

**The Katie A. Advisory
Panel Ninth Report
to the Court
November 17, 2008**

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Executive Summary

This brief report reflects the discussions between the County and Panel about the County's Strategic Plan, which has been under development for the past months. The majority of the Panel's recent interactions with the County have been about the content of that Plan. The report includes a summary of the Panels questions and concerns about the draft Plan and the County's responses to those questions. The County has now completed the Plan, submitted it to the Board and the Board has approved the Plan. The County plans to submit the Strategic Plan to the court in March 2009.

The Plan that the Board approved provides for the following in additional resources for the plaintiff class:

Strategic Plan Costs for 2008-2009 - \$18 million

Strategic Plan Costs for 2009-2010 - \$45.1 million

Full-Year Costs for 2014-2015 (full 5-year implementation) – \$119.9 million

While the Panel still has several concerns about elements of the Strategic Plan which the Panel and County will continue to discuss, this Plan represents a major improvement in the County's approach to implementing the Katie A. Settlement Agreement. The Panel commends DCFS, DMH and the Board for taking these positive steps. In the areas where the Panel has concerns, the Panel will track progress to determine if the strategies in question produce the results projected.

In a few areas, the Panel makes additional recommendations for specific actions in regard to the Plan. Some of the most important issues addressed in recommendations are:

1. The County still needs to work on improving the comprehensiveness and timeliness of status updates to the Panel on implementation of the Corrective Action Plan and the Joint County DCFS/DMH Mental Health Plan. The Panel and County discussed this issue at the most recent Panel meeting and the County agreed to address the Panel concerns.
2. While the County has made progress building capacity to accurately report outcome trends and patterns of use of mental health services, more work is needed to provide the Panel and court the information needed to determine if the status of class members is improving. The Panel, plaintiffs' and County will meet in December to work on plans to strengthen data availability.
3. Continued attention and work is needed to assure that class members living in their own homes have the same access to screening and home-based mental health services as children in out-of-home care.
4. More specificity is needed in the design of training strategies for DCFS, DMH and provider staff. The County agrees that more detail is needed and is open to Panel input in that regard.

**Katie A. Advisory Panel
Ninth Report to the Court
November 17, 2008**

I. Introduction

The following Ninth Report to the Court outlines the County's progress toward achieving the objectives of the settlement agreement, includes a description of its compliance with the current Joint DCFS/DMH Plan and Corrective Action Plan and discusses County's new Strategic Plan, recently approved by the County Board. Within that work, the County developed a more comprehensive set of strategies to address the breadth of system change needed to accomplish the objectives of the Katie 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 (Paragraph 6) imposes responsibility on DCFS for assuring that the members of the class:

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

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

- o immediately address the service and permanence needs of the five named plaintiffs;

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

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

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

Additionally, the Settlement directs that:

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

The Department prepared a Joint DCFS/DMH Mental Health Plan to describe its strategy for implementing the provisions of the settlement agreement. The Panel and plaintiffs identified issues in the Plan they believed needed additional attention and in a subsequent court hearing, plaintiffs and defendants proposed

submitting a joint finding of facts that would identify areas of agreement and disagreement. The court issued an order directing the County to revise its plan and submit the revision for review. That Corrective Action Plan was completed and provided to the Court. In subsequent discussions with the Panel, the County concluded that additional strategies were necessary to achieve the objectives for the plaintiff class and committed to developing an overarching Strategic Plan that would address remaining system design needs. The County has now completed its Strategic Plan and received County Board approval for implementation.

III. Panel Activities since the Eighth Report

Since the Eighth 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 discussions, the Panel reviewed a sample of Multidisciplinary Assessment Teams (MAT) assessments and interviewed DCFS/DMH staff involved with MAT in three DCFS offices.

IV. Current Implementation Plan Status

The following update relates to the implementation of the Corrective Action Plan. It should be noted here that the County Board has just approved funding for the Five-Year Strategic Plan the County and Panel have been working on for the past year. Annual funding for the Plan in the fifth year (2014-2015) is projected to total \$119.9 million. The following is a summary of progress made under the Corrective Action Plan and the section on funding summarizes the allocation of funds for the Strategic Plan. The Strategic Plan contents will be discussed in a later section of this report.

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

DMH states that it now has 128 staff co-located in DCFS offices, leaving only one regional office without co-located staff.

Additional staffing for the DMH ACCESS Hotline

One of 3 allocated positions remains vacant, which was the status of staffing at the time of the Panel's last report.

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 for the member class, which help identify progress achieved and the difference between the member class and all children served by DCFS. 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. The County projected the availability to the Panel of both proxy class data and specific data on issues such as service utilization, intensity and duration, for example, as well as on other outcomes relevant to compliance with the settlement agreement. Some of that information was made available in November 2008, but further discussions are scheduled about the continuing necessity of proxy class data.

