

**The Katie A. Advisory  
Panel  
Fifth Report to the Court  
August 16, 2005**

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

The following Fifth Report to the Court outlines the Department of Children and Family Services' progress toward achieving the objectives of the settlement agreement and includes a description of its compliance with Paragraphs 6 and 7 of the settlement agreement. The report also responds to the questions raised by the court in its order of June 2005.

**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 (in 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;

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

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

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

Additionally, the Settlement directs that:

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

### **III. PANEL ACTIVITIES SINCE THE FOURTH REPORT**

Since the last report, the Panel has conducted the following activities:

- Meetings with DCFS and DMH staff regarding Katie A. implementation
- Meetings with providers about claiming federal funds for mental health services to class members
- Meetings with DCFS SPA staff, local DMH staff and providers about the progress of Katie A. Implementation
- Participation in 5 DCFS workgroups: (1) Reduced Reliance on Out-of-Home Care, (2) Fiscal Planning, (3) Practice Change, (4) Tracking Outcomes, and (5) Implementation of the Strategic Plan.

### **IV. STATUS OF DCFS PLAN DEVELOPMENT**

#### **Background**

Other than monitoring and evaluating DCFS implementation of the settlement agreement, the key role of the Panel is to provide guidance and advice regarding strategies to achieve the objectives of the Agreement and to determine whether the County plans are reasonably calculated to achieve those objectives. In an effort to comply with these directives, the Panel requested, as early as June 2003, that the Department provide the following degree of detail in developing implementation plans.

- Discrete steps for implementation
- Specific timeframes and assignment of responsibility
- Scope in terms of individuals served
- Infrastructure, staffing and training changes and supports
- Goals and expected outcomes
- Cost and budgetary projections

None of the information was provided and until the Court's Order filed October 27, 2004, the Department embarked on implementation initiatives without providing the Panel with any plans, and without seeking or considering its guidance or advice.

The recent joint work of the Panel and DCFS Workgroups has provided a more functional process for plan design; however, detailed plans have still not been developed. In February 2005, in anticipation of this report to the Court, the Panel again requested an update on plans and implementation related to Paragraph's 6 and 7. In April 2005, the Panel received more detailed implementation plans for some initiatives. In response to the Panel's draft report issued June 16, 2005, the Office of County Counsel responded with a letter on July 22, 2005 criticizing the report and attaching a Draft Plan. This plan is another intention to plan and its primary new substance involves asking for funding to add up to another 200 DMH staff. Like the previous initiatives, the July plan falls short of providing enough detail to determine its viability

The County acknowledges that the Plan is incomplete and anticipates filing a more complete plan by August 16. The Panel does not anticipate seeing that draft plan in time to incorporate comments about it in this document.

In addition, the DCFS work groups function independently, with little integration of approaches and initiatives that are occurring concurrently. For example the Multidisciplinary Assessment Team effort, intended to develop better assessments for children in the system, has little or no connection to the need to expand home and community based mental health services for the plaintiff class. If they are effective, these assessment teams will undoubtedly identify needed services that are beyond the current capacity of the system to deliver. Yet there is no detailed plan to expand the availability of mental health services to meet identified needs.

The Department's response to the Katie A. settlement agreement has always been secondary to its broader child welfare improvement agenda, which is reflected by the fact that two years after the settlement agreement was approved, there is no detailed, comprehensive and integrated DCFS implementation plan regarding Paragraphs 6 and 7.

### **Assessment of Current DCFS Plans and Implementation**

The following is a brief summary of the status of DCFS initiatives within Paragraph 7 and those issues that the Department states are relevant to elements of Paragraph 6.

#### **Named Plaintiffs'**

##### ***• Immediately address the service and permanence needs of the five named Plaintiffs***

In response to this directive, DCFS reports that three of the named Plaintiffs' court cases were closed (J in July, 2003; G in March, 2004; and M in January, 2005). J was reunited with her family. G lives out-of-state with his father and M emancipated. H was reunited with his mother with wraparound services for a year and then returned to care following allegations of abuse by her. DCFS reports that a temporary, individualized therapeutic placement was created for him and he is ready to transition to a family willing to make a permanent home for him. K, after being provided Wraparound services, was in abscondence and her DCFS case was recently closed. She had been in foster care most of her life and was profoundly damaged both by early maltreatment and failure to provide trauma treatment and a permanent family home earlier in her life.

## **Structured Decision Making**

### ***• Improve the consistency of DCFS decision making through the implementation of Structured Decision Making***

DCFS reports that "all line staff have been trained to use SDM and current DCFS policy mandates its use by staff. As a result, there has been a decline of 23% of children in care since 6/02."

While the Panel commends decreases in children entering care and increases in children served in their families, it is difficult to assess the impact SDM has had on these changes, as the numbers of children in custody were declining before SDM was implemented

Declines in the number of children entering care must also be distinguished from the number of children in care because exits from care due to aging out or running away, being transferred to juvenile justice and adoption are not influenced by the use of SDM. Further study of those data is needed. However, the Panel is of the opinion that the Department did, as required in the Settlement Agreement, implement Structured Decision Making.

Existing staff was trained in the process originally in many large one-day meetings. Given the staff reductions in the Department's training office that occurred in the DCFS effort to redeploy non-case carrying staff to the field, a primary concern of the Panel is the Department's ability to deliver SDM training to new staff that have been hired since initial implementation.

## **Expand Wraparound Services**

DCFS reports that "in July, 2003, there were a total of 322 children who had received wraparound services. In April 2005, a total of 756 children have received wraparound services, with a current enrollment of 415 children. 848 DCFS staff members have attended training on Wrap, in addition, trainings have been held during general staff meetings in regional offices and in unit meetings in regional offices. There are currently 20 staff members dedicated to providing Wrap services and 8 agencies that deliver Wrap services. In 12/04 the state ordered DCFS to end Wrap enrollment for all federally eligible children, hence at this time DCFS is only able to enroll non-federally-eligible children. The State has negotiated to continue to fund currently enrolled federally eligible children until 6/05. As a result there have been significant challenges to the continuing expansion of Wrap in L.A. County."

A Panel member recently met with a number of Wraparound providers and found a consistent pattern of under claiming available federal dollars. One agency downsized its staff unnecessarily due to lack of knowledge of federal claiming practices. The Panel will discuss this issue further in another section of the report.

DCFS is currently working with the CAO, DMH and probation to explore alternate funding sources for Wrap and expects to make a recommendation to the Board of Supervisors regarding an alternate payment structure for wraparound services." Recent developments, while not having been approved by the Board of Supervisors, are encouraging. DCFS and Mental Health are in the final stages of approval of a new Request for Qualifications (RFQ) for Wraparound providers which intended to expand Wraparound services to 920 children. DCFS estimates that the RFQ would be released by September 2005 with additional providers selected by December 1, 2005. The Panel has not seen any written plan for this initiative and does not know if the County considers it a part of their Katie A. obligations. The Panel looks forward to receiving the Department's plan for implementation.

Parallel to this, the previous EPSDT audit conducted by a panel member, mental health and DCFS has concluded that there is substantial opportunity for maximizing EPSDT. As a result, DCFS has been able to construct a blended funding rate which they feel will support the continued expansion of Wraparound services to Federally and non-federally eligible children. To support the expansion effort the Department has recently begun EPSDT trainings (jointly delivered by DMH and DCFS). To date all current Wraparound agencies have participated. The Panel has not seen a training plan, but the Department reports that the first phase training appears to be on track. Both Departments have indicated that they are intending to provide ongoing training to ensure EPSDT maximization is achieved.

The Panel commends the county's achievement from data indicating that L.A. children who graduate from wraparound are significantly less likely to re-enter DCFS jurisdiction six months later compared to children who did not get wraparound. In a follow-up of twelve children who graduated from Wrap only one re-entered foster care a year later.

The Panel notes that about two-thirds of the referrals to wraparound are from DCFS, but the proportion of DCFS children/families currently in Wrap is unknown. The other children are DMH or Juvenile Justice clients.

The Panel has consistently raised the issue of quality in Wraparound: however, there has not been a concerted DCFS effort to address this issue. DMH recently acknowledged that the quality of wraparound services was variable across the eight providers, with the original three wraparound providers (who received longer and a higher quality training) providing the best services.

The Panel recognizes that even if resource issues were resolved, the current Wraparound providers cannot expand to serve thousands of class members. Consequently, the Panel has urged DCFS and DMH to embrace a shared set of practice standards and ensure widespread expansion of Medicaid-funded, intensive, home-based services, utilizing the practice principles of evidence-based approaches, but not solely through Wraparound programs.

## **Implement Team Decision Making (TDM)**

DCFS reports that "during the last quarter of 2004, 750 Team Decision-Making meetings were held by DCFS [and] 716 TDMs were held during the first quarter of 2005. There are currently 40 budgeted positions to provide TDM and FGDM services within DCFS. The TDM policy is currently in draft form and is being reviewed by the Annie E. Casey Foundation. At this time, TDM is used when a child is identified as being at moderate to high safety risk, to discuss initial placements for children, moves to less restrictive settings, termination of parental rights, guardianship, long term foster care or reunification." In the July 22, 2005 letter, County Counsel corrected this quotation from a DCFS document, indicating that "TDM is only used at the point that placement decisions are made and is not utilized to decide termination of parental rights or recommendations for guardianship or long term foster care.

The Panel commends any steps to consistently strengthen the process of deciding to remove a child or change a child's placement. Based on experiences in other states, the Panel recommended against (a) reliance on designated facilitators, because when case workers or supervisors convene their own family meetings, they use of family meetings more consistently throughout the case, not just at points of crisis; and (b) TDMs and Family Group Decision Making instead of a single method of family meetings that could be used from the first day of a case to case closing. Elsewhere, TDMs tend to be less inclusive of family members because of the placement focus of the approach, in contrast to early family meetings with family-professional collaboration. Since DCFS has gone ahead with facilitated TDMs and FGDMs, the Panel believes that carefully designed outcome studies and feedback from families must be employed to evaluate these approaches.

The information provided about TDMs by DCFS does not indicate how often extended family actually attends meetings, and if they do, whether placement with them is considered in lieu of foster care. Nor do we know that TDM occurs, as prescribed, within 24 hours of removal. To comply with this requirement of the settlement agreement, DCFS would have to demonstrate that there are enough facilitators for family meetings to occur within 24 hours of placement and would have to have the capacity to track when a TCM occurred and whether family members participated in each case in each office.

It is the opinion of the Panel that the Department has implemented TDM on a very small scale, but that there is little capacity to support the majority of class members and other children with family meetings designed to plan services and respond to crises.

## **Expand the Use of Family Group Decision Making**

DCFS reports that "since 6/04, there have been 340 FGDM meetings held, however, the number of meetings is declining as other teaming methods have enjoyed greater use. DCFS's goal is for the use of FGDMs to return to the pre-7/6/04 level of 64/month by 7/05. FGDM is used following TDMs when a facilitated, more in-depth process is needed

to gain consensus within the family and community. There are currently 40 budgeted positions to provide TDM and FGDM services within DCFS. Since 1998, approximately 440 DCFS staff have received FGDM training; 60 staff have received advanced coordination and facilitation training. L.A. County is hosting American Humane Association's 2005 conference on FGDM. DCFS's goal is to use FTDM (Family Team Decision Making – see below) for all children who require intervention by DCFS." DCFS planned to have all 21 DCFS offices with at least one trained FGDM facilitator and at least two units in each office volunteering to incorporate FGDM in their daily practice.

In May 2004, DCFS proposed a description of FTDMs as family-centered, avoiding the use of a full-time facilitator, and as a routine method of assessing needs and planning for all children and families throughout the life of the case. FTDM meetings were not to be used only for placement disruptions or emergencies, but rather as a routine practice of continuously engaging the family to help anticipate and resolve crisis situations. The Panel has seen no follow up attention to this draft concept.

The most recent information DCFS has provided describes Family-Centered Team Decision-making as the coordination of TDM, FGDM and regional permanency review teams in "a continuum of care where families will be heard, respected and valued." This "continuum" could mean three different meetings with different facilitators and different participants at each meeting. The description indicates that extended family and other individuals identified after the TDM would be included in the FGDM. This is a good idea, but is not an argument that supports differentiating TDMs from FGDMs. From the perspective of the family, a seamless series of family meetings using the same approach, convened by a familiar person (preferably their caseworker) makes more sense than a "continuum" of TDM, FGDM and RPRT with different participants each time. In addition, a seamless approach to family meetings would not be event-driven, but family meetings would occur throughout a case to assure that services being provided were effectively building on strengths and meeting the child's needs.

The Panel has described the training and coaching necessary to help caseworkers and supervisors develop the skills and confidence to facilitate strengths/needs-based service planning meetings instead of relying on facilitators. The training must be done by an individual who has led these meetings. Each worker must be coached as they lead a meeting. In the process, staff learn the complicated skill of how to identify the underlying needs connected to child safety, attachment and behavior. They also learn how to help a family and professionals collaborate in designing individualized services that will support the family and a foster family in meeting the child's needs and building on the strengths of the family.

The Panel believes that every caseworker should have a way to report in the DCFS information system when they have a meeting with the family (and foster family) present, or staffing with professionals (without the family). This would make consistent studies possible of, for example, the number of cases opened since mid-2004 that have had family meetings, and how frequently, correlated with outcomes such as speedier

reunification. Consistent feedback from families and foster families on cases with and without family meetings should also be compiled. Workers should receive both recognition for effectively utilizing family meetings and documentation of the positive outcomes of family meetings.

It appears to the Panel that the Department has implemented Family Group Decision Making. In fact, the initiative was begun prior to the execution of Settlement Agreement. Based on these sentences in our draft report, the county concluded that the Panel believed that Family Group Decision Making has been satisfactorily implemented. However, as we said in our draft by intentional design, recent use of this resource has declined in favor of the use of Team Decision Making. Moreover, the Department lacks the capacity to report on how many families have family meetings and what the obstacles are to having more family meetings. Last, the training staff have acknowledged that a major problem faced in the reform is the lack of agreement about a single method for family meetings, making it in their view very difficult to train staff to convene some of their own family meetings as the Panel has recommended.

### **Ensure That the Needs of Members of the Class for Mental Health Services are Identified and That Such Services are Provided to Them**

The July 22, 2005 letter from the County made it clear that DCFS is taking responsibility for assessment of children's mental health needs and DMH for enhancing and expanding services for class members. The Panel has commended the expanded collaboration between DCFS and DMH. The plans for unfolding the Hubs and MAT from DCFS are far more detailed than the DMH plan for expanding services and the expansion of the same interventions is unlikely to meet the needs of class members. The Panel's advocacy for DCFS and DMH training and coaching of staff is to ensure that the assessment of children's needs leads to family and foster family involvement in services and referral of children and families to effective services. The Panel's advocacy of improvements in the FFAs and design of intensive home-based services for children instead of group care are also components necessary to meet class members' needs. But the Panel's criticism of the county's lack of detail regarding expansion and improvement of mental health services is primarily a DMH problem.

#### ***1. The Hubs***

DCFS reports that "Board approval was sought and granted to create the first medical/mental health Hub in order to provide medical examinations and mental health screenings for all children served by DCFS on a 24/7 basis in order to quickly identify medical and mental health needs of children and to make appropriate placement and case plans. DCFS has agreed to contribute funding for costs not billable to EPSDT or other funding sources with MCC funding. Presently VIP at L.A. County USC is open and providing services. Other sites are being explored and negotiations have begun with at least four other sites. DCFS is exploring tracking methods to document the services children receive from Hubs and to ensure that necessary follow-up services are delivered. This tracking system will also serve to monitor performance measures and quality

assurance measures. DCFS procedures for use of the Hubs...[and] implementation plans specific to each Hub...have been drafted." DCFS has kept the Panel informed of discussions with each of the Hub sites regarding their capacity for medical and mental health assessments and referrals.

The Panel commends DCFS for trying to achieve universal mental health screening for detained children in compliance with EPSDT. We have no way of knowing the specific impact of the Hubs on the member class. We are looking forward to data on how many children who are screened require mental health services, the effectiveness of the Hubs in steering the family/foster family to the right services for the child and themselves, and the success of these services in meeting the needs identified in the screening. We have asked about the connection of the Hubs to the child and family worker and have been told that DCFS staff will be outstationed in the Hubs. Crucial evaluative information should be collected regarding the services recommended by the Hubs and the availability of those services within easy access of the family/foster family, and whether they are receiving those services and their effectiveness. This information should then be fed back to DMH and DCFS to plan needed expansion of services to the class.

Two Offices report that they do not currently send children to the one existing Hub for evaluation because of its distance from their regions. It follows that until the Hubs become more widely dispersed, the mental health treatment needs of many class members will not be identified at intake through use of this service.

