self-talk
- His foster mother, sister, teachers & CFS praising his caring and friendliness & his pro-social friendships including encouraging activities with friends

#### Recognizing Developmental Needs

School. Seven of the 20 reviewed cases got a low score on Learning and Development because their needs in school were not adequately understood. The school not being included in the team is described in the Teamwork section above, but other examples are illustrative of children's school-related needs not be addressed:

SG is a 16 year old Latina living with her mother, her brother and their maternal grandmother in her one-bedroom apartment in a retirement community since 1/12. Ten years ago SG's father was convicted of sexual abuse of his girlfriend's daughter. In 5/10 allegations of neglect were substantiated for SG and her brother, a Voluntary Family Maintenance case was opened and in 9/10 neglect and emotional abuse of SG by her mother resulted in placement. SG had seven placements and four schools while in care. SG's grades and attendance have been and continue to be poor. Academic testing completed in August 2011 indicated that SG was at an 11<sup>th</sup> grade level in Language Arts and a 5<sup>th</sup> grade level in Math. She does not have enough credits to start 10<sup>th</sup> grade.

DA is a 14-year old Caucasian male who lives in a foster/adoptive home. DA has been in 10 placements, in and out of child welfare in various counties and two states, and has reunified with his mother four times. His father has never been involved in DA's life. DA was born prenatally exposed to drugs and alcohol. When he was five years old, he was physically abused by his mother and exposed to substance abuse and domestic violence. The family became known to LA County DCFS in 2/10 due to his mother's mental health and substance abuse problems; DA was not going to school because he was worried about leaving his mother alone. DA was placed at age 12 in a foster home and said he knew he would not be reunifying with his mother this time. "The team would benefit to include school personnel since education is a strong area of need for DA. The school counselor stated that she was invited to one early CFT meeting and IEP meetings, but no one from school was invited to meet regularly at the weekly Wraparound meetings. As a result, the team was missing the support from the school because the school did not have the support from the team. Working

together as a team would have helped to communicate what each party was doing and become more cohesive in developing and executing both short-term and long-term goals. Although Wraparound Child and Family Specialist (CFS) went to DA's school to observe him to see how to reduce his negative behavior, the information was not communicated to the school counselor. Therefore, the school counselor did not know that anyone came out to observe him and missed an opportunity to work together to help DA. The school counselor felt isolated from the team."

Other developmental needs. Three of the 20 reviewed cases had a low score on Learning and Development because they had speech and/or processing problems that were not being addressed. In a child welfare sample of 20 receiving intensive mental health services, it is surprising to find only one diagnosed with Pervasive Developmental Disorder, one with an Auditory Processing Disorder, and one with a Phonological Disorder (although perhaps within the seven diagnosed with ADHD there are children who also have executive function and other developmental deficits).

MS is a 17-year old African American male placed with his aunt who is his legal guardian. MS came to the attention of DCFS when he was born with cocaine in his system. He was placed in the home of his maternal grandmother. His mother died when he was 6; at that time his case was closed with legal guardianship with his grandmother. She died when he was 12, and DCFS placed him with his maternal aunt who had no other children. MS does not have a relationship with his father. MS has been receiving Wrap services for 18 months. The Wrap facilitator told the reviewers that they were exploring Job Corps for MS and that they will assist MS if he wants to enroll in a community college. MS recently graduated from high school and his aunt told reviewers that MS has to leave her home when he turns 18 soon. She wants MS to go into the military but he does not want to, and according to his IEP, his cognitive abilities are in the below average range. His IEP reflects a diagnosis of ADHD and auditory processing and sensory motor skills challenges. MS was described as being 17 years old chronologically but emotionally at a level of a 12 or 13 year old. Neither MS nor his aunt understands his cognitive limitations and how they have to be taken into account in planning for independence and employment.

Other clinical issues.

One reviewed youth prescribed medication had not been seen by a psychiatrist for six months. For several youth, there was a significant lack of agreement about diagnosis among the providers. The most concerning example was FR, an 18-year old described above. According to the most recent court report (3/12) FR was diagnosed with ADHD, Anxiety NOS, and Enuresis not due to a medical condition. The psychiatrist indicated FR has a diagnosis of ADHD and Conduct Disorder (2/12). FR's therapist stated FR has ADD and Mild Depression. FR has been in treatment for 10 years with the same therapist, who does not work for the Wraparound provider, does not participate in team meetings and who he sees every other week, but little is known about FR's presenting issues and the treatment goals. "FR's need to feel connected to his family is not being addressed, in part due to his inability to open up and trust others. FR indicates that he is only comfortable discussing his family with his sister, and he states that he mainly talks about his transition issues in therapy. It will be important for him to explore his past trauma issues, as they impact his self-perception and relationship with others." One 13-year old had diagnoses of ADHD and Enuresis and whether the prescription of Risperdal, Desmopressin and Guanfacine fits those diagnoses warrants consideration. Three of the 20 reviewed children had diagnoses that were older than a year and were being reconsidered but had not been officially changed. In one case,

the Wraparound staff believed the teenager was prescribed a psychiatric medication but they did not know her diagnosis, the medication or whether she was taking it and assumed her therapist was knowledgeable about it.

### **Transition for The Future/Long Term View**

One of the successes of Wraparound was the support provided to youth in transition from foster homes and hospitals to their family's homes. But only four of the 20 reviewed cases received scores of 5 or 6 on Long Term View. Long Term View is the degree to which there is a shared understanding among the team members of the outcomes and functional life goals for the child and family. Long term view encompasses protective capacities, desired behavior changes, and natural or community supports for the child and family to achieve and sustain adequate daily functioning and greater self-sufficiency. Long term view is fluid but should be developed in the beginning to address the specific needs of the family and take into account such transitions as placement moves, school changes, emancipation/independent living/life skills, and vocational preparation. Essentially, long term view incorporates various family, developmental, and life transitions.

In eight of the reviewed cases, the reviewers expressed concern that planning for transition to the future had not been adequate.

