

**The Katie A. Advisory
Panel Eighth Report
to the Court
April 18, 2008**

**The Katie A. Advisory Panel
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Executive Summary

In this Eighth Panel Report to the Court, the Panel identifies areas of significant progress in the County's conceptualization of strategies for meeting the needs of the plaintiff class. A number of these areas, such as the use of child and family teams, a flexible approach to providing intensive home-based mental health services and training of staff based on the principles of the County's approach to practice, reflect prior Panel recommendations. The County has expressed an interest in adopting a qualitative review process for assessing the quality and effectiveness of services. The County is moving closer to implementing a mental health information system that will provide much more descriptive information about both the outcomes for the plaintiff class as well as extensive information about the services they are receiving. A more fully developed plan for reducing caseload and workload is evolving that may free up case manager time to attend intensely to individual child and family needs. The number of children placed in group homes and residential settings has declined and the County is near the Court's target for Wraparound expansion.

These approaches and initiatives are integral to the County's emerging overarching Strategic Plan that will encompass the County's initial DCFS/DMH Katie A. Plan, the Corrective Action Plan and broader strategies to meet the needs of the plaintiff class. To give focus and urgency to the planning and implementation process, the County recently appointed a senior level administrator in the Chief Executive's Office to oversee Plan development, a step the Panel is already seeing as beneficial to the pace and structure of Plan development. Most recently, the new Administrator committed to providing a more detailed and complete report on County progress, "the tracking log" as previously titled, which sorely needs attention.

The County and Panel are working intensely on the completion of this Strategic Plan, with the cooperative participation of plaintiffs' counsel. As part of Plan development, County staff and a Panel member made a site visit to the Arizona Children's Behavioral Health system, where useful ideas for implementing and financing intensive home-based mental health services were observed. The County hopes to have a general draft of the Strategic Plan by the end of April.

This report also identifies a number of challenges that remain in meeting the needs of the plaintiff class. First, while conceptually the emerging Strategic Plan is promising, much of it needs additional thought, work and detail before strategies are specific enough to judge its viability. Because implementation strategies are not complete, the projected cost of Strategic Plan implementation is

not yet available. However, implementing intensive home-based services as conceptualized will inevitably require additional revenue. The pace of implementation of the initial County plan and the Corrective Action Plan remains slow, with many of the new services projected far behind the original implementation schedule. Creating new services timely remains a daunting problem in the Los Angeles environment due to uneven provider interest, an extremely complex, slow and cumbersome County procurement process and workforce constraints.

The Panel expects to be able to provide additional detail of the Strategic Plan in its next report. We also expect to provide the Court trend data that begins to reflect the progress, or lack of it, for members of the plaintiff class. Despite the challenges that remain, the Panel commends the County for moving in the current direction and remains hopeful that the Strategic Plan will be a catalyst for a meaningful expansion of services and improvements in the quality of service delivery.

The Panel makes the following recommendations in its Eighth report.

- The County should add additional management staff, such as program analysts to the Child Welfare Mental Health Services Division to support implementation of Intensive Home-Based Mental Health Services (IHBS).
- The County should provide the Panel a formal report on action taken in regard to the Health Management Associates Report.
- The County should provide the Panel with information on the extent to which the current level of Team Decision Making facilitators can facilitate team meetings for the events inherent to the TDM model.
- The County should give priority to detailing the plan and costs for implementing the Intensive Home-Based Mental Health Services approach.
- The County should consider contracting with Arizona experts to help train Department and provider staff.
- The County should assess and report to the Panel the need for an additional wraparound expansion to meet the needs of the approximately 2600 additional class members needing intensive home-based mental health services.

- The County should establish specific projections for reductions in workload/caseload in the strategic plan.
- The County should include in the strategic plan an estimate of additional revenue needed to meet the needs of class members, its projected sources and if anticipated revenue falls short of projected needs, what steps the County will take to acquire needed funds.

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I. INTRODUCTION

The following Eighth Report to the Court outlines the County's progress toward achieving the objectives of the settlement agreement and includes a description of its compliance with the current Joint DCFS/DMH Plan. The County continues to work on revisions to that plan, pursuant to the Court's most recent order. Within that work, the County is developing a more comprehensive set of strategies to address the breadth of system change needed to accomplish the objectives of the Kathie A. Settlement Agreement.

II. BACKGROUND

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

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

- a. promptly receive necessary, individualized mental health services in their own home, a family setting or the most homelike setting appropriate to their needs;
- b. receive the care and services needed to prevent removal from their families or dependency or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability;
- c. be afforded stability in their placements, whenever possible, since multiple placements are harmful to children and are disruptive of family contact, mental health treatment and the provision of other services; and
- d. receive care and services consistent with good child welfare and mental health practice and the requirements of federal and state law.

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

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

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

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

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

Additionally, the Settlement directs that:

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

The Department prepared a Joint DCFS/DMH Mental Health Plan to describe its strategy for implementing the provisions of the settlement agreement. The Panel and plaintiffs identified issues in the Plan they believed needed additional attention and in a subsequent court hearing, plaintiffs and defendants proposed submitting a joint finding of facts that would identify areas of agreement and disagreement. The court issued an order directing the County to revise its plan and submit the revision for review. The County continues to prepare that revision and works with the Panel in strengthening its system improvement strategies.

