The Katie A. Advisory Panel
Fourth Report to the Court
December 30, 2004

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I. INTRODUCTION

The following Fourth Report to the Court outlines the progress by DCFS on planning to achieve the objectives of the settlement agreement and includes reports on studies of children placed in Metro State Hospital and children placed in D-rate (treatment level) foster homes.

II. BACKGROUND

The Los Angeles County Department of Children and Family Services (DCFS) and the plaintiffs in Katie A. et al. v. Diana Bont 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 agreed to implement a series of strategies and steps directed toward improving 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.

III. PANEL ACITVITIES SINCE THE THIRD REPORT

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

- Met with a representative of the Children's Commission and the Board of Supervisors;
- Reviewed a draft plan for achieving Katie A. outcomes by DCFS;
- Provided a suggested alternative organization of the DCFS plan, with some additions, to the Department;
- Reviewed revisions to the plan provided by the Department in response to the Panel's suggestions;
- Met with various DCFS planning work groups on the details of the Department's plan;
- Completed a study of services for children placed in D-rate (treatment level) foster homes;
- Completed a study of children placed at Metro;
- Completed basic information gathering about DCFS children admitted to psychiatric hospitals; and
- Continued, through the work of David Ambroz, focus group interactions with children in DCFS custody placed in group homes.

III. STATUS OF DCFS PLAN DEVELOPMENT

Following the issuance of the Department's last report and the Department's response, the Department provided the Panel with a draft written plan to achieve by July 31, 2006, five outcomes established by the Department. The outcomes are not the objectives for the plaintiff class referenced in the settlement, but are considered strategies for improving services to the plaintiff class. They include:

OUTCOME 1: Reduce the number of children under the age of 12 living in congregate care by at least 15%.

OUTCOME 2: Develop a plan to utilize Early Periodic Screening, Diagnosis and Treatment to expand Wraparound to provide supportive services to children in less restrictive settings.

OUTCOME 3: Continue to implement the Multidisciplinary Assessment Teams throughout the county by developing the capacity to serve children in SPAs 3 and 6.

OUTCOME 4: Continue to implement the Hubs by developing their capacity to serve children at County/USC Medical Center and MLK Medical Center.

OUTCOME 5: Ensure that children eligible for supplemental D-rate funding are properly identified, receive relevant treatment and that their prognosis is monitored.

A list of tasks to achieve these outcomes was included for each outcome (See Appendix __).

The Panel reviewed the plan and recognizing the effort to organize the planning already underway and detail strategies to achieve the objectives, responded with suggestions for additional detail and focus. The Panel's list of additional ideas included:

Diversification and Resource Development for Flexible Home-Based Services

The Panel believes that an aggressive strategy is needed to assist providers to diversify their services to permit class members to receive an individualized plan based on their unique strengths and needs. That strategy should include:

- Joint planning with providers at the SPA level
- Incentives for service development (from re-financing)
- Performance based contracting for flexible home-based services
- Support for caretakers in relative and D-rate homes
- Expand and strengthen Wraparound services (employing refinancing; Title XIX and expert technical assistance)
- Expand/strengthen family preservation services to meet mental health needs
- Collaboration with mental health (including advocating for revising the Medicaid plan where needed, forecasting the amount of services necessary so providers can plan, expansion of mental health services and creation of integrated practice standards for mental health and child welfare)
- Strengthen adult services (Shield may be a model of an exemplary provider)

Re-Financing

- Broader scope of group care diversion (targeting a larger reduction in the number of children in group care, which would free funds to be spent elsewhere)
- Use anticipated savings prospectively rather than after the fact to jump-start service development
- Maximize EPSDT, the gateway to Title XIX funding for children
- Strengthen utilization review and gatekeeping
- Insure that training takes advantage of the maximum in federal IV-E training funds
- Reinvest MacLaren funds in individualized services for class members.

Practice Development

- Develop child and family teams throughout the life of each case at the SPA/office level
- Strengthen training
- Provide training and coaching in family team conferencing for all staff
- Assure child and family teams have access to effective assessment (expand the Multi-disciplinary Assessment Teams [MAT] countywide quickly)
- Link the child and family team to the Multi-Disciplinary Assessment Teams
- Undertake a redesign of the core competency training
- Undertake an intensive practice coaching initiative for workers and supervisors at the SPA level
- Provide training for clinicians and child and family teams on evidence based approaches for intensive home-based services and non-pathologizing assessment

Track Outcomes for Plaintiff Class

- Create a working definition of the plaintiff class and track the progress of this subgroup
- Adopt a qualitative review process

Build Internal Capacity to Plan and Implement the Strategic Plan

- Develop capacity to provide front-line practice training and coaching within DCFS
- Strengthen the internal capacity to lead a provider diversification and resource development process
- Aggressively examine the effectiveness of federal revenue claiming and maximization of federal revenue, improving claiming where needed
- Strengthen DCFS capacity to oversee and assure timely implementation of Katie A. strategies
- Build SPA leadership capacity to manage the local organizational and practice change process

The Department invited representatives of County Mental Health to the meeting between the Panel and DCFS on the two sets of plans, which the Panel considers a very useful step. Obviously, the mental health system's assistance is essential in achieving the objectives for the plaintiff class.

Following a review of the Panel's ideas, the Department responded with a revision of its proposed plan. It also outlined the creation of a series of internal work groups assigned to each objective and suggested an assignment of a specific Panel member to each work group. In addition, the Department directed that the work groups communicate with the Panel in a set weekly conference call and proposed that the Panel meet with the Department on the complete plan monthly in a two-hour meeting. Since that time, Panel members have met with a number of the work groups.

Progress on Plan Development

At this point, the Panel is pleased at the Department's creation of task work groups and the effort to involve Panel members in joint planning. The Department of Mental Health (DMH) needs to be included as a key partner in the design of Katie A. strategies, so the involvement of mental health in these planning forums is encouraging, especially in light of the passage of Proposition 63 and the promise of additional revenue for mental health services for children in the State. The idea of regular conference calls among work group participants should help coordinate and accelerate the work on key strategies.

Regarding the weekly conference calls and set monthly meetings announced by the Department, if the Panel is to participate meaningfully, dates and times for Panel participation will need to be negotiated. Due to existing work obligations, travel considerations and time zone differences among the Panel, it will be impossible to commit to a weekly conference call or monthly meeting scheduled solely for the convenience of the Department. The Panel believes, however, that a practical schedule can be developed.

It is important to note however, that given the short time remaining in the term of the Panel, it will be increasingly difficult for these efforts to produce significant measurable improvements in outcomes for the plaintiff class by July 2005. Additionally, in an effort to support the Department's overtures of collaborative planning with the Panel, the Panel has largely set aside the resource development, re-financing and practice change strategies it envisions as needed in the work group discussions. The Panel continues to believe that these strategies, which it has consistently communicated over the past year and a half, remain essential to the achievement of the Katie A. objectives.

In submitting its planning approach to the court, the Department has chosen not to embrace many of the Panel's key suggestions, substituting it own five-outcome strategies. In addition, the Department explicitly rejected seven major components of the Panel's approaches, noting that they were either unrealistic to pursue, not required by state or federal law or beyond the legal obligations of the Department. They included:

- Expanding and strengthening Wraparound
- Revising the Medicaid Plan
- Strengthening adult services (primarily related to the needs of parents of class members)
- Using anticipated savings prospectively
- Using child and family teams throughout the life of the case
- Redesigning core training
- Utilizing a qualitative review process

It is the opinion of the Panel that the version of the DCFS plan that is the current subject of attention by the work groups is an improvement over former planning efforts. The Panel is hopeful that the Department's planning ideas, when sufficiently detailed and supported with adequate resources, will produce the progress the settlement was intended

to create. However, the Panel believes that the current DCFS plan does not yet have the scope or ambition to achieve the objectives of the settlement. We hope our work together successfully addresses this concern.

There is one very urgent difference of opinion between the Panel and the Department that directly impacts the Panel's ability to inform the court about progress toward achieving the objectives of the settlement. At this point, the information systems necessary to track the progress of all class members toward the objectives of the settlement, based on the trend indicators mutually agreed to, do not exist.

In the absence of a current data base that captures all the characteristics representing the plaintiff class, the Panel has suggest the use of a proxy, or working class definition that is accessible in current data systems. This would provide the court with a beginning baseline of outcome trends against which to compare future performance. The working definition consists of children served by DCFS placed in certain treatment settings, such as residential treatment and D-date homes, receiving Wraparound services and receiving services from mental health agencies.

The Department remains opposed to tracking the plaintiff class separately from the general population of children served by DCFS, describing separate tracking of this population as a "distraction" from larger reform efforts. The Panel spoke at length in its most recent prior report about the distorting effect mixing plaintiff class members and all other children in data analysis would have on the reliability of trends relative to the plaintiff class. As a result, despite having reached agreement between the Panel and DCFS on the overall trends to be tracked, it appears that no work is occurring on tracking the plaintiff class separately. The Panel has no ability to access these data without the Department's agreement on the definition.

IV. STUDY OF CHILDREN PLACED AT METRO STATE HOSPITAL

Summary

A copy of the complete Metro study is found in the Appendix. The 19 DCFS children at Metropolitan State Hospital in July, 2004, were studied. On average, these 12-17-year olds had been at Metro for 16 months; four had been there more than two years. Most have long histories of multiple placements, and some of the children have been in group care most of their lives. In May, 2003, a federal Department of Justice investigation documented significant clinical problems on the child and adolescent unit at Metro. Although Metro staff indicated that the program has been reorganized in response to the federal investigation, the lawyers representing children continue to complain about inadequate therapy and maltreatment by staff. A limited tour of the physical facility could not confirm improvements in Metro's clinical services for DCFS children. A thorough individual treatment review by DCFS clinicians of the adequacy of Metro's therapeutic services and permanency planning to meet the children's needs and build on their strengths should be conducted. In addition, a DCFS/DMH workgroup should be

designated to take active steps to prevent the movement of children from Metro (and other group care facilities) into Juvenile Hall for behavior that is symptomatic of their emotional problems and/or provoked by the actions of other residents or staff. This systemic work should be connected to the efforts of the Regional Permanency Review Teams in ensuring permanency and least restrictive placements for individual children at risk of moving into juvenile justice.