RD is an 18-year old Latina female living with her parents, younger brother, and adult sister and her sister's boyfriend and two children. She was placed in 5/11 because her mother and father used inappropriate physical discipline "because of RD's combative and explosive behaviors;" she was failing in school, used substances, did not comply with house rules or curfew and was raped. She asked to live with her aunt who did not think she could manage RD, so she was placed in an out-of-county foster home, and then was moved after two weeks to an FFA home near her parents, and in 1/12 she returned home. For several years she had been involved with Full Service Partnership, and was diagnosed with depression, but, she is not prescribed psychiatric medication. According to Wraparound progress reports, the family has greatly improved in communicating their needs to one another. RD appears more willing to compromise with her parents. RD's parents seem to be more understanding of RD's need for personal space and time out in the community. RD hopes to graduate from continuation high school in 2013 and her parents are supportive of this goal. Court terminated jurisdiction just prior to the review, and the family, DCFS, and Wraparound team agree on graduation from the program soon. The reviewers felt that RD's status will likely decline in the next six months: "RD does not appear to have age-appropriate self-management of emotions and behaviors. RD does not appear to have adequate independent and life skills nor has she developed the appropriate community supports and networks to prepare for adulthood. Although a referral was made to the Independent Living Program (ILP), RD ultimately did not qualify for ILP services because she was returned home. RD did receive some vocational preparation from the Wraparound team. Although RD has made much progress, it did not appear that she has adequately developed the coping skills necessary to help her in stressful and frustrating situations. The reviewers do not have confidence that success or progress made will be sustainable. Her mother expressed uncertainty of RD graduating from high school, and on the California Standards Test in 2010, RD performed Below Basic in Math and Far Below Basic in Language Arts. There is continuing tension between RD and her mother, and it seems that progress made by the family may be short-term with no long-term behavioral change."

DA, the 14-year old described above, also had special transition concerns requiring more attention: “Preparing and planning around transition is going to be the most immediate challenge as there are many transitions ahead for DA. He is entering high school and transitioning to a new school environment in less than a month. Once the adoption placement is completed in about a month, Wraparound Services will terminate. Such a sudden termination may cause regression in DA’s behavior and family functioning. Preparing the family to be ready to terminate the supports and services is a process that should be occurring from the beginning of Wraparound support, but difficult to achieve when it is unclear if the family is going to adopt. Also, the nature of Wraparound services can be intensive and the focus is on complex issues with DA, not on terminating. When the Wraparound Services were referred for this family, the caregivers were unsure about adopting DA and DA was unsure of being adopted as it would mean letting go of his wish to be with his mother. Over the course of Wraparound intervention, the caregivers and DA have decided that adoption would be the best plan for them. The caregivers expressed a need for Wraparound support until adoption finalization, but transition services beyond that time are necessary.”

AU is a 17-year old Latino male living with his mother and siblings; their family had 10 referrals to DCFS for neglect, physical abuse and domestic violence which were all inconclusive or unfounded. But in 2011 a voluntary case was opened due to his mother’s difficulty in managing AU’s anger and misbehavior. AU’s mother felt engaged and supported by their Wraparound team including their clinician who provided individual and conjoint sessions. His therapist said “he can now process his anger and manage his feelings and his volatility is almost gone.” The Parent Partner provided coaching on how his mother could fill the parental role, use parental authority to give direction and establish a stable, emotionally safer home environment for AU and his siblings. “AU’s mother would have benefited from domestic violence sessions and individual counseling to address some of her trauma, but the parent partner felt limited by funds to provide these additional services. AU is very behind in credits to graduate, and he is nervous about turning 18 and taking on adult responsibilities. Given the trauma AU experienced in the home (DV between parents, unstable housing with frequent moves, loss of father followed by disinterested step-father, loss of older brother), trauma informed care for his depression would have naturally been a core feature of his service plan and an identified component for post-Wrap service. This case seemed to have closed a little prematurely and there is concern that the status for AU and his family is likely to decline. Although everybody seemed to agree that AU and his mother had addressed the issues that brought them into the system and it was safe to close the case, this family would have benefited from a couple more months of services. AU is facing major developmental tests: he does not want to be 18 and leaving home for the Job Corps without the supports that have helped to this point. AU could have benefited from the team’s support through the Job Corp process and trauma therapy. Although the CSW agreed that the family could have benefited from further services, her belief was that the case needed to close because there was a court hearing and SDM indicated that the case should be closed (there were no safety concerns).” If the educators had been involved in the team, perhaps the school would have understood that his presumed lack of motivation was symptomatic of trauma; that he feared assuming responsibility for himself; that tardiness and incomplete assignments meant that moving him to a continuation school that required independent study and initiative would lead to more failure. The school might have understood that AU’s interest in drawing and dreams of designing decorative patterns for skateboards was a strength, a passion to work with instead of seeing his art as graffiti.

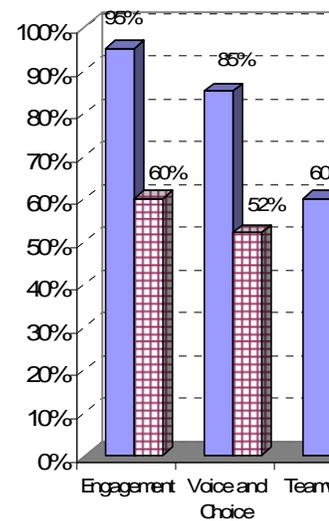
Lack of community networks was identified as one of the problems in transition planning. Ideally, the team should have enough community supports to support the family when Wraparound plans for graduation. Weak informal supports were described above under teamwork, but for some children and families their absence significantly compromised the future.

### COMPARING REVIEWED WRAP CASE SCORES TO COUNTY-WIDE QSR SCORES

In comparison to county-wide QSRs from 18 DCFS offices between June, 2010 and August, 2012 (N=210), the 20 Wrap cases had generally higher scores on practice indicators (percent in the acceptable range)<sup>9</sup>:

Practice Indicators:

Practice Indicator	WRAP	County-Wide
Engagement	95%	60%
Voice and Choice	85%	52%
Teamwork	60%	18%
Assessment-Child	60%	60%
Assessment-Family	61%	33%
Assessment-Caregiver	100%	65%
Long-term View	55%	41%
Planning	65%	41%
Supports and Services	100%	66%
Intervention Adequacy	70%	52%
Tracking and Adjustment	60%	45%