III. PANEL ACTIVITIES SINCE THE SEVENTH REPORT

Since the Seventh Panel Report, the Panel has continued to have regular planning meetings with the County as well as periodic conference calls, working on the strategic plan. In addition to these meetings, several County staff and a Panel member participated in a site visit to observe the operations of the children's mental health system in Arizona, where the system uses Medicaid funding extensively and flexibly to finance intensive home-based mental health services. The Arizona system also employs the regular use of child and family teams to engage families and create plans for support. This site visit has proven helpful in identifying approaches that can be adapted and transferred to Los Angeles. Panel members, plaintiffs' counsel and County staff also met with provider representatives to solicit feedback on the conceptual model for child and family teams and intensive, home-based mental health services.

IV. CURRENT IMPLEMENTATION PLAN STATUS

The Panel has worked actively with the County on the implementation plan, approved by the Board of Supervisors, pursuant to the Court's November 2006 order for Corrective Action. The parties continue to agree that the original

County plan and the Corrective Action Plan, taken together, do not fulfill the County's obligations under the Settlement Agreement, although they are good faith steps toward that objective. The parties and the Panel have agreed to develop a document that will capture the parties' and Panel's agreement and expectations about what steps are necessary for meeting the Settlement objectives and obligations. Originally, our goal was to have a draft of that document by November 30, 2007. The County now hopes to have a strategic plan framework by the end of April 2008.

The Panel and County agree that clear and complete strategies are needed to address the following areas. These strategies will incorporate the initial County Plan, the Corrective Action Plan and more fully address the Katie A. Agreement.

- Plan Structure and Breadth – The Panel believes that the Plan needs to reflect a comprehensive vision of the system of care being developed, not just its component parts.
- Workforce Issues – Additional strategies are needed to recruit, train and retain qualified staff and build capacity within the mental health provider community.
- Service Creation – The pace of service expansion has been much slower than projected and the scope of services insufficient to meet the needs of the plaintiff class. Attention is needed to removing the barriers to rapid service creation for the plaintiff class.
- Health Management Associated (HMA) Report – The HMA study was commissioned by the County to review the efforts of the County to implement its initial plan. It identifies a number of challenges and barriers that limit the County's ability to implement the settlement. Additional strategies need to be developed to address these concerns. A copy of the HMA report is included in the Appendix.
- Budget – The Panel believes that a projected budget is needed to identify funds that will be needed to implement the strategic plan.
- Exit Criteria – Once the Strategic Plan is completed and endorsed by the parties, the Panel recommends that attention be given to identifying exit criteria for the court to consider.

A number of discrete areas of strategic focus will become the core of the County's strategic work plan. These include:

- Use of child and family teams for planning and decision-making and implementation of intensive home-based mental health services
- Provision of individualized mental health services, including wraparound services to children in FFAs and in their own homes
- Screening children for mental health needs
- Training
- Caseload/Workload reduction
- Financing
- Data

One valuable step the County has taken since the last report is the appointment by the County's Chief Executive Officer of Lesley Blacher as the project manager for Katie A. within the CEO's office. One of the challenges faced by the County is that two separate agencies have the responsibility for Katie A. implementation, the Department of Children and Families and the Department of Mental Health. This bifurcation of responsibility left no single individual in charge of the planning and implementation process. The appointment by the County of a single County executive to manage the process is already resulting in improved organization of staff resources, focus on deadlines and a greater sense of urgency about completing the planning process. The County submitted the following document to the Panel reflecting its new organizational approach and structure.

County Update on Katie A. Leadership Structure and Strategic Plan Development

The Chief Executive Office (CEO) is committed to ensuring that the obligations of the Katie A. Settlement Agreement executed in 2003 are fulfilled more expeditiously. The County's governance structure changed in 2007 to provide greater responsibility and oversight to the CEO for managing day-to-day departmental operations, as well as long-term strategic activities. The County's new streamlined governance structure organizes like County departments into service clusters overseen by Deputy Chief Executive Officers. This new centralized governance provides a more effective mechanism for coordinating policy and process both within and across clusters by making it easier to

leverage/blend resources, integrate function-specific services across clusters, and improve operational efficiencies.

Our cluster staffs developed a joint oversight structure for Katie A. (please see Executive Leadership Structure document), which closely models the County's organizational framework, by providing centralized management and coordination between the Children and Families Well-Being and Health/Mental Health service clusters. The structure incorporates three tiers of oversight to ensure compliance with the Enhanced Specialized Foster Care Plan (Plan) and the Corrective Action Plan (CAP). Once a month, our cluster leadership meets with the Children and Family Services and Mental Health Department Heads to discuss policy issues related to funding, staffing, and service delivery. The departmental managers overseeing the development of a strategic plan for complying with the Plan and CAP have instituted set meeting schedules on a bi-monthly basis and formed focal workgroups to help inform the various plans. The Panel is a partner in this effort and acts in an advisory role on the Project Leadership Team and focal workgroups; conference calls have been scheduled with the panel the second and fourth Fridays of every month to keep all apprised. The addition of two more workgroups in relation to training and Katie A. data development is being discussed. Moreover, the CEO has appointed a dedicated liaison to provide the ongoing coordination, planning support and barrier-busting required to move this effort forward. On a parallel track, departmental liaisons from DCFS and DMH have been identified to oversee implementation of the work on the ground level. One of our first accomplishments was to expedite the allocation of 101 positions to Mental Health, previously delayed in classification processing. We believe this oversight structure to be an effective first step in addressing the hiring barriers and other impediments prolonging implementation. This new structure will promote greater accountability and advance the fulfillment of the settlement agreement, and more importantly, the implementation of a mental health continuum specifically designed to address the multi-faceted needs of children in foster care.

