The Katie A. Advisory Panel
Tenth Report
to the Court
July 1, 2009

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Executive Summary

This report addresses the progress by the County in implementing the Katie A. Strategic Plan and Corrective Action Plan, along with relevant elements of the Countywide Enhanced Specialized Foster Care Mental Health Services Plan. Generally, the County continues to make steady progress in implementing these plan provisions and is demonstrating a serious commitment to meeting the needs of the plaintiff class. The parties and the Panel continue to maintain a constructive and productive working relationship, which enhances compliance with the Settlement Agreement. The County has also demonstrated a significant financial commitment to implementation of the Agreement, as was referenced in the last report. That support continues even in the current difficult financial climate in state and county government in California. However the parties are concerned about the potential shortfall in government funding and its possible future effects on child welfare and mental health services in Los Angeles County and closely monitor budget developments at the executive and legislative levels in the State.

The elements of the Plans that the Panel and parties have focused on most intensely in the past months are mental health screening and assessment, training and coaching needed to implement the Strategic Plan, systems to track the experience of the plaintiff class, intensive, home-based mental health service expansion and exit criteria. It is largely in regard to these areas that the Panel makes recommendations in this report, summarized below.

Recommendations

Intensive Home-Based Mental Health Services

- Develop strategies to assist outpatient clinicians and other mental health staff develop the capacity to practice appropriately within the intensive, home-based mental health services model.

- Complete the strategy for training and coaching DCFS, mental health and provider staff to practice within the strength and needs-based, individualized model of practice expressed in the Strategic Plan.

- Document recent strategies for speeding the implementation of treatment foster care services and incorporate these into the Strategic Plan Project Data Sheets.

Tracking the Plaintiff Class and Exit Criteria

Complete the analysis of the experience and outcomes for the plaintiff class compared with those of the general child welfare population to permit decisions on recommendations for exit criteria.

Katie A. Advisory Panel
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I. Introduction

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

II. Background

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

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

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

b. receive the care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;

c. be afforded stability in their placements whenever possible, since multiple placements are harmful to children and are disruptive of family contact, mental health treatment and the provision of other services; and

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

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

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

III. Panel Activities Since the Ninth Report

Since the Ninth Panel Report, the Panel has met with the County's leadership team, shadowed Emergency Response staff, worked with the training workgroup and participated in numerous conference calls about implementation of the Strategic Plan. In early June, 2009 the Panel met with the Leadership Team and a group of training staff for discussions about training and coaching.

A Panel member also completed a brief analysis of young children in group care, preliminary to discussions with the team of County staff addressing group home issues. A summary of that analysis is provided below.

Children 9 Years Old and Under Placed in DCFS Group Homes

In March 2009, there were 31 DCFS children 9 years old and under placed in group care in 9 facilities. This is a huge reduction, compared to 2004, when 405 children under 12 were in over 40 group care settings (110 of whom were age 8 and under), and 71 under 10 in 16 facilities in 2007. In 2007, there were five 6-year olds, seven 7-year olds and 23 8-year olds in group care.

Of the 31 children 9 and younger in group care in 3/09, two were 6 years old, one was 7 years old, 12 were 8 years old and 16 were 9 years old. Six were girls and 25 were boys. Sixteen were African American, 9 were Hispanic, and 6 were Caucasian. The 31 children are in nine Level 12 placements:

Five Acres 14
Little People World 4
Hillsides 3
Maryvale 3
Leroy's 2
McKinley's 2
Bruce & Nelson 1
Dangerfield 1
O'Conner & Atkins 1

These children have been in this placement an average of 8.6 months. Eight have been in this placement longer than 8 months: 1 for 35 months, 1 for 21 months, 1 for 20 months, 1 for 18 months, 1 for 17 months, 2 for 15 months, and 1 for 14 months. This is the first placement for 5 children, the second for 3 and the third for 3. Twenty of the children have had 4 or more placements, with this being the 15th placement for one, the 14th placement for one, the 12th

placement for one, the 10th placement for one, and the 8th placement for 4. Their average age when placed in this placement was 8.6 years, with a range of 5.9-9.1 years. These children were removed from home on average at age 5.6 years. Three were age 3 or younger when they were removed; 3 were age 4, 4 were age 5, 7 were age 6, 7 were age 7 and 3 were age 8 when they were removed.

Of particular concern in the 31 youngest children in group care are the following children:

"A" from El Monte who is 6, was removed at age 5 due to caretaker absence and was in three other placements and "B" from Glendora, who is 7, was removed in 9/08 for physical abuse and has been in 5 placements and were both placed in a group home 12/08. What intensive services would meet their needs in a foster home or with relatives?