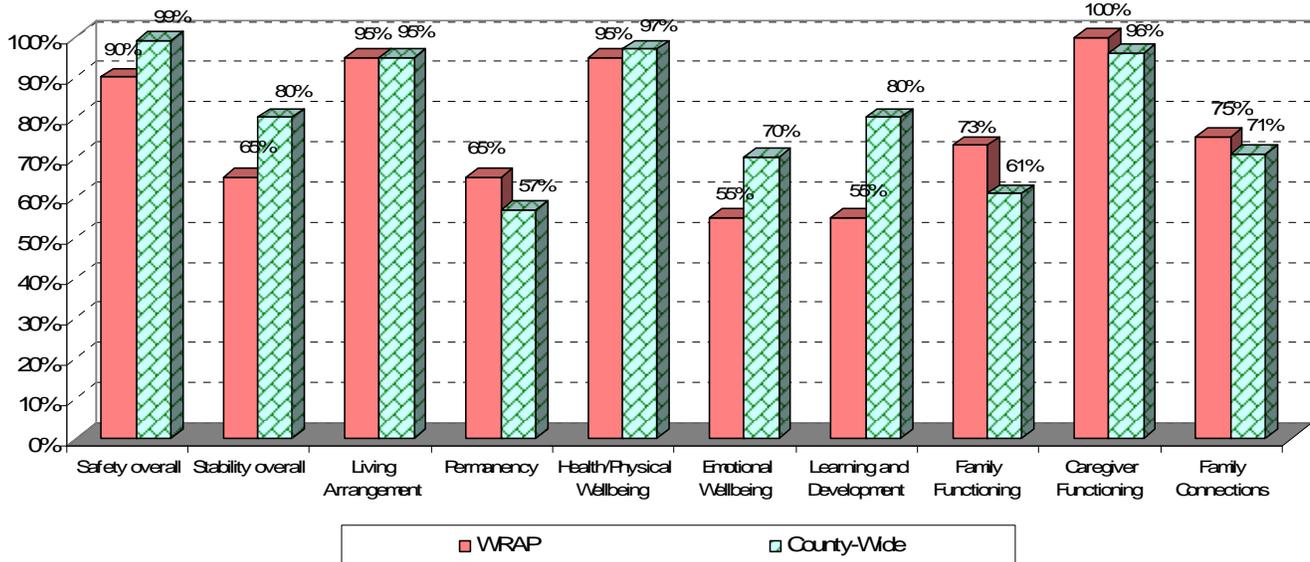
In comparison to county-wide QSRs from 18 DCFS offices between June, 2010 and August, 2012 (N=210), the 20 Wrap cases had some lower and some equivalent scores on status of the child indicators (percent in the acceptable range):

<sup>9</sup> Data from the QSR Report on the Wrap QSR by the Quality Improvement Section, August, 2012.

Status Indicators:

Status Indicator	WRAP	County-Wide
Safety overall	90%	99%
Stability overall	65%	80%
Living Arrangement (Overall)	95%	95%
Permanency	65%	57%
Health/Physical Wellbeing	95%	97%
Emotional Wellbeing	55%	70%
Learning and Development	55%	80%
Family Functioning	73%	61%
Caregiver Functioning	100%	96%
Family Connections	75%	71%

COMPARISON OF STATUS QSR SCORES



Some of these scores can be explained in two ways. The data tracked by the County and Katie A. Panel shows that class members (because of their high mental health needs) have more complex challenges, (all of the Wraparound youth had an intensive mental health need, which was not a requirement in the regional office QSR reviews). Furthermore, the Wraparound sample does not include children under the age of five like the countywide sample does, and we would expect the older population to have more emotional issues and school issues and generally be more challenging.

The Wraparound QSR practice and status scores above raise two important additional systemic concerns:

- Messages within and outside Wraparound appear to be hampering the creative tailoring of services and supports to build on the unique strengths and meet the unique needs of the child. Providers learn in training that individualized, creative interventions are central to Wraparound, but the review found that in most cases the Wraparound Parent Partner, Child and Family Specialist and Facilitator

used their impressive skills as the primary interventions (plus whatever the school offered and, in some cases, TBS). It appeared that the “Whatever It Takes” mantra of Wraparound was being interpreted to mean “Whatever Wraparound staff can do.”

- The finding from the cases reviewed is that LA Wraparound engaged families and provided concentrated supports so children remained in family homes. This is a significant achievement with children with complex mental health and school needs, often with long DCFS histories. However, in many of the reviewed cases, Wraparound did not appear to be functioning as an *intensive mental health intervention*. Trauma-related needs are not in most Plans of Care and most therapists are not providing trauma-related, clinical guidance to the teams, so it is not surprising that only half have emotional wellbeing in the acceptable range.:

## **Recommendations**

Recommendations from the Wraparound QSR require collaborative action and a system response. Concerns raised in the reviewed cases involve not only Wraparound but also DCFS and DMH practice. This is a shared practice model and a shared change process. Improved teamwork, a deeper appreciation of underlying needs, trauma treatment, and supports (formal and informal) and services pertaining to transitional planning contribute to better outcomes.

### **Teamwork:**

- Teamwork could be enhanced by further strategizing about ways to engage “missing players” such as CSWs, therapists, school personnel, community supports and the family’s natural supports. Innovations including use of technology (conference calling, web-based participation, etc.) would support participation and elevate the child and family team functioning. For instance, school staff participation in CFT meetings may increase if meeting were sometimes convened at the end of the school day at school.

Some CSWs, even with large caseloads, were enthusiastic participants in Wraparound Child and Family Team meetings. Others said they did not have the time to participate. Others said they would have to have a more flexible schedule to participate. Some Wrap providers proposed that since most team meetings occur in the home, a monthly meeting could be held at a time to coincide with the CSW’s monthly visit to facilitate increased participation. It is also important to make CFT participation positive so CSWs do not feel blamed when they participate.

- Locating family members to whom connections have been lost—particularly fathers and extended family—is necessary to ensure full participation in CFTs.
- The Wraparound CFT must be measured against the standard of whether the **formation of the CFT** contains “lifetime family supports” and key professionals and whether the **functioning of the CFT** reflects a coordinated and unified effort around a Wraparound Plan of Care that specifies a long term view.
- Training and coaching curriculum that will support the vision and achievement of better practice.

