The Katie A. Advisory Panel Seventh Report to the Court September 28, 2007

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Executive Summary

The Katie A. Panel's Seventh Report to the Court contains encouraging news regarding the County's progress. The Board of Supervisors has approved an eighty-five million dollar authorization for implementation of the County's Corrective Action Plan[1]. A copy of the County Corrective Action Plan is located in the Appendix. The Panel, Plaintiffs' and County have worked together in several multiple day planning sessions to more fully develop the strategies needed to bring the Corrective Action Plan into full compliance with the court's order and to complete the additional strategies required to meet the objectives of the settlement agreement. Of particular note, the parties and Panel have reached agreement on principles of practice that will guide the Plan's design and implementation of the of the settlement agreement.

The parties and Panel have also reached agreement on an operational definition of Intensive Home-Based Mental Health Services that should strengthen the County's ability to communicate to its staff and providers its expectations about the nature of practice plaintiff class members are entitled to receive. And the Panel and parties have agreed on the prospective scope of mental health services needed by the plaintiff class. This analysis estimated the number of children needing mental health services at 19,000, with conservatively 5,700 of that total needing intensive mental health services.[2] We also estimated that the current level of mental health service availability and the level of mental health service availability once the Corrective Action Plan is implemented would provide 3,115 intensive mental health service slots. This leaves an unmet need for an additional 2,585 intensive mental health service slots, a number beyond the scope of the Corrective Action Plan. Having agreement about the estimated unmet need permits the Panel and parties to have clarity about the target for additional service expansion.

This encouraging progress, however, is accompanied by continuing implementation challenges, which are the focus of continuing meetings with the County. First, implementation of a number of important tasks in the original Joint DCFS/DMH Plan are behind schedule in several important areas, particularly related to service expansion. Recruiting providers to respond to requests for proposals has been met with uneven success, leaving one of three Service Areas in Phase One still without available new mental health services.

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[1] By County Corrective Action Plan, the Panel means the Corrective Action Plan ordered by the court in its November 2006 order.

[2] The estimate of 5,700 needing intensive mental health services is a projection at this point, not a figure based on evidence.

The slow procurement process caused by County purchasing rules makes rapid expansion difficult.

Second and a contributor to the delays in service expansion, the County and providers continue to have significant workforce barriers that impede hiring and retaining competent staff, especially related to mental health service expansion. Some areas of the County with the highest percentage of plaintiff class members have the most limited workforce pool.

Third, within DCFS, caseloads remain high, to the point that they will negatively affect the Department's ability to support and deliver mental health practice consistent with the principles of practice recently adopted. Continuing difficulties in efficiently claiming MediCal dollars for some mental health services and uncertainty about the cost benefits of the Waiver limit opportunities to maximize revenue in a way that workloads could be diminished.

Fourth and perhaps the most challenging is changing the culture of child welfare and mental health practice in Los Angeles. As the definition of Intensive Home Based Mental Health Services contained in this report reveals, the principle driven practice expected requires strength and needs based, highly individualized responses to children in families, most frequently in their own homes or caregiver family settings. Converting a system employing conventional, office based approaches in many cases to this principle driven practice is a complex, time-consuming process. Intensive training, modeling and coaching of workers is needed to develop the values and skills required to change practice in this system.

It is the Panel's opinion that the current work on additional implementation strategies holds promise in solving the barriers to achieving the outcomes of the settlement. We hope that the next few months of work together will permit us to craft a complete Corrective Action Plan that effectively confronts the obstacles to progress and establishes a credible path to complying with the Katie A. Settlement. However, with only two months in which to address the kinds of barriers identified in this summary before the projected November 30, 2007 deadline for completion projected by the parties and Panel, an extra-ordinary amount of planning work will be required to develop the strategies that will bring the County Corrective Action Plan into compliance with the court's November 2006 order and develop the additional strategies that are needed to fully comply with the settlement agreement. Regardless, the November 30, 2007 estimated completion date remains a goal.

The Katie A. Advisory Panel
Seventh Report to the Court
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I. INTRODUCTION

The following Seventh Report to the Court outlines the County's progress toward achieving the objectives of the settlement agreement and includes a description of its compliance with the current Joint DCFS/DMH Plan. The County is now beginning work on revisions to that plan, pursuant to the Court's most recent order. This report also discusses some of the significant issues and challenges facing the County, resolution of which is critical to achieving the objectives of the settlement.

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):

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

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

- advise and assist the County in the development and implementation of the plans adopted pursuant to Paragraph 7;

- determine whether the County plans are reasonably calculated to ensure that the County meets the objectives set forth in Paragraph 6;

- determine whether the County has carried out the plans;

- monitor the County's implementation of these plans; and

- determine whether the County has met the objectives set forth in Paragraph 6 and implemented the plans set forth in Paragraph 7.

Additionally, the Settlement directs that:

> In the event that the Advisory Panel discovers state policies or funding mechanisms that impede the County's accomplishment of the goals of the agreement, the Advisory Panel will identify those barriers and make recommendations for change.
>
> The Department prepared a Joint DCFS/DMH Mental Health Plan to describe its strategy for implementing the provisions of the settlement agreement. The Panel and plaintiffs identified issues in the Plan they believed needed additional attention and in a subsequent court hearing, plaintiffs and defendants proposed submitting a joint finding of facts that would identify areas of agreement and disagreement. The court issued an order directing the County to revise its plan and submit the revision for review. The County is now preparing that revision and has invited participation from the Panel in that process.

