

**The Katie A. Advisory Panel
Report to the Court
Second Reporting Period of 2011
October 19, 2011**

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

Marty Beyer
Richard Clarke
William Jones
Paul Vincent
Edward Walker

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Executive Summary

Since its last report to the court, the Katie A. Panel has observed continuing progress in a number of areas related to County performance. These include:

Continued strong collaboration between DCFS and DMH

Referral of 90 percent of eligible newly detained children for a multidisciplinary assessment (MAT)

Ongoing implementation of the Qualitative Service Review process, which helps identify practice improvement opportunities and benchmarks performance

Broad implementation of the mental health screening process, which has resulted in 97 percent of appropriate children being screened, 97 percent of children with positive screens referred for mental health services and for children referred for mental health services, 96 percent receiving some type of mental health service activity

Growth of Tier II Wraparound, resulting in enrollment of 2,154 children, a pace ahead of the projected schedule

Increased County attention to the possible underutilization of mental health services by children served by FFAs and D-Rate homes

Implementation Challenges

As this report will note, the County also continues to encounter challenges in implementation, which are described in the following summary.

Training and Coaching

As the Panel has discussed previously, the County has yet to deliver training to the mental health community and DCFS staff with sufficient intensity and duration to materially affect practice. Training continues to be somewhat general and conceptual and coaching is not yet focused on the direct practice level with children and families, both of which will have to occur for the County to meet Katie A. objectives.

Development of Treatment Foster Care (TFC)

The Corrective Action Plan requires that the County develop 300 treatment foster care beds and at present only 58 children are in a TFC placement. As of the Panel's last report 51 children were in TFC placement. There are a number of obstacles that impact the development of this resource, but the slow pace of growth denies many children for whom this resource is appropriate the opportunity for a family

based placement. In the Panel's opinion, most of the high number of young children in group could be served in TFC settings.

In addition, of the 68 children that have exited TFC, half are reported to have returned to a higher level of placement. The County is concerned about this trend as is the Panel, but has not yet identified the reasons for this outcome.

Medical Hubs

In FY 2010-2011 the percent of newly detained children who received an initial medical examination at a medical hub fell from 80 percent to 70 percent. The County's objective is that 100 percent of newly detained children receive an initial medical examination at a medical hub. The County has several theories about why this decline may have occurred, but has not yet determined the reason for this trend.

Young Children in Group Homes

The number of children age 0-12 in group care has almost doubled to 190 children since 2010. It appears likely to the Panel that possible contributors to this troubling trend may be uneven gate keeping and lack of appropriate home-based mental health resources. The County has been encouraged to address this issue quickly.

Panel Recommendations

The challenges identified by the Panel have been consistently the same over recent reports. As a result, the Panel is making more specific recommendations about strategies in an effort to help the County identify approaches that may improve performance in these areas. Those recommendations follow.

1. Training and Coaching

The County has provided some training to DCFS staff related to core practice model elements, but as stated in prior reports, it provides more of an overview than modeling and practice in actual skills. Recently, there has been training of some mental health staff in practice model content, but it too has been relatively brief.

To the Panel's knowledge, coaching and mentoring of mental health staff in the practice model has not begun. Some coaching of DCFS staff is occurring in Compton, a pilot site, but it too is relatively generic in nature. The County reports that it has assigned eight trainers to coaching and mentoring duties and plans to provide all of them with QSR reviewing experience, which is a good foundational strategy.

The County's challenge in the area of training and coaching is twofold: communicating practice model expectations to staff and preparing them to use practice model approaches in their daily work with children and families. It is not possible for the County to undertake a wholesale practice change initiative in multiple sites at this point because of its own lack of capacity; so the Panel recommends that the County use Compton as both a laboratory for perfecting its implementation approach and for

building its internal capacity to move beyond Compton to other service areas. The Panel recommends the following steps:

Develop expectations that CSWs in Compton will begin using family teams in their work with families and assist the office to determine the types of cases with which to begin and the pace of implementation.

In an effort to address concerns about workload, allocate additional staff to Compton to reflect recognition of the need for time to implement regular family meetings.

Assist the new coaches assigned to master the teaming process so they can coach and mentor Compton staff. Possible approaches for beginning the development process could include sending a few coaches to Utah to observe their teaming work and observing staff of the Child Welfare Group providing teaming training and coaching for other systems. The Panel will also try to identify possible coaching resources. If resources for significant numbers of additional staff in Compton are limited, at least allocate additional staff to several units and begin the effort with them.

The Panel believes that early success in Compton will build internal capacity, provide direction to expanded implementation efforts and reassure staff that the teaming process is both achievable and effective.

2. Development of Treatment Foster Care Beds

The Panel has two specific recommendations related Treatment Foster Care. First, the County notes that providers do not have resources for recruitment and retention activities. Since TFC is considerably underspending what costs would be at full implementation, it seems likely that unspent funds might be available for redeployment. The Panel recommends that the County allocate a supplementary amount of funds to providers to support recruitment and retention efforts.

Second, to enable the County to better understand the reasons that a significant percentage of children transition to higher levels of care after discharge from TFC, conduct a QSR on a sample of children recently transition to higher levels of care to assess the reasons the service is not preventing such placements.

3. Availability of Home-Based Mental Health Services

Following the same approach as the pilot underway with DCFS staff in Compton, focus on mental health providers serving the Compton office as the target for intensive home-based mental health service implementation. To achieve this, the Panel recommends the following steps:

Amend the contracts of mental health providers with a significant presence in Compton or serving significant numbers of children and families in the Compton community to require the delivery of home-based services consistent with the County's model of practice. Require each contract provider to address how they will build home-based service capacity within the LA practice model framework to strengthen the practice of their work force. Bring in Arizona

mental health experts the County has visited before to help orient mental health providers to new approaches to practice. If there is a way to expedite the County procurement process, which has been a consistent barrier because of its complexity and lengthy time frame for completion, employ such options to speed up the amendment process.

Ensure that focused consultative attention is also attentive to MAT staff, directed at improving their ability to conduct strength and needs-based assessments and link their role with the family team.

Conduct a QSR of a small sample of cases served by major mental health providers for Compton and solicit participation of provider agency leadership as shadows or invite them to join already planned QSR reviews. Observing the QSR is very effective in helping professionals understand practice expectations.

4. Medical Hubs

Currently, the County is assessing the reasons that it is not closer to reaching its goal of securing medical examinations for all newly detained children and hopes a new tracking system will help identify barriers. In the meantime, the Panel recommends that the County, assuming that it can identify children who were not referred, select a sample of recent non-referred children for follow-up. Each worker and/or supervisor with a selected case should be contacted and interviewed about the reasons for non-referral. The Panel suspects that accountability issues may be a factor, either with CSWs or foster parents. From such interviews and the results of tracking system reports, the County should develop a clear plan to increase referrals to the HUBs. Such a plan should include accountability for non-performance.

5. Children in Group Care Settings

As previously mentioned, based on experience elsewhere the Panel believes that uneven gate keeping, lack of individualized home-based mental health services and lack of appropriate foster home resources are likely factors contributing to the increase of young children in group homes. Two immediate recommendations are made.

First, the County should forbid the placement of any child under age 10 in a group home.

For any child 0-12 for whom a group home placement would have been considered as the only option, issue a child/sibling group-specific RFP to providers asking that they design a specific program of services and supports leading to permanency for the child. Services should be provided in a family-based setting. This might necessitate a partnership between, for example, a Wraparound provider and a FFA or related caregiver.

6. Next Steps.

The Panel recommends that the County develop detailed formal plans to address the five implementation issues identified by the Panel. The Panel also recommends that the County begin now with plan

development so that draft strategies will be available in advance of the Panel's next meeting in December 2011.