"J" from El Monte, who is 6, was removed at age 1 due to neglect and has been in 13 placements, "E" from Pomona who is 8, was removed at age 2 due to neglect and has been in 14 placements, "R" from Torrance who is 9, was removed at age 1 due to neglect and has been in 11 placements, and "J" from Pasadena who is 9, was removed at age 2 due to neglect, and has been in seven placements. These are young children who have spent most of their lives in care and have probably been harmed by multiple placements. What additional services are necessary to meet their needs so they can move successfully to permanency?

"J" and "S" from Metro North who are 9, were removed at age 7 due to severe neglect and caretaker absence and have been in their first placements for 11/2 years, since 8/07. What additional services are necessary to meet their needs so they can move successfully to permanency?

The young children in group care highlight the efforts being made by DCFS and DMH to meet the needs of young children in care with intensive services in family homes to avoid group care. Also highlighted is the need to find more permanent homes with sufficient services for young children who are in group care.

During the April 2009 Panel visit, DCFS convened a meeting of its five treatment foster care providers (ITFC and MTFC), plus DCFS and DMH staff, to discuss whether treatment foster care—possibly with Wrap--could assist in supporting the children 9 years old and under out of group care and into their permanent home or a therapeutic foster home. The youngest children in group care, some of whom have had over 10 placements, had been written about for the meeting by DCFS and in addition to the interest in crafting something to meet the needs of each child, what was remarkable about the discussion that followed was: (1) readiness for open communication among providers and between providers and DCFS/DMH (e.g., one child had been identified by the CSW for a D-Rate home and the group asked, 'Why send him to a D-Rate home when within the same residential provider he can transition to TFC without changing clinicians?' Things were set in motion at the meeting to reconsider the D-rate referral); (2) interest in innovation (e.g., the providers were ready to do child-specific recruiting—relatives or others known to the child—of therapeutic homes, which might be a different individual than in the usual pool of foster parents and would likely mean the home would have the benefit of TFC training but only provide care for one child rather than a series of children); (3) positive reports

from the providers about RMP, the group now convened to discuss such children; and (4) ideas from providers and the agencies about how to intervene much earlier to prevent multiple placements and group care, including attention to the problem of children moving among foster homes within a FFA.

IV. Current Implementation Plan Status

Co-location of DCFS and DMH Staff

DCFS continues to make progress in co-locating mental health staff in DCFS offices. Currently, DCFS reports that there are 146 mental health staff co-located in DCFS offices, up from 128 at the time of the last report. Co-location now exists in all 20 DCFS Regional Offices. DMH also reports that it plans to fill 10 currently vacant positions and expects to add an additional 29 positions in 2009-2010.

Additional staffing for the DMH ACCESS Hotline

Of the three positions allocated, one is filled and two others were reallocated to provide co-located services.

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

The Panel and the County have reached agreement on nineteen outcome-related indicators that will be tracked for class members as well as on a set of process indicators that relate to issues like receipt of mental health screening, timely delivery of mental health services and types of mental health services provided. In the most recent meeting between the Panel and the County, the County proposed a change in the approach originally agreed to in collecting data for the indicators. Instead of tracking class member outcomes separately from the universe of children serviced by DCFS, the County proposed to track only the universe of the child welfare population, in part because there is no capacity to precisely identify all class members and because a mental health status is inconstant. Previously, the parties agreed to address this challenge by tracking an identifiable subset of class members, or proxy class, who were identifiable. Most recently, the subset considered consisted of all children currently receiving mental health services, served by DCFS.

In the most recent Panel meeting, after discussion of the Panel's strong opposition to the proposed change in methodology, the Panel and parties agreed to a process that would produce a comparative examination of the indicator data using the child welfare universe as one data set, compared with data based on the plaintiff class, defined as children served by DCFS and currently receiving mental health services. Additional discussion will be needed to create consistent conventions for defining current receipt of mental health services.

The Panel and parties had hoped that agreement could be reached on exit conditions related to indicator data which could be provided to the court for review; however, that agreement will be delayed until the comparative analysis is complete.

In the past, the Panel has expressed concern about the County's capacity to assess and track three groups of class members, described below:

- Members of the class newly entering care – Much of the tracking is designed to see whether all potential class members get screened at the Hubs, get referred to mental health services and get a MAT.

- Members of the class already in care -The majority of the class entered care before there were HUBS or MATs. They are being identified by locating DCFS children who are receiving mental health services.

- Children at risk of emotional problems who are not receiving mental health services - These could be recent entries into care who did not get identified by the HUBS or MAT as having mental health needs, but their behavior in care indicates otherwise. How are these tracked? Children at home at risk of placement, children with relatives and children in placement before 2008 who are experiencing emotional problems are an invisible sector or the class. How can they be tracked?

Panel members also noted that while the "data indicators" track HUBS screening and MAT assessment for large groups, it was not clear whether tracking individually looks at whether the child identified with mental health needs was referred to mental health services and what type of service was provided, nor is receiving services correlated with well-being and permanency. These outcomes are left to the QSR, which should include them, but larger scale outcome data than the QSR are also necessary.

