

**The Katie A. Advisory  
Panel  
First Report to the Court  
January 13, 2004**

**The Katie A. Advisory Panel  
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**I. INTRODUCTION AND BACKGROUND**

The Los Angeles County Department of Children and Family Services (DCFS) and the plaintiffs in *Katie A. et al. v. Diana Bont 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 (in Paragraph 6) imposes responsibility on DCFS for assuring that the members of the class:

- promptly receive necessary, individualized mental health services in their own home, a family setting or the most homelike setting appropriate to their needs;
- 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;
- 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
- 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 agreed to implement a series of strategies and steps directed toward improving 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 DCF’S 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.

This first report to the court is a description of the Panel's activities and findings to date.

## **II. INITIAL PANEL ACTIVITIES AND RECOMMENDATIONS**

The first Panel meetings were spent in meetings with DCFS staff, collecting general information about agency operations and receiving briefings on the strategies listed in

Paragraph 7. Shortly after the Panel was selected, a new DCFS Director, Dr. David Sanders, was appointed and met with the Panel on three occasions regarding his goals for agency improvement.

In initial meetings, the Panel and Dr Sanders reached agreement that while the initiatives in Paragraph 7. may have some positive impact on the plaintiff class, these efforts alone will not be sufficient to achieve the four primary objectives of the Settlement contained in Paragraph 6. The Panel offered to contribute its ideas and expertise to the design and implementation of a broader and deeper reform agenda, to which the Department responded favorably.

Three of the Panel meetings have each involved at least a day interacting with the DCFS deputies discussing the changes they are implementing. County Counsel and Plaintiffs' attorneys have been present for most of our meetings. We have visited DCFS field offices once, conducting several different focus groups of workers and supervisors. One of the Panel members has worked continuously with the Wraparound teams serving the named plaintiffs. We also met with Judge Nash, the presiding Juvenile Court judge and with the Children's Law Center attorneys who represent children in juvenile court.

In the Panel's December work, Panel members observed proceedings in Juvenile Court and talked with parents who were present in court. A Panel member met with DCFS and University training staff about pre-service training and with Emergency Response workers and supervisors. Panel members also met with a large focus group of foster parents.

The Katie A. Panel has sent Dr. Sanders a series of letters discussing our observations and proposing ways in which we could assist the change process (see Appendix II to this report). A status report by a Panel member on the named plaintiffs and a study of children discharged during the closing of MacLaren was provided. A copy of the MacLaren report can be found in Appendix I of this report.

After only a short period assessing the DCFS's ideas and performance, the Panel is not yet in a position to provide definitive opinions on all areas of the Department's functioning. The Panel has been encouraged by the Department's interest in a broader system change agenda and for example, found the Department's efforts to define a system practice model credible. While the Panel has not seen a final version of the practice model, if the Department fully and faithfully implements reform efforts consistent with the principles of its own practice model, substantive improvements in outcomes for children could be realized. At this point, however, the Department is choosing a number of different strategies.

To date we have not found the Department's primary strategies for improving practice and outcomes either consistent with the draft practice model or likely to achieve the objectives expressed in the Settlement. We have offered consistent feedback to the Department on the approaches we would consider to be most effective, as reflected in the

Eighteen about whom this information was available are taking medication prescribed by psychiatrists:

Depakote	7	Wellbutrin	3
Zyprexa	6	Cogentin	2
Lithium	4	Haldol	2
Seroquel	4	Zoloft	2
Celexa	3	Adderall	1
Effexor	3	Clonidine	1
Geodon	3	Paxil	1
Neurontin	3	Tenex	1
Risperdal	3		

Although the court is approving these medications, more serious attention should be given to the side effects and possible long-term damage of these medications for children--out-of-control and suicide behavior linked to the SSRIs (Celexa, Paxil, and Zoloft), diabetes linked to the new schizophrenia medications (Zyprexa, Geodon and Seroquel), suppressed growth linked to Adderall, and liver and pancreas damage linked to Depakote. In addition, since most of them are adolescents with limited ability to follow a physician's instructions, that many of these medications are unsafe in combination with alcohol or can have serious complications if the young person gets overheated should also be a concern when they are living in the community. A consistent method for well-informed DCFS/court oversight of medications is necessary.

Six have medical problems noted in their diagnoses (asthma-3, seizure-1, diabetes-1, and spina bifida-1). Additionally, one is HIV+, another one has seizures, and one had repeated testing for heart irregularities; the child with spina bifida also has only one kidney; two children are reported to be obese.

Only four have tested IQs in the normal range. Fourteen have tested IQs under 79. In their diagnoses, one was labeled borderline intelligence, eight mild mental retardation and one moderate mental retardation. Only two are reading at the high school level, one at the seventh grade level, one at the sixth grade level, two at the fourth grade level and eight at the third grade level or below. School information was provided for only ten of the children, typically either the name of the school and grade or that the child was in special education.

Strengths were indicated for only ten children. The 20 children were described as having the following primary problems:

depression	11
aggression	8
impulsivity	6
communication difficulties	6
anxiety	5
suicidal thinking/self-injury	5

agitation	5
labile moods	5

These problems, and associated anger, threats, tantrums, irritability, and distractibility, are the reasons given for the high rate of placement breakdown since (and usually before) their most recent discharge from MCC. The relatives, foster homes, and group homes to which they were discharged could not manage these behaviors.

The court reports give little information about the services provided to assist the children or their relatives, foster homes or group homes other than the four children receiving Wraparound and the five children receiving outpatient counseling.

#### WHAT CAN BE LEARNED FROM 20 CHILDREN UNSTABLE AFTER MCC DISCHARGE?

These children have multiple needs because they have been traumatized, are brain damaged because of prenatal and other factors, and have experienced repeated losses of family and many placements. Their problem behaviors--rather than their needs--appear to be the focus of the casework. Because there was little apparent tailoring of services in these complex cases, unsuccessful placements should not be a surprise.

Just as DCFS would recruit a specialized foster parent with the skills necessary to care for a medically fragile child, with these 20 children, relatives, foster homes and group homes must be informed that they have to meet the needs of depressed, aggressive, impulsive, anxious, self-injurious, agitated, moody youngsters who communicate poorly. In addition, before placement DCFS staff should meet with the children and the providers who will support them to agree on the underlying needs driving these behaviors. To the extent that these behaviors are functional for the children, they will have to be individually taught new, not harmful ways to meet those needs. Individual instruction of new behaviors and new self-talk is obviously essential to change habitual depression, aggression, and impulsivity. The goal of unconditional care must become a reality in practice to prevent the harm of multiple placement, and this can only occur through intensive supports for kin, foster parents, and group home staff.

#### 1. Learning disabled children

Although low IQ scores and low reading levels were documented for of the children, almost no information is provided in the court reports or mental health assessments regarding learning disabilities. One of the responsibilities of DCFS in ensuring that children in care can become successfully independent is to help them conquer the obstacles to learning so they can read and do arithmetic to become self-sufficient and to feel proud of themselves. Although prenatal substance exposure is repeatedly documented, in only one report are sequencing problems and difficulties with understanding cause and effect identified. Executive function deficits are common among children in care and are major obstacles to being able to function independently. Sequencing and executive function improvements can be achieved through specialized

instruction so children can develop minimal organization skills necessary for employment is achieved. Failing to do so is like not equipping a child with a physical disability with a wheelchair: it makes it impossible for them to achieve self-sufficiency.

Amina is a 14-year old African American who came into care at birth because she tested positive for cocaine. She lived with a guardian until age 7; she was subsequently removed from a foster home after being physically abused; her removal (10/01) from a group home where she had formed a trusting relationship with the director triggered a re-experiencing of her family separation and "an intense trauma reaction." She had 12 placements listed on the placement history, with an additional two unlisted psychiatric hospitalizations in 2001; she was previously at MCC in 2001 and 2002. She was admitted to MCC in 11/02, discharged six weeks later to a foster home for six months and another foster home for a few days. She has been in another foster home since 6/03, receives therapy and was referred to systems of care. Her permanency goal is guardianship by her foster mother. She wants to see her father who is in prison and has no contact with her mother; she wanted to be placed with her brother--she has contact with him and her paternal grandmother and uncle. She has a tested IQ of 66, her reading level is fourth grade; the Regional Center rejected her due to high functioning and age although the evaluation indicates she has the adaptive functioning of a 7-year old. She is in special education for SED and ADHD. No strengths were indicated. Her problems include difficulty complying with directives, difficulty with sequencing and understanding cause and effect, concrete, simplistic, aggression, anxiety, and low frustration tolerance. Her diagnoses include PTSD, Psychotic Disorder, Reading Disorder and Mild MR. She is prescribed Depakote, Neurontin and Zyprexa (2/02). Her last court date was in 7/03.

## 2. Recovering from trauma

Most of the children had been traumatized by physical or sexual abuse and repeated losses. In addition to the six diagnosed with Post Traumatic Stress Disorder, many of the depression, aggression and anxiety symptoms in these children are likely to be connected to trauma. Yet trauma treatment is seldom mentioned. Becoming successfully independent is unlikely for children who have not understood their maltreatment, learned to separate the past from present, and decided that they should not be harmed further (particularly by self-injury or interfering with their own success).

April is an African American 13-year old who came into care at age 6 as a result of physical abuse. She was in her first foster home for almost two years, had an unsuccessful return home, and she was placed with a relative for five months; there is an indication that she was abducted from a foster home in 1/03. She had 16 placements listed on the placement history. She was admitted to MCC in 1/03, and discharged two days later to a group home for six days and then a return to MCC for two weeks. She has been living at the Florence Crittenden group home since 2/03 and receives therapy. Her permanency goal is reunification, and she and her mother started conjoint therapy in 9/03; it is unknown whether she visits with her brother.

She has a tested IQ of 57, but her reading level is unknown. No strengths were indicated. Her problems include low self-esteem, depression, aggression, confusion, moodiness, and agitation. Her diagnoses include Major Depression with Psychotic Features and PTSD. She is prescribed Lithium, Zoloft and Zyprexa (6/03). Her last court date was in 9/03.

### 3. Children in care since early childhood who should have had permanent homes

Mayra is a 15-year old Latina who came into care at age 2 because of sexual abuse and physical abuse. She was born with one kidney and spina bifida and had several surgeries including a VP shunt. She was placed at Westside group home from age 2-11, with placements at MCC at age 2 and age 11. She had 12 placements listed on the placement history, with at least one additional unlisted psychiatric hospitalization. She was admitted to MCC in 7/02, discharged almost seven months later to a foster home for six months, a group home for a day, followed by four hospitalizations. She has been in a group home since 7/03 and receives TBS as well as Wraparound services to improve her relationship with her mother. Her permanency goal is LTFC. Her caseplan goal is to stabilize her behavior in a structured setting and transition her to a therapeutic foster home. She has had some visits with her mother. She has a tested IQ of 75, and her reading level is fourth grade. Her strength was being artistic. Her problems include depression, aggression and anxiety. She is not consistent with catheterizing herself every four hours, leading to chronic urinary tract infections. Her diagnoses include Oppositional Defiant Disorder and Major Depression. She is prescribed Effexor and Seroquel. Her last court date was in 4/03.

### 4. Children who should have been provided with intensive enough supports to have permanent homes while they were in elementary school

Carolina is a 17-year old born in Brazil who was abandoned with an unrelated caretaker, then moved to another caretaker; she entered care at age 7 as a result of physical abuse (she had been sexually abused at age 5). She was in her first foster home for more than two years and her second foster home for four years but was asked to leave for practicing witchcraft. She had 13 placements listed on the placement history, but had at least four additional unlisted hospital stays. She was admitted to MCC in 10/02, was discharged after three months to a foster home for three months which broke down when her friend committed suicide, and a group home for six weeks. She has been living at Hathaway since 6/03. Her permanency goal is LTFC. She has a tested IQ of 70, but her reading level is unknown. The strength that was indicated was that she likes playing soccer. Her problems include low self-esteem, depression and self-mutilating. Her diagnoses include Major Depressive Disorder and Sexual Abuse. She is prescribed Effexor and Risperdal. Her last court date was in 6/03.

Daniel C. is an African American 13-year old who entered care at age 7 as a result of physical abuse and extreme neglect by his developmentally delayed mother; he was born HIV+ but tested negative in 1998. His father is deceased; his mother was

in Metro but her whereabouts are unknown. He spent almost two years in his first foster home; his third home was a legal guardianship where he was placed with his brother. He has had 26 placements, including four previous stays at MCC (three times in 2001 and almost all of 2002). His most recent MCC admission was in 6/02, he was discharged after more than six months to a foster home where he remained for two weeks, followed by a foster home for six weeks and a group home for a month. He has been in a residential program (Morning Sky-outside LA) since 4/03. His older brother is in a group home, and they have phone contact. His permanency goal is LTFC. He has a tested IQ of 47, but reading level is unknown. The only strength indicated is that he has become a good photographer at the program. His problems include low adaptive functioning, difficulty following rules, depressed, assaultive, angry, impulsive, and anxious. His diagnoses include Depressive Disorder, Mild MR, and ADHD; previously he was psychotic. He is prescribed Risperdal, Neurontin, Depakote, and Zoloft (9/03). His last court date was in 9/03.

Isabel is a 12-year old Latina who entered care at age 10 as a result of extreme neglect and physical abuse of a sibling; subsequently her mother gave birth to a baby who tested positive for PCP. She has had 19 placements, including two previous stays at MCC in 2002. Her most recent MCC admission was in 9/02, she was discharged after three months to a foster home where she remained for two months, followed by two hospitalizations and a conservatorship. She has been at Harborview since 4/03. She has monitored visits with her mother and two siblings who are in foster homes; one sibling has been adopted. Her permanency goal of LTFC was established at age 11. She has a tested IQ of 78 and reads at the first grade level. The only strength listed is being artistic. Her problems include learning problems, being self-injurious, school problems, depression, being defiant, aggressive, and having temper tantrums. Her diagnoses include Dysthymic Disorder, PTSD/Oppositional Defiant Disorder, Learning Disorder and Borderline Intellectual Functioning. She is prescribed Geodon and Seroquel (5/03). Her last court date was in 5/03.