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

This Application is a comprehensive functional application tool to provide age category information regarding client outcomes. It is reported to be in use in Service Areas 1, 6 and 7 for children involved in Full Service Partnerships as well as for children receiving other mental health services. Additional analysis is needed to determine the extent and consistency of use of the assessment application.

Development of Multidisciplinary Assessment Teams (MAT)

The County provided the following update on MAT implementation.

To date, over 1,550 children have been assessed through the MAT Program. Each DCFS office will have an allocated position for a DCFS MAT Coordinator by October 14, 2008. Presently 14 DCFS MAT Coordinators have been hired with three additional Coordinators to be recruited. An additional DCFS MAT Central Manager position has also been allocated.

SPA 6 continues to lead expansion efforts, now providing MAT services to newly detained Command Post (after hours) children and consequently providing MAT assessments for 90% of those children who are eligible for these assessments. By comparison, SPA 3 is providing MAT assessments for approximately 60% of the potential MAT cases within the SPA. With the plan to include the Command Post cases in December of this year, SPA 3 will increase their MAT capacity significantly.

The DMH contract amendments that will allow for the provision of MAT services in SPAs 1 and 7 are anticipated to be completed in November or December of this year, and MAT services will start very shortly thereafter as provider training has already occurred in these two SPAs.

MAT provider orientation and solicitation has been completed in SPA 2, 4, 5, and 8 with provider selection and funding allocations now in process. DMH MAT Contract Amendments for these same SPA's are anticipated to be completed no later than March 2009.

It is anticipated that the MAT program will be operational across 12 DCFS Regional offices by the end of the calendar year and Countywide by no later than April 2009.

The Panel reviewed a sample of MAT assessments and its findings are found later in this report in regard to the County Strategic Plan.

Development of a Joint DMH/DCFS Master Person Index

This process, now in operation, permits identification of children served by both DCFS and DMH and is used to support the identification of mental health service activities and costs.

Implementation of the DMH Behavioral Health Information System

The County reports that the DMH information system (IBHIS), first projected for completion in June 2008, is now expected be completed in 2011.

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

The independent evaluation of implementation has been completed by Health Management Associates and information produced in the evaluation was utilized in the development of the new County Plan.

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

As will be referenced later in the section of this report related to the County's new Plan, the County has chosen to use the Qualitative Service Review (QSR) process to provide qualitative feedback on County practice performance. The County also has chosen to use the QSR as one of the Settlement agreement exit criteria. County staff are observing the use of the process in Utah during November 2008.

Development of a DMH Performance-Based Contracting System

The County reports that performance based contracting was implemented at the beginning of 2008 and that outcome expectations are included in all contract agreements for contractors.

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 in the section of this report related to the new County Strategic Plan.

Expansion for Funding

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

Strategic Plan Costs for 2008-2009 - \$18 million

Strategic Plan Costs for 2009-2010 - \$45.1 million

Full-Year Costs for 2014-2015 (full 5-year implementation) – \$119.9 million

Funding sources for 2014-2015 are:

EPSDT - \$53.1 million state and federal

Federal IV-E Training - \$1.5 million

MHSA – \$3.4 million

Net County Cost - \$61.9 million

In addition, the County has requested that the State expand the Medicaid Waiver and the State has expressed a willingness to discuss this topic. A conference call occurred between the State and County on October 28 and the County is currently in the process of drafting a letter to the State questioning whether certain Wraparound activities are EPSDT eligible.

Expansion of Staff Resources for Multidisciplinary Medical Hubs

The County reports that approximately 60 percent of newly detained children are assessed by the HUBs. From July 2007-February 2008, 6,121 children involved with DCFS were screened using the CIMH screening tool. Of that population, forty-two percent were found to need further mental health follow up.

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

The County now has 76 full time facilitators who conducted over 10,000 Team Decision Making (TDM) meetings last year. This number is up from 26 facilitators who were available in 2004. The county reports that it provides a TDM for every potential detention, but due to workload constraints, cannot meet the demand for TDMs when a placement change occurs or reunification is planned, both a standard for the TDM model. The Department estimates that it would require 14 more facilitators to have a TDM for each placement change, but does not plan to request further expansion at this time. This is because case managers and their supervisors are expected to be present at each TDM and workload constraints do not permit adding these additional duties.

However, the County does plan to mandate in December 2008 that a replacement TDM occur for all youth in or at risk of being placed in a RCL 6 or above group home. Earlier in the year the County hired 14 facilitators to focus on children in group homes and children in out-of-home care for more than two years. Eight additional facilitators are expected to be hired as well.

Implementation of the DMH CIMH 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.

(It should be noted that this tool was developed for use by non-mental health professionals.) Until that is resolved other levels of the organization will be expected to employ it, an issue about which the Panel continues to have concerns.