The County Department of Mental Health has recently, however, directed 3.2 million more dollars of Medi-Cal in FY06 to meet the mental health needs of class members served through the Multi-Disciplinary Assessment Teams and Assessment HUBS. This modest step represents one of the first tangible efforts to expand the availability of mental health services. No plan describing this initiative has been provided to the Panel

## ***2. The Multi-Disciplinary Assessment Teams (MAT)***

DCFS reports that "Board approval was sought and granted to work with DMH to create Multi-Disciplinary Assessment Teams (MAT) to provide comprehensive assessments of children's mental health, developmental, and educational status and to provide linkage to service providers within 30-45 days of detention. Following a successful pilot of this project, the scope of MAT provider contracts has been revised. Staff in SPA 6 will be trained...and MAT will begin in 5/05; MAT will begin in SPA 3 in 6/05. 2005-2006 EPSDT funds will be allocated to fund services to approximately 2,052 children projected to be detained and CalWORKS allocations have been identified to meet the service needs of the adult family members. Performance indicators have been identified and will be tracked. Rollout to the other SPAs will be forthcoming." In March 2005 DCFS and DMH collaborated on a MAT manual that describes the initial screening, comprehensive assessment, referrals, and tracking.

The Panel commends DCFS and DMH for strengthening the process of engaging families in the assessment of children's needs. All children new to DCFS who are class members

should be identified through the MAT and provided assessment and referrals. However, the Panel is concerned about the slow replication of MAT, the planned connection between MAT and FTDM/FGDMs, and the lack of sufficiently intensive services to meet the needs of class members once those needs have been identified. Elsewhere in the country intensive home-based services have been defined and paid for through Medicaid. The slowness of DMH in expanding evidence-based services by private and public mental health providers is a major obstacle.

DMH managers indicate that their concern is the absence of mental health, domestic violence and substance abuse treatment services for family members and the lack of funds for DMH to expand those services. The MAT was piloted successfully with Shields, a provider with its own substance abuse programs for adults, but this service is lacking in many children's mental health providers. Where services for adults are insufficient, MAT in every SPA must arrange for children's caretakers to have their service needs met by other community providers and bring together a team around the family to convene the family meeting, coordinate the providers' work to meet the children's needs, and to make sure the caretakers are receiving sufficient services to meet the children's needs.

A Panel member circulated a definition of intensive home-based services to meet the needs of class members and support their caretakers that includes wraparound and evidence-based approaches. Intensive home-based services could be offered by any provider using Medicaid funds (including those providers not currently offering wraparound or TBS services) and could serve both children in their families and in foster families. The Panel proposed an approach to dissemination of innovation would result in a dramatic increase in all parts of the county of mental health providers adhering to the clinical principles of services that have been demonstrated effective elsewhere. For example, the efficacy of trauma intervention through cognitive behavior therapy has been demonstrated and could meet the needs of many class members in each SPA, but providers must be guided in implementing it for thousands of children and families/foster families.

Implementation of MAT has begun, but is at the early developmental stage. As a result, it has little impact on class members two years after the settlement agreement was approved. The Panel has a serious concern that plans to expand mental health services have not matched the energy and resources invested by DCFS in creating a system to identify the need for them.

### ***3. Improvement in D-Rate Homes***

DCFS reports that it "...has revised its procedures regarding the authorization of supplemental foster care payments to foster care providers. Although the initial assessment of the child's eligibility to receive the supplemental rate will still be made by DMH, D-Rate section staff will review each child's case every six months following the initial authorization. This review will determine if the child still meets the criteria for D-Rate, and also...determine if the child is receiving appropriate services in order to meet

his/her special needs. If not, the D-Rate staff will work with DMH to determine if the child's treatment or case plan needs to be revised. The goal will be for the child to get well and ameliorate the need for the D-Rate. Community forums to explain these changes and to receive feedback on D-Rate services for foster children have been held. DCFS staffing has been hired and DMH has agreed to provide co-located staff for this project. D-Rate staff will be outstationed in the SPAs."

After the Panel released the draft report, DCFS informed us of two important elements of the D-Rate program. The Clinical and Placement Support (CPS) section is "designed to provide direct placement support to foster homes, FFAs, legal guardians, relative homes, private providers and other County agencies. CPS specialists will be available on a constant and immediate basis to help with crisis situations, mental health and psychotropic medication issues, behavioral problems, process concerns, placement resources and other interventions. In addition, CPS staff will send out notifications to social workers for all psychiatric hospital admissions so that hospitals can more easily access the worker."

The Panel's continuing concern has been the lack of sufficiently intensive services to meet the needs of class members, including home-based guidance for D-Rate foster parents. At this point, DCFS and DMH efforts to improve supports for D-Rate providers and children have not had a significant impact on the plaintiff class.

#### *4. Children in FFAs*

DCFS has not yet included this goal in its planning matrix, but the Panel, DCFS and DMH are in agreement that a collaborative process will be undertaken to ensure that services that effectively build on child and family strengths and meet children's needs are provided for class members in FFA homes (including the outcome measure that children not be moved from home to home within the FFA). A study similar to the Panel's D-Rate study will be undertaken in the FFAs, which house many more children (and presumably more class members) than the D-Rate homes. A crucial question will be to what extent sufficiently intensive services to meet the needs of class members and guidance for foster parents is being provided in the FFAs.

In the July 22, 2005 letter the Panel was informed that the FFA study was conducted by an outside researcher. Recent reports from the department indicate that the study was completed and that the data is currently being analyzed by the researcher. DCFS anticipates that the first draft of the report will be available by August 15, 2005. The Panel supports a carefully-designed assessment of the needs of class members in FFA homes, what services would meet those needs, what services they and their caretakers receive, and how services must be improved to meet their needs and support their caretakers (in part to reduce the high multiple placement rate within FFAs).

**Enhance Permanency Planning, Increase Placement Stability and Provide More Individualized, Community-based Emergency and Other Foster Care Services to Foster Children (Including Closing MacLaren Children's Center).**

*1. Points of Engagement (POE)*

DCFS reports that "after a successful pilot program POE is being expanded throughout the Department. Training is occurring in the Metro North, West LA, Torrance and Pomona offices. Full implementation of POE in these offices, as well as Compton and Wateridge will begin 6/05. The program will be Department wide by 4/06. POE will offer Differential Response by diverting unfounded referrals and families at low risk to community service providers. Alternative Response will serve families with low to moderate risk factors with interventions such as voluntary family maintenance services and family preservation. POE will integrate with Hubs, MAT and Concurrent Planning. The goal of POE is to intervene earlier with families at lower risk in order to improve the quality of care for children and to ensure that families get appropriate interventions in a timely manner to reduce the rate of recurrence of maltreatment to children."

The Panel was impressed with how completely DCFS staff in Compton embrace a philosophy of engaging families and their excitement about improved outcomes resulting from their change in philosophy. The Panel's continuing concerns about POE are that while it represents the practice change that all DCFS and DMH child mental health provider staff should adopt, achieving this change requires committed leadership at the SPA and Office levels and requires intensive skill-based training for workers of significantly more than the one-day event that DCFS plans to utilize. Additionally, for children with emotional and behavioral needs that make them new members of the class and whose families and foster families require special support beyond the services available through family preservation, family maintenance and outpatient mental health services, POE will have difficulty locating sufficiently intensive services to meet their needs.

DCFS released a supervision policy with laudable objectives including, among others: (a) develop CSWs who will use good judgment in making decisions and empowering families to make good decisions to keep children safe; (b) direct CSWs to focus on the family and to seek realistic solutions that result in good outcomes; (c) emphasize with CSWs the importance of partnering with families; and (d) evaluate for strengths and possible solutions from the family's perspective and work towards family-driven solutions that are created in collaboration with the family. These goals of supervision are included in a policy with SDM, although it will do little to achieve the change of practice represented by these practice improvements. The Panel has previously described the training and coaching necessary to help caseworkers and supervisors change their philosophy to conform both to this policy and to the approach of POE.

The Panel believes that the POE effort has promise, but that it has not yet impacted the majority of children and families served by the system. In addition, there needs to be a

consistent structure of clear performance expectations, training curricula, skilled trainers and local mentors to move this initiative beyond one innovative office.

## ***2. Concurrent Planning Redesign***

DCFS reports that "the Concurrent Planning Redesign Pilot will restructure case management responsibilities such that Adoption staff are assigned to the child's case much earlier in the life of the case so that the child will achieve permanency at an earlier date. Points of Engagement, Family Centered Team Decision Making and other teaming practices will be integrated into the Concurrent Planning Redesign. The pilot will begin in five DCFS offices; training has been completed in two offices, two offices have begun the pilot; all five offices will have begun the pilot by 6/1/05. A DCFS labor-management team will make a recommendation to the Exec Team regarding Department wide implementation of the CP redesign by 9/05. Existing DCFS staff will staff the redesigned program. The goal is to comply with the Federal goal of finalizing 32% or more of all adoptions in 24 months. DCFS plans to finalize 4,000 adoptions within 2005."

At this point, the Panel has not examined this initiative.

## ***3. Implementation of Permanency Partners Program (P3)***

DCFS reports that "the initial pilot of P3 in Lakewood was begun 10/04, targeted to foster youth ages 12-18 who had been in foster care for over 24 months who have no permanent connection to a responsible adult. The goal of P3 is to increase the number of youth who exit foster care with a legally permanent family. It has been deemed successful and is being expanded to eight more offices. The process includes intensive efforts to locate extended family, former foster parents, or others who had or have a relationship with the child that could lead to a permanent family. DCFS has received authority to hire 44 more retirees on 120-day contracts; they will begin training the week of April 18, 2005. Department wide implementation is scheduled for FY 05/06. Funds diverted from MCC funding will be used in the expansion of the pilot. The procedure governing P3 has been drafted and performance indicators have been identified through CWS/CMS and a supplemental tracking system."

At this point, the Panel has not examined this initiative.

## ***4. Reduced Reliance on Out-of-Home Care***

Workgroup 1 (Reduced Reliance on Out-of-Home Care) has been conducting two processes to impact the number of children 12 years and younger in group care. The first is an effort to systematically review the placements of all children under 12 years of age. This effort is based on the results of the John Lyons report that indicated that approximately 57% of the children in care could be served in less intensive community settings. The second is the implementation of a provider community Group Home Work Group. This workgroup is constructing a model for the utilization of group care and attempting to build consensus about the role of congregate care in a system of care.

Recent developments in this workgroup have focused on beginning a process to develop a centralized, comprehensive, and systematic assessment and placement decision-making process. The Panel has repeatedly suggested that the county develop a comprehensive Clinical Utilization Management Process to effectively manage the intake and discharge into congregate care. This is seen as the only viable way to ensure the provision of community home-based services and to ensure that children that actually need this level of care are not warehoused beyond their need for service. The Panel is encouraged at this recent development. Together these two efforts have resulted (as verbally reported by DCFS, on August 10, 2005) in a decline of children 12 years and younger in care from 570 in September 2003 to 405 as of August 10, 2005. It is estimated that 40 additional children will transition to home and community family-based service options by September 30, 2005. The success of these efforts have been recently accelerated by the department engaging in an intensive family finding process supported by national consultants. The department has agreed to develop a plan to focus the pilot intensive family finding effort on the recent of the 12 and younger children.

A missing piece of this effort is a viable parallel effort to develop intensive home-based services to support these children once they leave the confinement and structure of group care. It will take more than a focus on placement decision making to assure that these children achieve safety, stability, permanency and well-being in those placements.

## **Reporting Outcome Trends for the Plaintiff Class**

### **Data and Outcome Trends**

The Department's workgroup on data has been working cooperatively with the Panel for the past year to produce data on key outcomes that will inform the court and parties about the impact of the Department's implementation of the Katie A. settlement agreement. The Department recently produced trend data for the general DCFS population for the baseline year, 2002-2003 through December 2004. The Department also provided point-in-time and entry cohort data for the proxy for the plaintiff class for the same time period. These data provided a "point in time" snapshot of data indicators by month and for children in foster care, trends by entry cohort (meaning tracking groups or cohorts of children separately, based on the year they enter foster care). Tracking progress by entry cohort provides additional information about performance, because the status of children who entered care after the settlement agreement can be tracked annually, separately from children that may have been in care for many years. Cohort data provides a more accurate picture of progress than point-in-time data alone.

The DCFS information system does not distinguish children who are class members from those who are not. To attempt to track the plaintiff class, the Panel and DCFS agreed on a proxy population that based on selected characteristics, undeniably consists of children with significant mental health needs. The number is considerably less than the size of the total plaintiff class, but provides a basis for measuring progress among a percentage of the class. The indicators of class membership are children in D-Rate homes (foster homes for children with special emotional/behavioral needs), children served in

Wraparound programs, children in higher-level residential facilities and children receiving services through the Department of Mental Health (DMH).

Unfortunately at this time, the DMH data system does not accurately track the receipt of mental health services for all children, meaning that many DCFS children who also receive mental health services cannot be identified, resulting in a considerable undercount of children who would be class members. DMH hopes to be able to provide information on receipt of mental health services for all children in the future.

As a result, DCFS and the Panel are unable to provide the Court with any reliable data on whether the Department is making progress in improving outcomes and/or achieving greater access to mental health services for the plaintiff class, based on evidence found in data trends.

## **V. PANEL'S DETERMINATION OF DCFS COMPLIANCE**

The Panel has determined that the Department is not in compliance with the provisions of the Settlement Agreement, for the following reasons.

1. The Department has not provided the Panel with viable plans for implementation of the provisions of Paragraphs 6 and 7, sufficiently detailed to permit the Panel to make a judgment about their efficacy.
2. Implementation of initiatives within Paragraph 7 and which the Department believes relate to Paragraph 6, such as TDM, FGDM, MAT, HUBs and Wraparound, are either quite small in scope or at the early planning stages and as a result, affect only a small portion of class members. The Panel has yet to be informed of the Department's detailed plans regarding expansion.
3. There has been little or no expansion of home and community based mental health services for the plaintiff class and staff in the field report that access and wait lists are a significant problem for these children. As of yet, DCFS cannot even accurately identify plaintiff class members.
4. The collective data systems of DCFS and DMH do not yet permit the services provided and outcomes of class members to be tracked over time.

## **VI. RECOMMENDATION ON CONTINUATION OF THE PANEL**

The settlement agreement provides two years from the date of the court's approval of the settlement, the Panel is to address whether there is a need for the Panel to continue to meet. There is a need for the Advisory Panel to continue because the County (DCFS and

DMH) has not fulfilled the objectives of Paragraph 6 nor met all the objectives of Paragraph 7 of the Settlement Agreement. Although the parties recently reached a stipulation to continue the Panel for an additional year, the Panel has outlined below the reasons that it believes continuation of the Panel is necessary.

As Dr. Sanders emphasized in his first meeting with the Panel, his goals for DCFS are to reduce removals and re-abuse and to increase permanence. These are commendable goals and they exemplify the Department's focus on changing how it serves everyone within its area of responsibility. Undoubtedly the successful achievement of these broad goals will benefit many class members, but until the Court's Order docketed on October 27, 2004, the Department had largely disregarded its specific responsibilities to the Katie A. Class. The differences between the County's and the Panel's positions as to what Paragraph 6 requires for expansion and improvement in services specifically designed to meet the needs of class members undermined the first eighteen months of our work. Additionally, frequently DCFS failed to respond to Panel recommendations or requests or failed to inform the Panel of relevant initiatives in a timely manner.

A stunning example of the Department's unwillingness or inability to keep the Panel informed of vital plans for organizational change occurred during the week of June 13, 2005. The Panel has repeatedly criticized the Department's training for staff. The position of DCFS has been that revising the pre-service training curriculum is outside the scope of the Settlement Agreement and the purview of the Panel, a position reiterated by the Director on June 1, 2005. In a Practice Improvement workgroup meeting the week of June 13, which a Panel member joined by phone, the DCFS training director described a major initiative begun earlier this year to achieve some of what the Panel has been recommending. Like many other similar initiatives begun by the Department, nothing was provided to the Panel about this effort. The Panel is confounded by the Department's failure to provide the Panel this information sooner. The Panel finds it difficult to imagine that such lapses are anything other than an indication of the low priority the Katie A. Agreement enjoys within DCFS.

DCFS has no comprehensive plan for implementation of the Settlement Agreement and the plans required for Paragraph 7 have either not been produced or produced within the last few months, or are insufficiently detailed to be evaluated.

DCFS does not yet have a comprehensive strategy for funding the changes required by the settlement agreement. It has not engaged the FFA's in delivering new, more effective services for class members, is not maximizing Medical/Medicaid reimbursement or IVE training dollars, and has been slow to consider a comprehensive strategy for reinvesting savings from reduced placement costs into front-end services.

While implementation of tasks (a) through (e) in Paragraph 7 has occurred, and MacLaren Children's Center 7(g), has been closed, it cannot be determined whether DCFS has achieved the goals of 7(f), the first portion of 7(g), or the entirety of Paragraph 6 because of the County's inability to produce the data necessary to make those determinations. It should also be noted that the standards for compliance with most of the

items in Paragraph 7 are vague and indefinite, but that even total implementation of Paragraph 7 would not alone satisfy the objectives of Paragraph 6.