III. CURRENT CORRECTIVE ACTION PLAN STATUS

The Panel has worked actively with the County on the development of the Corrective Action Plan, ordered by the court in November 2006. In Panel meetings with the county and in periodic conference calls, the Panel and parties have discussed needed strategies for complying with the court's order and achieving the objectives of the settlement agreement. As the County refined its final draft of the Corrective Action Plan in July 2007, the Panel informed the County that while the plan reflected progress in describing strategies to expand needed mental health services, additional work was needed to fully comply with the court's November 2006 order and develop the strategies to achieve the objectives of the settlement agreement. Specifically, the Panel wrote in July 2007:

> In a conference call yesterday, the Panel discussed the areas of the plan that in our opinion still need additional development. We all acknowledged the progress the County has made creating the much-improved document now in place and commend DCFS and DMH staff for their hard work, critical thinking and openness to feedback.

> I believe that we are in agreement that for the Plan to be functional and responsive to what is learned through implementation, it will have to be a dynamic document. While we are not proposing that these changes be made in the version of the plan being provided to the Board this week, we do ask that these issues, which I will outline as general themes below, remain as areas for further discussion between the Panel and the County. They won't be unfamiliar, as they reflect feedback we have offered throughout the development process. However, we do want to be clear that we believe that additional work is needed, a perspective that we are obligated to convey to the court when it considers the proposed revised Plan.

In that letter, a copy of which can be found in the Appendix, the Panel identified six issues, or placeholders, that require additional attention. These are:

- Plan Structure and Breadth – The Panel believes that the Plan needs to reflect a comprehensive vision of the system of care being developed, not just its component parts.

- Workforce Issues – Additional strategies are needed to recruit, train and retain qualified staff and build capacity within the mental health provider community.

- Service Creation – The pace of service expansion has been much slower that projected. Attention is needed to removing the barriers to rapid service creation for the plaintiff class.

- Health Management Associated (HMA) Report – The HMA study commissioned by the County identifies a number of challenges and barriers that limit the County's ability to implement the settlement. Additional strategies need to be developed to address these concerns.

- Budget – The Panel believes that additional detail is needed on financing and budget issues to support the projected tasks.

- Exit Criteria – Once the Corrective Action Plan is approved, the Panel recommends that attention be given to identifying exit criteria for the court to consider

The Panel also recommended that the parties and Panel commit to a series of multiple day meetings in the coming months "to work intensively and

collaboratively on additional refinements to the plan." The Panel proposed a deadline of November 30, 2007 for completing work on the plan.

Action by The Board of Supervisors

On August 21, 2007, the Board of Supervisors approved a Corrective Action Plan designed to address the court's concerns as outlined in the Findings of Fact and Conclusions of Law. A copy of the County Chief Executive's letter to the Board of Supervisors recommending approval of the Plan and the County Corrective Action Plan can be found in the Appendix.

The Board approved a total of $40.6 million for the Corrective Action Plan in 2007-2008, reflecting a net County cost of $23.3 million, with the balance coming from state and federal funds. For the period 2008-2009, Katie A spending will reach $85 million, with a net County cost of $35.7 million. The $85 million projected cost does not cover Phase Two of the reform, which will include increasing co-located staff into all SPA's at an additional cost of $32.8 million. The County share will be $6.4 million.

This Plan does not fully address all of the concerns expressed by the Court in its November 2006 order and does not meet the Court's mandated timelines for implementation of a Treatment Foster Care Program. At this time, the Panel does not believe that the County has acted in bad faith in attempting to meet the Court's order. Rather, the plan does represent significant efforts by the County to comply with the Court's order and ultimately, the requirements of the Settlement Agreement. The County has committed to continue to work closely with the Panel on these issues.

The parties agree that the original county plan and the Corrective Action Plan, taken together, do not fulfill the County's obligations under the Settlement Agreement, although they are good faith steps towards that objective. The parties and the Panel have agreed to develop a strategic planning framework document that will hope to more specifically capture the parties' and Panel's agreement and expectations about what areas must still be addressed under the Settlement and what are the necessary steps towards meeting the Settlement objectives and obligations more fully. Our goal and expectation is to have a draft of that document by November 30, 2007.

Results of Strategic Planning Meetings

The Panel and members of the DCFS/DMH leadership team met for two days in August 2007 and two days in September 2007 to develop agreement on

remaining strategies needed to fully respond to the court's order for a Corrective Action Plan and achieve the objectives for the plaintiff class. The meetings were facilitated by Dr. Rigoberto Rodriguez of the University of California State Long Beach, with the support of The California Endowment.

The Strategy Session participants first focused their attention on two issues, the structure of the revised plan and the outcomes that will accurately reflect performance. The parties agreed that the Corrective Action Plan approved by the Board requires additional strategies to achieve the objectives of the settlement agreement and that to be effective, the plan will need periodic revisions to adapt to changing circumstances in the field. The Panel anticipates that revisions to the Corrective Action Plan will be provided to the court as implementation experience provides guidance on new strategies and directions.