This new structure has moved the County forward, in collaboration with the Panel, on framing a comprehensive and holistic strategic plan that incorporates the Settlement objectives incorporated in the Plan and CAP. A set of organizing principles centered around cultural competencies, using a strengths-based, team approach to serving families, families having to tell their story only once, timeliness of response etc. are guiding the service delivery for providing mental health services. The County has developed strategic planning documents for the following activities:

- *Mental health screening of class members entering foster care;*

- *Mental health assessments for class members entering foster care inclusive of FFAs, D-Rate and Group Homes;*
- *Delivery of intensive, home-based mental health services;*
- *Expansion of Wraparound;*
- *Training;*
- *Maximizing funding – Title IV-E and MHSA funds to support the plan;*
- *Caseload reduction;*
- *Tracking of indicators; and*
- *Exit Criteria/the development of a formal monitoring plan.*

The County is currently compiling these planning sections into one strategic plan that identifies goals, tasks, goal leads, and timelines for the individual tasks that roll-up to the overarching goals. The strategic plan will be organized into five continuums that span mental health screening, assessment, service delivery, tracking of indicators, and exit criteria. Cross-cutting strategies such as training, caseload reduction, and funding will be integrated in the plan as they touch multiple areas. The County currently envisions a five-year strategic plan divided into 3 phases consisting of 20 – month intervals. The County will have a rough draft of this plan available in April, with the objective of having a firm strategic plan in place by the end of the 2007-08 fiscal year. This strategic plan will provide a central reference and provides the overall vision for tying the Settlement objectives, Plan, and the CAP together, which will guide all planning and implementation activities for delivering mental health services to children in foster care.

While this change is promising, the County continues to be stretched thin administratively in a number of areas crucially important to implementation of the strategic plan. The Child Welfare Mental Health Services Division has significant responsibility in leading the development of child and family teams and implementing intensive home-based mental health services. Much of the planning work appears to fall largely on a few capable senior administrators. The Panel recommends that the County provide at least two program analysts as support to these administrators in their planning and implementation work.

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

Creation of a Child Welfare Mental Health Services Division

The County reports that this task has been completed.

Co-location of DCFS and DMH Staff

Forty-one of 48 positions projected for SPAs 1, 6 and 7.

Additional staffing for the DMH ACCESS Hotline

One of 3 allocated positions remains vacant.

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

The Panel and the County have reached agreement on nineteen indicators that will be tracked on an interim basis until the new DMH information system (IBHIS) is completed in 2009.

Recent progress in the implementation of the mental health information system promises to provide more complete data on the plaintiff class than the interim proxy class approach would produce. It appears that the County can soon begin providing data on both the original outcome indicators and mental health utilization. The Panel will provide the County with a list of mental health service indicators to be used to report on the status of the plaintiff class.

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

The County reports that this Application is a comprehensive functional application tool to provide age category information regarding client outcomes. It was reported to be in use in Service Areas 1, 6 and 7. Additional analysis is needed to determine the extent and consistency of use of the assessment application.

Development of Multidisciplinary Assessment Teams (MAT)

The County reports that approximately 60 percent of newly detained children in SPAs 3 and 6 are assessed by MAT. The County hopes to soon assess 100 percent of newly detained children in these SPAs. New DCFS MAT Coordinators have been hired in SPA's 1, 3, 6 and 7 and Coordinators for SPAs 2, 4, 5 and 8 are to be hired by the end of June 2008. In developing the strategic plan, the Panel and County have identified some important strategic issues that could affect MAT implementation. Consideration of these implications has

slowed MAT implementation somewhat in the interest of matching the MAT role with other processes under development.

Development of a Joint DMH/DCFS Master Person Index

DCFS/DMH recently developed the capability to produce reports for shared clientele. The capability will be able to provide a wide range of near real-time information for joint systems management, including tracking utilization and cost data that affect the implementation of mental health services provided class members.

Implementation of the DMH Behavioral Health Information System

The County reports that the completion of the DMH information system (IBHIS), first projected for completion in June 2008, is now expected be completed in January 2009.

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

UCLA declined to participate in the proposed evaluation, causing the County to select another provider, Health Management Associates (HMA). The Panel and the parties have reviewed the final report and are utilizing its findings in the ongoing strategy sessions. The Panel would like a final report on the action taken in regard to HMA recommendations. A copy of the HMA report can be found in the Appendix.

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

The Panel and County believe that this task should be undertaken after the next phase of strategic planning is complete, projected to be the end of April 2008. The County has expressed some interest in including a qualitative evaluation as part of the overall quality assurance effort.

Development of a DMH Performance-Based Contracting System

The County reports that performance outcomes are being incorporated into Legal Entity Agreements for all contractors and has asked the Panel for recommendations for strengthening this process. The Panel concurs that additional developmental work would be useful and will add this topic to the agenda of upcoming discussion with the County.

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

The County is developing a new training plan in this area as part of the overall strategic planning work. The issue is discussed more fully in the following section of this report.

Expansion for Funding to Support Implementation of the Initial Plan and the Corrective Action Plan.

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

Expansion of Staff Resources for Multidisciplinary Medical Hubs

The County reports that approximately 60 percent of newly detained children are initially assessed by the HUBs. From July 2007 – February 2008, 6121 children involved with DCFS were screened using the CIMH mental health screening tool. Of that population, 42 percent were found to need further mental health follow-up. The County will be providing the Panel with a HUB staffing update at a later date.