Benjamin is a 15-year old African American who entered care at age 8 because of physical abuse. He had 27 placements listed on the placement history, but had an additional seven unlisted hospital stays; he had six previous stays at MCC (three in 2000, one in 2001, and two in 2002). He spent 17 months at McKinley; reunification with his mother was unsuccessful, and he spent three months at Starview, 14 months at Vista del Mar and 15 months at Harborview. His most recent MCC admission was in 11/02, he was discharged after a month to a group home for more than four months, was admitted to Gateway hospital, and has been at Metro State Hospital since 5/03. The court report says a conservatorship was necessary because of "minor's habit of demanding to be moved every time he became anxious and thus never moving through the anxiety to a higher level of functioning." His caseplan goal is to re-evaluate the conservatorship. He has not visited with his mother since 5/02 and not seen his father in 10 years; there was no mention of when he last saw his five siblings. His permanency goal is a planned

permanent living arrangement. His IQ is 67; he reads at the third grade level. No strengths were indicated. His problems include being aggressive and depressed and hearing voices telling him to kill himself. His diagnoses include ADHD, Bipolar, Major Depressive Disorder and Mild MR. His current medications are Celexa, Zyprexa and Lithium (1/03). His last court date was in 6/03.

#### 5. Children who re-entered care

It is significant that almost half of these children came into care when they were young, lived with their families, and re-entered care as the behaviors that could have been anticipated from the maltreatment that originally brought them to DCFS' attention became too difficult for their families to manage. Re-placement prevention requires specialized services for families to meet the children's needs so their behaviors do not become unmanageable.

Deshawn is an African American 13-year old who entered care at birth as a result of testing positive for cocaine. Initially he was placed for more than two months in a county shelter (unidentified); then he spent two years with a relative, one year with another relative and returned to care at age 3 and subsequently was placed with his mother who sent to him to live with his father in San Diego around age 7; he was in a shelter four times and twice in Juvenile Hall in San Diego in 2000-2001. He returned to his mother and two half-sisters for a year at age 11 before returning to care. He has had 26 placements. His most recent MCC admission was in 2/03--he was discharged after a month to a hospital where he remained for almost two months, followed by a group home for less than a week, a foster home placement for 10 days, and another group home for three months. He was placed in a Harborview home in 8/03, but is now in Juvenile Hall accused of assaulting a group home staff member. His permanency goal is unknown. His caseplan goal is to place him in the home of a maternal aunt with Wraparound services. He has a tested IQ of 119, and the only strength indicated is that he is bright. His problems include grieving over the absence of his father, difficulty being attentive, giving up easily, being angry when he is teased, depression, irritability, and poor anger management. His diagnoses include ADHD and conduct disorder; he has asthma and is obese. He is prescribed Adderall and Geodon (3/03). His last court date was in 5/03.

Natasha is a Caucasian 13-year old who entered care at age 6 as a result of sexual abuse by her stepfather. Her maternal great grandparents adopted the sibling group of three, but could not manage Natasha as a teenager with conflicts with her half-sisters. She had six placements listed on the placement history, but had additional unlisted hospital stays. Her most recent MCC admission was in 10/02; she was discharged after a month to her great grandparents' home where she remained for three months, was hospitalized, was placed in a foster home for two weeks, followed by a foster home for six months. She has been living in another foster home since 8/03 with Wraparound services. Her permanency goal is reunification with her great grandparents who she visits on the weekends; her mother died recently. The only strength indicated is her interest in Egyptology. She has a tested IQ of 112 and reads

at the high school level. Her problems include suicidal thinking, low self-esteem, feeling worthless and unloved (especially when her family compares her to her mother who was a drug abuser), mood instability, impulsivity, anxiety, anger, and assaulting great grandparents and siblings. Her diagnoses include Bipolar, PTSD, and Oppositional Defiant Disorder. She is prescribed Risperdal, Neurontin, and Effexor (5/03). Her last court date was in 5/03.

Mario is a 15-year old Latino who first entered care at age 3 as a result of physical abuse. He returned to his parent and re-entered care in 1995, returned to his parent in 3/02 and re-entered care in 7/02. He has had 11 placements, including a previous stay at MCC in 2002. His most recent MCC admission was in 1/03, he was discharged after a month to a group home where he remained for a month, followed by a foster home placement for two months. He has been living with a relative since 5/03 with Wraparound services and medical treatment for a life-threatening illness; he refuses counseling. His permanency goal is LTFC. No strengths are noted. No mental health assessment was in his record. His last court date was in 7/03.

6. Children who have feel betrayed and special efforts must be made so they can trust a permanent caretaker and give up on the person they lost

Christopher is an African American 17-year old prenatally exposed to cocaine who entered care at age 1 because of his mother's mental illness. He was abandoned at age 12 by his guardians because he falsely alleged fondling by a foster brother, and the record indicates that he was "basically a good kid who was hurt when he was dumped by his guardians." He had 10 placements listed on the placement history. His most recent MCC admission was in 6/02 for six months; he was discharged to a foster home for four months and then a group home where he waited four months for Job Corps admission. He was incarcerated in 8/03 for writing a bad check; the record indicates that a probation camp would be harmful because of his small stature. His permanency goal is LTFC; his parents' whereabouts are unknown. His caseplan is to remain in a structured setting until emancipation. His IQ is unknown; he reads at the fifth grade level. No strengths were indicated. His problems include being depressed due to abandonment, feeling hopeless and engaging in risky behaviors, sabotaging himself when he is successful, and self medicating. His diagnoses include Depressive Disorder and Disruptive Behavior Disorder. He refuses prescription medication. His last court date was in 7/03.

George is a Caucasian 14-year old who entered care at age 9 after physical abuse by his stepfather; he may have been sexually abused. He has had 14 placements including an unsuccessful pre-adoptive placement and a five month stay at Five Acres; he had a brief previous stay at MCC in 1999. His most recent MCC admission was in 11/02 for three weeks; he was discharged to a group home for three months, another group home for two months, a foster home for two days and Hathaway for five months. He has been at a group home since 10/03. His six half-siblings have been adopted; he has his first visit with three of them soon. His permanency goal is LTFC (established at age 11); his father was a heroin addict

- To maintain her attachments to her sisters and great-grandmother without that contact undermining her happiness in another permanent home
- To believe she has a good future and that she is in charge of how it turns out

Kristin wanted a therapeutic foster home and placement in a "regular" high school. At times Kristin has been criticized for changing her mind, although it is not surprising that she feels hopeless because she has had so many placements and has no real prospects for permanency.

At UCLA Kristin was diagnosed with Post-Traumatic Stress Disorder and Reactive Attachment Disorder. We have heard that UCLA recommended that Kristin not be placed in a hospital or locked psychiatric facility but instead in residential treatment in Utah (Provo Canyon School/Heritage Center). Dr. Beyer indicated to UCLA that it puts Kristin at risk to wait for her to stabilize in a facility because (1) she cannot tolerate the anxiety about whether she will ever have a permanent home; (2) she cannot get enough individual attention to learn more acceptable ways to get what she wants; and (3) the staff cannot avoid reacting to her behavior which undermines her progress.

Immediate steps we recommend to meet Kristin's needs:

Kristin's needs would most effectively be met in treatment foster care: a talented full-time foster mother with no other children in the home who receives specialized individual training and clinical supervision to provide unconditional care and constant attention to Kristin. The foster mother should work on a team with a therapist, a mental health specialist (in the home daily) and Kristin's teachers. At first, the therapist must be in the home providing trauma treatment for Kristin and support for the developing relationship between Kristin and the foster parent. The mental health specialist must be clinically trained, experienced, and work under the therapist's supervision in order to teach Kristin new self-talk and to moderate her anger and her habit of self-harming at school, in activities, at home, and at visits. Finally, Kristin's teachers should be part of the team to reinforce the same self-talk at school.

It can be expected that Kristin will threaten to hurt herself, test the relationship with the foster parent, feel angry that she is not living with her family, identify with her mother, show reluctance to face the past, and experience self-doubt. All of these must be planned for with intensive mental health support, 24-hour on-call, and individual attention. In other communities, the risk of self-destructiveness in children like Kristin is handled in treatment foster care by a 24-hour watch as well as an active program of effective self-talk and success experiences designed by the therapist and implemented by the foster parent and mental health specialist (in times of stress, suicide precautions might require hiring an individual to stay awake at night). Considerable clinical support will be necessary to ensure that the foster parent and mental health specialist do not become reactive to Kristin's behavior, but remain focused on the needs driving the behavior. This treatment foster home should make a commitment to become Kristin's permanent home, with the goal that the intensive mental health services could be gradually decreased over time.

Kristin was released from UCLA to a group home where arrangements had been made to (a) house her by herself in a separate wing of the house with around-the-clock staffing; (b) continue her trauma treatment at CII; and (c) initiate a community school placement, initially part-time. However, staff were not fully prepared to understand or respond to her needs and she was hospitalized.

Intervention is necessary to assist a provider and DCFS to create a special home for Kristin with sufficiently intensive support to meet her needs.

## Janelle

Janelle is a 12-year old African American female who had 25 placements, including five with family members, 12 hospital stays at seven hospitals (Augustus Hawkins, BHC Alhambra, Charter Oaks Aurora, Del Amo, Kedren, UCLA and Van Nuys) and three stays at MacLaren during her nearly three years in care. She was returned to her family in September, 2002 and lives with her mother, twin and three other siblings. Janelle is intelligent, loving, close to her great-grandmother, father, mother, and stepmother, helpful around the house, active (plays ball, dances, goes to church, sings in the choir) and defends others who are being unfairly treated. Their mother, who was 19 when the twins were born, and their father separated in 1998. In 1999, both parents were in new relationships. Around the same time, their paternal great-grandmother, who had helped raise them since birth, had a stroke, which was especially upsetting for Janelle. Janelle, her twin and her younger sister were removed from their home in October 1999 for abuse when her parents tried to control Janelle's severe behavior outburst. Her father was convicted and incarcerated for this abuse; her mother was held in jail for a past theft of AFDC funds. A year later the twins returned to their mother's home (around the time that their father and stepmother were busy with their new baby), which appeared to be a stable placement without hospitalizations or reported problems for eight months. The twins lived with their father when their mother was about to give birth, but he found them difficult to manage and reportedly feared that Janelle might falsely report abuse that would violate his probation. They were briefly in a foster home and then returned to their mother in October 2001. Two weeks later, their mother was incarcerated when she took the baby to the hospital after he had ingested PCP. Janelle was at MacLaren, with several hospitalizations, from November 2001-September 2002. Although she had weekend home visits with no problems, her outbursts at MacLaren led to a request for a conservatorship which was denied.

At a meeting with Janelle's father, great-grandmother, a family friend who was willing to provide a home for Janelle, and Dr. Marty Beyer last year, Janelle's needs were identified:

- To learn to anticipate what gets her angry and be reminded to walk away and relax before she explodes
- To learn what to do when she feels jealous of her twin
- To understand that she wants to be in control because her parents' separation and grandmother's stroke scared her
- To have a lot of attention, especially private time with her great-grandmother, mother, and father
- To feel good about herself
- To learn how to speak up about things that are unfair without getting into trouble
- To learn how to pick her battles and not be so stubborn it gets her into trouble
- Not to blame herself for everything
- To talk about her worries and learn what to do when her worries are overwhelming

During a Wrap meeting soon after Janelle returned to her family (and subsequently by phone on several occasions), Dr. Beyer urged a focus on Janelle's safety needs. But the needs listed on the superficial wraparound plan underestimate the importance of family members understanding the needs behind Janelle's behavior:

- Family needs to feel stable
- Family needs the opportunity to learn how they work together to solve family problems, how to develop new tools, and to have fun together
- Family needs to be supported with strengths and weaknesses.

Wrap (Connections-Vista del Mar) services focus on helping Janelle's mother cope with being overloaded by working, making appointments, transporting children, dinner and bedtime; the financial, babysitting and housing assistance have been helpful to this family. For months since her discharge from MacLaren Janelle's behavior at home has been manageable, leading to the conclusion that it was safe to concentrate on the mother's needs. After months of delay, Janelle finally started therapy recently, but the therapist does not attend Wrap meetings and as far as we know, reports on progress in therapy particularly her feeling out of control (which is a safety need because it may result in aggression) have not been provided to the Wrap team; there is no apparent connection between Janelle's therapy and how her mother or the child and family specialist manage her. Recently Janelle has had behavior problems at school and home which are viewed as sibling rivalry with her twin; when she was placed, her special education program stated they would expel her if she acted out.

Janelle's mother is pregnant (due in August) and although her pregnancy appeared to be one contributor to Janelle's original aggressive outbursts, Wrap meeting notes indicate that her court case maybe closed in June, 2003, her mother granted full custody, and Wrap discontinued one month later.

Immediate steps we recommend to meet Janelle's needs:

1. Focus on Janelle's needs listed above: preventing Janelle from feeling out of control and becoming aggressive (possibly reflected in her deteriorating behavior), especially in response to her mother's pregnancy and having less time for her (and the alteration in her relationship with her father that may occur with a change in custody), by teaching Janelle and her mother new skills.
2. The therapist attending Wrap meetings, reporting on progress in meeting Janelle's needs listed above, and providing clinical supervision to the child and family specialist and Janelle's mother so they can guide her use of these new self-calming tools. This could mean the Wrap team meeting at the therapist's office.
3. Including her special education staff in the Wrap meetings to report on their progress meeting Janelle's needs listed above and agree on what helps Janelle not feel out of control. This could mean the Wrap team meeting at the school.
4. Wrap continuing at least six months past the delivery of the new baby.