### **Assessment and Understanding:**

- More coaching on identifying underlying needs, particularly trauma-related needs, is necessary with Wraparound teams so that all participants—including CSWs, therapists and school staff—could improve their practice. Since LA County has a shared practice model and a shared change process, shared coaching for DCFS, DMH and providers is important.
- The Wrap Plan of Care format is not conducive to clear statements of underlying needs. Because it is organized by domain, the trauma-related needs that are important in an intensive mental health intervention may get buried. The domains approach typically leads to a long shopping list of unprioritized behavioral needs in the Wrap Plan of Care. The revision of the Wrap Plan of Care format would go hand-in-hand with additional coaching in identifying underlying needs, particularly trauma-related needs.
- Linkages to parent services, especially adult mental health services, were identified as an ongoing resource issue and important need to help parents meet their children’s needs.
- Identification of a youth’s need for permanence is an essential need to be addressed by the Child and Family Team and in the Wraparound Plan of Care.
- The role of the child’s therapist on the team includes supporting all team members in understanding the needs behind the child’s behaviors and applying that to their unique role in meeting the child’s needs.
- Needs training that will enhance the Wraparound provider and County Wraparound staff’s skills around underlying needs.

**Innovative, Individualized Services:**

- Tailoring unique supports and services to build on child and family strengths and meet needs is an essential part of Wraparound.
- Wrap ensures interventions that build on child and family strengths, meet needs and assist caregivers/family in meeting child needs to achieve the shared Long Term View.
- What the family’s supports (extended family, community supports, etc.) provide are valued interventions and should be included in what is being done to build on child and family strengths and meet needs and assist caregivers/family in meeting child needs.
- Arranging trauma-responsive care that fits the child and family is not easy but is an important part of individualized services.
- The child’s therapist not only provides treatment to the child and guidance to caregivers and family but also clarifies how TBS and others will meet the child’s underlying needs.
- When Wrap is working with a child in an out-of-home placement and attachment to parents and other family is important for the Long Term View, Wrap and the child’s therapist guide not only the caretaker but also the parent in meeting the child’s underlying needs during visits.

- The residency status of the parent may restrict access to community resources, but Wraparound can assist these parents in locating special assistance.

### **Long Term View:**

- The child’s and family’s needs, as articulated on the Wraparound Plan of Care, should be incorporated into case planning from the beginning and to ensure the long term view is shared by the team with concrete steps to achieve case plan goals and to sustain success beyond safe case closure. Part of teambuilding is helping all the participants have a shared understanding of Long Term View even though their roles are different.
- The quality of the Wraparound Plan of Care must be measured against the standard of whether it articulates shared outcomes and functional life goals (i.e. required protective capacities, sustainable supports, real emotional and behavioral changes), enabling the child, family and those helping them to see both the next step forward as well as the “end point” – providing a clear vision of the path ahead – guiding the intervention and change process.
- Inclusion of a family’s natural supports is necessary, particularly when connections and supports do not exist already. Plans to develop meaningful connections and supports and repairing damaged connections are essential functions of the CFT and the Wraparound Plan of Care to promote legal and relational permanency. Alternatives must be developed in the event that the hoped-for permanent connection does not work out. The use of Family Finding is a critical need for youth who have not achieved legal permanency.
- Continuing intensive mental health services must be provided after Wraparound ends and the DCFS case closes. Clarifying how this can best occur, particularly through Intensive Care Coordination, is necessary. One aspect of continuity of mental health services is ensuring that the child and family understand why this assistance will be helpful after Wraparound ends and the DCFS case closes, despite the stigma associated with mental health care.
- For transition-age youth, the involvement of Youth Development Services may provide guidance and linkage to supports and services prior to and beyond case closure.

### **Systemic Changes:**

- Several of the cases reviewed had a long history of either services or referrals with DCFS prior to their referral to Wraparound. Children were also referred to Wraparound following multiple placement failures and others when there was not much time left during their voluntary case designation. These cases and others where children had prior hospitalizations or numerous replacements could have benefited from earlier intensive mental health services. Referrals seemed to have come “far down the road” and perhaps using the co-located mental health providers could have helped refer the child earlier.
- When a psychiatrist or other provider is funded under contract with DMH, there is an administrative clinical oversight role that must be used when deficiencies in diagnosis and medication described in a few of the cases are identified.

- In some reviewed cases, DCFS school consultants worked effectively with CSWs, but they may not continue with cases, and follow-up by the CFT is essential. There is a need for a deeper understanding of the role that educational consultants play in addressing children’s educational needs at the time of linkage, and the roles that they and other key players will have in any follow through that may be necessary.
- Improved system-wide understanding of the effectiveness of various models of trauma treatment, and greater availability of quality training for clinicians to provide trauma treatment is necessary.
- A better understanding of Wrap by CSWs and SCSWs will assist with earlier Wrap referrals and increased CFT involvement.

**Implications of the Findings of the Wrap QSR for Wrap Redesign:**

- Establish an expectation that CSWs will actively participate in the Wraparound process.
- Refine the role of the Interagency Screening Committees away from compliance driven oversight to a qualitative case consultation model. This will assist with trouble-shooting issues including engaging CSWs, therapists and school staff who may be challenging to engage to attend Child and Family Team meetings.
- Revise the Plan of Care to streamline the document and emphasize trauma-related and other underlying needs. In addition, allow the Child and Family team to prioritize the domains that are most important to the team. At the same time, the Plan of Care must be flexible and faithful to the spirit of Wraparound that the family is in charge and taking the time for them to understand underlying needs will be crucial for them to want them in the POC.
- Each Wraparound agency will be required to enhance their clinical supervision and coaching to identify and address trauma-related needs. Implement a Mental Health Status report to ensure there is administrative clinical oversight to track therapist participation, trauma-responsive practice and potential deficiencies in diagnosis or use of medication. Strengthening intensive mental health interventions and successfully meeting trauma-related needs will be essential as the County expands Wraparound in an effort to reduce psychiatric hospitalizations and group care placements.
- Clinical guidance for caregivers in how to meet underlying needs when responding to difficult behaviors will be essential for continued success.
- An approach for Wrap to support children while they are in group care in preparation for transition to a family home should be developed.

**Implications of the LA Wrap QSR for Statewide Katie A. Planning:**

- There is a common perception that therapist participation in CFT meetings should be limited due to restrictions in Medi-Cal claiming. The current claiming manual states that reimbursement is only approved for those activities that are related to a child’s mental health needs. If a therapist can only

be reimbursed for a portion of the time spent in a CFT meeting, it can present a financial barrier to mental health providers. Clarification in the State Medi-Cal Documentation and Claiming Manual is necessary overcome this barrier.