The following list of services is from the prior County Plan. The County reports that it plans to implement five of these, MTFC, Multisystemic Therapy, Functional Family Therapy, Trauma-Focused Cognitive Behavior Therapy and Incredible Years in Service Areas I, 6 and 7. The Panel needs to have further conversations with the County about expansion to other service areas.

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 Enhanced Specialized Foster Care Mental Health Services Plan provided for the development of intensive in-home mental health services programs, using selected evidence-based practice models, in Service Areas One, Six, and Seven. Contract providers are now providing Comprehensive Children's Services Programs (CCSP), including Functional Family Therapy, Incredible Years, and Trauma-Focused Cognitive Behavior Therapy, Multisystemic Therapy and Multidimensional Treatment Foster Care in Service Areas Six and Seven with funded capacity to provide these services to 379 DCFS-involved children. At present 436 (CCSP 362; MST 70, MTFC 4 for July 2007-September 2008) are enrolled in these service programs. The CCSP programs have generally operated at full-capacity in recent months, with enrollments to the MST programs being somewhat lower. Enrollments into the MTFC programs have proven somewhat difficult and have been slowed by program implementation, foster parent selection/certification/training, and client matching requirements. Presently, 11 MTFC homes have been certified, with three children currently placed.

Contract providers for these programs have been selected in Service Area One and the provider contracts are currently going through the contract amendment process. The California Institute for Mental Health (CIMH) is arranging for training with the model developers. Implementation is expected in the first quarter of 2009

Expansion of Wraparound by 500 Slots

As of May 2008, 1245 slots were filled out of the 1217 the court required to be in place by May 2008. Since that time, enrollment has fluctuated, but remains close to the 1217 projection. In working with the County regarding Wraparound services, Panel members have met with Wraparound providers and the Los Angeles Training Consortium and observed several Wraparound meetings. Richard Clarke also joined County Wraparound managers on a trip to Washington State to observe their tiered Wraparound model.

Targeted Mental Health Services for D-Rate Homes

Implementation is expected to begin in SPAs 1, 6 and 9 by March 2009. The county also provided the following update.

Currently, an average of one hundred and forty (140) initial assessments are being referred to DMH per month and an approximate three hundred and thirty (330) re-certifications completed per month. In addition, the D-Rate Section handles approximately one thousand six hundred (1,600) calls for consultations with CSWs, caregivers and the public per month.

The CAP increased the DCFS D-rate staffing allocation from ten (10) to fourteen (14) D-rate Evaluators, augmented by five (5) new DMH positions to support D-rate activities. All of these staff positions have been hired. Three (3) STC items have been allocated to replace the two (2) existing ITC items for Psychotropic Medication Authorization (PMA) protocol, effective in January, 2009, due to the extensive technical skills needed to effectively process County-wide PMA requests and notify parents/legal guardians, in a timely manner, of the administration of psychotropic medications to their children. DMH has improved its processing time for initial D-rate assessments, and DCFS has followed up on these initial assessments with clinical reviews of the child's status and efficacy of mental health treatment for these children every six months. In addition, a Psychotropic Medication Review and Monitoring Protocol is being developed for D-Rate Evaluators to identify the caregiver/children's expressed concerns/problems regarding the prescribed psychotropic medications. The concerns are immediately addressed and submitted by the D-Rate Evaluators to the prescribing physicians/psychiatrists for consultation and resolution. The monitoring protocol is projected to be implemented in March, 2009. Currently, over 90 percent of children in D-rate placements are receiving mental health services. Approximately five hundred (500) PMA requests are being processed per month.

Future Reports on the Joint Plan and CAP Implementation

As of the last report, the County committed to 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 has not yet occurred and the issue was on the agenda for the Panel meeting with the County, November 5 and 6. In that discussion, the Panel again stressed the need to have comprehensive, timely progress reports on implementation.

The County committed to improve its reporting and offered to provide additional narrative to supplement the matrix provided.

V. Panel Multidisciplinary Assessment Teams (MAT) Review

On August 5, 2008, three Katie A. Panel members, each accompanied by a DCFS representative, reviewed 30 MAT reports from the Wateridge, Pasadena, and Compton offices and interviewed DCFS, DMH staff and private providers from those three locations for the purpose of discussing how the MAT is functioning in those sites. The MAT reports provided useful information about the type of information included in MAT assessments; however there was not sufficient time to extract all the information needed for a comprehensive picture of the process. Also the sample size was small, limiting the ability to generalize from findings and observations. However the combination of record review and key informant interviews did produce consistent themes about the value of MAT and barriers to effectiveness, suggesting that the findings may be relevant to future planning related to MAT.