**Marcia**

Marcia (dob 11/6/85) is a 17-year old blind Hispanic female who is intelligent, independent, and compassionate. Her elementary school made repeated reports to Child Protective Services about her mother's abuse. At age 13, she and her two younger half-siblings were removed after being physically and emotionally abused and left unsupervised by their mother. Marcia was diagnosed with a sexually transmitted disease and disclosed that she had been sexually abused by her maternal uncle and stepfather. The other children were returned, but court-ordered counseling between Marcia and her mother failed because her mother, described as narcissistic and angry at Marcia, denied the sex abuse, with the last therapist recommending (2/01) that sessions be discontinued because "they leave Marcia feeling unworthy and unloved." Marcia's wish for a loving mother continues to drive her depression and hopelessness.

In three years, Marcia had more than 30 placements, including 16 hospital stays at seven hospitals (BHC Alhambra, Charter Oaks, Children's, College, Del Amo, Memorial, and UCLA), Starview and at least four stays at MacLaren. Her needs appeared to be:

- o To learn how to talk to herself to prevent self-destructive thoughts

- To be in charge because she was out-of-control of her life for so long but also learn to compromise and to let others know when she is getting frustrated by not getting what she wants
- To learn the steps she can take when she is disappointed to prevent getting too upset
- To understand that her mother's rejection is not because Marcia is bad or ugly and to make peace with her mother's preference for her half-siblings
- To have success in school
- To have a fulfilling social life

Marcia's impatience as MacLaren was closing of MacLaren led to her being moved quickly in December, 2002, into a therapeutic independent living apartment created by Wrap (Starview) hiring shift staff for 24-hour coverage plus numerous child and family specialists. Staff struggled with Marcia (a) not liking school and wanting to be homeschooled which staff thought was a bad idea because of her social needs; (b) not liking therapy; (c) seeing her mother which involved staff picking her mother up and driving her an hour to the apartment and driving her home; (d) socializing with people in their 20s; and (e) learning how to care for her dog which scared some staff.

Once again in May, Marcia became upset over a disappointment, got into the locked medication drawer in the staff office and nearly killed herself (while a full-time staff person was with her in the apartment). In a Wrap meeting the decision was made to return her to Starview because they believed she could not be kept safe in the apartment. When reminded that her needs, including her safety needs, had been identified before the home was developed, staff acknowledged that they had not formed a real team to meet those needs nor had they been clear that they were supposed to "act parental" toward Marcia and mostly placated her to keep her from getting upset. There was some recognition that the friction between Wrap and Marcia's CII therapist also reduced the effectiveness of the team in meeting her needs.

Immediate steps we recommend to meet Marcia's needs:

1. Assistance to staff working with Marcia including her CII therapist, to re-consider Marcia's needs listed above and how her safety needs could be met in a home in the community, including the intensive training and clinical support necessary to be more effective than just housing her. In terms of long term outcomes, especially because Marcia will be 18 in the fall, assistance in become safe in the community must be provided.
2. A facilitated process with Marcia to learn from her suicide attempt in order to design specific self-talk and other methods to manage disappointments, which should be taught by someone clinically skilled immediately.

**Greg**

Greg (dob 7/2/88) is a 14-year-old Caucasian male who likes to play the guitar and skateboard. His mother voluntarily placed him and his older sister in foster care more than a year ago because she felt overwhelmed by their behavior, partly due to her own disability. During his six months in foster care, Greg had three placements, at MacLaren and two group homes. He returned to his mother because there was no where else to place him, and in her home he was at high risk of arrest or permanent school expulsion. Wraparound struggled to engage Greg and his family and was unsuccessful in arranging a school placement or therapy. It appeared that Greg's needs included:

- To participate in defining fair rules and reasonable rewards for following them and reasonable consequences for breaking them
- To get to sleep before midnight so he can get up in the morning; to negotiate later bedtime and later rising on the weekends

- To recognize when he is frustrated and learn ways to express his anger that do not hurt others or get him in trouble
- To recognize when he is bored and learn positive things to do to alleviate boredom
- To accept that he has a learning disability and that he can learn methods to improve his reading, math, spelling, organizational skills, and understanding instructions
- To accept that his brain has difficulty seeing consequences and to practice sequencing
- To have opportunities for success in art, guitar, computers, and working with his hands
- To have positive friends and non-risky activities he does with them

Greg's needs for limits and the supports to be successful in school were high priorities. Wraparound tried to arrange larger housing and purchase a car for his mother and did crisis intervention when Greg and his sister got into altercations. During Wraparound's involvement Greg's niece, who is a toddler, was removed from the home.

Last summer Greg got reacquainted with his father who he visited in Idaho. When he returned for a visit in December, 2002, his father filed for custody. Greg remains in Idaho where he was placed on probation for sexually abusing his half-sister last summer. He is not allowed to baby-sit, call 900 numbers, contact the victim without his therapist's approval, or leave the state of Idaho; he must attend sex offender treatment and random drug testing. His father says he is attending school and therapy which he did not want to do in LA. It was proposed that the DCFS worker, Wrap and his GAL have a family meeting with Greg, his father, therapist and teacher in Idaho, but it is unknown whether his father has been helped to understand the underlying needs that drove Greg's behavior. The question of whether the DCFS case in LA will remain open and pay for his therapy is unclear. How his attachment to his mother, sister and niece in LA will be supported has not been addressed.

Immediate steps we recommend to meet Greg's needs:

Wrap in LA working with mental health in Idaho to convene a meeting regarding Greg's needs, especially his attachment needs, that includes both his parents and helps them not argue with each other.

At this point, it appears that DCFS will not be able to meet the needs of these youth without additional assistance. Even with help from DCFS headquarters, the current providers have been unable to meet the needs of the named plaintiffs, putting all of them at continued risk. We recommend that the Department bring in a consultant who has worked with wrap providers outside the county successfully to facilitate effective plans and interventions with the named plaintiffs and where possible, help wraparound providers look at ways to improve their practice.

We would like to discuss with you these cases and the larger systemic challenges they reveal in our next Panel meeting July 23 – 25. Thank you for your attention to these concerns.

Sincerely,

Paul Vincent

Cc Katie A. Panel Members  
 Catherine Pratt  
 Ira Burnim  
 Amy Pellman

**The Katie A. Advisory Panel**  
c/o 2033 East 2<sup>nd</sup> Street  
Montgomery, AL 36106

*Marty Beyer*  
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July 14, 2003

David Sanders, Director  
Los Angeles County Department of  
Children and Family Services  
425 Shatto Place  
Los Angeles, CA 90020

RE: System Improvement Strategies

Dear Dr. Sanders:

In our meeting, you described three areas that are your highest priority at this time: serving more children at home, shortening time in care, and reducing repeat allegations of abuse at home and in foster care. Following that meeting, Panel members discussed how we might offer assistance to you and the Department in achieving those goals. We identified six systemic improvements and reforms for your consideration that we have seen succeed elsewhere. I am outlining them below.

1. IMPROVE STRENGTHS/NEEDS-BASED PRACTICE

We believe that strengths and needs based practice is foundational to achieving the outcomes you have identified. It is at the heart of several of the initiatives you now have underway, especially the Wraparound approach. We have found it effective for a set of practical reasons that include the following:

- Children and families are more likely to enter into a helping relationship when the worker or supporter has developed a trusting relationship with them.
- The quality of this relationship is the single most important foundation for engaging the child and family in a process of change.

- Children and families are more likely to pursue a plan or course of action that they have a key role in designing.
- When children and families see that their strengths are recognized, respected and affirmed, they are more likely to rely on them as a foundation for taking the risks of change.
- Assessments that focus on underlying needs, as opposed to symptoms and services, provide ~~the best~~ the best guide to effective intervention and lasting change.
- Plans that are needs based, rather than service driven, are more likely to produce safety, stability and permanency.
- The service array should be sufficiently flexible to be adapted to the unique needs of each child and family. Services and supports best meet child and family needs when they are provided in the family's natural setting or for children in custody, the child's current placement. Services should be flexible enough to be delivered where the child resides and move with the child.
- The family's informal helping system and natural allies are central to supporting the family's capacity to change. Their involvement in the planning process provides sustaining supports over time.
- Child and family interventions are more relevant, comprehensive and effective when the family's team (consisting of the family, their informal supports, foster parents, providers, teachers and other significant case contributors) makes them. Families should always be core members of the team.
- Coordination of the activities of case contributors is essential and works most effectively and efficiently when it occurs in regular face-to-face meetings of the family team.
- Many of the services and resources that children and families find most accessible and responsive are those provided within their own neighborhoods and culture.

*effective too?*

Regarding the implementation of strengths and needs based practice we recommend that three steps be taken.

- a) Strengthen the training and coaching given new and existing workers in engagement skills, assessment, needs based planning and intervention skills. Training for supervisors is especially critical.
- b) Create a team with continuity for every child and family at the earliest point of intervention and involve the child and family in team meetings throughout the life of the case.
- c) Examine the multiple team decision making models in Los Angeles and seek a common approach that can be used by all staff. We find the wraparound child and family team meeting approach to be one that is most strength and needs based. Wraparound meetings are expected to be needs based, not just event based and are designed to prevent case and practice failures, not merely to respond to them.

## 2. RECRUIT FOSTER HOMES AND PLACE CHILDREN AT THE REGIONAL LEVEL

When children remain in the same school or in close proximity to their families, visit consistency increases and children adjust better. And as you know, frequent visits are

closely linked with reunification success. Spreading the Family-to-Family philosophy of positive birth family-foster parent relationships system wide cannot occur with so many children being placed far away from their families. Giving foster homes a regional connection and limiting placements to children from that region will reinforce strengths/needs-based practice. Making placements locally will be enhanced by:

- a) Providing housing subsidies for families accepting sibling groups within each region.
  - b) Providing housing subsidies to expand the availability of licensed homes in low income neighborhoods.
  - c) Creating licensing exceptions/flexibility for non-related extended family.
  - d) Developing more intensive in-home supports for kinship/non-related extended family and for foster parents to achieve the goal of first placement as the last placement for each child and to ensure families are meeting children's needs.
3. DECREASE THE INCIDENCE OF REPEATED CHILD ABUSE AND NEGLECT REPORTS AND THE NUMBER OF CHILDREN ENTERING CARE WITHOUT COMPROMISING SAFETY

There are multiple reasons that children experience repeated abuse and neglect (as well as multiple reasons the Department receives repeated reports of abuse and neglect regarding the same families). Consequently, there is not a single strategy that will significantly reduce the incidence of repeated harm. There are, however, approaches that have been successful elsewhere that we recommend the Department consider.

- a) Underlying many unsuccessful efforts to prevent the reoccurrence of abuse and neglect is a child and family assessment that fails to identify the child's underlying needs. Interventions based on symptoms rather than the underlying needs and conditions that are causing the harm are unlikely to address the real problem. In retraining staff in strengths/needs based practice, attention is needed to insuring the assessment of child and family strengths and needs, extended family resources and each family's understanding of its children's safety needs. Especially in an urban setting with high concentrations of poverty like Los Angeles, in-service training should be developed to increase workers' capacity to access poverty and housing services quickly instead of placing children due to neglect. Availability of flexible funds to help secure housing will enhance the effectiveness of these skills.
- b) Many children enter care unnecessarily when police do not have any alternatives to removal when they become concerned about risk and safety. We recommend that efforts be made to develop protocols with local police to provide emergency family assessments and in-home interventions by the Department when police discover risk and safety

issues. Often simple alternatives to placement can be found when skilled child welfare staff are involved.

- c) The worker who removes the children and the worker to whom the case has been assigned should appear in court at the first hearing following removal. This is the most critical stage of a dependency case. Many important decisions are made and actions taken that chart the course for the remainder of the life of the case. It is at this hearing that the relationships among the players in the process are established and that the tone is set for their ongoing interactions. These hearings can facilitate and expedite the ultimate resolution of the case. It is difficult to achieve these benefits, however, if the worker is not present.

Additionally, without the worker present to describe the system's efforts, the reasonable efforts issue cannot be addressed in any meaningful way and an accurate determination regarding the necessity of removal is difficult. Finally, if the worker is not held accountable for the removal, there is little incentive for the pursuit of other options. The result is that some children will be removed unnecessarily and others will remain in substitute care when there are better alternatives.

- d) There are alternatives to removal for children born positive for drugs. An infant's safety and attachment needs are often met most effectively by not placing the child outside the family. As part of the child and family team's safety intervention strategy, systems have found the use of intensive in-home nursing care for children an effective health and safety support. A child's need to be healthy and safe can be met in numerous ways other than placement. Home based supports, when carefully used, also offer the opportunity to observe the capacity of the family to meet the child's needs.
- e) Interventions such as these will be enhanced if the system develops the capacity to serve families on a voluntary basis using workers with low caseloads.
- f) Out-of-home safety is improved when there is a cohesive child and family team with the parents, child (where age appropriate) and foster parents/caregiver as members, meeting regularly to share information on well-being, assessment and progress.