Members of the class have not been identified and unknown numbers of them are not receiving necessary mental health services because their needs for those services are not being assessed (DCFS expects that the Hubs and MATs that are under development will eventually help address this deficit) and because existing services are insufficient or inadequate. A specific plan for a major expansion of intensive home based services for class members and specialization of outpatient services necessary to meet their needs among the hundreds of DMH directly operated and contracted mental health providers has not been completed.

Significantly, DMH reported at a meeting with the Panel and DCFS on June 2, 2005, that it would not begin implementation of a plan to link class members who are determined to have mental health treatment needs with available community services until January of 2006.

DMH repeatedly indicates that an obstacle to meeting class members' needs is that many of the parents of children who are in the custody of DCFS also have mental health and/or substance abuse treatment needs which must be addressed before their children can return home, but such services are in short supply and being dependent on DCFS and DMH for information that is not available, the Panel cannot estimate how large a gap in adult mental health and substance abuse services is in each SPA or its impact on permanency for children. Although these adult services are reportedly being incorporated into other initiatives, we do not know the degree to which they are designed address the families of class members because the County does "not see such services as part of our obligations under the terms of the Agreement and have, therefore, not included discussion of them in the Draft Plan" (July 22, 2005 letter).

DCFS has not yet been able to bring any of its promising initiatives to scale. Wrap, for example, works well in some locations, but does not exist in others, and even before the cutback in federal funding, the need for the service far exceeded capacity. And Point of Engagement is an exemplary program in Compton that serves many class members well, but is just beginning to be replicated. Replication of successes requires fidelity and consistency in implementation, which is a significant challenge with so many dispersed communities and offices, and part of the joint DCFS/DMH planning must include assessment of compliance with established clinical principles in meeting the needs of class members by any public or private provider as well as countywide outcome studies.

DCFS has, however, made definite progress, particularly in recent months, and DMH has been increasingly engaged in supporting and assisting DCFS's efforts, and in fulfilling its own responsibility to the plaintiff class. Much remains to be done though, by both agencies, before it can be concluded "...that the County Defendants have...complied..." with the conditions of the Settlement Agreement.

## **VII. THE PANEL’S CORRECTIVE ACTION PLAN**

In its most recent order, the court requested that the Panel respond to several questions in its final report. Those questions are,

“1.... is the Settlement Agreement causing an unintended adverse effect on the County’s duty to find emergency housing for children” and “2. Are there state policies or funding mechanisms that have impeded the County’s accomplishment of the goals of the Agreement? If so what changes does the Panel recommend?” In addition, if the Panel concludes in its Final Report that the County defendants have not fulfilled the objectives of paragraph 6 or have not met their obligations under paragraph 7, in proposing a corrective action plan pursuant to paragraph 19, the Panel should list in priority of importance, concrete measures. The Panel should do so not by listing goals or even timetables for achievement of goals, but precise means. E.g., “by not later than [date], the D.C.F.S. should complete training for 35 newly hired social workers.”)

“In addition, if the budgeting processes allow for it, the Panel and the County shall jointly specify how much public funding currently is available and budgeted for the measures specified in Paragraph 7 of the Agreement, how much of it is provided by Federal, State and County agencies, (respectively) and how much additional funding, if any, is necessary to comply with the settlement agreement.”

In the following section, the Panel will respond to those to questions.

### **Katie A. Impact on Defendants’ Duty to Find Emergency Housing for Children**

It is the opinion of the Panel that the Katie A. Settlement Agreement is having no unintended adverse effect on the ability of the County to find emergency housing for children. In fact, the provisions of the settlement agreement were designed in part to prevent the practice of housing class members and other children overnight in DCFS offices. The settlement agreement sets a priority on family and community based services for children, designed to prevent unnecessary placement and where placement is needed, to place those children in family based settings appropriate to their needs. Indeed, the settlement anticipates that savings from the closing of the MacLaren Children’s Center would comprise part of Defendants’ funding to achieve those goals. To date, the Department has made little progress in expanding services for plaintiff class members. While there is a small new initiative to expand and strengthen supports for children in D-Rate homes, there has been little effect on the D-Rate population to date. Growth of the Wraparound effort has stalled and the plan for expansion is under development and has yet to be fully approved by the Board of Supervisors. The Multi-Disciplinary Assessment Teams effort, which conceivably could assist the plaintiff class, is quite small and is not connected to any viable plan to expand mental health services.

DCFS, DMH and the State are missing opportunities to increase their level of federal reimbursement through the federal EPSDT program, because they are not providing guidance and consultation to providers on the most effective and cost-beneficial method of billing for services. The County has access to federal financial resources that could be used to expand intensive home-based services. With joint technical assistance to the provider community by the State and County, providers would be able to identify significantly more services that qualify for federal funds.

The Department has provided little or no training to prepare line casework staff to improve its work with children with mental health needs. As a result, it is missing opportunities to permit class members to avoid placement through the provision of services in their own homes or foster homes and to avoid disruption of placements through the provision of individualized support services.

It is the opinion of the Panel that the failure of the Department to implement the provisions of the settlement agreement is a significant contributor to the problem of class members being housed overnight in DCFS offices.

### **State Policy and Funding Mechanisms Impeding Compliance**

There are several major areas where State funding mechanisms are impeding compliance. The Panel has identified these through conversations with DCFS staff, providers and advocates about the challenges faced by the system.

In the preceding section, the Panel identified the problem of the lack of guidance and consultation to providers by DCFS and the State on maximizing claiming for federal funds. This underclaiming impedes the expansion of services for the plaintiff class. In addition, the current Medicaid claiming system requires that discrete services be documented in records, reported and billed. So for a Wrap provider, dozens of individual professional contacts and activities would have to be reported and claimed separately for the same day for each child. This process creates a burdensome and expensive record keeping system and requires significant expertise on the part of providers to take maximum advantage of available federal funds. That expertise not being present, opportunities to expand services to children through greater recovery of federal dollars are lost.

This problem would be almost eliminated if the State created broader categories of services that encompassed most of the professional activities of services such as therapeutic foster care or Wraparound services within one service definition. As a result there would be a rate for therapeutic foster care for example, dramatically simplifying the claiming process and expanding the costs that can be recovered. The “bundled rates” as they are called, have proved to be very effective in implementing new services and expanding others in other states in the country.

The Panel finds that the State DMH has not adopted standards of care that would address issues such as wait lists, access to care, best practices (child and family team, for example) and mandated core services statewide, which would significantly enhance supports for the Katie A. class.

An additional barrier that the Panel has recent encountered is the imposition by the State of a 10 percent matching requirement on counties for mental health services provided through EPSDT. This barrier, which essentially constitutes a cap on funding, seriously impedes the provision of needed services and implementation of plans for creation of new services.

The Panel has been advised that funding for the State's mental health System of Care, which has been a resource for Katie A. class members and other children with mental health needs, has been eliminated by the Governor's office. This creates a significant gap in resources for the plaintiff class.

### **Funding Available for Paragraph 7**

Regarding the Court' interest in knowing "how much public funding currently is available and budgeted for the measures specified in Paragraph 7 of the Agreement, how much of it is provided by Federal, State and County agencies, (respectively) and how much additional funding, if any, is necessary to comply with the settlement agreement.", the Panel is requesting that the County assist it in identifying these funding resources.

### **Katie A. Panel Plan for Achieving the Objectives of the Settlement Agreement**

As is evident from the Panel's prior reports and the County's responses, the Panel and DCFS and DMH diverge significantly on what it will take to achieve the objectives of Paragraph 6 of the settlement agreement. The Panel believes that the most important test of compliance is achieving the objectives of Paragraph 6, which addresses major systemic changes and requires that members of the class:

- e. promptly receive necessary, individualized mental health services in their own home, a family setting or the most homelike setting appropriate to their needs;*
- f. 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;*
- g. 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*

- h. receive care and services consistent with good child welfare and mental health practice and the requirements of federal and state law.*

The Department focuses primarily on Paragraph 7, which is directed at implementation of discrete programmatic initiatives.

*To achieve these four objectives, DCFS committed to implement a series of strategies and steps intended 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;*
- o implement Team Decision Making at significant decision points for a child and his/her family;*
- o expand the use of Family Group Decision Making;*
- o ensure that the needs of members of the class for mental health services are identified and that such services are provided to them;*
- o 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 Panel believes that the items in Paragraph 7, which may be useful generally, are not alone sufficient to meet the needs of Katie A. class members or the objectives of Paragraph 6. A much broader system improvement strategy is needed to assure for class members the provision of necessary mental health services, safety, permanence and stability, and care and services consistent with good mental health and child welfare practice.

### **Limitations of Current DCFS Planning**

#### ***Family Teams***

In DCFS implementation planning, the Department focuses on initiatives where experts and or external resources can be employed to substitute for the competence and skill of the individual front line worker. For example, in the use of family teams for planning and problem solving, which the Panel believes should be available to all class members throughout their experience in the system, the Department relies on a small number of

expert facilitators, totaling only approximately 40 staff at present, to facilitate all of the family planning meetings for all of the cases served in DCFS. To appreciate the slight capacity 40 facilitators represent, there are 25,000 children in custody in LA County and thousands more receiving services in-home. With such a modest commitment of resources, class members will have little access to a functioning family team. Because of the approach used for meetings, which focuses primarily on responding to crises rather than preventing them and because of the limited numbers of facilitators available and affordable, few families experience the value of these meetings when they are needed. Yet the Department has chosen not to prepare its own staff to facilitate these meetings, which would significantly expand their use and value.

### ***Assessment***

Another example of the DCFS practice of relying largely on external resources is its initiative related to “Medical Hubs” and external Multidisciplinary Assessment Teams (MAT), which are to be loci of assessment. First, implementation of the Hubs and MAT has been extremely slow and little capacity has been built at this point. In addition, little attention has been given to improving the assessment skills of the line professionals that work with class members daily. The MAT design may provide a useful assessment for some children in the system, but cannot address all of the assessment needs of the children served by DCFS. Nor is a single assessment durable and relevant beyond a limited period, as the needs of children and families change frequently. It will undoubtedly fall to the individual caseworker and whatever consultative resources he or she can access to provide the continuous assessment that this population demands, and that the settlement anticipates.

The Panel believes that in regard to these two vital elements of practice with children and families, family team planning and problem solving and assessment of needs, more than the currently envisioned DCFS Team Decision Making initiative and MAT assessment initiatives are needed. We believe that the larger DCFS work force needs to become more competent in contributing to teaming and assessment through an intensive training and coaching process, not just a small number of experts. This recommendation is based on the Panel’s successful prior experience with improving the level of practice at the front line in other systems and on the practical reality of available resources. The Department will never be able to acquire enough external practice capacity to improve practice and outcomes for the plaintiff class and will be unable to meet the needs of the class unless it also uses its own frontline casework staff to engage in these new approaches.

### ***Preparing Staff for Improved Practice***

DCFS efforts to train line staff related to current reforms have been essentially superficial. And the pre-service training provided new workers, which the Panel has addressed previously, does not meet the needs of new workers of the children and families in the system.

During meetings in the SPAs, for example the Panel heard widespread dissatisfaction about the DCFS training academy and the lack of cross training among child welfare and mental health staff. These criticisms can be included:

“University training is too far away from what’s real and practical.”

“When a new worker comes from eight weeks of Academy training, I have to assume they know nothing.”

“It used to be better when they started for several weeks in our office (where they would be placed) and went out with staff. Some dropped out at that point. Those that didn’t could apply what they learned at the Academy to what they saw before they started.”

“The question about training always is, ‘How much of it are they getting?’ It would be better to cut the Academy in length, to teach the legal mandates of the work, and then learn the practice from mentoring in the office. But this would require supervisor training to make such a big culture change happen.”

“We want practical, outcome-oriented training with tools to deal with specific client populations that is community-specific, with much more information about the resources available in our community.”

In the SPAs, supervisors express a desire to have caseworkers, who are mostly BA-level, develop confidence in engaging families, identifying children’s needs, tailoring individualized services and connecting children and families with those services. DMH acknowledges that most therapists are MA-level, often with little exposure to evidence-based practice or methods of trauma treatment appropriate for DCFS children and their families and foster families.

That feedback parallels the Panel’s previous findings on training, reported in the Panel’s Third report, which is repeated below.

The current training design, which the Department training staff recognize needs improvement, is seriously flawed. First, the Panel is concerned about the design of the basic pre-service curriculum. Rather than being based on the foundations of good practice, which are engaging families, effective teaming and coordination, thorough assessments of strengths and needs, individualized planning and effective interventions, the curriculum is topical. Topical curricula focus on specific child and family conditions, programs, life events or behaviors rather than on the universal elements of practice.

There is no evidence of a coherent framework of practice that underpins these course offerings, just individual subject presentations, provided by a variety of different presenters in block of time ranging from a few hours to a half day. The priorities suggested by the amount of time devoted to topics seem

in some instances unrelated to the importance of the subject. The only topic to which multiple full days are devoted relates to learning how to use the Department's computer system. The agenda seems to require that as much time be spent on writing court reports as on dealing with the effects of attachment, separation and loss and child placement issues. Case planning, a critical area of practice that the Department agrees needs improvement, appears to merit only a half day.

In these short blocks of time it is not possible for training, especially when delivered to group as large as forty participants, to actually teach skills. These sessions are inevitably information based, which is useful, but doesn't go far enough to actually help staff acquire discrete skills. A worker might learn to recognize the harm of a child's separation and loss from family, for example, but would not be given the skills to practice in a way to mitigate the harm, or avoid it.

Effective training begins with knowledge and information, but focuses most heavily on:

- Modeling the skills to be acquired
- Providing training activities that permit participants to demonstrate the skills
- Providing feedback to participants on their performance
- Coaching participants to improve their skills

Presenters in LA are often part-time, having duties in other organizations and may present only their one part of the curriculum. In the opinion of the Panel, without a structured training of trainers initiative, trainers often do not possess the ability to model the skills in a training environment. Such fragmented training delivery invites inconsistency with a common theme of practice and the interjection of personal views and philosophies into training content. Full time trainers can provide much greater fidelity to core training expectations and better integration of the content of the modules provided.

Beyond pre-service training, a bigger challenge is in-service training for the approximately 2500 DCFS staff that engage in direct practice daily – the same direct practice that the Department wants to change. The current in-service effort has been focused on strength based practice and concurrent planning, each one-day deliveries to large groups of staff. Future in-service plans involve training on teaming/shared decision making, case planning and visiting. It is anticipated that each of these three training deliveries will be brief as well.

The Panel sees no likelihood that brief, large group training in any of these topics will create lasting practice improvement, for the same reasons referenced in the discussion on pre-service training. With a maximum of

fourteen training staff, the training unit does not have the capacity to expand these planned deliveries. Several systems familiar to the Panel that have achieved significant improvements in outcomes through re-training had to deliver multiple weeks of skill based re-training to the entire work force, not a few days. All of the trainers were first carefully prepared to model and coach the required practice skills.

DCFS responded that it has accomplished a major training initiative on strengths-based practice but while many staff attended, this was a one-day training session in large groups that provided little time for anything but information sharing. As the Panel has previously noted, effective training should also permit experienced trainers to model/demonstrate new skills, provide time for participants to demonstrate and learn to practice those skills and allow abundant opportunities for trainers to provide feedback and coaching on performance. Considering the analogy of learning to drive a car, students need basic information about the functioning of a car, driving techniques and safety rules. However, they also need to observe an experienced driver perform and have the opportunity to practice driving, receiving guidance and feedback from the instructor. Considering that child welfare work is considerably more complex than driving a car, DCFS training efforts to date will have little effect on the level of skills among its work force or outcomes for the plaintiff class.

To achieve Paragraph 6 requirements for more effectively meeting the needs of class members and their families and foster families, a major new training and staff mentoring effort must be undertaken by DCFS and DMH collaboratively. A combination of joint training and specialized training and mentoring is necessary for DCFS caseworkers and supervisors and DCFS contractors and DMH directly operated and contractual providers. A complete overhaul of the current DCFS training approach offered through a small training unit and five area universities is necessary.

Several principles are behind this new approach to DCFS/DMH training and staff mentoring:

- Meeting the needs of class members and their families and foster families effectively requires skilled case-specific guidance; large group classroom training and traditional administrative supervision are insufficient.
- For supervisors to provide this skilled case-specific guidance, or mentoring, requires special preparation by individuals who have previously trained child welfare and mental health staff in how to mentor effectively.
- Designing individualized services to build on the strengths of families and meet the needs of children requires a fusion of children's mental health principles and child welfare principles that are embraced and practiced at all levels of DCFS and DMH and among their contractors. These cannot be practices unique to a particular provider or pilot project, but rather are principles that cut across both staff preventing children from entering care and those serving children in care in FFAs, D-rate, and relative homes and

group care and staff attached to specialized outpatient, wraparound, and intensive home-based services.

- Teaching the effective assessment of children's needs and engaging family members and others in designing individualized services, whether in the classroom or in the field, requires individuals who themselves are experienced in strengths/needs-based work with families and crafting services with providers and are up-to-date on the practice principles embraced by DCFS and DMH.