A barrier to full implementation noted by the County and Panel in prior HUB reports, space limitations at several HUBs, remains.

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

The County reports hiring fourteen additional TDM facilitators to conduct permanency conferences. Prior to the next Panel report, the Panel would like the County to report the extent to which the current facilitator resources is able to provide facilitated team meetings for all the events anticipated in the TDM Model, such as removals, disruptions and permanency plan development.

Implementation of the DMH Mental Health Screening Tool

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

The County is now working on a plan to enlarge and restructure the screening process. Panel questions about the strategy are found in the following section of this report regarding the strategic plan. Currently, the County is working with the union on the issue of unlicensed DCFS staff utilizing this tool.

Expansion of Mental Health Services

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

The County reports the following regarding the expansion of specific mental health services:

The Plan references several possible evidence-based models that the County would consider in Phase One. Ultimately, the County chose to develop three intensive in home models, including five evidence-based practices, including Multidimensional Treatment Foster Care (MTFC), Multisystemic Therapy (MST), and the Comprehensive Children’s Services Program (CCSP), which includes Incredible Years, Trauma-Focused Cognitive Behavior Therapy, and Functional Family Therapy. In Service Areas Six and Seven contracts for these services are in place, including 60 slots of MST and 259 slots of CCSP. Two providers have also been contracted to provide 60 slots of MTFC and the clinical team and foster family training have been completed. The first few MTFC homes in Los Angeles County are now available and additional foster parent recruiting will expand current capacity. Currently 230 children in Service Areas Six and Seven are enrolled in these programs.

In Service Area One, contract agencies have been identified to provide an additional 95 slots of these three programs. Contracts are being prepared for MST and CCSP and the MTFC implementation planning is underway. Training is being arranged via contract with the California Institute for Mental Health.

As mentioned in our last report, the County's Plan does not meet the Court's mandated timelines for implementation of a Treatment Foster Care Program.

Further, since our last report, the County has had trouble implementing this program even within the longer time frames called for in the Plan. However, the Panel continues to believe the County is making reasonable efforts to comply with the Court's order for Treatment Foster Care. And, the Panel will continue to monitor this situation and work with both parties to address the ongoing planning and implementation issues.

A major obstacle to accelerated implementation of any new service modality Los Angeles, even if there are interested providers, is the extremely complicated and time consuming process mandated by the County for procurement. The contracting process is lengthy and compared with many of the states in which Panel members are familiar, extremely cumbersome.

Expansion of Wraparound by 500 slots

As of March 2008, 1153 slots were filled out of 1217 projected.

Targeted Mental Health Services for D-Rate Homes

The County reports that the hiring of D-rate case managers and evaluators has resulted in 90 percent of D-rate children receiving mental health services. Currently, according to the County, 14 D-rate evaluators serve 2,600 children, with the support of other team members. The Panel would like to know from the County how this compares with mental health utilization by this population prior to the addition of D-rate staff. In addition the Panel requests that the County identify the number of D-rate children receiving intensive home-based mental health services as envisioned by the current conceptual development of the approach. Based on the Panel's experience, these children are most likely to be receiving conventional mental health services due to the slow pace of service expansion.

The County reports that full implementation of 24/7 crisis stabilization teams to help stabilize the foster care population as envisioned in the CAP, will occur in SPAs 1, 6 and 7 by August 2008. Expansion of the teams County-wide is planned for Phase II, with no projected date provided.

Future Reports on the Joint Plan and CAP Implementation

The County is working on a new format for reporting on implementation the initial Joint DCFS/DMH Plan, the Corrective Action Plan and plans emerging from the current strategic planning work. This format should better integrate the three planning commitments and provide more complete information on progress

deadlines and challenges. The Panel commends this effort as a significant improvement over the current reporting process.

V. CREATION OF A JOINT DCFS/DMH STRATEGIC PLAN FOR KATIE A. IMPLEMENTATION

The work by the County and Panel to create an overarching plan for achievement of the objectives of the Katie A. Settlement Agreement, as previously mentioned, is focused on a number of major system change areas. The plan is expected to cover a five-year period, with three phases of implementation. An update on the progress of that work and the remaining challenges follows.

Intensive Home Based Services

DCFS and DMH have collaborated well and have included mental health providers and FFAs in the process of designing intensive home-based services (IHBS). The workgroup used the Panel's proposed shared practice principles for child welfare and child mental health (which are the foundation for IHBS) and a proposed definition of IHBS (based on several national efforts to define best practice).

Following each monthly meeting of the work group, DCFS and DMH revised the plan for IHBS, incorporating participants' contributions with the goal of moving from practice principles to refining an implementation plan. The biggest challenges in this process were: (1) clarifying the undererved and unserved children with high mental health needs and their families and foster families who should be reached by IHBS; (2) defining specifically how high quality intensive mental health services will be implemented; and (3) the concern by providers that some IBHS services could not be financed by EPSDT under current State billing procedures. Also, some providers have concern that they could be subject to State audit disallowances if training and billing procedures do not fully guide their documentation.. The Department of Mental Health believes that inflexible state definitions for covered services under Medi-Cal would not permit including some aspects of IHBS.

Panel members are familiar with the common response to innovative practice in other jurisdictions with the simultaneous and conflicting reactions of providers and public agencies, such as, "We're already doing it" and "We can't do it." The Panel has attempted to support the county in figuring how to do IHBS as something different.