There was important agreement on a crucial element of the plan's design, the principles of practice on which it will be based. Those adopted are described below.

FUSION OF PRACTICE PRINCIPLES
CHILD WELFARE AND CHILDREN'S MENTAL HEALTH

Ensuring that the needs of children are identified and that individualized, intensive home-based services to meet their needs and build on the strengths of their relatives and foster families are provided in order to increase placement stability and permanency requires a fusion of practice principles from child welfare and children's mental health.[3]

The shared goal of DCFS, DMH, and private providers in Los Angeles is a comprehensive, interagency, community-based system of care in which service providers, relatives, foster families and informal supports work together collaboratively to meet children's emotional needs to prevent them from entering foster care and while they are in foster care. Improvement in the well-being of children and families is measured by achievements in five outcome areas: safety, health, social and emotional well-being, economic well-being and education/workforce readiness.

[3] The primary sources for this fusion are the Surgeon General's Report and principles proposed by the Katie A. Panel, which were similar to the RC principles in Alabama and the "Arizona Vision" for behavioral health services in the J.K. settlement. After each principle in parentheses is noted SG (for Surgeon General), KA (for Katie A Panel), DMH's Guiding Principles (DMH), and SOC and Family Support Principles (SOC) to identify its source.

This fusion of practice principles from child welfare and children's mental health is organized around the three main elements of systems of care: family strengths/child needs-based approach, multi-agency collaboration in the community and cultural competence.[4]

1. **SERVICES ARE DRIVEN BY THE NEEDS OF THE CHILD AND PREFERENCES OF THE FAMILY AND ARE ADDRESSED THROUGH A STRENGTHS-BASED APPROACH**

• Children and families are more likely to enter into a helping relationship when the worker or supporter has developed a trusting relationship with them. (KA) Staff and families work together as partners in relationships based on equality and respect (SOC).

• The quality of this relationship is the single most important foundation for engaging the child and family in a process of change. (KA)

• Children and families are more likely to pursue a plan or course of action that they have a key role in designing. (KA)

• When children and families see that their strengths are recognized, respected and affirmed, they are more likely to rely on them as a foundation for taking the risks of change. (KA) Programs focus on the families' strengths and enhance their capacity to support the growth and development of all family members, adults, youth and children (SOC).

• Assessments that focus on underlying needs, as opposed to symptoms, provide the best guide to effective intervention and lasting change. (KA)

• Plans that are needs based, rather than driven by the availability of services, are more likely to produce safety, stability and permanency. (KA)

• Children receive the care and services needed to prevent removal from their families or, when removal cannot be avoided, to facilitate reunification and to meet their needs for safety, permanence and stability and that they 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 (SOC).

• Provide incentives for scientifically proven and cost-effective prevention and treatment interventions that are organized to support families and that consider children and their caregivers as a basic unit (e.g., family therapy, home-based treatment, intensive case management). (SG)

2. **THE LOCUS AND MANAGEMENT OF SERVICES OCCUR IN A MULTIAGENCY COLLABORATIVE TEAM AND ARE GROUNDED IN A STRONG COMMUNITY BASE**

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[4]Burns

• Children experience trauma when they are separated from their families. When children must be removed to be protected, their trauma is lessened when they can remain in their own neighborhoods and maintain existing connections with families, schools, friends and other informal supports. (KA)

• The family's informal helping system and natural allies are central to supporting the family's capacity to change. Their involvement in the planning process provides sustaining supports over time. (KA)

• Decisions about child and family interventions are more relevant, comprehensive and effective when the family's team makes them. Families should always be core members of the team. (KA) The family serves as a principle decision-maker in collaboration with members of a multidisciplinary team and a facilitator who assists in the coordination of needed services (DMH).

• Coordination of the activities of case contributors is essential and works most effectively and efficiently when it occurs in regular face-to-face meetings of the family team. (KA)

• Success in school is a reliable predictor of child well-being. When the direction of planning for safety, stability and permanency is fully integrated with school plans and services, children are more likely to make progress. (KA) Systems of behavior support at the school level should emphasize universal, primary prevention methods that recognize the unique differences of all children and youth, but should include selective individual student supports for those who have more intense and long-term needs. (SG)

• A common language must be used to describe children's mental health, emphasizing adaptive functioning and taking into account ecological, cultural and familial context. A common language is important to facilitate service delivery across systems. (SG)

• Issues of confidentiality must be addressed in ways that respect a family's right to privacy, but encourage the coordination and collaboration among providers in different systems. (SG)

• Youth must be included in treatment planning by offering them direct information, in developmentally appropriate ways, about treatment options. As much as possible, allow youth to make decisions and choices about preferred intervention strategies. (SG)

• Untreated mental health problems place children and youth at risk for entering the juvenile justice system. Mental health programs designed to divert youth with mental health problems from the juvenile justice system must be supported. (SG)

• An infrastructure must be provided for cost-effective, cross-system collaboration and integrated care, including support to healthcare providers for identification, treatment coordination, and/or referral to specialty services and the

development of integrated community networks to increase appropriate referral opportunities. (SG)

3. THE SERVICES OFFERED, THE AGENCIES PARTICIPATING, AND PROGRAMS GENERATED ARE RESPONSIVE TO CULTURAL CONTEXT AND CHARACTERISTICS