- In the new service language contained in the Katie A. State case, mental health participation in CFT meetings will be claimed to Intensive Care Coordination (ICC), and it will be critical that examples of mental health participation are included in the documentation manual in order to give providers a clear sense of what kinds of CFT related services are able to be claimed to ICC.
- Multiple case plans (e.g. the DMH Client Coordination Plan, the DCFS Case Plan and the Wraparound Plan of Care) are a challenge to effective teaming and planning. These plans are rarely shared and don't have common goals for the child and family. The development of an Individual Care Plan that is a cross-system/multi-public agency plan will assist in reducing the silos that currently exist.
- Misperceptions about confidentiality and information sharing are barriers to forming a functional Child and Family Team. Clarification about sharing information within a CFT is crucial to statewide implementation.

## APPENDICES

Appendix 1 - Job Aid QSR Indicators (HSO).....	Page 26
Appendix 2 - Job Aid QSR Guide for Indicator Ratings (HSO).....	Page 29
Appendix 3 - QSR Baseline Status and Practice Graphs.....	Page 30
Appendix 4 -QSR WRAP Status and Practice Graphs.....	Page 31

# APPENDIX 1

**Quick Study  
Job Aid for  
Reviewers**

**QSR CHILD/YOUTH PROTOCOL:  
Listing of Status, Progress,  
and Practice Indicators**

**QSR INDICATORS**

The QSR Protocol provides reviewers with a specific set of indicators to use when examining the status of the child and caregiver and analyzing the responsiveness and effectiveness of the core practice functions prompted in the CPM. Indicators are divided into two distinct domains: *status* and *practice performance*.

- ◆ **Status indicators** measure the extent to which certain desired conditions are present in the life of the focus child and the child's parents and/or caregivers—as seen over the past 30 days. Status indicators measure constructs related to *well-being* (e.g., safety, stability, and health) and *functioning* (e.g., the child's academic status and the caregiver's level of functioning). Changes in status over time may be considered the near-term outcomes at a given point in the life of a case.
- ◆ **Practice indicators** measure the extent to which *core practice functions* are applied successfully by practitioners and others who serve as members of the child and family team (CFT). The core practice functions measured are taken from the CFT and provide useful case-based tests of performance achievement. The number of core practice functions and level of detail used in their measurement may evolve over time as advances are made in the state-of-the-art practice.

**QSR CHILD & CAREGIVER STATUS INDICATORS**

This version of the QSR Protocol provides ten qualitative indicators for measuring the current status of a focus child and the child's parent and/or caregiver. Status is determined for the most recent 30-day period, unless stated otherwise in the indicator. A status measure could be viewed as a desired outcome for a child, parent, and/or caregiver who, at an earlier time, may have experienced significant difficulties in the area of interest.

- 1a. **SAFETY - Exposure to Threats of Harm:** Degree to which: • The child is free of abuse, neglect, and exploitation by others in his/her place of residence, school, and other daily settings. • The parents and caregivers provide the attention, actions, and supports necessary to protect the child from known safety factors in the home.
- 1b. **SAFETY - Risk to Self Others:** Degree to which the focus child: • Avoids self-endangerment. • Refrains from using behaviors that may put others at risk of harm. *[For a child age three years and older]*
2. **STABILITY:** Degree to which: • The child's daily living, learning, and work arrangements are stable and free from risk of disruptions. • The child's daily settings, routines, and relationships are consistent over recent times. • Known risks are being managed to achieve stability and reduce the probability of future disruption. *[Timeframe: past 12 months and next 6 months]*

3. **PERMANENCY:** Degree of confidence held by those involved (child, parents, caregivers, others) that the child/youth is living with parents or other caregivers who will sustain in this role until the child reaches adulthood and will continue onward to provide enduring family connections and supports in adulthood.
4. **LIVING ARRANGEMENT:** Degree to which: • Consistent with age and ability, the focus child is in the most appropriate/least restrictive living arrangement, consistent with the child's needs for family relationships, assistance with any special needs, social connections, education, and positive peer group affiliation. • [If the child is in temporary out-of-home care] the living arrangement meets the child's needs to be connected to his/her language and culture, community, faith, extended family, tribe, social activities, and peer group.
5. **HEALTH/PHYSICAL WELL-BEING:** Degree to which the focus child is achieving and maintaining favorable health status, given any disease diagnosis and prognosis that the child may have.
6. **EMOTIONAL WELL-BEING:** Consistent with age and ability, the degree to which the focus child is displaying an adequate pattern of: • Attachment and positive social relationships, • Coping and adapting skills, • Appropriate self-management of emotions and behaviors, • Resilience, • Optimism, • A positive self-image, and • A sense of satisfaction that his/her fundamental needs are being met.
- 7a. **EARLY LEARNING STATUS:** Degree to which: • The child's developmental status is commensurate with age and developmental capacities. • The child's developmental status in key domains is consistent with age- and ability-appropriate expectations. *[For a child under 5 years of age]*
- 7b. **LEARNING & ACADEMICS:** Degree to which the focus child [according to age and ability] is: (1) regularly attending school, (2) placed in a grade level consistent with age or developmental level, (3) actively engaged in instructional activities, (4) reading at grade level or IEP expectation level, and (5) meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent. *[For a child age 5 years or older]*
- 7c. **PREPARATION FOR ADULTHOOD:** Degree to which the youth [according to age and ability] is: (1) meeting academic requirements for annual promotion and course completion leading to a high school diploma or equivalent; (2) gaining life skills, developing relationships and connections, and building capacities for living safely, becoming gainfully employed, and functioning successfully upon becoming independent of child services; - OR - (3) becoming eligible for adult services and with the adult system being ready to provide (without waiting or disruption) continuing care, treatment, and residential services that the youth will require upon discharge from services.
8. **FAMILY FUNCTIONING & RESOURCEFULNESS:** Degree to which the parents [with whom the child is currently residing or has a goal of reunification]: • Have the capacity to take charge of family issues, enabling family members to live together safely and function successfully. • Are able to provide the child with the protection, assistance, supervi-

sion, and support necessary for daily living. • Take advantage of opportunities to develop and/or expand a network of social and safety supports in establishing and sustaining family functioning and well-being.

9. **CAREGIVER FUNCTIONING:** Degree to which: • The substitute caregivers, with whom the child is currently residing, are willing and able to provide the child with the assistance, protection, supervision, and support necessary for daily living. • If any added supports are required in the home to meet the needs of the child and assist the caregiver, the supports are meeting the needs.
10. **FAMILY CONNECTIONS:** Degree to which family connections are maintained through appropriate visits and other means when children and family members are living temporarily away from one another, unless compelling reasons exist for keeping them apart.