### ***Expansion of Mental Health Services***

While the Department cannot identify the size of the plaintiff class, data from other sources about the numbers of children with mental health needs involved in child welfare systems provide a useful frame of reference for estimating the size of the plaintiff class in Los Angeles. According to a Department of Health and Human Services study, 85 percent of the children in the foster care system in California have developmental, emotional or behavioral problems. Over 50 percent have a diagnosed mental illness. A Child Welfare League of America Study found that 60 percent of children in out-of-home care have moderate to severe mental health problems. The study also found that adolescents placed with foster parents had four times the rate of serious psychological disorders of children living with their own parents.

A 2003 Massachusetts study found that almost two-thirds of the children served by child welfare received mental health services in the 2003 fiscal year. A recent study of former foster youth by the Chapin Hall Center for Children found that one third of all young adults interviewed have at least one mental health diagnosis, ranging from alcohol abuse to major depression.

It is clear that a significant proportion of the children served by DCFS have diagnosable mental health conditions, conservatively estimated by the Panel to be at least 50% of the children served. It is this incidence that makes the creation of home based, individualized mental health services so vital and so urgent. Two years into this Settlement Agreement, the County has just begun this process.

The settlement places a strong emphasis on the creation of home and community based services that support family based living arrangements, as opposed to congregate settings. Based on information provided by providers, children and families and DCFS staff in the field, the Panel sees little evidence of any expansion of mental health services for the plaintiff class or of any viable plan for expansion. In fact, the Panel has identified to DCFS a significant opportunity to expand mental health services by making more efficient use of the federal Early Periodic Screening, Diagnosis and Treatment (EPSDT) dollars that would significantly expand mental health services with primarily federal funds. To date, little, if any, action has been taken by the Department.

The Department is pursuing a Panel recommendation on the reduction of the use of group care for class members, especially young class members, that would involve a

diversification and expansion of services offered by group care providers. However, no viable plan has been developed to achieve this goal. Also, existing group care providers, even if they do diversify their services to provide home and community based supports, are not likely to be able to meet all of the needs of the plaintiff class, especially those class members with serious emotional/behavioral needs. Without a significant expansion of mental health services, the Department cannot comply with the provisions of either Paragraph 6 or 7.

A fundamental problem is the split between DCFS and DMH in responsibility for compliance with the settlement agreement despite collaboration between the leadership of the two Departments. Meeting the needs of at least 10,000 class members requires new mental health services currently not being provided in the county and, coordinated with that expansion of services, change in practices among thousands of DCFS, DMH and provider staff. The Panel has been provided much more information about DCFS plans to improve child welfare services, including assessment through the Hub/MAT initiatives. In the absence of a detailed DMH plan for expansion of mental health services, the Panel has urged DCFS to invest MacLaren dollars and saved residential placement dollars in services to meet the needs of class members and their families and foster families. The County has responded essentially that the expansion of mental health services in DMH's responsibility. DCFS appears to be moving faster than DMH, and the lag in increasing mental health services and the failure to design new, more effective mental health services will be harmful to class members. The Panel believes this harm could be avoided.

### **Limitations of the DMH Plan**

DMH presented its January, 2005 draft plan for "Improving the Mental Health Service Delivery System for Children, Youth and Families in the Los Angeles County Child Welfare System" to the Commission and Board; it was revised March 25, 2005 and is currently being revised again. DMH calls its plan an algorithm which is defined as "a step-by-step process for addressing a problem. The DMH Child Welfare Algorithm is a shorthand method for representing the logical flow of activities and decisions that are proposed as a model for improving the mental health services available to children, youth, and families under the supervision of DCFS. The algorithm is composed of interconnected *boxes*, representing various activities, *diamonds*, identifying key decision-making points, and *arrows*, reflecting the direction of the flow through the system".

The 11-page narrative for the algorithm includes screening and assessment, enrollment, case management and tracking, comprehensive mental health evaluations, mental health treatment, outcome evaluation, current DMH programs and initiatives, service delivery gaps, service area plans, and evaluation. The draft concludes that "The service delivery system described by this Algorithm would significantly enhance the ability of the Department and its contract agencies to provide mental health screening, assessment, and treatment services to children and families involved with the Department of Children and Family Services (DCFS). The proposed service delivery system is based on timely identification of service needs, referral to an accessible, qualified, and culturally

competent network of service providers, aggressive tracking and oversight of service delivery, and monitoring of service outcomes. The Algorithm was developed consistent with the core values, guiding principles, and recommendations for critical service delivery elements published by the Georgetown University Child Development Center as well as the policy recommendations of the American Academy of Child and Adolescent Psychiatry and Child Welfare League of America (Attachment B). Major improvements over current systems elements provided through the Algorithm include:

1. Universal mental health screening of children and families entering the County child welfare system.
2. A DMH division, the Child Welfare Services Division (CWSD) to provide countywide support, training, information management, and oversight of service delivery and service outcomes.
3. A network of DMH directly operated mental health programs co-located within each DCFS Regional office to provide local systems navigation support and consultation.
4. An enrollee-based system of providers with improved capability to meet the unique needs of children and families in the child welfare system.
5. Adoption of a shared set of developmentally appropriate screening and assessment tools, to be used for mental health screening, needs and strengths assessment, service planning and outcome evaluation.
6. Establishment of a “real time” database of client, service delivery, and outcome information to improve service decision-making.
7. A mental health “hotline” available to DCFS staff, the children, youth, and families under their supervision, and other social service providers to respond to requests for information, provide referrals, and address concerns or complaints about mental health services.
8. Promotion of evidence-based and best practice models for service delivery;
9. Increased service delivery capacity to children aged birth to five and their families.
10. Expanded research, technical assistance, and training capacity, in collaboration with university-based affiliates.
11. Use of result-based decision-making practices to develop and guide the development, implementation, and adaptation of the system in a cost-effective manner.
12. Increased collaboration and coordination of service-related activities with other child welfare partners, including DCFS, the Department of Public Social Services, the Department of Health Services, the Probation Department, schools, dependency court, and other social service agencies.”

In our May 31-June 1, 2005 visit to Los Angeles, the Panel requested a meeting with DMH separate from the joint DCFS-DMH workgroups to discuss the DMH plan for improving services to class members. While DMH provided documents requested by the Panel to prepare this report, we were told that the tight timetable for completing plans for Prop 63 funds for mental health services for children meant that DMH could not schedule a meeting with us. We were instead invited to observe a stakeholder planning meeting

where representatives from providers, parents and others were discussing the Prop 63 plans.

The DMH narrative acknowledges it has “a fragmented patchwork of services unevenly distributed across the County with little coordination of effort or attention to service outcome.” DMH indicates that it has “no centralized database that could be used to identify which DCFS-involved youth are being served, what kinds of services are being utilized, and what outcomes are being achieved.” The current array of services for children and families through DMH includes:

- Children’s System of Care (SOC)
- Wraparound Services
- Permanency Planning Teams
- AB 3632 Services
- Therapeutic Behavioral Services (TBS)
- Day Treatment Intensive and Day Rehabilitation Treatment Programs
- Community Mental Health Services (County Directly Operated and Contract Providers)
- School Based / School Linked Programs
- Supportive and Therapeutic Options for Programs (STOP)
- Emergency Outreach Bureau (EOB) – Children’s Crisis Teams and PMRT-Psychiatric Emergency Team response
- Countywide Case Management

The DMH narrative goes on: “There has also been very little development of evidence-based programs for children/youth within the County. Evidence-based programs are specific treatment protocols that have been studied with the strict requirements of scientific methodology in clinical trials and shown to be effective in treating specific presenting emotional and behavioral problems. Several such programs have been developed specifically for the kinds of youth served by the child welfare system and offer a significant improvement over traditional psychotherapy approaches.” In addition, “DMH and DCFS have agreed that it would be desirable to have mental health programs co-located within DCFS regional offices to operate as consultants and system navigators to DCFS social workers. While several mental health efforts are co-located within DCFS regional offices, notably ICAT and START, the majority of DCFS regional offices have no such programs.”

Three pages of the DMH narrative focus on the planned changes in each of the eight service areas, beyond co-locating services, including “both the development of directly operated children’s mental health services and expansion of contract providers to offer access to a comprehensive array of mental health care. Services will target the mental health needs of children and their families...providing assessment, treatment, linkages to appropriate community resources...intensive case management, individual and family in-home services, expansion of the Multidisciplinary Assessment Team (MAT)...participation in the DCFS Point of Engagement program...participat[ing] in the various case planning conferences including Team Decision Making and the Multi-

agency Regional Placement Resource Team (MA-RPRT) process... enhanced coordination and collaboration to facilitate access is the provision of increased mental health services that are targeted toward foster children in local schools...development of a modified wraparound program for children at high risk of placement failure, including a respite care component, targeted behavioral interventions, psychiatric stabilization, and ongoing contact, consultation, and support for the parent or foster family...developing a Transitional Age Foster Youth Academy that will assist clients with housing, employment and educational opportunities...assist[ing] with removing systemic and program barriers, tracking the progress of the referrals...providing consultation and technical assistance to DCFS workers.”

The most recent Draft Plan from DMH sent to the Panel with the July 22, 2005 letter, does not provide more detail on the services to be provided to class members. The plan devotes nearly three pages to screening and assessment and a few paragraphs to services. There is a specific timeline for hiring of 200 new DMH staff, without information on the type of staff and the services they will be able to deliver. It appears that what is planned is an expansion of the same mental health services that exist in LA county.

The DMH goal to assist DCFS with preventing entries into foster care through assessment and referral to mental health services and to provide “an array of comprehensive mental health services to children in out of home placements and their families,” especially children in D-rate foster homes, children placed with Foster Family Agencies, children at-risk for placement disruption, and children being discharged psychiatric hospitals” is what Katie A. requires. But the DMH plan does not present any estimate of the number of children, families and foster families who will require various level of intensity of services, particularly services that do not exist or are only provided in small quantities currently. Nor does the DMH plan indicate how its directly operated children’s mental health services and contract providers will rapidly expand evidence-based services throughout the county both for class members in their own homes and in foster care. In meetings at the SPA level with DCFS and DMH staff, Panel members repeatedly heard that a dramatic expansion of services is essential for children in their own homes and in foster care and their caretakers.

However, DCFS and DMH staff and providers showed little understanding of treatment methods more effective than traditional outpatient services and no information about the size of the population in need. They could not answer the question, “If more than 50% of the children in foster care in this SPA require intensive home-based services, what would it take for your mental health providers to meet their needs and guide their caretakers?” They responded that lack of funds and difficulty in recruiting qualified staff would make rapid expansion of new mental health services unlikely. If a child in an FFA or D-Rate foster home requires daily support to change behaviors and their foster parent (and the parent with whom reunification is planned) require assistance in understanding and intervening in their behaviors, DCFS and DMH respond that Wraparound is the only alternative to Level 12 or 14 group care. They know that an expansion of Wraparound to serve hundreds more children in their SPA is not going to occur, yet they seem not to be

thinking about other EPSDT-supported methods for dramatically expanding home-based services for these children.

Both DCFS and DMH, in their central offices and in the SPAs, emphasize improvements in assessments of children at risk of entering foster care and referrals for services to keep them safe with their families. Most of the innovations and expansions in the DMH plan and by DCFS, such as the MAT and the Hubs, are front-end assessment and referral. Some of these children and their families will benefit from traditional outpatient services, especially to the extent that DMH develops evidence-based early intervention services, such as “The Incredible Years” to build on families’ strengths in nurturing their children. However, a substantial number of children who are prevented from entering foster care will require much more intensive mental health interventions than are currently contemplated with the family preservation programs. The Panel sees no evidence that DCFS and DMH are building intensive home-based services to support families in raising their SED children, which is essential to keeping them from entering foster care.

### ***A Different Approach is Required to Meet the Needs of Class Members***

Paragraph 6 requires a different approach to meeting the needs of class members. It recognizes that SED children, especially those who have been traumatized by abuse, exposure to violence, separation from their families and multiple placements, require much more intensive services than traditional once weekly therapy. The Panel sees no indication that in the County’s draft plan for hiring 200 new caseworkers and clinicians DMH will depart from current practice in the County which relies on weekly office-based therapy (where “outreach therapy” is provided, our observation is that it is not more frequent than once a week and is not designed to guide caretakers in managing children’s difficult behaviors; a redesign of TBS services would be necessary to

Based on the federal CASSP principles and the literature on evidence-based services for SED children and families, intensive home-based services can be defined as:

Intensive home-based services are a well-established intervention designed to meet the child's needs in his/her birth, foster or adoptive home and in the community where the child lives. The planning and provision of intensive home-based services require an individualized process that focuses on the strengths and needs of the child and the importance of the family in supporting the child. Intensive home-based services describe several discrete clinical interventions, including, at a minimum, comprehensive strength-based assessment, crisis services, clinical case management, family teams, and individualized supports including one-on-one clinical interventionists. These services must be provided in a flexible manner with sufficient duration, intensity, and frequency to address the child's needs and guide his/her caregivers.

Individualized services must be designed to meet the unique needs of each child and build on the child and family's strengths. It is essential to have birth, adoptive and foster families involved in planning services with professionals from mental health, child welfare, school and other agencies and the family's informal supports. Intensive home-based services describe an individualized child-focused, family-centered approach that is offered by a range of providers and is not limited to wraparound or system of care programs. The complex needs of these children require integrated services, and team planning is essential and cannot be separated from the interventions. Effective services for severely emotionally disturbed children require enhanced care coordination, often daily individual clinical interventions for the child, and guidance for caregivers (including teachers) for which traditional outpatient therapy is not sufficient in number of hours, flexibility, or family functioning focus. Safety, stability and permanency for children are most likely when birth, adoptive and foster families are guided to manage their behaviors and do not have to travel to receive intensive services.

Traditional Outpatient Services Lack Intensity. Typically children and families are limited to once weekly outpatient therapy, sometimes with an additional once monthly psychiatric visit for medication. Weekly assistance cannot meet the needs of children whose behavior constantly impairs home, school and community adjustment. Many children coming out of residential programs and psychiatric hospitals, as well as children for whom home-based services could prevent residential and psychiatric hospital placement and disruption in foster homes, require daily in-home support and their families and foster families require daily guidance. These services have to be provided by clinically trained and supervised individuals.

Traditional Outpatient Services Have Limited Duration. The time limits imposed on outpatient services may be reasonable for some children and families. But the chronic problems of SED children may necessitate services for months or years. Meeting the needs of SED children and their families requires intensive home-based services with the capacity to change the number of hours of services for the child and/or support for the family based on the level of need. Until they learn improved self-regulation and their caretakers strengthen their skills at managing their behavior, these children are at daily risk for crises and acting out and possible placement breakdown, hospitalization, or arrest. While some children and families may be able to transition to outpatient services after intensive home-based services for several months, many SED children who have been traumatized will require developmentally sequenced treatment into young adulthood and their families and foster families will require differing levels of support as their children encounter new challenges to master.

Traditional Outpatient Services are not Comprehensive. To meet the complex needs of SED children requires tailoring services to fit the child's needs and build on the family's strengths, which in many cases requires delivery of a range of therapeutic services at home, school and outside activities where the child's behavior problems occur. It is an unrealistic expectation that these children will develop social skills and effective methods for managing anxiety and anger through services only provided during the school day through special education services. Opportunities for these children to be coached in

normal behavior during time with peers and family outside of school is essential. Furthermore, birth, adoptive and foster families cannot manage their SED children without assistance after school, on the weekends, and in the summer. Lacking this range of services delivered in a variety of settings, SED children are likely to exhaust school staff and their families, leading to disruptions and placement in unnecessarily restrictive care.

Intensive home-based services include a coordinated combination of services, uniquely designed for the child and family, including:

- A clinical team working with the child and family
- Assessment of the child's needs that guides the family and providers
- In-home therapy, including trauma treatment
- Behavior support for the child by clinically trained individuals
- Guidance for the child's family/foster family in managing the child's behavior
- Crisis intervention by clinicians who know the child and family

It is less desirable when the services come from different agencies (as is often the case in LA with family support, for example, provided through Wrap but the child sent to a therapist in another agency not well-connected to the team or therapy by one provider and TBS by another or crisis services coming from a centralized on-call site), and when this is the case more funds, and a different approach to case coordination, must be available to ensure a functioning team.