• Many of the services and resources that children and families find most accessible and responsive are those established in their own community, provided within their own neighborhoods and culture. (KA) A comprehensive and culturally competent continuum of care for all children. Services and supports are available and accessible to children and families in their respective local communities. (DMH)

• Programs acknowledge cultural differences, provide culturally competent services, and affirm/strengthen families' cultural, racial, and linguistic identities, while enhancing their ability to function in a multicultural society. (SOC)

• Programs are embedded in their communities and contribute to the community building process. (SOC)

• Families are resources to their own members, to other families, to programs, and to communities. (SOC)

• Practitioners work with families to mobilize formal and informal resources to support family development. (SOC)

• Reunification occurs more rapidly and permanently when visiting between parents and children in custody is frequent and in the most normalized environment possible (office based visits and supervised visits are the least normalized environment). (KA)

• Children in foster care who are transitioning to adulthood are most successful in achieving independence when they have established relationships with caring adults who will support them over time. (KA)

• The service array should be sufficiently flexible to be adapted to the unique needs of each child and family. Services and supports best meet child and family needs when they are provided in the family's natural setting or for children in custody, the child's current placement. Services should be flexible enough to be delivered where the child and family reside. (KA)

• A menu of seamless (non-categorical) mental health, substance abuse and related support services and resources should be provided. (DMH)

• Programs should advocate with families for services and systems that are fair, responsive, and accountable to the families served. (SOC)

• Accessible, culturally competent, scientifically proven services that are sensitive to youth and family strengths and needs must be provided. (SG)

Defining Intensive Home-Based Mental Health Services

To provide greater clarity for the County and service providers about the approach to serving children and families, the parties and the Panel developed the following working definition of Intensive Home-Based Mental Health Services.

INTENSIVE HOME-BASED SERVICES

Based on the federal Child and Adolescent Service System Program (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, kinship, 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 incorporate 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's and family's strengths. It is essential to have birth, kinship, 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. The complex needs of these children require integrated services, and team planning is essential and cannot be separated from the interventions. Intensive home-based services are an individualized child-focused, family-centered approach that is offered by a range of providers and is not limited to wraparound, system of care, MST, MTFC or FFT programs. If providers are not offering one of these programs, they will be given guidance to incorporate the clinical principles and approaches of evidence-based practices as they design culturally-competent intensive home-based services. Effective services for 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, kinship, adoptive and foster families are guided to manage their behaviors and do not have to travel to receive intensive services. Usually the team will not plan office-based services for the child and family, with the exception of medical services and medication management that cannot be provided in the home or community. Intensive home-based services do not designate a position to provide one-on-one support to the child (such as a mentor or Therapeutic Behavioral Services) or to guide the caregiver (such as a parent advocate or a family specialist): the team decides whether a therapist or a paraprofessional can most effectively meet this child's needs and the provider ensures that this person has the clinical training and supervision to do so. Usually the team will provide crisis services so the child and family know the individuals helping them in a crisis (instead of an unknown mobile crisis team). When the child is living with kin or a foster family, not only will that family be provided guidance for caring for the child, but the prospective permanent home where the child is likely to be placed will also be prepared for meeting the child's needs with similar intensive home-based services during visits. When the child is living with his/her siblings, a team will be assembled with all the individuals supporting all the children to develop a needs list for each child and tailor intensive home-based services to meet their needs and support their caretakers . When the child is a teenager, he/she will be actively involved in the team with the goal that she/he will agree with his/her needs list and contribute to the design of services.

Unmet Mental Health Service Needs

In the most recent joint strategy planning session with the parties, the participants worked to project the unmet needs for mental health services for the plaintiff class. The participants agree that it is essential to know the projected needs of the target population to plan effectively to respond to those needs. The following content outlines the total DCFS population and the projected current needs by class members for mental health services. Data represent point-in-time needs, not the annual cumulative class member needs.

<u>DCFS Child and Family Population</u>
20,000 Out-of-Home Placement
18,000 In-Home (not in custody)
38,000 Total

50% of the total, or 19,000, are considered to need mental health services

30% of the total, or 5,700 of the 19,000 are considered to need intensive mental health services

Estimated intensive in- home mental health service needs	5,700
Estimated less intensive mental health needs, some of which should be in-home	13,300
Estimated total mental health service needs	19,000

Current County Mental Health Service Capacity

The County is now providing capacity for 1,490 slots delivering some form of intensive mental health services (Wraparound or other services).

Wraparound	1200
Children's System of Care	250
Therapeutic Behavioral Services	40
Total	1490

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Planned capacity expansion through the Corrective Action Plan, Mental health Services Act and Phase One of the original Joint DCFS/DMH plan totals an additional 1,625 intensive mental health slots (Phase II will not begin until 2009).

Expanded Capacity

Child Full Service Partnership	531
Transitional Age Youth	400
Comprehensive Children's Services Program	314
Multi-Systemic Therapy	80
Multidimensional Treatment Foster Care	80
Intensive Treatment Foster Care	220
Total	1625

The total of the 1,490 current slots and 1,625 additional slots projected is 3,115 intensive mental health slots available/projected.

Calculating the current need for intensive mental health slots as 5,700, the current and projected capacity of an additional 3,115 slots leaves an unmet need for an additional intensive mental health service 2,585 slots.

