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7 UNITED STATES DISTRICT COURT
8 CENTRAL DISTRICT OF CALIFORNIA
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KATIE A. by and through her next friend Michael Ludin; **MARY B.** by and through her next friend Robert Jacobs; **JANET C.** by and through her next friend Dolores Johnson; **HENRY D.** by and through his next friend Gillian Brown; **AND GARY E.** by and through his next friend Michael Ludin; individually and on behalf of others similarly situated,

Plaintiffs,

v.

DIANA BONTA, Director of California Department of Health Services; **LOS ANGELES COUNTY; LOS ANGELES COUNTY DEPARTMENT OF CHILDREN AND FAMILY SERVICES;** **ANITA BLOCK**, Director of the Los Angeles County Department of Children and Family Services; **RITA SAENZ**, Director of the California Department of Social Services, and **DOES 1 through 100, Inclusive**

Defendants.

Case No.: CV-02-05662-JAK (SHx)

ADVISORY PANEL'S REPORT TO THE COURT - FIRST REPORTING PERIOD OF 2013, AUGUST 24, 2013

The Hon. John A. Kronstadt
Courtroom: 750

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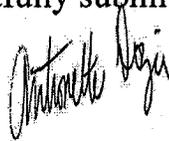
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1 Pursuant to this Court's Order, Plaintiffs are filing the Advisory Panel's
2 Report to the Court - First Reporting Period of 2013, August 24, 2013. The parties
3 have conferred with the panel and the panel has offered to appear before the court
4 on October 2nd, October 3rd, or at any other time convenient to the Court, to answer
5 any questions regarding implementation. A true and correct copy of the Advisory
6 Panel's Report to the Court is attached hereto.

7
8 DATED: September 5, 2013

9 Respectfully submitted,

10 

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12 By _____
13 ANTIONETTE DOZIER
14 Attorneys for Plaintiffs

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The Katie A. Advisory Panel
c/o 428 East Jefferson Street
Montgomery, AL 36104

Marty Beyer
Paul Vincent
Edward Walker

September 3, 2013

Honorable John A. Kronstadt
US District Court Judge
255 East Temple Street
Courtroom 750 - 7th Floor
Los Angeles, CA 90012-3332

Case No. CV02-05662-AMH (SHx), KATIE A. V. DIANA BONTA

Dear Judge Kronstadt,

Attached is a copy of the Katie A. Panel's Report to the Court for the First Reporting Period of 2013, covering the period of January 1, 2013-June 30, 2013. The Panel will be following up with a bound copy for your use. The Panel is meeting in Los Angeles October 2 and 3, 2013 and if it would be helpful for you to speak with the Panel personally while we are there we would be happy to meet with you at your convenience. Also, we could schedule a trip specifically for that purpose if that is more practical. We can easily combine such a meeting with other ongoing on-site monitoring we engage in.

We would be happy to respond to any questions you may have about this report.

Sincerely,



Paul Vincent
Panel Chair

cc Panel Members
Phillip Browning
Kim Lewis
Ira Burnim
Antionette Dozier
Laura Quinonez
Richard Saletta

**The Katie A. Advisory Panel
Report to the Court
First Reporting Period of 2013
August 24, 2013**

**The Katie A. Advisory Panel
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Marty Beyer
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Executive Summary

System Progress

The County has made progress in a number of important areas of strategic plan implementation, which are highlighted below.

A major contribution has been made by the County in essentially serving as a pilot for the design and implementation of the State Katie A. Settlement. Developmental work by the County has helped shape the State's Core Practice Model, which contains the principles and approaches to be employed and the manner in which class members and their families are treated. County representatives have dutifully served on State work groups, commented on proposed State policies and standards and regularly joined informational and problem-solving forums.

The County continues to have success in implementing its Multidisciplinary Assessment Team process (MAT) for newly detained children. Currently, 99.5 percent of all newly detained children are referred for a MAT Assessment. Those assessments were completed in 80 percent of cases and for the cases not assessed, some were still in process at the time of reporting, some children returned home before completion, had private insurance that rendered them ineligible for MAT, were on runaway status, moved out of the County or State or were otherwise inaccessible.

In seeking to expand home-based mental health service availability, the County is piloting a unique model of the provision of intensive direct home-based supports for class members and their families, using five interested providers to demonstrate the efficacy of a broader expansion of the concept. The Panel has asked to meet with the providers selected in its October 2013 meeting. This model has been successful in a similar reform effort in Arizona and the Panel commends the county for exploring this innovation.

The County continues to be successful in operating its initiative to provide a comprehensive medical examination for all newly detained children through its Medical Hubs. In the period between June 2012 and May 2013, 86 percent of all newly detained children were referred to a Medical Hub for a medical evaluation. The County continues to work toward achievement of its goal of referring 100 percent of newly detained children for medical evaluation.

The County is seeking to provide mental health screening to all newly detained children in DCFS and continues to screen a high percentage of children. Sixteen thousand sixty-one children were screened during the reporting period. As of March 2013, 98 percent of children requiring a screen received a mental health screen. Eighty-two percent of those screened were determined to be in potential need of mental health services. Of those with a potential need for mental health services 99 percent were referred for mental health services and 94 percent began receiving mental health services (assessment, treatment, case management and/or consultation).

Over the past two years, after expressions of concern by the Panel, the County has reduced its growing number of young children (age 0-12) in group care from 179 in February 2011 to 91

children in April 2013. As of April 2013 there were no children 6 or younger in group care and except for 1 seven-year old and 5 eight-year olds, the remaining children were age 9-12. The Panel commends these gains, but expects that the numbers will be reduced further as a result of the expansion of home-based mental health services. It should be rare for children of this age range to be in group care. Typically the needs of children in this age group can be more effectively met in family homes with intensive services.

System Challenges

The system challenges experienced by the County include many of the same as those noted in prior Panel reports and continue to pose barriers to achieving the Katie A. Settlement objectives.

Workload

Caseworker workloads/caseloads remain high. There has been some variability in caseload size during the term of Katie A., but current ongoing caseloads of 28.53 and Emergency Response caseloads of 16.87 make it difficult for staff to fully support the County's model of practice. The Core Practice Model involves developing a full understanding of child and family needs, participation in regular Family Team Meetings and regular contact with families to track progress and where needed, modify interventions. New strategies are needed to achieve the County's goal of lower caseloads. DCFS is also challenged in having a reliable method of measuring caseload in a manner that provides accurate and reliable data.

Treatment Foster Care

The growth of treatment foster resources continues to be slow. The County is unable to project when it might meet the court ordered goal of 300 beds. There are several complex issues that have limited growth, including rate issues and the difficulty of some caregivers being able to afford not to work in order to provide therapeutic care. There continue to be children in overly restrictive levels of care who could move to a family setting if more treatment foster care resources were available.

Availability of Reliable Information about Maltreatment in Group Homes

One of the outcome indicators measured as part of the Katie A. Settlement is the rate of maltreatment of children placed in out-of-home care. The DCFS child abuse and neglect reporting system only identifies maltreatment in family foster care settings, meaning that reports of abuse and neglect in group homes are not recorded in the automated system. As a result, the full incidence of maltreatment by out-of-home caregivers is not known.

Expansion of Home Based Mental Health Services

The parties and Panel hope that the implementation of the State Katie A. Settlement will accelerate the implementation of home-based mental health services, which have grown slowly up to now. As referenced under System Progress, the pilot intensive direct support contract with five providers could speed up service expansion. However that work has just begun and it will

take months to identify those practices that are replicable. Once a model is developed that can be used for expansion, the slow and cumbersome procurement process for new contracts in the County could substantially delay home-based mental health service growth.

Training and Coaching of DCFS and Mental Health Staff

For DCFS and DMH staff and providers to practice in accord with Katie A. Principles and the Core Practice Model, a significant shift is necessary in the approach to serving children and families and the skills employed to successfully implement the new practice approach. As is evident in the Qualitative Service Review scores recorded to date, significant additional improvement is required in assessing the needs of children and families, in working with them through a team, in individualizing the services provided to meet their needs and in adapting and revising interventions that are not meeting objectives.

Strengthening practice requires a capacity to training and coach front-line staff in the Core Practice Model approach that the County does not possess. New strategies and resources are needed to support the training and coaching required to change practice across the entire work force.

The Qualitative Service Review Process (QSR)

The County's implementation of the Qualitative Service Review process, a Continuous Quality Improvement process designed to assess the quality of practice, continues to be one of its strengths. However, at this stage of implementation, additional steps are needed to strengthen the fidelity of the review process and to involve community partners and other stakeholders in the review process. These steps are critical to assuring the continuing reliability of data and to orient the child welfare and mental health community to Katie A. implementation, expectations and accountability.

Insufficient Family Foster Care Resources and Placement of Children in Short-Term Settings (Holding Rooms)

Information has recently become available about the significant lack of family foster care placement resources in the County and the subsequent practice of placing children and youth in inappropriate, short-term holding rooms within DCFS offices while placements are sought. In some cases children and youth are moved through a series of short-term placements waiting for a suitable appropriate placement. Reports indicate that in a recent two-month period over 600 children were housed in a holding room. The County states that while the need for additional foster homes, especially those that accept young children, has been growing for some time, placement of children in holding rooms is a relatively recent challenge which the County is trying to address.

The placement of youth already traumatized by removal from families, placement disruptions or serial short-term placement in settings such as holding rooms can create and elevate mental health needs, which the system will be taxed to meet. In essence, such inappropriate placements create Katie A. class members. The County has noted previously that it has a particular shortage

of foster families for young children. The Panel is requesting that the County provide additional information about the dimensions and causes of the placement resource problem. The Panel is also connecting DCFS with professionals from other systems who have successfully addressed foster care recruitment and retention challenges, with the expectation that those experiences can be useful in Los Angeles County.

The Panel cautions against turning to group home and residential treatment providers as a solution to this challenge, as such settings are not appropriate placements for a significant majority of children awaiting placement. Part of the solution lies in continuing to implement the Katie A. objective of expanding the availability of home-based mental health services. Such services can prevent removals and placement disruptions that occur because caregivers cannot manage children's behavior. They can also speed reunification of children with emotional and behavioral needs by equipping parents with the skills needed to manage children's behavior. These interventions can lower placement demands.

Panel Recommendations

The following recommendations are made by the Panel to foster implementation of the strategic plan and achieve the goals of the settlement.

1. Strengthen the Methodology for Measuring DCFS Caseloads and Workloads and Allocate Resources to Lowering Caseloads

Confer with the Panel to identify options for developing a methodology that reliably measures caseload and workload relative to function. Seek opportunities to provide additional DCFS front-line staff through reallocation of existing resources and new revenue.

2. Track and Report Child Maltreatment by Group Home and Residential Provider Staff

The County should identify current reporting mechanisms for reporting abuse and neglect of children placed in congregate settings and provide the Panel with a description of steps that would be required to integrate this information into current reporting and/or report it separately.

3. Develop a Specific Plan to Increase TFC Beds to 300

The Panel recommends that time be set aside in the upcoming October Panel meeting to discuss current barriers to TFC expansion and identify possible strategies for reaching the goal of 300 beds.

4. Expansion of Intensive Home-Based Mental Health Services

The County's decision to pilot IHBS among five providers appears to be a sound strategy. The Panel recommends that as part of implementation planning, the pilot providers be asked to provide feedback on three specific areas: 1) the type and availability of services identified in

needs-based planning as required by class members; 2) the training needed for successful IHBS implementation and 3) the coaching needed by staff for implementation of IHBS.

The Panel also recommends that as IFCCS team meetings occur, there should be policy and processes to ensure that CSWs are actively involved.

5. DCFS and DMH Training and Coaching

The County should develop a larger pool of full-time coaches, sufficient in number to provide ongoing coaching and mentoring to staff in office settings and in actual work with families. The primary coaching focus at this time should be on identifying strengths and underlying needs of children and families, designing individualized services and supports to meet those needs and build on strengths and developing the capacity of CSWs and mental health practitioners to facilitate child and family team meetings. To achieve these goals, the County should develop a group of coaches who can also develop new coaches, allowing for a broader and more intense coaching implementation.

To expand coaching capacity, the Panel recommends that DCFS and DMH use unspent Wraparound funds to contract with a capable provider to supply skilled coaches for both agencies. The County must ensure that provider coaches are well-trained and deliver coaching consistent with the practice model.

6. The Qualitative Service Review Process

Based on the analysis summarized previously, the Panel recommends that the County:

- a. Expand the current review pool to include key stakeholders representing service providers, legal partners, staff from the juvenile justice and public health community and others;
- b. Ensure that QSR “Grand Rounds” is also used to assess QSR scoring fidelity;
- c. Develop a process for use with new and experienced reviewers that assesses inter-rater reliability; and
- d. Have each written case story carefully reviewed for fidelity to scoring guidance and congruity between narrative descriptions and case score. Cases in which incongruity exists between scores and narrative should result in a conference with the review team and revisions in scores and/or narrative. The Panel should be made aware of cases where revisions are required.
- e. Regularly track replacements of cases selected in the sample to identify any outliers in case selection.

7. Family Foster Home Recruitment

The Panel asks that the parties confer by conference call and in the upcoming Panel meeting about the scope and causes of the placement shortage and potential foster home recruitment and retention strategies. In addition, the Panel will be identifying the additional data it may need

about placement settings and availability, placement type and duration and placement changes among the foster care population.

**Katie A. Advisory Panel
Report to the Court
First Reporting Period of 2013
August 24, 2013**

I. Introduction

The following Report to the Court outlines the County's progress toward achieving the objectives of the Settlement Agreement and 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;
- o 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 objectives of the settlement agreement. The Panel and plaintiffs' attorneys identified issues in the Plan they believed needed additional attention and in a subsequent court hearing, plaintiffs and defendants proposed submitting a joint finding of facts that would identify areas of agreement and disagreement. The court issued an order directing the County to revise its plan and submit the revision for review. That Corrective Action Plan was completed and provided to the Court. In subsequent

discussions with the Panel, the County concluded that additional strategies were necessary to achieve the objectives for the plaintiff class and committed to developing an overarching Strategic Plan that would address remaining system design needs. The County has now completed its Strategic Plan and received County Board approval for implementation.

III. Panel Activities Since the Last Report

The Panel met with County DCFS and DMH staff in March and June, 2013 to discuss implementation of the strategic plan. In addition, one Panel member, Dr. Marty Beyer, provided six half-day training sessions in December, 2012 and March, 2013 for mixed groups of DCFS, DMH and provider staff, including Wraparound, Multidisciplinary Assessment Team coordinators, Treatment Foster Care and Practice Model coaches. The purpose of the sessions was to clarify how to assess the needs behind a child's behavior and reach agreement among team members about those needs and tailor services to meet them.

On May 7, 2013 Dr. Beyer provided a half-day training-for-trainers session so DMH, DCFS and provider staff would be able to train staff in how to reach agreement within teams about children's underlying needs. Another Panel Member, Edward Walker, participated in two Qualitative Service Reviews: in the Vermont Corridor office, April 8-11, 2013 and in the Wateridge office, May 13-16, 2013.

The Panel also visited the DCFS Children's Welcome Center (CWC), adjacent to USC Hospital, on June 17, 2013. The Panel was greeted by the HUB pediatrician who has played a leadership role in the CWC. Being adjacent to the HUB allows for continuity of care for high needs children after their medical screening, but the primary motivation for developing the CWC was to have caring child care staff and a child-friendly environment for children instead of having them wait at the Command Post or DCFS office for placement. Children are allowed to stay in the CWC for 23 hours and if a placement has not been found for them after being at their CSW's office during the day they may return to the CWC for an additional 23 hours.

The CWC Director led the tour and the Assistant Regional Administrator from the DCFS Emergency Response Command Post also responded to Panel questions. Since opening in July, 2012, the CWC has averaged between 50 and 60 children per week. The CWC has a capacity of 15 children, newborn to age 11, but also includes older siblings and teenage mothers and their infants. The CWC has indoor play space and supplies, cribs and children's beds and an outside enclosed playground area and serves hot meals. The CWC is staffed with CSWs, SCSWs, aides, and professional child-care workers.