V. STUDY OF DCFS CHILDREN PLACED IN PSYCHIATRIC HOSPITALS

Summary

The results of a limited study of DCFS children in psychiatric hospitals are in the Appendix.

Combining April, June, September and October, 2004, 111 DCFS children (an average of 28 children per month) had 125 admissions to eight psychiatric hospitals. A tenth of the children had more than one admission during those four months. Those admitted in one month averaged 12 days in the hospital. Based on this limited summary of psychiatric hospitalization of DCFS children, the Panel recommends the appointment of a workgroup to (1) assess how the access to intensive treatment alternatives can be improved to reduced the hospitalization of DCFS children and (2) implement a method for monthly review of the rate, length of stay and usage patterns of psychiatric hospitals for DCFS children.

VI. STUDY OF DCFS CHILDREN IN D-RATE HOMES

Summary

A copy of the complete D – Rate study is in the Appendix.

In a study of 34 children in 23 D-Rate foster homes, the Panel found dedicated, loving foster parents. In too many cases, foster parents were tolerating challenging behaviors of emotionally children. The foster parents did not know how to access improved, targeted services designed to address the children's symptoms and guide the foster parent. For too many of the children, the foster parents do not believe the school program is addressing their needs. More than half of the children are not having consistent, positive visits with birth families, and arrangements for them to live permanently in this home must be carefully planned.

APPENDIX

APPENDIX A

DCFS PLAN

Five DCFS Outcomes and Summary of Plans to Achieve Outcomes
(Katie A. Compliance Period Ending July 2005

(To be inserted in final draft)

APPENDIX B

DCFS CHILDREN IN D-RATE HOMES IN LOS ANGELES

There are about 3,000 children in D-Rate homes in Los Angeles County. According to DCFS policy, "the D-Rate is the rate paid on behalf of hard-to-place children with severe and persistent emotional and/or behavioral problems. This rate can be paid for eligible children placed in the following types of out-of-home care facilities if they have been Certified for the D-Rate: foster family homes, non-related legal guardian homes, non-related extended family member homes, foster care-eligible relative homes, and small family homes which are not vendorized by Regional Center but are licensed for mentally disordered/emotionally disturbed children." The standard rate for foster care is the B-Rate which varies with the age of the child. If the child is eligible for D-Rate, the child's caregiver will receive the basic B-Rate plus a specialized increment rate (the D-Rate) regardless of their relationship to the child (about $1,100 per month per D-Rate child). D-Rate homes are county foster homes, relative homes and guardian homes, but not FFA homes--if a child with mental health needs is placed with an FFA, the FFA is expected to arrange services to meet those needs and support the foster parent with the funds provided in its contract.

According to DCFS policy, the D-Rate child's characteristics are:

- Age 5-18 years old;
- Displays severe and persistent emotional and/or behavioral problems;
- Current clinical evaluation (within 24 months) substantiating D-Rate eligibility or is receiving SSI for emotional needs

The requirements of D-Rate homes are:

- Caregiver has been a foster parent (or been employed working with emotionally disturbed children) at least two years;

- Caregiver has attended the 16-hour initial specialized certification caregiver training and the 15-hour specialized D-Rate renewal training annually (offered in community colleges); and
- Caregiver has had a D-Rate home evaluation and been approved by DCFS.

The expectations of D-Rate homes are:

- Caregivers must enroll children in a "psychological treatment program," provide transportation and be willing to participate in the treatment of the child, including
- being involved in family counseling;
- Caregivers must become knowledgeable about special education and the IEP process, advocating for the child's educational needs, developing partnerships with teachers, and ensuring the child does schoolwork;
- Caregiver must provide social and recreational activities for special needs children;
- Caregivers should participate in support groups and attend regional caregiver meetings.

The policy requires the CSW to request an IEP from the child's school and verify it has been completed. The policy does not require that the CSW verify that the child is participating in mental health services.

The policy requires that when a D-Rate eligible child is to be placed in a foster family home, existing certified D-Rate homes/spaces are to be utilized whenever possible. If the home is not D-Rate certified, the CSW refers the caregivers to the community college for the 16-hour D-Rate certification-training program. Once the child is determined D-Rate eligible, the CSW completes a form requesting approval for a rate adjustment for the home.

D-Rate foster homes cannot have more than two D-Rate children. Small Family Homes may not have more than three D-Rate children unless (a) the caregiver can meet the needs of all the children and the placement is not clinically contraindicated; (b) the caregiver has one or more assistant caregivers; and (c) there are no other D-Rate foster family homes available to meet the needs of the child without exceeding the two-child limit.

The D-Rate children placed in relative homes are supposed to be children who are placed with relatives while they receive family reunification services. The children who are placed with guardians may either be placed with relatives who became guardians or with foster parents who became guardians. If a caregiver receiving the D-Rate obtains legal guardianship and continues to meet the listed criteria, the D-Rate may continue. However, relative legal guardians cannot receive D-Rate if they opt for the KinGap program (and close the child's case with DCFS). As a result, DCFS often keeps services open to children placed with their relative guardians if the child is eligible for a D-Rate.

At the time of this study, it was difficult to get a snapshot of the characteristics of the 3,000 D-Rate children in care. Creating a spreadsheet of the 152 D-Rate children in one DCFS office, Metro North, found that they ranged in age from 5 to 20; 58% were boys, 42% were girls; 46% were Hispanic, 41% African American, 11% Caucasian, and 1% other. Forty-six percent were in D-Rate foster homes, 36% in D-Rate relative homes and 16% in D-Rate guardian homes. About a third had been in these homes for three years or more.

Planned D-Rate Improvements

DCFS has authority to hire 10 new CSWs, 2 SCSWs, 5 medical case workers (DMH) who will become D Rate staff. All the CSWs are licensed; most are former line CSWs. Each CSW will cover two DCFS offices; each medical caseworker will cover four DCFS offices. They will begin to identify children currently receiving D Rate and assess them. They will also process new assessments. Every six months they will case manage for continuity of care. It is possible that the rate the caretaker receives will move up or down after these assessments. Any major change such as removing a child from D-Rate will be reviewed. Referrals will still likely come from the CSW, who will make a referral to DMH. Once started, the goal is to have the assessment occur in 2-4 weeks after the referral. In addition, issues of permanency in D-Rate homes and whether the rate should change, and how, when the child progresses, are being discussed for possible improvements.

Interviews with D-Rate Foster Parents

Panel members Bill Jones and Marty Beyer interviewed 23 D-Rate foster homes with a total of 34 D-Rate children. DCFS staff made the arrangements for the interviews, and the foster parents graciously welcomed us into their homes. The children ranged in age from 5 to 17 years old; more than a third were ages 10-12 and a third were 15-17. Half were female and half were male. Twelve were in elementary school, 8 in middle school, 12 in high school, one in preschool, and one in a GED program. Almost all of these D-Rate homes were unrelated foster homes, with five being relatives and one being the child's guardian. Four of the 23 homes have two children who are siblings; the other 26 children do not have a sibling in the home. The children had been in their D-Rate homes from four months to nine years; about a third had been in the home less than a year and nearly half for one to two years. Nine children had been in the home for three years or longer, for example:

> Sisters age 17 (in twelfth grade) and 15 (in tenth grade) have been in this home for seven years. Their foster mother, a full-time teacher, reports that they "had a very deprived childhood," and both had problems with stealing, learning disabilities, depression and fighting with each other. There are five other children in the home, all teens: one is adopted, one is in a guardianship, two others are expected to be classified D-Rate and one is F-Rate (medical disability). The foster mother anticipates that the sisters may be assessed as no longer eligible for the D-Rate because of improvements in their functioning in school and emotionally.
>
> A 16-year old in eleventh grade has been in this home nine years. His foster mother indicated he is D-Rate because he was traumatized by his parents when he was small and is depressed as a result. Surprisingly, he has never had an IEP. His older brother, also D-Rate, was in this home for about eight years before going to college.

A 14-year old in eighth grade and his 12-year old sister in sixth grade have been in this home for four years. Their mother was killed and their father was abusive. They are being adopted by an aunt out-of-state.

Asked about the best characteristics of the D-Rate children, six foster parents volunteered "he/she's just like my own child," and the foster parents emphasized:

Affectionate
Smart
Helpful
Athletic
Friendly
Polite
Neat, clean
Tries hard

Some of the foster parents were enthusiastic about the children:

A13-year old "is very kind and very patient. When he is in a good mood he is very helpful around the house, often of his own initiative. He is a good golfer. He is smart and does very well in school. Just brought home a report card with four A's. He has good leadership skills and helps run the lunch program at the school."

A 15-year old "gets mad, but gets over it. She is able to say how she feels. She expresses her affection readily. She's a good girl. I'm so happy with her."

A 16-year old "respects his elders and is very helpful. He is a good basketball player. He has a good attitude. He plans for the future. He's trying to get his grades up"

A 10-year old "is affectionate, hugs me, tells me he loves me. He's helpful. He tries to learn and to control his behavior. He drives me crazy, but I love him like I love my own kids."

However, the children's problems list was much longer than the strengths described by their foster parents. The most frequently mentioned difficulties were:

School problems	16
Depressed	10
Aggressive	9
Disobedient	9
Temper; easily angered	9
Needs a lot of attention	8
Hyperactive	8
Short attention span	6
Lying	5

Destroying property	5
Grieving the loss of a parent	5
Mood swings	5
Stealing	4
Unsocialized	4

For some of the children who had been in the home for more than a year, the severity of their emotional problems was just becoming apparent.

> Sisters age 9 and 11 who have been in this home a year "are behind in school. They had to be held back. They have difficulty reading. I help with homework, but I'm not a teacher. It really concerns me. They won't be able to function if they can't learn. They had never been in school consistently and so when they first came to me they had to be tested to determine their school placements."

> An 11-year old in this home a year "has a very short attention span. He self-mutilates, pulls his hair out and picks at his cuticles until they bleed. He used to be angry and would lash out physically. He got into a couple of fights at school, was a bully, was acting out sexually and exposing himself at school."

> Another 11-year old in his home nearly a year has "a real bad temper, would scream, curse, destroy property, hit people, spit in the principal's face. At home he'd pout, but he was never disrespectful. Our only problem with him was what he did outside the house. He was embarrassed by his inability to do school work. Could only read a little, nowhere near his grade level. Kids teased him and he was embarrassed and exploded; he threw chairs and the police were called."