Based on these figures the County needs to augment the planned capacity in the Corrective Action Plan to provide intensive in-home mental health services to an additional 2,585 children.

Projections of the current capacity to serve the remaining 13,300 children that need less intensive mental health services, some of which are presumably receiving traditional office based mental health services, are not available, nor are data about the type of less intensive services actually appropriate. The Plan assumes that additional services to this population will be predominately through MAT assessments, heightened screening for those not needing MAT, Child and Family Support Teams and case management. Additional work is needed to assess the needs and current capacity to serve this population

IV. OTHER PANEL ACTIVITIES SINCE THE SIXTH REPORT

Since its last report, in addition to meetings with the parties regarding the Corrective Action Plan, the Panel has reviewed a small sample of the case records of proxy class members (a child in each of 50 cases), met with the County DCFS/DMH management team and data system staff, reviewed new data on the status of the proxy class and interviewed Judge Mike Nash, the presiding juvenile court judge.

Case File Review

The Panel conducted a brief case review of 50 class members in one Phase One office. The Panel chose to conduct this review to gather information about the degree to which the work of co-located mental health staff was assisting class members and the availability of new intensive, in-home mental health services. The small sample prevents generalizations about the County as a whole, but in this review the Panel found the following:

- There was evidence of children being referred to co-located mental health staff, but little documentation in case files of the actual activities of co-located staff.

- Except for a small number of children benefiting from wraparound services, the Panel found little evidence of children receiving intensive, in-home mental health services. Outside of the children receiving wraparound, most children reviewed were continuing to receive traditional, office-based mental health counseling.

- One additional product of the case review was confirmation that the limits of case file reviews in providing meaningful information argue for a more qualitative evaluative approach, involving in-depth interviews with all members of each child and family team.

Interview with Judge Nash

On August 22, 2007, Panel members met with Judge Mike Nash, Presiding Judge of the LA County Juvenile Court, to gather information about system improvement needs related to the plaintiff class.

Judge Nash reported being pleased that Structured Decision-Making (child abuse and neglect risk assessment tool) has been implemented and believes that it is working, but also realizes that it will take time before it can be said that it is working as well as one might hope. He thinks that it is a good tool and that experience over time is needed to evaluate its success.

Concerns Judge Nash expressed were the slow pace of expansion of mental health services, the challenges of recruiting and retaining capable staff at DCFS and DMH, the need for a "culture change" within both agencies in order to achieve practice improvements, a change he likened to a religious conversion and that will require intense training and quality supervision.

When asked to say what the biggest barrier is to success in dependency cases, Judge Nash quickly answered "the number of cases." He went on to say that the average caseload for attorneys is 272 and that the caseload of CSWs is also much too high, making it difficult to provide quality services to each child and family. The remainder of the conversation focused on Crossovers from Dependency to Delinquency or vice versa, Drug Courts, and psychiatric hospitalization.

There are 20 full-time Dependency Courts in the County, 19 at the Children's Court and one in Lancaster, and 28 Delinquency Courts scattered around the county. The number of Dependent children who are transferred to the Delinquency system has been between 5 and 10 per month in Pasadena where the Court's dual status pilot project is being implemented. Over the last 2 and 1/2 months the total was 15. A process has been established for conducting a meaningful assessment of each potential cross-over child that identifies his or her strengths, needs and risks. The process includes a multi-disciplinary team comprised of representatives from Probation, DCFS, DMH and Education, which develops a case plan for the child and makes recommendations to the assigned

Judge who conducts a hearing to determine whether a child should be transferred to the other court. Regardless of that decision, one or more representatives of the team serve as case manager for
the youth until the case is closed.

Judges are frustrated by school and group home referrals to the delinquency system for relatively minor behaviors that could be addressed more appropriately by those institutions.

The plan for rolling out drug courts is to divide the county into 20 sections to match the number of Dependency courts. Each section would have approximately the same volume of dependency cases. Each judge would be assigned a section and all the cases that involve children who live in that section. The judge would become familiar with that section, its characteristics, strengths, needs, challenges and the available services and their providers. Over time, each judge would implement a drug court for the substance abuse treatment needs of parents whose children reside in that section. The roll-out will be deliberately slow, however, in order to establish the most appropriate division of the county into sections and to assure that quality substance abuse services are available before the drug court for that section begins operation.

V. STATUS OF DCFS/DMH JOINT PLAN IMPLEMENTATION

Based on interviews and observations by the Panel and a review of the County's reports of progress, the following describes the County's current status of Plan implementation.

Creation of a Child Welfare Mental Health Services Division

The County reports that this task has been completed.

Co-location of DCFS and DMH Staff

According to the County, 83 percent of co-located positions have been filled. A hiring freeze that impeded filling positions was lifted April 1 2007.

Additional staffing for the DMH ACCESS Hotline

Two of the three positions allocated have been filled.

Creation and Staffing of DMH Mental Health Units in Each of the Eighteen DCFS Regional Offices

The County reports that all of the 48 positions allocated for this function have been filled.

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

The Panel and the County have reached agreement on nineteen indicators that will be tracked on an interim basis until the new DMH information system (IBHIS) is completed in June 2008. The Panel has received indicator data on the proxy class, which is referenced in this report. The ongoing strategy sessions continue to focus on refining data needs to measure performance.