Participants in each site were asked to respond to the following questions:

1. What's working well in the MAT process?
2. What changes have you seen in the MAT process?
3. What is the current volume of MAT referrals?
4. Are you able to keep up with the volume?
5. Generally, how long is it taking to complete each one?
6. What's the role of the child/family in the MAT process?
7. What's the role of the CSW or other DCFS staff in the MAT process?
8. How do you relate to co-located DMH staff?
9. What information do you get from DCFS about a child who is referred?
10. What is your involvement if any in referring or arranging for services?
11. Are there areas of specialized expertise you need in MAT assessments that are hard to access, such as neurological evaluations, trauma expertise, etc?
12. Do you have a sense of how available services are when you recommend them?
13. What training was provided to prepare you for the MAT role?
14. Are there tools or resources you need to make the MAT process effective?
15. Do you get feedback about service delivery after you complete a MAT referral?
16. What barriers exist to an effective MAT process?
17. If you had the power to change one or two things about the MAT process, what would you choose?

The collective replies of participants identified the following themes about the MAT process.

Strengths	Challenges
Has expanded service referrals	Assessments are often not available before disposition, meaning MAT assessments do not affect case plans or court orders. These problems result from volume, wait lists for

	expert input and difficulty scheduling contacts
Written assessment more useful for case managers	Lack of judicial familiarity with MAT-Some judges relying on other sources of information
Access to expert assessment is valuable	Teachers not routinely part of the MAT team
Provides a more comprehensive picture of the family	Can be hard to access expert input on sexual abuse, neurological issues or trauma
Families like having a neutral party conduct the assessment	Hard to access DMH, Public Health or Educational files
Effective partnership between DCFS and DMH	Can be hard to get judicial authority to conduct a MAT, but seeing improvement
	MAT assessments fail to impact plan in many cases
	Not enough flex funds to address needs identified
	MAT not available for voluntary cases
	MAT not available system wide
	Recommendations are limited to what is available even if not matched to family needs

Panel Assessment of Qualitative Issues

In reading the MAT reports, the Panel found that they did provide a somewhat brief assessment of key family and child issues and a family history, so they might include more than would be known otherwise. They consistently substituted services for needs, however, and didn't have much clinical depth. There were strengths referenced, but they were fairly general and few were what we consider functional strengths that would be useful to build a plan upon. It was very surprising to see how small a MAT team might be and that teachers weren't involved, especially since MAT reports deal with educational issues. The Panel assumed that the team would have more clinical depth than was found. In a number of cases, the team recommended clinical assessments, since it lacked that capacity within the team.

If the MAT reports are completed post-disposition and thus don't impact the dispositional order, if they remain service driven rather than needs driven, and if recommendations are limited to what is available (in conflict with the "whatever it takes philosophy underpinning the practice model), the added value of this process is open to question.

These conclusions about MAT were generally confirmed in a separate interview with a representative of the Children's Law Center.

County Response

The county responded to the assessment above which was provided in the draft version of the report. Their comments are provided below.

The panel should note that the cases reviewed were some of the earlier MAT cases. At that point, there weren't any dedicated MAT Coordinators to ensure the quality of the

MAT Reports or ensure that they were appropriately incorporated into the child's case plans. Current MAT Coordinators are improving the timeliness of MAT completion and ensuring that these get to court as soon as possible. The MAT manager is also working with the Children's Law Center to ensure that the MAT reports get to court as soon as they are completed.

The Panel is not convinced that these problems have been so easily solved and plans to conduct additional reviews of MAT performance. As recently as November 2008, Children's Law Center staff interviewed by a Panel member reported significant delays in receipt of MAT reports.

VI. Panel Comments on the County's Draft Strategic Plan

The Panel and County have been conferring regularly on the content of the County's Strategic Plan, approved by the County Board October 14, 2008. Plaintiffs' counsel has been a regular participant in these discussions as well. On August 27, 2008 the Panel provided the County with a summary of its input to the Plan, which the County had provided to the Panel as a final draft before its presentation to the County Board. In the Panel's letter, which the County also provided to the Board, the Panel began by stating the following.

The Panel has reviewed the latest draft of the Katie A. Strategic Plan and our comments are provided below. First, we do want to recognize the progress this Plan represents. From where this planning process began, the Panel is encouraged at the attention the County has paid to areas the Panel believes are critical to achieving the objectives of the settlement. The County now has developed a practice model and approach to providing intensive home based mental health services, delivered in the environment of a child and family team that serves both a planning and decision making purpose. The model fully recognizes the importance of the family voice in the planning process and makes a commitment to a "Whatever it takes" philosophy.

There is also an intense focus on ensuring that children are screened and assessed to determine the extent of their mental health needs. For those children with intensive needs, the County is working on training and technical assistance approaches to maximize MediCal funding, an issue the Panel has consistently promoted.

The strategies developed for achieving the settlement objectives have benchmarks, which should assist the County and Panel in tracking performance and progress. Likewise there are specific time lines projected and better clarity about the units and individuals responsible for tasks which should support organizational accountability.