(1) CLARIFYING THE UNDERSERVED AND UNSERVED CHILDREN WITH HIGH MENTAL HEALTH NEEDS AND THEIR FAMILIES AND FOSTER FAMILIES WHO SHOULD BE REACHED BY IHBS

DMH and DCFS estimate that IHBS will be expanded to serve approximately 2600 children and youth in addition to those children planned to be served by the ongoing Wraparound expansion, Children's System of Care (CSOC), Full Service Partnerships (FSP), Multisystemic Therapy (MST), Multidimensional Treatment Foster Care (MTFC), and Intensive Treatment Foster Care (ITFS).

The Panel encouraged the design of IHBS particularly for children with high mental health needs at risk of having to leave their relatives' homes, FFAs or other placements into more restrictive care. The Panel urged that IHBS be designed so they could be provided immediately to children and families in need without waiting for a complex referral process, a lengthy assessment, or convening of a CFT or TDM.

Two cases exemplify this goal of starting IHBS services immediately to meet urgent needs:

- A 5-year old who is present when her father kills her mother and is being placed in relative care with her maternal aunt.
- A 9-year old is placed in an FFA home with no known behavior problems and two months after placement is suspended from 3rd grade in his new school for aggressive behaviors which are also becoming a problem in the foster home.

Both children are eligible for IHBS services because they are at risk of placement breakdowns. Both have obvious urgent needs and their caregivers—a grieving aunt and a FFA foster parent who says she cannot manage the 9-year old's aggression—require immediate support before they become too stressed. A separate assessment before the referral to services would slow down the urgently needed help. Providing separately-operated crisis stabilization services would not make sense because both children's needs and their caretaker's support requirements are not short-term so the immediate response should be the first part of services that will continue. Both could be referred on the day of their urgent need to an IHBS provider with a request for an immediate response—going into the home within 24 hours to do a combined initial assessment and interim service plan with the family and begin to provide those services while a case manager gets involved and prepares for the first child and family team meeting.

The Panel also proposed that IHBS be designed to support DCFS cases closing as quickly as safely possible. Two groups are particularly important in this regard: (1) children and families whose needs would require continuing mental health services after the DCFS case closes (if DCFS case managed/facilitated, the child and family team and services would be disrupted when the case closed); and (2) relatives and foster parents who delay adoption/guardianship out of a fear that mental health services will end. Another important goal is to design IHBS to support safely keeping children from entering DCFS. High needs children and families could be referred from an initial investigation if DCFS determines there is no reason to open a case as long as mental health services are provided.

As of mid-March, 2008, the County's plan for IHBS includes the following:

“The initial target population for Intensive Home-Based Services and the associated Child and Family Teams is those members of the Katie A. class with urgent and/or intensive mental health needs that do not meet the referral criteria for existing intensive home-based programs such as Wraparound and System of Care, Focal populations for Intensive Home-Based Services, at least initially, will be:

- *Children in family or relative placements (including VFM/VFR/FM)*
- *Children in D-rate placements*
- *Children in Foster Family Agencies*
- *Children and families that can be diverted from entering the Child Welfare system through the provision of such services*
- *Children and families that whose exit from the Child Welfare system can be facilitated by the provisions of such services*

Identification of potential children and families to be served by Intensive Home-Based services can be initiated in one of two ways:

*1. **Urgent Need:** Intensive Home-Based Services can be provided in response to urgent child needs for crisis and stabilization services for short periods of time (up to 60 days) without formal authorization in order to prevent a change in placement, or*

*2. **Intensive or Complex Needs:** Intensive Home-Based Services can also be initiated at a variety of key decision-making points within the Child Welfare system including Team Decision Making (TDM) meetings, the Multi-Disciplinary Assessment Teams (MAT) process, and/or via screenings and assessments conducted by DMH co-located staff.”*

At this point, the County is considering initiating IHBS for a small portion of the 2600 unserved high needs children. Rather than a small demonstration project, a Panel member suggested 100 children in each SPA. This aspect of the implementation is still being planned. Hopefully IHBS can be implemented as an add-on to current providers' contracts without issuing an RFP and with the agreement of the union, which has been encouraging the County to avoid renegotiating staff duties by not starting a new IHBS or CFT programs.

(2) DEFINING SPECIFICALLY HOW INTENSIVE MENTAL HEALTH SERVICES WILL BE IMPLEMENTED

After much discussion, the County plans to implement IHBS (and CFTs) through the current Wraparound providers, Full Service Partnership providers and perhaps other intensive mental health service providers, but as a more flexible and clinically competent intensive approach without the eligibility limitations or the cost formula of the original Wrap program. There is a range of services in LA (operating with different names) and a plan to expand intensive interventions, and what is envisioned is linking them together under an umbrella of child needs-driven, family centered care with a single clinical management system and a set of practice principles as well as a coordinated referral process. Final decisions on an implementation strategy are needed.

The County sent a team of three DMH leaders, two DCFS leaders and one Panel member on a two-day visit to Phoenix to observe the Arizona system identified as a model of IHBS. Brian Lensink (Arizona Department of Health Services) provided guidance from the public mental health agency perspective. Then the visitors had the opportunity to hear from a provider network, a parent and youth advocate organization (Family Involvement Center), and an intensive home-based service provider (Child and Family Support Services).