Development of the DMH Children's System of Care Assessment Application

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The County reports that this Application is a comprehensive functional application tool to provide age category information regarding client outcomes. It is reported to be in use in Service Areas 1, 6 and 7.

Development of Multidisciplinary Assessment Teams (MAT)

The County did not provide an update in the tracking log for Multidisciplinary Assessment Teams.

Development of a joint DMH/DCFS Master Person Index

The Master Person Index is an element of the information system under development and will permit matching of children between DCFS and DMH information systems. Confidentially provisions in state law prevent the sharing of data between DCFS and DMH, limiting the ability of the County to track performance related to the plaintiff class. The recent order from Judge Matz, permitting such sharing of information, is expected to remedy this barrier.

Implementation of the DMH Behavioral Health Information System

The County reports that the completion of the DMH information system (IBHIS), first projected for completion in June 2008, is now expected be completed in

January 2009. The County reports that it is waiting for State DMH to issue guidelines needed to complete this project.

Contract with the UCLA School of Medicine to Conduct an Independent Implementation Evaluation

UCLA declined to participate in the proposed evaluation, causing the County to select another provider, Health Management Associates (HMA). The Panel and the parties have reviewed the final report and are considering its findings in the ongoing strategy sessions.

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

There has been no reported action on this task.

Development of a DMH Performance-Based Contracting System

The County reports that it expects to convert existing contracts to performance based contracts by December 2007.

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

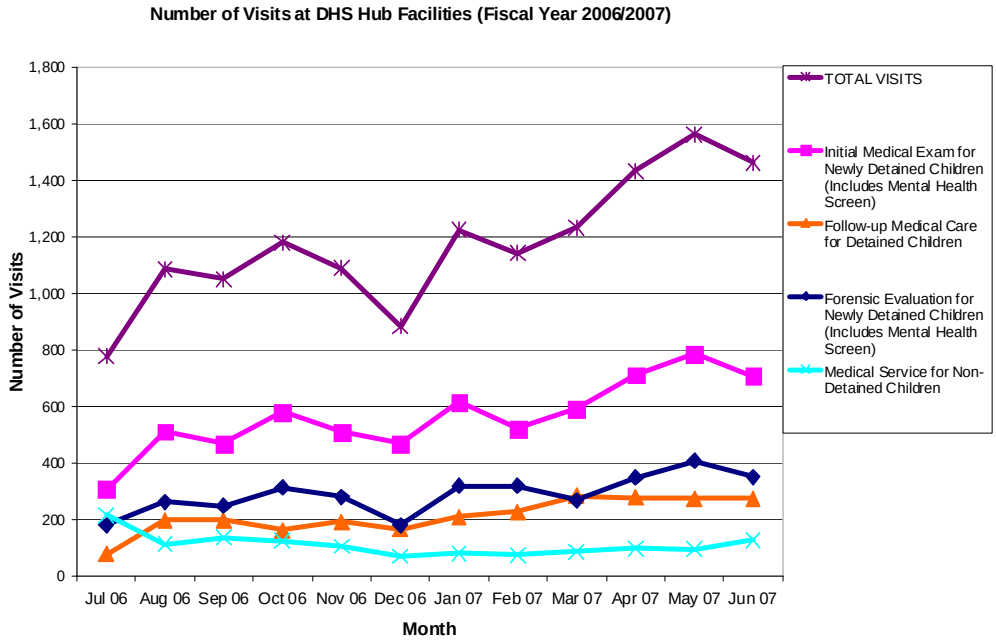
The County reports that it has hired a training coordinator for each of the impacted service areas and developed a Power Point presentation for core curriculum training. The Panel is requesting copies of the relevant curricula for review.

Expansion for Funding to Support Implementation of the Joint Plan

The County Board has approved the $85,000,000 requested by the County to fund the Corrective Action Plan.

Expansion of Staff Resources for Multidisciplinary Medical Hubs

The County reports that six medical hubs are fully operational but that space limitations continue to impede full functioning. The County provided the following chart to reflect the pattern of Hub use:



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

The County reports that DMH participation in TDM is fully functional. However, based on knowledge of the volume of team decision-making meetings required to retain fidelity to the TDM model and on interviews with County staff, the Panel is of the opinion that there are not enough TDM facilitators to accommodate the number of meetings required. The Panel has requested information on the total number of facilitators allocated, the number of position filled and the number of facilitators needed to meet the needs of the plaintiff class.

Implementation of the DMH Mental Health Screening Tool

The Panel has reviewed the screening tool and believes that it is appropriate for the needs of the plaintiff class. The County reports that it is in use in all of the Hubs.

Expansion of Wraparound Capacity

Wraparound has now been expanded to 1,000 slots.

Expansion of Mental Health Services

- **Intensive In-Home Mental Health Services**
- **Early Intervention Foster Care**
- **Multidimensional Treatment Foster Care (MTFC)**
- **MTFC "Lite"**
- **Multisystemic Therapy**
- **Functional Family Therapy**
- **Incredible Years**
- **Trauma Focused Cognitive Behavioral Therapy**
- **Positive Parenting Program**

The County reports that it has selected providers for intensive, home-based mental health services in Service Areas 6 and 7 and projects implementation in August/September 2007. As of yet, the County has had no response expressing interest in requests for proposals for coverage in Service Area 1. It also reports that the California Institute for Mental Health contract for training and technical assistance has been approved. Now that the State has approved the use of Intensive Treatment Foster Care rates for use with the County's models, the County reports that it is preparing a statement of work.