We particularly appreciate the commitment of the County to provide significant data about the DCFS population and plaintiff class, through the combination of outcome indicator tracking and service delivery measurement using the Cognos Cube. When this system is operational and we hope that will occur very soon, we should both have access to a considerable amount of performance and outcome data.

Last, while there remains considerable work to be done on quality assurance approaches and exit criteria, we have been heartened at the County's decision to adopt a Qualitative Service Review approach and to agree to a three tiered approach to designing exit standards. We believe that the progress described above can be a strong foundation for this Plan.

Following that statement in recognition of the strengths of the County's work, the Panel offered the following questions, concerns and suggestions about the Plan's content.

Panel Approach to Reviewing the Plan

Each of the Panel's comments on the Strategic Plan is followed by an italicized excerpt of the County's reply to the Panel. Even though the Board has approved the Plan, the Panel believes that some issues continue to need attention before implementation. For that reason, we are including them in this section. In reviewing the County's Plan, the Panel limited its focus to three fundamental questions related to each section; is the strategy likely to result in (1) identification and assessment of mental health treatment needs of the child and family, (2) ensure linkage to timely, appropriate mental services and (3) sustain fidelity to the practice model necessary for the child and family?

Areas of Panel Concern

1. Mental Health Screening, Assessment and Referral

The County has developed an intricate and extensive plan for screening, assessment and tracking, including Medical Hubs, Multidisciplinary Assessment Teams, Coordinated Service Action Teams (CSAT), Team Decision Making events, the Resource Utilization Management Process (whose members are also CSAT members), Interagency Screening Committees and a Family Centered Services Referral Tracking System. This system would also have to interact with Wraparound teams and child and family teams. The County points to recommendations in the Health Management Associates Report as one reason for the tracking system. That report recommends that the County assess the current process for screening and assessment and speaks to "an urgent need" for a tracking system.

Barriers to Effectively Screening and Assessing Plaintiff Class Members

The Panel has an overarching concern about the growing trend by the County to create external processes and mechanisms to manage what would routinely be the role of the caseworker. As the paragraph above reflects, there are at least seven entities other than the caseworker involved in screening and assessing children and families, making decisions about their needs, referring them to services, tracking their progress and reviewing the appropriateness of service selection. The Panel is aware that DCFS caseloads are high, especially in foster care cases and that these mechanisms were intended to in part deal with the high workload faced by case workers. However, the externalization of case management raises other challenges that could impede the

effective delivery of mental health services that the Plan does not recognize. The Panel's concerns about these challenges are as follows.

- The Panel continues to be concerned about the multiple layers of external screening, assessment and tracking roles and their possible effect of diffusing the importance of child and family teams and distancing them from key decisions about resource selection, service intensity and duration. Child and family needs are at risk of getting lost in the diffusion of responsibility. How will the County ensure that these additional layers of screening will not undermine the role of the child and family team, which knows the child best, in assessment, planning and service delivery?

County Response: *The Coordinated Services Action Team (CSAT's) primary objective is to ensure the systematic and timely screening, referral and assessment of mental health needs of children served by DCFS; to coordinate staff/programs currently linking children to service; and to monitor capacity, access, and utilization of services, as described on page 15 of the Plan. The intent of the CSAT is not to add additional bureaucracy, but to better integrate existing services and to provide a structure to ensure efficient clinical care management. The CSAT provides Children's Social Workers with access to a group of system navigation experts within each DCFS area office with whom they can discuss the needs and most appropriate service linkage for each child. The role of the Child and Family Team (CFT) will not be undermined, and they will still be in charge of the planning and service delivery provision for the child. Once the CSW in conjunction with the CSAT screens a child and it is determined he/she is in need of intensive mental health services, the CSAT refers the child to the Interagency Screening Committee (ISC), which is currently operational in each of the eight Service Planning Areas (SPAs) and the ISC. Service providers in that region comprising the CFT and CSW then determine which tier is appropriate to meet the needs of the child. If the child is detained, a Multidisciplinary Assessment (MAT) Team Summary of Findings (SOF) will be completed. If a determination is made for intensive mental health services, the CFT is linked to the case at the MAT SOF meeting so as not to delay the planning/service provision for the case. The CFTs will have the authority to transition services across the three tiers as necessary, and will be responsible for notifying the ISC in their SPA of any changes made and provide a rationale for such changes. In some cases, another intensive-in home service model such as Multidimensional Treatment Foster Care (MTFC), Comprehensive Children's Services Program (CCSP), or Multisystemic Therapy (MST) could be what the child needs, and in that case the CFT would take a secondary role during the provision of those services.*

- Effective child and family teams should be able to make prompt decisions about child family supports and have considerable flexibility in matching providers to children and matching services to needs. Multiple layers of organizational decision making often detract and delay service provision to the child and family. How will these processes relate to the child and family team?