During the Panel tour, there were eight children at the CWC, ranging in age from a month to nine years old. At the time of the visit, the youngest four children each had individual care by four staff who rocked, fed and comforted them; the other children were playing with other staff. The CWC was calm, quiet, clean and cheerful. At about 4 PM, a CSW from the ERCP arrived with a sibling group of three; the oldest child appeared worried and was caring for the toddler. One CWC staff person began talking to the oldest child while another engaged the toddler in play and another worked with the CSW to complete forms. The Panel was shown nearby space now set

aside for the Teen Welcome Center for which funds for renovation and furnishings are being sought.

In the four months previous to the Panel’s visit (2/1/13-5/31/13), 1,252 children stayed at the CWC, which included 249 sibling sets (on average 313 children, with 62 sibling sets, per month). Almost half were 0-2 years old (45%); about a quarter were 3-5 years old and a quarter were 6-10 years old (23% each); 5% were 10-13, 3% were 14-16, and a few were 17 and 18. The population was 44% female and 56% male. Fifteen percent stayed at the CWC less than four hours, 11% stayed 4-8 hours, 68% stayed 9-23 hours and 6% stayed 24 hours and longer. Most were initial referrals (74%), with the remainder being replacements (17%) and open cases (9%).

The CWC appeared to be a caring, safe and well-run program. The Panel’s concern is that the pressure from increased entries into care and insufficient placement resources could result in DCFS relying on the CWC or other settings to house more children and teenagers for longer stays. DCFS reports that it is having great difficulty in finding placement resources for young children and does not have sufficient foster homes in general. The Panel plans to discuss these challenges further with the County.

IV. Current Implementation Plan Status

The following section describes the current implementation status for tasks which the County committed to complete to achieve the goals of the settlement.

DMH Staffing

The County’s plan includes the co-location of mental health staff in DCFS offices. The County has maintained the level of DMH staffing in support of Katie A. Implementation at the same levels reflected in the last Panel report. Current staffing levels are shown below.

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

Additional staffing for the DMH ACCESS Hotline

DMH no longer sees a need to allocate the three staff originally allocated to Hotline duties and has transferred these positions to more vital Katie A. functions related to the Qualitative Service Review process and coaching. The Panel concurs with this proposed change.

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 reported to the parties and the court. Outcome tracking and reporting occurs routinely and the latest update on outcome performance is included in a later section of this report.

Development of Multidisciplinary Assessment Teams (MAT)

The County committed to implement Multidisciplinary Assessment Teams that would assess the needs of all newly detained children. The County provided the following report on implementation of the Multidisciplinary Assessment Team (MAT) process, a commitment to provide a multidisciplinary assessment of all newly detained children within 45 days of entry.

County MAT Update

In March 2013, 99.5 percent of all eligible newly detained children Countywide were referred to a MAT assessment. This compares to 100 percent referral rate reported in the prior Panel Report. From July 2012 through March 2013, there were 4,753 MAT referrals and 3,772 MAT assessments completed. Of those referred, approximately 20 percent were not completed. Ten percent were in the process of being completed and another 10 percent were cancelled after referral for numerous reasons described in detail on the following pages.

Table 1: MAT Compliance March 2013

MAT Eligible	MAT Referred	Percent	
SPA 1	12	100%	
SPA 2	78	100%	
SPA 3	116	100%	
SPA 4	46	100%	
SPA 5	12	100%	
SPA 6	132	98%	
SPA 7	85	99%	
SPA 8	98	100%	
Total number of DCFS MAT referrals:	579	576	99.5%

From July 2012 through March 2013, the average timeline from MAT referral acceptance to completion of the final Summary of Findings (SOF) report was 47 days.

Approximately 55 percent were completed in 45 days or less, 74 percent were completed by the 50th day and 90 percent were completed by the 60th day.

As indicated above, approximately 20 percent of children referred to MAT did not have completed assessments as of the end of the Fiscal Year (2012-13). Of this 20 percent, 10 percent of children were in the process of receiving a MAT assessment, so those could not be counted as complete at the time FY data was collected. The remaining ten percent were initially referred to MAT, but did not have completed assessments due to the following "MAT Cancellation Reasons:"

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

A total of 269 MAT Quality Assurance (QA) Checklists and 115 MAT Children's Social Worker (CSW) Interview Surveys were submitted from July 2012 through April 2013. Overall, 99 percent of the MAT QA Checklist's Domain 6 (Recommended services and supports made in the SOF were consistent with the assessment information and specific enough to be implemented) were rated positive and 99 percent of the MAT CSW Interview Survey's two domains (including the children, families and caregiver's voice was taken into account in the decision-making process and strengths of the children, family and caregivers were adequately described) were rated positive. Domains/Areas that rated positive on the MAT QI checklist included great teamwork and collaboration between CSW and the MAT assessor, Summary of Findings (SOF) meetings and SOF report provided additional insight which facilitates case plan development for the families, and the resourcefulness of the MAT assessors. Domains/Areas that presented as challenging included assessors continuing to have difficulty recognizing the signs of trauma in children under the age of three, the utilization of the families' formal and informal supports systems and building upon the child and family's functional strengths during the SOF meetings.

Additionally, DMH has continued to conduct site visits to multiple MAT provider agencies to offer technical assistance and support regarding billing and documentation concerns. The MAT agencies have been receptive to this and, as a result, there has been improved communication between DMH and the MAT agencies and there has been a significant reduction in DCFS dollar spending per MAT assessment. In site visits staff determined that the identification of child and family strengths were sound in some cases, there were examples of thorough clinical assessments, progress was occurring in

identifying underlying needs, many SOF reports were completed within the time frame and good engagement was occurring with biological and foster parents.

DMH established a workgroup to address many providers' concerns about the SOF report. The workgroup focus was to examine the SOF document while addressing some of the recurrent concerns shared among the members. The workgroup consisted of a collaboration of members that included representatives from DMH, DCFS, providers and Association of Community Human Service Agencies (ACHSA).

After successfully collaborating and incorporating the appropriate changes to address the concerns mentioned in the workgroup, the workgroup introduced the revised SOF report for providers' to implement. The revised SOF document has been received extremely well among the providers and they have provided valuable feedback. The positive feedback received includes an emphasis on the family/child's strengths. For example, the Family Story section allows parents to identify past successes and positive qualities that will assist them in the reunification process. The Family Vision section allows parents to think about their needs and goals differently and to make personal decisions for their family. Last, the Child Needs section is more user friendly, allowing the assessor and CSW to draw in team members such as formal or natural supports to help the child meet his/her underlying needs.

DMH continues to provide ongoing trainings to further assist MAT assessors with improving the quality of their SOF reports. The following trainings have been offered:

- Train-the-trainers model on Identifying Underlying Needs by Marty Beyer,
- Trauma Responsive Practice for the 0-5 population,
- Creative Consistency in Child & Family Team Meetings,
- ICARE,
- Reflective Supervision,

While these indicators reflect progress in MAT implementation, the Panel notes continuing challenges in MAT. During this reporting period, only 55 percent of MAT assessments were completed within 45 days or less, compared to 60 percent in the preceding reporting period, reflecting a small decline in the completion rate. The County has improved the timeliness of its completion rate compared with past years but still struggles with meeting the 45 day time frame. Delays can affect the value of the assessment to the Family Court, which issues dispositional orders within 30 days of removal. The County continues to work on improving MAT performance, which is referenced in the County's update, particularly on the quality and functionality of assessments. The Panel plans to review the MAT process further in subsequent reporting periods, especially the quality of identification of underlying needs.

Implementation of the DMH Behavioral Health Information System (IBHIS)

The County committed to implementing a new DMH Behavioral Health Information System early in the Katie A. planning process, assuming that the State DMH development of a statewide Behavioral Health Information System would support County Katie A. needs. This system is intended to enhance tracking and reporting on the status of children served, the services they receive and various other elements of the provision of mental health care. Frequent delays at the State level have significantly delayed the original completion date. Regarding this Panel Report, DMH reports that it has implemented an aggressive planning and testing process to design and bring up an information system that will integrate clinical, administrative and fiscal data. DMH has adjusted the target production date to December 2013. The following overview and completion projection was provided by the County.

INTEGRATED BEHAVIORAL HEALTH INFORMATION SYSTEM (IBHIS)

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

Status: DMH selected the Avatar system from Netsmart, Inc. (Netsmart) as the result of an RFP process. The Board of Supervisors approved an Agreement with Netsmart on October 18, 2011. Work with Vendor began in November 2011; the project team is currently engaged in module testing as well as preparations for user training and integrated testing. The target date for first production use of IBHIS has been moved from mid-2013 to possibly December 2013, but that date is tentative at this point pending agreement with Netsmart on a revised project schedule.

Critical Future Policy Issues: **Workforce Issues:** An electronic health record (EHR) with integrated administrative and financial functionality will create a work environment in which nearly all DMH employees will need to be computer literate. Computer literacy is not universal in DMH, although nearly so now with the implementation of e-timekeeping. "Opting out" of using the IBHIS to do assigned work will not be possible, so substantial training may be required. Existing job specifications may need to be modified, and potentially union MOUs, in order to make computer literacy and use of an information system a requirement for most existing job classifications. DMH is currently providing IBHIS Readiness Training in basic computer skills and typing to anyone who self-identified as needing such training.

Contract Providers: Approximately half of all DMH clients receive services delivered through contract providers of mental health services. The contract providers currently have direct access to DMH's computer system, but under IBHIS they will not. They will, instead, exchange

information with DMH electronically. Initially the content of this exchange will be only slightly expanded from the current focus on health care claims, but may eventually include substantial portions of the consumer health record. This is a major change for most contract providers. The Los Angeles (LA) County DMH MHSA IT Plan includes the use of MHSA funds to facilitate this transition for contract providers. Nearly all eligible providers have submitted plans to make use of the funds to become EDI ready by the time they are scheduled to transition to IBHIS. DMH is reaching out to those who have not submitted such plans in the hope that they will avail themselves of this unique opportunity.

Consumer Access to Healthcare Information: The Avatar system includes a client portal. This will allow DMH clients to securely access selected portions of their healthcare record from any location in which they have access to the Internet. Setting up the client portal has been deferred until a substantial portion of DMH provider sites are using IBHIS.

KeyFuture Milestones:
Fiscal/Financial Information: Initial Production Use – moved tentatively to December 2013
IBHIS contract expenses for FY 12-13 are projected at approximately \$2.5M; project salary expenses are another \$2.5M.

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

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

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

Consistent with its strategic plan, the County continues to conduct Qualitative Service Reviews (QSR), an interview-based evaluation of the quality of frontline practice involving a sample of cases in each office. Additional detail on current QSR review findings are provided in a subsequent section of the Panel's report.

Service Provision to Katie A. Class Members

Provision of Necessary, Individualized Mental Health Services in Family-Based or Most Homelike Setting Appropriate to Class Member Needs

One of the stated objectives of the Katie A. Settlement is “*Provision of Necessary, Individualized Mental Health Services in Family-Based or Most Homelike Setting Appropriate to Needs*”. The Panel is specifically addressing this issue separately in this report because of information that has become available subsequent to the formal reporting review period, January 1, 2013 to June 30, 2013, regarding the placement of children and youth in holding rooms due to the lack of appropriate placement settings. Reports indicate that the number of children held in such settings has become large and an increase in detentions and the lack of appropriate family foster home settings is a primary cause of these unsuitable placements.

Beyond the fact that placement practices such as use of holding centers and multiple short-term placements are incompatible with settlement objectives, the Panel raises concerns about placements in inappropriate settings because it is harmful to children. Children already traumatized by removal from their families, serial short-term placements or placement disruptions are likely to have their mental health needs exacerbated by placement in inappropriate settings like holding rooms.

In essence, such inappropriate placements create Katie A. class members. In response to this placement challenge, the Panel cautions against looking to other congregate settings as a solution to insufficient placement resources. Group homes and residential treatment settings are unlikely to be the most appropriate placement setting for most of the children and youth now in temporary, short-term settings.

Expanding family foster care resources should not be viewed as a singular solution to insufficient placement resources. The expansion of home-based mental health services, another settlement objective, can prevent removals and placement disruptions that occur because caregivers cannot manage children’s behavior. They can also speed reunification of children with emotional and behavioral needs by equipping parents with the skills needed to manage children’s behavior. These interventions can lower placement demands.

The Panel is in discussions with the County and plaintiffs’ about the need for additional appropriate family based placement settings and will be requesting additional ongoing data about placement trends and strategies for expanding placement resources. The Panel is also seeking best practice strategies from other professionals and child welfare systems nationally who might assist the County.

Expansion of Home Based Mental Health Services

Among the central objectives of the State and County settlement agreements is the expansion of delivery of intensive home-based services to class members. The County has faced many challenges in implementing this objective and is now deeply involved in integrating its initial and current efforts to expand intensive home-based services with its obligations under the State

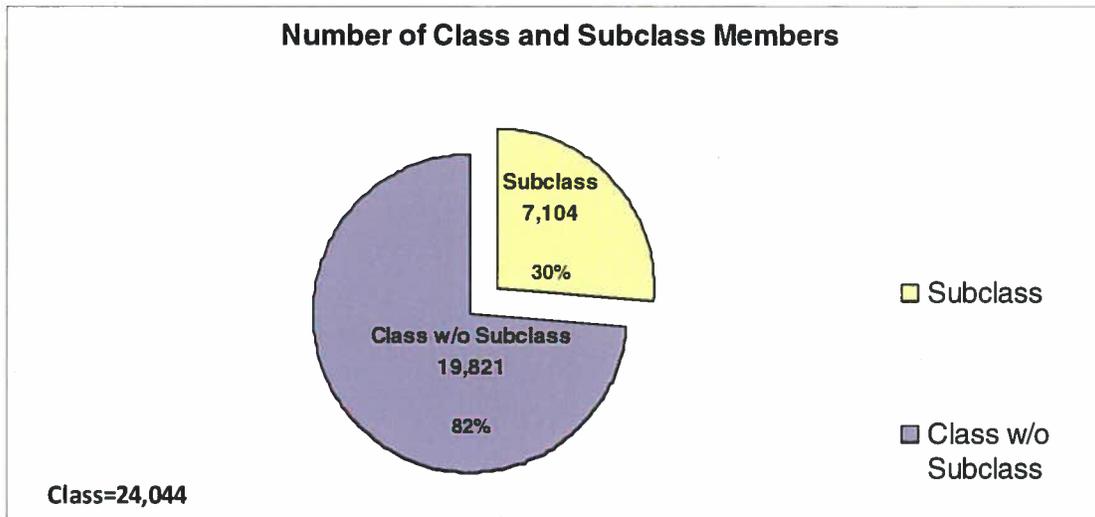
settlement. One of the initial obstacles to assessing achievement of this objective was the lack of a comprehensive information system to track and report on the delivery of mental health services, especially related to intensity and whether delivery was office or home-based.

There has been significant growth in Wraparound services, but the growth of more flexible and individualized intensive home-based services has been modest. The Panel has requested additional information about mental health service delivery, an issue the County also has a strong interest in. The following content reflects new information provided by the County about the scope and type of services currently provided to class members, including costs.