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I. Introduction

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

II. Background

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

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

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

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

- o immediately address the service and permanence needs of the five named plaintiffs;
- o improve the consistency of DCFS decision making through the implementation of Structured Decision Making;

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

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

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

Additionally, the Settlement directs that:

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

The Department prepared a Joint DCFS/DMH Mental Health Plan to describe its strategy for implementing the provisions of the settlement agreement. The Panel and plaintiffs identified issues in the Plan they believed needed additional attention and in a subsequent court hearing, plaintiffs and defendants proposed submitting a joint finding of facts that would identify areas of agreement and disagreement. The court issued an order directing the County to revise its plan and submit the revision for review. That Corrective Action Plan was completed and provided to the Court. In subsequent discussions with the Panel, the County concluded that additional strategies were necessary to achieve the objectives for the plaintiff class and committed to developing an overarching Strategic Plan that would address remaining system design needs.

The County has now completed its Strategic Plan and received County Board approval for implementation.

III. Panel Activities Since the Last Report

Since the last report the Panel has met twice with County staff about emerging implementation issues and exit conditions.

IV. Current Implementation Plan Status

Co-location of DMH Staff

The County has allocated 316 DMH positions to directly support Katie A. implementation. These include central office managers and staff who have either managerial, clinical or administrative roles and staff in each service area. Service area staff also have a similar mix of roles. Katie A. DMH staff are allocated as follows:

LOCATION	NO. OF ITEMS
Child Welfare Division	48
D-Rate	12
Service Area 1	29
Service Area 2	24
Service Area 3	34
Service Area 4	17
Service Area 5	4
Service Area 6	84
Service Area 7	39
Service Area 8	23
MHSA Items	3
TOTAL	317

Additional staffing for the DMH ACCESS Hotline

The County has found that all three positions originally committed to the function are not needed and that duties can be fulfilled by the single position currently filled.

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

There is agreement between the parties about the outcome indicators to be tracked and an update on performance is found in another section of this report. The parties have also agreed to the qualitative indicators to be measured. Concurrence about the qualitative performance standards will be sought from the Board in October 2011, after which the proposed standards will be presented to the court.

Development of Multidisciplinary Assessment Teams (MAT)

The County reports the following status of MAT implementation.

In August 2011, 90 percent of all eligible newly detained children Countywide were referred to a Multidisciplinary Assessment Team (MAT). This compares to an 83 percent referral rate reported in the prior Panel Report. From July 2010 to August 2011, there were 5,878 MAT referrals and 4,366 MAT assessments completed. The performance of individual Service Planning Areas for August 2011 is reflected in the following table.

Table 1: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	43	16	37%
SPA 2	62	62	100%
SPA 3	104	101	97%
SPA 4	41	41	100%
SPA 5	5	5	100%
SPA 6	66	60	91%
SPA 7	59	50	85%
SPA 8	64	64	100%
Total number of DCFS MAT referrals:	447	403	90%

It is important to note that the low referral rate in SPA 1 is due to limited MAT Provider capacity. Currently, there are only four MAT providers in SPA 1, where most other SPAs have ten or more. To address this capacity deficit, the County has entered into negotiations with two additional providers to conduct MAT assessments in SPA 1. Although several SPA 1 MAT agencies are having difficulty filling positions due to the shortage of eligible staff candidates in the area, when the capacity is limited, the county reports that the DMH Specialized Foster Care (SFC) staff is able to prepare a comprehensive mental health assessment and provide linkage to mental health services as needed.

From July 2010 through August 2011, the average timeline from MAT referral acceptance to completion of the final SOF (Summary of Findings) report was 45 days. The expected timeline for completion is 45 days. The percentage completed in 45 days or less was approximately 61%. The percent completed by the 50th day was 78%

In terms of completing the MAT assessment by case disposition, DCFS MAT Coordinators report approximately 70% of MATs are completed prior to disposition. The remaining 30% are delayed for numerous reasons including:

1. Variance in timelines to disposition within the court process. While DMH MAT providers have 45 days to complete the assessment, disposition can occur prior to the 45 days.
2. CSW compliance in obtaining consent/referral documents delayed some initial MAT referrals, thereby delaying the timeline to completion.

3. Benefits establishment, including verifying Medi-Cal and Medi-Cal applications/troubleshooting.
4. Toward the end of the fiscal year, there were provider capacity issues in several SPAs, which delayed the acceptance of referrals.

Panel Appraisal of MAT Performance

Since its implementation, the Panel has had concerns about the timely completion of MAT assessments and will begin asking the County to regularly report on timeliness. MAT staff estimate that approximately 30% of assessments are not completed by case disposition, which generally means that the court does not get the complete assessment in time to make full use of it in addressing the content of the case plan. Since the court-ordered case plan significantly influences the DCFS intervention and the parent's obligations, lack of a timely MAT assessment is a lost opportunity.

The Panel also is interested in an update on the quality of MAT assessments. In prior joint reviews by the Panel and County, there was agreement that MAT quality needed improvement in the depth of assessment and the individualization of recommendations. Following the most recent review, the County provided additional training to providers. The Panel will recommend that a follow-up review occur.

Implementation of the DMH Behavioral Health Information System (IBHIS)

The County provided the following specific update relative to IBHIS, which is the same as reported to the Panel in March 2011.

The County initiated the Request For Proposal (RFP) process to select a vendor to develop the Integrated Behavioral Health Information System (IBHIS) in 2008. After the receipt of the RFP proposals, the State of California issued new rules that significantly impacted the claiming process. Therefore, the RFP had to be cancelled and a new RFP process was initiated and is near the end of the procurement process. Once a vendor is selected, full implementation is expected to take approximately two years. Due to unexpected delays with the IBHIS, the Panel's eighth report to Court in April 2008 explained that IBHIS would be delayed and subsequently revised that estimate again in the Panel's tenth report to Court in July 2009. Since July 2009 the Panel reports to Court have consistently indicated that IBHIS is scheduled to be completed in 2013. In the interim, DMH developed a Katie A. Cognos Cube which has enabled DMH and DCFS to share client information, therefore, no longer requiring the use of the IBHIS system for this purpose. While the IBHIS system will improve the County's ability to capture clinical information related to those children who receive mental health services, the Cognos Cube does provide an ability to track service levels and associated costs of mental health services for Katie A. class members.

The Panel, in follow-up asked if this timeline had changed and was advised that DMH reports that implementation is now expected in 2014.

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

The County continues its implementation of the Qualitative Service Review process, which satisfies this provision. The Panel expects to share findings to date in its next report.

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

The County reports the following update to its progress in training for staff and mental health providers.

DCFS and DMH have developed curricula that encompass training for CSWs, co-located DMH staff, and community mental health providers to “Enhance Practice Skills”. Enhanced Skill-Based Training (ESBT) offers an overview and rationale of the content as well as training towards Strengths-Needs Based Practice, Engagement, and Teaming. To date, ESBT has been rolled out to 65 percent of Line Supervisors and 30 percent of CSWs. In addition, along with the Los Angeles Training Consortium, DCFS has implemented coaching for Emergency Response (ER) supervisors to reinforce the ESBT in all DCFS offices. In July 2011, In April 2011, DMH completed the first of a 2-day CPM training for the SPA 6 children’s mental health providers. This four-module training uses a train-the-trainer approach and will be subsequently provided to mental health providers in the remaining service areas by September 2011. This classroom training will then be augmented by a series of coaching calls and meetings to support the implementation of the CPM. In addition, training has been provided to Specialized Foster Care, MAT and Wraparound providers in the key practice areas of: Cultural Competency, Needs-Based Assessment, Family Engagement, Dual Diagnosis, Crisis Management and Mental Health Interventions with the birth to five population and their families.

Training was completed countywide in September 2011 and approximately 78 contract providers, 7 directly operated children’s clinics, and 18 DMH SFC co-located sites were trained. A total of 382 supervisors and lead clinicians were trained countywide. The previously planned CPM Consultation calls were cancelled so as to better align with the coaching and mentoring being conducted by DCFS.