County Response: *There are no multiple layers of decision making in relation to the CFTs. The CFTs in conjunction with the CSW and ISCs initially determine which tier is*

appropriate to meet the needs of the child, after that the CFT has the authority to transition children across tiers dependent on their changing needs. The CFTs will be responsible for providing reasoning/documentation for service changes, after the change is made so as not to delay the provision of service. The Wraparound Liaisons (DCFS representative to the ISCs) provide care management oversight per SPA by tracking enrollments, disenrollments, graduations, reviewing CFT Plans of Care, system navigation, technical assistance, and trouble shooting. The CSAT will support the CFT when needs are identified that the CFT does not have the expertise to address. Only when this occurs will the CSAT become active in the case again. At that time, the appropriate member of the CSAT team will join the CFT and will act in consultation with the CFT to secure the most appropriate services for the child.

- The multiple screening, assessment and referral entities and processes introduce yet more handoffs of information about child and family and increase the likelihood of delay and miscommunication that could impede timely provision of timely, appropriate mental health services. The County is already having difficulty in completing MAT assessments within its 45 day time frame for completion. How will the County insure that these processes enhance mental health service delivery, not delay it?

County Response: *The duration of time needed to complete a MAT assessment has often exceeded the 45 day goal, but this delay has generally been significantly reduced with the recent advent of dedicated program staff (i.e., MAT coordinators) providing much needed program support and infrastructure. We anticipate further reductions in delays as the program's infrastructure strengthens over time and MAT providers gain more experience and become more proficient in their assessments. We feel that MAT has been an example of the need for specified staff to be dedicated to such support roles in order to reduce the delay in the provision of appropriate services to children and families and to ensure that linkages to services such as mental health have been successful. Additionally, the objective of the Referral Tracking System is to automate referral tracking and increase the timely delivery of services. This tracking system will be monitored frequently by CSAT staff and managers in order to detect areas in which services are being delayed so the barriers can be addressed individually and systemically. As to the example of MAT assessments, the MAT provider is able to provide services to the child and family once the need is identified, regardless of the status of the MAT Summary of Findings report.*

There are other areas of the Plan's screening, assessment and referral process where additional detail is needed to assess whether class members will be effectively assessed and provided appropriate mental health services. These include the following.

- If the Panel understands the County Plan correctly, the mechanism for identifying (screening) children suspected of having mental health needs other than through the MAT process is for CSW's to utilize the California Institute of Mental Health Screening Tool (MHST) for cases newly opened and not in foster care. Because of workload and liability concerns raised by the union, this strategy has not been implemented at this time. The Plan mentions implementation of CSAT as a way of reducing CSM workload related to referral and tracking, which is expected to reduce workload to some extent. However,

until and unless the union agrees to utilize the MHST, we do not find a strategy for screening non-custodial class members.

County Response: *The plan is for the CSW to screen non-custodial class members. Labor negotiations are currently underway with the union, and as long as the Department “meets and consults” in good faith, we currently see no reason why this will not go forward. The Department has a management rights clause that reserves the right to direct the workforce and to take other actions necessary to conduct its operation. The Department’s human resources manager believes the Department is within its rights to require CSWs to complete the CIMH MHST forms. The union may object and may take it to arbitration, however, it would be unlikely that an arbitrator would rule against the Department given that “meet and consult” sessions occurred in good faith and efforts are already underway within the Department to reduce workload in other areas. Moreover, a series of focus groups with DCFS/DMH staff are currently being planned to brief staff on the major components of the Strategic Plan. These focus groups will provide an opportunity for regional management and program staff to provide their feedback and any suggested revisions to address implementation obstacles or to amend the implementation timeline.*

- The County mentions that implementation of the tracking system may be impeded by federal SACWIS (data systems) regulations. If this does occur, what steps are planned to address workload issues with other strategies?

County Response: *The County continues to research how the Referral Tracking System can be implemented and will work with the State to try and resolve any conflict with SACWIS. However, if the County is not successful in building the Referral Tracking System as originally envisioned, the County remains committed to building a Referral Tracking System (primarily on the DMH side) to automate the tracking and completion of a child’s screening, assessment, and service linkage. The Referral Tracking System, even if not built as originally envisioned, will reduce and simplify the process required for DCFS children to be screened, assessed and linked to treatment as needed.*

In addition, the Caseload Reduction Workgroup is looking to reduce workload in three areas as described on pages 58-64 of the Plan in terms of reduced front-end referral rates and case openings; increased permanency and practice rates; and improved human resource practice and rates. Moreover, a comprehensive prevention initiative is underway through DCFS which enlists community-specific strategies to reduce the incidence of child abuse and neglect by providing supportive services before a family’s ability to care for their child(ren) necessitates the Department’s intervention, which should help to deflect new cases. Similarly, DMH through its Prevention and Early Intervention (PEI) initiative is aimed at curbing the onset of more serious mental health issues for key populations such as at-risk families, children and youth by mitigating risk factors/stressors and improving resiliency factors to promote greater well-being. Early intervention supportive services will be directed at children and families for whom a short, relatively low-intensity intervention is required to ameliorate mental health problems and avoid the need for more extensive mental health treatment. Collectively,

the community-based approaches employed by the two Departments should have a positive effect of diverting new cases from the child welfare and mental health systems that would otherwise enter care, if not for these interventions.