Two examples of how SED children benefit from intensive home-based services when traditional outpatient therapy and residential treatment were ineffective might help with understanding the kinds of services DCFS and DMH must expand substantially throughout the county:

#### ALEX

Alex is a lively 9-year-old boy who lives with his grandmother who was prenatally substance exposed and was abused in his mother's care until his grandmother took him as a toddler. He had a significant language delay and was easily frustrated and aggressive. He had many diagnoses and numerous medication trials, with little agreement about his needs or the services that could meet them. School staff thought Alex had a low IQ, while mental health staff viewed him as autistic. His increasing aggression in school put him on the verge of residential placement. A thorough evaluation concluded that Alex had global developmental delay, post-traumatic stress disorder and a severe language disorder. A meeting was convened with everyone who had contributed to the evaluation, Alex's grandmother, the staff of a new special education program he would attend (including speech and occupational therapists), and the behavior specialist, trauma therapist and psychiatrist from a private mental health provider of intensive home-based services. They agreed that Alex had the following needs:

- To improve in reading nonverbal cues, understanding the perspective of others, sustaining conversations and learning the rules of games;

- To become more aware of and respect personal boundaries and learn acceptable ways to satisfy his hunger for touch;
- To be helped to avoid getting over-stimulated, which contributes to his getting out of control;
- To be reminded to think before acting, especially when he is anxious.
- To learn how to calm himself instead of reacting by hitting or throwing things; and
- To modulate the speed of his speech and articulate words more clearly.

To meet these complex needs, they designed a combination of intensive services including a Masters level behavior specialist (with experience with children with developmental delay and PTSD) working 15 hours a week with Alex at home and additional time guiding his grandmother, supervising his recreation specialist, and convening weekly meetings at the school that involved the speech therapist and occupational). The recreation specialist worked on the weekends and provided in-home respite one evening a week. Everyone on the team had a role to play in meeting the underlying needs contributing to Alex's aggression, violation of personal boundaries, difficulty following directions, language delays, and limited peer relationships.

#### JACQUELINE

After being sexually abused by her stepfather, Jacqueline, now 13, has been in ten placements, including foster homes, group care, and a psychiatric hospital. She has been separated from her siblings (who were in foster homes and with relatives) and has had only intermittent contact with them, her mother and other family members. Her behaviors associated with PTSD, including self-harming and running away, have made her family members worried about being overwhelmed by her problems. In a meeting that included Jacqueline, her uncle, caseworker, group care staff, and a prospective foster parent, her strengths and the specific needs underlying her behavior were identified:

- To have a lot of attention from and positive interaction with adults who reassure her and make her feel she belongs
- To resolve the conflict between wanting to be part of a family and being afraid of intimacy
- To be in charge of her own pace of trusting and getting close to others
- To feel she is pleasing others, especially her sister and uncle, even though they sometimes disagree or they criticize her
- To learn to talk about what she believes others are thinking about her before she reacts
- To learn to slow herself down when she gets dramatic, especially in family situation

To meet these challenging needs and protect Jacqueline from her self-harming and runaway behaviors, they collaborated on tailoring a combination of intensive services including a therapist providing trauma treatment twice weekly and supervising a trained behavior specialist working daily with Jacqueline in the foster home and in every Saturday at her uncle's home and additional time teaching her foster parent and uncle in how to

reassure her and remind her to use her new techniques in school and in the foster home and her uncle's home.

Intensive home-based services, like those provided to Alex and Jacqueline and their family members and foster parents, must be provided for thousands of class members in LA. They must be individualized and planned with families, foster families and teenagers. They must be provided by clinically trained and supervised individuals. They must have the possibility of daily intervention over durations longer than a year, while being flexible to taper as quickly as permitted and still meet needs or increasing quickly in response to a crisis. These services must be implemented both in foster homes (FFAs and D-Rate) and with relative caretakers as well as during visits in preparation for reunification and in the homes of children who are not in care.

The services designed to meet the needs of Alex and Jacqueline are not available, except in rare circumstances, in LA County. The current children's mental health service array lacks intensity, duration, and comprehensiveness which severely impacts class members. At best, "outreach therapy" is provided, but typically not more frequently than once a week, and it is not designed, consistent with the clinical principles of evidence-based practice, to guide caretakers in managing children's difficult behaviors. Moreover, while TBS staff can be assigned to work with a child as much as daily in the home, the clinical training of these individuals is limited and typically they do not function as a member of the clinical team and their supervision does not come from the child and family clinician. Neither the current functioning of the outreach therapist nor TBS staff allows for adequate crisis intervention to prevent placement breakdown. All the key elements of intensive home-based services—a clinical team working with the child and family, assessment of the child's needs that guides the family and providers, as much as daily in-home therapy and behavior support for the child and intensive guidance for the caretaker, and crisis intervention by clinicians who know the child and family—must be provided to each class member and their family.

Based on experience in other states, a number of the elements of intensive home-based services can be funded through the existing Medicaid billing codes in California. State level barriers, as mentioned elsewhere, prevent more comprehensive Medicaid claiming. However, what most providers are accustomed to billing and the staff most providers hire is different from intensive home-based services, and existing services are fragmented instead of the assessment, crisis services, home-based therapy, behavior support and caretaker guidance all being done within one clinical team. To provide all the elements of intensive home-based services for at least 10,000 class members will require a dramatic change in all the children's mental health service providers in the county. This change in their approach to hiring, supervising and scheduling staff, coordinating services within single teams, evaluating outcomes, and billing for these services requires much more than 200 new DMH staff, which is the latest proposal from the Department.

## **Outcome and Performance Evaluation**

The Department is currently unable to provide accurate annual outcome trend data on the plaintiff class, largely because reliable information from the Department of Mental Health is not current for some of the DCFS population. It is not known when such data will become available. This limitation prevents DCFS and the Panel from knowing the size of the plaintiff class and the extent to which mental health needs are being addressed through services. Nor does the Department have a mechanism for examining immediate trend data, such as the number of class members that are currently stable, currently functioning acceptably regarding their emotional/behavioral needs or being provided sufficient mental health services. The Department has objected to a Panel recommendation for the development of a process that provides such immediate feedback, described by the Panel as a qualitative review process.

As a result, the Department has no reliable method for tracking the long term outcomes for the plaintiff class, for assessing the degree to which their current status is acceptable, for evaluating the quality of DCFS and mental health services or the types, intensity and duration of the mental health services they receive. The Panel currently has no basis for judging the degree to which the implementation of the Katie A. settlement agreement affects the quality of the lives of the plaintiff class.

## **Panel Proposed Corrective Actions**

The Panel believes there are at least 10,000 class members who DCFS and DMH must be able to identify efficiently as they enter their systems and those already in them. These children and their foster families, families and other caretakers require intensive home-based services which necessitates not only a huge expansion of mental health services but a change in the types of interventions provided, the training and supervision of the staff providing them, and the way current MediCal billing codes are used. As DCFS develops the methods of assessing the children's needs and DMH develops the services that will meet those needs, the line staff of both agencies must have improved skills (and reasonable caseloads) to engage families and support collaboration among professionals and families and foster families which results in the achievement of permanency and child well-being outcomes. Parallel to these changes in DCFS and DMH, their providers-FFAs, wraparound, mental health, TBS, family preservation, group care and others-must be supported in overhauling what they now offer. In addition, improved outcome data and quality data must be consistently produced so DCFS, DMH and providers can refine their interventions and systems over time.

The Panel provided proposed corrective actions to DCFS and DMH in draft form on June 16, 2005 and requested that we meet to jointly revise them on dates the Panel was available. On July 22, 2005 the County responded by letter. At that point, the only date the Panel could meet in LA was July 27, and the County's indication that further response by the County to the Panel's proposed corrective actions would not be forthcoming by that date led to the decision by the Panel not to travel to LA but to have a lengthy

conference call with the county on July 27. In that call, County Counsel made it clear that agreement on corrective actions could not be reached anytime soon. As a result, the Panel decided to revise the draft report and submit it to the court on time on August 16, 2005 rather than proposing additional delays.

Two years after the Katie A. Settlement was approved, the Department has still not demonstrated a commitment to achieving the objectives of the settlement. It has not even developed a detailed and comprehensive plan for implementation that the agreement anticipated. The Panel believes that the failure to develop a viable plan is a consequence of the low priority given the settlement agreement by the Department and a lack of internal ability within the Department to analyze information, develop organizational strategies and plan. The Panel has little confidence that the corrective action planning process outlined in the agreement will produce the commitment and planning needed to achieve the objectives of paragraph 6.

As a solution to this lack of action, if the court desires, the Panel is willing to develop a detailed and comprehensive corrective action plan itself, with the discretion to involve DCFS and DMH in designing the details to operationalize the corrective action plan and have the funding to involve consultants as necessary. If the Panel is given this authority, it is likely that the Panel would need additional consultant or staff resources to assist in the planning process.

**Identifying the Plaintiff Class**

There is currently no mechanism to accurately identify the size and needs of the plaintiff class. The proxy definition used by the Panel as a temporary measure identifies only a small percentage of class members in custody and fewer who remain in their own homes. To plan effectively for development of needed mental health services and assure that class members are appropriately served, DCFS and DMH should implement a process to identify and track class members at the SPA level. Using a tool and process approved by the Panel, DCFS and DMH should identify the class members in each SPA and describe their needs and the services currently received. A process should be designed to identify existing and new class members that permit them to be tracked by the DCFS information system.

<b>Task</b>	<b>Action Completed</b>
Assist the Panel in creating a working definition of class membership for the purpose of tracking class members	October 15, 2005
Appoint and convene a joint DCFS/DMH work group that can assist in designing manual data collection measures until automated system are available	October 15, 2005
Develop a tool for identifying class members	November 15, 2005
Pilot in one SPA a mechanism for tracking class members, including the type, duration and intensity of service provision	February 15, 2006
Based on the pilot revise as needed and implement use in all SPA's	April 15, 2006
Complete the identification of current and new class members and current service provision in all SPAs.	August 15, 2006

## **Improving Front Line Practice**

As mentioned previously, the DCFS efforts to equip staff with the competencies needed to effectively serve children with mental health needs has been largely superficial. The Panel spoke in its earlier reports to the court about the inadequacy of the pre-service training for staff. We have also addressed the inadequacies of the brief-in-service training that has been provided. Most of this training has been without specific skill-based content regarding the specialized needs of the plaintiff class. Now, two years after the settlement agreement was approved, little change has been made in the basic skills of line staff. They and class members are dependent on incomplete and untested supports, such as MAT and the Hubs and new mental health services that are yet to be created. It is critical that DCFS give urgent priority to providing better training to frontline staff and their supervisors that will enable them to improve their assessment of, planning for and services to the plaintiff class.

With the advice and approval of the Katie A. Panel, the Department should develop a three-day training initiative in a strengths/needs based family child and family team meeting approach that has individualized planning as well as crisis resolution as it's purpose. The three-day training will be delivered to existing facilitators, DCFS trainers and expert coaches in each office, who will be responsible for training (on the part of trainers), and coaching all front line staff in the office. Coaching in this context means demonstrating child and family team meetings in actual practice for participants and co-facilitating/mentoring participants in the facilitation of actual meetings. These new coaches will occupy new, full time roles. Each staff member trained will be coached by a facilitator (hired as staff or under contract), skilled in the strengths/needs based family child and family team meeting approach.

Family meeting facilitators and ultimately, case carrying front-line staff should be developed to possess the following core competencies and enabling abilities:

### **Core Competencies**

- Apply the basic principles of a family team or partnership approach when working with families
- Maintain a primary focus on child safety, permanency and well being
- Ensure that each family team maintains a focus on safety
- Use assessment tools that reflect a systems orientation
- Select and put into practice appropriate interpersonal helping skills used in engaging individuals and families
- Be sensitive to cultural differences
- Adapt to cultural differences and make adjustments that support engagement
- Observe and participate in structured family team meetings
- Apply skills necessary to prepare for and facilitate a family team meeting
- Recognize limitations and be able to find additional supports to help families.

### **Enabling Abilities (which support the core competencies):**

- Recognize and discuss the importance of developing a working agreement with family members
- Appreciate the value of community partnership
- To discuss the benefits and challenges of implementing a family team approach to practice.
- To define the origins of family meetings in child welfare
- To define what a family team conference is and how family conferencing supports the development of an individualized plan.
- To identify principles and strategies for practicing in the strengths/needs based family team model
- Identify ways to help people disclose private or hidden information
- To identify and use techniques to help people discover and share hidden information
- To identify the skills used in developing the core conditions for helping
- Identify and discuss the use of engagement skills in a demonstration interview
- Apply engagement skills in an interview
- Practice use of exploring skills: attending and reflecting
- Practice use of the focusing skill of positive reframing
- Offer and receive strengths based feedback based on practice of engagement skills
- To be able to model strategic selection of skills to help families explore their strengths and needs
- To identify sculpting as a technique for viewing families
- To read and interpret a genogram
- To recognize and identify interdependencies among family members
- To describe ways in which separation and loss can lead to unmet underlying needs
- To discuss and describe how underlying needs can manifest as symptoms of dysfunction
- To identify ways in which substance abuse and domestic violence can impact on family functioning
- To identify early events in individuals' lives that can lead to separation and loss in a family later on
- To recognize strengths, challenges and resiliency in family
- To identify personal feelings of empathy in relation to a case family
- To identify needed interventions in finding solutions for the family
- To differentiate underlying needs from behavioral expressions of needs
- To recognize how families develop resilience in the face of challenges
- To identify ways to apply the cycle of need and the challenge model to build trust with families
- To define consensus building
- To examine how consensus building reduces or helps to manage conflict

- To explore how consensus building will help to produce greater performance outcomes
- To recognize how leadership style affects results
- To be able to recognize the key characteristics of a systems-oriented view of families and teams
- To be able to identify ways to discuss family interactions rather than just the behavior of individual family members
- To discuss how day-to-day informal and formal supports may be used differently during a crisis
- To identify strengths and needs in a case study family
- To differentiate between inventory and functional strengths
- To be able to translate inventory strengths into functional strengths
- To identify five forms of solution-focused questions
- To practice the use of solution-focused questions
- To describe a model for providing feedback
- To provide feedback that is strengths-based.
- To apply skills necessary for preparing a family or team member for positive contributions to a family meeting
- To apply skills necessary to help family members identify their strengths and their needs as they relate to child safety
- To discuss roles and responsibilities of team members, including agency staff, in facilitating or participating in a family team conference.
- To be able to explain the steps of facilitating Child and Family Team Meeting with team members
- To recognize the need, and discuss ways to develop a child and family team of caseworker, family and community partners that:
  - Incorporates the child and family's community and culture
  - Invites participation from a broad membership to assist in assessment and case planning
  - Broadens the definition of family
  - Includes the participation of foster parents or other caregivers when the child is in care
- To identify and discuss ways in which the application of a combination of facilitation skills can support positive outcomes for families. These include skills related to
  - Cooperation
  - Validation
  - Sharing Power
  - Shared Leadership
- Identify and discuss the importance of facilitation skills to conduct a child and family meeting that meets the short and long term needs of the child and family
- To select cases for application of the model and to initiate the process in actual cases
- To co-facilitate family team conferences with a coach/mentor

- To consult with supervision and coaches regarding process and outcomes of meetings
- To facilitate family team conferences <sup>1</sup>

In support of this training and coaching effort, the Department should issue policy expressing the right of all class members to a functioning child and family team, facilitated by a trained facilitator and utilized to plan the delivery of services needed to achieve safety, permanency, stability and well-being. Linked to this training as a second stage, with the advice and approval of the Katie A. Panel, the Department will develop a four-day training session on strength based assessment and individualized planning, which may be delivered in two, two-day sessions. Each case carrying front line staff member and supervisor will complete the four-day training.

This new in-service training and coaching should be informed by evidence-based practice so that DCFS, DMH and provider staff all understand how to conform their practices to the clinical principles of proven methods of meeting the needs of class members and their families.

With the advice and approval of the Katie A. Panel, the Department should revise the basic pre-service training design to be consistent with the Panel’s training recommendations in its Third Report. This and other training recommended by the Panel should be developed collaboratively with the Department of Mental Health.

The design of this pre-service training, including core competencies and enabling abilities, should enable staff to practice consistent with the following practice principles.

## **Practice Principles**

### **I. General Principles**

*Children should live with their families. Exceptions should be made only when it is not possible through the provision of services (including intensive home-based services), to protect a child living with his/her family from harm or to protect a child from harm upon reunification with his/her family.*

*The most natural and effective way of helping children to achieve safety, permanency and well-being is usually by strengthening the capacity and skills of their own families.*

*The system’s efforts to assist children to achieve permanency should be conducted with the urgency appropriate to a child’s sense of time.*

*The response to children and families shall not discriminate based on race, sex, religion ethnicity, national origin or sexual preference.*

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<sup>1</sup> Use of these descriptions of Family Team Conferencing Core and Enabling Abilities requires the prior written consent of The Child Welfare Policy and Practice Group.