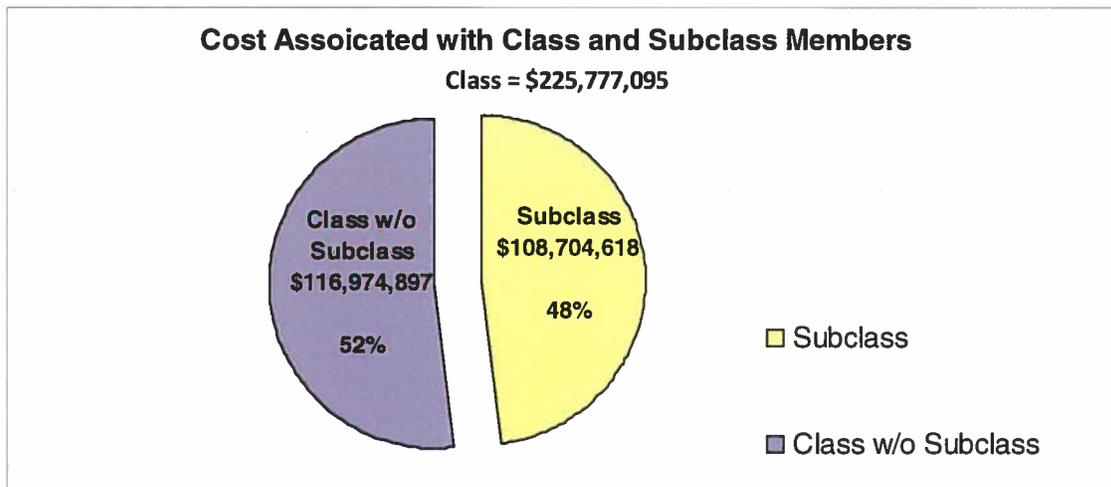
DMH Service Provision Report

DMH conducted a recent analysis, using matched client data from the 2011-2012 fiscal year, to identify members of the Katie A. class and subclass and determine the levels of mental health services they were provided. The analysis used the definition of the class and subclass contained in the settlement agreement in the Katie A. State case. The data reported below is based upon the match and contains only class and subclass members who received mental health services. The data do not contain information on children who are considered at-risk. The analysis revealed the following:

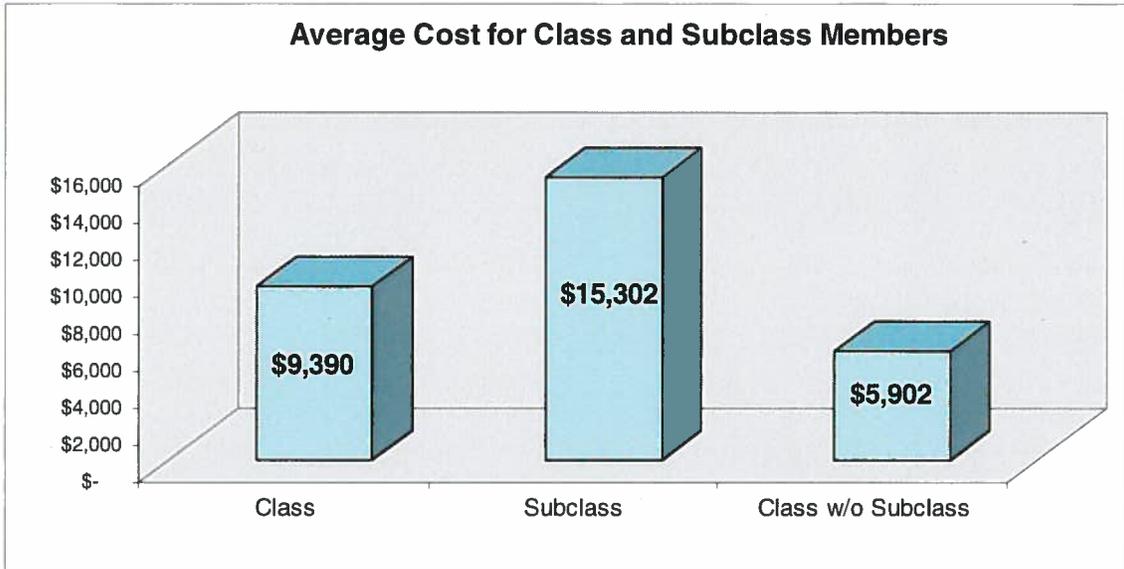
- 1) From the total amount of DCFS clients (approximately 58,000), 41% of those clients were Katie A. class members. About 30% of the Katie A. class are subclass members and received more intensive mental health services. (According to data provided by DCFS, it appears that there may have been approximately 350 potential subclass members who did not receive mental health services during this time period, with the large majority of these falling into the subclass because of three or more placements over the past 24 months). The following graph shows the breakdown of class and subclass members, as well as a category we have identified as class members that does not include subclass members (Class w/o Subclass – 82%).



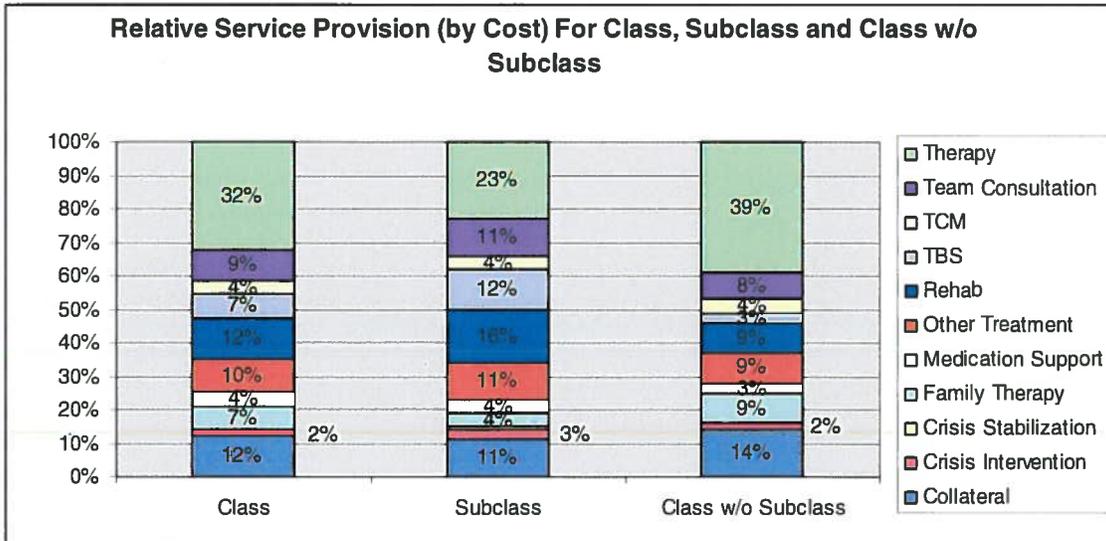
2) The cost associated with providing mental health services to the Katie A. class was approximately \$225 million. While the subclass makes up only one third of the entire class, the mental health costs associated with providing services to this group is almost half of the total costs (48%) provided.



3) Upon closer look at the mental health service costs that were provided to subclass members, the data shows that the average mental health costs associated with subclass members (\$15,302) is much higher than the average cost of mental health services for class members who are not part of the subclass (\$5,902). More specifically, subclass members are receiving more services than the average class member not belonging to the subclass.

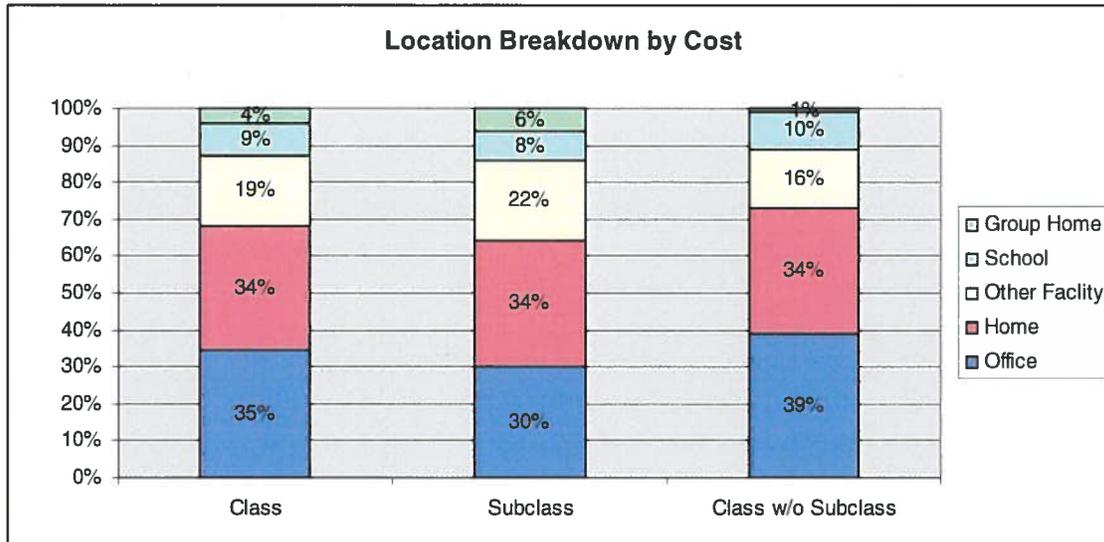


4) The mental health service array also varies slightly between class and subclass members. Subclass members received less therapy (23%), more rehabilitation services including TBS (28%) and targeted case management including team consultation (15%) as compared to what class members who are not part of the subclass received, on average for therapy (39%), rehabilitation services (12%) and targeted case management (12%). The mental health service array for subclass members is more in line with the intensive services we would expect subclass members to receive and hypothesize that this type of service array would be more equivalent to ICC and IHBS and thus contribute to higher success rates for this population.



5) Currently, the location of services differs slightly when comparing class and subclass members. The graph below shows that 39% of the mental health service costs provided

to class members who were not part of the subclass were provided in the office while only 30% of the mental health service costs for subclass members were provided in the office. This is also more in line with ICC and IHBS, as these services are expected to be more accessible and thus, primarily be provided in the home or most home-like setting.



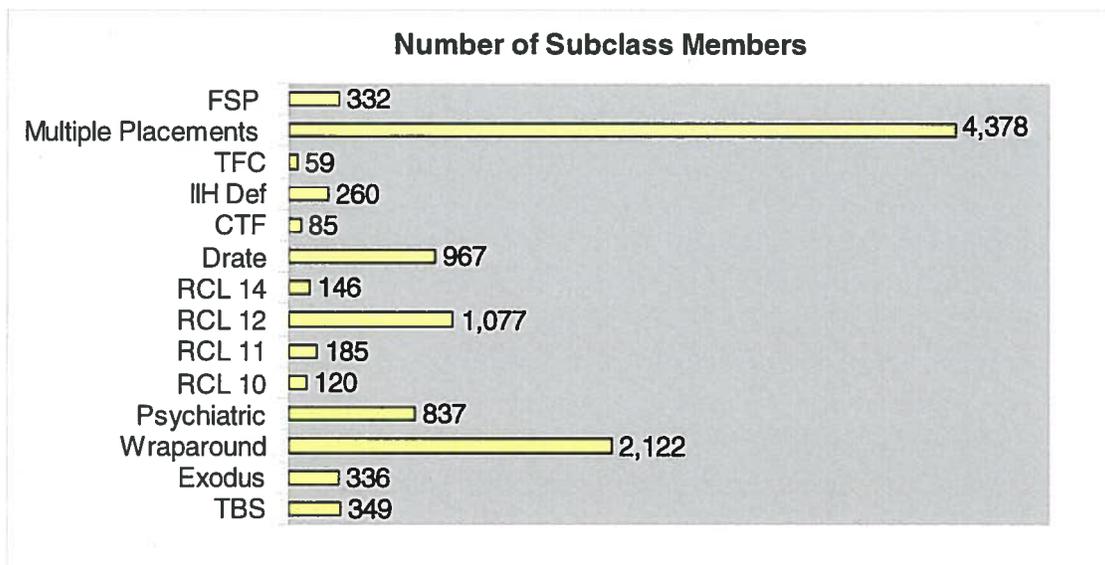
Using fiscal year 2011-2012 data, we identified some of the mental health services that were provided to subclass members that we identified as being similar to services provided within ICC and IHBS.

- 1) Subclass members are receiving a variety of services to meet their mental health needs. We have identified these services and programs as providing a high intensity of service, frequency of services and services more often provided in the youth’s home or most home-like setting. Based on the subclass definition, we have developed a chart below of the criteria or programs youth were in that contributed to them being in the subclass. The majority of youth had three or more placements (4,378), Wraparound (2,122) or were placed in RCL 12 (1,077). Many of our youth fell into multiple categories below.

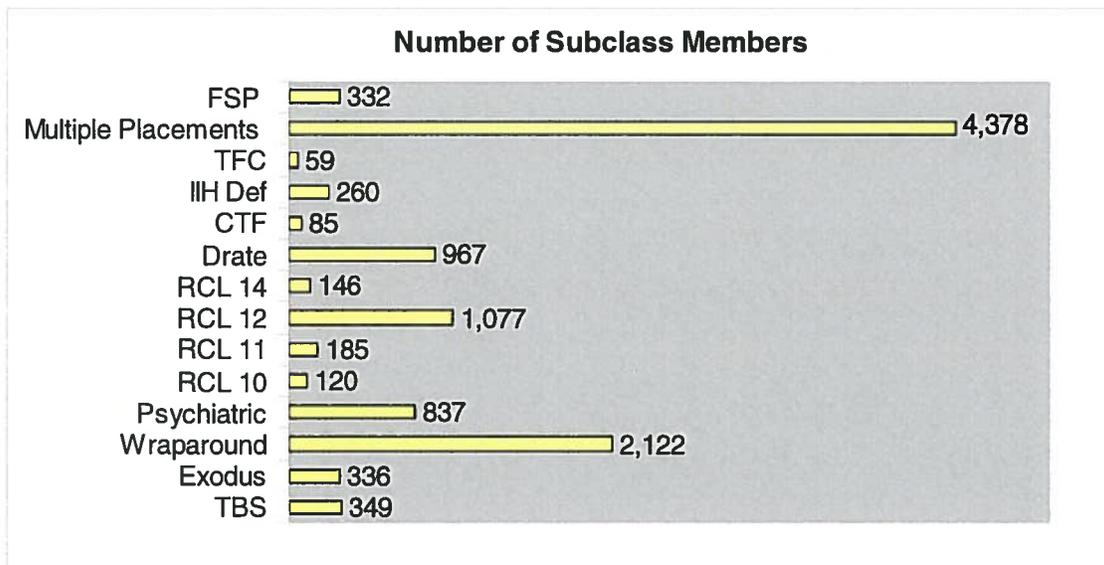
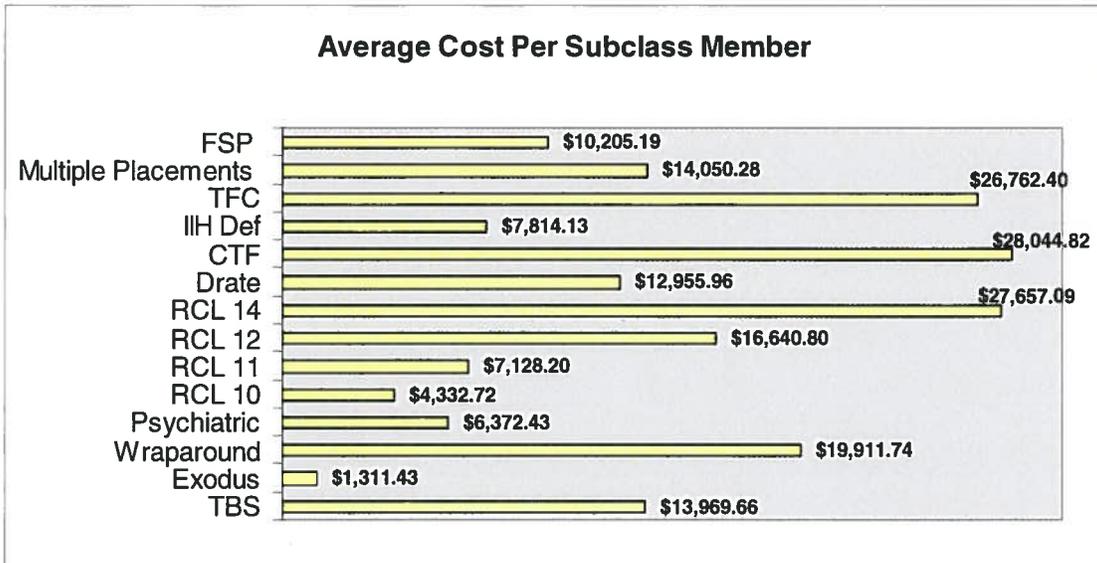
Using this same data set, we also identified some of the mental health services that were provided to subclass members.