> A 10-year old in this home more than a year "changes moods quickly, gets mad and screams at me, screams in my ear, says he doesn't want to be in this home. He loses it! He stays up late and makes noise. He has trouble adjusting to changes in routine or special events."

> A 17-year old in this home two years "has ADHD, is temperamental, has a very, very short attention span, and because of his low IQ has to be continually reminded to do things. He paces a lot. He doesn't take responsibility for his behavior. He's very family-oriented and no one has reached out to him from his family."

> An 11-year old in this home for six years "was starving when he arrived, ate like an animal, had never slept in a bed, urinated on the floor and smeared his feces. He is one of 10 siblings in foster care. He steals. He denies he takes money out of my purse. He is so destructive of furniture. The older he gets, the worse he gets."

Surprisingly, foster parents indicated that four of the D-Rate children were getting no services outside of school. Twenty-seven were receiving therapy, four had 1:1 (TBS or another individual support), three were in drug treatment, two were in independent living groups, and one received respite. Some of the foster parents are satisfied with the services the children receive:

A 10-year old in his home a year is in therapy four times per week, once in the home and three times in the clinic. "I don't know what I'd do without the therapist. If it wasn't for the therapy, I think I would have gone nuts myself." His behavior has improved with the assistance of the therapist and the private school he attends.

A 17-year old teen mother in her home more than a year likes the therapist she sees weekly. Her foster mother says about their wraparound provider: "They come here. I really like them; they're very good. She calls them and confides in them. She has a person she can contact 24/7, who takes her to see her baby."

A 13-year old in his home more than a year goes to individual therapy weekly, group therapy weekly, and sees a psychiatrist at the mental health clinic co-located with his non-public school. He goes to enrichment class once per week that helps identify his strengths and then the school works with him to build on his strengths, to focus on what he does best.

Sisters age 9 and 11 in their home a year "have therapy once every two weeks. I made these arrangements myself based on a reference from a family member. Medical pays the entire expense. I'm involved whenever the therapist wants me to be. I'm usually in the sessions because in the beginning they wouldn't talk. They're talking more now, so I will probably be less involved. I really like the therapist; I'm really pleased with her."

A 17-year old's foster mother commented, "Therapy helps him calm down, but he's resistant, and it took a long time to get him to consider therapy. He's afraid of his secrets getting out--he has a lot of grief and loss. He'll do better for a while and then he slides backward. He goes from one extreme to the other." His foster mother works with the therapist helping him control his temper and dealing with his losses, which she is especially sensitive to, having been raised in foster care herself.

A third of the foster parents commented that the therapy provided is not effectively addressing the children's numerous problems:

The foster mother of a 5-year old in the home for three years was dissatisfied with her office-based therapist. Another foster parent helped her arrange having a therapist from a different agency come into the home for weekly therapy. But she sees no benefit from the play therapy: "The therapist is not talking with her about her past trauma or about her

present behavior. She has sexual behaviors but has never talked her about sexual abuse and has to get it out of her system or she's going to explode."

An 11-year old had a home-based therapist who came twice a week. "I didn't see any benefit. They'd play ball; he'd take him to McDonalds. He was street smart and had lived in the street with his mother. He manipulated his therapist."

A 5-year old in the home nearly a year has in-home therapy once a week that was supposed to reduce impulsivity and defiance, but the foster mother does not get guidance in understanding what she can do to help the child.

Fourteen-year old and 12-year old siblings have seen three different therapists since they were placed in this home four years ago. Their foster mother commented, "I think I do more than the therapist by talking with them all the time. I go with them to the therapist sometimes, but they don't like to talk with the therapist. Then later on they may talk with me."

The foster mother of a 15-year old who ran away from her home commented, "They offered me Systems of Care. They were OK. They'd come visit, take her out, and meet her at school. They'd ask how they could help. But the provider went bankrupt and it was a month before they hooked her up with another program. By then her behavior had gotten worse. She was stealing money. She's a compulsive liar. She was very stubborn; she wants her way and doesn't accept 'No.' I tried, but she insists on being an adult before her time."

Nine of the D-Rate children are in school above the first grade and do not have IEPs. For children who qualify for the D-Rate never to have had an IEP should be rare, yet it is true for nearly a fifth of the children. One foster mother is pushing for an IEP for the 10-year old in her home for more than a year: "he was tested and it was determined that he processes things slowly and special classes were recommended." His foster mother is working closely with the CASA and is pleased with her assistance in trying to get the IEP scheduled. While some of the foster parents have participated in IEP meetings, others were surprisingly uninformed. One foster mother was not sure whether the child was in special education, while another indicated the child "is too smart to have an IEP." Another foster mother was frustrated with the IEP process:

A 10-year old in his home seven months came without an IEP and his behavior triggered an evaluation, which determined he should have special education services. Before an IEP was completed, the school excluded him for his behavior (even though the foster mother insisted they could not do so) and she says an agreement was made between DCFS and the school to do in-home schooling, but it never happened. "The social worker promised to

arrange it, but did not." The foster mother believed that was why he was recently placed in residential.

The D-Rate foster parents report different experiences in working with the schools. About a third seem to have no active involvement in school. About a third are positive about the school the child attends and their communication:

The foster mother of a fifth grader in her home for a year reported a good working relationship with his school: " I have a buddy book with his teacher. We communicate back and forth by writing notes to each other in that book and he carries it back and forth."

A tenth grader goes to a school her foster mother of two years describes positively: "The school works well with me. When I have problems I call the therapist at the school."

The foster mother of a second grader reaches out to her school and commented: "I volunteer at the school and have gotten to know the staff and we work well together. When the school sees that I am interested and supportive of her, they are more responsive to her needs."

About a third of the D-Rate foster parents described their dissatisfaction with the school their children attend:

The foster mother of a tenth grader who has been in her home for seven years, commented, "I have to stay on the school to get her what she needs. She has ADHD, but the IEP doesn't address her behavioral or emotional problems. It's like pulling teeth to get tutoring for her."

Another youngster is getting ready to complete school and would like to join the Navy, but his foster mother does not think he will get accepted because of his low IQ. " He needs more assistance planning for the future. He's not close to being ready to get a job. I want him to study a trade and the school does not offer that."

Although her foster mother says she reaches out to school and goes to parent-teacher conferences, she is very concerned about her fourth grader who does not have an IEP and is "in regular classes that are way too large. She needs more one-on-one instruction--she doesn't grasp things as quickly as others. I try to explain things to her."

Two foster parents reported cooperating with the school, but the child apparently was making little progress:

The foster mother of a ninth grader who never attended school in Mexico before entering her home two years ago, reports a good working relationship with the school. "They call when she acts up or when they

> realize she didn't take her medication. Every three months I go to talk about her IEP." Yet, she commented, "She has trouble learning. She doesn't know numbers, can't count money or make change. She is taught in English at school but doesn't understand more than a few words. She can't read or write, even in Spanish."
>
> The foster mother of a tenth grader said, "They try and we work together, but it doesn't help. My daughter has tried to help him too. She gets email assignments and reports from the teachers, but we can't affect any change."
>
> Twenty-four of the 34 D-Rate children are taking medication for their mental health problems and all but four of the foster parents believe it has benefits. There were no complaints about access to monthly medication checks with psychiatrists. The most common medications were Wellbutrin and Risperdal. Medications to treat ADHD were the most frequently prescribed-62% of those taking medication (Adderall, Clonidine, Concerta, Ritalin, Wellbutrin (also used for depression)). Almost half of those taking medication were prescribed antipsychotics (Abilify, Risperdal, Seroquel, Zyprexa). Four were being medicated for bi-polar disorder (Depakote, Lithium) and four for depression (Celexa (SSRI), Paxil (SSRI), Trazadone, Zoloft (SSRI)). (SSRI's are the anti-depressants recently acknowledged by the FDA as being linked in children to suicide and behavior problems.)

Only half these D-Rate children visit with their parents, and half of those have positive, consistent visits:

> The foster mother for an 11-year old in her home two years commented, "His Mom visits on weekends. He was freed for adoption, but the judge gave Mom one more chance. He didn't want to be adopted. He was very insistent he wanted to return to his Mom. This is the first time Mom has achieved unsupervised visits; she now has good drug tests. He is happy when he returns from visits. I believe it is good for him to return to his mother if she continues to make progress."
>
> A 10-year old who has been in this home a year visits several times a week with his father, who has had heart surgeries. "He is very devoted. He went to his IEP meeting. The boy goes to court soon and the recommendation will be placement with his father. His father is trying to make arrangements to keep him in the same school."
>
> Before her baby was born, a 17-year old who has been in this home a few months, visited every weekend at her grandmother's house and saw her little sisters. They all visited her at the hospital and are resuming visitation on weekends, now that she has recovered from the delivery.
>
> An 11-year old meets every Saturday with his mother and siblings. "He loves his mother and looks forward to seeing her. He's fine when they part because he knows he'll see her the next week."

A 10-year old's mother, his foster mother's half-sister, was at the home for Thanksgiving and visits regularly.

Some visits are problematic:

Before they were recently reunified after eight months in this home, a 6-year old's mother came from out-of-state: "That child was so glad to see her mother! She was here for about a week and saw her every day. But the child was impatient to be returned to her mother and became more agitated. All the progress we'd made with her behavior went out the window."

A 17-year old has weekly visits with his mother and siblings and wants to return to them. His foster mother of two years, who usually supports reunification, does not think his mother can care for him. "The social worker says he can stay in my home past age 18, but he may decide to leave. I'm afraid he'll slide backward quickly."

Sisters ages 17 and 15 have irregular visits in the foster home where they have lived for seven years: "We tried to visit Saturdays, but their mother is not consistent. They'd like to see her once in awhile. There was a long period of time when they didn't see her and were worried about her."

The foster mother for a 12-year old commented, "Her Mom is in El Salvador with an older daughter. She visits her Grandma but there doesn't seem to be much interest by Grandma, who doesn't call or initiate seeing her. She is upset by the lack of contact. She says she 'hates' her father because he is not involved in her life."