One Panel member proposed that SCFS and DMH do a study of a large group of children identified by caseworkers as needing mental health services. While not all the class members and certainly not a replacement for the agreed-on indicators, a study of a large group of children would help to answer questions about members of the class already in care and those at risk of emotional problems who are not receiving mental health services. Such a study would also provide outcome information and could provide guidance in developing the QSR.

In response to these questions, the County responded as follows:

> The Katie A. Implementation Plan describes the systematic process by which all children in new and currently open DCFS cases will be screened for mental health needs, and if screened positive, assessed for mental health services. The Coordinated Services Action Team (CSAT) will oversee the Referral Tracking System (RTS) and produce a Summary Data Report (RTS Summary Report) which provides a number of data elements related to the screening, referral and service linkage process. In addition to raw data on the basic activities associated with the screening, referral and service linkage process, the report provides the participation rates and other data elements important to track in measuring compliance and progress. The report is currently organized so the data can be

viewed within each screening and assessment track by regional office, defined as follows:

Track #1: Newly Detained

All children in newly detained cases will receive a comprehensive assessment (including mental health) and linkage to service through the Multidisciplinary Assessment Team (MAT) Program.

Track #2: Newly Open Non-Detained

All newly opened non-detained children (family maintenance or voluntary family reunification) will receive a mental health screening by the CSW using the California Institute of Mental Health/Mental Health Screening Tool (CIMH/MHST) and, based on a positive mental health screen, referred for mental health services through the co-located DMH staff and/or Service Linkage Specialist (SLS).

Track #3: Existing Open Cases

All existing open cases will receive a mental health screening by the CSW using the CIMH/MHST when the next case plan update is due or a behavioral indicator is present (unless the child is already receiving mental health services) and, based on a positive mental health screen, referred for mental health services through the co-located DMH staff and/or SLS.

The attached RTS Summary Report reflects the mental health screening, referral and service linkage activities for a total of 639 DCFS children during the first month of CSAT implementation (May 1 - 31, 2009), demonstrating noteworthy progress in the completion and data tracking of activities in accordance with the Katie A. Strategic Plan.

Since May 1, 2009, staff from DMH, DCFS and other agency programs, both public and privately funded, completed the following activities:

- Reviewed a total of 639 DCFS children in open cases for mental health service needs and found 153 of those children already receiving mental health services;
- Completed mental health screenings for 439 children out of 465 required (at a 94% compliance rate);
- Referred 164 children for mental health services out of 166 required (at a 99% compliance rate); and

- Initiated mental health services for 144 children out of 164 (at an 88% compliance rate).

The RTS Summary Report quantifies progress towards fulfillment of the objectives identified through the Katie A. Settlement Agreement and the integration of these objectives into an infrastructure designed to support success and address challenges. In analyzing the data, it is important to note the point in time the data is extracted and that the final compliance rate for screenings required for the report period of May 1 – 31, 2009 is not expected until the first week in July. The final referral rate for May cases will occur through the first week in August and the service access rate for May cases can last through the first week in September.

Development of Multidisciplinary Assessment Teams (MAT)

The Strategic Plan forecast that 100% of newly detained children would receive a MAT assessment by January/February 2009. That forecast was revised to project full implementation by July 2009. The Department now projects that MAT implementation will begin in SPAs 1 and 7 by February 2009, which has occurred. While all new cases are being assessed in SPA 7, DCFS reports that progress is slower in SPA 1 due to provider capacity limitations. DCFS has not projected a new implementation timeline for SPA 1 at this time.

MAT implementation for SPAs 2, 4, 5 and 8 was originally scheduled for June 2009. Implementation is still scheduled in June 2009 for SPAs 4 and 8; however implementation for SPA 2 will begin in July 2009. The County reports that MAT referrals have now been initiated in SPA 4 and that MAT referrals will be initiated in SPAs 2 and 8 on July 1, 2009. According to the County MAT implementation for SPA 5 which is the only SPA behind schedule, will not occur until October 2009. The County now projects that it will achieve MAT assessment of all newly detained children by the end of FY 2009-2010.

Between July 2008 and April 2009, 1,405 children were referred to MAT and 1,180 were completed (84%). For April 2009, 164 children were referred to MAT and 137 assessments were completed (83.5%).

Implementation of the DMH Behavioral Health Information System

Last Report -The County reports that the DMH information system (IBHIS) was first projected for completion in June 2008 and is now projected for completion in September 2013. The County reports that this delay was caused by State-mandated changes which required reissuing the RFP.

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

The County has decided to adopt the Qualitative Services Review (QSR) process as its mechanism for assessing the quality of practice and system performance. A workgroup is

meeting regularly to create an implementation plan. Tentatively the Department plans to review 100 cases per year, completing a review in each SPA over a two year time frame. Implementation of the QSR is scheduled for September 2010.