Panel and County Training and Coaching Discussions

In the Panel meeting September 15-16, 2011, the Panel and County staff spent considerable time discussing the training and coaching under way, especially in Compton, the DCFS office selected for initial intensive supports for practice model implementation. There are training and coaching activities underway, but in the Panel’s opinion the training is largely conceptual rather than skill-based and more attentive to readiness for coaching than in demonstrating skills and providing performance feedback to staff. Coaching, as described by the County, does not include modeling practice model skills or mentoring staff in their use, which in the Panel’s opinion is the only way for new practice to be developed.

Expansion of Funding

According to the County, the FY 2010-11 Katie A. budget closed with \$15.3 million in net County cost savings. The budget closed with \$22 million in net County cost savings in 2009-2010. The savings are primarily due to vacant Wraparound slots. As done with prior year savings, the Chief Executive Office (CEO) has rolled the FY 2010-11 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2011-12 and FY 2012-13 in support of the incremental rollout of the Strategic Plan. The County reports that most of the savings occurred due to a slower roll-out than projected.

Expansion of Staff Resources for Multidisciplinary Medical Hubs

In Fiscal Year (FY) 2010-2011, approximately 70 percent of newly detained children received an Initial Medical Examination at a Medical Hub. In FY 2009-2010, 80 percent of newly detained children received an Initial Medical Examination at a Hub. The County's initial medical examination goal is 100 percent of children.

The County does not yet fully understand why there has been a drop in completed medical assessments, but reports that DCFS is implementing a tracking system that will provide additional information about whether children were referred and timeframes for completion. It is not clear as to how this will inform the system about why children are not referred. At present, the Panel is unaware of any concrete strategy for addressing under referrals, although the County states that it will develop action plans where needed.

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

DCFS reports a 17 percent increase in TDM meetings from the number referenced in the Panel's prior report. For the period November 2010 through February 2011, 4,880 team meetings were held. The County also reports a modest increase in team meetings for youth entering and leaving a group home and for youth replaced (placement change). At this point, however, the County is unable to provide team meetings for all youth at risk of group home placement or youth exiting group homes, despite the County's belief that team meetings in such circumstances help improve outcomes. The County hopes that the return of team facilitators from temporary deployment to Emergency Response duties will improve the frequency of team meetings. The County also reports that managers are looking for ways to improve compliance.

While the County recognizes that additional attention is needed to address team meeting accountability, the Panel has not found any concrete strategy for resolving this issue.

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

The County reported the following performance related to the revised mental health screening tool and associated rollout as of September 30, 2011 (data current to July 31, 2011).

Number of Children Screened - (of a total of 17,346 children):

14,399 children required a screen (17,346 children minus those currently receiving mental health services, in a closed case, who ran away, or were abducted);

13,954 (96.91%) children were screened;

9,230 (66.15%) of those children screened were determined to be in potential need of mental health services.

Screening Compliance – (of the 14,399 children who required screens):

9,230 (64.10%) children screened positive of those children requiring screens;

4,724 (32.81%) children screened negative of those children requiring screens;

445 (3.09%) children have screens pending of those children requiring screens.

Acuity Determination (of the 9,230 children who screened positive):

13 (0.14%) children were determined to have acute needs;

357 (3.87%) children were determined to have urgent needs;

8,369 (90.67%) children were determined to have routine needs;

491 (5.32%) children's acuity level was pending determination and/or data entry.

Number of Children Referred for Mental Health Services:

Of 9,230 children who screened positive (minus children for whom consent was declined, whose case was closed, who ran away, or who were abducted), DCFS staff referred 8,726 (97.09%) children for mental health services.

Average Number of Days Between Screening and Referral to DMH:

Children with acute needs were referred on the same day for mental health services, children with urgent needs were referred in one day and children with routine needs were referred in 5 days on average for mental health services.

The Panel asked for specific data on timeliness and the County provided the following as of May, 2011.

Days/ number of children referred for mental health services

Acuity	0 - 3 days	%	4 - 7 days	%	8 - 13 days	%	14 - 20 days	%	21 days and over	%	Total
Acute	21	100.00									21
Urgent	443	95.47	11	2.37	5	1.08			5	1.08	464
Routine	8,469	88.26	269	2.80	256	2.67	237	2.47	364	3.79	9,595
Total	8,933	88.62	280	2.78	261	2.59	237	2.35	369	3.66	10,080

The County has made significant strides in implementing the screening process and promptly referring children for mental health services.

Children Receiving a Mental Health Service Activity:

Of 8,726 children referred for mental health services: 8,381 (96.05%) children began receiving mental health service activities such as assessment, treatment, case management and consultation.

Number of Days from Screening to Start of Service):

Average of 10 days from case opening/case plan update to mental health screening;

Average of 5 days from receipt of a positive screen to a referral for mental health services;

Average of 3 days from referral to the start of mental health service activities.

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

Days of number of children receipt of mental health activity.

Acuity	0 - 3 days	%	4 - 7 days	%	8 - 13 days	%	14 - 20 days	%	21 days and over	%	Total
Acute	19	90.48	1	4.76					1	4.76	21
Urgent	425	91.59	23	4.96	5	1.08	3	0.65	8	1.72	464
Routine	7,337	76.47	594	6.19	541	5.64	461	4.80	662	6.90	9,595
Total	7,781	77.19	618	6.13	546	5.42	464	4.60	671	6.66	10,080

Coordinated Services Action Team (CSAT)

The County reports that the CSAT process requires expedited screening and response times based upon the urgency of a child’s needs for mental health services. As a result of a January 2010 Board Motion and subsequent case review, the Child Welfare Mental Health Screening Tool (MHST), the CSAT Screening and Assessment Policy, and the related DMH practice guidelines were revised to ensure the timely screening for, referral to, and provision of mental health services according to acute, urgent, and routine mental health needs identified. All CSAT previously trained offices have been retrained and are now implementing the CSAT redesign. The CSAT redesign training and implementation was completed in August 2011.

Expansion of Mental Health Services

Treatment Foster Care (TFC)

The Corrective Action Plan requires that the County develop 300 Treatment Foster Care beds. Previous Panel reports have noted the difficulty the County has experienced in developing this capacity, with only 51 children in placement as of the Panel’s last report. There are now only 58 children in placement as of September 2011. The Panel asked the County for a report on implementation progress and barriers, to which the County responded as follows.

The target population for TFC is for the most emotionally or behaviorally challenged youth in, or at risk of placement in, group homes or psychiatric facilities. TFC provides an alternative to

group home care for these children by providing intensive in-home therapeutic and behavioral

management services in a foster home with a limit on the number of children placed in that home. Although TFC program placements and contracts have increased, program growth was slowed due to time consuming and costly requirements placed on foster parents. Potential foster homes were required to obtain approval for foster as well as adoptive care. As a result,

DCFS executive management has now waived this requirement for all TFC foster parents and will begin the process for modifying existing contracts with the Board of Supervisors.

Table 2: TFC Placement and Capacity (as of September 30, 2011)					
	No. of Placed Children	Certified Homes	Certified Home Vacancies	Inactive Homes	Upcoming Beds
Intensive Treatment Foster Care (ITFC)					
	41	57	5	9	15
Multidimensional Treatment Foster Care (MTFC)					
	17	36	7	10	3
Grand Total	58	93	12	19	18

Overall, a total of 131 youth have received TFC services. Sixty-eight youth have transitioned out of the program with half recidivating to a higher level of care and the remainder graduating to a lower level of care (i.e. home of parent, legal guardian, relative and/or foster home). The success of TFC is also evidenced by those youth who remain stable in their TFC placements as this is a successful step toward permanency, pro-social stability, and as a result, present the County with a significant annual fiscal savings.

In June 2011, DCFS and DMH TFC staff developed a workgroup to increase the delivery of intensive treatment services to DCFS-involved youth (particularly those youth in D-Rate homes). Since the target populations for the TFC, Wraparound and D-Rate programs share similar needs, behaviors and risk factors, the DCFS/DMH workgroup will explore ways of utilizing existing Wraparound and D-Rate resources to provide a more flexible array of therapeutic services for the TFC target population. In addition, this workgroup will review and analyze the differences between those youth who have recidivated versus those who graduated from the TFC program.