The Arizona experience underlined the importance of ensuring that the “Whatever It Takes” approach to meeting the child’s needs and building on the family’s and child’s strengths philosophy is as unlimited as possible. The Arizona IHBS provider encouraged the LA representatives to assume that—other than philosophy—every child/family’s intervention will look different, with no routine staff teams, no parent partner for every family, no assumption flexible funds will be necessary, no formula for how many hours of services by which type of staff in particular delivery places (home, school, community, office) or particular schedules, no required parenting class, etc. This means that a foster family having trouble managing a 4-year old’s aggression, a relative having trouble tolerating a teenager’s self-destructiveness, and a teenager coming out of repeated hospitalizations into supported apartment living could all be receiving entirely

different types and amounts of IHBS by a collection of paraprofessionals and clinicians working under one clinical supervisor. Parent and foster parent/kin support is crucial, both clinically-guided assistance in responding to the child's needs and parent-to-parent encouragement to reduce isolation, but how each is offered to each family should be unique and culturally-competent. This approach to creating a unique in-home service to fit the needs of the child and family rather than providing categories of service could include services similar to parent coaching or 24 hour crisis response, but be offered by the in-home staff known to the child and family. While the majority of children are likely to require trauma treatment, this intervention by the IHBS provider should also be carefully tailored to the child and family. In addition, sometimes the in-home worker will help the family get involved in the CFT and community activities while in other situations an informal support (kin or friend) might be asked to accompany the parent to a parent support group or other activity.

The Arizona experience also envisions a structure that allows IHBS to be supervised by skilled clinicians with a Whatever It Takes philosophy who support non-clinically trained staff to meet children's needs and support caretakers in meeting children's needs. IHBS requires an innovative approach to recruiting, training, scheduling and paying staff.

Part of the challenge in implementing IHBS (and CFTs) as a more flexible and clinically competent intensive approach within the current Wraparound providers is that while LA Wraparound providers get high scores on a measure of fidelity to the national wraparound principles, this measure assesses the engagement of families in the planning and service process which is an important strength of Wraparound in Los Angeles. But it does not measure the quality of the services provided to the child and family, specifically the degree to which the mental health needs of the child are met. Have the child's behaviors been reduced? Is the child participating more successfully in school and normal activities? Are the effects of trauma less intrusive the child's life? Does the parent feel more able to support the child in regulating his/her behavior in recovering from trauma? Not only will these outcomes have to be measured after the IHBS services are implemented, but they must be designed into more clinically-sound intensive services.

The Panel member on the Arizona visit recommended contracting with Arizona's Child and Family Support Services to provide their training in how operate IHBS, facilitate CFTs and case manage and to do follow-up coaching because they provide IHBS to very complex kids and families and have had success in recruiting and training staff (going from 8 to 170 fulltime and part-time staff providing IHBS in five years).

As of mid-March, 2008, the County's plan for IHBS includes the following:

“Intensive Home-Based Services represent a “WHATEVER IT TAKES” approach and may include, but are not limited to:

- *A comprehensive assessment of needs and strengths*
- *Targeted case management with 24/7 access to services*
- *Parent/relative/foster parent training and coaching*
- *Individual and family therapy*
- *Crisis intervention*
- *Medication management*
- *Skills training and other rehabilitative services*
- *Behavior coaching and other skill building with the child, including support during school and after-school activities*
- *Access to flexible funds to support non-billable activities, such as:*
 - *Respite care*
 - *After school activities*
 - *Tutoring*
 - *Behavioral incentives*
 - *Recreational activities*
 - *Creation of an informal support activity*
 - *Emergency rent subsidies*
 - *Other one time expenses*

As of mid-March, 2008, the County's plan for IHBS includes the following:

“Significant training, both initially and supported through ongoing coaching and mentoring of staff, will be required to implement and sustain these efforts with fidelity to the Los Angeles Vision, practice principles, and day-to-day practice standards. All new DCFS and DMH staff, as part of their initial training would be oriented to the vision and practice principles, so IHBS is not viewed as another program, but as the driving philosophy. Training options include contacting with the University of California at Davis, the Los Angeles Wraparound Consortium, the California Institute for Mental Health, the Community Services and Supports Program (Phoenix), and members of the National Wraparound Initiative”

(3) CONCERN REGARDING THE FINANCING OF IHBS

Brian Lensink and the providers in Arizona believe that even without major changes in billing codes in LA, IHBS can be claimed under Medicaid and LA

provider concerns about audit problems can be addressed. It was interesting that none of the Arizona interviewees mentioned flexible funds without being questioned about it by LA staff. They started a wide variety of activities being Medicaid covered, but without flexible dollars. When they want money, as they often do (e.g. to take a kid to an activity) they get it out of administrative funds.

The County team came back from Arizona committed to re-examine paying for IHBS, with the assistance of Plaintiffs' counsel, and their progress is documented in this report under the Financing Workgroup.

The County believes that while current California claiming regulations will permit many of the costs of IHBS to be claimed for Medicaid reimbursement, some like respite or a case rate for this service could require a Waiver. The County reports that it has begun exploring the option of a Waiver with the State DMH. Further analysis is needed to assess the sufficiency of current State Medicaid regulations to fully support IBHS. If needed, the Panel fully supports this effort and would see it as vital to Katie A. Implementation.

Child and Family Teams

DCFS and DMH have collaborated and included providers in designing Child and Family Teams (CFT). The workgroup accepted the Panel's proposed description of CFTs, taken largely from the Child Welfare Policy and Practice Group and the County's plan incorporates more than 10 pages about CFTs.