QSR provides a close-up way of seeing how individual children and families are doing in the areas that matter most. It provides a penetrating view of practice and what is contributing to results.

**QSR PRACTICE PERFORMANCE INDICATORS**

This version of the QSR Protocol provides nine qualitative indicators for measuring certain core practice functions being provided with and for the focus child and the child's parents and/or caregivers. Practice performance is determined for the most recent 90-day period for cases that have been open and active for at least the past 90 days.

1. **ENGAGEMENT:** Degree to which those working with the focus child and family (parents and other caregivers) are: • Relating with the child/youth, biological family, extended family, primary caregiver, and other team members for the purpose of building a genuine, trusting and collaborative working relationship. • Identifying a support system and/or finding family members who can assist with support and permanency for the focus child. • Developing and maintaining a mutually beneficial trust-based working relationship with the child and family that involves having unconditional positive regard, respect for diversity, an inclusive planning process, and the ability to understand and work through resistance to participating in services. • Focusing on the child and family's strengths and needs. • Being receptive, dynamic, and willing to make adjustments in scheduling and meeting locations to accommodate family participation. • Offering transportation and childcare supports, where necessary, to increase family participation in planning and support efforts.
2. **VOICE & CHOICE:** Degree to which the focus child, parents (including the non-custodial parent), family members, and caregivers are active ongoing participants (e.g., having a significant role, voice, choice, and influence) in shaping decisions made about child and family strengths and needs, goals, supports, and services.
3. **TEAMWORK:** Degree to which: (1) The "right people" for this child and family have formed a working Child and Family Team that meets, talks, and plans together. (2) The CFT has the skills, family knowledge, and abilities necessary to define the strengths and needs of this child and family and to organize effective services for this child and family, given the level of complexity of

circumstances and cultural background of the child and family. (3) Members of the child and family's team collectively function as a unified team in planning services and evaluating results. (4) The decisions and actions of the team reflect a coherent pattern of effective teamwork and collaborative problem solving that builds upon child and family strengths and needs to benefit the child and family.

4. **ASSESSMENT & UNDERSTANDING:** Degree to which those involved with the child and family understand: (1) Their strengths, needs, risks, preferences, and underlying issues. (2) What must change for the child to function effectively in daily settings and activities and for the family to support and protect the child effectively. (3) What must change for the child/family to have better overall well-being and improved family functioning. (4) The *big picture* situation and dynamic factors impacting the child and family sufficiently to guide intervention. (5) The outcomes desired by the child and family from their involvement with the system. (6) The path and pace by which permanency will be achieved for a child who is not living with nor returning to the family of origin. [Need, as used in this indicator, is based on the *Framework for Assessing and Responding to Needs* presented in the introductory section of the practice performance domain.]
5. **LONG-TERM VIEW:** Degree to which there are stated, shared, and understood safety, well-being, and permanency outcomes and functional life goals for the child and family that specify required protective capacities, desired behavior changes, sustainable supports, and other accomplishments necessary for the child and family to achieve and sustain adequate daily functioning and greater self-sufficiency. [*Current goals guiding planning of interventions over the past 90 days*]
6. **PLANNING:** Degree to which a well-informed, well-reasoned, family-centered, team-driven planning process is being used to direct strategies and resources for: (1) meeting near-term child and family needs; (2) achieving child safety, well-being, and permanency outcomes; and (3) supporting and sustaining the family or permanent caregiver.
7. **SUPPORTS & SERVICES:** Degree to which the strategies, supports, and services planned the child and family are available on a timely and adequate basis to meet near-term child and family needs and to achieve the outcomes planned.
8. **INTERVENTION ADEQUACY:** Degree to which planned interventions, services, and supports being provided to the child and family have sufficient power (precision, intensity, duration, fidelity, and consistency) and beneficial effect to produce results necessary to meet near-term needs and achieve outcomes that fulfill the long-term view.
9. **TRACKING AND ADJUSTMENT:** Degree to which those involved with the child and family are: • Carefully tracking the child's/family's intervention delivery processes, progress being made, changing family circumstances, and attainment of functional goals and well-being outcomes for the child and family. • Communicating (as appropriate) to identify and resolve any intervention delivery problems, overcome barriers encountered, and replace any strategies that are not working. • Adjusting the combination and sequence of strategies being used in

response to progress made, changing needs, and knowledge gained from trial-and-error experience to create a self-correcting intervention process.

These nine core practice indicators, drawn from the Core Practice Model, define the focus and scope of inquiry into case practice for a focus child and the child's parents and/or caregivers.

**SUMMING-UP ACROSS INDICATORS WITHIN DOMAINS**

The QSR Protocol provides directions to reviewers for determining an overall status rating and practice performance rating in a case for which a review has been completed for all of the indicators in each domain. Each domain (status and practice) has key criteria for determining the minimum conditions under which Overall Status and Overall Performance are deemed acceptable. For example, the status of the focus child cannot be regarded as acceptable if the child is unsafe or persons in the focus child's daily settings are not safe from the focus child. Likewise, the overall practice performance domain would not be considered acceptable in a case where any of the following five core practice functions were found to be inadequate: engagement, assessment, teaming, planning, or intervention adequacy. More information regarding the sum-up process for the two review domains are in Section 4 of the QSR protocol.

**TIMEFRAMES AND RATING SCALES**

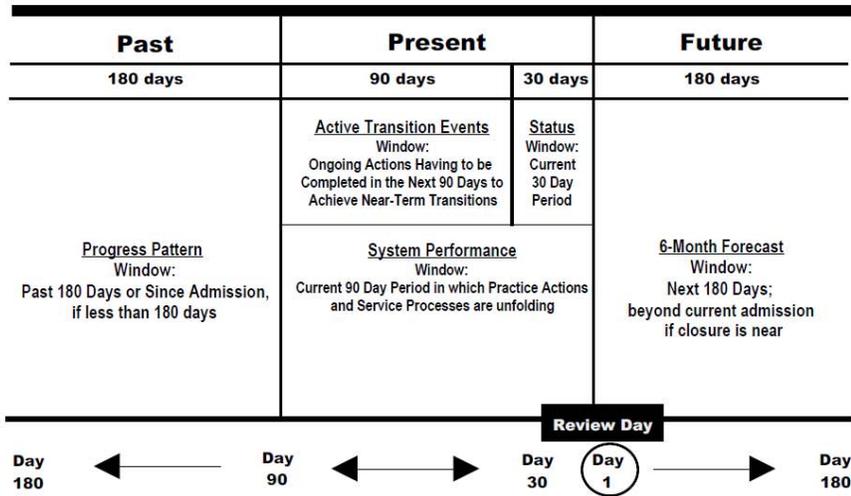
Timeframes for Review

Presented below is a display illustrating the timeframes used for rating indicators. QSR provides a point-in-time review that uses varying time parameters depending on the type of indicator being applied in a case review.