*Children should have freedom from excessive medication, unnecessary seclusion and restraint.*

## **II. Principles Relating to Resource Allocation and Service Design**

*Neighborhood and community resources and institutions should be treated as key partners in serving children and families, both in planning for individual families and as a partner in system design and operations.*

*Children and their families should have access to a comprehensive array of services, including intensive home-based services, designed to enable children to live with their families or to achieve timely permanency.*

*Services should be flexible and adapted to child and family needs. Children and families should not be expected to adapt to ineffective services.*

*To enable children to live safely with their families, vigorous early intervention services should be offered families-at-risk before the level of risk rises to a level necessitating involuntary intervention.*

*The system should be sensitive to cultural differences and the special needs of minority ethnic and racial groups. Services should be provided in a manner that respects these differences and attends to these special needs. These differences and special needs should not be used as an excuse for failing to provide services.*

## **III. Principles Related to Assessment, Planning and Intervention**

*Services to children and their families should be planned and delivered through an individualized service plan crafted by the child and family team. Children, their parents, the family's informal support network, caregivers and foster parents should be full participants in this team. Involvement should include regular participation in family team meetings as a point for engagement, assessment, planning intervention and assessment of progress.*

*Children, parents and foster parents should be accurately and timely informed, in language understandable to them of their rights, the goal for the child/family and individualized service plans.*

*Children and their families should receive individualized services based on their unique strengths and needs. Children and parents should be encouraged and assisted to articulate their own strengths and needs, the goals they are seeking for themselves and what services they think are required to meet these goals.*

*The assessment process should address the underlying conditions creating the challenges experienced by the child and family, not just the symptoms of functioning. The system's assessment should be developed with the suggestions and contributions of the full family team.*

*The mix of services provided should be responsive to the strengths and needs of the child and his/her family. Conceptualizing the needs based plan should not be constrained by the availability of services. Where needed services are unavailable, appropriate services should be created.*

*The system should ensure that the services identified in individualized service plans are timely, accessible and responsive to children and families and delivered in a coordinated and therapeutic manner that integrates the efforts of the contributors.*

*The system should carefully monitor implementation of the individualized service plan and the progress being made toward the goal and objectives of the plan.*

*The goal and the objectives of the individualized service plan should be updated as needed. Services identified in the plan should be modified as needed to meet the goal and objectives of the plan (for example, by adding new services or providing services in a different way).*

#### ***IV. Principles Relating to the System's Response to Alleged Child Abuse or Neglect***

*The system should respond promptly to reports of abuse and neglect.*

*The response to reports of abuse and neglect and requests for assistance should be met with an offer of help.*

*Where children are found to be unsafe, immediate safety (protection) plans should be implemented.*

#### ***V. Principles Relating to Children Who Must be Placed in Foster Care***

*When children cannot live safely with their families, the first considerations for placement should be with kinship connections capable of offering and demonstrating the resource of a safe, stable and appropriate home.*

*Siblings should be placed together. The system should develop a policy identifying circumstances in which exceptions to this principle may be permitted.*

*Children should be placed in their own communities, where they can maintain relationships with family and friends and continue to attend the same school they were in prior to placement.*

*Placements should be made in the least restrictive, most normalized setting responsive to the child's needs.*

*The system should avoid temporary, interim placements. Children should be placed in settings that could reasonably be expected to deliver long term care if necessary. To this end, the use of congregate shelter placements should be avoided in favor of family based*

*settings. The system should not place children younger than six in congregate settings unless it is necessary to maintain connections with siblings placed in the same setting. When shelter is used, the placement should be short term.*

*Children should receive prompt and appropriate attention to their health care needs.*

*The system should vigorously seek to assure that children, when in foster care or custody, are integrated to the maximum extent feasible into normalized school settings and activities and achieve success in school.*

*The matter of visiting, both between children in care and their parents and among siblings should be addressed in the child's individualized service plan. The frequency and circumstances of visiting should depend on age and need. Visiting should be viewed as an essential ingredient of family reunification services. Hence, when the goal is for the child to return home or live with a family member, visiting should be actively encouraged. Visiting plans that require agency oversight or participation should take into account the work, education and obligations on the part of the parents. After hours and weekend visits should be options to permit parents to meet necessary obligations. Visiting may be arranged by the child, the child's parents or family, or the foster parents, as well as by staff and the staff of residential facilities, in accordance with the individualized service plan.*

*Supervision of visiting should be required only when there is a danger that the parent or family member with whom the child is visiting will harm the child unless the visit is supervised.*

*The system should forbid summary discharges of children from placement. The system should develop a policy that describes steps that should be taken prior to a child's discharge from a placement. The system should be based on the philosophy that the disruption of a placement is a failure of the system, not a failure of the child.*

## ***VI. Principles Related to Transitions from Care to Reunification or Independence***

*Families whose children are reunified should receive ongoing supports that will enable them to safely sustain their children in their homes.*

*Youth in custody who are expected to remain in care until adulthood should receive a full array of preparatory supports for independent living, addressing educational, emotional, relationship and vocational development.*

*The system should promote smooth transitions for children to adult service. Planning for youth in custody who will reach adulthood without permanence should connect them with caring adults, both relatives and other resources, whom they can turn to for help after system supports are no longer available.*

**VII. Principles Related to Effective Collaboration with Other Service Systems**

*Communication and interaction with the court should reflect timeliness, preparation, knowledge, respect and accuracy*

*The system should take an active role in seeking to ensure that local education agencies (i) recognize children’s educational rights and (ii) provide children with educational services in accord with those rights.*

To assist staff in the field to fully develop and apply the skills acquired in classroom training, the Department should expand the number of staff available to coach and mentor new and experienced staff in new approaches. The Department should hire 80 staff mentors, who will supplement the mentoring available from existing facilitators.

To the extent possible, this new training and staff mentoring will be funded out of Title IV-E training dollars by changing the pre-service and in-service training now offered by the universities.

<b>Task</b>	<b>Action Completed</b>
<p>Revise pre-service training</p> <ul style="list-style-type: none"> <li>• Create a DCFS-DMH-University Consortium design team</li> <li>• Develop core competencies that will govern knowledge and skills content</li> <li>• Develop training activities based on core competencies and enabling abilities</li> <li>• Design mentoring experience for new staff that that permits reduced caseloads for initial months</li> <li>• Recruit and train four mentors in each SPA to supervise and coach new staff</li> <li>• Recruit trainers with front-line child welfare practice experience available to teach the entire curriculum that can model the skills in the curriculum</li> <li>• Pilot the training, solicit feedback and complete revisions to the pilot</li> <li>• Provide training of trainers</li> <li>• Provide training to entry level staff, including new trainers and mentors</li> </ul>	<p>October 30, 2005</p> <p>February 28, 2006</p> <p>September 30, 2006</p> <p>September 30, 2006</p> <p>September 30, 2006</p> <p>October 30, 2006</p> <p>November 30, 2006</p> <p>January 30,2007</p> <p>February 28, 2007</p>

<b>Task</b>	<b>Action Completed</b>
<p>Train family meeting mentors and staff in family meeting facilitation</p> <ul style="list-style-type: none"> <li>• Develop clear standards on the use of family meetings with class members as a routine engagement, assessment, planning and coordination approach at all key planning events in the life of a case.</li> <li>• Develop a three-day curriculum based on the competencies described earlier in this section</li> <li>• Recruit eighty mentors that can coach staff in the family meeting process</li> <li>• Recruit six, two person training teams to train staff</li> <li>• Deliver the training to mentors</li> <li>• Provide modeling and coaching to the mentors in actual family meetings using skilled facilitators to develop their skills</li> <li>• Train front-line supervisors and staff</li> <li>• Provide coaching by mentors to case carrying staff (as a minimum, staff should observe the preparation of class members and families for their initial meeting, lead the process coached by a mentor, observe meetings facilitated by the mentor and co-lead meetings with the mentor)</li> <li>• Develop a mechanism to track the use and assess the quality of family meetings</li> </ul>	<p>October 15, 2005</p> <p>January 30, 2006</p> <p>January 30, 2006</p> <p>January 30, 2006</p> <p>March 1, 2006</p> <p>April 15, 2006</p> <p>August 15, 2006</p> <p>October 1, 2006</p> <p>October 1, 2006</p>

<b>Task</b>	<b>Action Complete</b>
<p>Develop in-service training for existing staff on strengths/needs based assessment and individualized planning for class members</p> <ul style="list-style-type: none"> <li>• Develop core competencies and enabling abilities on assessment and planning consistent with the practice principles listed previously</li> <li>• Develop training activities based on core competencies and enabling abilities</li> <li>• Recruit ten, two person training teams to deliver the in-service training to existing staff</li> <li>• Train the training teams in the delivery of the assessment and planning curriculum</li> <li>• Pilot the curriculum with existing staff</li> <li>• Revise the curriculum based on the pilot experience</li> <li>• Deliver the four-day curriculum to current staff</li> </ul>	<p>November 15, 2005</p> <p>February 15, 2006</p> <p>March 1, 2006</p> <p>May 1, 2006</p> <p>June 15, 2006</p> <p>August 16, 2006</p> <p>March 1, 2007</p>

## **Expanding Mental Health Services**

The Panel estimates that conservatively, at least 50 percent of the children served by the Department are members of the Plaintiff class. DCFS and DMH must develop an expanded array of services available to the plaintiff class, specifically to provide intensive home-based mental health services, provide clinical interventions for traumatized children, and create stable family homes for seriously emotionally disturbed children and youth.

### ***1. Develop Countywide Intensive Home Based Services***

Using baseline data on services with the baseline on the class, design a comprehensive process for developing intensive home-based services throughout the county to meet the needs of the class. This process should include RFP(s) for contractor(s) to manage the expansion of service capacity in various providers, including centralized technical assistance and training. The expansion design should include timelines, financing, and methods for determining providers' adherence to specific clinical principles. The process should also be coordinated with the Wrap expansion, reduction in group care, and the training of DCFS and DMH staff."

Intensive home-based services include a coordinated combination of services, uniquely designed for the child and family, including:

- A clinical team working with the child and family
- Assessment of the child's needs that guides the family and providers
- In-home therapy, including trauma treatment
- Behavior support for the child by clinically trained individuals
- Guidance for the child's family/foster family in managing the child's behavior
- Crisis intervention by clinicians who know the child and family

Usually these services should be designed with the family or foster family to come from one provider to avoid coordination problems. Intensive home-based services should be developed within each SPA to prevent transportation obstacles, but through a countywide process of implementing adherence to the clinical principles of evidence-based practices so that all the providers and DCFS and DMH staff are held accountable to the same outcomes across SPAs.

The implementation countywide of intensive home-based services for thousands of class members cannot be accomplished through expansion of existing children's outpatient mental health services, crisis services or TBS. Achieving this corrective action requires a complete overhaul of the county's mental health services for class members and change in practice by DCFS, DMH and provider staff.

This initiative should be coordinated with the financing strategy consultants. One difficulty of projecting a target for expansion of these services is the lack of accurate information about the current level of service provision. Baseline data is needed.

In addition to the expansion of the availability of these services, providers need assistance in developing their expertise in delivering these services. This need is particularly acute for providers that deliver trauma treatment for children. To improve the capacity of providers to deliver quality intensive home based, trauma and crisis mental health services, the department should, with the assistance of the Department of Mental Health and the Panel, enlist external consultants to provide training and consultation in these areas for the provider community.

<b>Task</b>	<b>Date Completed</b>
Develop baseline data on the amount of these mental health services delivered in LA County	January 30, 2006
Create definitions and standards for intensive home-based mental health services	March 30, 2006
Utilize the financing technical assistance provider to develop Medicaid claiming guidance for providers providing these services	March 30, 2006
Using the financing technical assistance provider and Panel for guidance, develop and issue RFP's to develop the types of intensive, home-based mental health services described by the Panel. The scope of services should be sufficient to expand capacity be 25 % in year one.	March 30, 2006
Award contracts and provide training on claiming to providers	July 30, 3006

Secure expert technical assistance to train providers on use on intensive home-based services	October 30, 2006
Initiate services	January 1, 2006
Expand services through RFP by 20%	July 1, 2007

## 2. Expand Wraparound Services

The Department has demonstrated some success in improving outcomes through the provision of Wraparound services, but the resources currently committed to this service fall far short of meeting the needs of the plaintiff class. The information DCFS shared orally in August 2005 about the Department's anticipated expansion of Wraparound is not in their draft plan, so the relevance and likelihood of this initiative occurring is not known. Expansion is needed and the Department must strengthen the quality of Wrap programs now in operation and to assure the quality of new programs that are developed. Expanded and improved Wrap programs should be a form of intensive home-based services. In concert with the Department of Mental Health, the Department should implement a two-year initiative to significantly increase available Wraparound slots and to provide training and technical assistance to Wrap providers. As part of the quality assurance effort, with the advice and approval of the Panel, the Department should retain Wraparound consultants that will assist in the development of providers and strengthen the expertise within the Department and Department of Mental Health to provide ongoing technical assistance. In addition, the Department should expand eligibility for Wraparound services to include children who do not have intact families and those placed in Level 10 and above residential settings.

<b>Task</b>	<b>Action Completed</b>
Revise policy to include children without intact families and in Level 10 and above residential settings	September 30, 2005
Retain a Wraparound consultant to help with RFP design and expectations, training of providers and evaluation	October 30, 2005
Draft an RFP for expansion by 500 Wraparound slots	December 15, 2005
Design training for new Wrap providers and for existing Wrap providers	February 15, 2006
Issue Wrap RFP and select provider(s)	March 1, 2006
Select provider (s) and provide training	June 15, 2006
Evaluate performance of new and existing providers	March 15, 2007
Based on Evaluation, revise contract performance standards, select providers for the fiscal year and expand Wrap by 500 more slots for 2007-2008	June 30, 2007

### 3. Create Treatment Foster Care

A substantial number of class members who are seriously emotionally disturbed experience placement in congregate settings inappropriate to their needs, frequent placement disruptions, failure in school, lack of permanency, entry into the juvenile justice system and/or may become runaways. When they leave the Department's custody at age 18, many become homeless, are unemployed and/or enter the adult correctional and mental health systems. The Department has no effective clinically appropriate resource for these youth and spends countless dollars ineffectively responding to the impact of unmet needs. To meet the needs of these children and youth, the Department should implement a treatment foster care initiative, with the assistance of the Oregon Social Learning Center (OSLC), employing their approach. This initiative should be coordinated with the Department of Mental Health.

<b>Task</b>	<b>Action Completed</b>
Retain consultation from OSLC for design, training, implementation assistance	October 30, 2005
Observe operations at (OSLC) in a joint DMH/DCFS site visit. and with the assistance of OSLC, develop and issue a RFP to create 300 therapeutic foster care slots	February 15, 2006
Select providers and through OSLC provide training and consultation for start-up	May 15, 2006
Begin operations with initial providers	July 1, 2006
Evaluate performance, guided by OSLC	March 15, 2007
Award 2007-2008 contracts based on prior performance and evaluation and add 200 additional slots for the new contract year	July 1, 2007

### 4. Transitioning Youth from Group Care to Family Based Settings

Utilizing the data from John Lyons on the over-utilization of group care the Department needs to establish an aggressive downsizing and redirection target for group care. The John Lyons report suggested that 57% of the children and youth in level 12 and 14 group care could be effectively served with home-based services options. The total state and county dollars associated with this need to be identified and redirected to help fund the development of home-based options. If State approval is required for the state dollars immediate steps should be taken to secure the necessary waivers. To prevent back-filling of group care a systematic clinical utilization management system needs to be established to ensure only appropriate referrals to group care are made and that children and youth instead are provided intensive home-based services with families and foster families sufficient to meet their needs and prevent placement breakdown.

<b>Task</b>	<b>Action Completed</b>
Establish group care downsizing targets	October 1, 2005
Identify the intensive home-based services needed and capacity targets	October 30, 2005
Identify development and service dollars needed for support of group care alternatives and obtain approval for redirection of state and county dollars	January 30, 2006
Design and implement a county-wide clinical utilization management system	March 15, 2006

### **5. Implement a Financing Strategy**

Improving front line practice and expanding mental health services will require additional resources. To identify the cost of needed system improvements and to maximize the use of existing county, state and federal financial resources, the Department should, with the advice and approval of the Panel, retain the assistance of consultants expert in the claiming of Medicaid and Title IV-E training, California funding procedures and redeployment of existing funds. The consultants, with the participation of the Panel and DCFS staff, should analyze opportunities to increase revenue available for the needs of the plaintiff class and identify the changes and actions needed to maximize existing resources and develop new resources.

In addition, in its input to the State's plan for use of new Proposition 63 dollars, the County should insure that the services identified as needed in this plan are included.

The Department and County and State Mental Health staff should utilize the expertise of financing consultants to provide technical assistance to providers on making maximum use of Medicaid. The Department should create the internal capacity to continue to provide training and consultation to providers.

<b>Task</b>	<b>Action Completed</b>
Retain consultants for Title XIX, Title IV-E and clinical utilization management to assist the Panel, DCFS and DMH with financing strategies	October 15, 2005
Identify changes/actions needed	December 30, 2005
Implement identified actions	March 1, 2006
Develop and deliver training and technical assistance to providers on Title XIX claiming and to DCFS cost allocation staff on IV-E claiming	April 15, 2006
Create a Department unit/structure to deliver technical assistance.	May 15, 2006

## 6. Improve Data Outcome Trend Analysis and Implement A Qualitative Review Process

### Data Trend Analysis Reporting

The ability to track outcome trends is crucial to determining the Department’s compliance with the Katie A. settlement agreement. After two years of effort by the Panel and the Department, the Department still cannot track the most basic indicators of progress for the plaintiff class. In deference to the complexity of this task, tracking a sub-group of the larger population would be difficult for any child welfare system, especially when another agency, DMH, possesses critical elements of the data needed. The Panel is not expert in designing data systems or extracting data from them and DCFS and DMH face several significant obstacles in reporting trends and service use accurately.