The Department also proposes to use the QSR results as an exit condition, a decision the Panel concurs with. Further discussions are needed to determine a numerical QSR standard that will be applied as an exit threshold. The Department recently hired a new staff member to lead the development process. The County continues to hold regular work group meetings on QSR development, which the Panel is invited to join.

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

For six months, Panel members have been providing feedback to DCFS and DMH regarding training staff and providers in strengths/child needs-based, family-engaged services. We have a had a series of conference calls with the training workgroup (composed of DCFS, DMH, and the university trainers) regarding their recently-developed Core Practice Model and their interest in incorporating coaching of staff (in addition to classroom training) and teaching supervisors how to be coaches. One of the challenges in designing intensive services for emotionally disturbed children and their families and foster families and implementing Child and Family Teams is figuring out children's needs. Of course, CSWs, clinicians, Wrap providers and others want to meet children's needs. Yet, service plans, court reports, and CFT plans often do not state the child's needs. The child's behavior, rather than what drives it, frequently drives the services (even though controlling children's behavior is rarely successful). Sometimes what is listed are service needs (e.g., "the child needs counseling"), but these are services, not the needs behind behavior. Often the family's needs are the focus of the plan even though the child comes to the attention of child welfare and mental health because of the unmet needs of the child. The Panel has raised this concern in reports and meetings with the County for years. In January, 2009, a short paper by Panel member Marty Beyer about why it is difficult to focus on children's needs led to discussions with DCFS and DMH regarding strengths/needs-based practice and training. Children's needs are at the heart of the fusion of practice principles proposed by the Panel and integrated into the County's Strategic Plan, but how DCFS and DMH and their providers would actually make the change to strengths/needs-based practice was unclear.

In April, 2009, Dr. Beyer was invited to discuss focusing on children's needs with Wraparound providers and DCFS and DMH staff. In the cases that were briefly described, it was apparent what a struggle it is even for experienced Wrap providers to help a family (and school) who cannot tolerate a child's behavior figure out why the child has temper tantrums, for example. If the child does it primarily to get adult attention, the team might agree "J needs one-on-one attention from an adult several times a day." But if the behavior is the result of anxiety when things do not go the way the child imagined, and that reaction is leftover from when the child was a powerless victim of abuse, then the team might instead say, "J needs a lot of reassurance, as well as preparation before there is a change he will have to adjust to, and reminders about how he can calm himself down." The foster parent, the parent during visits, the teacher, and the child's therapist would all do very different things to meet the first need (attention) than the second need (reassurance). The next day, a meeting of the training workgroup with the Panel

included a lively discussion following a brief demonstration of figuring out the needs of a child, where the agency's and the parent's views of safety were in opposition.

The Panel has had frequent communications with the County about training and coaching of staff that will be implementing the new practice model. After several months of conference calls and written communication, the County presented the Core Practice Model which is a big step toward implementation of the strengths/needs-based approach outlined in the Katie A. strategic plan. Most recently, the Panel and parties spent a full day on June 9 exploring the approach to strengths/needs based practice with trainers and leadership staff, including a role play with County staff, led by a Panel member. The joint work on strength/needs based practice included the following.

Technical Assistance Session

The questions leading to the June, 2009 session were:

How is a strengths/needs based approach practiced in daily contacts with children and families and service providers and in team meetings?

How will supervisors coach caseworkers in strengths/needs based practice?

What training and coaching must be designed to teach strengths/needs based practice?

The day began with DCFS leadership leading a discussion of the just-released Core Practice Model description. This was followed by applying it to a summary of a family prepared by the training staff (changing identifiers from a real case). "Patrick," age 16, is residing in a group home which is his fourth placement since he came into DCFS care two years ago after his mother was unwilling to pick him up at Juvenile Hall (following Patrick throwing something at his mother's boyfriend). Patrick had lived until age 12 with his father and stepmother on the east coast when conflict with his stepmother led to his move to his mother's in LA. Patrick does not want to live in the group home or with his mother's boyfriend and wants to return to his father but his stepmother is refusing. We emphasized working with Patrick through his strengths: he is a good artist, smart and "always wants to run his own program." We discussed getting behind Patrick's runaway and other behavior to understand his needs. His need to feel recognized for his talents would generate individual support for Patrick to obtain art opportunities and alter his school program so he could excel. To meet his need not to feel abandoned by his family might lead to help for his parents in communicating caring for Patrick without living with him and to therapy for Patrick specifically designed to make peace with the hurtful things that happened to him. We discussed how to help Patrick identify his own needs and take charge of services, rather than forcing them on him.