The Child Welfare Policy and Practice Group's formulation of CFTs envisions a child welfare agency training its staff to convene and facilitate teams in all their cases as a method for working collaboratively with families and ensuring coordinated care, but DCFS case workers indicate that their caseloads are too high to add the responsibility of teams. The County is planning to have contract providers offering IHBS also convene teams for children and families receiving those services (and at this point not for others). One of the dangers of having CFTs not done by DCFS is that it will remain outside of CSW's casework rather than the center of what is reported to court and what is informing permanency decisions. Training and coaching in the role of being an active CFT participant is just as important as in facilitation.

As of mid-March, 2008, the County's plan for CFTs includes:

“It is essential to have birth, kinship, adoptive and foster families involved in planning services with professionals from mental health, child welfare, school and other agencies and the family's informal supports. The complex needs of

these children require integrated services, and team planning is essential and cannot be separated from the interventions.”

--and--

“For children with more ongoing intensive or complex needs, Child and Family Teams should be the service planning process. Child and Family Teams can be initiated by the family via the CSW and/or DMH co-located staff, the child/family’s therapist, teacher, MAT, or other professional working with the family. Some referrals will be generated from the Team Decision Making (TDM) meetings, including those that are part of the Resource Utilization Management Process, held within DCFS Regional Offices. Children and youth who are the subject of these meetings and who meet the criteria will be considered to be “pre-authorized” for service and will be referred to the Countywide Care Coordination Unit, composed of DMH and DCFS staff. Ideally, the Intensive Home-Based Services in the SPA would have attended the TDM, so the family and the provider can start the planning process at the TDM. Referrals will be reviewed for appropriateness and those that are deemed appropriate will be “authorized” by the Countywide Care Coordination Unit.”

Services to Class Members Served by FFAs

The County proposes to complete mental health screening of all children in SPA 1, 6 and 7 with an open case (except those in D-Rate status), not just those in FFAs, at their next plan update. Children identified will be referred to the specialized foster care units. Some additional staff are also projected to be hired. Until the new strategic plan is implemented and provides the capacity to utilize intensive home-based mental health services, children identified will be served through conventional mental health service services and existing services available in FFA’s. The Panel has concern about the system’s current capacity to expand services to this newly identified population of children needing mental health services.

Mental Health Screening and Assessment

This plan section established the goal of providing mental health assessments for all class members. Tasks include:

- Create Coordinated Screening and Assessment Teams throughout the system, inclusive of hiring necessary team members.
- Hire dedicated Multidisciplinary Assessment Team (MAT) Coordinators in SPA 1, 6 and 7.

- Amending provider contracts.
- Create a D-Rate Clinical Evaluation Team, inclusive of hiring new Clinical Evaluators.
- Recruit and train D-Rate providers.
- Create six crisis stabilization teams.
- Implement a Resources Utilization Management Process (RMP) to manage the delivery of services to children placed in/at risk of placement in RCL 6-14 placements.
- Add staff to the DMH specialized foster care units.
- Expand mental health service capacity in SPA 1, 6 and 7 in May 08 and later in remaining SPAs.
- Identify EPSDT eligibility for children with positive mental health screens.

This Plan section reflects significant attention to screening and assessment. The Panel would like to know the additional cost associated with this effort. Additionally, the Panel is unclear about how these new screening/assessment teams will relate to the anticipated child and family teams, wraparound teams, the Hubs, MAT, new D-Rate Clinical Evaluation teams, the Resources Utilization Management Process, new co-located DMH Specialized Foster Care staff (projected to be added) who will support screening in FFA's and additional provider staff to be added to provide screening and assessment. How will they coordinate their work and what boundaries of responsibility are anticipated? The Panel believes that clarity is needed to assure that a child with urgent mental health needs will not have to wait for this complex assessment process to evolve to access IHBS. The approach seems to insert a number of additional layers in the assessment process and has an apparent level of fragmentation that seems at odds with the more seamless child and family team/intensive home-based mental health service concept that is the logical locus for assessment activity.

Wraparound Expansion

As of March 2008, 1153 slots were filled out of 1,217 projected. County projects to reach the 1,217 goal by June 2008. The Panel and parties agree that at least 2600 additional class members need intensive home based services that are not yet available. Clearly further expansion of Wraparound will be needed.

Training

In the most recent meeting between the County and the Panel, the County proposed a new approach for training of staff and practitioners related to Katie A. needs. This approach represents a significant improvement in the conceptualization of an approach to training and reflects many the Panel's prior

suggestions about the design of a training system. The approach described is anchored in a set of principles mirroring the principles in the county's plan for intensive home-based services and the use of child and family teams, a convergence the Panel commends. At this stage, however, the plan does not contain needed details about exactly who would be trained, how intensive the training would be, how trainers would be developed to teach skills needed to practice consistent with stated principles or the amount of resources committed to provide additional training. The Panel raises the following questions:

Who will be trained, both DCFS and DMH staff? Will both existing staff as well as new staff be trained?

Will there be more emphasis on coaching than on classroom training? Previously almost all DCFS training has been half-day or one-day classroom instruction, which is not sufficient for supporting staff in changing their philosophy of working with children and families.

How will providers be trained in new approaches? Will the previous plan to use the California Institute for Mental Health for training and technical assistance be a part of this plan? Will the Panel's recommendation that Child and Family Support Services, an experienced Phoenix provider, be hired to provide training and coaching on IHBS be part of this plan?