Targeted Mental Health Services for D-Rate Homes

The County reports the D-rate unit is fully operational.

VI. DATA TRENDS

The County provided the Panel data on the proxy class, using a matching process that improves the accuracy of data. The proxy class data, however, provide a limited picture of a portion of the plaintiff class and are an imprecise description of the Katie A. Population.

Panel Analysis of DCFS Data by Calendar Year (CY)
on the Proxy Class

The number of children removed from their families is increasing

CY 2003	CY 2004	CY 2005	CY 2006
5,173	5,510	6,678	6,903

Children are placed far from their families

	CY 2003	CY 2004	CY 2005	CY 2006
1-5 miles	26%	27%	27%	25%
6-10 miles	29%	30%	31%	30%
10-25 miles	33%	33%	31%	31%
25-50 miles	11%	9%	10%	13%
> 50 miles	1%	1%	1%	1%

Note: As many as 2,000 children removed from their homes each year have no recognized address—this accounted for a third of the children in 2006 not being included in the analysis above. DCFS DATA

In most communities, placement more than ten miles from home would be seen as unusual and undesirable, although in LA it is the situation for nearly half the children in foster care. Long distances interfere with weekly visits and with families participating in pediatric appointments and school activities while their children are in care. For DCFS to substantially increase the number of children placed within 5 miles of home and decrease the number of children placed more than 10 miles from home would require: (a) a reduction of children entering care to increase the available beds in foster care; (b) a placement system that allows not only a matching of child characteristics with foster families but also with the child's home address; and (c) a method to quickly find a recognized address for the family and enter it in the information system.

Entry Cohort Data Analysis

Children in the Proxy class are more often removed than other children
The removal rate for all children hovered around 42% across three years, but for the Proxy class, it was 72% in 2003, 64% in 2005, 67% in 2007.

Children in the Proxy class are more often placed in D-Rate and Residential (RCL 12 & 14)

	ALL CHILDREN		PROXY	
	2003	2005	2003	2005
FFA	35%	35%	27%	21%
Foster Family Home	9%	6%	13%	13%
Group Home	4%	3%	29%	35%
Relative	42%	48%	23%	23%

Note: The Proxy class was defined, in part, as children in D-Rate homes and RCL 12 & 14.

This indicates a lack of intensive home-based support, especially for emotionally disturbed children and their relatives, but also for these children in FFAs. If DCFS had the goal of cutting the percentage of the Proxy class in group homes substantially, effective supports are necessary so their behaviors could be managed with relatives and FFAs.

It was noted when this information was presented that about 1200 children annually go to FFAs for about 3-5 days before they are placed with relatives while DCFS waits for the live scan on the relative to be returned. This appears to be a poor use of FFA beds: what steps could be taken to speed up the relative placements for these children?

Children in the Proxy class who remained at home subsequently enter care at a greater rate than other children

	ALL CHILDREN	PROXY
	2005	2005
3 months Family Maintenance	40%	84%
3-6 months Family Maintenance	21%	67%
6-12 months Family Maintenance	7%	26%

This indicates a lack of sufficient intensive home-based support, especially for emotionally disturbed children and their relatives. It is crucial that DCFS and DMH staff quickly provide support services to the child with behavior problems and to the family so the child can safely remain at home.

Children in the Proxy class are more often multiply placed than other children

	ALL CHILDREN		PROXY	
	2003	2005	2002	2005
3 or more plcts 3 mos after removal	12%	10%	22%	21%
3 or more plcts 6 mos after removal	18%	17%	37%	37%
3 or more plcts 12 mos after removal	27%	25%	52%	53%

3 or more plcts 24 mos after removal	42%	44%	63%	73%

Multiple placements for all children and the Proxy class have continued at the same levels, with the exception of an increase for the Proxy class remaining in care more than two years.

That a quarter of all children in DCFS care change placements in their first year in care is disturbing. It is well-known that the loss of attachment and the consequent delay of social and academic progress are a result of changing placements. That half of the most troubled children in DCFS care change placement in the first year indicates a lack of intensive home-based support, especially for emotionally disturbed children and their caregivers.

Children in the Proxy class are more often abused or neglected in care than other children

The abuse/neglect of children in care, including the Proxy class, has decreased slightly, from 2% in 2003 to 1.5% in 2005 for all children and 5.9% in 2003 and 5% in 2005 for the Proxy class.

	ALL CHILDREN 2005	PROXY 2005
FFA	1.1%	5%
Relative Home	1.3%	5%

Children in the Proxy class leave the foster care population at a higher rate, with a lower number having permanency exits than other children

	ALL CHILDREN 2005	PROXY 2005
Remained in care	42%	50%
Permanency exit	51%	33%
Non-permanency exit	7%	17%

That 17% of the Proxy class leave foster care due to running away, incarceration, rejecting services, emancipation, abduction or death indicates a lack of intensive home-based support to foster parents and group home providers to prevent teenagers from getting into trouble before a permanent home is arranged for them. That only a third of the Proxy class, as compared to half of all children, leave foster care through reunification, adoption and guardianship indicates a lack of intensive home-based support, especially for emotionally disturbed children and their intended permanent family.