- The timeframe for *current status* indicators is generally 30 days unless stated otherwise in an indicator.
- The timeframe for reviewing *practice performance* is the past 90 days. These indicators focus on events that have already occurred recently and/or on recent processes that have been and are continuing to occur at the time of review.
- The *six-month prognosis* focuses on the near-term future looking forward 180 days from the time of the review.

The two displays presented on the next page illustrate and explain the logic of the 6-point rating scales used with the QSR indicators.

**Timeframes of Interest in Case Reviews**



## APPENDIX 2

### QSR Interpretative Guide for Status Indicator Ratings

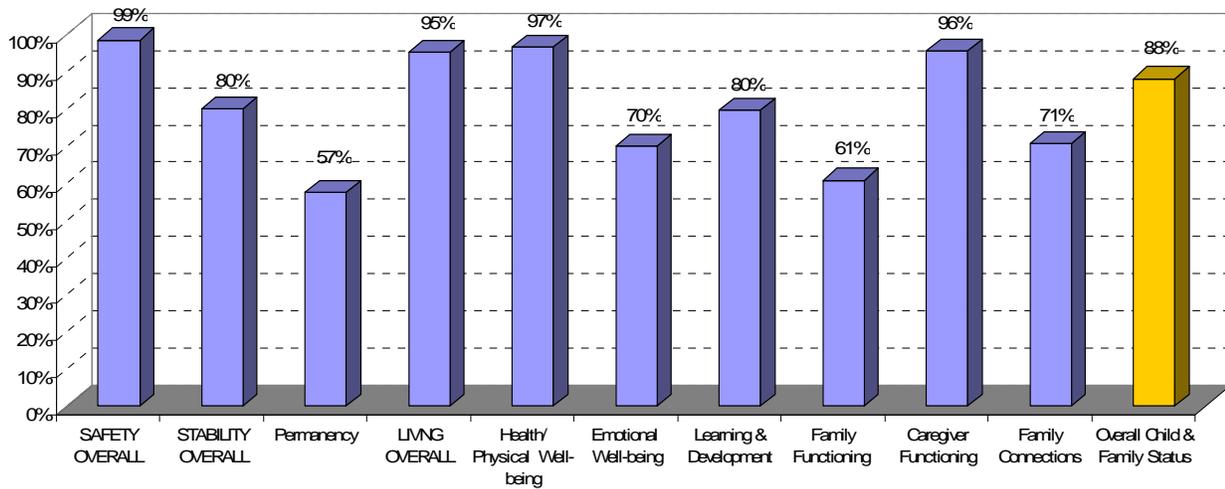
<p style="text-align: center;"><b>Maintenance Zone: 5-6</b></p> <p>Status is favorable. Efforts should be made to maintain and build upon a positive situation.</p>	<p><b>6 = OPTIMAL &amp; ENDURING STATUS.</b> The <u>best or most favorable status presently attainable</u> for this individual in this area [taking age and ability into account]. The individual is <u>continuing to do great</u> in this area. Confidence is high that <u>long-term needs or outcomes will be or are being met</u> in this area.</p> <p><b>5 = GOOD &amp; CONTINUING STATUS.</b> Substantially and dependably positive status for the individual in this area with an <u>ongoing positive pattern</u>. This status level is <u>generally consistent with attainment of long-term needs or outcomes</u> in area. Status is "looking good" and likely to continue.</p>	<p style="color: blue; font-weight: bold;">Acceptable Range: 4-6</p>
<p style="text-align: center;"><b>Refinement Zone: 3-4</b></p> <p>Status is minimum or marginal, may be unstable. Further efforts are necessary to refine the situation.</p>	<p><b>4 = FAIR STATUS.</b> Status is at least <u>minimally or temporarily sufficient</u> for the individual to <u>meet short-term needs or objectives</u> in this area. Status has been no less than <u>minimally adequate</u> at any time in the past 30 days, but may be short-term due to changing circumstances, requiring change soon.</p> <p><b>3 = MARGINAL INADEQUATE STATUS.</b> Status is <u>mixed, limited, or inconsistent</u> and <u>not quite sufficient to meet the individual's short-term needs or objectives</u> now in this area. Status in this area has been somewhat inadequate at points in time or in some aspects over the past 30 days. Any risks may be minimal.</p>	
<p style="text-align: center;"><b>Improvement Zone: 1-2</b></p> <p>Status is problematic or risky. Quick action should be taken to improve the situation.</p>	<p><b>2 = POOR STATUS.</b> Status is and may continue to be <u>poor and unacceptable</u>. The individual may seem to be "<u>stuck</u>" or "<u>lost</u>" with <u>status not improving</u>. Any risks may be mild to serious.</p> <p><b>1 = ADVERSE STATUS.</b> The individual's status in this area is <u>poor and worsening</u>. <u>Any risks of harm</u>, restriction, separation, regression, and/or other poor outcomes <u>may be substantial and increasing</u>.</p>	<p style="color: blue; font-weight: bold;">Unacceptable Range: 1-3</p>