#### 4. INVEST IN IMPROVED WRAPAROUND SERVICES

The practices of Wraparound providers working with the named plaintiffs, as described in our previous letter to you, are seriously flawed. Rather than having a concentrated training program from nationally recognized Wraparound trainers, the new Wraparound programs have been trained by the first phase of Los Angeles Wraparound providers. The new providers were asked to staff up to serve children with complicated needs and the new staff were not sufficiently experienced or clinically trained. The Wraparound philosophy promulgated nationally is consistent with child-focused, family-centered

strengths/needs-based child welfare practice, but in Los Angeles it appears that Wraparound concentrates on concrete services for families (such as financial, childcare and transportation assistance). While concrete services are valuable, the unmet safety and developmental needs that brought the children into care and supporting families to meet those needs should be the Wraparound plan. However, it appears that there has not been a consistent quality assurance effort to get providers to take this approach.

As a result, Wraparound providers tend to keep clinicians at a distance. Several of the named plaintiffs were not provided with therapy in a timely fashion and therapists have not been encouraged to function as part of the team. Consequently, what happens in therapy is not connected to what happens in the home. Furthermore, due to the waiver design, Wraparound in Los Angeles is oriented toward working with birth parents and extended families. While this is a desirable goal, when such placements are not available, Wraparound should be flexible and design services around a foster or adoptive home. Wraparound providers lack placement authority so they must rely on the DCFS worker to refer a child for a traditional foster home even though a specialized recruitment is necessary to meet the child's needs.

Because Los Angeles does not have treatment foster care (which consists of much more than a higher rate of TBS), for Wraparound to create a therapeutic placement would require clinical supervision for staff to assist the foster parents. If the Wraparound providers were not so competitive with each other, they could share home finders and staff trainers and clinical supervisors for children not living with birth and extended families.

The pace of Wraparound expansion has been slow. A well-intentioned effort by providers and staff not to overwhelm staff that are new to the skills has slowed the growth of Wraparound and has limited its ability to serve many more children effectively. Using outside experts to build skills and capacity would help accelerate the development process without compromising the quality of services.

Steps that would address these limitations include the following.

- a) Provide training to Wraparound providers, using national experts experienced in the model.
- b) Ensure that there is a quality assurance mechanism to examine the quality of work by Wraparound providers.
- c) Support the use of Wraparound with foster and adoptive parents.
- d) Set expectations and support the sharing of resources among Wraparound providers.
- e) Implement a strategy to speed the expansion of Wraparound, using consultation by skilled Wraparound experts.

##### 5. IMPROVE RESPONSES TO CHILDREN'S EMOTIONAL NEEDS

The challenges presented by the named plaintiffs and many other children in the system are substantially related to the lack of appropriate responses to the trauma these children have experienced. Their behavior as a result of the trauma, loss of family and frequent moves makes stability and permanency difficult to achieve. Increased understanding of the process of recovery from trauma for children, inclusion of clinicians as active members of the team, improved integration of strengths/needs-driven clinical services (including increasing home-based intervention and enhancing clinical skills of TBS workers) and clinical supervision in casework with children and families are essential. These practice limitations would benefit from intensive training of Department staff and providers and the encouragement of trauma treatment designed to meet the unique needs of children in DCFS care.

6. AN ADOPTION WORKER ON EVERY UNIT IN THE REGIONS

Not only does having an experienced adoption worker on every unit enable children's permanency needs to be met, but it allows caseworkers to concentrate on taking care of other aspects of their cases in which their expertise may be greater. Elsewhere, the cost of these positions has saved money, reducing stays in foster care and court costs.

In conclusion, we hope that these ideas are responsive to your strategic goals for the system at this stage. I hope that your staff would consider the experience and expertise of the Panel members in these and other areas as a resource available to you. We would be happy to discuss these recommendations further in our July meeting.

Sincerely,

Paul Vincent

cc Catherine Pratt  
Ira Burnim  
Amy Pellman

**The Katie A. Advisory Panel**  
c/o 2033 East 2<sup>nd</sup> Street  
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*Marty Beyer*  
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*William Jones*  
*Joe Loftus*  
*Paul Vincent*

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July 30, 2003

David Sanders, Director  
Los Angeles County Department of  
Children and Family Services  
425 Shatto Place  
Los Angeles, CA 90020

RE: Named Plaintiffs

Dear David,

We felt that we had a productive meeting last week and want to thank you for contributing to our effort of make our work supportive of your priorities. While there is still developmental work for us to do internally, we see progress in shaping our approach. Also, please thank your leadership staff for making themselves available on such short notice. We have several things to communicate in the next week or so, the first being a request regarding the named plaintiffs. In a follow up letter, we will offer some suggestions about the focus of our next meeting for you to consider.

Regarding the named plaintiffs, there seemed to be general agreement between the Panel and your staff that these youth continue to have many unmet needs that need prompt attention. Toward that end, we are asking the Department to take a number of steps that will result in more effective plans for the 5 named plaintiffs and to provide us with copies of revised plans by August 15. Those steps are as follow.

1. Assess the strengths and needs across comprehensive life domains of each child, including as a minimum those needs set out in the Panel's letter of July 3, 2003. Caregiver needs that must be met to achieve the child's needs should also be assessed.
2. Identify the treatment and other supports and services that will be employed to meet the identified needs.
3. Detail the strategies for creating needed services that do not currently exist.

4. Identify the sources of funding required for each component of the plan.
5. Identify each of the treatment and other service providers that will implement the plan, including their qualifications, how the Department will supervise them and by whom and how the quality of provider performance will be assured.
6. Establish an implementation and completion deadline for each step of the plans.
7. Utilize the development of these plans and resources as a means for identifying the systemic barriers to providing class members with the care and services to which they are entitled by Paragraph 6 of the Settlement Agreement.
8. Utilize the expertise of Katie A. Panel members Marty Beyer and Richard Clarke or other experts they may recommend in the development of these plans.
9. Identify the Departmental employee with the skills, knowledge and authority to insure that these plans are implemented.

Ordinarily, we would not choose to be this directive and specific in making requests of the Department and certainly would prefer not to at this stage of our engagement with staff. However, the urgency of the needs of the named plaintiffs, the priority they have in the eyes of the court and the specific responsibilities of the Panel, pursuant to Paragraphs 6(a)(b) and (c), 7(a) and 15(a) and (b) of the Settlement Agreement, give this issue particular urgency.

Sincerely,

Paul Vincent

cc Catherine Pratt  
Marty Nagel  
Ira Burnim  
Amy Pellman

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August 26, 2003

David Sanders, Director  
Los Angeles County Department of  
Children and Family Services  
425 Shatto Place  
Los Angeles, CA 90020

Dear David,

I am writing in preparation for the Panel's conference call Friday and am suggesting agenda ideas for the September meeting on which we would like your input. As you know, we asked if it would be possible for us to meet with you and your senior management staff or deputies about how the system will respond to the needs of children in or at risk of entering the Department's custody. We don't have a final schedule yet, but are thinking about using September 10 and 12 for field work and the 11<sup>th</sup> for the meeting with you and your staff. One of the main reasons for writing is to get your thoughts about the most useful way to spend the 11<sup>th</sup>.

We feel that the Panel is in a transitional stage at this point. We have the formal responsibility to review the Department's plans in a number of areas and to report on the Department's progress in meeting the objectives in the settlement agreement. A number of those plans and initiatives predate the settlement and while they have merit, based on prior conversations with you, they may not be the complete set of strategies appropriate at this time. Also, it appears that the planning needed has not been completed.

Concurrent with our examination of the plans for serving the plaintiff class, we also want to be available as a technical assistance resource to the Department. The Panel believes that its most sustainable value may be in the advisory role. In our earlier meetings with you, you outlined some of your preliminary ideas and priorities for system improvement and we hope to be of assistance to you in implementing them.

So in that regard, we have a suggestion for our meeting on the 11<sup>th</sup>. We could begin by hearing about the Department's plans for meeting the needs of these children and their families, especially the plaintiff class. As we review the Department's strategies for improvement, our responses will be influenced by our respective experience serving this population and knowledge about has been proven to be effective systemically in responding to their needs. Or if you wish, so that Department staff will have some idea of what our opinions will be, we could begin the meeting with the Panel sharing its beliefs about how the Department might respond to the needs of these children. Content would include Wraparound design and operations, training and skill building, case decision-making, court relationships, financing and data, at a minimum. Other issues we would want to discuss are the named plaintiffs, the current status of children discharged from MacLauren and our plans for information gathering in the field.

Sharing our experiences in changing front line practice, designing clinical and Wraparound interventions, dealing with the judicial system and modifying critical system processes may help contribute some structure to the strategies that are chosen by the Department. This discussion could also identify the Panel expertise staff may choose to tap if technical assistance is desired. Alternatively, if the timing is not right for us to assume a more consultative role, we could concentrate our activities more exclusively on evaluation of the system's functioning.

Regarding the latter, the judge made it clear in the recent status conference that he expected us to be expansive in our assessment and involved in direct conversations with children, caseworkers and other key contributors in the system. To date, our review of the Department's operations has been preliminary and admittedly somewhat spontaneous. To structure our work thoughtfully and to avoid overwhelming your staff with requests for data on short notice we want to develop a plan for evaluative work that could include the following:

- Visiting some Mac kids and Wrap kids and their families
- Various focus groups (workers, kids/families, providers, lawyers (GAL's and agency attorneys), foster parents, etc.
- Examining data
- Attending court(s)
- Reviewing/attending training
- Reviewing case records
- Assessing the intake process
- Reviewing fiscal structures

Since some Panel members will be present on the 10<sup>th</sup> and 12<sup>th</sup>, we would like to begin some of this work at that time. We are suggesting meeting with several key informant groups of caseworkers and separately, meeting with some caseworkers of MacLauren children who have had successful post-discharge experiences to learn what worked for them. We will correspond with Marty Nagel about the planning for these days.

I hope these ideas will provide some structure for this week's conference call and look forward to speaking with you.

Sincerely,

A handwritten signature in cursive script that reads "Paul Vincent". The signature is written in black ink and is positioned above the typed name.

Paul Vincent

**The Katie A. Advisory Panel**  
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September 3, 2003

David Sanders, Director  
Los Angeles County Department of  
Children and Family Services  
425 Shatto Place  
Los Angeles, CA 90020

RE: Agenda

Dear David,

I have attached a draft agenda for our meeting on the 11th for your review and comment. Basically, I suggest that we begin with a discussion of a set of principles that would be the foundation of a practice model. I have attached a set that we use in working with systems on this task that may give us a point to begin. It includes principles from both child welfare and children's mental health best practice. Richard may have additional content to contribute from the wraparound literature. You and your staff may have similar sets of principles to contribute as well. I would hope that we could spend approximately an hour and a half on this process before moving to the more challenging task of operationalizing the principles, which could take most of the balance of the day. During this discussion we can add what we've learned from evaluation efforts and practice experience nationally about what works.

Sincerely,



Paul Vincent

**Draft Agenda  
Practice Model Development  
September 11, 2003  
9:00 – 4:30**

9:00 – 9:30

Introductions and Purpose

9:30 – 11:00

Discussion/Selection of Practice Model Principles

11:00 – 11:45

Operational Implications of the Principles

Policy	Providers/Contracting
Training	Staffing
Services	Other
Financing	
QA/Evaluation	
Organization	

11:45 – 1:00

Lunch

1:00 – 4:00

Operational Implications of the Principles

4:00 – 4:30

Next Steps

**The Katie A. Advisory Panel**  
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September 21, 2003

David Sanders, Director  
Los Angeles County Department of  
Children and Family Services  
425 Shatto Place  
Los Angeles, CA 90020

RE: Meeting Summary

Dear David,

Thank you for meeting with us and making your leadership team available for our recent discussions. Having them there made the discussion of the development of a practice model much more substantive. While I am not attempting to provide detailed minutes of our discussions, I will summarize some of the key themes.

In reviewing an existing set of practice principles provided by the Panel as a beginning point, you and other Department staff identified a number of elements that you wanted to strengthen. They included:

- Revising the goal statements to emphasize the importance of keeping children with families;
- Recognizing that "protection from harm" includes the fact that separation from parents is also harmful;

- Providing more assertive language about the primacy of engaging families and involving them in decision making;
- Including not only a stronger emphasis on the urgency of permanency, but on all elements of a child's needs;
- Communicating a greater focus on community-based connections; and
- Adding further emphasis about team decision making as a fundamental practice.

If I haven't faithfully recorded the content of this discussion, please feel free to amend this summary. I know that the next step for the Department is to reshape the draft within about two weeks to create its own practice model. We look forward to receiving a copy of it.

As we began to operationalize the principles, based on your preference, we focused on the principles related to strengthening individualized, strengths and needs based practice. Marty Beyer helped take us from a theoretical discussion to a practical one by outlining a case example, asking participants how desired practice would be developed for such a case at the unit and office level. There was not time to complete this exercise in depth; however, participants did identify a number of steps that would be necessary to achieve consistent strengths and needs based practice. They are as follows:

- Achieve clarity about the goals and objectives of the agency (linked to the practice model discussion);
- Provide training and coaching (includes both formal training and consultation at the worker/unit level, including the use of actual cases as a teaching tool);
- Provide vignettes in training/coaching of best practice/contrasted with "old" practice;
- Develop a plan for new practice development for each office;
- Address the competition of paperwork duties with time needed to engage in best practice;
- Adapt policy to the practice model;
- Strengthen the supervisory capacity to coach best practice;
- Model strengths and needs based practice within the leadership team;

- Improve links to schools (included a discussion of the need for educational advocacy by workers/system);
- Increase/improve access to flexible funds and resources that would be needed to implement individualized plans;
- Help providers diversify and build capacity to meet individualized needs; and
- Develop qualitative standards for provider practice.

At the conclusion of this discussion you mentioned several next steps: finishing the practice framework, completing the list of capacity building steps and setting some priorities on which to focus. These could be the focus of our next meeting, the content of which we agreed to determine in a follow up conference call. We set the next meeting dates as October 21 and 22 and two days within the span of December first, second and third.