Later in the day, a Panel member played a caseworker role in facilitating a team meeting with staff acting in the roles of mother, foster mother and teacher of 7-year old "Thomas." Thomas being good at math and his mother's attentiveness during their positive visits since he has been in foster care were important strengths. His need to feel successful might lead to one-on-one attention from a provider that would be beyond what the foster parents could provide. His mother

and foster mother united around his need to return to his mother as soon as possible, which led to his mother asking for more assistance in addressing her mental health and housing problems. This demonstration was discussed by many individuals from DCFS, DMH, their providers and the university trainers because it shows a different way to engage families, foster families and schools: “We all think we are focusing on the child's needs, when we really aren't” was perhaps the quote of the day.

The conclusion of the day was a demonstration with the same Panel member role playing a supervisor coaching a caseworker asking for help with “Gilbert,” a smart, verbal, and sociable 15-year old with numerous placements in five years in care since he was abused by his mother. The worker felt helpless about the likely breakdown of his group home placement because of his behavior and the inability of family members to manage him. The supervisor guided the worker in using her abilities to stay focused on the needs behind Gilbert's behavior and to encourage the group home to understand his needs, meet them and accept additional services to meet them.

We talked about how the materials in the case records often were problem-focused, not revealing many strengths and concentrating on placement crises rather than the children's needs. We also discussed different kinds of individualized services than currently exist to meet some of the needs in the example cases.

It is a daunting task to train and coach more than two thousand DCFS workers and support coaching by more than four hundred DCFS supervisors. The application of the core practice model to DMH and its contractors and training and coaching for them has yet to be fully conceptualized and described in the Plan. The County recently reports that initial internal discussions about the issue are focusing on an interagency conference to help agency partners have a common understanding of the approach. The Panel intends to devote a considerable portion of its attention in the next months to County strategies for practice model implementation.

The County has decided that it should develop a more comprehensive description of its practice model, which will begin under the leadership of a senior member of the management team. No specific deadline has been established for the completion of this task.

The County has been providing an extensive overview of the Strategic Plan to staff in regional presentations, the PowerPoint slides for which have been provided to the Panel. Neither the Strategic Plan nor the Project Data Sheets used to record plans for each Plan initiative reflect a schedule for implementation of Core Practice Model training and coaching in strengths/needs based practice.

Expansion for Funding

The Panel previously reported that the County Board has approved the $85,000,000 requested by the County to fund the Corrective Action Plan. The County’s new Strategic Plan was approved by the Board on October 14, 2008 and provides for the following additional funding:

Strategic Plan Costs for 2008-2009 - $18 million

Strategic Plan Costs for 2009-2010 - $45.1 million
Full-Year Costs for 2014-2015 (full 5-year implementation) – $119.9 million

Funding sources for 2014-2015 are:

EPSDT - $53.1 million state and federal
Federal IV-E Training - $1.5 million
MHSA – $3.4 million
Net County Cost - $61.9 million

At present, these commitments are still valid. However, the County points out that the severe budget crisis in California and the evolving projections for deficit reduction make it difficult to predict the impact of budget reductions on Katie A. implementation at this time.

Expansion of Staff Resources for Multidisciplinary Medical Hubs

The County reported that as of November 2008, 64% of newly detained children received an initial medical examination at a HUB. As of February 2009, 69% of newly detained children had received an initial examination at a HUB.

The Department projects increasing this percentage to 100% by June 30, 2010. To accomplish this goal, the County identified five initiatives that must be completed, which include:

- Opening a Satellite HUB in El Monte
- Revised policy on referral time frames
- Mandates on universal referral of newly detained children
- Tracking of HUB referrals
- Electronic submission of referrals from DCFS to the HUBS

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

As of the Panel's Ninth Report to the Court, 76 TDM facilitators were employed. DCFS reports that an additional 8 facilitators have been hired. DCFS also is requiring that mandatory replacement TDM's be provided for youth in or at-risk of being placed in RCL 6 or above group homes.

Implementation of the DMH Mental Health Screening Tool

The County is implementing the mental health screening process within the implementation of the Coordinated Services Action Team (CSAT) process, which according to the Strategic Plan is scheduled to begin phased implementation in the last offices by June 2010 (San Fernando Valley and Santa Clarita). The County's update on progress, below, reflects a revised date on complete implementation not by June 2010, but by December 2010.

The CIMH Mental Health Screening Tool (MHST) is currently used by every HUB during a child's initial medical examination. Positive mental health screens are currently reviewed by DMH Specialized Foster Care staff and children are referred for mental health assessments and linkage as needed. Tracking of the CIMH MHST results, however, is being done in the Referral Tracking System when the CSAT is implemented in each DCFS office. At this time, the only two DCFS offices that have implemented the CSAT are in SPA 7 (the Belvedere and Santa Fe Springs offices). Those offices implemented CSAT on May 1, 2009. Implementation in SPA 6 (the Compton, Wateridge and Vermont Corridor offices) is scheduled to occur on August 1, 2009 and SPA 1 (Lancaster and Palmdale offices) will implement on September 1, 2009. By September 2009, all Phase I offices will have implemented CSAT. Following full implementation in Phase I offices, DCFS will begin hiring, training and planning for the implementation of CSAT in the Phase II offices beginning in January 2010. DCFS expects to have full implementation of CSAT in all of the offices by December 31, 2010.