- 2) Subclass members received a variety of services to meet their mental health needs. We have identified these services and programs as providing a high intensity of service, frequency of services and services more often provided in the youth’s home or most home-like setting. Based on the subclass definition, we have developed a chart below of the criteria or programs youth were in that contributed to them meeting subclass criteria. The majority of youth had three or more placements (4,378), Wraparound

(2,122) or were placed in Rate Classification Level 12 (1,077). During this timeframe, many of our youth fell into multiple categories below. *[The subclass criteria below include Full Service Partnership (FSP), clients that have had three or more placements within 24 months (Multiple Placements), Treatment Foster Care (TFC), Intensive In-Home Definition (IIH – youth that within a 30 day period, received at least eight face-to-face contacts, at least two occurrences of Targeted Case Management and at least two occurrences of Team Consultation), Community Treatment Facility (CTF), D-Rate placement, Rate Classification Levels 10 -14 (RCL 10 – 14), Psychiatric Hospitalization (Psychiatric), Wraparound, Exodus, and/or Therapeutic Behavioral Services (TBS)].*



- 3) The average cost associated with the identified criteria or programs varies greatly, with costs associated with Treatment Foster Care (\$26,700), Community Treatment Facilities (\$28,000), Rate Classification Level 14 (\$27,700) and Wraparound (\$20,000) being the programs associated with the highest costs for subclass members (see chart below).



The Panel believes that these data provide a useful baseline for further IBHS expansion. In the coming year with IBHS and ICC implementation, the Panel anticipates an increase in intensive mental health services and improvements in the outcomes of children with a high level of mental health needs. The Panel will request and review a similar analysis of data regarding intensive home-based services regularly.

Utilization of Evidence-Based and Promising Practices for Class Members

As a corollary to the Panel's interest in home-based intensive service expansion, the County also provided additional information about the use of evidence-based and promising practices. That report is provided below. The Panel will request and review a similar analysis of data regarding intensive home-based services regularly.

Evidence-Based and Promising Practices

Using fiscal year 2011- 2012 data, DMH identified the Evidenced-Based and Promising Practices that were delivered to class members. DMH reports below the number of class members that received these services and the number of legal entities in Los Angeles County that provided these services to class members. The chart also breaks out the number of Birth to Five class members that were served by these services.

Evidence Based and Promising Practices	Number of Clients Served (All Ages)	Number of Legal Entities (All Ages)	Number of Client Served (0 – 5)	Number of Legal Entities (0 – 5)
Multisystemic Therapy (MST)	39	13	5	4
Functional Family Therapy (FFT)	334	14	15	8
Brief Strategic Therapy	42	9	7	2
Child Parent Psychotherapy (CPP)	773	37	711	35
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	47	9	4	2
Incredible Years (IY)	263	16	104	14
Parent-Child Interaction Therapy (PCIT)	220	15	159	13
Strengthening Families	43	6	3	2
Trauma Focused - Cognitive Behavioral Therapy (TF-CBT)	4153	79	549	56
Triple P Positive Parenting Program	658	37	210	25
UCLA Ties Transition Model	39	2	28	2
Aggression Replacement Training (ART)	606	26	17	5
Alternatives for Families - Cognitive Behavioral Therapy (AF - CBT)	52	4	6	3
Managing and Adapting Practice (MAP)	2476	76	301	52
Seeking Safety	1433	56	17	8

In total, almost 9,000 DCFS involved children received treatment using an evidence-based or promising practice at a service cost of over \$40 million.

Intensive Home-Based Services and Intensive Care Coordination

The County continues to use the Intensive Home-Based Services (IHBS)/Intensive Care Coordination (ICC) Workgroup composed of representatives from DMH, DCFS, community providers, as well as an outside consultant to discuss, further develop and carry-out the IHBS/ICC implementation plan in Los Angeles County. The *Medi-Cal Manual for ICC, IHBS & TFC for Katie A. Subclass Members* and *Pathways to Mental Health Services – Core Practice Model Guide* were released March 1, 2013. The Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) are facilitating technical assistance conference calls for these new Katie A. implementation resources. In addition, the State is conducting a number of trainings throughout California to ensure that counties understand the new services. They will be conducting an all-day training in Los Angeles County on May 29, 2012 and we have invited DMH and DCFS representatives, community providers, as well as

other stakeholders. DMH and DCFS have also invited Tim Penrod, founder of Child and Family Support Services in Arizona, as a consultant to assist Los Angeles County in further developing our plan and he will be providing training to Los Angeles County, specifically related to current practice standards, lessons learned, training and outcomes for IHBS. On May 14, 2013, Tim Penrod provided an ICC and IHBS training to DMH, DCFS, Intensive Field Based Clinical Services (IFCCS) providers and other stakeholders.

The State also issued an All County Information Notice on May 03, 2013 advising Counties of the Intensive Care Coordination and Intensive Home Based Services requirements for Katie A. subclass members and instructing them how to modify their information systems to submit claims for these services to the State. DMH has made these adjustments and amended contract language for the Wraparound, Treatment Foster Care, and IFCCS providers to allow them to claim for these services.

DMH is also in the process of preparing a contract service exhibit regarding the Core Practice Model that will direct contract providers to adopt these principles for children with open child welfare cases and to provide ICC and IHBS for members of the Katie A. subclass. DMH has shared a draft of this document with plaintiff attorneys to solicit their review.

DCFS and DMH have also worked together to complete the Katie A. Readiness Assessment Tool and Service Development Plan requested by the California Department of Health Care Services and California Department of Social Services as part of their strategy to support the implementation of these services.

The County has developed a phased approach to implementation expansion in which Los Angeles County DMH will be providing ICC and IHBS by the end of December 2013. IFCCS is Phase 1 of the ICC and IHBS rollout and began of June of this year. at Wraparound and Treatment Foster Care (TFC) will roll out ICC and IHBS beginning in August 2013 (Phase 2). DMH is considering expansion of ICC and IHBS through the Full Service Partnership program next year as Phase Three of the implementation effort. Each of these phases will include formation of an implementation team, amendment of policies and procedures related to providing these new services, as well as, training to ensure that providers understand the new services and what is expected of them.

Intensive Field Capable Clinical Services (IFCCS)

IFCCS are an array of services intended to expedite access to ICC and IHBS. These services are firmly grounded in the Shared Core Practice Model and delivered to Katie A. sub-class members. Specifically, IFCCS are targeted to youth who are discharging from the Exodus Recovery Urgent Care Centers (UCCs), discharging from Psychiatric Hospitalizations, awaiting placement at the DCFS Emergency Response Command Post or Children's Welcome Center, or the subject of a joint response from the DMH Field Response Operations Team without a psychiatric hospitalization. Exodus UCCs are

crisis stabilization centers, where youth 12 and older can stay for a maximum of 23 hours.

The goal of IFCCS is to ensure that children and families, who have historically been more difficult to link to appropriate resources, are engaged effectively as a part of a Child and Family Team consistent with Los Angeles County's Shared Core Practice Model. Through implementation of this practice model, agencies are expected to assess the underlying needs of the children and youth, develop a care plan, and identify intervention strategies and resources to meet the identified needs.

To be eligible for the IFCCS program, the child/youth must:

- 1) Have an open DCFS case, and
- 2) Be between the ages of 0-15, and
- 3) Have full-scope Medi-Cal, and
- 4) Have received no mental health services within the last 60 days; or been in a psychiatric hospitalization, at Exodus, ERCP, or had FRO involvement more than one time in the last 30 days; or has no stable placement upon discharge. (Note: The limitation of no receipt of mental health services within the past 60 days is used because of the small size of the program and efforts to target children and youth who have become disconnected from mental health services.)

Intensive Field Capable Clinical Services Implementation

As stated above, IFCCS is Phase 1 of implementation for ICC and IHBS in LA County. DMH released a Statement of Eligibility and Interest to children's mental health providers to solicit interest in providing these services. Five providers were selected who had existing DMH contracts to provide IFCCS, Wraparound, and Treatment Foster Care or Children's Comprehensive Services Program services. DMH then drafted a Service Exhibit outlining the expectations of services for IFCCS, which was ultimately approved by County Counsel on April 30, 2013. The DMH Administrative team drafted a program procedural guide and conducted a full day's training for the newly identified IFCCS providers on April 17, 2013, covering ICC and IHBS, the Shared Core Practice Model, and specifics related to IFCCS Program Operations. All of the referring sites were also provided an orientation, as well as a training on how to refer to the program. All contracts were signed and returned to DMH's contract division by May 30, 2013. The program staff notified all agencies to begin sending and accepting referrals. The first case was referred and services provided on June 7, 2013.

To ensure quality of service provision, Quality Assurance will be evaluated on multiple levels. The program will be utilizing a qualitative review process to evaluate how well the program is using Core Practice Model Strategies. All children and youth who are enrolled in IFCCS may be subject to a clinical records review. This review process will

include a random selection of mental health records (clinical chart) that will involve a review of clinical documentation to ensure that it is consistent with guidelines provided for Medi-Cal claiming and billing. DMH will also be providing Technical Assistance through monthly roundtable meetings, periodic trainings, and consultation/coaching. Consultation/Coaching will be provided through a “Train-the-Trainer” model. Each program will be offered consultation/coaching on how to best implement the elements and strategies of the Core Practice Model within IFCCS. Coaching/Consultation will be conducted through a case review process, usually in the context of the monthly roundtables, and will allow the consultants/coaches to assess individual skill development. Once IFCCS program supervisors have achieved the desired skill-level, it is expected that program supervisors would then be able to provide a similar level of consultation/coaching to their direct service providers.

The Panel anticipates that as IFCCS evolves this year, children and youth with high mental health needs and their families and caretakers will receive intensive services that prevent hospitalization and placement disruptions and that the children will show improvements in emotional well-being, school and be moving toward permanency. Of particular interest will be the trauma treatment provided to the children and their caretakers and families and the measurable outcomes resulting from those services. In addition, the Panel expects providers to demonstrate successfully tailoring services and supports to meet the unique needs and build on the strengths of children—the successful approach taught by Tim Penrod-- rather than providing the same package of services to all.

Treatment Foster Care (TFC)

As a result of slow progress in the County’s efforts to expand therapeutic foster care, the County was directed by the court in its Corrective Action Plan order to expand therapeutic foster care to 300 beds. Since the order the County has made gradual progress in TFC expansion. As of April 30 2013 there were 91 youth receiving TFC services, compared with 77 youth receiving TFC services in September 2012. At the same point in time there were 107 certified TFC beds, compared with 91 certified beds in April 2012.

The Department has been working to increase the number of available beds though a series of initiatives, including serving on the State TFC workgroup, adding staff positions to support the expansion of TFC and addressing recruitment and retention issues. DCFS reports that retention is the greatest challenge in this effort. Effective July 1, 2012, in Los Angeles, the TFC Foster Family Agency rate was increased by the State from \$4,028 per month to \$5,581 per month, with an increase in the caregiver stipend from \$11,200 to \$2,100. The County and State hope that this increase will assist in recruitment and retention. When the State completes its work on implementing the TFC requirements under the State Katie A. Settlement, additional supports should be available.

A total of 196 beds have been certified since implementation; however 92 beds were lost through attrition. A full description of the County’s efforts to expand TFC can be found in the Appendix. The following table displays growth and exit outcomes over time.

	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13 (Jul-April 2013)
New Intakes	26	30	68	62	54
Youth Exiting TFC	14	27	36	49	49
Exit to Higher Level of Care (GH, Hosp)	9 of 14 (64%)	12 of 27 (44%)	17 of 36 (47%)	14 of 49 (29%)	17 of 49 (35%)
Exit to a Lower Level of Care (HOP, LG)	5 of 14 (36%)	15 of 27 (55%)	19 of 36 (53%)	35 of 49 (71%)	32 of 49 (65%)
Youth Receiving TFC Services in FY	30	41	81	95	90

Expansion of Funding for Katie A. Implementation

The County reports that it is projecting ongoing cost savings for FY 2012-13. According to the County, the savings were primarily due to the slow growth of the Wraparound program over the last 12 months. As done with prior year savings, the Chief Executive Office (CEO) has rolled the FY 2012-13 savings into a Provisional Financial Uses (PFU). The Departments are exploring the possibility of using these savings to enhance coaching and capacity.

During this fiscal year, DMH has allocated 3.3 million dollars of Mental Health Services Act (MHSA) funding to support the implementation of IFCCS. IFCCS is Phase 1 implementation for ICC and IHBS within the County. DMH is also in the process of augmenting the EPSDT contracts of several Wraparound providers by a total of 2.1 million dollars for fiscal year 2013-2014. This will bring the total EPSDT allocation for Wraparound to \$53.6 million dollars countywide. Finally, the Exodus UCC contract has been augmented by \$96,000 to expand services for DCFS involved children and youth.

Expansion of Staff Resources for Multidisciplinary Medical Hubs

In its strategic plan, the County committed to providing a comprehensive medical examination for all newly detained children. These assessments are delivered by a series of Medical Hubs, located in hospital settings.

The County reports that between June 2012 and May 2013, 86 percent of newly detained children were referred to a medical hub for a medical evaluation, the same percentage as reported in the prior reporting period. The County's goal for referrals is 100 percent of newly detained children. The County now uses tracking tools to follow up on newly detained children that have not been referred. The County also has its Health Services Section Managers provide presentations on Department policy at Regional Offices regarding changes made to its procedural guide. The County also reports the following efforts to increase referrals:

DCFS continues to collaborate with the Medical Hubs through the implementation of a pilot that has provided additional out-stationed CSWs and out-stationed PHNs to serve all the Medical Hubs, including after hours at the 24/7 LAC+USC Medical Center Hub and Children's Hospital, Los Angeles, the private sector Hub. The out-stationed CSWs, as reported previously, continue to significantly contribute to the efficiency of DCFS

making referrals to the Hubs and to the work flow/operations of the Hubs. The out-stationed PHNs are contributing to case management and care coordination to children served by the Medical Hubs.

Moreover, the DCFS CWHS Section has recently implemented a tool entitled “Medical Hub Exam Results Entered into CWS/CMS”. This tool serves as a report that is easily accessible to identify the status of the results of the Initial Medical Exams received from the Medical Hubs through DHS’ E-mHub System, being entered into CWS/CMS.

The Panel believes that the County continues to make progress in this area and is working to address implementation barriers.

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

In its strategic plan the County committed to expand the number of Team Decision Making Facilitators to meet the needs of children served. These facilitators convene and facilitate meetings between families, their informal supports and the professionals serving them at key events in their involvement with the child welfare system. These events include the goals of convening a meeting when a child enters care, when they experience a placement disruption and at other significant points. The County has not had sufficient staff to regularly convene TDM’s other than at initial placement.

The County had 83 TDM facilitator positions filled at the time of the Panel’s last report and now has 76 facilitator positions filled. The number of team meetings held in past years is:

- Calendar Year 2010: 16,602 TDM Meetings Completed
- Calendar Year 2011: 15,545 TDM meetings completed
- Calendar Year 2012: 16,062 TDM meetings completed
- Calendar Year 2012: 1st Quarter - 3,975 TDM meetings completed and 2nd Quarter – 1,664 TDM meetings completed, for a total 5,639 TDM meetings completed through May 9, 2013.

The County is currently standardizing the manner in which team meetings are conducted to conform to the Core Practice Model. According to the County, work is underway with Casey Family Programs to develop a Family Team Meeting curriculum and coaching/training guidelines to support teaming practice. Ultimately, the County has committed to prepare the larger casework work force to facilitate such meetings, which will enable more frequent joint planning with families and other team members. The Panel is strongly supportive of this goal and in fact believes that achieving it is essential for exit from the settlement. To date, few CSW staff are facilitating child and family meetings themselves, despite the efforts to expand coaching. Later in this report the Panel will discuss the status of the County’s efforts in this area and its concerns over the slow progress occurring.

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

The County committed in its strategic plan to provide mental health screening to all newly detained children in DCFS. The County provided the following information about its initiative to provide mental health screening to all eligible children. The report also provides data on the referral of children with positive mental health screens to services and the timeliness of delivery of subsequent mental health services.

Number of Children Screened Data from 7/1/12 – 3/30/13 (of a total of 17,166 children):

- 16,677 children required a screen, (17,166 children minus those currently receiving mental health services, in a closed case, who ran away, or were abducted);
- 16,061 (98.19 percent) children were screened.
- 308 (1.81 percent) screens are showing pending.
- 13,123 (81.70 percent) of those children screened (16,061) were determined to be in potential need of mental health services (received positive screens).

Screening Compliance – (of the 16,061 children screened):

- 13,123 (82.81 percent) children screened positive of those children requiring screens (16,677);
- 2,558 (15.33 percent) children screened negative of those children requiring screens (16,677);

Acuity Determination (13,123) children screened positive):

- 3 (0.02 percent) children were determined to have acute needs;
- 146 (1.15 percent) children were determined to have urgent needs;

- 12,615 (96.12 percent) children were determined to have routine needs;
- 375 (2.85 percent) children’s acuity level was pending determination and/or data entry.