Marty Beyer had a useful meeting with Wraparound providers where issues with the named plaintiffs were the focus. Providers are struggling with the issue of developing truly individualized plans from strengths and needs assessments. Marty believes that the group, which included DCFS staff, would benefit from some follow up training that Marty, Richard and another provider in Oregon could provide. A day and a half of training would be a useful support for the providers. That is offered for your consideration. A copy of Marty's summary was forwarded to you previously and is attached to this letter.

There was one concluding appraisal provided by the Panel in regard to the approach to strengthening practice, which we have communicated before. We worry that the multiple approaches to family team meetings present in the system will be very confusing to staff and will encourage the destructive "dueling models" conflicts among Wrap, TDM and FGDM proponents that we have seen elsewhere in the country. As part of the development of a practice model, we hope that attention will be given to agreeing on a single conferencing approach that:

- Is based on the principle of strong family involvement in decision making;
- Follows the strengths and needs based individualized planning approach;
- Is utilized from the first entry of the case throughout the child and family's involvement with the system for assessment, case plan development, plan implementation and crisis response (as opposed to being employed only after critical events, such as removals, disruptions and the failure of reunification efforts); and

- Is not totally reliant on specialized facilitators (developing caseworkers and supervisors to facilitate conferences).

I will follow up later about scheduling a conference call.

Sincerely,

Paul Vincent

Attachment

cc Katie A. Panel  
Attorney for the Department  
Attorneys for the Plaintiffs

## Attachment

Dear Dr. Sophy:

You asked for my comments on the plans for the named plaintiffs, which follow. I indicated in an earlier email that I would welcome the opportunity to work with the wraparound providers again to design services intensive enough to meet the needs of the children. As the complaint from one provider (that they searched for homes and made a placement, only to have the child bounce out quickly) indicates, providing sufficient services to ensure unconditional care is seen as an ideal, rather than something they are responsible to do.

Before you got to the meeting, I stressed that I had not written the right needs statements and they are outdated: what is crucial is that the entire team, including school and clinicians, understand what drives the child's behaviors and agree on the child's specific needs and design whatever it takes to meet the needs underlying the behaviors.

I am willing to discuss the children and the design of services to meet their needs by being included in meetings on speaker phone or come to LA if that would be helpful.

Marty

KRISTIN

The new plan of care has the needs listed by MB, but these are not matched with services at this time or apparently being used to guide the staff who will work with her in the future. It is crucial that the interagency group of professionals working with Kristin decide themselves on her needs list which anyone working with her would be accountable to meet.

There is an assumption that Kristin should be in a transitional placement between Metro State Hospital and a therapeutic foster home (for which DCFS may put out an RFP): which of her needs would be more effectively met in

prospective transitional placements than in the hospital and why?  
Rather than  
deciding on placement based on the limited spaces that are  
available, services  
should be arranged that would teach her how to soothe herself, manage  
her  
feeling of being out of control, and get attention differently--a  
trauma  
therapist and a trained coach working under the therapist's  
clinical  
supervision could begin to meet Kristin's needs immediately regardless  
of placement  
and continue with her as she moves to a therapeutic foster home

The plan concludes "no concerned parties are opposed to utilizing  
Wraparound services." In the past, the Wraparound provider was  
unable to arrange a  
therapeutic home for Kristin (and in another case was unable to  
hire  
trained staff and provide adequate clinical supervision) or adequate  
intensity of  
services and did not design its interventions to meet Kristin's  
needs.

#### MARCIA

It was explained at the Panel meeting that DCFS is planning to  
discharge  
Marcia to an adult transitional facility by her 18th birthday on  
November 6,  
2003 out of a worry that she will not want additional services.  
Marcia's  
emotional needs interfere with her being able to progress into  
independence safely.  
Clinicians and DCFS have an obligation to help her plan services she  
will  
accept after she turns 18 and to make sure that the funding is set up  
for the  
daily coaching she requires in conjunction with therapy. She was  
removed from her  
mother's home after abuse and neglect but has not had trauma treatment.  
She  
will continue to require special education and specialized support for  
functioning in the community because of her disability. She aspires to  
graduate from  
high school, but her low self-esteem and desire to be successful  
socially  
undermine consistent school participation.

The cumbersome new 6-page plan quotes Marcia's views about her  
strengths  
and service desires as if no one with more clinical sophistication than  
Marcia  
can contribute to her needs list. Marcia and the individuals who have  
worked  
with her recognize that she wants to "be able to talk about her  
feelings

before hurting myself" and "have someone to talk to when I have an issue," but at the time she is disappointed, she acts. She needs instruction and practice in order to:

- learn how to talk to herself to prevent self-destructive thoughts
- learn the steps she can take when she is disappointed to prevent getting too upset
- learn to compromise and to let others know when she is getting frustrated by not getting what she wants (because she needs to be in charge as a result of being out-of-control of her life during years of maltreatment)

This instruction and practice must happen daily, not just in therapy once or twice a week, be provided by a trained individual working under the clinical supervision of her therapist, and assist in her real responses to frustration and disappointment, such as with her mother or boyfriends. Marcia's need to have a fulfilling social life is not going to occur easily when the Braille Institute includes her on outings--she has to be taught how to be involved in these activities without setting herself up for disappointment.

The section entitled "Family," particularly "family therapy when Marcia is ready," appears to have been prepared without considering the well-documented work of clinicians in the past who reported to the court that Marcia's mother was too narcissistic to be safe for Marcia to be around and that she was likely to continue to blame Marcia for her conception, her disability, and her allegations of sexual abuse. Marcia needs to understand that her mother's rejection is not because Marcia is bad or ugly and to make peace with her mother's preference for her half-siblings--this does not mean that Marcia will benefit from contact with her mother, but will do this work as part of trauma therapy starting where she is now which is still wishing her mother would stop criticizing her and hoping her mother will call or visit her weekly. "Verbalizing her feelings of abandonment" will not be enough for Marcia to stop punishing herself for her mother's rejection.

#### HARLAND

Harland's voluminous 17-page plan must be difficult for his mother and providers to get direction from. The strategies under the emotional/behavioral domain are more specific than other wraparound plans. The stated need "Harland

needs help with reducing his anger and anxiety through expressing his feelings appropriately" is still too vague. Harland was physically and sexually abused and felt abandoned. He is still angry about this maltreatment and is easily triggered when he feels something is unfair. Because he could not do anything to stop the maltreatment, he gets anxious when things seem out of his control or he feels threatened. He needs

- To have his anxiety recognized, get reassured, and be helped to relax
- To feel it is safe to talk about incidents that have been hurtful and to tell his mother about being scared and hurt in the past
- To have his mother say that she did things and allowed things to hurt him in the past and that she won't do it again
- To have attention immediately when he asks for it
- To have consistent limits & expectations -- predictability reduces his anxiety
- To recognize he is getting frustrated and take a walk or dance/sing
- To label what he is angry about and talk about it
- To know that an adult is always there to take care of him

These are emotional needs, although they overlap with his safety need not to be hurt or threatened. At the Wraparound providers meeting, we worked on defining what constitutes a "safe home" --this should be spelled out for his mother and the providers. Safe for Harland does not just mean free of neglect and abuse--safety entails everyone who is with him helping him reduce his anxiety. To prevent sexualized behavior, does Harland need someone to help him soothe himself before he escalates and/or teach him to make friends without sexuality and/or show him how to express his anger when something seems unfair without doing something that other people will not like?

At the meeting I tried to guide them through their hiring and training an extraordinary teacher/coach who could meet Harland's needs and guide his mother in meeting his needs, perhaps as much as full time co-parenting for his mother (or foster parent) to make sure the home did not fall apart.

The proposed "Harland needs to be provided with appropriate educational services" is too vague. Anyone working with Harland in school and outside of

school must have an understanding of the degree to which his processing and learning is affected by (a) low IQ; (b) learning disabilities; (c) short attention span; and (d) tactile learning style. How can his 1:1 in school help Harland improve his reading without clarity about the challenges he faces? How can his mother and child and family specialists working with him in the home and activities help Harland improve academically and in social skills without clarity about the learning challenges he faces?

Therapy for Harland and his mother and Harland together, training and clinical supervision for a child and family specialist, collaboration on a seamless approach with the school and his classroom 1:1 should be starting now so everyone is working as a team as Harland begins longer visits with his mother.

#### GREGORY

The narrative plan of care has Gregory's needs listed clearly, although in the attached chart the needs category contains a jumble of statements, many of which are not needs, and all are vague.

Basically his father and a once weekly counselor are supposed to meet

Greg's significant mental health needs:

- To recognize when he is frustrated and learn ways to express his anger that do not hurt others or get him in trouble
- To recognize when he is bored and learn positive things to do to alleviate boredom and get attention
- To participate in defining fair rules and reasonable rewards for following them and reasonable consequences for breaking them
- To have positive friends and non-risky activities he does with them

In 5/02 Erikson indicated that Greg was reading and doing math at the level of an 8-year old and now his father reports he is doing well in high school--how is this possible?

#### JANELLE

Basically the DCFS case closed and Wraparound transferred the case to System of Care. System of Care will provide case management, in-home therapy, and medication. Have Janelle's needs been conveyed in writing to System of Care with the expectation that their treatment plan will list those needs?

**The Katie A. Advisory Panel**  
c/o 2033 East 2<sup>nd</sup> Street  
Montgomery, AL 36106

*Marty Beyer*  
*Richard Clarke*  
*Barbara Fitzgerald*  
*William Jones*  
*Joe Loftus*  
*Paul Vincent*

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October 31, 2003

David Sanders, Director  
Los Angeles County Department of  
Children and Family Services  
425 Shatto Place  
Los Angeles, CA 90020

Dear David,

I am writing in follow up to our meeting with your staff last week. The Panel has labored over this letter, wanting to be sure that our respect for your vision for change in Los Angeles and for the immense challenges you face is clear. We know that the Department's obligations to the Katie A. class compete with obligations to all of the children you serve. We also agree with you that completing the plans outlined in section B. 7. in the settlement alone is not enough to meet the objectives that are the settlement's measurements of performance. It is in helping the Department achieve those objectives that we have the greatest interest.

In our first meeting with you, you outlined your priorities for the near term, which are:

1. Serving more children at home;
2. Shortening the length of stay in care; and
3. Reducing repeat allegations of abuse at home and in foster care.

In keeping with our mutual desire that the Panel would offer technical assistance in regard to these and other strategies, we have offered a number of suggestions about how to achieve these priorities and the Katie A. objectives. It became clear to us in the last meeting that the Department has a different set of strategies for achieving your goals, which has not varied much despite our suggestions. I would like to use this letter to share our perception about the response to our advice to you and your leadership team. I will also summarize our feedback about the plans that were presented by staff and underscore our hope to be helpful. However, I think we are at a stage where we need to decide whether continuing to pursue the direction we have been taking will be fruitful. If the Department has concluded that it believes the current strategies being undertaken are the

most sound, then the Panel needs to concentrate on the specific obligations in the settlement regarding our fact gathering role and proceed with that work. We intend no implied threat in this appraisal and trust that we have an open enough relationship to reach agreement about how we work together. If moving to the fact gathering stage is the preferred course for the panel, we will complete that with the same good will we have extended in other matters.

Moving on to our assessment of current planning, we thought that the Department's version of a practice model provided a solid foundation for a final description of the agency's approach to practice. The subsequent discussion about refinements was constructive and will, I hope, permit the quick adoption of a useful final product.

In the discussion about operationalizing the principles in the Department's practice model, your staff focused on three primary strategies; redeploying non-case carrying staff to the field, adopting a case flow for decision making and centralizing the implementation of Wraparound, the family conferencing models and the Permanency Teams into a single organizational unit. Gains through these initiatives may be achieved, but we remain concerned about the ability of these efforts to achieve the outcomes we both desire. We have even greater concerns about the likely impact of the strategies on the Katie A. Class specifically and the objectives of the settlement.

**Redeployment** Regarding the redeployment of staff, while I know that final decisions have not been made about the total number staff to be redeployed, current plans are described as involving approximately 100-120 staff. I know how challenging the personnel and morale issues are for even more modest redeployments and we commend the consideration of this step. However, the overall impact of such a comparatively small number of employees, compared with total staff, is not likely to have a significant impact on practice. Of equal or greater concern, there was discussion by Department staff of using redeployed staff to team with investigative staff in field work as a method of increasing the number of staff engaged in decision making about removals. We do not believe that "another pair of eyes", employing current practice approaches, is likely to result in more strength focused practice or improved decisions.

The only way we know to affect strength based decision making is to retrain staff to engage in strength based practice. You will face the challenge not only of retraining the redeployed staff in strengths and needs based practice, but also their supervisors, if you want the changed practice to be sustained.

I realize that you are focusing on the front end with these redeployments. We think that you might also consider using the opportunity to assign workers to an adoption role to assist with moving those children that are ready for permanency, but waiting for final steps to be taken. This could measurably lower your caseloads.

**Case Flow** As we understand the case flow plans, the Department has decided to employ team decision making exclusively at this time. Using existing staff involved in FGDM and Team Decision Making (possibly with Permanency Team members who may be redeployed for a facilitation role) as facilitators, it was estimated that at the maximum,

this work force would be sufficient only for team meetings immediately following removal.

As we have stated several times, the most effective use of family conferencing models occurs as a routine method of assessing needs and planning for all children and families, beginning with the first weeks of intervention and throughout the life of the case. Through this mechanism, removals, disruptions and lack of permanency can often be anticipated and prevented. Reliance on team meetings only after crises limits the team's ability to successfully achieve safety, stability well-being and permanency. Using an event driven teaming approach will be particularly unlikely to meet the needs of Katie A. class members.

We recommended that the Department use the staff it plans to make facilitators as coaches and mentors who would develop facilitation skills in all front line staff and supervisors, so that team conferencing could occur based on child and family needs, not only after key events.