It is the opinion of the Panel that additional external technical assistance is needed to facilitate the design of the process for providing trend data. In addition, there are likely to be additional elements of data not yet contemplated that will enhance the measurement of progress by the plaintiff class. Research and technical expertise is needed to assess these additional refinements. In consultation with and with the approval of the Katie A. Panel, DCFS should retain a research organization, such as the Chapin Hall Center for Children, to assist it and the Panel in measuring the progress of the plaintiff class.

Tracking mental health services provided to each class member by SPA is necessary, including the needs of each child, the specific services provided to the child and family, the outcomes, and the refinement of services for the child and family to achieve improved outcomes.

<b>Task</b>	<b>Action Completed</b>
Retain data/evaluation consultant to assist in tracking data trends	October 15, 2005
Examine the current DCFS and DMH data system with the consultant to identify capacities and limitations	January 15, 2006
Under the direction of the Panel, with assistance from the data consultant, provide a list of measures of class member status currently available and reliable and those needing to be developed	April 15, 2006
Under the direction of the Panel, with assistance from the data consultant create a realistic and detailed work plan of tasks, costs and resources needed to produce data on key outcome measures	August 15, 2006
Implement the data plan	October 1, 2006

Provide an accurate report on class member characteristics, consistent with the Panel’s prior requests and the data plan	July 30, 2007
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**7. Development of a Qualitative Review Process**

The Panel has previously recommended that DCFS expand its approach to evaluating outcomes and developing implementation strategies by adopting a qualitative review process that examines current child and family status and system performance. The Panel believes that employing such a process would significantly enhance the planning for and measurement of progress within the system. The Department should participate in the qualitative review of 200 cases of plaintiff class members, selected randomly, and stratified by the percentage of children in group care, foster care and bio-family/kinship settings in the general population of the class. The Panel will develop the qualitative protocol and reviewers will be selected and trained by the Panel.

DCFS staff should be assigned to observe (shadow) the case reviews and key stakeholders will be invited to observe as well. The Panel would prepare a report of findings. For the period of the settlement agreement’s term such a review will be conducted annually. A goal of the process will be to train and develop reviewers within the DCFS workforce, who can constitute a portion of the review work force in future reviews.

***Rationale for a Qualitative Review Process***

The qualitative review process has been utilized in the following states:

- |           |                |
|-----------|----------------|
| Alabama   | North Carolina |
| Georgia   | Hawaii         |
| Iowa      | Connecticut    |
| New York  | Kentucky       |
| Missouri  | Tennessee      |
| Wisconsin | Arizona        |
| Florida   | Washington, DC |

It is also the basis case based portion for the federal government’s state child welfare performance measurement process, the Child and Family Service Review (CFSR). It is used as a practice improvement tool within state child welfare systems and in a growing number of states where child welfare class action settlement agreements are in place, it is used by court monitors to judge compliance and progress. Alabama, where the process originated, Utah, Hawaii, Washington, DC, Tennessee and New Jersey are states where the process is a part of formal court monitoring.

Use of the process has grown because no single measure of performance and outcomes is sufficient to provide the information needed to evaluate system functioning. Long-term

trend data, such as the Panel is now seeking from DCFS and the Department of Mental Health, are needed to measure the extent of progress and its sustainability over time. The limitation of trend data at this stage is that months and years must elapse before the data can reliably identify trends and that the data do not provide information about whether change is or is not occurring. Also, trend data do not provide information about why progress is not occurring. For long-term trend data to be effective, it must be paired with an approach to examine qualitative factors. Because it examines current child and family status (safety, stability, emotional well-being, progress in school, for example), the qualitative review approach provides immediate feedback about the level of child and family functioning. The process also helps identify why outcomes are not being achieved, information vital to developing plans for corrective action. It is the opinion of the Panel that both processes should be in place to measure progress, to identify barriers to progress and to strengthen accountability.

The qualitative review process employs a protocol defining good child welfare and mental health practice that assists in collecting information from a small sample of cases, where the primary source of information about current outcomes and system performance comes from detailed in-person interviews with all parties involved in the case. Interview information collected from parents, foster parents, children, caseworkers, mental health therapists, teachers, attorneys and other providers on each case and aggregated across the entire sample gives an accurate picture of current status and the system's performance. Performance is quantified on a six-point scale and when aggregated to provide an acceptability score for the population reviewed, helps identify if the system is being successful over time and how it is achieving success (or failing to achieve it). The process collects information on a series of domains related to current child and family status (outcomes) and on system performance. A typical instrument design looks at the following areas for each child.

### **Child and Family Status (Current Outcomes) Summative Questions:**

**Safety** Is the class member safe from manageable risks of harm (caused by others or by the class member) in his/her daily living, learning, working and recreational environments? Are others in the class member's daily environments safe from the class member? Is the class member free from unreasonable intimidation and fears at home and school?

**Stability** Are the class member's daily living and learning arrangements stable and free from risk of disruption? If not, are appropriate services being provided to achieve stability and reduce the probability of disruption?

**Appropriateness of Placement** Is the class member in the most appropriate placement consistent with the class member's needs, age ability and peer group and consistent with the class member's language and culture?

**Prospects for Permanence** Is the class member living in a home that the class member, caregivers, and other stakeholders believe will endure until the class member becomes independent? If not, is a permanency plan presently being implemented on a timely basis that will ensure that the class member will live in a safe, appropriate, permanent home?

**Health/Physical Well-Being** Is the class member in good health? Are the class member's basic physical needs being met? Does the class member have health care services, as needed?

**Emotional/Behavioral Well-Being** Is the class member doing well, emotionally and behaviorally? If not, is the class member making reasonable progress toward stable and adequate functioning, emotionally and behaviorally, at home and school?

**Learning Progress** Is the class member learning, progressing and gaining essential functional capabilities at a rate commensurate with his/ her age and ability?

**Caregiver Functioning** Are the substitute caregivers, with whom the class member is currently residing, willing and able to provide the class member with the assistance, supervision, and support necessary for daily living? If added supports are required in the home to meet the needs of the class member and assist the caregiver, are these supports meeting the need?

**Family Functioning and Resourcefulness** Does the family, with whom the class member is currently residing or has a goal of reunification, have the capacity to take charge of its issues and situation, enabling them to live together safely and function successfully? Do family members take advantage of opportunities to develop and/or expand a reliable network of social and safety supports to help sustain family functioning and well-being? Is the family willing and able to provide the class member with assistance, supervision, and support necessary for daily living?

**Satisfaction** Are the class member and primary caregiver satisfied with the supports and services they are receiving?

**Overall Class member Status** Based on the Service Test findings determined for the Class member Status Exams 1-11, how well is this class member presently doing? Overall class member status is considered acceptable when specified combinations and levels of examination findings are present.

### **System Performance Indicators**

**Class member/Family Participation** Are family members (parents, grandparents, and stepparents) or substitute caregivers active participants in the process by which service decisions are made about the class member and family? Are parents/caregivers partners in planning, providing, and monitoring supports and services for the class member? Is the class member actively participating in decisions made about his/her future?

**Class member/Family Team and Team Coordination** Do the people who provide services to the class member/family function as a team? Do the actions of the team reflect a pattern of effective teamwork and collaboration that benefits the class member and family? Is there effective coordination and continuity in the organization and provision of service across all interveners and service settings? Is there a single point of coordination and accountability for the assembly, delivery, and results of services provided for this class member and family?

**Functional Assessment** Are the current, obvious and substantial strengths and needs of the class member and family identified through existing assessments, both formal and informal, so that all interveners collectively have a “big picture” understanding of the class member and family and how to provide effective services for them? Are the critical underlying issues identified that must be resolved for the class member to live safely with his/her family independent of agency supervision or to obtain an independent and enduring home?

**Long-Term View** Is there an explicit plan for this class member and family that should enable them to live safely without supervision from class member welfare? Does the plan provide direction and support for making smooth transitions across settings, providers and levels of service?

**Class member and Family Planning Process** Is the service plan (SP) individualized and relevant to needs and goals? Are supports, services and interventions assembled into a holistic and coherent service process that provides a mix of elements uniquely matched to the class member/family’s situation and preferences? Does the combination of supports and services fit the class member and family’s situation so as to maximize potential results and minimize conflicting strategies and inconveniences?

**Plan Implementation** Are the services and activities specified in the service plan for the class member and family, 1) being implemented as planned, 2) delivered in a timely manner and 3) at an appropriate level of intensity? Are the necessary supports, services and resources available to the class member and family to meet the needs identified in the SP?

**Formal/Informal Supports** Is the available array of school, home and community supports and services provided adequate to assist the class member and caregiver reach levels of functioning necessary for the class member to make developmental and academic progress commensurate with age and ability?

**Successful Transitions** Is the next age-appropriate placement transition for the class member being planned and implemented to assure a timely, smooth and successful situation for the class member after the change occurs? If the class member is returning home and to school from a temporary placement in a treatment or detention setting, are transition arrangements being made to assure a smooth return and successful functioning in daily settings following the return?

**Tracking and Adaptation** Summative Questions: Are the class member and caregiver's status, service process, and results routinely followed along and evaluated? Are services modified to respond to the changing needs of the class member and caregiver and to apply knowledge gained about service efforts and results to create a self-correcting service process?

**Caregiver Support** Are substitute caregivers in the class member's home receiving the training, assistance and supports necessary for them to perform essential parenting or caregiving functions for this class member? Is the array of services provided adequate in variety, intensity and dependability to provide for caregiver choices and to enable caregivers to meet the needs of the class member while maintaining the stability of the home?

**Effective Results** Summative Questions: Are planned education, therapies, services and supports resulting in improved functioning and achievement of desired outcomes for the class member and caregiver that will enable the class member to live in an enduring home without agency oversight?

**Overall System Performance** Based on the Qualitative Case Review findings determined for System Performance exams 1-10, how well is the service system functioning for this class member now? Overall system performance is considered acceptable when specified combinations and levels of examination findings are present. A special scoring procedure is used to determine Overall System Performance for a class member.

Such reviews also provide a written case story for each case reviewed that puts a "human face" on the circumstances of children in the child welfare system. The case stories also identify themes regarding system performance that guide system improvement efforts to address those themes. An illustrative case story from a review in another state is included in the Appendix to provide an example of the details that can be identified through individual case reviews. In this case of "Susan", a pseudonym, her experience and that of others reviewed identified the weaknesses in face-to-face teaming, assessment, coordination and lack of long-term perspective about children's needs that characterize this system. The system's corrective action efforts focused on strengthening caseworker practice in these areas, not creating a new program to address each one.

The qualitative scores in reviews of the Salt Lake Region of the Utah DCFS system, where this process is employed by the court monitor to judge compliance, illustrate an example of the progress in outcomes and performance. The statewide reviews there involve a total of approximately 170 cases reviewed annually. The following table clearly shows the progression of improving outcomes and system performance that have occurred in this urban region as system reform strategies have been implemented.

**Salt Lake Region System Performance**

	# of cases		FY00 FY01 FY02 FY03 FY04				
	# of cases	Needing Exit Criteria 70% on Shaded indicators	Baseline				
	Acceptable	Improvement Exit Criteria 85% on overall score	Scores				
Child & Family Team/Coordination	54	15	36.7%	29.4%	34.7%	54.3%	<b>78.3%</b>
Functional Assessment	49	20	26.6%	36.8%	33.3%	54.3%	<b>71.0%</b>
Long-term View	48	21	33.3%	36.8%	31.9%	41.4%	<b>69.6%</b>
Child & Family Planning Process	52	17	47.6%	30.9%	48.6%	60.0%	<b>75.4%</b>
Plan Implementation	60	9	69.6%	67.6%	56.9%	71.4%	<b>87.0%</b>
Tracking & Adaptation	57	12	69.0%	54.3%	56.9%	57.1%	<b>82.6%</b>
Child & Family Participation	54	15	64.3%	50.0%	44.4%	62.3%	<b>78.3%</b>
Formal/Informal Supports	65	4	86.7%	76.5%	73.6%	82.9%	<b>94.2%</b>
Successful Transitions	54	13	68.6%	52.9%	49.3%	63.8%	<b>80.6%</b>
Effective Results	61	8	73.2%	64.7%	66.7%	72.9%	<b>88.4%</b>
Caregiver Support	43	1	92.0%	88.1%	91.1%	97.9%	<b>97.7%</b>
<b>Overall Score</b>	<b>59</b>	<b>100%</b>	<b>47.6%</b>	<b>52.9%</b>	<b>48.6%</b>	<b>58.6%</b>	<b>85.5%</b>

**Salt Lake Region Child Status**

	# of cases		FY00 FY01 FY02 FY03 FY04				
	# of cases	Needing	Baseline				
	Acceptable	Improvement Exit Criteria 85% on overall score	Scores				
Safety	67	4	86.7%	91.2%	94.4%	97.1%	<b>94.4%</b>
Stability	57	12	69.0%	76.5%	72.2%	72.9%	<b>82.6%</b>
Appropriateness of Placement	68	1	90.6%	95.5%	90.3%	95.7%	<b>98.6%</b>
Prospects for Permanence	54	15	64.3%	74.6%	59.7%	61.4%	<b>78.3%</b>
Health/Physical Well-being	68	1	97.6%	95.6%	95.8%	98.6%	<b>98.6%</b>
Emotional/Behavioral Well-being	60	9	76.2%	89.7%	75.0%	81.4%	<b>87.0%</b>
Learning Progress	61	8	88.1%	88.1%	79.2%	76.8%	<b>88.4%</b>
Caregiver Functioning	45	0	100.0%	95.2%	95.6%	100.0%	<b>100.0%</b>
Family Resourcefulness	31	5	60.0%	75.0%	56.8%	51.4%	<b>86.1%</b>
Satisfaction	63	6	86.4%	80.9%	84.5%	81.4%	<b>91.3%</b>
<b>Overall Score</b>	<b>64</b>	<b>7</b>	<b>86.7%</b>	<b>89.7%</b>	<b>87.5%</b>	<b>88.6%</b>	<b>90.1%</b>

Such reviews also provide a written case story for each case reviewed that puts a “human face” on the circumstances of children in the child welfare system. The case stories also identify themes regarding system performance that guide system improvement efforts to address those themes. An illustrative case story from a review in another state is included in the Appendix to provide an example of the details that can be identified through individual case reviews. In this case of “Susan”, a pseudonym, her experience and that of others reviewed identified the weaknesses in face-to-face teaming, assessment,

coordination and lack of long-term perspective about children’s needs that characterize this system. The system’s corrective action efforts focused on strengthening caseworker practice in these areas, not creating a new program to address each one.

An approach such as this, even for a relatively small group of children and families, would provide current critically important feedback on an ongoing basis about outcomes and the areas of system performance that need improvement to affect outcomes. In the absence of longitudinal data about system performance and achievement of outcomes, annual qualitative reviews would provide immediate feedback on the extent to which DCFS is making progress in achieving the outcomes desired for the plaintiff class. There is enough data on the qualitative review process nationally that the process thresholds could be established for acceptable performance.

Developing the capacity for using this process would include:

- Developing an acceptable protocol
- Selecting and training local reviewers
- Selecting a review sample and conducting a review
- Determining a baseline of outcomes and performance from the review
- Preparing a report of findings
- Designing system improvement strategies to address the findings of the review

<b>Task</b>	<b>Action Due</b>
<p>Develop a qualitative review process and capacity for regular reviews</p> <ul style="list-style-type: none"> <li>• DCFS leadership and QA staff attend the Utah Salt Lake Qualitative review as observers</li> <li>• DCFS and DMH assist the Panel in the design of a review tool/protocol</li> <li>• DCFS assist the Panel in recruiting and contracting with external reviewers needed to review a minimum of 200cases in the first review</li> <li>• Reviewers and DCFS participate in training provided by the Panel</li> <li>• DCFS assist the Panel in selecting the sample and arranging individual case interviews</li> <li>• DCFS and DMH participate in the baseline review</li> <li>• Panel to provide a report of findings</li> </ul>	<p>December 30, 2005</p> <p>February 15, 2006</p> <p>March 15, 2006</p> <p>June 30, 2006</p> <p>August 30, 2006</p> <p>November 30, 2006</p> <p>February 15, 2007,</p>

## 8. Standards for Exit

The lack of data available to provide feedback on DCFS progress impacting class members has significantly limited the Panel's ability to inform the court of compliance. Also, the settlement itself is general in content rather than precisely defining each task the County must achieve. This broad content related to goals and outcomes in particular is valuable, in that settlement language cannot anticipate the complex design of settlement implementation in detail. However, such broad requirements create a challenge in attempting to measure compliance.