It is unclear how many of the large number of children who have no contact with family are permanently placed in their D-Rate homes:

The parents of sisters age 9 and 11 in their foster home a year "call once a month to say 'Hi.' Their parents choose not to visit. I would be willing to meet them in the park, but the occasional phone call is all they want. The children visited with an aunt for a while, but it was upsetting to them, and they would be in tears every time they would talk. She was scaring the kids and she caused me problems. She was making our lives miserable. She hasn't been trying to visit recently."

A 15-year old's family is in Mexico and she has been in this home two years.

Parental rights have been terminated for a 13-year old who has been in his foster home more than a year. His mother is from El Salvador and his father is in Mexico. His uncle was going to adopt him, but did not. He has no contact with his family and he does not talk about them. He asked recently

> if his foster mother knew where his little brother, suffocated by their mother nine years ago, was buried. He sometimes sees his older sister.
>
> A 14-year old in this home for nearly a year has not seen his parents for years. His father is in prison and his mother's whereabouts are unknown. He sees his younger brother twice a month and his older sister in court.
>
> Although he is only ten years old, another youngster does not see his parents and has a plan of long-term foster care, according to his foster mother of more than a year. His younger sisters have been adopted and he cannot see them and he has lost contact with his older sisters.
>
> The foster mother of a 15-year old who has been in her home two years commented, "her mother is a prostitute and a drug user." Her social worker tried to set up a visit with the mom one Saturday, but the mom never showed up. She now says she doesn't want to see her mother, but she worries about her mother because she's in an abusive relationship. Her father has not been identified." She has been trying to see her younger brother whose guardian is opposed to their contact.
>
> A 9-year old's great aunt takes her to see her siblings every week and has tried to encourage visits with her mother during the year she has been there. "My door is open to her. She could see her at her grandmother's house after school anytime, but she rarely goes by there."

It was surprising that other than the few children who seemed to have a realistic plan of reunification, only one foster parent raised the problem of permanency for children in D-Rate homes:

> The foster mother of a 5-year old does not know why it has taken more than a year for her adoption papers to be filed--she says her worker says she is waiting for approval from Sacramento, but the child has been in her home for three years. Another foster parent helped her request an adoption subsidy at the D-Rate level and MediCal to continue through age 21. She says foster parent have to be persistent.

More of the D-Rate children visit with siblings than see their parents:

> It is quite a project for ten siblings, two with their mother (ages 2 and 2), one with a maternal aunt, two in foster care, and five with their paternal aunt and uncle, to get together, but their caretakers try to orchestrate a visit every month.
>
> Four siblings who are spread among two foster homes and their maternal grandmother meet every Saturday and include their mother.
>
> A 15-year old has twin in a foster home in Fresno, from whom she has been separated six months since she was placed in a residential program in

LA. Her foster mother says she has insisted that DCFS pay for an airplane ticket once a month for 4-day weekend visits.

One of the most important findings from these interviews is that although the D-Rate foster parents are aware of the severity of the children's emotional problems, they did not know what would meet their needs more effectively. Twelve of the foster parents apparently had not heard about or did not think they could access services that would assist them, including several who indicated they did not know how to get specialized services. The service wish list of the the D-Rate foster parents includes:

Help with school	12
After-school activities	5
Special bus service	3
Regional Center	3
Summer program	3
Independent living services	3
1:1	2
Respite	2
Medical care	2
Group counseling	2

Despite the obvious need, none of the foster parents said they wanted help to make visits improve between children and their birth families or assistance to support the child's remaining with them permanently.

Asked about the obstacles to getting the services on their wish list, six reported the problem was their social worker that had not arranged them. Others said tutoring and other school assistance is not available. Three foster parents blamed the cost of services. Two children needed but were still not receiving Regional Center services. Two teenagers were described as not wanting services.

One foster parent said it took a year and a half to get a mental health assessment for the child, during which time the foster parent received a regular rate. The pediatrician prescribed Concerta and gave paperwork to the foster mother recommending treatment, which she gave the caseworker. She said she repeatedly asked the caseworker for a therapy referral. Finally, she got an assessment and therapy. But she said therapists believe they are the experts and do not talk with foster parents either to coordinate care or to get or give suggestions, which she thinks are very important. She said, "It is very difficult to get good mental health services and that the wait is always long. Only a few therapists are willing to come to the foster home. Only a few therapists will go to the school to observe the child's social and academic problems. Therapists say they cannot discuss the child with the foster parent because of confidentiality--this is ridiculous. I am caring for the child and want to improve what I do. It's supposed to be a collaboration, to help me help the child. But the therapist discards what I say. Too many professionals look down on foster children. They don't treat the child or the

foster parent the way they would if a parent brought in their own child for therapy. But I consider her my child." She believes a mental health assessment should occur within the first two months of placement of a special needs child, with services soon after. "The social worker drops the ball. We have to go through our own informal network to get services. But we still have to have a referral from the social worker. Sometimes mental health will provide a service if we have the court order requiring it, but usually the social worker doesn't give us the minute orders. We have to be very proactive as foster parents."

One foster parent said she had been desperate for help and kept asking. The Regional Center would not provide help. She had three other children in the home but one took all her individual attention for two years. "I had to learn about bipolar by reading about it."

"Is there a group for sexually abused children, and would it be right for her? Who would I ask to find out?"

"The worker was unresponsive. If I'd had more support and he'd had a one on one, he would still be here. I was so disgusted with the system that I need a break before I take any more kids. They're just putting kids wherever they can find a place."

"When I started foster parenting, we had respite care, but not anymore. We really need that break. It would help prevent burn out, which would benefit the kids and help retain foster parents. I get no support from the social worker. She's been here three times in 14 months. I get calls from her saying he is too fat and he needs to see his sister and where are the reports on his health, etc. If she'd ever visit she'd get answers to all those demands. I asked her for information about adoption and she never sent it. I've never had a problem with a social worker before. I've had some who are extraordinary.

Asked if they would like additional training, despite feeling so challenged by the children's behavior, many of the D-Rate foster parents did not have ideas for training that would assist them. A surprising number responded that they had been foster parents for years and would not benefit from additional training. Several parents were critical of the D-Rate training, while others said it was helpful.

"D-rate classes were informative, but it was just 16 hours and these kids have such extraordinary needs that I just do the best I can."

"I'd like training on how to deal with misbehavior, and particularly aggressive behavior. And how to find doctors and therapists who will take MediCal."

"I go to the renewal classes, which are helpful. My mom and I are going to one on nutrition. Training on their medications and side effects would be helpful."

"I would like to take sign language."

Two foster parents wished training were in Spanish.

"I don't know if there is training. I would like to learn more about how to communicate with her. I've watched how calmly and gently her therapist talks to her--sometimes I get upset, but I'm learning to calm down. I never had problems with my daughter; school was very important to my daughter and me. This is new to me--it doesn't make sense that she acts out in school."

"Foster parents need training in bi-polar disorder and how to help the child get better."

"Over the years the children and doctors have really educated me. I'm always eager to learn. I enjoyed being in the refresher class but I really didn't learn anything new that I hadn't heard about. I wish I had more training in managing resistant teenagers."

Four foster parents, while well-intentioned, did not understand the D-Rate children's needs and seemed unaware that more services are urgently required:

The foster mother's description of a 10-year old in her home for more than a year who does not speak, demonstrated her lack of understanding of autism and unrealistic expectation that the school would "fix" him. "He bites himself and scratches himself until he bleeds and then licks the blood. He doesn't watch TV or play with toys. He makes motions as if he were playing a piano, so I bought him a keyboard and he tore it up in one day. Sometimes he dumps his food on the floor. I have him pick it up and then he dumps it again. He can feed himself, but otherwise you have to wait on him hand and foot. He has broken up two TVs and his bed frame many times and now his mattress is on the floor and he's tearing it up. He likes to destroy things. Sometimes he cries for no apparent reason."

The foster mother of a 12-year old who has been in her home more than a year, described his low self-esteem, but did not recognize his limitations or his fears and insecurities. She seems unaware that her judgmental parenting style does not meet his needs. She went on and on about his misbehavior, and her responses, which is to tell him what to do and not to do and to belittle his failures. She blames him for bedwetting. She withholds affection because she is afraid of how he would react, if she were to hug him, for example, and she does not want to lose her license. "He says, 'Nobody loves me and nobody cares about me.' I say, 'I love you, but if you don't like it here, I'll ask them to put you somewhere else. Then he'll say, ' I don't want to leave.' He says he

> wishes he was dead. I say, 'Well, you aren't, so you might as well make the best of it.'"
>
> An elderly foster mother is over her head with a 12-year old who has lived with her for years. She described her efforts to socialize him by taking him out to eat to teach him table manners while she says his school problems go untreated and she believes his therapy does nothing. I observed her treat him like a young, disobedient child when he presented as a pre-delinquent who did not want her to know what he was doing. She worries about "bad influences" in the neighborhood, which is why he is out of school, while she demands he be transported to a better school not too far away but in another district. She complains that his medication, which is an antipsychotic, "hasn't changed his temper tantrums or stealing." She does not seem informed either about the origins of his behavior and learning problems or the necessity of specialized treatment. Instead she blames him for his worsening behavior, and seems unaware that without intensive intervention he will likely be arrested.
>
> Another foster mother's prenatally substance exposed 3-year grandchild who has been with her since he was eight months old, was diagnosed with an expressive language disorder and received Regional Center services for a while. But she did not know why they were discontinued, and whether he was supposed to be receiving other early childhood intervention for his obvious delay.

Although they may not be asking enough for services that meet the children's needs or enhance their skills even further, D-Rate foster parents are remarkable, caring individuals:

> One foster mother is one of 13 children, six of whom are women. Each of the six has three biological children and three adopted girls!
>
> One foster mother has five biological children in the home and took in her D-Rate nephew.
>
> One foster mother has raised two accomplished children who are now professionals and says, "God blessed me and I have a duty to care for others." She wants to provide a permanent home for the teenage girls in her home.
>
> The mother of one D-Rate foster mother lives across the street and has been a foster mother herself for 30 years. Her sister, a schoolteacher who lives down the street, has adopted two children. Raising her son’s substance-exposed infant of her son's, she heard in the hallway of the courthouse that his half-sister (unrelated to her) was going to be adopted. Not even knowing the child, she said she would adopt her.
>
> Another foster mother says she needs respite care, "but on the other hand I don't want to leave them with people who don't know my kids and don't know how to treat them. I'm pleased with my social worker. He responds to

calls and requests quickly. I sent one of them to Sacramento on a school field trip in an airplane. They are going to Vegas to compete in cheering. They'd never been to the beach. We went to Magic Mountain. We went camping. Serena and Venus Williams practiced near where we live so we're all going to learn to play tennis."