A secondary concern relates to the availability of funding for the supports and services that are identified in team meetings. While Wraparound meetings are integral to a funding source for services, TDM and FGDM are not. We worry that the right services will not be available to implement the plans developed in the latter approaches. This will be especially critical with Katie A. class members, many of whom do not receive Wraparound.

In addition, we thought that you agreed that structured decision making tools would not yield the improved decision making gains you desire and that they would place families in a defensive posture. We see that they remain in the case flow and are confused about plans for their use.

*Wraparound, FGDM, TDM Coordination and Permanency Teams* We had little time to discuss this strategy. Placing the three initiatives under one organizational unit provides some additional coordination of effort, but our concerns about using so many different conferencing models remain.

### **Additional Panel Suggestions**

*Strengthening the front end* While the general objective of strengthening practice at the front end was not an explicit theme of the meeting's discussions, we do have some thoughts about how to achieve improvements with this part of the work force. We agree that a significant change in practice can have a beneficial effect at the front end, including better safety planning, a reduction of entries into care and strengthened kinship care. However, we believe that for this to happen, four other simultaneous changes will need to occur.

1. Change the philosophy and coaching capacity of front end supervisors. This will necessitate new training in strengths and needs based practice.

2. Change practice among ER and other front end line staff . We don't see Team Decision Making, as currently envisioned, markedly affecting current ER practice. Our experience has been that when engaging in strengths and needs based practice in a team setting is a separate expert's responsibility, in this case the TDM facilitator, line staff do not feel responsible for or confident in engaging in that practice themselves. Externalizing practice change in this manner impairs sustainability. Retraining will obviously be necessary for practice to change. Therefore, considerable attention will be needed to training design and delivery. Your staff have confidence that your universities will be able to provide such a redesign. However, we have not found that developing curricula for strengths and needs based practice comes easily to the university training academies in use around the country, in part because they have never practiced in this environment. Additionally, coaching for the redeployed staff and their supervisors will be important if they are to make the transition from classroom experience to actual practice.
3. Develop effective, intensive, strengths/needs-based services that can be put in place quickly in cases where there are unmet safety needs that could result in a re-referral, but may not rise to the level of imminent risk that would cause a child to be removed. These would be services for children, families they already live with, and supports from kin they might temporarily live with (without the case going to court). Keeping cases out of court can save resources, but if effective services are not accessible to families and kin, children will be at unacceptable risk. This may be your plan for redeploying funds if you were to receive a IV-E waiver, but an unfolding plan is needed now for accessing these services and for family meetings to tailor these services at the beginning of a case. Although there are some family preservation programs, needed mental health, school and housing services seem most inaccessible. But even without additional funds DCFS could have an effective method through front end family team meetings to wrap services around families where children are at risk of entering care.
4. Have the removing worker appear at the earliest court hearing to personally describe the family's strengths and needs. In other jurisdictions, this practice has made that hearing a meaningful event that engages the issues of ensuring the child's safety, making reasonable efforts to avoid removal, and if necessary, identifying placement alternatives. The practice demonstrates respect for the child and family and is an early opportunity for a family meeting. These hearings can resolve some cases quickly and in the others, it has the benefits of identifying needs and services, clarifying expectations and next steps, and engaging the family at the outset in constructive ways. It has proven in many jurisdictions to be an efficient use of time for the court and the agency. It would, of course, be necessary to partner with the court to achieve many of these benefits. However, even without more substantive court hearings, having the removing worker or supervisor present would improve in court's knowledge of the child and family's status and potential.

***Family meetings at the front end*** We have addressed our suggestions about family meetings previously, but want to underscore our rationale. Every case would benefit

from a family meeting that is designed as an integral part of the ongoing team planning process. We recommend that workers be trained to facilitate these meetings, particularly as an information-gathering tool for investigation and as a method for transferring the case from the front end to continuing worker. We recommend flexibility that would designate supervisors and others who could facilitate the minority of especially complex or risky meetings where the caseworker feels unable to facilitate.

***Wrap meetings as a model*** While we feel strongly that you need a different model of family meetings, we do not encourage the use of the current Wraparound meeting as practiced in LA because it is family-centered, but not child need focused. We think you could design a new form of family meeting that incorporates the best of Wraparound, TDM, FGDM and the Family Team Conferencing approach into your own strength/child-need focused family centered meeting and teach it as an engaging and service design method of your new practice to all workers, with a method for accessing at the regional level additional assistance in meeting facilitation for some cases.

***MCC study*** Although more than a third of the 91 children discharged from MCC after December 1, 2002 remain in the place they were discharged to from MCC, it is troubling that more than a third have had more than one placement since discharge and more than a quarter were discharged to probation or after being AWOL. Twenty of the children with unstable placements were reviewed, looking at their placement history, most recent court report and mental health assessment (see attached report). All but one are in at least their third placement since their final MCC discharge. Since entering care, these children have not been stable: all but five have had 12 placements or more. Nine have the goal of long-term foster care, including two with that goal since age 11. These 20 children have serious diagnoses: half are diagnosed with depression, six with Post Traumatic Stress Disorder, and five with Bipolar Disorder. More than 10 are prescribed Depakote, the new schizophrenia medications, or SSRIs, all of which have serious risks. These children have multiple needs because they have been traumatized, are brain damaged due to prenatal and other factors, and have experienced repeated losses of family and many placements. Their problem behaviors--rather than their needs--appear to be the focus of the casework. There was little tailoring of services evident in these complex cases, and without effective teams that can arrange intensive enough supports for each child, they are likely to continue to be unstable.

***Future Steps*** The Panel has been assessing the current status of our work together on system improvements, recalling the chronology of discussions that have led us to this point. We were pleased to hear of your interest in engaging the Panel to assist in the development of a practice model and on strategies to strengthen family engagement. You also asked in our conference call to plan last week's meeting that we discuss ways that the Panel could be specifically helpful in providing technical assistance. We do see that the work on the development of a practice model has been productive. However, based on the proposals to operationalize the practice model presented in last week's meeting, we got a clear message from Department staff that our prior suggestions for other strategies (combining conferencing models, using conferencing throughout the life of the case, retraining Wraparound providers, and others) were not compatible with agency plans. And with your absence from the meeting, pursuing the issue of additional Panel technical assistance did not seem to be a priority.

Our worry about the Department's preliminary plans for change have been heightened by a study completed by Marty Beyer of the status of a group of children recently discharged from MCC. The experience of these children strengthens our opinion that the practice remedy for children who enter care, become unstable, are placed in congregate settings and do not have permanency is to employ a strength and needs based practice and conferencing model before these harmful events occur. Different training and coaching for staff and development of new flexible services will be essential to serving this population effectively.

At this stage, we want to be accurate in our perceptions about the utility of continuing to work predominately in an advisory role, as we don't feel that the Department is finding our suggestions useful. Within the Panel, there is not consensus about whether we should continue to engage in consultative discussions about strategies rather than focusing primarily on fact gathering about performance and outcomes. However, we have decided to share our candid concerns and outline again where we think we might be helpful. You can consider these offers in light of the agency's needs at this point. The areas in which we are willing to provide assistance include the following:

- Review training curricula/delivery and offer suggestions to strengthen practice content, especially related to engaging families (we will need to look at training in relation to our evaluation role, regardless);
- Develop short-term training that supports a strengths/needs based family conferencing approach;
- Provide coaching and training on strengths/needs based practice and conferencing in a pilot site;
- Assist in working with the court about a case planning format that reflects strengths/needs based practice and is consistent with the improvements in case plans your staff are contemplating;
- Assist in designing a process whereby the removing worker or the worker's supervisor appear in court at the initial detention hearing;
- Assist in developing teams that would work with children discharged from MCC to provide stability, permanency and well-being (see attached summary of the status of this population); and
- Consultation on financing, dealing with the unions and design of the IV-E waiver.

Meanwhile, we are proceeding with plans to deepen our understanding of the system's current functioning and will be looking at data, interviewing children, families, staff and stakeholders and observing court hearings, among other tasks. We are asking the court for permission to delay our first report from October to December 15, to permit time for additional evaluation and to reach clarity with the Department about our technical assistance offers. In our next full Panel visit, December 2 and 3, we are likely to be

working individually on some of the fact gathering tasks described above. Panel members may also spend some time between now and then doing additional fieldwork, gathering information on system practice and performance. If areas are identified where the Panel can provide technical assistance, we will reconsider this schedule.

Please let me know how the Department would like to proceed in regard to the observations outlined in this letter.

Sincerely,

Paul Vincent

cc Catherine Pratt  
Ira Burnim  
Amy Pellman  
Miriam Krinsky

**MacLaren Children's Center:  
A Study of 20 Discharged Children with Unstable Placements**

As MacLaren Children's Center (MCC) was closing, the last 91 children discharged after December 1, 2002, consisted of: 33 children with stable placements (in September, 2003 they remained in their first placement: home of relative (8), foster home (5), group home (19), hospital (1)) 23 children no longer in DCFS custody: probation/Juvenile Hall (14), AWOL (7) and emancipated (2) 35 children with unstable placements (these included seven children who were readmitted to MCC after they were discharged in 12/02).

Twenty children with unstable placements were studied by reviewing the most recent court report, mental health assessment and placement history. All the children had been to court since their discharge from MCC, although their unstable placements did not appear to trigger any special court review process. Despite the severity of their emotional problems, some of the children had not had a recent mental health assessment: three date back to 2001, five are more than a year old (before 10/02) and one did not have an assessment.

The characteristics of these 20 children are:

Gender	Female 11	Male 9				
Ethnicity	African American 9	Hispanic 8	Caucasian 2	Other 1		
Age	12 (1)	13 (5)	14 (3)	15 (6)	17 (3)	18 (1) 19 (1)

Eight are from SPA 6 and five from SPA 3. Their caseworkers are in 13 offices: Antelope Valley East, Belvedere, BSP East (2), Century (4), Deaf Services Unit, Hawthorne, North Hollywood, Pasadena, Pomona, South County, Torrance (2), Wateridge (3), and West LA. Three entered care at birth, eight others first entered care before the age of 4, and the remainder before they were 10. Nine had returned to their families and re-entered care between ages 11-15. The reasons for entering care were:

Physical abuse	8
Prenatal substance exposure	5
Sexual abuse	3
Abandonment	2
Parent/child conflict	2

Since entering care, these children have not been stable. All but five have had 12 placements or more. Seven have had 20 placements or more. One has had 41 placements.

Eight had their final discharge from MCC in 12/02, six in 1/03, five in 2/03 and one in 3/03. All but one are in at least their third placement since their final MCC discharge. One is in her seventh placement since being discharged in 2/03 and three are in

their fifth placement (since 12/02, 1/03, and 2/03). Two were originally discharged from MCC to family, seven to foster homes, seven to group homes, one to residential and three to hospitals. Currently, one is with family, two in foster homes, seven in group homes, six in residential, two in Regional Centers, one at Metro, and one is incarcerated.

Most of them appear unlikely to get a permanent home, including two whose permanency goal of long-term foster care was established at age 11. Their permanency goals are:

Placement with family	4
Guardianship	2
Long-term foster care	10
Developmental Center	2
Emancipation	1

No permanency goal was evident in the court report for three children. Of the nine youngest children, three 13-year olds have a goal of placement with family and one 14-year old of guardianship. But the 12-year old has a goal of LTFC as do one 14-year old and two 15 year olds; a 15 year old has a goal of emancipation. Only five children appear to be having regular visits with their families, two who have reunification as their goal; four others have inconsistent visits. Most apparently have no contact with siblings.

These 20 children have serious diagnoses:

Depression (includes a range of severity)	10
Post Traumatic Stress Disorder	6
Bipolar Disorder	5
Oppositional Defiant Disorder	4
Psychosis	3
Attention Deficit Hyperactivity Disorder	2
Intermittent Explosive Disorder	1

Eighteen about whom this information was available are taking medication prescribed by psychiatrists:

Depakote	8	Cogentin	2
Zyprexa	5	Haldol	2
Geodon	4	Lithium	2
Seroquel	4	Zoloft	2
Celexa	3	Adderall	1
Effexor	3	Clonidine	1
Neurontin	3	Paxil	1
Risperdal	3	Tenex	1
Wellbutrin	3		

Although the court is approving these medications, more serious attention should be given to the side effects and possible long-term damage of these medications for children--out-of-control and suicide behavior linked to the SSRIs (Celexa, Paxil, and

Zoloft), diabetes linked to the new schizophrenia medications (Zyprexa, Geodon and Seroquel), suppressed growth linked to Adderall, and liver and pancreas damage linked to Depakote. In addition, since most of them are adolescents with limited ability to follow a physician's instructions, that many of these medications are unsafe in combination with alcohol or can have serious complications if the young person gets overheated should also be a concern when they are living in the community. A consistent method for well-informed DCFS/court oversight of medications is necessary.

Six have medical problems noted in their diagnoses (asthma-3, seizure-1, diabetes-1, and spina bifida-1). Additionally, one is HIV+, another one has seizures, and one had repeated testing for heart irregularities; the child with spina bifida also has only one kidney; two children are reported to be obese.

Only four have tested IQs in the normal range. Fourteen have tested IQs under 79. In their diagnoses, one was labeled borderline intelligence, eight mild mental retardation and one moderate mental retardation. Only two are reading at the high school level, one at the seventh grade level, one at the sixth grade level, two at the fourth grade level and eight at the third grade level or below. School information was provided for only ten of the children, typically either the name of the school and grade or that the child was in special education.