Coordinated Services Action Team (CSAT)

See County response to mental health screening above.

Referral Tracking System

Implementation began in the first SPA in May 09.

Expansion of Mental Health Services

In previous plans, the County committed to provision of the following discrete services:

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

More recently, the County has reported that it has identified five evidence-based modalities from the list above to implement. These are Multidimensional Treatment Foster Care (MTFC), Multisystemic Therapy (MST), Functional Family Therapy, Incredible Years and Comprehensive Children's Services Program (CSSP). The Comprehensive Children's Services Program includes Functional Family Therapy, Incredible Years and Trauma Focused Cognitive Behavior Therapy.

Currently, the Department's progress in implementing these selected initiatives is as follows:

MTFC – 80 beds projected, 80 beds under contract: 8 children in placement
MST – 80 slots projected: 59 children currently enrolled
CSSP – 314 slots under contract: 282 children enrolled

The County also committed in the Corrective Action Plan to develop 220 Intensive Treatment Foster Care beds. To date the County has contracted for 72 ITFC beds and 11 children are in placement. The County continues to work on addressing recruitment and contract performance issues which are barriers to serving the number of children projected to be served.

Expansion of Wraparound by 500 Slots

The County reports that in FY 08/09, Wraparound was expanded to 1,400 slots, which far exceeds the 500 slot increase which totaled 1,217 slots.

Targeted Mental Health Services for D-Rate Homes

In its Corrective Action Plan, the County committed to begin providing urgent response teams serving children in D-Rate homes. The County projected implementation in SPAs 1, 6 and 9 by March 2009. The County has now informed the Panel that because it has discovered that 90% of D-Rate children were already receiving mental health services, staff allocated to urgent response teams have been absorbed into the co-located mental health programs.

Referral and Tracking System

See report on CIMH screening tool

Caseload Reduction

DCFS has adopted three goals for caseload reduction, which are:

- Reducing front-end referral rates and case openings (the County accepts a significantly higher percentage of abuse and neglect reports than the rest of the State)
- Increased permanency practice and rates
- Increased or improved human resource practice and rates

It also set objectives to reduce Emergency Response and Generic caseloads by 15 percent.

The County has a series of initiatives underway to address caseloads which are beginning to have positive effects. Most significantly in past years is the reduction in the number of children in out-of-home care from 27,421 in FY 2003-2004 to 15, 766 in April 2009. Current County reports reflect progress in caseload reduction efforts as follow:

- An 8.35 % reduction in the screen-in rate since May 2008
- A 16% reduction in response time to reports of abuse and neglect

- Achieving the initial goals for caseload reduction in Emergency Response and Generic cases (ER caseload average now at 21.92 children and Generic caseload now at 22.56 children)

Functionally, caseloads still remain relatively high compared to workload, but DCFS is demonstrating progress at this stage of implementation.

Intensive Home-Based Mental Health Service Delivery

The County has committed to a two-tiered model of intensive in-home mental health service delivery. Tier-One is the existing Wraparound program, to which the County committed a minimum of 1,400 slots. Tier-Two is an expansion of the current Wraparound program and is focused on children who do not meet the eligibility criteria for Wraparound, but still need intensive mental health services. Two thousand, eight hundred slots are allocated to Tier-Two. The County Reports that Wraparound training was provided for both DCFS Supervising Children's Social Workers and DMH co-located staff to promote the identification and referral of children appropriate for this service.

While not designated as a separate tier, the County is also conceptualizing a broad strengths and needs based approach for children with somewhat less intensive mental health needs. This approach will also employ the "Whatever it takes" approach characteristic of Wraparound and use a form of teaming for planning, assessment, coordination, decision making and tracking. However it is designed to utilize DCFS, mental health and provider staff as team facilitators. Developmental work on this model continues, with attention still needed to strategies to train staff and providers in this approach. Training of DCFS, mental health and provider staff in the skills necessary to practice in this intensive home-based mental health services environment is critical to the success of this initiative. The County acknowledges the urgent need to deliver the training and coaching necessary to assure that practice is faithful to the model.

The County reported to the Board that Tier-Two rollout was to begin in May 2009. Recent County reports to the Panel state that 50 Tier-Two slots were under contract and 33 were filled as of June 2009.