Another foster mother, who is a former school teacher and worked in a residential program, articulated a clear parenting philosophy which she learned from her upbringing. The single mother of a 3-year old, she believes in avoiding power struggles and not giving orders; instead she "listens to the child first, communicates all the time, explains the reasons for everything and prevent explosions by not putting pressure on the child. Be respectful to the child. Use a lot of praise." She also believes that children should be occupied all the time in positive activities, which she arranges and gets the help of a 1:1 to transport. She presents herself as a parent who practices the recommended combination of being loving and firm. "D-Rate is a lot of work. Every child is different. You have to figure out what is so complicated for this child, what is the reason for this child's behavior. You have to be organized and focused." She believes that most children would do better in D-Rate homes than group care and that most psychiatric hospitalizations could be avoided by experienced D-Rate foster parents.

With a 5-year D-Rate child in their home, foster parents welcomed a sibling group of four (ages 1-4) whom they described as being in the worst shape of any abused children they had seen in foster care. The 1-year old was in a body cast. The 3-year old had been hospitalized for more than a month for a bone infection and arrived using a walker, and the 2-year old had a metal pin sticking out of her elbow from an old fracture repair. The 3-year old continue to be regressed, not speaking and not being toilet trained. The 4-year old have a speech delay and is hyperactive. Two of the children are still seeing orthopedic surgeons. Several of the children were prenatally substance exposed, are easily agitated, and have nightmares. The foster mother observes more aggressive, competitive behavior among the children than she considers normal sibling rivalry. Beyond their efforts at home, she thinks the children would benefit from therapeutic instruction in playing cooperatively and less aggressively. She believes they need treatment for their aggressive behavior and social skills training. Two of the children get a regular rate and two get a medical rate. At the time of the interviews, none of the children was getting a D-rate. She has repeatedly requested an assessment, but in five months no evaluation has occurred and the children have not received mental health treatment they need. Two of the children get a regular rate and two get a medical rate.

A professional woman who was on the board of directors of a large group home and while volunteering became friends with a 7-year whose intelligence and athletic skills she encouraged. Sexually and physically abused, he had been in ten placements. She had no children and had never considered being a foster parent but decided to sell her home and move to a place more suitable for him. She was critical of the foster parent and D-Rate training and the guidance of

the group home clinicians, "none of which prepared me for reactive attachment disorder or how to manage a child with so many fears." She helped get the child placed in a gifted program and sought a therapist for him and herself, and he was accepted into her extended family for holidays and vacations. She had begun the adoption process when, nearly two years after his placement with her, his mother, who had been out-of-state for years, returned and began supervised visits. His behavior deteriorated, and his foster mother said DCFS returned him to the group home. After his mother hit him during a visit, his foster mother said the court ordered him back to her home and she placed him in Catholic school where he was successful academically and athletically. She encouraged his little sister (who was in foster care) to visit their home despite his increasing aggression, which she attributed to Wrap beginning meetings with his elderly alcoholic father who the boy was terrified of. Her criticism was, "How can Wrap decide which is the family he belongs in?" Now alienated from the group home, the Wrap provider and the DCFS worker, she became frustrated with the 1:1 staff who were not trained to help him manage his behavior and repeatedly called the police to her home rather than de-escalating the situation: "They want to take him out of the home every time he is aggressive, which makes no sense; unqualified Wrap staff don't believe in therapy and say, 'We'll teach him skills.'" When he was removed from her home and placed in the Wrap provider's group home with no therapy, she felt they blamed her, reinforcing her belief that they did not understand severe attachment disorder or his need to recover from his early trauma.

In conclusion, interviews with 23 D-Rate foster parents showed their remarkable dedication. They have worked with schools, mental health providers and their social workers to arrange services for the children. Most troubling about the interviews was that although the foster parents described difficult behaviors that had continued, often for more than a year, and many were dissatisfied with services, neither more intensive interventions nor more assistance for the foster parents appeared to be available. While it is therapeutic for a child to experience the unconditional love offered in D-Rate homes, children also require help specifically designed to address the underlying needs causing their behavior. It is necessary to provide more than group training for foster parents and relatives responding to the challenging symptoms presented by these emotionally disturbed children.

Home-based guidance for the foster parents, therapeutic approaches directed at aggression, depression, anger and stealing that are often associated with past trauma, intensive family strengthening services provided at visits, and more effective school services are necessary for at least half of these D-Rate children. The D-Rate foster parents want to help the children function better, but have to be offered more targeted in-home support, rather than being expected to cope with unchanging behavior problems. While the symptoms of severely emotionally disturbed children may not be completely eliminated the interventions are inadequate and must be improved when their behaviors significantly interfere with daily functioning for more than six months. D-Rate foster homes are a valuable resource and could provide more therapeutic care for more emotionally disturbed children if access were increased to substantially more effective

mental health and school services. In addition to the steps being taken to enhance the evaluation of D-Rate children, DCFS and DMH must ensure that providers know how to coach foster parents in therapeutic approaches with traumatized children and that intensive in-home services for children and guidance for foster parents are accessible on a daily basis, if necessary throughout the county.

Finally, for the majority of the D-Rate children who are not having positive, consistent visits with family, more attention must be paid to permanency. Sustaining the gains made in therapeutic foster care is a national child welfare issue and must be addressed in LA: when children cannot be placed with their families, how can their D-Rate foster home become their permanent home if the foster parent cannot manage on the lower rate? Perhaps a special permanent home rate (larger than the B-Rate, smaller than the D-Rate) for children who were formerly D-Rate and have improved, which will protect them from moving (which would likely cause deterioration) should be considered.

APPENDIX C

DCFS CHILDREN AT METROPOLITAN STATE HOSPITAL

This study and report was conducted by Marty Beyer.

At the end of July, 2004, DCFS reported that there were 19 DCFS children at Metropolitan State Hospital. In mid-August, I requested that DCFS re-schedule for September 9, 2004 my tour of Metro which had been approved but then canceled due to a court hearing months before. Three attorneys concerned about their clients' placements at Metro asked that I interview them. I subsequently requested that DCFS arrange for me to attend treatment team meetings for these children in addition to the tour of Metro. In the first week of September, DCFS county counsel was told that the Attorney General had to approve my Metro visit. After days of discussion, the tour and team meetings were denied. On September 9, I went to Metro with the attorney for one DCFS child who

asked that I participate in her legal visit, with the approval of the DCFS staff who met me at Metro, and we were told that only the individual(s) named on the minute order from the court could visit. Later that day, the conservator/relative of another child requested that I participate in her visit during regular visiting hours with the child, and I was told by Metro staff that the Attorney General had instructed them that I was not permitted on the unit even with the approval of DCFS to interview the child who is in their custody. A Metro tour was arranged for me for November 4, 2004.

Federal CRIPA Investigation of Metro

In the summer, 2002, the Federal Department of Justice investigated Metro's child and adolescent unit pursuant to the Civil Rights of Institutionalized Persons Act. At that time there were about 100 children and adolescents at Metro, ranging in age from 11 to 17. Because Metro was the only public mental health institution for children and adolescents in the state, they came from counties throughout the state. They were described as having an average length of stay at Metro of 350 days (30% had been there more than a year, with 14% there more than two years). Typically they had 10 to 12 failed placements prior to their Metro admission. The CRIPA investigation found "significant and wide-ranging deficiencies in patient care" for children and adolescents at Metro. Psychiatry, psychology, nursing and special education services departed from generally accepted professional standards, particularly a failure to provide adequate evaluations and treatment planning, a therapeutic environment, and appropriate medication management.

The findings included making unsupported diagnoses to justify the use of psychotropic medication and the use of medication appropriate for chronically mentally ill adults, not children or adolescents: "...these medications are prescribed to control individuals' behaviors in lieu of an appropriate medication regimen and/or of therapeutic treatment interventions." In addition, the report documented that "abandonment issues and past trauma are nearly universal problems for the patients...[but] these disorders often are not identified as a focus of treatment." The report went on, "...a number of children and adolescents receive virtually no active treatment...nearly every treatment plan lists the same generic interventions. Treatment plans should be tailored to meet the individualized needs of the patients and should take into account factors such as the patient's functioning level, history of trauma and medical conditions. None of the plans were individualized or sufficiently detailed... none of the plans included any treatment for, or acknowledgment of, the patients' severe traumatization and multiple out-of-home placements." Therapy was poorly documented, Spanish-speaking children did not have Spanish-speaking therapists, and "the lack of clinical oversight of group therapy raises serious concerns."

The report also concluded that "Metropolitan fails to identify and address patients' cognitive, adaptive and academic deficits.....[and] no one is accountable or responsible for coordinating patients' overall treatment." The report criticized the point and level system and also found that the program "...is characterized by a great shortage of staff-initiated, positive interactions. Rather, staff's interactions...were mainly reactive and/or directive in nature, and at times resulted in power struggles with patients, exacerbating crisis situations." Weak discharge planning was also documented. Long psychiatric hospitalization, exposure to excessive use of seclusion, restraint and as-needed medication, counterproductive treatment, and serious side effects from medications were

some of the harmful results of the unacceptable practices at Metro. The 53-page findings letter, dated 5/13/03, concluded with eighteen remedial measures for psychiatric services, 20 for psychology, six for special education, five for nursing, three for protection from harm, nine for general medical care, infection control, dental care, and pharmacy, three for dietary, six for appropriate placement, and two for ensuring constitutional rights.