Will there be cross-training with DCFS, DMH and providers receiving training together?

Will training and coaching in the facilitation of CFTs by providers, involving DCFS, DMH and private providers in CFTs and the integration of CFTs in child welfare casework, including court reports be provided? ?

What are the timelines for actual completion of training?

While this is a useful step forward, at this stage of planning, the training plan remains a plan to plan.

Caseload/Workload Reduction

The County has produced an extensive list of steps to attempt to reduce caseloads (and subsequently workloads) in an effort to make additional staff time available for intensive work with children and their families. This effort assumes that employing child and family teaming and managing intensive home-based work with class members would require more time than conventional case practice.

Tasks to be achieved include:

- Strengthening assessments in cases newly identified to more effectively serve and deflect cases to appropriate community resources
- Increasing adoptions
- Revising contract expectations for FFA's for achievement of permanency
- Increasing KinGap (subsidies for kinship providers) enrollment and expanding post-permanency supports
- Seeking an amendment to the Waiver to permit financial supports like KinGap to be extended to non-related legal guardians
- Establishment of a baseline target for staffing
- Using case management to close cases more timely
- Continue to strengthen the process to reduce placements in residential settings and shorten stays of children and youth residing in residential settings

The County cannot estimate a projected workload savings as a result of these strategies at this time. The Panel has recommended that specific goals for caseload/workload reduction be included for each task in the final strategy document.

Financing

As mentioned previously, as a result of information gathered in the County's site visit to Arizona and its internal analysis of the comparability of the Arizona Medicaid plan with that of California, the County believes that a number of the elements of child and family team functioning and intensive home-based mental health services eligible for Medicaid billing in Arizona are allowable under Medi-Cal. The County is now analyzing the differences between the two state plans and developing case scenarios to assess areas under the model of practice that can be claimed to Medi-Cal. As mentioned in the section on Intensive home-based services, the County believes that a Medicaid Waiver, may be needed to claim all the elements of the Arizona IHBS model and that it has begun exploring the option of a Waiver with the State DMH. Further analysis of this issue is needed.

The financing plan does not yet speak specifically to how the County plans to support provider claiming consistent with the new conceptual model for intensive home-based services. Additional planning work is needed to define and assign the tasks required to maximize Medi-Cal claiming under current State Medicaid rules.

The County has reduced the group care population and those cost savings might be a source of funding for the plaintiff class; however the County reports that such savings are tied to the Waiver and that there are numerous concurrent activities under the waiver competing for these funds. It seems unlikely that these savings will be a source of revenue for expansion of intensive home-based mental health services. The County is allocating \$3,360,000 in MHSA Growth Funds to serve 525 child slots and 223 Transitional Age Youth Full Service Partnership slots in FY 2008-2009.

The final financing strategy should include an estimate of how much revenue is needed to meet the needs of class members, its projected source and if anticipated revenue fall short of projected needs, what steps the County will take to acquire needed funds.

Data Trends

The County continues to work on the new mental health data system, IBHS. This system promises to significantly add to what can be learned about the status and progress of Katie A. class members when complete. The County estimates that the system will be fully functional by January 2009.

As mentioned previously, the County believes that progress in implementing the Mental Health information system will permit more complete and accurate reporting on the plaintiff class than the proxy class approach, used as an interim system. It appears that such reporting could be available relatively soon. The Panel will provide the County with a list of mental health service indicators that can be used to describe outcomes and service delivery to the plaintiff class.

Proposed Exit Criteria

Work on this objective has not begun.

VI. RECOMMENDATIONS

The Panel makes the following recommendations in this report.

- The County should add additional management staff, such as program analysts to the Child Welfare Mental Health Services Division to support implementation of Intensive Home-Based mental health Services.
- The County should provide the Panel a formal report on action taken in regard to the Health Management Associates Report.
- The County should provide the Panel with information on the extent to which the current level of Team Decision Making facilitators can facilitate team meetings for the events inherent to the TDM model.
- The County should give priority to detailing the plan and costs for implementing the Intensive Home-Based Mental Health Services approach.
- The County should consider contracting with Arizona experts to help train Department and provider staff.
- The County should assess and report to the Panel the need for an additional wraparound expansion to meet the needs of the approximately 2600 class members needing intensive home-based mental health services.
- The County should establish specific projections for reductions in workload/caseload in the strategic plan.
- The County should include in the strategic plan an estimate of additional revenue needed to meet the needs of class members, its projected sources and if anticipated revenue falls short of projected needs, what steps the County will take to acquire needed funds.

VII. GLOSSARY OF TERMS

ADHD-Attention deficit hyperactivity disorder

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

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

Comprehensive Children’s Services Program – Services and supports including a combination of intensive case management and access to several

evidence-based treatment practices, including Functional Family Therapy, Trauma-Focused Cognitive Behavior Therapy, and Incredible Years.

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

DMH-Department of Mental Health

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

ER-Emergency response

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

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

FGDM-Family Group Decision Making

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

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

IEP-individual education plan

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

MAT-Multi-Disciplinary Assessment and Treatment Team

PTSD-Post-traumatic stress disorder

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

RPRT-Regional Permanency Review Teams

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

Treatment Foster Care – A therapeutic approach for children with emotional or behavioral needs, provided by highly trained caregivers and supportive intensive services

TBS-Therapeutic behavioral services

TDM-Team decision making (a family conferencing approach)

Title XIX-Medicaid

VIII. APPENDIX

Health Management Associates Report