Barriers to Expansion

The County believes there are several barriers to full implementation. These include financial disincentives (caregivers generally may serve only one child and one must not work), the challenges presented by the children referred, limited resources for recruitment and retention and limited central office management resources. The County hopes the resolution of the State Katie A. case and possible State level attention to fiscal barriers will help address the financial disincentives issue. It is also communicating with other municipalities using TFC about successful strategies experienced elsewhere. And the County has established a workgroup to further assess implementation. As of yet, however, the Panel has not found that there is a specific plan in which the County has confidence that will significantly and quickly increase the number of TFC beds or children placed in TFC. On the current path the County projects that it will not reach 300 bed capacity until 2015.

Another implementation issue about which the Panel and County have concern is that of the 68 youth that have exited TFC, half returned to a higher level of care. This percentage is surprisingly high. The County believes that some of these youth returning to a higher level of care may not have been appropriate for TFC to begin with. It is also possible that their transition after discharge was not well planned and that appropriate resources were not available to them upon discharge. The lack of suitable less-intensive family-based settings could also be a factor. Regardless of the cause of these poor outcomes, this trend needs significant attention.

Expansion of Wraparound by 500 Slots

The County reports that as of June 30, 2011, cumulatively 2,154 children have been enrolled in Tier II Wraparound, which is ahead of the projected target (1,850). Tier I enrollments (1,034) have increased due to the temporary suspension of the RMP enrollment requirement to Tier I and the implementation of the Residentially-Based Services (RBS) program. As of September 9th point-in-time data there were 1,161 filled Tier I slots and 1,402 filled Tier II slots. The County also reports the following.

The Wraparound program is also undergoing a major redesign process in preparation for the new contract in 2014. Five workgroups have been created to address different focus areas: Fiscal, Contracts, Program, Practice, and Quality Improvement/Assurance. The objective of these workgroups is to make Wraparound more efficient and incorporate lessons learned, new advances in the field, and feedback from consumers and community stakeholders. In addition, the County continues to discuss the impact of the two-tiered case rate system for Wraparound Tier I - \$4,184 (inclusive of placement) and Tier II - \$1,250 (exclusive of placement). To address this issue, the fiscal redesign workgroup has begun looking to combine the two rates and to maximize the use of EPSDT to support Wraparound services. The workgroup members have conducted a cost analysis of Tier I to help inform the case rate discussion and the development of new Wraparound contracts. DMH has continued to increase mental health contracts to support the expansion of the Wraparound program and has now provided EPSDT funding to support 3,115 Wraparound slots.

Intensive Home-Based Service Delivery

Tier II Wraparound is a somewhat less intensive and more flexible form of Wraparound for less intensive cases. The County committed to developing 2,800 slots by FY 2014 – 2015 and currently 2,154 children were enrolled as of June 30, 2011. The following table shows the County’s performance vs. projections.

Tier II Enrollment/Target Analysis			
Month-Year	Target	Cumulative	% of Target Achieved
Jan-11	1475	1699	115%
Feb-11	1550	1792	116%
Mar-11	1625	1898	117%

Apr-11	1700	1993	117%
May-11	1775	2088	118%
Jun-11	1850	2154	116%

Some providers have raised questions about the lack of distinction between some of the children referred for Tier II and those served in Tier I Wraparound, noting that emotional and behavioral differences between children in the two groups may be modest or non-existent. This is one reason the County is considering combining the two models. Providers also mentioned that the rate differences between the two models can limit the intensity and capacity of services in Tier II.

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

In its prior 2010-2011 report the Panel described the results of its request to the County for data on utilization of mental health services by children in FFAs and D-Rate Homes. Data showed a surprising mental health service underutilization among these populations. In providing an update for the current report, the County reports the following.

DMH and DCFS have begun to review the needs of D-Rate children and the mental health services offered to them in an effort to better identify the programmatic needs of this population and to make reforms to the D-Rate program that could offer a more defined place on the DCFS/DMH spectrum of care. After careful review, DCFS and DMH determined that the MAT reports (performed within the prior 12 months) contain clinically relevant information needed to establish D-Rate eligibility and will now be integrated into the child’s placement and treatment planning. Although this process has just begun and is not subject to formal procedural guidelines, the County reports that this new practice appears to be more efficient, less costly and has subjected children to fewer assessments.

In addition, DCFS and DMH have met to discuss the enhanced coordination between Wraparound services and Treatment Foster Care (TFC) utilizing D-Rate certified foster parents and relative caregivers. Although these discussions are preliminary in nature, DCFS and DMH are exploring the increased level of intervention available to D-Rate children and the degree to which D-Rate caregivers are able to receive additional support and guidance from Wraparound providers cross-trained in the TFC model.

The Panel welcomes this consideration. The Panel also recommends that the County assess the receipt of mental health service by children placed with relative providers.

Caseload/Workload Reduction

The County reports that the DCFS total out-of-home caseload has declined from 15,650 (October 2010) to 15,429 (April 2011). Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, this allows the Department to redirect dollars to much needed services to strengthen families and achieve safety, permanency, and well-being.

According to the County, the individual CSW generic caseload average in April 2011 was 26.79, which is an increase of 1.82 children per social worker since October 2010 (24.97). The ER caseloads also depict a slight increase in number of referrals from October 2010 (17.10) to April 2011(17.5). These increased caseload averages reflect ongoing parallel ER over 60-day investigations. The County notes that both the generic and emergency response averages represent the expected seasonal fall and early spring Child Protection Hotline referral peaks. These peaks also generate an increase in Emergency Response Command Post follow-up referrals, increased workload related safety measures in emergency response activities/investigations and caseload averages.

In interactions with local DCFS staff, the Panel has learned that these averages do not reflect experience in some localities where turnover and resultant vacancies can place individual caseloads much higher. For that reason, the Panel will begin asking for caseload data for each local office to more accurately assess workload.

Young Children in Group Homes

There were 100 children age 0-12 in group homes at the end of 2009 and 163 children age 0-12 in group homes at the end of 2010. The County reports that in June 2011, 190 children age 0-12 were in group homes, so the number has almost doubled since 2009. The table below shows the distribution of placements by office for this population.

***GROUP HOME REPORTS FOR CHILDREN 0 TO 12 (by office location)
JUNE 2011***

OFFICE NAME	NUMBER OF CHILDREN
Adoption	1
Asian Pacific/American Indian	2
Belvedere	6
Compton	11
Deaf Unit	2
El Monte	2
Family First Unit	2
Glendora	12
Lancaster	10
Medical Placement Units	5
Metro North	8
Palmdale	9
Pasadena	25
Pomona	8
Santa Fe Springs	10
San Fernando Valley	11
Santa Clarita	7
South County	8
Torrance	3
Vermont Corridor	16

Wateridge	19
West Los Angeles	6
West San Fernando Valley	7
TOTAL	190

**GROUP HOME REPORTS FOR CHILDREN 13 TO 21 (by office location)
JUNE 2011**

OFFICE AGE	13	14	15	16	17	18	19	20	21	Total (Age 13 and Older)	12	Total (Age 12 and Older)
Adoption	1		1	1			1			4	1	5
Asian Pac / Am Indian	2		3	3	3	2				13	1	14
Belvedere	5	6	6	13	5	1				36	2	38
Compton	4	16	12	18	12	7	2			71	3	74
Deaf Unit	1			2						3		3
El Monte	1	2		2	4					9		9
Family First Unit			1	1						2		2
Glendora	7	11	11	10	14	6	4			63	3	66
Lancaster	2	9	6	10	6	1	1			35	4	39
Medical Placement Units	2	2	5	11	7	3				30	3	33
Metro North	1	4	7	5	8	10				35	2	37
Palmdale	1	1	5	5	10	4	1		1	28	6	34
Pasadena	5	10	14	13	11	9	2	1		65	6	71
Pomona	3	5	10	9	12	3	2			44	3	47
S F Springs	5	4	7	3	13	2				34	2	36
San Fernando Valley	5	13	7	9	8	4				46	1	47
Santa Clarita	1	1	8	7	10	1				28	2	30
South County	3	12	13	11	11	5	1			56	3	59
Torrance	4	6	7	7	9	4				37	1	38
Vermont Corridor	15	8	16	20	23	7	2	2		93	7	100
Wateridge	8	11	17	14	19	5	2			76	7	83
West LA	2	3	2	11	3	3				24	2	26
West San Fernando Valley	3	5	3	4	4	2				21		21
Grand Total	81	129	161	189	192	79	18	3	1	853	59	912

In June 2010, for the group home population age 13-21, 777 children 13 and older, 53 children age 12 and 830 children age 12 and older were in group care. The total number of children in group care in these age groups came down somewhat in 2011.