Number of Children Referred for Mental Health Services:

- 13,123 children could be referred to mental health services minus children for whom consent was declined, whose case was closed, who ran away, or who were abducted.
- 12,313 (98.93 percent) children were referred for mental health services.

The following chart provides a breakdown of timeliness from screening to referral for FY 2012-2013 as of May 21, 2013).

Days and number of children from screening to referral for mental health services.

Acuity	0-3 days	%	4 - 7 days	%	8-13 days	%	14-20 days	%	21-30 days	%	31 days or over	%	Total
Acute	2	66.67	1	33.33									3
Urgent	108	73.97	17	11.64	7	4.79	8	5.48	4	2.74	2	1.37	146
Routine	6,965	56.22	1,984	16.02	1,383	11.16	862	6.96	652	5.26	542	4.38	12,388
Total	7,075	56.43	2,002	15.97	1,390	11.09	870	6.94	656	5.23	544	4.34	12,537

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

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

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

Children Receiving a Mental Health Service Activity:

- Of 13,123 children referred for mental health services: 12,313 (93.87 percent) children began receiving mental health service activities such as assessment, treatment, case management and consultation.

Number of Days from Screening to Start of Service):

- Average of 3 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 1 day from referral to the start of mental health service activities.

The Panel asked for timeliness data on the receipt (vs. referral) of mental health services. The following table reflects that performance, which is also positive, especially for children with acute or urgent needs in FY 2011-2012. It is important to note that a mental health activity does not necessarily mean therapy.

Days and number of children from positive screening to receipt of a mental health activity.

Acuity	0 - 3 days	%	4 - 7 days	%	8 - 13 days	%	14 - 20 days	%	21 - 30 days	%	31 days or over	%	Total
Acute	3	100											3
Urgent	145	100											145
Routine	9,798	80.40	644	5.82	594	4.87	512	4.20	392	3.22	246	2.02	12,186
Total	9,946	80.64	644	5.82	594	4.87	512	4.20	392	3.22	246	2.02	12,334

The County continues to show improvement in implementing the screening process and promptly referring children for mental health services. As progress is made in implementing the Integrated Behavioral Health Information System and Intensive Home Based Services, the Panel would like to see more detailed data on the type, duration and intensity of mental health services children who have been screened are connected to. The Panel also expects the types of services provided to increasingly be Home-Based Mental Health Services.

Coaching of DCFS and DMH Staff in Core Practice Model Practice

DCFS Training and Coaching

The Panel has long been concerned about the small number of trained DCFS and DMH coaches available to support practice improvement. The concern extends especially to the development

of CSWs in utilizing a strengths/needs-based approach in their work with children and families and in convening family team meetings. DCFS and DMH agree that coaching is an essential element of practice improvement during and after training in new skills.

To date, four DCFS offices have had coaching, which continues as new units get coached: Compton, Pomona, Wateridge and Torrance. Currently, there are five DCFS coaches who each coach in DCFS offices an average of 13 hours per week, with a total of 53 hours per week of coaching being provided across four offices. Three DMH coaches provide a total of 12 hours/weekly across three DCFS offices.

Although the number of trained coaches remains small, the Panel has been impressed with their skill and effectiveness. In March, 2013, the Panel visited two DCFS offices (Torrance and Pomona) where it heard from managers and SCSWs who are being coached. It was impressive that the staff presented most of the observations themselves and they had pride in the practice changes they are making as a result of coaching. Supervisors described how coaching changed their supervision, especially moving away from a "Fix It" mentality to learning how to help workers slow down and reflect. A Parent Advocate and Community Partner who were part of the Pomona Implementation Team and were described as instrumental in the development of coaching made positive presentations. In one office, staff believed coaching has been so successful in part because their caseloads are about 20, in contrast to other offices where caseloads of 30 are typical. Staff believes coaching takes more time for SCSWs and CSWs.

DCFS and DMH plan to have training for staff in the Core Practice Model timed just before coaching begins. The coaching approach utilizes DCFS and DMH coaching teams working with their staff and community agencies, one office at a time. Coaches begin in an office by discussing the practice model and what to expect from the coaching process with the newly implementing units. The DCFS regional office/DMH Service Area Implementation Team, including SCSWs and community representatives, is essential to ensure that practice improvements fit the office culture and produce lasting change. Those meetings also make the connections among the Shared Core Practice Model, the major Data Dashboard indicators and the QSR indicators and applied to SCSWs. Coaches work with the identified SCSWs and their managers to prepare them to apply coaching techniques on their own. Coaches provide group and individual coaching to CSWs initially with their supervisors and then encourage SCSWs to coach the CSWs with input from the coach. Coaches lead ongoing practice strategy sessions with implementing units to build skills in identifying underlying needs. DCFS and DMH agree with the Panel that if all CSWs do not routinely bring together family teams themselves (in cases that do not have teams convened by IHBS), teaming will not be adequately implemented and scores on the QSR are not likely to achieve an acceptable level. Sometimes family teams will present challenges that require convening by an SCSW or facilitator, but a system can never have sufficient facilitators for all family team meetings. The coaches developed a Child and Family Team guide and a Strengths-Needs-Team Matrix to walk the SCSW and CSW through an intentional process of reflecting on the family's goals/strengths/worries and underlying needs and how to team with the family to discuss these. Confidence that they can convene family meetings is building slowly, with six CSWs in Pomona, one SCSW in Wateridge and two SCSWs in Torrance who are convening their own family team meetings.

In March, 2013, the coaches were moved under the DCFS High Risk Services Division. Each of the four implementing offices has an “anchor coach” who is a member of the regional office Implementation Team. DCFS is considering a conversion of some TDM facilitators (and potentially other internal resources) to coaches. A conversion of these staff to coaching is in conflict with achieving a reduction in caseloads and the number of workers supervised by supervisors which also supports practice model implementation. With training, shadowing and being guided by experienced coaches, preparing a new coach takes 2-3 months. DCFS decisions about the next group of implementing offices have not yet been made, nor has training for new coaches been planned. By August 2013 DCFS plans to complete implementation readiness assessments of each regional office and mental health service area to inform the selection of the next offices to implement coaching later in the year.

There are three DMH coaches who are training six additional administrative staff as coaches. DMH and LATC (the DMH contractor who provides Wraparound training and now has more than 10 trained coaches who also work for provider agencies) are focusing on coaching DMH co-located SFC staff and mental health providers: in SA 3 – Pomona office, SA 6 – Compton and Wateridge offices; and SA 8 – Torrance office. The plan for LATC is to coach the intensive mental health providers, such as Intensive Field Capable Clinical Services (IFCCS), Treatment Foster Care (TFC) and Wraparound. It is estimated that as many as 40-50 DMH coaches may be required for the implementation of coaching for practice improvement countywide. DMH has 65 mental health providers rendering services to children in the child welfare system and contracts with approximately 30 group homes which include RCL 12s and RCL 14s. DMH also has 18 SFC co-located programs and approximately 7 DMH directly operated children's clinics. Hopefully each SA will have its own coaching team that could address the needs of directly operated programs and contract providers within the SA.

The County’s summary report of DCCF Training and Coaching efforts is placed in the Appendix.

Expansion of Wraparound by 500 Slots

The County committed to expanding Wraparound by 500 slots and has significantly surpassed that target. The County projects that enrollments will increase by approximately 200 children this fiscal year June 2012	1048	1475	2323
July 2013	995	1616	2611

The County also reports that it released a new Request for Proposals for the new Wraparound contract in July 2013. The new contract will incorporate key elements of the Katie A. State

Settlement agreement including Core Practice Model, Intensive Care Coordination and Intensive Home Based Services. The County plans to shift the funding mix for Wraparound to maximize EPSDT and reduce reliance on County general funds. The County is experiencing some resistance to this concept from Wraparound providers, who in the Panel’s opinion find it simpler to utilize the existing case rate.

Caseload/Workload Reduction

The strategic plan addresses strategies to lower CSW caseloads out of recognition that current high caseloads impede DCFS capacity to fully implement the Core Practice Model. Caseloads and workloads are cited by the County as one reason that child and family team meetings have not been significantly implemented.

Recent caseload trends provide some context about the overall agency workload. The following figures are point-in-time data as of July for each year referenced.

Year	Emergency Response (Abuse and neglect investigations)	Family Maintenance (Service to children living in their own homes)	Out-of-Home (Children placed in foster family, kinship, group home, adoption, guardian home and other settings)
2003	13,348	9,341	29,595
2008	13,246	10,766	22,278
2013	13,129	13,847	20,036

There have been notable gains in the numbers of children served under Family Maintenance and a significant reduction in the number of children in out-of-home care between 2003 and 2013, both of which are commendable improvements.

In its most recent previous report the Panel found that the CSW generic caseload was 28.53 (Jan 2013), an increase over the prior period from 26.55 (Jan 2012). Emergency Response (ER) caseloads had risen from 15.84 (Jan 2012) to 16.87 (Jan 2013) at the time of the report. According to the County, the total ER case totals rose from 11,614 (Jan 2012) to 11,795 (Jan 2013); the Continuing Services case totals rose from 30,671 (Jan 2012) to 31,121 (Jan 2013).

The County has experienced some difficulty in reconciling the methodology used for past caseload reports with that used in the current period. Further discussions are needed between the Panel and County to identify a reliable caseload and workload analysis methodology. Additionally, new strategies appear to be needed to reduce caseload and workload to a manageable level.

Young Children in Group Homes

The Panel expressed its concern over growth in the number of young children in group homes over a year ago. The County shared the Panel's concern and has lowered the census of children age 0-12 in group care from a high of 179 in February 2011 to 91 children in April 2013. As of April 2013 there were no children 6 and younger in group care and one seven-year old and 5 eight- year olds in group care. The remaining young children in group care are 9-12 years old.

DCFS has accomplished this by requiring a review of referrals at the level of the DCFS Director's office, referring group home candidates to Wraparound and Therapeutic Behavioral Services (TBS) and by considering treatment foster care as an alternative. The Panel commends the County for this significant accomplishment and encourages continued efforts to reduce the number of young children in group care further. Effective implementation of Intensive Home Based Services should facilitate reductions of placement of all children in group care.

A table reflecting the number of group home placements of young children by office is provided below.

GROUP HOME REPORTS FOR CHILDREN 0 TO 12 BY OFFICE LOCATIONS FOR THE MONTH OF APRIL 2013

CSW LOCATION	OFFICE NAME	TOTAL CHILDREN
S1251	American Indian	<u>1</u>
S1250	Asian Pacific	<u>1</u>
S3253	Belvedere	<u>3</u>
S1277	Compton	<u>6</u>
S0249	Deaf Unit	<u>1</u>
S1280	El Monte	<u>3</u>
S1254	Glendora	<u>6</u>
S8234	Lancaster	<u>6</u>
S0222	Medical Case Management Services (MCMS)	<u>4</u>
S3239	Metro North	<u>3</u>
S8236	Palmdale	<u>3</u>
S5252	Pasadena	<u>7</u>
S1255	Pomona	<u>2</u>
S4261	S F Springs	<u>3</u>
S5211	San Fernando Valley	<u>3</u>
S8251	Santa Clarita	<u>4</u>
S7207	South County	<u>12</u>

S2213	Torrance	<u>3</u>
S6219	Vermont Corridor	<u>7</u>
S2217	Wateridge	<u>15</u>
S6260	West LA	<u>2</u>
S5212	West San Fernando Valley	<u>2</u>
TOTAL		97

The total number of children in group care has declined from 2,153 in 2002-2003 to 1,069 in March 2013.

Qualitative Service Review (QSR)

The County committed to implementing a process to measure the quality of its casework practice performance using the Qualitative Service Review (QSR) process. The Qualitative Service Review is an interview-based quality assurance method that permits an examination of the quality of services – not just whether or not the service was delivered, as well as an assessment of the child’s current status. Each DCFS office is reviewed in an 18-month cycle. QSR performance is an element of the Katie A. Settlement Agreement’s exit criteria for the County.

The QSR Baseline was completed in August 2012 and the corresponding QSR Baseline Report was completed and issued in early 2013. The second QSR Review cycle began the first week of December 2012, with the DCFS Belvedere office followed by the Santa Fe Springs, Compton, Vermont Corridor, Wateridge and Pomona offices. The following is the QSR schedule for the remainder of the year, subject to change:

Glendora	August 5-8, 2013
El Monte	September 16-19, 2013
San Fernando Valley	October 21-24, 2013
Pasadena	December 4-5, 2013 December 9-10, 2013

The QSR provides a basis for measuring, promoting, and strengthening the Shared Core Practice Model and the protocol includes two domains; child and family status indicators measure how the focus child and the child’s parents/caregivers are doing within the last 30 days. Practice indicators measure the core practice functions being provided with and for the focus child and the child’s parents/caregivers for the most recent 90-day period. The team consists of trained DCFS and DMH reviewers who conduct a case review, and conduct interviews within a two-day period with key players in the life of the child and family’s case.

The team assesses status and performance indicators to be able to determine facts such as:

Child and Family Status

- Is the child safe?
- Is the child stable?

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

Practice Performance

- Are the child and family meaningfully engaged and involved in case decision making (called Voice and Choice)?
- Is there a functional team made up of appropriate participants?
- Does the team understand the child and family's strengths and needs?
- Is there a functional and individualized plan?
- Are necessary services available to implement the plan?
- Does the plan change when family circumstances change?
- Is there a stated and shared vision of the path ahead leading to safe case closure and beyond?

Overall, scores are reflective of the aggregate scores of each of the indicators for each case reviewed in the sample. Opportunities for organizational learning and practice development include providing the CSW and CSW supervisor in face-to face feedback on findings in the cases reviewed. In addition, oral case presentations are made in group debriefings called "Grand Rounds" and a written case story for each case reviewed is produced to provide context for the scores and to enhance learning.

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

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

Overall Score Passing Score (Status): 85% Passing Score (Practice): 85%

The following tables reflect the performance for Belvedere, Santa Fe Springs, Compton and Vermont Corridor offices during the second cycle as compared to their QSR Baseline results. Immediately below each section are the corresponding baseline results for comparison purposes.

QSR Second Cycle Status Indicators (2012-2013) – Percent Acceptable

Office	Safety Overall	Stability	Permanency	Living Arrangements	Health	Emotional Well Being	Learning & Development	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
Belvedere	100%	83%	92%	100%	100%	92%	75%	57%	100%	67%	100%
Santa Fe Springs	92%	83%	58%	100%	100%	83%	75%	50%	100%	67%	83%
Compton	92%	73%	67%	92%	100%	83%	67%	63%	100%	38%	75%
Vermont Corridor	100%	91%	82%	100%	91%	100%	64%	60%	100%	88%	100%
Overall	96%	83%	75%	98%	98%	90%	70%	58%	100%	65%	

Note: Overall percentages have been rounded to the nearest full percent.

QSR Baseline Status Indicators (2011-2012) - Percent Acceptable

Office	Safety Overall	Stability	Permanency	Living Arrangements	Health	Emotional Well Being	Learning & Development	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
Belvedere	100%	92%	22%	100%	100%	54%	77%	73%	100%	N/A	85%
Santa Fe Springs	100%	71%	60%	86%	93%	64%	79%	40%	100%	71%	71%
Compton	100%	85%	62%	85%	100%	54%	77%	64%	88%	56%	77%
Vermont Corridor	100%	86%	43%	93%	93%	64%	79%	36%	80%	67%	86%
Overall	100%	83%	47%	91%	96%	59%	78%	53%	92%	65%	

QSR Second Cycle Practice Indicators (2012-2013) - Percent Acceptable

	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Belvedere	92%	64%	33%	58%	67%	50%	67%	55%	58%	67%
Santa Fe Springs	75%	67%	8%	50%	50%	42%	67%	58%	50%	58%
Compton	75%	67%	17%	42%	50%	50%	58%	58%	50%	58%
Vermont Corridor	55%	45%	9%	36%	55%	27%	36%	36%	27%	45%
Overall	74%	61%	17%	46%	55%	42%	57%	52%	46%	

QSR Baseline Practice Indicators (2011-2012) – Percent Acceptable

	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Belvedere	46%	31%	8%	45%	23%	38%	62%	38%	31%	31%
Santa Fe Springs	79%	64%	29%	52%	36%	36%	57%	43%	36%	36%
Compton	38%	46%	0%	59%	23%	23%	69%	54%	46%	31%
Vermont Corridor	36%	36%	7%	30%	36%	14%	57%	43%	14%	21%
Overall	50%	44%	11	46%	29%	28%	61%	44%	32%	

Comparing the baseline review results with those in the second cycle (for these four offices), there has been practice improvement in most of the status and practice indicators. Within Child and Family Status indicators, the improvements in Permanency and Emotional Well-Being have been the most significant. Permanency scores went from 47 percent acceptability to a surprisingly high 75 percent acceptability. In this regard it is important to know that the Permanency indicator addresses progress toward permanency, not permanency achievement and permits an acceptable score for youth who will age out of the system without legal permanency in some circumstances. In such cases there would have to be confidence that the youth is likely to live with current foster caregivers until exit. Under Practice Performance, gains in Engagement, Assessment and Planning have been the most noteworthy.