- A central part of the Plan involves the MAT, which are intended to provide a timely, comprehensive assessment of all newly detained children. Non-EPSTD eligible and non-custodial children, who would include class members in this status, are not eligible. We noticed that the Plan states that over 11,000 children per year are detained, all of which the County ultimately would want to receive a MAT assessment. To date, the County reports that more than 1,400 MAT cases have been completed over a multiple year period. How long will it take for MAT to be fully available in all SPAs? What will federal and non-federal costs be to achieve the objective of MAT assessments for all newly detained children? How will the County be able to fully implement MAT, as designed?

County Response: *Currently the MAT Program is in two SPAs and due to come up in two additional SPAs by October 2008. It is projected that there will be a department wide roll-out by the end of the fiscal year 2008-2009. MAT costs are estimated at approximately \$2,500 per child, of which \$2,000 are expected to be covered by EPSTD Medi-Cal funds and \$500 are non-federal. These non-federal costs are currently paid by DCFS. If these are applied to the approximately 4,500 new detentions per year, the total cost would be \$11,250,000. Approximately \$9,000,000 would be covered by EPSTD and the remaining \$2,250,000 would be non-federal costs. As currently envisioned, MAT will not be offered to non-custodial children. As these children remain with their parents, DCFS depends on the families' service providers to work with the children and their families to identify unmet needs and to procure the services to meet those needs. The CSAT will be available to CSWs in these cases and can assist families and providers with resources that the providers and families need assistance to procure.*

- Because MAT represents a significant investment of funds and due to the importance of assessment to matching appropriate services to class member needs, the Panel reviewed a small sample of MAT case files from three offices, followed by group interviews with local staff involved with MAT in those offices. County staff participated in the review, which was helpful to both the Panel and County. In our review we found that the assessments did provide a useful overview of child and family history and functioning. Local staff were enthusiastic about the value and potential of MAT and candid about barriers to implementation. The sample of cases was small; however the Panel found enough consistency among the barriers found to have confidence that they reflect a broader pattern of practice. Barriers identified were:
- Most MAT reports reviewed confused services with needs. That means that rather than identifying the underlying cause of a behavior, for example, the MAT report listed a service as the child's need, such as, "John needs mental health counseling." For the assessment to be useful in responding to needs, the team must first understand why a child is feeling or behaving in a certain way to select the appropriate service.

County Response: *As part of the application of the MAT administrative infrastructure/staffing, clinical performance refinements will be addressed. For example, coaching providers to begin to describe first, the needs of the child and then linking them to appropriate services, will be facilitated by DMH MAT clinical psychologists responsible for quality assurance. Likewise, securing more timely specialized assessment input will also be expedited by the same MAT DMH psychologists. DCFS and DMH meet monthly with MAT providers to address such training issues and will be emphasizing this aspect of quality assurance in upcoming trainings.*

- There did not seem to be much clinical depth on the MAT teams the Panel interviewed, resulting in a need to secure such expertise externally, which involves delays. MAT team members reported difficulty in securing more specialized assessment input, such as certain psychological evaluations or neurological exams in a timely manner. The County should describe how it will address the issue of timely access to key professionals needed to assess child and family functioning.

County Response: *Most of these specialized assessments have been delayed due to the lack of practitioners in these specialty areas that accept Medi-Cal. We anticipate that as MAT providers and MAT staff gain more experience, they will become more familiar and will build more relationships with specialized practitioners. This will reduce delays as well.*

- It appears uncommon for the child's teachers to be part of the MAT team, which omits a critical perspective about the child's needs and functioning.

County Response: *Yes, we agree the child's teacher should be a critical component of the MAT review. More outreach will be conducted to involve teachers in the review and to apprise school officials of their responsibilities through AB 490 - the Educational Rights Directive for Probation and Child Welfare involved children.*

- MAT team members reported that completing the MAT process often took longer than the County's target time frame (45 days), meaning that such MAT reports were received by CSMs, the family and court after the dispositional hearing. In such cases, the court's order/case plan would be unlikely to reflect MAT input. We heard that in a notable number of cases, service recommendations are tempered by what's available rather than what is actually needed by the child and family. If this is a frequent occurrence, the practice severely impedes the provision of appropriate and effective mental health services and is inconsistent with the CFT process. The Panel was also told that some judges place more reliance on the Dependency Investigator Report (DIR) than the MAT and sometimes enters orders without mention of MAT recommendations or knowledge of them. The County needs a strategy to address these issues. It also needs to have a process for assessing the effectiveness of initiatives like MAT so that barriers are quickly identified. The Department's intent to implement a qualitative review process will help in this regard.