The Children's Lawyers' Concerns about Metro

On August 26, 2004 Miriam Krinsky of the Children's Law Center sent the Katie A. Panel a report about the concerns of lawyers representing about 20 DCFS children at Metro, including:

- Long length of stay (three over one year, six over two years): children are unable to maintain the behavior required for long periods before being deemed eligible for discharge; few placements are willing to accept children from Metro
- "Discharge" from Metro to Juvenile Hall
- Staff who are poorly trained and lack compassion (taunting and cursing at children) leading to power struggles and a worsening of behavior
- Lack of consistent therapy (individual therapy is short and infrequent; group sessions are poor quality)
- IEPs are not implemented and children frequently miss school
- Lack of supervision (children have sex in the bathroom; children feel afraid)

In a meeting with Panel members in September, 2004 at the Children's Law Center, lawyers from several firms reiterated these concerns based on recent visits to their Metro clients. They also described four additional problems: (1) the widespread use of medications, including SSRIs which the FDA has recently warned about, that are not been approved for use with children; (2) having one conservator assigned to the children at Metro reduces the effectiveness of individualized protection a person in that role can provide; (3) a dispute about whether DCFS or Metro has the primary responsibility for arranging discharge services and permanency; and (4) the failure of the regional center to provide intensive services for some youth, resulting in long stays at Metro.

One of the children about whom the Children's Law Center is most concerned is a 121/2 year old African American male who has been at Metro since shortly before his 11th birthday (12/02) and has a relative ready to accept him in her home. He entered care at age 9 1/2 after allegations of physical abuse by his paternal grandmother. He was placed in a group home where he remained for a month before being hospitalized for six weeks. He spent more than a year at MacLaren, with about ten psychiatric hospitalizations during that time. His father is deceased; his mother is incarcerated. His paternal aunt, who is his conservator, visits him regularly, talks to staff frequently, and is actively involved in treatment planning. His diagnoses include Bipolar Disorder and ADHD; he is prescribed Lithium, Zyprexa, and Ritalin. His 7/04 court report indicated that his behavior problems and peer relationships had improved and he was scheduled to be interviewed by a Wraparound provider.

I met with his aunt outside his Metro unit, since she was hoping to include me in her visit with him. She is a well-informed, committed advocate. She believes he cannot improve at

Metro; the way the program is designed, he is unable to earn enough points to progress to discharge. He is terrified by a large adolescent who has been at Metro for years and is assaultive; he complains to his aunt about daily bullying and physical threats by the bigger males on his unit. He tells his aunt that he loses points because he defends himself. He was only able to earn one visit to her home last month. It was a good visit and she has reminded him daily to keep working to earn another visit. She was planning for his discharge and complained he was overly drugged. A new psychiatrist started working with him and she has changed his medications and is monitoring them closely. His aunt feels changes in Metro staff and the replacement of his DCFS worker have set back planning for his discharge for months. She has begun weekly Wraparound meetings to get ready for the move to her home. She involved an educational advocate who helped her convene an IEP meeting at Metro which was necessary to apply for special education in the school near her home. Her biggest concern, other than the bureaucratic obstacles to discharge, is whether Wraparound is able to arrange sufficiently intensive services to prevent his sexualized behavior in her home and at school.

Another child the Children's Law Center raised concerns about is a 16-year old recently discharged to Starview after nearly three years at Metro. He tested positive for drugs at birth and was removed as an infant after his mother's boyfriend sexually abused his sister. At age 2 he had a goal of long-term foster care. He has been in care essentially his whole life, with nine placements: a shelter for a month, a foster home for eight months, another foster home for more than six years, a foster home for two months, Hathaway group home for three months, a shelter for a month over Christmas at age 8, Sycamores for more than four years, a trial home placement that lasted two months at age 13 until his mother requested his removal after she observed sexual behavior between him and his younger sister, MacLaren for three months, and a psychiatric hospital. During his nearly three years at Metro he achieved in the level system and was considered for discharge, but then he always "regressed to negative behavior [in part] because of his low frustration tolerance." While at Metro he had "immature tantrums," engaged in mischievous behavior and horseplay, and was aggressive. The court report blamed him for not making progress: "the outlook remains undetermined as he continues to avoid addressing his therapeutic issues or his tendency toward violent behaviors...he has never discussed his sexual behaviors." He was in 10th grade at Metro, with low average reading and math. According to the superficial court report, he was prescribed "Wellbutrin for ADHD and Seroquel for behavior control." His mother had several surgeries and could only visited irregularly. The 6/04 court report gave no indication that discharge was being considered, and his lawyer was shocked that he was moved to Starview without notification to her.

I visited him with his lawyer at Starview. He is a shy, polite young man who has lost 30 pounds in the past six months, and on Ritalin he continues to slim down. He said he was "totally surprised" by his move to Starview. He went to his monthly treatment team meeting and they told him he had the rest of the day to say goodbye to staff he had lived with for years. He had enjoyed his first two weeks at Starview, swimming everyday, eating better food than at Metro, and doing enjoyable activities at school. His mother had not visited yet, but he told Starview he wanted to plan for discharge to his 23-year old brother. He believes if he works hard he could get out of Starview in a few months. He says he does not have problems with aggression anymore and since his arrival he had only one upsetting incident where a resident poured urine on him and he wanted to hit

him but he did not. At Metro he had started working on Saturdays with a nearby auto mechanic and Starview had been transporting him a long distance to continue this training program because he wants to get a certificate so he can be a mechanic. He said he hated Metro and feels it should be shut down and that most of the children do not belong there. He said there was at least one fight a day, most of the staff are "not good," and "a lot of the problems are the result of the director" who does not pay attention to what happens on the units or in the school, which is "real bad." His lawyer had not been to a Starview treatment team meeting and did not know what services were being provided to treat his sexualized behaviors and keep them from getting him sent to Juvenile Hall.

Follow-up with this youngster's lawyer in 12/04 found that he likes the Starview program, is getting straight A's in school and visits with his mother frequently. Than he could have been so abruptly moved from Metro to Starview and done so well at Starview for more than three months raises questions about the appropriateness of his metro placement.

Observations from the Metro Tour on November 4, 2004

Los Angeles County purchases 35 beds for DCFS, DMH and probation children ages 12-17 at Metro (this is a reduction since May, 2004 when 50 beds were designated for LA children). On November 4, 2004, there were a total of 52 children and adolescents at Metro, housed in four units which are physically similar (two for girls and two for boys). It is an old mental hospital and although the units are bright and clean, little can be done to reduce their institutional appearance. Staff were meeting in the typical glass nursing station, the day room is a big box with unattractive furniture, and each of the six dull dormitories housing 2-3 children are personalized only by stuffed animals on the beds. Each unit has its own fenced patio where children can relax and have meals. Although staff wish for a gymnasium, there are large outdoor fenced basketball and volleyball courts that are used everyday as well as for weekend barbecues. One girls unit currently houses 13 girls age 13-17, with four nursing staff; an additional 1:1 staff for a child and several student interns were working when I visited. The "treatment mall" is a separate two-story building where all 52 children go everyday afterschool for two one-hour group sessions.

Considerable creative effort has gone into decorating and supplying the nine rooms used for anger management and social skills groups, arts, computer, bike repair, band, relaxation classes, gardening, and many more. All staff are involved in leading these groups (the units are closed from 3-5 PM daily, and nursing staff assist with the children during activities at the treatment mall). Every 12 weeks, the treatment mall develops a new schedule (of 7-9 groups for each of the two hour afternoon sessions, five days a week), based on the unit recommendations of what skill development each resident would benefit from. Then staff sign up to lead groups, most of which are co-educational and have 5-7 children. Each child has electives, in addition to assigned groups, so in the course of a week, a resident might be able to play in one of the three music groups almost every afternoon in the well-equipped band room as well as being in a daily counseling group. Upstairs is the "snoozling room," with low lighting, florescent stars that glow on the walls and ceiling, music and soft pillows for "sensory time" that they report has

benefits for many children. The store, which children can visit during the day, offers clothes, stuffed animals, personal supplies, and snacks that can be purchased by points. Children are encouraged to save their points (with the possibility of earning 100/day to buy 500 point t-shirts, 300-point lotion, 150-point snacks, etc.); the store operates in "real time points" that are entered in the computer throughout the day. This point system is unusual in that it is assigned individually based on the area the child most requires incentives to improve. So a child reluctant to go to school will have a larger portion of their 100 points/day allocated to the school. The school program, which meets five hours/day, is now housed in two buildings but will be consolidated in a building planned for construction this fall. The classrooms have 6-7 children with several teachers and assistants in each supplied by the county and state; most children have IEPs.

The tour turned out to be limited to a walk-through of the buildings; observation of children could not occur and questions about treatment were referred to the director who was not present. Asked to describe the changes in the program since the CRIPA report, they indicated that all aspects of the program--staff training, treatment planning, the school, and the treatment mall--have improved substantially. They described a change away from a medical model to a "recovery model," stressing individualized services and more positive interactions between staff and children. They are proud of the admission process, which includes several level 14 programs meeting weekly to discuss children and to recommend placement. They said that some of the recently-arrived residents stabilized within a few months, and were placed elsewhere and that other placements had become much more positive about accepting children from Metro since the program has improved.

DCFS Children at Metro

The 19 DCFS children at Metro in July, 2004, ranged in age from 12 to 17 years old. Ten were male and nine were female. Six were African American, six were Caucasian, five were Hispanic, and two were American Indian. The average length these 19 DCFS children had been at Metro was 16 months; four had been there more than two years, six had been there 12-23 months, and nine had been there less than a year. On average they were 14 years old when admitted to Metro (four were 12 or under on admission). On average they were 8 years old when they entered foster care. On average, they had seven non-hospital placements prior to being admitted to Metro.

The severity of the mental health problems of the children at Metro are exemplified by:

> A 14-year old male has been at Metro since 10/03. He was removed in 1999 (age 9) because his mother could not manage his behavior. He was placed in a group home for almost two years followed by a series of short foster home placements, several stays at MacLaren starting at age 11, and a 2-year placement at Starview when his assaultive behaviors increased. He has hallucinations and paranoia and is prescribed Zyprexa, Trileptal and Seroquel. He receives individual therapy once/week as well as communication skills, stress management, social skills and anger management groups. He has a borderline IQ and

is a Regional Center client. His mother visits him periodically and he corresponds with his father who is incarcerated.