Under Child and Family Status, the Family Functioning indicator, which measures the readiness of families to regain custody of their child or children, scored at 58 percent acceptability. In Practice Performance, Teamwork scored only 33 percent acceptability, Voice and Choice 61 percent acceptability, Long-Term View scored 55 percent acceptability, Planning scored 42 percent acceptability and Tracking and Adjusting scored 46 percent acceptability.

The County is working on plans to strengthen coaching to help improve practice in the areas noted.

Outcome Data Performance

The parties identified a series of child outcomes in the areas of safety and permanency that would be tracked to reflect progress over time. As part of this process, the parties agreed to exit targets for each indicator, meaning that the targets would have to be met as one of several exit targets that are a condition of ending court oversight. 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 assured that current performance at that time would be a floor that the County does not fall below.

Overview of the System Population

The table below is informational and shows the difference in placement experience of class members (children with mental health services) compared with non-class members (children without mental health services). This table reflects that a smaller percentage of class members initially entered foster care in the year their case was opened in 2010-2011 (50.77%) than in 2002-2003 (54.46%). In that same period non-class members experienced a much greater reduction in rate of removal.

Population of FY 2002-2003 to FY 2011-2012

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
2010-2011	15,007	64.72%	8,182	35.28%	23,189	5,849	49.23%	6,031	50.77%	11,880	9,158	80.98%	2,151	19.02%	11,309
2011-2012 (Mar 12)	10,751	67.35%	5,211	32.65%	15,962	4,731	53.46%	4,118	46.54%	8,849	6,020	84.63%	1,093	15.37%	7,113

Safety Indicator 1. Repeated Reports of Abuse and Neglect

This indicator tracks the degree to which children that are the subject of a substantiated abuse or neglect report (referrals) but are not removed from home, do not experience another substantiated report during the case open period up to 12 months. The goal would be to assess risk and provide supportive services effectively enough that maltreatment would not reoccur. Data shows that the County's performance on this indicator has improved from 80% of class members having no subsequent referrals within 12 months for 2002-2003 to 87.3% of class members having no subsequent referrals within 12 months in 2010-2011.

Minimum Performance Level – 82.8%
Aspire To – 83.3%

The County currently meets the Minimum Performance Level goal.

Safety Indicator 1: Percent of cases where children remained home and did not experience any new incident of during case ,
substantiated referral open period

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%
2010-2011	15,007	13,685	91.2%	5,849	5,105	87.3%	9,158	8,580	93.7%
2011-2012 (Mar 12)	10,751	9,695	90.2%	4,731	4,106	86.8%	6,020	5,589	92.8%

Minimum
Performance
Level
82.8%

Aspire to
83.3%

Notes:

1. Intent of indicator: Of those children who initially remained home in the Fiscal Year, how many did not experience any new (first occurrence of re-abuse)

substantiated referrals during the case open period, up to 12 months?

2. The table above excludes evaluated-out referrals.

3. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.

4. Data Source is CWS/CMS Datamart as of 4/16/2013.

**Safety Indicator 2.
Incidence of Maltreatment by Foster Parents.**

This indicator reflects the incidence of maltreatment of children by their foster parents. The incidence is small and the County’s performance for class members has been consistently in the 99% range, meaning that over 99% of class members in foster home settings experienced no substantiated foster parent maltreatment. In 2010 and 2011, 98.5% of class members experienced no substantiated foster parent maltreatment. Unfortunately the indicator does not include the experience of class members in group home and residential settings due to a feature in the design of automated reporting that does not identify the specific alleged perpetrator in congregate settings. This reflects a significant gap in performance tracking.

Minimum Performance Level – 98.4%
Aspire To – 98.6%

The County meets the Performance Level goal, however current data does not reflect all maltreatment in out-of-home care.

Safety Indicator 2. Of all children served in foster care in the Fiscal Year, how many did not experience maltreatment providers by their foster care? (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%
2010-2011	23,191	22,908	98.8%	16,232	15,995	98.5%	6,959	6,913	99.3%
2011-2012 (Mar 12)	19,605	19,379	98.8%	14,246	14,060	98.7%	5,359	5,319	99.3%

Minimum Performance Level 98.4%

Aspire to 98.6%

Notes:

- The table above excludes children with abuse/neglect in group homes and guardian homes.
- Children placed in group homes are not included in this data due to inability of correctly identify and accurately code alleged perpetrator information for these placements.
- Children placed in guardian homes are not included because DCFS policy identifies legal guardianships as permanent placements and not as out-of-home placements.
- The table is based on "Soundex" match of perpetrator's name and substitute care provider's name.
- All children served in foster care includes: children already in foster care on the first day of the Fiscal Year, children who initially entered foster care in the Fiscal Year and children who entered foster care as a result of a FM disruption.
- Children with DMH services are: children already in foster care on the first day of the fiscal year - those who received DMH services between 12 months before and 12 months after the first day of the fiscal year, children who initially entered foster care in the fiscal year and children who entered foster care as a result of an FM disruption - those who received the DMH services between 12 months before and 12 months after the DCFS case start date.
- Data Source is CWS/CMS Datamart as of 4/16/2013.

**Safety Indicator 3.
Recurrence of Maltreatment Within 6 Months**

This indicator measures the percentage of all children that came into contact with DCFS and were victims of a substantiated abuse and neglect referral without being victims of another substantiated referral within six months. It provides some evidence of the effectiveness of efforts to prevent subsequent abuse and neglect. Class members are not identified separately in this indicator.

The data show improvement in reducing subsequent substantiated referrals between 2002-2003, when 89.5% of children did not have subsequent referrals within six months, and 2010-2011 when 93.18% of children did not have a subsequent referral.

Minimum Performance Level – 92.3%
Aspire To – 92.8%

The County is meeting the Minimum Performance Level.

Safety Indicator 3. No recurrence of maltreatment within 6 months (Federal CFSR 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	12,845	13,878	92.56%
	Jan 2011 - Jun 2011	13,700	14,702	93.18%
2011-2012	Jul 2011 - Dec 2011	12,371	13,259	93.30%
	Jan 2012 - Jun 2012	12,998	13,937	93.26%

**Minimum Performance Level
92.3%**

**Aspire to
92.8%**

Notes:

1. Intent of indicator: Of all children who come into contact with DCFS and were victims of a substantiated maltreatment referral during the 6-month time period, what percent were victims of another substantiated maltreatment referral within the next 6 months?
2. The table includes children who had a substantiated referral in the 6-month time period indicated.

3. The table above excludes allegations of 'at risk, sibling abused' and 'substantial risk'.

4. No maltreatment includes children who were not victims of another substantiated maltreatment referral within 6-months of the initial substantiated referral of maltreatment.

5. This is a referral based report and DMH match is not applicable.

6. Data Source is CWS/CMS Datamart as of 4/16/2013.

Permanency Indicator 1. Median Length of Stay in Out-of-Home Care

This indicator measures the median number of days class members are in out-of-home care, grouped by the year they entered care. The County has reduced the median length of stay for class members from 656 days in 2002-2003 to 427 in 2010-2011. The decline over time reflects meaningful improvement, but fails to meet the performance level.

Minimum Performance Level – 409 Days
Aspire To – 383 Days

The County is not meeting 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
2010-2011	8,182	5,113	325	6,031	3,470	427	2,151	1,643	77
2011-2012 (Mar 12)	5,211	2,851	252	4,118	2,089	265	1,093	762	99

Minimum Performance Level
409 days

Aspire to
383 days

Notes:

1. Intent of indicator: Of all the children who were initially placed into foster care within the fiscal year, what is the median number of days that the children remained in foster care?
2. The table used SAS survival analysis that provides a Kaplan-Meier estimate of the number of days that half of the children will exit foster care and half will remain in foster care.
3. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.
4. Data Source is CWS/CMS Datamart as of 4/16/2013.

**Permanency Indicator 2.
Reunification Within 12 Months**

This indicator reflects the County’s success in returning children to their parents quickly. The County has improved its reunification achievement from 14.5% of class members being returned within 12 months in FY 2002-2003 to 37.8% in 2010-2011.

Minimum Performance Level – 36.4%

Aspire To – 45.6%

The County currently meets the Minimum Performance Level.

Permanency Indicator 2. Reunification within 12 months (Federal CFR 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%
2010-2011	8,182	3,015	36.8%	6,031	2,281	37.8%	2,151	734	34.1%
2011-2012 (Mar 12)	5,211	1,722	33.0%	4,118	1,370	33.3%	1,093	352	32.2%

Minimum Performance Level
36.4%

Aspire to
45.6%

Notes:

1. Intent of indicator: How successful is DCFS at reunifying all children under its supervision quickly?
2. The table includes all children who exited foster care through reunification within 12 months of removal from home.
3. The table is based on removal date and episode end date.
4. The table includes placement episodes with 8 days or longer.
5. % equals children reunified within 12 months divided by children initially removed from home.
6. Children with DMH services are those who received the DMH services between 12 months before and 12 months after the DCFS case start date.
7. Data Source is CWS/CMS Datamart as of 4/16/2013.

Permanency Indicator 3 Adoption Within 24 Months

This indicator reflects the County's success in quickly moving children under its supervision that cannot return home to adoption quickly. Data reveal improvement, showing that the percent of children adopted within 24 months rose from 0.6% in 2002-2003 to 2.7% in 2010-2011.

Minimum Performance Level – 2.0%

Aspire To – 2.9%

The County is meeting the Minimum Performance Level.

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%
2009-2010	8,906	255	2.9%	6,131	167	2.7%	2,775	88	3.2%
2010-2011 (Mar 11)	6,075	232	3.8%	4,410	153	3.5%	1,665	79	4.7%

Minimum
Performance
Level
2.0%

Aspire to
2.9%

Notes:

1. Intent of indicator: How successful is DCFS at moving children under its supervision into finalized adoption quickly?
2. The table includes all children who exited foster care through adoption within 24 months of removal from home.
3. The table is based on removal date and placement episode end date.
4. Fiscal Year 2011-2012 does not meet the 24 month requirement and the data is unavailable.
5. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.
6. % equals children adopted within 24 months divided by children initially removed from home.
7. Data Source is CWS/CMS Datamart as of 4/16/2013.

Permanency Indicator 4. Reentry Into Foster Care

This indicator reflects the County's success in ensuring that children returned to their parents remain with them after reunification. The following table indicates that the County's success rate declined from 7.7% of class members reentering care in 2002-2003 to 13.6% reentering care in 2010-2011. Evaluating reentry rates requires sensitivity to the fact that the more intensely an agency is focused on reunification the more likely it is that rates will be higher than systems without a reunification priority. The County has much greater success with non-class members, which is to be expected.

Minimum Performance Level – 13.9%

Aspire To – 12.9%

The County is meeting the Minimum Performance Level.

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%
2010-2011	7,050	837	11.9%	4,781	649	13.6%	2,269	188	8.3%
2011-2012 (Mar 12)	4,591	621	13.5%	3,260	503	15.4%	1,331	118	8.9%

Minimum
Performance
Level
13.9%

Aspire to
12.9%

Notes:

1. Intent of indicator: How successful is DCFS at ensuring children successfully remain with their parents after being reunified with parents?
2. The numerator is children who re-entered foster care within 12 months of reunification.
The denominator is children who were reunified during the fiscal year. Placement episodes less than 8 days were included according to the Federal Methodology.
3. Children with DMH services are those who received the DMH services between 12 months before and 12 months after the DCFS case start date.
4. Data source is CWS/CMS Datamart as of 4/16/2013.

**Permanency Indicator 5a.
Placement Stability in First Year of Placement**

This indicator measures, “Of those children in foster care less than 12 months, how many remain in their first or second placement?” The County’s performance has improved from 74.0% of class members having no more than two placements in their first year of care in 2002-2003 to 86.9% in 2010-2011.

Minimum Performance Level – 82.5%
Aspire To – 84.1%

The County meets the Minimum Performance Level

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%
2010-2011	3,246	2,872	88.5%	2,398	2,083	86.9%	848	789	93.0%
2011-2012 (Mar 12)	1,884	1,640	87.0%	1,479	1,268	85.7%	405	372	91.9%

**Minimum Performance Level
82.5%**

**Aspire to
84.1%**

Notes:

1. Intent of indicator: Of those children who are in foster care for less than 12 months, how many remain in their first or second placement?
2. This table includes all types of placement moves.
3. This table includes children who were in foster care for at least 8 days, but less than 12 months.
4. Children in foster care less than 12 months is determined by placement episode end date and removal date.
5. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.
6. Data Source is CWS/CMS Datamart as of 4/16/2013.

**Permanency Indicator 5b.
Placement Stability in Second Year of Placement**

This indicator measures the experience of class members in foster care for 12 months but less than 24 months without a third or more placements in year two. In 2002-2003, 89.5% of class members did not experience a third or more moves compared to 92.8% not experiencing a third or more moves in 2010-2011.

Minimum Performance Level – 89.2%

Aspire To – 89.7%

The County meets the Minimum Performance Level.

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%
2009-2010	1,916	1,772	92.5%	1,574	1,460	92.8%	342	312	91.2%
2010-2011 (Mar 11)	600	554	92.3%	486	450	92.6%	114	104	91.2%

**Minimum Performance Level
89.2%**

**Aspire to
89.7%**

Notes:

1. Intent of indicator: Of those children in foster care for 12 months but less than 24 months, what percent did not move to a third or greater placement(s) in the second year?
2. This table includes all types of placement moves.
3. The denominator is children who were in foster care 12 months but less than 24 months.
The numerator is children who did not move to a third or greater placement in the second year.
4. Children in foster care 12 months but less than 24 months is determined by placement episode end date and removal date.
5. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.
6. Data Source is CWS/CMS Datamart as of 4/16/2013.

**Permanency Indicator 5c.
Stability for Children in Care for More than 24 Months**

This indicator is similar to 5a. and 5b., except it applies to the stability of children in care more than 24 months. The County performance has improved with this indicator, with 45.2% of class members in care more than 24 months or more experiencing no more than two moves in 2002-2003 compared with 64.2% in 2010-2011. The differences between class members and non-class members are particularly striking in this indicator.

Minimum Performance Level – 58.8%

Aspire To – 61.7%

The County currently meets the Minimum Performance Level.

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%
2010-2011	6,966	5,037	72.3%	4,432	2,846	64.2%	2,534	2,191	86.5%
2011-2012 (Mar 12)	6,350	4,531	71.4%	4,018	2,586	64.4%	2,332	1,945	83.4%

**Minimum Performance Level
58.8%**

**Aspire to
61.7%**

Notes:

1. Intent of indicator: Of those children in foster care for at least 24 months, what percent did not move to a third or greater placement(s) during the Fiscal Year?
2. This table includes all types of placement moves.
3. The denominator is children who were in foster care on the first day of the fiscal year and who have been in foster care for 24 months or more.
The numerator is children who have not experienced a move to a third or greater placement(s) during the fiscal year.
4. Children with DMH services are those who received DMH services between 12 months before and 12 months after the first day of each fiscal year.
5. Data Source is CWS/CMS Datamart as of 4/16/2013.