The Panel is concerned over this increase in young children being placed in congregate settings, especially after the County's earlier success in reducing this number. The trend is even more troubling

given the fact that there have been unfilled Wraparound slots and that slow TFC implementation is limiting the availability of treatment foster care as an option for these children.

Concerted action is needed to prevent such congregate placements and create appropriate placement alternatives.

Qualitative Service Review (QSR)

The County’s QSR implementation continues capably. The County reports that to date, 78 cases have been randomly selected and reviewed. An average of nine children, youth, caregivers, family members, service providers and other professionals per case have been interviewed and the results have been fairly consistent across the seven DCFS regional offices reviewed – Belvedere, Santa Fe Springs, Compton, Vermont Corridor, Wateridge, Lancaster and Palmdale. On average, 86 percent of the cases across the offices are scored favorably overall (average of all indicators) on the Child and Family Status Indicators and roughly one-third of the cases scored favorably on the System Performance Indicators. The most significant challenges are reflected in the indicators of Permanency, Family Functioning and Resourcefulness, Teaming, Assessment, Planning and Long-Term-View. Findings are expected to be utilized by local DCFS leaders and practice partners to stimulate and support efforts to improve practice. Results are also to be used at the central office level to identify system barriers and needs for technical assistance supports at the local level. The Panel plans to follow up with local offices that have been reviewed to assess the response to QSR findings.

The QSR schedule through June 2012 is below.

Office(s)	QSR dates
El Monte	Oct 3-7, 2011
Pasadena	Nov 14 - 18, 2011
SFV	Jan 17 - 27, 2011
WSFV & Santa Clarita	Feb 27 - Mar 2, 2012
Metro North	Mar 19 - 23, 2012
West LA	Apr 23 - 27, 2012
Torrance	May 14 -18, 2012
South County	Jun 4 - 15, 2012

Exit Criteria

QSR

The parties have reached tentative agreement on the exit conditions for QSR performance. The County reports that it briefed the Board on the proposed exit agreement in September 2011. Formal Board approval on the QSR and other exit conditions is anticipated during October 2011. Following Board review, QSR standards will be presented to the court for review. For local offices to know and respond to expectations for QSR performance, it is vital that this standard be finalized as soon as possible.

V. Outcome Indicators

Background

Some of the outcome indicators being tracked are based on definitions determined by the federal Children's Bureau, by which it monitors state child welfare performance and holds states accountable to federal performance standards. Others were developed solely for application to Katie A. class members. To enable the parties and court to track the experience of Katie A. class members separate from children who do not have mental health needs, for purposes of outcome tracking, the following definition of class membership is being used. A Katie A. class member is a child being served by DCFS who is receiving a mental health service or who has received a mental health service between 12 months before and up to 12 months after the DCFS case start date. This definition is narrower than the settlement agreement's definition and does not capture all of the "at risk" population. However, to track outcomes across the entire population of children served through the case management system, there must be an open case and identified need for mental health services. DCFS children not yet screened for mental health services and not receiving a mental health service, for example, would not be counted. The methodology chosen, however, seems to the Panel likely to provide a representative picture of the results of the settlement related to child outcomes.

Most of the indicators reflect County performance based on what are called entry cohorts. Rather than tracking performance by capturing data on all children served in a single point in time, such as the last day of the year, most indicator data in this report reflect the year in which children enter out-of-home care or otherwise had their case opened. The problem caused by only tracking point-in-time data annually is that the experience of children who may have entered foster care years ago and experienced many moves is combined with that of children who only entered foster care in the prior month, for example. So a measure of length of stay in foster care traditionally involves an average. What's deceptive about this approach is that the progress made in a reform effort would be distorted by poor practice in past years, including older children who had poor outcomes and remain in the system. Assuming that reform efforts have been successful in shortening length of stay, the progress in achieving permanency experienced by children entering care in the past year would be masked by averaging the two subpopulations.

In tracking outcomes by entry cohort, all children entering care in each year would be tracked separately over time from those entering care in other years. As a result, it would be possible to determine if children entering care after the reform began had a different experience than those who entered care prior to reform efforts.

Entry cohort tracking is employed in all of the indicators except the stability indicators, where both entry cohort data and exit cohort data (children who exited in a given year) are used to ensure that the experience of all children is captured.

Tracking data begins with 2002-2003, the year in which the Settlement Agreement was signed and extends to the most current period in which complete annual data are available. For each indicator, the status of non-class members (children without DMH services) is better than class-members.

Outcome Exit Targets

The parties have agreed to exit targets for each indicator. There is a minimum level of performance target and an aspirational target assigned to each indicator. The aspirational target is an improvement goal unrelated to exit. Minimum Performance Levels were set only after these data became available and essentially assure that current performance will be a floor that the County does not fall below.

In the Panel's August 2010 report all performance levels were met. In this current report, two indicators fell slightly below minimum performance levels. The following tables reflect the outcome measures that are subject to an exit performance standard.

Overview of the System Population

There is no exit condition for this indicator. It is presented for informational purposes.

Population of FY 2002-2003 to FY 2009-2010															
Fiscal Year	All Children					With DMH Services					Without DMH Services				
	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total
2002-2003	9,699	55.98%	7,627	44.02%	17,326	1,624	45.54%	1,942	54.46%	3,566	8,075	58.68%	5,685	41.32%	13,760
2003-2004	10,381	58.66%	7,316	41.34%	17,697	1,830	46.68%	2,090	53.32%	3,920	8,551	62.07%	5,226	37.93%	13,777
2004-2005	11,939	59.53%	8,116	40.47%	20,055	2,364	48.93%	2,467	51.07%	4,831	9,575	62.89%	5,649	37.11%	15,224
2005-2006	11,632	58.62%	8,212	41.38%	19,844	2,421	46.64%	2,770	53.36%	5,191	9,211	62.86%	5,442	37.14%	14,653
2006-2007	11,224	55.32%	9,064	44.68%	20,288	2,486	40.79%	3,609	59.21%	6,095	8,738	61.57%	5,455	38.43%	14,193
2007-2008	10,923	56.37%	8,456	43.63%	19,379	2,845	42.46%	3,856	57.54%	6,701	8,078	63.72%	4,600	36.28%	12,678
2008-2009	10,370	56.23%	8,071	43.77%	18,441	3,060	40.84%	4,433	59.16%	7,493	7,310	66.77%	3,638	33.23%	10,948
2009-2010	13,393	60.06%	8,906	39.94%	22,299	4,521	42.44%	6,131	57.56%	10,652	8,872	76.17%	2,775	23.83%	11,647

A notable characteristic of the data in this table is that outcomes for the plaintiff class are considerably poorer than that of non-class members. In 2009-2010, for example, 39% of the total number of children referred were removed. For class members only, 57% were removed upon referral. The same pattern is true for most indicators, although the degree of difference between class members and non-class members varies.