Children Have Long Placements at Metro

More than half the DCFS children have been at Metro longer than a year, for example:

A 15-year old has been at Metro since 4/99. He was prenatally substance exposed and was removed from home at age 7 after being physically abused by his substance abusing parents. He was placed directly at Bienvenidos, followed by three brief stays at different group homes and four months at MacLaren before going to Sycamores where he stayed 15 months until he was admitted to Metro at age 9 1/2. Three of his siblings were placed in the guardianship of their grandmother and another sibling was placed with his aunt and visits with him at Metro monthly; his mother lives out-of-state. He is described as assaultive and is restrained every week. His diagnoses are Conduct Disorder, ADHD, Dysthymic Disorder, and Mixed receptive expressive language disorder. He is prescribed Concerta, Ritalin and Zyprexa. The Metro school information was limited to describing his behavior as impeding his learning (apparently he was charged with an assault at the school), so other than being ineligible for Regional Center services, the court report is not informative about his cognitive abilities. The 8/04 court report indicated that Metro is the appropriate placement and that he is not likely to be adopted because of his behavior.

A 15-year old female has been at Metro three years. She has had 33 placements since being removed at age 4 after being sexually abused. Her first five years in care she was in specialized foster and group homes due to a life-threatening illness. Then she spent more than a year at a group home, was placed at MacLaren at age 11, spent two months at Juvenile Hall at age 12, returned to MacLaren where she bounced back and forth to psychiatric hospitals for more than a year, with two short group home stays until her admission at Metro. The most recent court report indicates that the DCFS is planning with a prospective foster parent who is completing licensing requirements; the report indicates that the foster mother understands her special medical and emotional needs. She is diagnosed with Bipolar Disorder, PTSD, and Mild Mental Retardation. Her primary behavior problems were described as sexual inappropriateness and self-destructiveness. The CSW had not received a report from the school at Metro so there was no educational information in the court report. There have been problems arranging counseling for her and she is now on a waiting list for a special counseling program at Children's Hospital for children with life threatening illnesses. She has intermittent visits with her sister who is with a foster family adopting her. Their mother is deceased and she has no contact with her father.

A 17-year old male has been at Metro since 12/01. He was removed in 12/96, placed in a group home, spent nine months at Five Acres and went to MacLaren for a year (at age 12). Then his placement record says he was "released" with no explanation. He returned to care more than two years later, and spent six weeks at MacLaren before being placed at Metro. Five younger siblings are listed on the court report. The rest of the court report is blank.

A 17-year old female has been at Metro since 12/02. She was removed in 1999 (age 12) after being sexually abused by an adult friend of her parents who were drug addicts. She had a succession of three short foster home and one group home placements during her first three months in care, followed by a seven month group home stay before entering Starview in 9/00 where she stayed until her admission to Metro. The court report explains little about her emotional problems other than a diagnosis of bipolar and being raised in a "toxic environment." The court report states that her behavior is "being reinforced while at the hospital despite the intensive therapy and medication management she is receiving: the hospital is always chaotic and crisis-ridden where something negative (fights, threats, screaming, cursing) is always happening...[her] behavior and mental condition has not improved." She is self -destructive, assaultive, anxious and isolates herself. She functions at the fourth grade level in math and sixth grade level in reading. She is prescribed Seroquel, Centrox, and Rivia. Her younger sister is stable in a foster home, although she wishes their mother (who lives out-of-state) would visit them instead of just calling; they have had no contact with their father. Although the CSW complains that the FFA and foster parents do not assist with driving, the CSW transports her younger sister to Metro for monthly visits and conjoint therapy; they like seeing each other but their telephone calls usually deteriorate because her sister still blames her for reporting the sexual abuse.

Children at Metro Have Experienced Multiple Placements

Several children had ten or more placements before being admitted to Metro:

A 16-year old female with 13 prior placements is on a second admission at Metro since 3/04. She was removed from her father's home at age 8 after being sexually abused and neglected; her mother's whereabouts were unknown. She was first placed at Bienvenidos in 1/97, was in a foster home for nearly a year, had three short placements, spent more than a year at Hathaway, had two foster home placements (in one home she was sexually abused by her foster father), returned to Hathaway for almost a year, lived with a guardian for nearly two years, went to MacLaren for a week, was placed at Harborview where she was charged with assaulting a staff person and spent two weeks at Juvenile Hall, and returned to her guardians. After being placed at Metro in 2003, an attempt was made to return her to her guardians, but she took an overdose of medication and was returned to Metro five months after discharge. Her guardians visit as often as they can,

although Metro is very far from their home. The court report provides no treatment details, describing her as bipolar and not interacting with peers.

A 15-year old female with 13 prior placements has been at Metro since 1/04. She was removed in 11/95 (age 6) after being sexually abused by a friend of her addicted mother. Parental rights were terminated and the court ordered adoption services in 1999. Her long placement history includes: an 18 month foster home placement, a 15 month foster home placement, an 11 month foster home placement, MacLaren (age 10) for three months, Five Acres for 19 months, a guardianship placement for a few months at age 12 with former foster parents (who adopted her sister), three short stays in other foster homes, a brief return to her guardian, Hathaway for 16 months and several hospitalizations. She continues to cut on herself and get involved in fights. Her guardians are actively involved, bring her sister for visits twice monthly and want her to return to their home. There are no details about her intellectual ability other than an indication that she is bright, easily bored and her attitude toward authority and behavior such as throwing things and fighting have interfered with school in all her placements. She is diagnosed with Bipolar Disorder and Conduct Disorder but apparently does not swallow her Seroquel or Lithium which are not at the therapeutic level. She is described as having an unrealistic desire to re-unite with her mother (who lives out of state and apparently initiated a home study which she failed).

A 17-year old female with 11 prior placements was readmitted to Metro in 5/04 (a previous admission is not noted on her placement history). She was removed at age 7 (1993) due to her father's alcoholism and substance use and placed with her brother with their paternal grandparents for more than three years where they were sexually abused by their cousin; she was placed with another relative for three weeks, a foster home for nearly a year, and Hollygrove for five months and was returned to her father at age 13. Two years later she was sexually abused by an unrelated male and removed, placed in two foster homes for less than two months each, a group home and Vista del Mar for two months each, was hospitalized, went to a group home for a year, and "a small family home" for a few months before going to Metro. She is diagnosed with Major Depression, PTSD, oppositional defiant disorder and polydrug use. She is not taking medication. The last court report indicated she completed her high school diploma and wants to apply to college. She is seen once a week by Sycamores Wraparound who has been working with her on her college plans and would help her make a transition to a group home if one accepts her. "Currently there is not a placement available because she has graduated high school but has not turned 18," so the plan was to have her stay at Metro until her 18th birthday this fall. She wants to return to her father, who has visited her at the hospital; she has asked to visit with her siblings; her mother's whereabouts are unknown.

Some Children at Metro Have Been in Group Care Most of their Lives

Some of the problems children present at Metro may be the result of lengthy prior residential stays.

> A 17-year old female was removed from home at age 3 and has not lived in a foster home since she was 4. Her mother was incarcerated; both her mother's and her father's whereabouts are unknown. She was in a guardian home for six months, a foster home for 11 months, a group home for three years (age 4-7), another group home for almost six years, another group home for almost a year (age 14 1/2-15 1/2), a small family home for a month, and a different group home for five months (where she was charged with biting someone for which she was put on probation). She was admitted to Metro in 12/03. Since her behavior has improved at Metro, staff proposed that she move into a D-rate home with Wraparound services in the fall, 2004. Her goal for the future is to go to college to study drama and live in a dorm (the 8/04 court report indicated she had worked on a transitional independent living plan and an emancipation contract; her SSI would continue when she went to college).
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> A 13-year old male admitted to Metro in 3/03 has been in group care (with the exception of a few months in a foster home) since he was removed at a year old. He spent more than three years in the group home where he was placed after his removal, Florence Crittenden for two years, Hollygrove for almost two years, a foster home, Hollygrove for another five months, Childhelp for nearly two years, MacLaren for a month, and nearly two years at SGCC Children's Team Center. His court report was blank.
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> A 16-year old female with spina bifida who has to self-catheterize has been at Metro since 1/04. She was removed from home at age 2 after being sexually and physically abused and placed at MacLaren where she remained six months. She was placed at Westside group home before her third birthday, where she stayed for more than four years, moving to a foster home for three months, and back to Westside for more than three years. She spent two months at MacLaren at age 11, followed by nearly three years at a "small family home," MacLaren for four months, hospitalization when she was 14, a month at MacLaren, six months in a foster home, three months at a group home, and another hospitalization. The 4/04 court report indicated that Sycamores Wrap program had started working with her mother and helping with visits. She is self-injurious which makes her mother uncertain about having her return to her home where she has younger children. The court report did not provide information about cognitive abilities or school progress.

Is Placement at Metro Partially the Result of Having No Local Relatives?

Some children get stuck at Metro because they have difficult behavior and no prospects for being placed with family members.

A 14 year old male has been at Metro since 10/03, seven months after entering care at age 13. He was sexually abused by an adult male relative when he moved into his aunt's home due to his mother's medical problems (his mother lives in Mexico). The court report describes Metro treatment to address gender identity issues and sexual abuse and to help him make a transition into a transgender program at L.A. Children's hospital. He works with a bilingual therapist, but does not get along with the other residents at Metro. He reportedly has average intelligence, PTSD, depression, anxiety, low self-esteem and self-destructive behaviors.

A 17-year old male was placed at Metro in 8/03, less than two years after he entered care at age 14 after his grandmother, who was his guardian, died. His mother was incarcerated in 1996 (when he was 9) for four years in Missouri for abusing her children; his father was convicted of child sexual abuse (victim not indicated) and his whereabouts are unknown. His first placement was MacLaren for a week, from which he entered a psychiatric hospital where his placement history indicated he stayed almost a year, and then spent almost six months at Olive Crest where his sexual behavior was a problem. At Metro he tried to run away and is self-injurious, assaultive, and sexually aggressive. His diagnosis is Depressive Disorder; he has borderline cognitive functioning, but was found not eligible by the Regional Center. The 5/04 court report indicated he was interviewed by Ozanam residential treatment program, which has an independent living program. The reports goes on to say that an Interstate Compact with Missouri was being initiated, but it is unknown whether Ozanam is in Missouri. His younger brother is at Five Acres; the court report does not indicate whether the brothers visit. Both boys expressed a desire to live near their mother in Missouri.