Exit Criteria

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

V. Panel Analysis of Strategic Plan Implementation

The County is undertaking a major reform agenda in implementing the County Katie A. Settlement and IBHS and ICC within the State Katie A. Settlement, linking the associated planning and implementation between two separate departments, DCFS and DMH. In addition the County must carry out the ongoing missions of protecting children, providing for their permanency and well-being and meeting the mental health needs of the children of Los Angeles County. As the Panel has mentioned frequently, DCFS and DMH are working closely together in integrated planning and implementation. Fortunately, the County's early practice model development in response to the County Katie A. settlement has contributed to State Katie A. implementation strategies, making the two implementation plans compatible and more accessible to integration. In light of the many initiatives underway in the County DCFS and DMH, the Panel's analysis and recommendations will focus on a few primary challenges, believing that strategic and focused attention to these areas will produce the most gains for class members.

Workload

Current average caseloads are 28.53 for ongoing caseloads and 16.87 for Emergency Response, a level somewhat higher than referenced in the past report. Caseloads have remained near this level since the County Settlement occurred and are high, relative to the demands of the Core Practice Model. It is difficult for CSWs to engage children and families, comprehensively understand their needs, work within ongoing team meetings, plan individually, match services to needs and maintain sufficient contact with cases to track progress effectively with workloads this high. The County should review existing strategies for caseload reduction, which do not seem to be affecting the issue and consider new approaches to address workload barriers.

There have also been difficulties in reconciling current caseload size reports by the County with the methodology used for past reports, making the comparison of caseload size over time difficult. Additional work is needed to develop a baseline workload measure. The Panel plans to engage the County in further discussions about this issue.

Treatment Foster Care (TFC)

The County currently has 107 certified TFC beds, almost 200 short of the 300 beds ordered in the Court's Corrective Action Plan. Progress has been slow for a variety of complex reasons, some of which are most effectively solved at the state level, such as related to rate issues. The lack of sufficient TFC beds limits the County's ability to offer stable family-based placement settings to children in group care and children who experience frequent placement disruptions in family foster care homes not suited to their higher needs. The Panel hopes the State

Settlement will help address some of this problem, but believes that recruitment and retention efforts at the County level will also need strengthening.

Reporting of Maltreatment

When the parties agreed to the outcome indicators to be tracked, Safety Indicator 2, Incidence of Maltreatment by Foster Parents, was limited by the reporting system in place at the time, which did not include the experience of class members in group home and residential settings. The maltreatment reporting system does not identify the specific alleged perpetrator in congregate settings. The Panel believes the current indicator reporting limitations significantly impede the ability of the court, the parties, the Panel and the public to assess child safety in out-of-home care. The Panel is cautious about recommending yet another complex information system change; however, it is important that maltreatment in congregate care be identified and reported by the Panel. The Panel intends to explore further with the County methods that may be used to capture child maltreatment in group home and residential settings.

Expansion of Home-Based Services

The County is implementing a strategy to expand the delivery of intensive home-based services by beginning with five providers, which will pilot a design to deliver highly individualized home-based services. The Panel commends this step and believes that it can also help inform the larger implementation of IHBS and ICC Countywide. The Panel and County recognize that the shift from traditional service provision to the strength and needs-based, individualized practice model required by Katie A. will present many challenges to the provider community. Ultimately, the Panel expects that provider selection will be highly influenced by an agency's commitment and capacity to practice within the Katie A. model of practice.

CFS and DMH Training and Coaching

DCFS and DMH face significant challenges in delivering sufficient training and coaching to their staff and providers. Neither Department has a sufficient number of capable coaches to develop a system the size of Los Angeles County. Much of the training provided has been brief, often a day or less, and at a largely conceptual level. The implementation of ICC and IFBS as part of the State Katie A. Settlement will place additional demands on capacity-building resources. The expansion of coaching is hampered by the inability of DCFS and DMH to hire additional coaches at this time due to limitations on staff growth placed by County administration. A major training and coaching effort is needed to achieve the objectives of the Katie A. Settlement

The QSR Process

DCFS and DMH have formed a strong partnership in the use of the Qualitative Service Review. The Departments have instituted a structured schedule of office reviews that permits each office to be reviewed every eighteen months, a strong pool of DCFS and DMH QSR reviewers has been developed and the QSR process is fostering strategic conversations within the agencies about how to use QSR results to strengthen practice.

Now that DCFS and DMH have developed a functional capacity to evaluate the quality of practice, there is a need to further strengthen the reach and integrity of the QSR process by expanding the reviewer pool to include a broader array of stakeholders, to expand the operational understanding of the Core Practice Model among community partners, to continually strengthen the fidelity of practice appraisal and to ensure that findings among the reviewer pool are reliable and independent. Potential external reviewers can include providers, attorneys, partner organizations such as public health and juvenile justice as well interested community leaders. A balance of external and internal reviewers can strengthen the independent appraisal of system performance and help provide assurance that ratings are fair and accurate. Exposing external stakeholders to the QSR is also an effective strategy to engaging other organizations in adopting the County's model of practice.

There is an underlying tendency in all systems using the QSR for reviewers internal to the system being reviewed to score more generously than reviewers from outside the system. Several systems have tracked this tendency and found that highly experienced reviewers from outside the system tend over time to rate performance more critically than those inside the system. Within the pool of system reviewers, designated Quality Assurance staff tend to rate system performance somewhat less critically than seasoned external reviewers, but more critically than local office part-time "peer" reviewers. This tendency of variation can be managed with strong fidelity processes and a balance between internal and external reviewers.

An additional practice that is critical to maintaining QSR fidelity is utilizing the "Grand Rounds" meetings where individual cases are discussed as a forum to assess scoring fidelity. It can be difficult for peers to question the scoring judgment of colleagues, but the development of the Grand Rounds process began with that specific purpose. The QSR review coordinator should model the priority needed for fidelity by asking follow-up questions when narrative descriptions of case findings may not be fully consistent with scores assigned. Reviewers should also be taught to expect peer consultation in this process.

Another method of ensuring fidelity is to periodically perform inter-rater reliability test of reviewers, using written case narrative scoring simulations to assess how closely reviewers conform to a scoring norm. Such a process also helps identify reviewer training needs. The Panel has several scoring simulations that can be made available if useful. Also, a thorough review of each case story by QA staff for fidelity and congruence between the case narrative and scoring can provide an additional safeguard against inaccurate ratings of status and performance.

Last, a fidelity measure that serves a preventive purpose is to carefully track the percentage of cases in each office sample that must be replaced due to parent/family unwillingness to be reviewed or other circumstance that prevents participation. Intentionally or unintentionally, local staff arranging interviews can communicate the purpose and value of the QSR to families in a manner that makes the process seem unimportant or unappealing, resulting in families declining to participate and sampling that is unrepresentative of actual performance. If any offices demonstrate a disproportionately high number of case replacements, follow-up is needed.

Beyond fidelity measures, the County has recently accelerated the QSR review schedule, which will place additional workload demands on an already modest QSR staffing level. The County will need to ensure that sufficient trained QSR staff is available to meet this schedule.

Use of Short-Term Shelter Placements and Foster Family Recruitment

The Panel addressed the County's challenges with family foster care recruitment and retention and the use of holding rooms to house children waiting for placement earlier in the report. The reasons for this problem are likely to be multiple and complex. The County needs to identify the extent to which recruitment efforts need strengthening, if follow-up with applicants is unresponsive and why foster parents are choosing to conclude the fostering role. Foster care payments in the range of \$600 per month, which are relatively low comparable to costs of living, may be a barrier. In many systems foster parents complain that the intensity and quality of system supports for youth in care, such as mental health services, are insufficient. In such cases, placement disruptions increase.

Many foster parents work or wish to, which can make caring for younger children a barrier due to day care costs and accessibility. Foster parent preparation and training may need improvement. A lack of respite supports, which can be useful in giving foster parents a break from caregiving, is sometimes a factor in retention. Worker turnover is a frequent foster parent frustration due to the lack of continuity in caseworker involvement, relationships and support.

In developing strategies to expand family foster care resources and make family-based settings immediately available when needed, the County will need to fully understand the barriers to foster home resource growth. This is likely to entail analysis of resource trends and placements, interviews with foster parents, caseworkers and other stakeholders and interaction with other systems about strategies that have been effective.

VI. Panel Recommendations

The following recommendations are made by the Panel to foster implementation of the strategic plan and achieve the goals of the settlement.

1. Strengthen the Methodology for Measuring DCFS Caseloads and Workloads and Allocate Resources to Lowering Caseloads

Confer with the Panel to identify options for developing a methodology that reliably measures caseload and workload relative to function. Seek opportunities to provide additional DCFS front-line staff through reallocation of existing resources and new revenue.

2. Track and Report Child Maltreatment by Group Home and Residential Provider Staff

The County should identify current reporting mechanisms for reporting abuse and neglect of children placed in congregate settings and provide the Panel with a description of steps that would be required to integrate this information into current reporting and/or report it separately.

3. Develop a Specific Plan to Increase TFC Beds to 300

The Panel recommends that time be set aside in the upcoming October Panel meeting to discuss current barriers to TFC expansion and identify possible strategies for reaching the goal of 300 beds.

4. Expansion of Intensive Home-Based Mental Health Services

The County's decision to pilot IHBS among five providers appears to be a sound strategy. The Panel recommends that as part of implementation planning, the pilot providers be asked to provide feedback on three specific areas: 1) the type and availability of services identified in needs-based planning as required by class members; 2) the training needed for successful IHBS implementation and 3) the coaching needed by staff for implementation of IHBS.

The Panel also recommends that as IFCCS team meetings occur, there should be policy and processes to ensure that CSWs are actively involved.

5. DCFS and DMH Training and Coaching

The County should develop a larger pool of full time coaches, sufficient in number to provide ongoing coaching and mentoring to staff in office settings and in actual work with families. The primary coaching focus at this time should be on identifying strengths and underlying needs of children and families, designing individualized services and supports to meet those needs and build on strengths and developing the capacity of CSWs and mental health practitioners to facilitate child and family team meetings. To achieve these goals, the County should develop a group of coaches who can also develop new coaches, allowing for a broader and more intense coaching implementation.

To expand coaching capacity, the Panel recommends that DCFS and DMH use unspent Wraparound funds to contract with a capable provider to supply skilled coaches for both agencies. The County must ensure that provider coaches are well-trained and deliver coaching consistent with the practice model.

6. The Qualitative Service Review Process

Based on the analysis summarized previously, the Panel recommends that the County:

- a. Expand the current review pool to include key stakeholders representing service providers, legal partners, staff from the juvenile justice and public health community and others;
- b. Ensure that QSR "Grand Rounds" is also used to assess QSR scoring fidelity;
- c. Develop a process for use with new and experienced reviewers that assesses inter-rater reliability; and
- d. Have each written case story carefully reviewed for fidelity to scoring guidance and congruity between narrative descriptions and case score. Cases in which incongruity exists between scores and narrative should result in a conference with the review

team and revisions in scores and/or narrative. The Panel should be made aware of cases where revisions are required.

- e. Regularly track replacements of cases selected in the sample to identify any outliers in case selection.

7. Family Foster Home Recruitment

The Panel asks that the parties confer by conference call and in the upcoming Panel meeting about the scope and causes of the placement shortage and potential foster home recruitment and retention strategies. In addition, the Panel will be identifying the additional data it may need about placement settings and availability, placement type and duration and placement changes among the foster care population.

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 Care Coordination (ICC) – ICC is similar to the activities routinely provided as Targeted Case Management (TCM); however, they must be delivered using a Child and Family Team Process to guide the planning and service delivery process. Service Components and Activities are related to the elements of the Core Practice Model.

Intensive Field Capable Clinical Services (IFCCS) – phase one of the county’s implementation of ICC and IHBS. Target population is youth who are in DCFS’ Emergency Response Command Post, Exodus Recovery Urgent Care Center, discharging from a psychiatric hospitalization, or had a response by Field Response Operations or PMRT without a psychiatric hospitalization.

Intensive Home-Based Mental Health Services (IHBS) – – IHBS are intensive, individualized, and strength-based, needs-driven intervention activities that support the engagement of the child and family in the intervention strategy. IHBS are medically necessary, skill-based interventions

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

Appendix

DCFS and DMH Training and Coaching Report

DCFS Coaching

The Panel continues to view training and coaching as a foundational element in the County's Practice Model implementation. Coaching began in Compton, then Pomona, and is now in Torrance and Wateridge. The coaching process has developed into an approach designed for each office. According to the County, coaching involves collaboration among the DCFS and DMH coaches. DCFS coaches are in the four early implementing offices five days per week with one lead/anchor coach and one coach that supplements availability two to three days per week.

The process begins with orientation to the shared Core Practice Model, including the 23 practice behaviors, for the participating units in the office. The coaches meet twice per month with the SCSWs, guiding them in how to coach workers in the 23 practice behaviors that are part of the practice model. Coaches have one or two individual sessions with each worker; they accompany CSWs into the field when possible; they provide group coaching with their units before TDMs and CFT meetings and lead debrief sessions after the meetings. Typically after six weeks, the SCSWs assume the coaching role for their own CSWs and the coaches begin the process again with the next cohort of units in the office while supporting the implementing supervisors. Assistant Regional Administrators (ARAs) and Regional Administrators (RAs) will be involved in the coaching process as well. Some ARAs have participated in being coached and have expressed interest in having a regular coaching session scheduled so that they can better support their SCSWs and CSWs. Coaches are working on developing a Coaching Group that will support leadership teams in the offices.

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

The implementing units are as follows:

Office	Implementing Units (as of 5/17/13)
Pomona	6
Compton	8
Torrance	4
Wateridge	4

Both Departments and the Panel members recognize the importance of providing support and continued professional development for the coaches. DCFS and DMH are developing an

ongoing monthly support group for the DMH and DCFS coaches who are exposed to vicarious trauma on a daily basis as they work with challenging families and sometimes resistant staff and community providers. Planning is underway to develop additional coaching capacity that would provide for additional coaches for each DCFS office. This will help ensure that the CPM takes hold, and is consistently implemented across all the life domains of families involved in the child welfare system. It is essential to provide an adequate level of highly skilled coaches in order to embed the practice model change throughout the Department.

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

DMH and DCFS report that they reached a consensus on five core trainings which included: Core Practice Model (CPM), Trauma Responsive Practice, Identify Underlying Needs, Teaming and Cultural Awareness and Humility. The following tables outline training provided and scheduled 2012 thru May 2013.

Training	Date of Training	Hosted by	Number of Participants	Participants Included:
Core Practice Model (CPM)	9/13/2012	DMH	25	Staff from Violence Intervention and Prevention (VIP) provider and DMH Children's System of Care
CPM & Coaching	10/2/2012	DMH	31	SA 2 outpatient mental providers, DMH and DCFS staff
CPM	10/2/2012	DMH	40	DCFS staff and Community Partners from SA 3
CPM & Coaching	10/5/2012	DMH	20	SA 8 outpatient mental providers, DMH and DCFS staff
CPM & Coaching	11/6/2012	DMH	12	DMH CSOC staff
CPM & Katie A. Overview	12/3/2012	DMH	31	Fee for Service Providers Network
Identifying Underlying Needs by Marty Beyer	12/3/2012	DMH & DCFS	64	Wraparound facilitators, Parent Partners, Child and Family Specialist, therapists, DMH and DCFS staff.
Identifying Underlying Needs by Marty Beyer	12/4/2012	DMH & DCFS	66	Wraparound facilitators, Parent Partners, Child and Family Specialist, therapists, DMH and DCFS staff.
CPM & Katie A. Overview	12/11/2012	DMH	38	Fee for Service Providers Network
CPM & Katie A. Overview	12/20/2012	DMH	35	Fee for Service Providers Network
Teaming Trainings	1/28/2013	DMH	30	TFC agencies, TBS, DMH and DCFS administration staff
Trauma Responsive Practice for 0-5 population	1/31/2013	DMH	69	DCFS staff, DMH staff, and mental health providers such as MAT, Wraparound, Therapeutic Behavioral Services (TBS) and Specialized Foster Care
Teaming Trainings	2/11/2013	DMH	40	MAT and Wraparound agencies
CPM	2/25/2013	DMH	26	Staff from contracted DMH Providers
Trauma Responsive Practice for 0-5 population	2/28/2013	DMH	90	DCFS staff, DMH staff, and mental health providers such as MAT, Wraparound, TBS and Specialized Foster Care
Creative Consistency in Child & Family Team Meetings	3/4/2013	DMH	44	Providers, MH co-located Staff. Target population Wrap and MAT

Training	Date of Training	Hosted by	Number of Participants	Participants included:
Identifying Underlying Needs by Marty Beyer	3/13/2013	DMH	96	54 in am session and 42 in pm session. DMH Staff, Parent Partners, Wrap Coordinators, Coaches, DCFS staff and MAT Coordinators.
CPM & Katie A. Overview	3/13/2013	DMH	9	Fee for Service Providers Network
CPM & Katie A. Overview	3/14/2013	DMH	7	Fee for Service Providers Network
CPM	3/18/2013	DMH	66	Children Providers & DMH co-located staff
CPM	3/19/2013	DMH	11	Co-located DMH staff SA 8 Office
CPM & Katie A. Overview	3/27/2013	DMH	16	Fee for Service Providers Network
CPM & Katie A. Overview	3/28/2013	DMH	20	Fee for Service Providers Network
CPM & Coaching	4/25/2013	DMH	18	DMH-CWD Administration staff
Underlying Needs	5/7/2013	DMH	56	Mat, Coaches, DCFS, DMH and Wrap Staff
Intensive Care Coordination	5/14/2013	DMH	30	Intensive field Capable Services, DMH & DCFS staff
CPM	5/20/2013	DMH	33	PSW's, Community Workers, Coordinators, Wrap, FSP & Providers.