Safety Indicator 1: Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period, up to 12 months									
Fiscal Year	All Children			With DMH Services			Without DMH Services		
	Children initially remained home	Children without any substantiated referrals	%	Children initially remained home	Children without any substantiated referrals	%	Children initially remained home	Children without any substantiated referrals	%
2002-2003	9,699	8,759	90.3%	1,624	1,300	80.0%	8,075	7,459	92.4%
2003-2004	10,381	9,368	90.2%	1,830	1,510	82.5%	8,551	7,858	91.9%
2004-2005	11,939	10,785	90.3%	2,364	1,980	83.8%	9,575	8,805	92.0%
2005-2006	11,632	10,457	89.9%	2,421	2,020	83.4%	9,211	8,437	91.6%
2006-2007	11,224	10,161	90.5%	2,486	2,097	84.4%	8,738	8,064	92.3%
2007-2008	10,923	9,843	90.1%	2,845	2,357	82.8%	8,078	7,486	92.7%
2008-2009	10,370	9,369	90.3%	3,060	2,564	83.8%	7,310	6,805	93.1%
2009-2010	13,393	11,970	89.4%	4,521	3,789	83.8%	8,872	8,181	92.2%

Minimum Performance Level – 82.8%

Aspire To – 83.3%

The County met the Minimum Performance Level for class members.

Safety Indicator 2. Of all children served in foster care in the Fiscal Year, how many did not experience maltreatment by their foster care providers? (Federal CFSR Measure: Methodology specific to Katie A)									
Fiscal Year	All Children			With DMH Services			Without DMH Services		
	All children served in foster care in Fiscal Year	Children with no maltreatment	%	All children served in foster care in Fiscal Year	Children with no maltreatment	%	All children served in foster care in Fiscal Year	Children with no maltreatment	%
2002-2003	32,822	32,398	98.7%	10,798	10,529	97.5%	22,024	21,869	99.3%
2003-2004	30,239	29,817	98.6%	10,762	10,495	97.5%	19,477	19,322	99.2%
2004-2005	28,843	28,498	98.8%	11,025	10,815	98.1%	17,818	17,683	99.2%
2005-2006	27,749	27,490	99.1%	11,272	11,120	98.7%	16,477	16,370	99.4%
2006-2007	28,250	27,933	98.9%	12,479	12,280	98.4%	15,771	15,653	99.3%
2007-2008	27,247	26,911	98.8%	13,166	12,956	98.4%	14,081	13,955	99.1%
2008-2009	25,031	24,763	98.9%	13,637	13,460	98.7%	11,394	11,303	99.2%
2009-2010	24,255	23,879	98.4%	15,647	15,340	98.0%	8,608	8,539	99.2%

Minimum Performance Level – 98.4%

Aspire To – 98.6%

The County did not meet the Minimum Performance Level for class members.

Safety Indicator 3. No recurrence of maltreatment within 6 months (Federal CFSS Measure)

Fiscal Year	Time Period	No Maltreatment	Total	Percent
2002-2003	Jul 2002 - Dec 2002	11,649	12,950	89.95%
	Jan 2003 - Jun 2003	11,179	12,328	90.68%
2003-2004	Jul 2003 - Dec 2003	10,118	11,062	91.47%
	Jan 2004 - Jun 2004	11,013	12,025	91.58%
2004-2005	Jul 2004 - Dec 2004	10,174	11,111	91.57%
	Jan 2005 - Jun 2005	10,715	11,664	91.86%
2005-2006	Jul 2005 - Dec 2005	9,337	10,145	92.04%
	Jan 2006 - Jun 2006	9,767	10,530	92.75%
2006-2007	Jul 2006 - Dec 2006	8,848	9,558	92.57%
	Jan 2007 - Jun 2007	9,314	9,983	93.30%
2007-2008	Jul 2007 - Dec 2007	8,734	9,394	92.97%
	Jan 2008 - Jun 2008	9,732	10,534	92.39%
2008-2009	Jul 2008 - Dec 2008	9,743	10,485	92.92%
	Jan 2009 - Jun 2009	9,461	10,199	92.76%
2009-2010	Jul 2009 - Dec 2009	11,795	12,762	92.42%
	Jan 2010 - Jun 2010	12,326	13,527	91.12%
2010-2011	Jul 2010 - Dec 2010	12,858	13,876	92.66%

Minimum Performance Level – 92.3%

Aspire To – 92.8%

The County met the Minimum Performance Level.

Permanency Indicator 1. Median length of stay for children in foster care									
Fiscal Year	All Children			With DMH Services			Without DMH Services		
	Children initially removed from home	No. of children who exited foster care	Median Days	Children initially removed from home	No. of children who exited foster care	Median Days	Children initially removed from home	No. of children who exited foster care	Median Days
2002-2003	7,627	7,208	578	1,942	1,759	656	5,685	5,449	549
2003-2004	7,316	6,887	522	2,090	1,893	596	5,226	4,994	475
2004-2005	8,116	7,460	444	2,467	2,145	531	5,649	5,315	423
2005-2006	8,212	7,292	429	2,770	2,297	518	5,442	4,995	394
2006-2007	9,064	7,354	389	3,609	2,778	442	5,455	4,576	284
2007-2008	8,456	5,755	295	3,856	2,364	409	4,600	3,391	231
2008-2009	8,071	6,668	293	4,433	2,740	401	3,638	2,706	199
2009-2010	8,906	5,667	328	6,131	3,591	417	2,775	2,076	140

Minimum Performance Level – 409 Days

Aspire To – 383 Days

The County did not meet the Minimum Performance Level for class members. The median number of days in care is significantly higher for class members than non-class members.

Permanency Indicator 2. Reunification within 12 months (Federal CFSR Measure: Methodology specific to Katie A)									
Fiscal Year	All Children			With DMH Services			Without DMH Services		
	Children initially removed from home	Children reunified within 12 months	%	Children initially removed from home	Children reunified within 12 months	%	Children initially removed from home	Children reunified within 12 months	%
2002-2003	7,627	1,509	19.8%	1,942	281	14.5%	5,685	1,228	21.6%
2003-2004	7,316	1,667	22.8%	2,090	384	18.4%	5,226	1,283	24.6%
2004-2005	8,116	2,401	29.6%	2,467	639	25.9%	5,649	1,762	31.2%
2005-2006	8,212	2,481	30.2%	2,770	713	25.7%	5,442	1,768	32.5%
2006-2007	9,064	3,135	34.6%	3,609	1,120	31.0%	5,455	2,015	36.9%
2007-2008	8,456	3,306	39.1%	3,856	1,402	36.4%	4,600	1,904	41.4%
2008-2009	8,071	3,089	38.3%	4,433	1,633	36.8%	3,638	1,456	40.0%
2009-2010	8,906	3,310	37.2%	6,131	2,313	37.7%	2,775	997	35.9%

Minimum Performance Level – 36.4%

Aspire To – 45.6%

The County met the Minimum Performance Level for class members.

Permanency Indicator 3. Adoption within 24 months (Federal CFSR Measure: Methodology specific to Katie A)									
Fiscal Year	All Children			With DMH Services			Without DMH Services		
	Children initially removed from home	Children adopted within 24 months	%	Children initially removed from home	Children adopted within 24 months	%	Children initially removed from home	Children adopted within 24 months	%
2002-2003	7,627	230	3.0%	1,942	12	0.6%	5,685	218	3.8%
2003-2004	7,316	250	3.4%	2,090	20	1.0%	5,226	230	4.4%
2004-2005	8,116	382	4.7%	2,467	36	1.5%	5,649	346	6.1%
2005-2006	8,212	373	4.5%	2,770	58	2.1%	5,442	315	5.8%
2006-2007	9,064	359	4.0%	3,609	71	2.0%	5,455	288	5.3%
2007-2008	8,456	352	4.2%	3,856	84	2.2%	4,600	268	5.8%
2008-2009	8,071	305	3.8%	4,433	111	2.5%	3,638	194	5.3%

Minimum Performance Level – 2.0%

Aspire To – 2.9%

The County met the Minimum Performance Level for class members.