A 15-year old female has been at Metro since 5/03. She was removed from home at age 12 for sexual and physical abuse; her mother abandoned her with a relative and returned to Guatemala and she has no visitors at Metro. She was in one foster home for three months, another foster home for a month, another foster home for two months, was hospitalized four times in one month at age 12, was at Augustus Hawkins for six months, Metro for about a year (3/02-4/03), a group home for a month, and was readmitted to Metro in 5/03. She is self-injurious and assaultive and frequently restrained. Her diagnoses are Bipolar and ADD. She has a low IQ, but was found ineligible for the Regional Center "because her problem is mainly mental health and not a developmental disability problem."

Discharge of Children from Child Welfare to Juvenile Justice

The problem of children being prosecuted for behavior while in child welfare has resulted in national attention on the poor outcomes for children moved from foster care to juvenile justice who, as a result, do not receive assistance in achieving permanency before age 18. The Panel raised concerns that 15% of children discharged from MacLaren were in Juvenile Hall or on probation within a few months (14 of the last 91 children discharged

after December 1, 2002; from a follow-up after MacLaren closed included in the first Panel report to the court).

Lawyers representing children at Metro described discharge to juvenile justice as a major problem. They reported that children were prosecuted for behavior "that was the reason they were sent to Metro" and could have been prevented had Metro staff used proper de-escalation techniques. The lawyesr are critical of DCFS and Metro staff favoring the movement of emotionally disturbed children from child welfare to juvenile justice. For example:

> Now almost 16, this young person was first placed at Metro when he was 11. Advocates report that his mother contacted them in 2001 to report that he had been physically abused by a staff person at the hospital who was later fired, and that he was spending most of his time in restraint and seclusion. He was placed with his mother who later was incarcerated for drug use and he was placed at two group homes before being returned to Metro in 2003. After 14 months at Metro, he was sent to Juvenile Hall. An educational diagnostician working with him at Juvenile Hall wrote in her 8/04 evaluation: "The current charges...stem from an incident at Metro where remarks made by a substitute teacher led to a confrontation. He was charged with assault with a deadly weapon (pencil) and making terrorist threats. I am dismayed that an agency that exists solely to serve persons with mental and cognitive disabilities would so quickly resort to legal intervention in such an incident especially when it was caused and aggravated by the remarks and behavior of a staff member...the behavioral outburst was a predictable result of the disability...and therefore not subject to standard disciplinary measures." The assessor found that he had low average intelligence, learning disabilities, immature executive function, an attention deficit disorder, was reading at the second grade level, and was easily frustrated.
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> When he was at Metro, DMH had been working with an interagency group attempting to find a placement for him, and five out-of-state residential programs rejected him. After he left Metro, both the delinquency and dependency court judges reportedly wanted him to remain in child welfare, because they did not want him sent to CYA and believed he could get the best services from Starview. He had subsequently tried to hang himself at Juvenile Hall and was charged for hitting a staff member at Juvenile Hall, but since being out of Metro his fights with peers had stopped. He spent nearly five months in Juvenile Hall (during which time his DCFS placement history lists him as being at Metro, which makes it impossible to track juvenile justice admissions). In August, 2004, Starview agreed to accept him if he was provided with a one-to-one aide and had a crisis plan. DCFS continued to insist that he be sent to the CYA until in late September when the Dependency Court ordered his placement at Starview with a one-to-one aide. He had been at Starview in the past before being sent to Metro was eager to return to Starview.
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> The DCFS court report does not describe the Starview treatment plan, and no mention is made in the court report of the connection between his aggression and

the violence he experienced at home. Since his removal from home at age 13 after physical abuse by his father, he had inconsistent contact with his parents. According to his lawyer, his father has been visiting consistently and wants reunification, but DCFS has been unwilling to include him in planning for his son's permamency. There has been a debate among DCFS, Metro, diagnosticians and treatment providers about the effects of prenatal substance exposure on his disorganized thinking and behavior. The lack of sophistication in the DCFS court report about this serious treatment issue is surprising. All the individuals involved with this young person, including the 1:1 staff, should have training in the special techniques for working with children who have been affected by prenatal substance exposure, including methods for teaching him to think before acting that are significantly different than for other children.

Conclusions

Metro staff presented a completely overhauled program, but lawyers for children at Metro remain concerned about the quality of treatment, educational services and discharge planning even after the 2002 CRIPA investigation. The information in the DCFS court reports on the 19 children at Metro was insufficient to discern their needs, figure out the goals of the services being provided, or assess the effectiveness of the treatment in enhancing the children's functioning. A limited tour of the physical facility did not help in ascertaining whether the clinical services at Metro are meeting the needs of DCFS children. A thorough individual treatment review by DCFS clinicians of the strengths and needs and adequacy of Metro's therapeutic services and permanency planning to meet DCFS children's needs should be conducted.

In addition, a DCFS/DMH workgroup should be designated to take active steps to prevent the movement of children from Metro (and other group care facilities) into Juvenile Hall for behavior that is symptomatic of their emotional problems and/or provoked by the actions of other residents or staff; this systemic work should be connected to the efforts of the Regional Permanency Review Teams in ensuring permanency and least restrictive placements for individual children.

APPENDIX D

ADMISSION OF DCFS CHILDREN TO PSYCHIATRIC HOSPITALS

April, June, September & October, 2004

On average, nearly one DCFS child is admitted to a psychiatric hospital each day in LA. Combining April, June, September and October, 2004, 111 DCFS children (an average of 28 children per month) had 125 admissions to eight psychiatric hospitals. Eleven children had more than one admission during those four months (10%). The children ranged in age from 7 to 17 years old; their average age was 14 and one-third were 12 and under. More than half the psychiatric admissions of DCFS children in April, June, September and October, 2004 were to two hospitals: Aurora Charter Oak and Del Amo:

Aurora Charter Oak 30% (37)
Del Amo 26% (32)
College Hospital-Cerritos 18% (22)
BHC Alhambra 14% (18)
College Hospital-Costa Mesa 6% (7)
Gateways 6% (7)
Kedren 1% (1)
Las Encinas 1% (1)

DCFS started tracking psychiatric hospital admissions centrally in the spring of 2004 and still does not track psychiatric hospital discharges centrally. There is a hope that DMH will be able to track admissions and discharges soon. At this point it is the responsibility of the Regional Administrator (who receives the monthly list of admissions) to track each child who is admitted from their office in order to monitor discharge planning activity. In order to study DCFS psychiatric hospital admissions county-wide, each admitted child's social worker has to be contacted for the discharge date from the hospital. At the Panel's request, DCFS central office staff contacted the CSWs individually and were able to ascertain the discharge dates for 18 of the children admitted to psychiatric hospitals in June, 2004. They averaged 12 days in the hospital (Range=2-13 days).

In April, 2004, 42 DCFS children had 44 admissions to eight psychiatric hospitals: Aurora Charter Oak, BHC Alhambra, College Hospital-Cerritos, College Hospital-Costa Mesa, Del Amo, Gateways, Kedren, and Las Encinas. The children ranged in age from 7 to 17 years old; their average age was 14; ten were age 12 and under (24%). were male and were female. BHC Alhambra (14 admissions) and Aurora Charter Oak (11

admissions) each had three days in the month of April when they admitted two DCFS children.

In June, 2004, 23 DCFS children were admitted to five psychiatric hospitals: Aurora Charter Oak, BHC Alhambra, College Hospital-Cerritos, Del Amo and Gateways. The children ranged in age from 9 to 17 years old; their average age was 14; eight were age 12 and under (35%).

In September, 2004, 26 DCFS children had 28 admissions to three psychiatric hospitals: Aurora Charter Oak, College Hospital-Cerritos, and Del Amo. The children ranged in age from 8 to 17 years old; their average age was 13; ten were age 12 and under (39%).

In October, 2004, 30 DCFS children were admitted to seven psychiatric hospitals: Aurora Charter Oak, Aurora Vista del Mar, BHC Alhambra, College Hospital-Cerritos, College Hospital-Costa Mesa, Del Amo and Gateways. The children ranged in age from 8 to 17 years old; their average age was 14; ten were age 12 and under (33%). None were admitted more than once in October.

The 11 children with multiple psychiatric hospital admissions during the four-month period were:

- a 10-year old female admitted to Del Amo on 6/9/04 and to Aurora Charter Oak on 10/21/04
- a 10-year old male admitted to College Hospital-Cerritos on 9/11/04 and to Del Amo on 9/30/04
- an 11-year old female admitted to Aurora Charter Oak on 4/26/04 and 9/904
- a 12-year old female admitted to Del Amo on 9/7/04, 9/30/04 and 10/28/04
- a 13-year old male admitted to BHC Alhambra on 4/12/04 and to Gateways on 6/20/04
- a 13-year old male admitted to College Hospital-Costa Mesa on 4/19/04, to Aurora Charter Oak on 4/25/04 and re-admitted to Aurora Charter Oak on 4/30/04
- a 13-year old female admitted to College Hospital-Costa Mesa on 10/6/04 and to Aurora Charter Oak on 10/21/04
- a 14-year old female admitted to Aurora Charter Oak on 6/20/04 and to College Hospital-Cerritos on 10/23/04
- a 16-year old male admitted to Aurora Charter Oak on 4/19/04 and to Del Amo on 6/22/04

- a 16-year old male admitted to Del Amo on 9/26/04 and to College Hospital-Cerritos on 10/7/04

- a 17-year old male admitted to College Hospital-Costa Mesa on 4/22/04 and to Del Amo on 6/3/04

Most troubling of these children is the 10-year old who had three psychiatric hospitalizations in 2004 at three different hospitals. The 3/04 court report describes the first of these as a hospitalization following her mother's call to the Mobile Assessment Team. A few weeks before, DCFS had investigated allegations that the child was being abused and neglected by her mother who lived with three children and her boyfriend in a van after being asked to move out of a friend's home and a shelter due to her alcohol use. Her special education teacher said she did not have behavior problems, but her mother complained she had out of control aggression toward her younger sister. The court report indicated her mother said her daughter told her "something is wrong with me" and "just kill me," and, although the admission and discharge reports were not attached, this use of a psychiatric hospital for a 10-year old should be re-examined by clinicians in DCFS.

Based on this limited summary of psychiatric hospitalization of DCFS children, the Panel recommends the appointment of a workgroup to (1) assess how the access to intensive treatment alternatives can be improved to reduced the hospitalization of DCFS children and (2) implement a method for monthly review of the rate, length of stay and usage patterns of psychiatric hospitals for DCFS children.