Strengths were indicated for only ten children. The 20 children were described as having the following primary problems:

depression	11
aggression	8
impulsivity	6
communication difficulties	6
anxiety	5
suicidal thinking/self-injury	5
agitation	5
labile moods	5

These problems, and associated anger, threats, tantrums, irritability, and distractibility, are the reasons given for the high rate of placement breakdown since (and usually before) their most recent discharge from MCC. The relatives, foster homes, and group homes to which they were discharged could not manage these behaviors.

The court reports give little information about the services provided to assist the children or their relatives, foster homes or group homes other than the four children receiving Wraparound and the five children receiving outpatient counseling.

#### **WHAT CAN BE LEARNED FROM 20 CHILDREN UNSTABLE AFTER MCC DISCHARGE?**

These children have multiple needs because they have been traumatized, are brain damaged because of prenatal and other factors, and have experienced repeated losses of family and many placements. Their problem behaviors--rather than their needs--appear to

be the focus of the casework. Because there was little apparent tailoring of services in these complex cases, unsuccessful placements should not be a surprise.

Just as DCFS would recruit a specialized foster parent with the skills necessary to care for a medically fragile child, with these 20 children, relatives, foster homes and group homes must be informed that they have to meet the needs of depressed, aggressive, impulsive, anxious, self-injurious, agitated, moody youngsters who communicate poorly. In addition, before placement DCFS staff should meet with the children and the providers who will support them to agree on the underlying needs driving these behaviors. To the extent that these behaviors are functional for the children, they will have to be individually taught new, not harmful ways to meet those needs. Individual instruction of new behaviors and new self-talk is obviously essential to change habitual depression, aggression, and impulsivity. The goal of unconditional care must become a reality in practice to prevent the harm of multiple placement, and this can only occur through intensive supports for kin, foster parents, and group home staff.

#### 1. Learning disabled children

Although low IQ scores and low reading levels were documented for of the children, almost no information is provided in the court reports or mental health assessments regarding learning disabilities. One of the responsibilities of DCFS in ensuring that children in care can become successfully independent is to help them conquer the obstacles to learning so they can read and do arithmetic to become self-sufficient and to feel proud of themselves. Although prenatal substance exposure is repeatedly documented, in only one report are sequencing problems and difficulties with understanding cause and effect identified. Executive function deficits are common among children in care and are major obstacles to being able to function independently. Sequencing and executive function improvements can be achieved through specialized instruction so children can develop minimal organization skills necessary for employment is achieved. Failing to do so is like not equipping a child with a physical disability with a wheelchair: it makes it impossible for them to achieve self-sufficiency.

Amina is a 14-year old African American who came into care at birth because she tested positive for cocaine. She lived with a guardian until age 7; she was subsequently removed from a foster home after being physically abused; her removal (10/01) from a group home where she had formed a trusting relationship with the director triggered a re-experiencing of her family separation and "an intense trauma reaction." She had 12 placements listed on the placement history, with an additional two unlisted psychiatric hospitalizations in 2001; she was previously at MCC in 2001 and 2002. She was admitted to MCC in 11/02, discharged six weeks later to a foster home for six months and another foster home for a few days. She has been in another foster home since 6/03, receives therapy and was referred to systems of care. Her permanency goal is guardianship by her foster mother. She wants to see her father who is in prison, has no contact with her mother and wanted to be placed with her brother; it is unknown whether she visits with her brother. She has a tested IQ of 66, her reading level is fourth grade; the Regional Center rejected her due to high functioning and age although the evaluation indicates she has the adaptive functioning of a 7-year old. She is in

special education for SED and ADHD. No strengths were indicated. Her problems include difficulty complying with directives, difficulty with sequencing and understanding cause and effect, concrete, simplistic, aggression, anxiety, and low frustration tolerance. Her diagnoses include PTSD, Psychotic Disorder, Reading Disorder and Mild MR. She is prescribed Depakote, Neurontin and Zyprexa (2/02). Her last court date was in 7/03.

## 2. Recovering from trauma

Most of the children had been traumatized by physical or sexual abuse and repeated losses. In addition to the six diagnosed with Post Traumatic Stress Disorder, many of the depression, aggression and anxiety symptoms in these children are likely to be connected to trauma. Yet trauma treatment is seldom mentioned. Becoming successfully independent is unlikely for children who have not understood their maltreatment, learned to separate the past from present, and decided that they should not be harmed further (particularly by self-injury or interfering with their own success).

April is an African American 13-year old who came into care at age 6 as a result of physical abuse. She was in her first foster home for almost two years, had an unsuccessful return home, and she was placed with a relative for five months; there is an indication that she was abducted from a foster home in 1/03. She had 16 placements listed on the placement history. She was admitted to MCC in 1/03, and discharged two days later to a group home for six days and then a return to MCC for two weeks. She has been living at the Florence Crittenden group home since 2/03 and receives therapy. Her permanency goal is reunification, and she and her mother started conjoint therapy in 9/03; it is unknown whether she visits with her brother. She has a tested IQ of 57, but her reading level is unknown; for some reason, she was ineligible for special education. No strengths were indicated. Her problems include low self-esteem, depression, aggression, confusion, moodiness, and agitation. Her diagnoses include Major Depression with Psychotic Features and PTSD. She is prescribed Lithium, Zoloft and Zyprexa (6/03). Her last court date was in 9/03.

## 3. Children in care since early childhood who should have had permanent homes

Mayra is a 15-year old Latina who came into care at age 2 because of sexual abuse and physical abuse. She was born with one kidney and spina bifida and had surgeries for a VP shunt, a catheter, and bladder augmentation. She was placed at Westside group home from age 2-11, with placements at MCC at age 2 and age 11. She had 12 placements listed on the placement history, with at least one additional unlisted psychiatric hospitalization. She was admitted to MCC in 7/02, discharged almost seven months later to a foster home for six months, a group home for a day, followed by hospitalization(s). She has been in a group home since 7/03 and receives Wraparound. Her permanency goal is LTFC. Her caseplan goal is to stabilize her behavior in a structured setting and transition her to a therapeutic foster home. She has had some visits with her mother; it is unknown whether she sees her sister. She has a tested IQ of 75, and her reading level is fourth grade. Her strength was being artistic. Her problems include depression, aggression and anxiety. Her diagnoses

include Oppositional Defiant Disorder and Major Depression. She is prescribed Effexor and Seroquel. Her last court date was in 4/03.

4. Children who should have been provided with intensive enough supports to have permanent homes while they were in elementary school

Carolina is a 17-year old born in Brazil who was abandoned with an unrelated caretaker, then moved to another caretaker; she entered care at age 7 as a result of physical abuse (she had been sexually abused at age 5). She was in her first foster home for more than two years and her second foster home for four years but was asked to leave for practicing witchcraft (she still wants to return to that home). She had 13 placements listed on the placement history, but had at least four additional unlisted hospital stays. She was admitted to MCC in 10/02, was discharged after three months to a foster home for three months which broke down when her friend committed suicide, and a group home for six weeks. She has been living at Hathaway since 6/03. Her permanency goal is LTFC. She has a tested IQ of 70, but her reading level is unknown. The strength that was indicated was that she likes playing soccer. Her problems include low self-esteem, depression and self-mutilating. Her diagnoses include Major Depressive Disorder and Sexual Abuse. She is prescribed Effexor and Risperdal. Her last court date was in 6/03.

Daniel C. is an African American 13-year old who entered care at age 7 as a result of physical abuse and extreme neglect by his developmentally delayed mother; he was born HIV+ but tested negative in 1998. His father is deceased; his mother was in Metro but her whereabouts are unknown. He spent almost two years in his first foster home; his third home was a legal guardianship where he was placed with his brother. He has had 26 placements, including four previous stays at MCC (three times in 2001 and almost all of 2002). His most recent MCC admission was in 6/02, he was discharged after more than six months to a foster home where he remained for two weeks, followed by a foster home for six weeks and a group home for a month. He has been in a residential program (Morning Sky-outside LA) since 4/03. His older brother is in a group home, and they have phone contact. His permanency goal is LTFC. He has a tested IQ of 47, but reading level is unknown. The only strength indicated is that he has become a good photographer at the program. His problems include low adaptive functioning, difficulty following rules, depressed, assaultive, angry, impulsive, and anxious. His diagnoses include Depressive Disorder, Mild MR, and ADHD; previously he was psychotic. He is prescribed Risperdal, Neurontin, Depakote, and Zoloft (9/03). His last court date was in 9/03.

Isabel is a 12-year old Latina who entered care at age 10 as a result of extreme neglect and physical abuse of a sibling; subsequently her mother gave birth to a baby who tested positive for PCP. She has had 19 placements, including two previous stays at MCC in 2002. Her most recent MCC admission was in 9/02, she was discharged after three months to a foster home where she remained for two months, followed by two hospitalizations and a conservatorship. She has been at Harborview since 4/03. She has monitored visits with her mother and her four siblings, three in foster homes and one in an adoptive home. Her permanency goal

of LTFC was established at age 11. She has a tested IQ of 78 and reads at the first grade level. The only strength listed is being artistic. Her problems include learning problems, being self-injurious, school problems, depression, being defiant, aggressive, and having temper tantrums. Her diagnoses include Dysthymic Disorder, PTSD/Oppositional Defiant Disorder, Learning Disorder and Borderline Intellectual Functioning. She is prescribed Geodon and Seroquel (5/03). Her last court date was in 5/03.

Benjamin is a 15-year old African American who entered care at age 8 because of physical abuse. He had 27 placements listed on the placement history, but had at least an additional seven unlisted hospital stays; he had six previous stays at MCC (three in 2000, one in 2001, and two in 2002). He spent 17 months at McKinley and a trial discharge with his mother was unsuccessful; he spent three months at Starview and 15 months at Harborview. His most recent MCC admission was in 11/02, he was discharged after a month to a group home for more than four months, was admitted to Gateway hospital, and has been at Metro State Hospital since 5/03. The court report says a conservatorship was necessary because of "minor's habit of demanding to be moved every time he became anxious and thus never moving through the anxiety to a higher level of functioning." His caseplan goal is to re-evaluate the conservatorship. He has not visited with his mother since 5/02 and not seen his father in 10 years; there was no mention of when he last saw his five siblings. His permanency goal is LTFC. His IQ is unknown; he reads at the third grade level. No strengths were indicated. His problems include being aggressive and depressed and hearing voices telling him to kill himself. His diagnoses include ADHD, Bipolar, Major Depressive Disorder and Mild MR. His current medications are Celexa, Geodon, and Depakote (1/03). His last court date was in 6/03.

#### 5. Children who re-entered care

It is significant that almost half of these children came into care when they were young, lived with their families, and re-entered care as the behaviors that could have been anticipated from the maltreatment that originally brought them to DCFS' attention became too difficult for their families to manage. Re-placement prevention requires specialized services for families to meet the children's needs so their behaviors do not become unmanageable.

Deshawn is an African American 13-year old who entered care at birth as a result of testing positive for cocaine. Initially he was placed for more than two months in a county shelter (unidentified); then he spent two years with a relative, one year with another relative and returned to care at age 3 and subsequently was placed with his mother who sent to him to live with his father in San Diego around age 7; he was in a shelter four times and twice in Juvenile Hall in San Diego in 2000-2001. He returned to his mother and two half-sisters for a year at age 11 before returning to care. He has had 26 placements. His most recent MCC admission was in 2/03, he was discharged after a month to a hospital where he remained for almost two months, followed by a group home for less than a week, and a foster home placement for 10 days. He has been in a group home (Sycamores) since 5/03. His

permanency goal is unknown. His caseplan goal is to place him in the home of a maternal aunt with Wraparound services. He has a tested IQ of 119, and the only strength indicated is that he is bright. His problems include grieving over the absence of his father, difficulty being attentive, giving up easily, being angry when he is teased, depression, irritability, and poor anger management. His diagnoses include ADHD and conduct disorder; he has asthma and is obese. He is prescribed Adderall and Geodon (3/03). His last court date was in 5/03.

Natasha is a Caucasian 13-year old who entered care at age 6 as a result of sexual abuse by her stepfather. Her maternal great grandparents adopted the sibling group of three, but could not manage Natasha as a teenager with conflicts with her half-sisters. She had six placements listed on the placement history, but had additional unlisted hospital stays. Her most recent MCC admission was in 10/02; she was discharged after almost two months to her great grandparents' home where she remained for two weeks, followed by a foster home for six months. She has been living in another foster home since 8/03 with Wraparound services. Her permanency goal is reunification with her great grandparents who she visits on the weekends; her mother died recently. The only strength indicated is her interest in Egyptology. She has a tested IQ of 112 and reads at the high school level. Her problems include suicidal thinking, low self-esteem, feeling worthless and unloved (especially when her family compares her to her mother who was a drug abuser), mood instability, impulsivity, anxiety, anger, and assaulting great grandparents and siblings. Her diagnoses include Bipolar, PTSD, and Oppositional Defiant Disorder. She is prescribed Risperdal, Neurontin, and Effexor (5/03). Her last court date was in 5/03.

Mario is a 15-year old Latino who first entered care at age 3 as a result of physical abuse. He returned to his parent and re-entered care in 1995, returned to his parent in 3/02 and re-entered care in 7/02. He has had 11 placements, including a previous stay at MCC in 2002. His most recent MCC admission was in 1/03, he was discharged after a month to a group home where he remained for a month, followed by a foster home placement for two months. He has been living with a relative since 5/03 with Wraparound services and medical treatment for HIV+ for which he is prescribed Trivizir; he refuses counseling. His permanency goal is LTFC. No strengths are noted. No mental health assessment was in his record. His last court date was in 7/03.