Permanency Indicator 4. Reentry into foster care during the Fiscal Year and reentry within 12 months of the date of reunification (Federal CFSR Measure)									
Fiscal Year	All Children			With DMH Services			Without DMH Services		
	Children who were reunified	Children who re-entered foster care	%	Children who were reunified	Children who re-entered foster care	%	Children who were reunified	Children who re-entered foster care	%
2002-2003	5,612	288	5.1%	1,528	118	7.7%	4,084	170	4.2%
2003-2004	5,690	293	5.1%	1,733	144	8.3%	3,957	149	3.8%
2004-2005	5,925	360	6.1%	2,068	195	9.4%	3,857	165	4.3%
2005-2006	6,706	723	10.8%	2,485	385	15.5%	4,221	338	8.0%
2006-2007	6,980	741	10.6%	2,737	379	13.8%	4,243	362	8.5%
2007-2008	7,638	830	10.9%	3,335	464	13.9%	4,303	366	8.5%
2008-2009	7,445	916	12.3%	3,793	597	15.7%	3,652	319	8.7%
2009-2010	7,260	852	11.7%	4,294	596	13.9%	2,966	256	8.6%

Minimum Performance Level – 13.9%

Aspire To – 12.9%

The performance target of 13.9 was met. Re-entry rates have risen for both class-members and non-class members as measured by this indicator.

Permanency Indicator 5a. Children in foster care less than 12 months with 2 or less placements (Federal Measure: Methodology specific to Katie A)									
Fiscal Year	All Children			With DMH Services			Without DMH Services		
	Children in foster care less than 12 months	Children with 2 or less placements	%	Children in foster care less than 12 months	Children with 2 or less placements	%	Children in foster care less than 12 months	Children with 2 or less placements	%
2002-2003	1,934	1,702	88.0%	385	285	74.0%	1,549	1,417	91.5%
2003-2004	2,065	1,819	88.1%	490	384	78.4%	1,575	1,435	91.1%
2004-2005	2,858	2,495	87.3%	775	601	77.5%	2,083	1,894	90.9%
2005-2006	2,889	2,517	87.1%	851	683	80.3%	2,038	1,834	90.0%
2006-2007	3,520	3,116	88.5%	1,257	1,028	81.8%	2,263	2,088	92.3%
2007-2008	3,641	3,151	86.5%	1,530	1,263	82.5%	2,111	1,888	89.4%
2008-2009	3,372	2,973	88.2%	1,769	1,504	85.0%	1,603	1,469	91.6%
2009-2010	3,615	3,143	86.9%	2,475	2,096	84.7%	1,140	1,047	91.8%

Minimum Performance Level – 82.5%

Aspire To – 84.1%

The County met the Minimum Performance Level for class members.

Permanency Indicator 5b. Children in foster care 12 months but less than 24 months, without a move to a third or greater placement(s) in the second year									
Fiscal Year	All Children			With DMH Services			Without DMH Services		
	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%
2002-2003	2,330	2,184	93.7%	600	537	89.5%	1,730	1,647	95.2%
2003-2004	2,292	2,158	94.2%	697	625	89.7%	1,595	1,533	96.1%
2004-2005	2,217	2,042	92.1%	689	589	85.5%	1,528	1,453	95.1%
2005-2006	2,189	1,979	90.4%	782	664	84.9%	1,407	1,315	93.5%
2006-2007	2,315	2,139	92.4%	1,064	949	89.2%	1,251	1,190	95.1%
2007-2008	1,975	1,825	92.4%	961	865	90.0%	1,014	960	94.7%
2008-2009	1,879	1,683	89.6%	1,204	1,047	87.0%	675	636	94.2%

Minimum Performance Level – 89.2%

Aspire To – 89.7%

The County did not meet the Minimum Performance Level for class members.

Permanency Indicator 5c. Children in foster care on the first day of the Fiscal Year who have been in foster care for 24 months or more, and have not experienced a move to a third or greater placement(s) during the Fiscal Year									
Fiscal Year	All Children			With DMH Services			Without DMH Services		
	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%
2002-2003	18,945	11,616	61.3%	7,959	3,600	45.2%	10,986	8,016	73.0%
2003-2004	17,039	10,459	61.4%	7,955	3,710	46.6%	9,084	6,749	74.3%
2004-2005	14,959	9,243	61.8%	7,535	3,638	48.3%	7,424	5,605	75.5%
2005-2006	13,136	8,202	62.4%	7,136	3,609	50.6%	6,000	4,593	76.6%
2006-2007	11,760	7,709	65.6%	6,587	3,587	54.5%	5,173	4,122	79.7%
2007-2008	10,545	7,285	69.1%	5,992	3,525	58.8%	4,553	3,760	82.6%
2008-2009	9,115	6,509	71.4%	5,376	3,332	62.0%	3,739	3,177	85.0%
2009-2010	7,829	5,572	71.2%	4,980	3,076	61.8%	2,849	2,496	87.6%

Minimum Performance Level – 58.8%

Aspire To – 61.7%

The County met the Minimum Performance Level for class members.

VI. Panel Analysis of Strategic Plan Implementation

The population of Los Angeles County is nearly 10,000,000 people, making it the most populous county in the United States, with more citizens than most states. Its child welfare and mental health systems are large and complex organizations to begin with and the integration of their work in service to the Katie A. class makes them even more complicated. In that context the two systems are undertaking a reform of immense proportions. In any system, improvements such as those expected through the Katie A. settlement and strategic plan take years to complete. The scale of Los Angeles County means that reform won't occur as rapidly as it might in smaller jurisdictions. The Panel recognizes the challenges faced by the County and views the progression of improvements and challenges within that context. The County has made progress and has much yet to accomplish.

In the first years of the settlement, DCFS believed that it had foundational work to accomplish regarding safety and permanency before it could commit fully to the Katie A. objectives and expected that such work would also benefit class members. Implementation of Strategic Decision Making (a child protection risk and safety assessment process), the Multi-Disciplinary Assessment Process and the Medical Hubs are examples of the foundational work addressed. In the past few years there has been a much more intensive focus on Katie A. objectives and some important gains have been made in developing a new model of practice, expanding Wraparound and implementing mental health screening, for example. Also, mental health staff are co-located in DCFS offices and there is increasing integration of planning and implementation between DMH and DCFS at the leadership level. In addition, the implementation of the QSR provides sophisticated feedback about both system performance and the progress experienced by class members.

These Katie A. improvements are themselves foundational, providing a platform for developing two of the most important other objectives of the strategic plan, changing and improving practice and expanding home-based mental health services. It is in these two areas that the greatest challenges remain and about which this analysis will devote most of its attention.

Training and Coaching

As mentioned in several past reports, the County has provided some practice model training to DCFS staff, although the Panel notes that it is relatively brief and addresses concepts rather than skills. Less practice model training has been provided to mental health staff, although some training was recently provided. It too was brief and highly conceptually focused.

Presently, the County does not have the capacity for supervisors or a small number of dedicated coaches to go beyond transferring conceptual knowledge about practice model approaches to front-line staff. Staff are not experiencing modeling of skills by coaches or mentoring on their actual practice. To compare the current learning environment to another field, no one would fly with a pilot whose skills never went beyond what was learned in classroom instruction and small group discussions. Until flight students can observe an instructor fly and then practice flying with the instructor guiding and coaching, they are incapable of flying safely. The County is currently struggling with the challenge of providing enough competent coaching to prepare staff to meet the needs of class members.

At the heart of the Katie A. Practice Model is the use of child and family teams for each family, which provides a forum for engagement, assessment, planning, service provision and coordination. The use of such teams from the beginning of each case opening has been a leading strategy in many systems now

undergoing statewide reform and in the three systems exiting court supervision in multiple years. The County's current capacity to use teams is limited to specialized services like Wraparound and TDM meetings. However, Wraparound is limited to a high needs subset of the class and TDM meetings are too infrequent and mainly devoted to decision-making, not ongoing planning. The other systems using teams referenced previously all expect case managers to facilitate their own teams. The County has committed to that concept in its strategic plan, but has not yet been prepared to implement it. Concerns about high caseworker caseloads seem to be the greatest concern.