### QSR Interpretative Guide for Practice Indicator Ratings

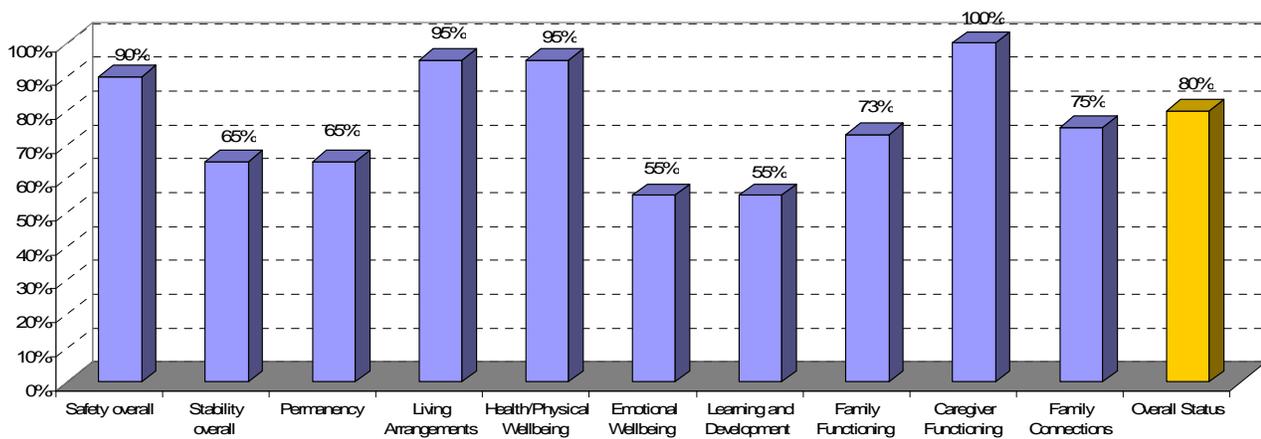
<p style="text-align: center;"><b>Maintenance Zone: 5-6</b></p> <p>Performance is effective. Efforts should be made to maintain and build upon a positive practice situation.</p>	<p><b>6 = OPTIMAL &amp; ENDURING PERFORMANCE.</b> <u>Excellent, consistent, effective practice</u> for this individual in this function area. This level of performance is indicative of <u>well-sustained exemplary practice and results</u> for the individual.</p> <p><b>5 = GOOD ONGOING PERFORMANCE.</b> At this level, the system function is <u>working dependably</u> for this individual, under changing conditions and over time. Effectiveness level is <u>consistent with meeting long-term needs and goals</u> for the individual.</p>	<p style="color: blue; font-weight: bold;">Acceptable Range: 4-6</p>
<p style="text-align: center;"><b>Refinement Zone: 3-4</b></p> <p>Performance is minimal or marginal and maybe changing. Further efforts are necessary to refine the practice situation.</p>	<p><b>4 = FAIR PERFORMANCE.</b> This level of performance is <u>minimally or temporarily sufficient to meet short-term need or objectives</u>. Performance in this area may be no less than <u>minimally adequate</u> at any time in the past 30 days, but may be short-term due to change circumstances, requiring change soon..</p> <p><b>3 = MARGINAL INADEQUATE PERFORMANCE.</b> Practice at this level may be <u>under-powered, inconsistent or not well-matched to need</u>. Performance is <u>insufficient for the individual to meet short-term needs or objectives</u>. With refinement, this could become acceptable in the near future.</p>	
<p style="text-align: center;"><b>Improvement Zone: 1-2</b></p> <p>Performance is inadequate. Quick action should be taken to improve practice now.</p>	<p><b>2 = POOR PERFORMANCE.</b> Practice at this level is <u>fragmented, inconsistent, lacking necessary intensity, or off-target</u>. Elements of practice may be noted, but it is <u>incomplete/not operative on a consistent basis</u>.</p> <p><b>1 = ADVERSE PERFORMANCE.</b> Practice may be <u>absent or not operative</u>. Performance may be <u>missing (not done)</u>. - OR - Practice strategies, if occurring in this area, may be <u>contra-indicated or may be performed inappropriately or harmfully</u>.</p>	<p style="color: blue; font-weight: bold;">Unacceptable Range: 1-3</p>

### APPEDIX 3

**QSR STATUS INDICATORS PERCENT ACCEPTABLE :  
County-Wide**

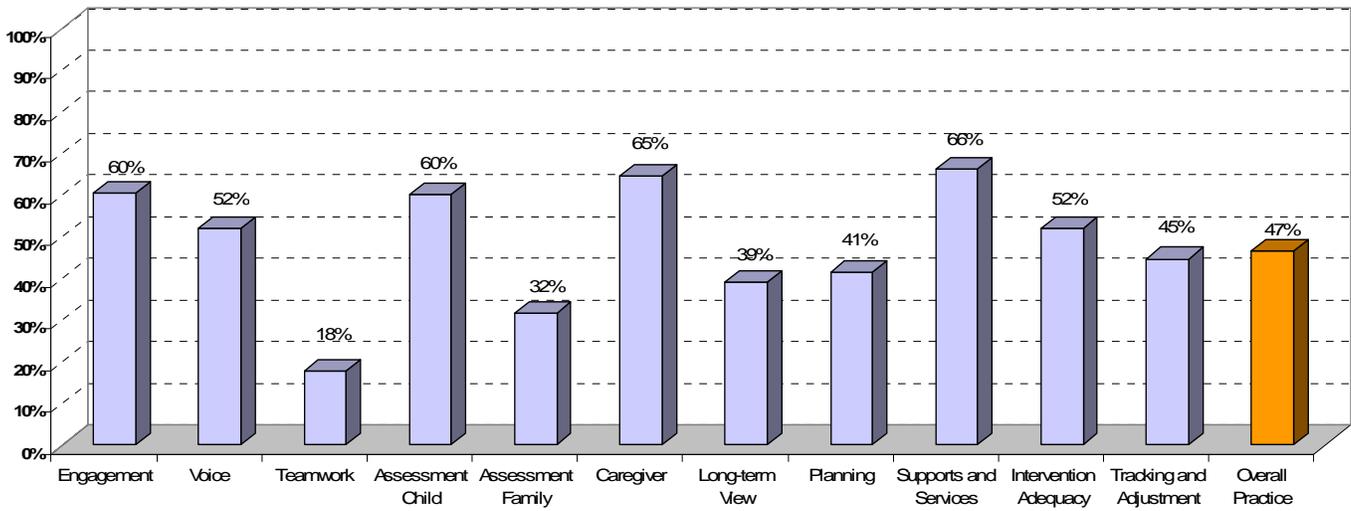


**QSR STATUS INDICATORS PERCENT ACCEPTABLE :  
WRAP**



## APPENDIX 4

**QSR PRACTICE INDICATORS: PERCENT ACCEPTABLE**  
County-Wide



**QSR PRACTICE INDICATORS: PERCENT ACCEPTABLE**

WRAP

100%