Training	Date of Training	Hosted by	Number of Participants
Trauma Response in Infants	9/7/2012	CSOC	37
Culturally Sensitive Practice	11/14/2012	CSOC	40
Trauma Informed Care & Non-violent Parenting	11/28/2012	CSOC	28
Substance Abuse and Trauma	1/15/2013	CSOC	33
Trauma Response in Infants	2/26/2013	CSOC	37
Culturally Sensitive Practice	3/15/2013	CSOC	26

DMH Coaching

The Coaching kick-off began during the Compton Pilot in February 2012 and originally included two DMH Psychiatric Social Workers (PSW) as coaches. After completing many successful coaching sessions, the coaches shared their concerns regarding the risk of liability associated with their roles and the appropriateness of their coaching suggestions or teachings to other departments and/or agencies' staff. Due to these concerns, the DMH Risk Management Unit and the Human Resources (HR) Bureau were consulted and agreed to meet on October 29, 2012, to discuss the role of coaching with the Children's Systems of Care Deputy Director and the District Chief and Program Head from DMH-Child Welfare Division (CWD). The concerns that were raised by the DMH staff/coaches were as follows:

1. The job of the coach is somewhat unique, and it is unclear if it falls within the class specifications of the PSWII position
2. There are questions regarding the appropriateness of a DMH staff member coaching the staff of another department or staff from a contract agency

The recommendations that the Risk Management and HR staff made included:

1. Discontinue coaching to DCFS staff and contract mental health providers pending further analysis
2. Adhere to job specifications and scope of practice for the PSWII positions
3. Contract with vendors for coaching services for contract mental health providers
4. Develop coaching guidelines for review by DMH, County Counsel and the Union to determine the impact of coaching on staff and potential need for specific items

CWD discontinued coaching to DCFS staff and the mental health providers on December 6, 2012.

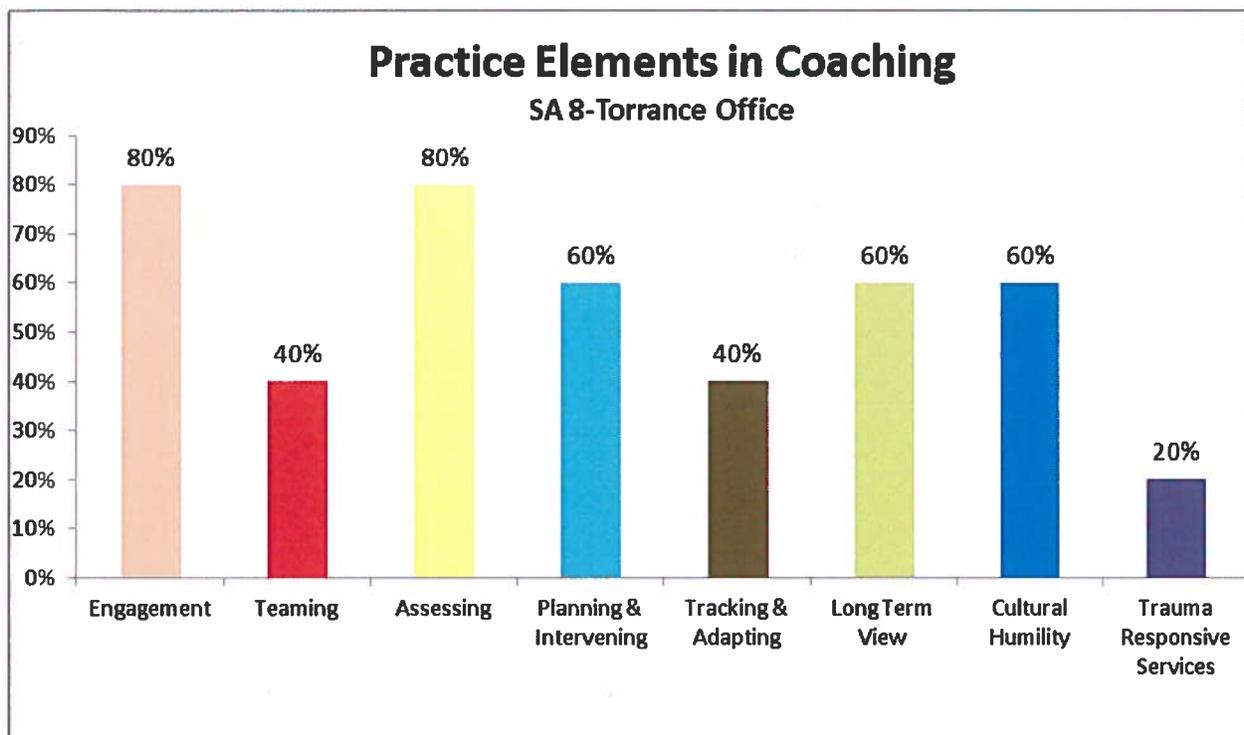
In an effort to address one of the recommendations above, CWD in collaboration with DCFS, submitted a proposal for coaching services to mental health providers to the Los Angeles Training Consortium (LATC). The contract was submitted on January 7, 2013 and approved by DCFS in mid-May 1, 2013. The contract proposes that LATC render coaching services to 20 Clinical Supervisors from 12 TFC Providers.

CWD administration and the DMH coaches met with DMH co-located administration and co-located Supervisors to apprise them on the status of coaching, to obtain input on the development of the coaching guidelines and to discuss revisions to the coaching tools. The Service Area (SA) 6 meeting was held on January 22, 2013, SA 8 was February 5, 2013 and SA 3 was February 20, 2013.

On January 31, 2013, there was a follow-up meeting to discuss coaching with DMH HR Bureau. It was agreed that DMH HR Bureau would arrange for the following:

1. Consult with County Counsel and the Unions
2. Develop a formal process for documentation by the DMH coaches
3. Revise the classification specifications to include the coaching function for all mental health positions

The first draft of the DMH Coaching Guidelines and DMH Coaching tools (see attached) were completed in March 2013. In an effort to capture information during each coaching session conducted, the DMH Coaching Data Log was piloted in the Torrance office. The coaching log that CWD has piloted is an adaptation of the log used by the California Partners for Permanency (CAPP) and is the document that is being used by DCFS' co-located supervisors at the Wateridge, Torrance and Pomona offices. The graph below represents the CPM elements that were coached to in SA 8-Torrance office.



The coach assigned to SA 8-Torrance office piloted the DMH Coaching Log, on five coaching sessions with one supervisor. As coaching continues in the SA 8-Torrance office and spreads throughout other SAs, CWD will capture the detailed information specific to the CPM elements being gathered during the coaching sessions. Due to the reorganization in the SAs, the pilot of the coaching log in SA 3-Pomona office and SA 6-Compton and Wateridge offices will be implemented at the beginning of July 2013.

DMH HR Bureau arranged a meeting on April 11, 2013 with County Counsel for further discuss implications of DMH staff coaching to DCFS staff and mental health providers. The Coaching Guidelines, data log and process tool were reviewed and recommendations made as follows:

- Replace the term “coaching” with “consultation”
- Include a dispute resolution section
- Include certification process section

- Clarify the limitations of consultation

During the meeting it was decided that DMH staff would be able to coach mental the health providers.

County Efforts to Expand Treatment Foster Care

Since October 2010, the County has participated on the two state workgroups examining various elements of TFC, including rate setting, contracting, service provision, and evaluation. In May of 2012, the workgroups were suspended in order to accommodate the state efforts in developing the Katie A. Settlement Implementation Plan and the initial draft of the documentation manual for ICC and IHBS. During the hiatus, the Special Master obtained two Medicaid TFC consultants to assist the TFC workgroup. The consultants canvassed other states that have successful therapeutic foster care systems and developed a working model for California that the TFC workgroups will use as the foundation for the re-organization of TFC. On May 16, 2013 a joint TFC workgroup was convened and started fleshing out the model for California. The County will continue to participate in the TFC workgroup through December 2013 when the final statewide documentation manual with the directives for TFC is expected to be completed. This manual and the outcome of the TFC workgroup will shape the modifications to the existing state statutes and regulations for therapeutic foster care.

LA County agreed to add three additional staff positions to support the expansion of the TFC Program in the FY 12-13 budget. These items were approved in December 2012, and both DCFS and DMH were allowed to hire a Children's Services Administrator I (CSA) and two Clinical Psychologists II (CP). The CSA I has already been hired and is currently working as a part of the TFC Administrative Team, and DMH is in the process of hiring two CPIs to help coordinate the program's clinical services, develop systematic training curriculum for staff and foster parents, and assist the Foster Family Agencies develop their infrastructure around Foster Parent Recruitment.

Beginning in December of 2011, TFC Program Management began collaborating with DCFS' Permanency and Recruitment Unit (PRU) to focus more effort and energy on recruitment and retention of TFC Caregivers. In addition to screening calls from interested foster parents and forwarding them to our program for dissemination, PRU has also provided marketing materials (brochures and promotional items) that we use at various recruitment events throughout the county. In addition, PRU has hosted a series of Faith-Based outreach events and have invited our TFC providers to participate, specifically our TFC Caregivers who serve as panel members who share their experiences with the program to other prospective foster parents.

On February 5, 2013, DCFS, DMH and their 12 contracted FFAs hosted the second annual foster parent recognition, training, and recruitment event. The goal of this event was to offer support and training to existing TFC caregivers and to help sustain existing homes. To support recruitment for the program, each caregiver was encouraged to bring individuals interested in becoming a TFC caregiver. DCFS' PRU assisted with refreshments, conference bags, and other conference materials. The training topic was "Understanding Vicarious Trauma and the Role of Self Care" and featured a guest speaker; Dr. Leslie Ross from Children's Institute, Inc. Forty-seven of the TFC foster parents attended and seven potential foster parents were identified. The participant evaluations of the event were very positive. The third annual event will be planned for February 2014.

In May 2013, LA County provided a five-day training for all TFC providers. DCFS and DMH Program Managers identified a need for a more uniform therapeutic foster care training protocol

as well as one that aligned with LA County's Shared Core Practice Model. After much comparative research, the curriculum developed by Brad Bryant and Michael Johnan of People Places, Inc. was ultimately selected. It is one of the most respected therapeutic foster care programs in the country. Brad Bryant delivered the training in LA. The main components of the training included: a one-day overview of the goals and basic principles in therapeutic foster care model including staff development and recruitment strategies; a three-day train-the-trainer introduction and skills-building module which serves as the pre-service training curriculum for therapeutic foster parents; and finally a one-day hands-on application of the underlying principles in the training curriculum with current Intensive Treatment Foster Care foster parents. Three representatives from each of the twelve TFC providers attended all five days. The training emphasized the importance of the foster parents' relationship with the youth, the family, and the professional team. The curriculum is child-focused and promotes the examination of behaviors as a pathway to uncovering underlying needs. Each provider was given two sets of training materials. The TFC Program Management are optimistic that the use of this curriculum as the foundation of the TFC program will allow not only for a more uniform approach to TFC service delivery, but also as a means to deepen the understanding of the TFC youth and their needs. The principles of this curriculum as well as the Core Practice Model will be reinforced through monthly Roundtable meetings that include opportunities for coaching and case consultation.

In January 2013, DCFS initiated, as part of its general strategic plan, a TFC workgroup to examine the barriers to increasing capacity within the TFC Program and to develop strategies for improvement. The workgroup is co-chaired by two DCFS managers not heretofore involved with TFC. The workgroup members include: the DCFS TFC Program Manager, the DCFS PRU Manager, five other DCFS Managers, and the DMH TFC Program Supervisor. The workgroup has developed an objective and timeline to meet the target of 300 beds by December 2014. Action items will include: (1) a collaborative meeting with the Executive Administrators of the twelve TFC providers on June 19, 2013 to collect their input on the barriers and possible solutions; (2) surveying the TFC provider recruiter, ITFC staff, and their foster parents to obtain feedback from the direct service agents at each TFC agency; and (3) using the findings to revise the current TFC Contract and Statement of Work to strengthen the expectation of program growth.

DCFS Efforts to Reduce Caseload and Workload

DCFS has continued with rigorous development of its Departmental Strategic Plan with Strategic Plan Objective Teams forming and completing work in key areas related to safe caseload and workload reduction. Implementation of the Shared Core Practice Model is at the top of this list along with other key initiatives around coaching and training. Key areas of focus and updates for the same through January 2013 are included below.

- Initiated a Departmental Reorganization which focuses on increased accountability and responsiveness especially in the initial phase of engagement, investigation and service delivery (Emergency Response)
- Continued implementation of Data Driven Decision Making to review statistics linked to key outcomes and improve performance including a newly installed data dashboard to allow staff to monitor performance measures
- Initiated a rewrite and overhaul of the Department's Policy Manual and system to access the same with improved search capability, plain language content and linkage to practice guidance based on the Core Practice Model
- Reduced children under 12 in group home placement from 179 to 104 (42%) through development of accelerated placement teams
- As part of the Strategic Planning process, began a redesign of the IUC Academy to improve staff training and develop a DCFS University model to enhance learning, evaluation and skill development
- Initiated an Education Based Discipline program with SEIU to make discipline more appropriate and improve performance thus maintaining increased workforce capacity to serve children and families
- Purchased 275 i-Phones with "talk to text" for Emergency Response Workers to pilot improved communication, to streamline work, increase safety and expedite completion of case records
- Initiated a Caseload Equity Analysis designed to accurately deploy staff to Regional Offices, ultimately in support of Core Practice Model implementation
- Redesigned the child fatality review process to concentrate on "systemic issues" and expedite the disciplinary process
- Successfully completed the IV-E Waiver base period with measureable progress identified in an
- LA evaluation submitted to the State for submission to the Federal Government
- Initiated research into a new risk assessment tool designed to assist workers
- Successfully managed a budget of \$1.8 billion serving over 35,000 children and families
- Developed a High-Risk Youth Project to ensure placement of youth in the least restrictive setting and provide
- Developed a new SDM tool to identify youth who are at a risk of becoming delinquent before behaviors escalate which automatically alerts staff so action can be taken

- Implemented a new web-based solution to speed up getting results of drug testing and eliminated the need for manual faxing of 20,000 test results
- Developed an automated system which is in test mode to allow staff access to academic information from LAUSD
- Expanded the use of the Court JADE system to all users to improve access to minute orders and court reports
- Successfully finalized over 1,500 adoptions
- Successfully reunited more than 9,000 families to ensure permanence
- Responded to more than 180,000 allegations of abuse and neglect
- Increased Timely Response to ER Referrals (Immediate response) from 97% to 99%
- Participated in more than 100,000 Judicial Court hearings on behalf of children
- Increased Timely Response to Five Day referrals from 94% to 97%.

Some of the most important accomplishments are through the IV-E Waiver where the out-of-home care has dropped by over 5,000 children and the average length of stay in care has dropped by 38%.