The Panel realizes that DCFS has high caseloads. It appears to us that to some extent the County is hoping that some external support, resource or innovation will help address the workload issue over time, but until then is not confident that it can commit to full implementation of child and family teaming due to workload concerns. The Panel believes that practice model implementation is the best strategy for lowering caseloads. The Panel has seen systems lower their caseloads by implementing strengths/needs-based, team-driven practice one family at a time, which can help keep children home safely and returns children from placement more in a more timely fashion. Obviously CSWs can't develop teams for their entire caseload immediately, but by starting with a modest number of cases, they develop teaming skills and can begin to see the value child and family teams provide in achieving safety, permanence and well-being outcomes. And they can see their caseloads affected.

Expansion of Home-Based Mental Health Services

Expansion of home-based mental health services is an important objective of the settlement. Mental health screening, Medical Hubs, CSAT, RMP and MAT are valuable additions to the County's capacity and can facilitate improved services to children, but they are not home-based mental health services. Like the issue of developing child and family teams, progress in home-based mental health service expansion seems to be limited. And in areas like the Antelope Valley, there seems to be even less expansion. Wraparound and TFC have been expanded, but these will never have the capacity to serve the majority of Katie A class members and their appropriateness is targeted to higher intensity cases. Concentrated efforts are needed to expand the array of home-based mental health services.

In a related matter, the Panel understands that the County is examining the possibility of combining Tier I and II Wraparound. While we are happy to see continued growth in Wraparound capacity, there is an issue we want to raise. There appears to be a continuing problem with getting sufficient Wraparound referrals to make full use of available capacity. This underutilization deserves particular attention because this service could help limit the growing number of young children who are placed in group care. The County needs an effective strategy to make full use of this important resource.

Treatment foster care is a variety of home-based services. Presently, the Department seems to be stuck in finding effective strategies to expand TFC capacity. The recruitment barriers the County has identified do seem to be valid obstacles, but other systems have overcome such problems. There also needs to be attention to the appropriateness of TFC referrals, the quality of the service and the availability of transitional supports once children leave TFC homes. The Panel believes that expansion of home-based mental health services would help provide the needed supportive transitional resources.

Young Children in Group Care

The number of children age 0-12 in group care has almost doubled to 190 children since 2009. Group care is rarely appropriate for children this age and should not be used for very young children. The Panel suspects that the growth is probably because of a combination of gaps in gate keeping and lack of adequately supported family-based placements. The slow growth of treatment foster care is certainly a contributor, as it is a common alternative elsewhere. Multiple strategies will be needed to reverse this trend, including placement oversight, creation of additional home-based mental health services and expansion of TFC.

VII. Panel Recommendations

1. *Training and Coaching*

The County has provided some training to DCFS staff related to core practice model elements, but as stated in prior reports, it provides more of an overview than modeling and practice in actual skills. Recently, there has been training of some mental health staff in practice model content, but it too has been relatively brief.

To the Panel's knowledge, coaching and mentoring of mental health staff in the practice model has not begun. Some coaching of DCFS staff is occurring in Compton, a pilot site, but it too is relatively generic in nature. The County reports that it has assigned eight trainers to coaching and mentoring duties and plans to provide all of them with QSR reviewing experience, which is a good foundational strategy.

The County's challenge in the area of training and coaching is twofold: communicating practice model expectations to staff and preparing them to use practice model approaches in their daily work with children and families. It is not possible for the County to undertake a wholesale practice change initiative in multiple sites at this point because of its own lack of capacity; so the Panel recommends that the County use Compton as both a laboratory for perfecting its implementation approach and for building its internal capacity to move beyond Compton to other service areas. The Panel recommends the following steps:

Develop expectations that CSWs in Compton will begin using family teams in their work with families and assist the office to determine the types of cases with which to begin and pace of implementation.

In an effort to address concerns about workload, allocate additional staff to Compton to reflect recognition of the need for time to implement regular family meetings.

Assist the new coaches assigned to master the teaming process so they can coach and mentor Compton staff. Possible approaches for beginning the development process could include sending a few coaches to Utah to observe their teaming work and observing staff of the Child Welfare Group providing teaming training and coaching for other systems. The Panel will also try to identify possible coaching resources. If resources for significant numbers of additional

staff in Compton are limited, at least allocate additional staff to several units and begin the effort with them.

The Panel believes that early success in Compton will build internal capacity, provide direction to expanded implementation efforts and reassure staff that the teaming process is both achievable and effective.

2. *Development of Treatment Foster Care Beds*

The Panel has two specific recommendations related Treatment Foster Care. First, the County notes that providers do not have resources for recruitment and retention activities. Since TFC is considerably underspending what costs would be at full implementation, it seems likely that unspent funds might be available for redeployment. The Panel recommends that the County allocate a supplementary amount of funds to providers to support recruitment and retention efforts.

Second, to enable the County to better understand the reasons that a significant percentage of children transition to higher levels of care after discharge from TFC, conduct a QSR on a sample of children recently transition to higher levels of care to assess the reasons the service is not preventing such placements.

3. *Availability of Home-Based Mental Health Services*

Following the same approach as the pilot underway with DCFS staff in Compton, focus on mental health providers serving the Compton office as the target for intensive home-based mental health service implementation. To achieve this, the Panel recommends the following steps:

Amend the contracts of mental health providers with a significant presence in Compton or serving significant numbers of children and families in the Compton community to require the delivery of home-based services consistent with the County's model of practice. Require each contract provider to address how they will build home-based service capacity within the LA practice model framework to strengthen the practice of their work force. Bring in Arizona mental health experts the County has visited before to help orient mental health providers to new approaches to practice. If there is a way to expedite the County procurement process, which has been a consistent barrier because of its complexity and lengthy time frame for completion, employ such options to speed up the amendment process.

Ensure that focused consultative attention is also attentive to MAT staff, directed at improving their ability to conduct strength and needs-based assessments and link their role with the family team.

Conduct a QSR of a small sample of cases served by major mental health providers for Compton and solicit participation of provider agency leadership as shadows or invite them to join already planned QSR reviews. Observing the QSR is very effective in helping professionals understand practice expectations.

4. *Medical Hubs*

Currently, the County is assessing the reasons that it is not closer to reaching its goal of securing medical examinations for all newly detained children and hopes a new tracking system will help identify barriers. In the meantime, the Panel recommends that the County, assuming that it can identify children who were not referred, select a sample of recent non-referred children for follow-up. Each worker and/or supervisor with a selected case should be contacted and interviewed about the reasons for non-referral. The Panel suspects that accountability issues may be a factor, either with CSWs or foster parents. From such interviews and the results of tracking system reports, the County should develop a clear plan to increase referrals to the HUBs. Such a plan should include accountability for non-performance.

5. *Children in Group Care Settings*

As previously mentioned, based on experience elsewhere the Panel believes that uneven gate keeping, lack of individualized home-based mental health services and lack of appropriate foster home resources are likely factors contributing to the increase of young children in group homes. Two immediate recommendations are made.

First, the County should forbid the placement of any child under age 10 in a group home.

For any child 0-12 for whom a group home placement would have been considered as the only option, issue a child/sibling group-specific RFP to providers asking that they design a specific program of services and supports leading to permanency for the child. Services should be provided in a family-based setting. This might necessitate a partnership between, for example, a Wraparound provider and a FFA or related caregiver.

7. *Next Steps.*

The Panel recommends that the County develop detailed formal plans to address the five implementation issues identified by the Panel. The Panel also recommends that the County begin now with plan development so that draft strategies will be available in advance of the Panel's next meeting in December 2011.

VIII. Glossary of Terms

ADHD – Attention deficit hyperactivity disorder

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

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

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

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

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

DMH – Department of Mental Health

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

ER – Emergency response

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

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

FGDM – Family Group Decision Making

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

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

IEP – Individual Education Plan

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

MAT – Multi-Disciplinary Assessment Team

PTSD – Post-traumatic stress disorder

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

RPRT – Regional Permanency Review Teams

TAY – Transitional Age Youth