Exit Criteria

As previously reported, the Panel and County have agreed upon outcome indicators, such as the frequency of placement changes and process indicators, such as timeliness of provision of mental health services, to be tracked. What remains is agreeing upon a performance standard for each indicator that must be met to merit exit consideration.

There is also agreement upon the use of the Qualitative Service Review (QSR) as an exit condition. Similarly, the Panel and County need to agree on the performance standard for each of the QSR indicators.

Both the Panel and County hope that these agreements can occur quickly once there is agreement upon the extent to which plaintiff class members are tracked separately from the entire child welfare population.

Next Steps

The parties plan to file the Strategic Plan with the court in the near future, requesting approval of the Plan. In addition, the parties intend to ask the court to extend the term of the Panel through 2010. The parties will also identify for the court the remaining steps to finalize the exit criteria for submittal to the court and propose a mechanism to ensure that the Plan provides adequate service capacity to meet the needs of class members once they have been fully assessed. Conversely, should the County discover through systematically screening children for mental health needs that excess service capacity exists that the County be able to modify previous mandates to supply mental health service slots in accordance with documented need. The Panel concurs with the intent of the parties to request the court's approval of the Strategic Plan.

In its submittal of the Plan to the court, the County intends to provide a document comparing key elements of the earlier Countywide Enhanced Specialized Foster Care Mental Health Services Plan developed in 2005 and the Corrective Action Plan developed in 2007 with the currently operative Strategic Plan which supersedes and replaces those earlier initiatives . This "crosswalk" is intended to clarify the relationship of the three plans and the evolution of various programs discussed in each.

V. Panel Recommendations

The Panel is pleased with the ambitious efforts underway in the County to implement the Strategic Plan. The County has significantly improved the organization and intensity of planning efforts, which is reflected in the progress being made in a number of areas. The Panel has identified three areas where it believes the most urgent attention is needed, which are summarized below.

Intensive Home-Based Mental Health Services

Although DCFS is expanding Wrap and developing ITFC and DMH is contracting for evidence-based practices and MTFC and implementing full service partnerships, an unanswered question is what intensive home-based services will be provided by outpatient mental health staff? As families work with DCFS, DMH and providers to design services that meet a child's needs and fit the family, a variety of new services requests will result including one-on-one coaches for children and one-on-one supporters for parents and foster parents more than once a week. These are therapeutic functions. If the child is in therapy and/or the family is in family therapy, it would make sense to have the therapist provide clinical support to these individuals doing these functions. It seems likely that more than a thousand Katie A. class members whose needs require intensive home-based mental health services while living at home, with relatives, in foster homes and in group care, would be served by outpatient providers, not through Wrap, MST, Incredible

Years or MTFC. For this large group of children, the capacity of outpatient therapists to collaborate with DCFS in strengths/needs-based practice and tailor intensive services to the needs of the particular child and the strengths of the child, family and foster family is essential. Who is hired to provide one-on-one support and how these services are billed are also important questions.

The detailed planning for implementation of the approach for delivery of intensive home-based mental health services other than Wraparound (Tier 1 and Tier 2) should be a high priority. Because its success depends on the delivery of effective training and coaching on the team-based, "Whatever it takes" approach to practice, the plan for training and coaching should receive a similar priority. A considerable amount of work remains to plan and provide the necessary capacity building.

The County acknowledges the delays in implementing Intensive Treatment Foster Care, where 220 beds were projected with 8 children currently in placement and Multidimensional Treatment Foster Care, where 8 of 80 projected beds are filled. In its most recent meeting with the County, DCFS staff described recent strategies to increase the number of treatment foster care beds utilized. The Panel recommends that the County incorporate these strategies into the Strategic Plan's task descriptions, called Project Data Sheets.

Tracking the Plaintiff Class and Exit Criteria

The Panel and County have worked under the assumption that the experience of class members as reflected by outcomes would be tracked separately from the general child welfare population since the court first spoke to the need for data on outcomes early in the term of the Settlement Agreement. Various improvements in the DCFS and DMH data systems have now made it possible to track most, but not all of the plaintiff class separately. Currently, there is no way to identify the "at-risk of mental health needs" DCFS population. However, now that cross-system data matching software applications have made the identification of children served by DCFS who also receive mental health services more accurate, it is in the opinion of the Panel possible to determine the extent to which these children are achieving permanency and stability, for example, compared with children who are not class members. The data systems also permit the determination of whether outcomes for most class members are improving over time. It was to achieve this matching that the parties approached the court several years ago with a draft order addressing confidentiality barriers to effective matching.

At present, the County has concerns about the fact that some class members, such as the at-risk population, cannot be identified and tracked. The County also points out that mental health needs can be transitory or episodic, raising questions about how such a status would be identified with some children.

This issue has particular relevance to setting exit criteria related to outcomes. The County would like the Panel to consider tracking the entire DCFS population related to outcome indicators and exit criteria. For example, instead of establishing that eighty percent of class members should experience no more than two placement changes in a prescribed time period, the County would

prefer that the percentage target apply only to all children in out-of- home care, not a class member subset.