DMH Data

After matching DMH and DCFS data, DMH found that at least 86%-88% of the Proxy class received mental health services. However it seems unlikely, for example, that fewer than a third of the Proxy class in 2003, 2004 and 2005 received individual outpatient therapy (and that was the most frequently received of eight different services). Furthermore, the analysis of diagnoses, in which nearly half of the children in the Proxy Class who received outpatient services were classified as other, indicates that additional work on the DMH data is necessary.

The data staff and managers were very receptive to the following suggestions from the Panel:

(a) A DCFS-DMH team bringing data to workers in the field. Work has begun on "scorecards" regarding a caseworkers caseload, but adding some of the indicators at an office level to help convey the importance of and recognize workers for reducing moves in care, increasing children living with siblings, etc.

(b) Regular work together by the DCFS and DMH data staff to ensure joint products, rather than separately producing documents and sending to each other.

Next Steps

The Panel and parties will meet again in October and November 2007 in additional strategic planning sessions, intended to further the plan development process begun in August 2007 and complete needed revisions by November 30, 2007.

VII. GLOSSARY OF TERMS

ADHD-Attention deficit hyperactivity disorder

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

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

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 – A therapeutic approach to foster care for children with emotional or behavioral needs, provided by highly trained caregivers and supportive intensive services

FGDM-Family Group Decision Making

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

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

IEP-individual education plan

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 (a family conferencing approach)

Title XIX-Medicaid

VIII. APPENDIX

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The Katie A. Advisory Panel

c/o 428 East Jefferson Street
Montgomery, AL 36104

Marty Beyer
Richard Clarke
William Jones
Joe Loftus
Paul Vincent

July 10, 2007

Brandon T. Nichols
Deputy County Counsel
Social Services Division
500 West Temple Street
Los Angeles, CA 90012

Dear Brandon,

In a conference call yesterday, the Panel discussed the areas of the plan that in our opinion still need additional development. We all acknowledged the progress the County has made creating the much-improved document now in place and commend DCFS and DMH staff for their hard work, critical thinking and openness to feedback.

I believe that we are in agreement that for the plan to be functional and responsive to what is learned through implementation, it will have to be a dynamic document. While we are not proposing that these changes be made in the version of the plan being provided to the Board this week, we do ask that these issues, which I will outline as general themes below, remain as areas for further discussion between the Panel and the County. They won't be unfamiliar, as they reflect feedback we have offered throughout the development process. However, we do want to be clear that we believe that additional work is needed, a perspective that we are obligated to convey to the court when it considers the proposed revised plan.

Plan Structure and Breadth

The County received recommendations about the plan's structure and organization from Joe Loftus and Pat Chesler that the Panel believes are still relevant to making the plan a more functional planning and management tool. We would like to resume this discussion in our next meeting in hopes of crafting a plan that reflects a comprehensive vision of the system of care being developed, not just its component parts.

Workforce Issues

The Panel has written about the workforce development issues in prior reports. Under this heading, we propose to continue discussion about recruitment, retention, training, provider development and capacity building, credentialing and other strategies that will produce competent staff in sufficient numbers to achieve the objectives of the settlement.

Service Creation

We believe that additional work is needed to describe the strategies for creation of new services, especially those not part of expansion of Wraparound and treatment foster care. For the population of children living in their own homes and those not served by Wrap or TFC, we propose that you and we continue working to describe the population to be served, its scale and the strategies to assuring that its mental health needs are appropriately met.

Health Management Associates Report

The County contracted with HMA to evaluate its implementation of Phase I of the Enhanced Specialized Foster Care Mental Health Services Plan, according to HMA, "to provide recommendations to Los Angeles County in preparation for countywide implementation of the plan." Since the planning deadlines did not permit utilization of the HMA findings in the current draft, the Panel would like to discuss the recommendations made by HMA and how they might influence further planning.

Budget

The Panel recognizes that the evolving nature of the plan makes a precise projection of anticipated costs a challenge; however, we do believe that a more comprehensive picture of programmatic, administrative and provider costs is needed. We would like to work toward the development of a budget overview that reflects total costs, anticipated revenue and savings available for reinvestment.

Exit Criteria

We agreed to defer work on exit criteria until the court had acted on the proposed plan. Assuming the court acts promptly, we would like to structure some time to discuss this issue at length.

Next Steps

In our meeting next week we would like to spend some time deciding how to approach additional plan development. In that regard, we suggest setting aside several consecutive days in the next two months during which we can work intensively and collaboratively on additional refinements in the plan. We believe that we can make more progress in that manner than in short conference calls and exchanges of drafts. To create a focus for this work, we also propose a deadline of November 30, 2007 for completing additional work on the plan.

In closing, the Panel recognizes the importance of the upcoming meeting with the Board and wants to support the Board's approval of the current draft. We have no wish to involve ourselves in issues between the County and the Board, but if the County believes that our expressed support could be helpful, the Panel would be happy to make that support known to the Board at the meeting on July 17.

Sincerely,

Paul Vincent

cc Katie A. Panel
Brandon Nichols
Kim Lewis
Ira Burnim