6. Children who have feel betrayed and special efforts must be made so they can trust a permanent caretaker and give up on the person they lost

Christopher is an African American 17-year old prenatally exposed to cocaine who entered care at age 1 because of his mother's mental illness. He was abandoned at age 12 by his guardians because he falsely alleged fondling by a foster brother, and the record indicates that he was "basically a good kid who was hurt when he was dumped by his guardians." He had 10 placements listed on the placement history. His most recent MCC admission was in 6/02 for six months; he was discharged to a foster home for four months and then a group home where he waited four months for Job Corps admission. He was incarcerated in 8/03 for writing a bad check; the record indicates that a probation camp would be harmful because of his small

stature. His permanency goal is LTFC; his parents' whereabouts are unknown. His caseplan is to remain in a structured setting until emancipation. His IQ is unknown; he reads at the fifth grade level. No strengths were indicated. His problems include being depressed due to abandonment, feeling hopeless and engaging in risky behaviors, sabotaging himself when he is successful, and self medicating. His diagnoses include Depressive Disorder and Disruptive Behavior Disorder. He refuses prescription medication. His last court date was in 7/03.

George is a Caucasian 14-year old who entered care at age 9 after physical abuse by his stepfather; he may have been sexually abused. He has had 14 placements including an unsuccessful pre-adoptive placement and a five month stay at Five Acres; he had a brief previous stay at MCC in 1999. His most recent MCC admission was in 11/02 for three weeks; he was discharged to a group home for three months, another group home for two months and a foster home for two days. He has been at Hathaway since 5/03. He has six half-siblings but it is unknown whether he has contact with them. His permanency goal is LTFC (established at age 11); he wants to live with his aunt out-of-state; his father was a heroin addict who is incarcerated and his mother is out-of-state; he worries about his stepfather who was hospitalized for muscular dystrophy. His tested IQ is 96; he reads at the twelfth grade level. His strengths are being bright and prosocial. His problems include low self-esteem, helplessness, insecurity, depression due to loss and abandonment. His diagnoses include Dysthymia, PTSD, and Asthma. He is prescribed Celexa. His last court date was in 7/03.

#### 6. Intensive support for reunification

When children have strong attachment to family but family members cannot meet their needs, specialized, intensive services must be designed starting with therapeutic visitation and strong transitional support to ensure the child does not sabotage a successful return to family or the family does not get too stressed by the extra demands of the child's needs.

Melody is an African American 13-year old who entered care at age 2, lived with a relative for a year, was returned to her mother at age 5 and moved to Texas. She re-entered care at age 12 when her mother abandoned her three children at a shelter; she had been physically and possibly sexually abused. She had 21 placements listed on the placement history, but had at least one additional unlisted hospital stay in 3/03; she had one previous stay at MCC in 2002. Her most recent MCC admission was in 12/02, she was discharged after two months to a foster home for a few days, another foster home for three weeks, a group home for five months, and another foster home for two weeks. She has been at Devereux group home (Goleta) since 8/03. Her half-siblings are with their father and she has no contact with them; her mother disappeared but visited Melody in the hospital. Her permanency goal is reunification with her mother. She has a tested IQ of 57, functions at the level of a 5-year old, and reads at the second grade level. No strengths were indicated. Her problems include wanting constant attention, irritability, being easily frustrated, anxious, disruptive, easily agitated and threatening to others. Her diagnoses include Oppositional

Defiant Disorder, Depressive Disorder, Mild MR and Asthma. She is prescribed Zyprexa, Wellbutrin, Clonidine (11/02). Her last court date was in 5/03.

Marcos is a diabetic 15-year old Latino who entered care at age 5, returned home, and re-entered care at age 11 when his mother died; he was the youngest of eight children who had cared for their mother during a long illness; his father had died years earlier. He had nine placements listed on the placement history, but had at least two additional unlisted hospital stays; he had a previous stay at MCC in 2002. His most recent MCC admission was in 10/02, he was discharged after four months to a group home for a month. He has been living in Devereux-Colorado since 3/03. His siblings visited him regularly until he was placed out-of-state; one sister is in care and was sexually abused in a previous foster home. His permanency goal is LTFC. His IQ is 55; he reads at the kindergarten level. No strengths were indicated. His problems include limited communication skills and being impulsive and aggressive, with rapidly escalating anger. His diagnoses include Mood Disorder, Learning Disorder and Mild MR. His current medication is Depakote (6/03). His last court date was in 6/03.

Astrid is a 15-year old Latina born in Guatemala who entered care at age 13 because of parent-child conflict after she "caused" the separation of her mother and stepfather when she discovered her mother having an affair. She had been sent to Guatemala, met her biological father, was raped by a 19 year old, and returned to the U.S. She had 18 placements listed on the placement history, but had at least an additional three unlisted hospital stays; she had three previous one month stays at MCC in 2002. Her most recent MCC admission was in 9/02, she was discharged after almost three months to a group home for three months and three foster homes (each for about two weeks). She has been living in a group home since 7/03 with START services and a referral to Kedren MH. She has inconsistent visits with her mother and aunt; there was no mention of contact with her two younger half-siblings. It was unclear but appeared the permanency goal was TPR. She has a tested IQ of 100 and reads at the seventh grade level. Her listed strengths are being bright and writing poetry. Her problems include suicidal thinking, running away, hyperactivity, poor impulse control, depression, irritability, agitation, sexual activity and substance abuse. Her diagnoses include Major Depressive Disorder, PTSD, and Cannabis and PCP abuse. She is prescribed Wellbutrin. Her last court date was in 7/03.

## 7. Independence

Because emotional obstacles interfere with successful independence and traumatized children are often less mature than their agemates, special supports are necessary for many children in care to achieve successful independence--this was not reflected in these records.

Daniel G. is a deaf 15-year old Latino who entered care at age 9 as a result of physical abuse and neglect by his mother who is also deaf. He has had 19 placements, including a hospitalization in July that is not on the placement history and five previous stays at MCC (the first when he was 11). His most recent MCC admission was in 2/02, he was discharged after almost a year to Five Acres where he

remained for two months, followed by two foster home placements (with foster parents who sign) each for two months. He has been living in a group home since 7/03 with Wraparound services; therapy stopped in 3/03 after a placement change. His permanency goal is LTFC; he wants to be placed in the residential program of the School for the Deaf. His caseplan goal is to stabilize in a structured setting so he can prepare for independent living. He has a tested IQ of 71, and reads at the kindergarten level. His language skills--even with sign language--are limited and concrete. No strengths were indicated. His problems include labile moods, impulsivity, being oppositional and aggressive, getting angry when picked on and having tantrums. His diagnoses include Conduct Disorder (Bipolar deferred). His current medications are Depakote, and Wellbutrin, although the record indicates that Depakote was "discontinued to prevent liver damage." His last court date was in 7/03.

#### 8. Developmentally Disabled Children

Some of these children appear to be caught between agencies. These are children for whom inadequate services are provided by DCFS while they get old enough to qualify for Developmental Centers. The lesson to be learned is that DCFS should provide the services that are available in the Developmental Centers to these children when they are young (whenever possible by wrapping them around kin and foster families). It is no mystery what techniques are used with DD populations--why not have those contractors offer their functional behavioral analysis and individual instruction as services to children living with families?

Jessica is a 19-year old Latina who entered care at age 2 1/2 as a result of sexual abuse of her sister by her stepfather. They lived with a guardian until 1991. She has had 41 placements, including 14 previous stays at MCC (in 1991, 1995, 2000, and 11 times in 2001). Her most recent MCC admission was in 8/02, and she was discharged after almost five months to a hospital. She was placed in 1/03 at a Regional Center (Bungalows, for mentally ill, developmentally disabled individuals). Her permanency goal is an adult group home. She visits with her mother, monitored by her sister who is her conservator. Her IQ and strengths were not indicated, but she reads at the first grade level and has "significant neuropsychological deficits." Her problems include aggression and depression. Her diagnoses include Bipolar, Mild MR and Seizure Disorder. She is prescribed Depakote, Geodon, Cogentin, and Haldol (5/03). Her last court date was in 8/03. She must have been diagnosed by Harborview in 2000, but just had SSI applied for recently as a result of being placed in the Developmental Center.

Stacey is an African American 14-year old who had prenatal cocaine exposure, was raised by her paternal grandmother, her father died of sickle cell, her mother's rights were terminated, she was placed with another relative for almost three years, and entered care at age 11. She has had 13 placements. She was admitted to MCC in 2/03, she was discharged after two days to a group home for two weeks, a hospital for a week, and four foster homes (for several days each). She has been living in a Regional Center group home since 4/03 and likes swimming, music, stickers, jewelry, and crafts there. Her permanency goal is LTFC. She has a tested IQ of 40, functions at the level of a 5-year old, and reads at the first grade level. She has had

autistic behaviors since early childhood. Her problems include poor expressive and receptive language, suicidal acts since the death of her grandmother, agitation, and obesity. Her diagnoses are Bipolar Disorder and Moderate MR. She is prescribed Depakote, Seroquel, and Tenex (8/03). Her last court date was in 9/03.

Zeynab is an Iranian 18-year old who entered care at age 13 because her father could not care for her and her mother had disappeared out-of-the-country. She had 20 placements listed on the placement history, but had additional unlisted hospital stays; she had seven previous stays at MCC (two in 1999, three in 2000, and two in 2002). In 2001-2 she was in one foster home for 18 months. Her most recent MCC admission was in 12/02, she was discharged after three days to a hospital, returned to MCC, and was hospitalized again for two weeks. She has been living in a crisis group home since 1/03. Her permanency goal is a Developmental Center home. She has no contact with family. Her IQ, reading level and strengths are unknown. Her problems include self-injury, confusion, impulsivity, distractibility, and inappropriate touching. Her diagnoses include Psychotic Disorder and Mild MR. She is prescribed Depakote, Cogentin, Haldol, Seroquel, Celexa, and Zyprexa (6/03). Her last court date was in 4/03.

Jason is an African American 17-year old who entered care after his mother, who was drunk, dropped him on his head at two months; his maternal aunt cared for him for 15 years; both his parents died. He had six placements listed on the placement history, but had at least two additional unlisted hospital stays; he had a brief previous stay at MCC in 2001. His most recent MCC admission was in 1/03 for less than a week; he was discharged to a relative's home for two months and then was admitted to Harborview. He was previously denied Developmental Disability eligibility three times, but has been living in the Developmental Center-Porterville since 7/03. He has 10 siblings but it is unknown what contact he has with them. His permanency goal is unknown. His tested IQ is 67; he has the adaptive behavior of a 10-year old; he reads at the second grade level. No strengths were indicated. He was prenatally exposed to substances, has had behavior problems since early childhood, and was permanently expelled from school in 2001. His diagnoses include Intermittent Explosive Disorder, Depressive Disorder and Mild MR. He is prescribed Lithium and Zyprexa (2/03). His last court date was in 9/03.

#### 9. Improvements in reports

The court reports on these children are inadequate.

- The main purpose of the court reports appears to be to list the activities of the caseworker since the last court hearing.
- Court reports do not give a succinct history of the child.

Sometimes the report contains lengthy quotes from the original allegations (often more than 10 years old), but most of the history since is missing. Court reports should start with a readable introductory paragraph summarizing entry into care, number of

placements, current placement, permanency goal and the child's needs. (Permanency goal was not indicated on three children's court reports).

- Court reports do not articulate the child's strengths.

One caseworker was being threatened with contempt for, among other things, failing to staple a current picture of the child to the report. Far more informative about the child would be a description of what they do well.

- Court reports do not articulate the child's needs.

The child's behaviors are usually described. Diagnoses do not explain a child's needs.

- Court reports do not indicate what services are being provided and in what ways those services have been tailored to the child to build on strengths and meet his/her unique needs.

Mental health and other services being provided to the child and support services to the child's caretakers should be listed

- Court reports do not give details about the child's school adjustment.

Court reports should contain a succinct summary of schools attended, current school, tested IQ, current reading level (not the grade the child is placed in, which is basically a reflection of age, not skills), special education history, disability, the details of how the school is meeting the child's learning and emotional needs, and how the school, case worker, mental health staff and the child's caretakers are collaborating.

- Court reports do not list the medications the child receives, dates of medication checks, the side effects the child is experiencing and the consideration given to the potential long-term risks of many medications. (Medication, or the child's refusal to take medication, was not indicated on six children's court reports).

In addition, the DCFS placement history print-out does not include most psychiatric hospitalizations (they are just unaccounted-for days). It is unknown why a few psychiatric hospitalizations are indicated. This means that DCFS cannot use the placement history for management purposes to track trends in multiple placements or use of psychiatric hospitals.

Finally, DCFS uses "white" instead of "Caucasian." Because "Hispanic" or "Latino" is not usually indicated, trends in disproportionate minority representation in different levels of care or multiple placements cannot be tracked.

**The Katie A. Advisory Panel**  
c/o 2033 East 2<sup>nd</sup> Street  
Montgomery, AL 36106

*Marty Beyer*  
*Richard Clarke*  
*Barbara Fitzgerald*  
*William Jones*  
*Joe Loftus*  
*Paul Vincent*

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November 14, 2003

David Sanders, Director  
Los Angeles County Department of  
Children and Family Services  
425 Shatto Place  
Los Angeles, CA 90020

Dear David,

At the risk of overwhelming you with correspondence, I have an additional request. As you know, we will be providing our first report to the court by December 15 and we need to be able to discuss the status of the plans referenced in paragraph 7. of the settlement (named plaintiffs, structured decision making, Wraparound, Team Decision Making, provision of mental health services to class members and enhanced permanency, stability and individualized, community based services)

Could you provide us with these plans or if they have not been completed, provide a summary of their current status? You might refer to our letter of June 16, where we described what we would expect the plans to include. Thank you for your help.

Sincerely,



Paul Vincent

cc Catherine Pratt  
Ira Burnim  
Amy Pellman  
Miriam Krinsky  
Katie A. Panel Members