Because there is clear evidence that children with mental health needs experience poorer outcomes that children without such needs, the Panel believes that combining class member experience with non-class members would mask the actual experience of class members, making it difficult to know the extent to which the delivery of intensive home-based mental health services was effective in improving outcomes for the class.

In recent discussions, the Panel and County agreed to create some data conventions that would address the episodic nature of mental health needs among some children, such as adopting the assumption that class membership reflects the receipt of mental health services during the past 12 months, which would help address accounting for the episodic nature of mental health needs. This would permit comparative reports of outcomes for the entire DCFS child population with children that are class members.

The Panel recommends that this comparative analysis be produced quickly, so agreement can be reached on exit criteria. The Panel is willing to participate in teleconferences to identify the necessary conventions that will permit reliable definitions of class member status. We hope we can resolve this issue quickly so agreement can be reached on exit criteria.

Training for DMH Staff and Contractors

Training must also be designed for outpatient mental health staff, now accustomed to providing office-based therapy, so they can (a) provide and/or clinically supervise intensive home-based services designed individually to fit the child and family and (b) participate effectively in strengths/needs-based team meetings.

VI. Glossary of Terms

ADHD – Attention deficit hyperactivity disorder

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

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

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

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

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

DMH – Department of Mental Health

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

ER – Emergency response

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

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

FGDM – Family Group Decision Making

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

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

IEP – Individual Education Plan

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

MAT – Multi-Disciplinary Assessment 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

VII. ATTACHMENT

ENHANCED SPECIALICED FOSTER CARE PLAN	CORRECTIVE ACTION PLAN	STRATEGIC PLAN IMPLEMENTATION UPDATE

Primary Provisions From the Respective Plans

❖ Closure of MacLaren	❖ Expansion of systems to screen & assess mental health services, i.e. Multidisciplinary Assessment Teams. Introduce idea of CSW using CIMH/MHST to conduct screenings	❖ Clinical Care management referral/assessment structure Coordinated Services Action Team (CSAT) – Phase I offices (SPA 7,6,1) will implement by 9/09, Phase II offices (SPA 2,3,4,5,8) will implement by 12/10
❖ Creation of DMH Child Welfare Mental Health Services Division	❖ Expansion of MAT from SPAs 3 & 6 to 1 & 7 – Countywide in FY 2008-09	❖ Child and Family Team, Two-Tiered Wraparound Model – Tier I – 1,400 slots; Tier 2 – 2,800 slots. Tier two rollout – 25 DCFS slots per month starting in 5/09, 50 FSP slots per month starting in 7/09
❖ Co-located DMH staff in DCFS Area Offices	❖ Resource Utilization Management/ Resource Utilization Management Process structure to transition children out of congregate care (RCL 6-14) more quickly using CANs	❖ Enhanced training structure using DCFS Core Practice Model as the guide
❖ Expansion of Medical Hubs from 1 to 6 to perform additional forensic evaluations including mental health screenings	❖ Expansion of intensive mental health services - Wrap (1,217) & Treatment Foster Care (300)	❖ Caseload Reduction initiatives: ER caseloads will be reduced to child count of 14 in 2011 & Generic Caseloads will be reduced to a child count of 15 in 2011
❖ Expansion of mental health screening for out-of-home population through Hubs & Team Decision Making (TDM) meetings	❖ Expansion of services to children in D-Rate through 24/7 crisis response & stabilization teams	❖ Enhanced inventory of data indicators: Safety; Permanency; & Operational Efficiency & expansion of the Cognos Cube
❖ Implement Children's System of Care Assessment Application for tracking purposes & a unique Master Person Index to track joint clients. Eventually transfer to Integrated Behavioral Health Information System (IBHIS)	❖ Title IV-E Waiver demonstration initiatives: Expansion of Family Team Decision Making; Upfront assessments for MH, SA, DV; prevention initiative; expansion of family finding & engagement	❖ Development of Interim Referral Tracking System - 5/09
❖ Contract with UCLA to conduct independent evaluation of implementation efforts	❖ Greater data sharing between DCFS & DMH ordered by the Court & development of Cognos Cube to store data	❖ Incorporating Qualitative Service Review as part of the Exit Criteria (formal adoption of Strategic Plan & progress on a discrete set of indicators) for complying with the Settlement Agreement
❖ Development of 1,220 Intensive MH service slots & 3,150 Basic MH service slots		
❖ Expansion of Wrap from 322 to 513 slots		
❖ Evidence-based intensive mental health treatment models available: Multidimensional Treatment Foster Care; Multisystemic Therapy/ Family Functional Therapy; Incredible Years; & Trauma Focused Cognitive Behavioral Therapy		