The parties did not choose to set specific exit criteria at the time of settlement, but the Panel believes that such a step is now timely if there are to be clear targets for improvement. Based on experience in other settlements where exit criteria have been established, the Panel recommends the following three areas be adopted as exit criteria. Under this recommendation, to achieve compliance, the Department would have to achieve all three of the standards listed below.

### a. Successful Completion of a Meaningful Implementation Plan

One of the Panel's recommendations refers to its willingness to assume responsibility for the completion of a meaningful implementation plan, preferably with the participation and cooperation of DCFS and DMH. The Panel recommends that it be authorized to identify key elements of the completed plan that would become enforceable and serve a key element of compliance measurement. This process was included in the recent New Jersey child welfare settlement and appears to be an effective way to structure exit criteria at this stage.

### b. Acceptable Class Member Status and System Performance Scores on a Qualitative Review Process

Based on an annual review of cases using the qualitative review process, exit standards would require an overall score of 85% on status and system performance, with at least the following elements core of system performance measurement each achieving at least 70%:

- Assessment
- Long-Term View
- Service Planning
- Teaming
- Family Engagement/Involvement
- Plan Implementation

Exit standards such as this are used in settlement agreements in Alabama, Utah and Hawaii and are being considered in several other states already under settlement agreements.

c. Acceptable Progress on Outcome Trend Indicators

Because there is yet no baseline of performance related to outcome trends for the plaintiff class, the Panel is not comfortable recommending specific outcome targets as a standard, such as “No more than 15% of class members will experience more than three placement changes during a placement episode”. At this point, we do not know how far DCFS is from such targets. What the Panel does recommend is that once a baseline is established, the Panel be authorized to recommend to the court exit standards for achievement of outcomes. The New Jersey settlement also contains a provision such as this.

The Panel is aware that it is not a party to this case and that any decision about exit criteria ultimately rests with the court. It is with respect for the authority of the court and the role and rights of the parties to the settlement agreement that the Panel offers these exit criteria recommendations.

## **GLOSSARY OF TERMS**

ADHD-attention deficit hyperactivity disorder

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)

Treatment Foster Care – (Define)

FGDM-Family Group Decision Making

FM-family maintenance services

Hub-six regional sites where children will receive a comprehensive medical Evaluation, mental health screening and referral for services

IEP-individual education plan

MAT-Multi-Disciplinary Assessment and Treatment Team

PTSD-post-traumatic stress disorder

RCL-Rate Classification Level (levels of group home care, with RCL 14 being considered residential treatment; about 2,000 children are in about 125 group homes)

RPRT-Regional Permanency Review Teams

SPA-Service Planning Area (LA is divided into 8 regions)

TBS-therapeutic behavioral services

TDM-team decision making

Title XIX-Medicaid

# **APPENDIX**

# Attachment 1

## Sample Qualitative Review Case Story

County Qualitative Service Review  
Illustrative Case Story “Susan”  
Review Dates: April 24-28, 2000

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### Child/Family Status Summary

#### 1. Facts About the Child and Family.

Susan is an 11-year-old girl currently placed in the shelter, where she has been for almost a month. She is a sturdy, attractive child who related to the reviewers with the vocabulary and poise of an adult. She entered DHS custody due to her behavior originally, but was later adjudicated as “A Child in Need of Assistance” due to parental neglect. The neglect was determined when Susan was ready for discharge and could not be returned because her mother’s condition had deteriorated and Susan had nowhere else to go. Susan lived in a variety of settings prior to placement, including several shelters due to homelessness, domestic violence and substance abuse. She has experienced a series of foster care placements that have disrupted due to her behavior. She also spent 9 months in a residential treatment setting, making the total number of placements since November 1998, 7 placements. Her mother is diagnosed as Bipolar and has had a history of substance abuse. Susan’s father died in 1999. Susan had had little recent contact with him. She has a younger half sister that lives with Susan’s former stepfather. The stepfather and Susan’s mother are divorced (the divorce issues were bitterly fought). Susan’s half-sister has behavior problems also, but is maintained in a family setting. There has been a history of conflict between the siblings.

Susan has a therapist, but has not seen him for three weeks. Susan’s most recent diagnosis (11/99) is Major Depressive Disorder w/o Bipolar Disorder. This is in the case record, but is not employed currently by the worker as a diagnosis. She attends school at the shelter where she tests at the 7<sup>th</sup> grade level, despite being in the 5<sup>th</sup> grade. She is performing well in school and had been a model resident in the shelter. She proceeded through the levels system very quickly and is now permitted the optimum level of independence in the shelter. Susan is said to be ashamed of her mother and speaks to her disrespectfully.

Susan's mother was her caregiver prior to placement. Stakeholders report that Susan parented her mother and sibling much of the time due to her mother's mental illness and substance abuse. The family situation was described as unstable and chaotic. Susan's mother now lives alone in a Section 8 subsidized apartment in a community approximately 30 miles from \_\_\_\_\_. She receives SSI and does not have a car, so transportation is a problem. She has a therapist whom she sees regularly and is on psychotropic medications for her mental illness. She visits Susan, but home visits are no longer allowed because she tested positive for drugs recently. Perhaps due to her medication, the mother was lethargic and her speech was slightly slurred. She also seemed very apprehensive and wary of the interview and responded to questions very minimally.

There is a prior abuse allegation against Susan's mother, which was not confirmed. A prior abuse allegation against her father was also not confirmed. Susan's permanency goal is reunification with her mother.

This case has been challenging enough to the worker that he described it as his nightmare case.

## 2. Child's Current Status.

Susan is doing well in the shelter placement. She is not exhibiting any behavior problems and is performing well in school. She is said to be a mentor for her roommate regarding behavior and performance in the shelter. Susan enjoys the on and off campus activities she participates in and gets along well with the other children. Susan is awaiting another placement and believes that it will be in a family foster home. Her DHS worker, however, stated to the reviewers that he was considering a group home placement because Susan was doing so well in shelter. Susan's mother visits at the shelter, but Susan has little contact with her half-sister. In the brief interview, she did not manifest any symptoms of depression, nor is it noted as a current issue by her worker, therapist or the shelter social worker.

The worker states that Susan can be very uncaring to her friends and will berate or ignore them if they do not respond to her wants and needs. She has behaved this way with foster parents and the kinship provider she was placed with. She was said to have played the kinship provider couple (who were quite young and had no children) off against each other. Susan was given substantial material possessions in one disrupted placement, such as a computer and other privileges. This was considered a somewhat privileged setting by stakeholders. In one placement, after declaring that she wanted to be moved, Susan wrote a note describing the kind of foster care placement she wanted next.

Susan's conversation with reviewers about her life was instructive in its content. She takes some pride in her maturity, saying that she got frustrated when others expressed surprise at her life experience and maturity. She spoke of using her wisdom in helping other residents. Susan also boasted of the possessions she had accumulated at such an early age (mainly electronic equipment) and remarked that others were surprised that she

had acquired these items. She also described an incident where an aunt was unable to respond to her infant's choking and Susan took charge and helped the child expel the item. She expressed puzzlement that the aunt was so concerned about the infant's vomiting on her and stated, "Would she have rathered that the child died?" These adult-like perspectives were common in the interview.

At present, Susan's status is neither stable nor permanent. The reason for the behavior that triggers her frequent moves is not clearly known. There is no indication that she will be returning to her mother in the foreseeable future. DHS staff thinks that this is unlikely in the long run due to her mother's limitations. This belief is not reflected in the current plan and apparently is not known by the mother. While a move from shelter is expected, the identity of the next placement is not known.

Susan is also in a placement more restrictive than merited by her needs. The structure in the shelter and lack of expectation that she will have to make lasting attachments possibly contribute to her adjustment in the shelter, but this not a suitable environment for an 11 year old with her resilience and assets. Susan described for reviewers the type of environment she wanted in her next placement and noted her desire to be respected, to have a predictable schedule and to have independence (she noted that she accustomed to preparing her own meals).

### 3. Family's Status.

Susan's mother is receiving several psychotropic medications for her Bipolar disorder, which may be the reason for lethargy and slurred speech during the interview. Her apartment is 30 miles from \_\_\_\_\_ and without a car, transportation is a problem. She is still connected to her therapist and denies that her positive drug test was a result of illegal drugs, rather a symptom of her psychotropic medications.

Her therapist states that the mother has recently begun to engage in "telephone dating" with men she has not met before. It was not clear whether this behavior was a form of out call behavior or something more spontaneous. According to the therapist, she has gone to the apartment of one man whom she had not met and had sex with him. The therapist is trying to help her understand how to protect herself from the dangers of such encounters. The mother was described as a person with very poor judgment and little capacity to understand such risks.

The mother's life is more stable than when Susan lived with her. She is not in a shelter and has stable housing and income from SSI. She has family in the community, but was very uncommunicative about their availability as a resource. She cares about Susan and would like for her to come home. She says with some exasperation that she has done everything she has been asked to do, but reunification still has not occurred. While there has been progress toward independence, Susan's mother appears to be a person who, because of her mental health issues, history of substance abuse and poor judgments about

issues like the men in her life, will need some level of system support indefinitely. She lives with some independence at this time, but not sufficiently so for her to resume a parenting role.

#### 4. Factors Contributing to Favorable Status.

There are several favorable factors in this case. Susan has many assets. She is extremely resilient, having survived the chaotic life at home with so many abilities and interests intact. She is intelligent and likes school, where she performs well. In some settings, she relates well to others. She has a commanding facility for language and likes to read (she spoke enthusiastically about her love of the *Harry Potter* series and other favorite books). She can be clear about expressing her needs. She has family and a mother who despite her limitations, cares for her. Some of her adult caregivers like her personally. And although her “parentified” behavior (as labeled by the system) is seen as negative regarding relationships, it reflects her ability to be responsible (as was the case at times when carrying the parent role in her family’s chaotic days). She does not appear to need medication and as of yet does not carry an operational mental health diagnosis that would permanently label her in a negative way. (i. e., conduct disorder, oppositional defiant, or others). The Bi-Polar diagnosis referenced in the record is generally ignored.

Her mother is more independent than she has been in the past and has a caring therapist. Her medication seems to improve her stability and she has demonstrated the ability to live alone, with supports. She cares about her daughter.

#### 5. Factors Contributing to Unfavorable Status.

Susan is dangerously close to becoming “adjusted” to a lack of permanency and stability. When reviewers noted her calmness regarding the uncertainty of her next placement, she said, “When you’ve lived like I have, you have to be ready to move at any time.” She spoke of a lengthy period of instability with pride in her ability to survive it rather than sadness over the loss and uncertainty. Her adult-like manner could interfere with peer relationships, especially because her needs for self esteem seem to drive her to speaking a in a superior way about things like her worldliness, intelligence and achievement.

These traits are likely to challenge caregivers, especially those in a family setting who expect to parent her like an average 11 year old. Her need for independence and “respect” could be difficult for unprepared caretakers to manage. Her boasting about possessions may similarly reflect compensatory behavior.

Her mother’s expectations and those of the system regarding permanency do not match. This not only makes planning uncertain for the mother, but also for Susan regarding her expectations for placement and permanency. The challenges for Susan’s mother regarding independence have been previously mentioned.

### System Performance Appraisal Summary

## 6. What's Working Now?

The shelter is providing good supports to Susan and she is achieving there and in school. According to her therapist, they have a trusting relationship and are exploring what he describes as her anger about her past life experience. Efforts are made to keep Susan connected to her mother through visits. DHS staff, though challenged by her behavior in the past, is trying to identify the right match for her needs and are open to suggestions about improving outcomes for her. They are willing to provide needed services, where identified as needed.

Susan's mom is involved with a therapist whom she sees regularly and is receiving medication that has stabilized her mental health issues. Section 8 housing supports were made available and she is getting SSI.

## 7. What's Not Working Now and Why?

Team members are struggling with developing a sound functional assessment of Susan. The causal differences for her behavior in group care settings compared to that in family settings are not yet understood. Her behavior in the settings that have disrupted have focused system attention on deficits to the extent that her many assets are under-recognized and appreciated. Although Susan is not manifesting obvious symptoms of depression, it was identified in 1999 and there seems to be little attention to it at this time. The therapist references focusing on getting Susan to deal with her anger, which may be appropriate, but did not mention attention to what seem to be obvious loss and attachment issues, which may be the reasonable basis for her anger.

The service team does not meet regularly. The DHS worker mentions his high caseload as one of the barriers to frequent meetings. The therapists note that they are not compensated to attend team planning meetings. As a result, valuable information possessed by team members is not adequately shared with other members. Two compelling examples of the effects of infrequent team meetings and poor coordination are illustrated by the following.

- ❑ Reviewers learned that Susan's therapist has not seen her in three weeks. He explained that therapists did not try to convince clients to schedule appointments and he had not heard from Susan or the shelter. DHS staff did not know this and were concerned that he had not followed up. As a result of the lack of information exchange, Susan has faced much of the experience of another disruption, rejection and new placement without the support of her therapist.
- ❑ Reviewers also learned from the mother's therapist about her telephone dating behavior. Apparently, therapists had not considered the risk of Susan visiting at home unsupervised with her mother at a time when the mother was involved sexually with perfect strangers. Reviewers were told that the cessation of unsupervised visits was only temporary until the mother passed has several drug tests. DHS staff, which seemed somewhat aware of the mother's behavior, did

not seem fully informed of the full details. This child would be very vulnerable in such an environment with unsupervised visits at home.

It was not apparent that Susan's teacher was a part of team planning with the entire team. With the team not meeting regularly and the DHS worker's caseload so high, case coordination was insufficient.

The difficulty with functional assessment and team functioning made case planning difficult. The system's case plan template focuses on problems more than strengths (although some strengths were noted). It also is not needs based, rather addressing outcomes that have to be attained. As a result, it did not serve as a step-by-step roadmap for Susan, her mother or the team. Neither was it sequenced to permit early successes. Susan's permanency plan (reunification) does not seem to be likely to occur, yet the team has not dealt with this fact or begun to discuss it with Susan and her mother. Concurrent planning regarding the option of an open adoptive placement, for example, is not reflected in the plan or in discussions with contributors.

Resource availability was a barrier. Susan had been in shelter approximately one month and a suitable placement had not been located, nor was one being considered at the time of the review. This child will need a very experienced and skillful foster care provider if she is to remain stable.

The challenge of developing an adequate functional assessment makes development of a long-term view of the case problematic at this time. Case perspective still focuses on the next placement. If the placement moves continue, this child is likely to develop a serious attachment disorder, leading to even less stability. Transitions are clearly not anticipated, currently or in some of the prior placements. Susan is facing the loss of caregivers and peers with whom she has developed positive relationships and who like her. She will face placement in yet another school and with new caregivers. The current plan and planning do not yet reflect attention to these transitions.

Plan implementation in the past has lacked the capacity to fully address the stresses of Susan's behavior on caregivers. As a result, she has had to move rather than the effective intensity and type of services being applied where she resides.

#### 8. 6-Month Prognosis/Stability of Findings.

Given current planning and supports, the six months prognosis is status quo, or continued unstable placements, for Susan. System contributors have not yet developed a plan that reflects Susan's desires, adequately assesses the underlying causes of her behavior, builds on her strengths, matches services to her needs and manages the transitions in her life. Without change, the team cannot adequately track and adapt the plan to changing circumstances. The "right" placement, matched to all her needs, may not be available. Without the ability to bring services to the child, rather than constantly chasing the "best" placement, frequent moves are very likely.

9. Practical Steps to Sustain Success and Overcome Current Problems.

- The team, including all contributors, should meet to begin developing a better functional assessment of Susan's needs. Susan should be involved to the extent possible, as should her mother, to determine Susan's needs and wishes. It may not be appropriate for Susan and her mother to be at all meetings together. The team should pay particular attention to attachment issues, the possibility of depression and should communicate honestly with Susan and her mother about permanency plans. The option of an open adoption should not be ignored if Susan has an interest in such a plan. The team should also address the safety issues of visits home. Although Susan has conflict with her sister, the team should explore Susan's interest in continued contact. The team will need to thoroughly assess the risks of unsupervised visits.
- Therapy for Susan should be resumed immediately.
- Potential family foster care providers should be selected for their experience with challenging children, their maturity and willingness to commit to unconditional care. Susan does not need to experience another placement move. Potential caregivers should have trial visits with Susan and have an opportunity to meet regularly with the team and Susan to plan for the placement. They should be prepared to be tested by Susan and willing to accept her need for respect and independence. A crisis plan should be developed as a contingency. Susan will not behave like an 11 year old in most interactions and she will not be as mature as she seems. Adjusting to this combination of child and adult behavior will require preparation. School transitions should be anticipated and teachers should be included in the team.
- Susan's strengths should be utilized. She is unlikely to abandon her adult-like behavior as she gets older, so opportunities should be sought to use it to meet Susan's self-esteem needs. Mentoring other youth, leadership roles in foster youth activities and other roles should be made available to foster Susan's need for success and affirmation. It may be helpful for the therapist to help Susan understand the effect her behavior can have on her peers, so she does not invite further rejection.

**Attachment 2**  
**Draft DCFS July 22, 2005 Implementation Plan**  
**Provided to the Panel**