County Response: *Since MAT originated as a pilot program, but is now being rolled out countywide there has been a lack of consistency at the Court in how MAT findings are used, when MAT reaches full-scale implementation and is a routine occurrence, the Court should develop a better understanding of the importance of MAT findings and how to incorporate them into the Court ordered case plans. MAT trainings for Court personnel are being considered in the future, so that the Courts fully understand the objectives of the MAT assessments. Some of the quality assurance issues mentioned above will be addressed by the MAT administrative staffing rolling out Countywide. Fidelity to MAT scope of work will be demonstrated by routinely measuring the completion of deliverables – health, education, developmental, dental, mental health, and others by applying a MAT quality assurance check list for every completed MAT case.*

- System coordination that lies outside the MAT process needs attention, especially promptly establishing Medi-Cal beneficiary status so the DMH EPSDT provider agency can be involved during the MAT process.

County Response: *Meetings are currently under way to further align DMH Revenue Management and DCFS Revenue Enhancement activities to begin to establish more responsive benefits establishment/maintenance operations. We plan to have Medi-Cal beneficiary status established as the case is being referred to MAT.*

- Respondents identified as a barrier the fact that MAT is not available Countywide, limiting the access of class members to a MAT assessment and confusing partners, like the court, about where the resource is available. The Panel believes that the Plan should address how class members will be fully assessed until MAT is available system wide.

County Response: *MAT is being rolled out Countywide on an aggressive timetable. MAT is currently available in SPAs 3 and 6 and will be operational in SPAs 1 and 7 by the end of October 2008. The rollout for SPAs 2, 4, 5 and 8 will be completed by the end of FY 2008-09. Implementing a separate assessment process for detained youth in offices that do not have MAT at this time would divert attention from the task at hand, which is supporting the rollout of MAT.*

- Although not raised by MAT members interviewed, the Panel believes that the MAT management team at the central office level does not have enough staff resources to continuously assess implementation in a manner that would permit barriers like this to be quickly identified and properly addressed. To assure that design and implementation challenges in the assessment and referral systems are regularly evaluated to determine if children's needs are identified and intensive home-based mental health services are provided quickly, evaluative systems like the qualitative review process should be in place. This is another area where a qualitative review process would be helpful.

County Response: *We agree that MAT central management does not currently have enough staff resources to continuously assess implementation and troubleshoot barriers. We also agree that a standardized qualitative review process is needed and should be in place. DCFS is currently requesting another position to assist in MAT management at the*

central level. To ensure the quality of the MAT assessment, DMH is currently hiring one MAT psychologist per SPA to take on the role of quality assurance for the MAT assessments. DMH is also hiring one MAT Coordinator per SPA to assist with trouble shooting any MAT related issue. It is anticipated that these staff will help synchronize the implementation of MAT countywide.

The Panel believes that the Plan should describe how barriers such as these would be addressed.

2. Team Decision Making

For the delivery of appropriate mental health services to be effective, it is important that there be a central point of control and case management, coordination of action and clarity of role. Because the Department is planning to implement child and family teams to assume this central role as part of its Plan, a step the Panel commends, it will be important to ensure that the TDM process does not contradict or substitute itself for the legitimate role of the CFT process as we have seen in other jurisdictions. We would like to see the Plan clarify how these overlapping roles will be managed.

CFTs must be designed, in addition to engaging the family, to understand the child's mental health needs, tailor services to meet those needs, and provide support for the family/kin/foster/adoptive family to meet the child's needs. CFTs must be regularly evaluated for effectiveness in defining and meeting children's needs, flexibly altering those services in response to the changing needs and adapting supports necessary for the family to meet the child's needs.

County Response: *Currently, TDM and Wraparound work well together. There is a clear understanding that TDM is a process for placement decisions and the Wraparound is the overall planning process for the youth and family. When a DCFS Wraparound youth is experiencing a potential placement disruption, the Wraparound Team comes to the TDM as an active participant. Although it may seem to be redundant, or have the potential for contradiction, the Wraparound providers have found the TDM process to be very beneficial. We are planning for the same collaboration to take place for the planned expansion of Wraparound. Additionally, with the implementation of RMP we expect it will make the process even more collaborative because we envision the same facilitator who oversees the enrollment in Wraparound to also oversee any future placement disruptions while in Wraparound.*

3. Resource Management Process

Has the County assessed the projected workload, including the volume of referrals for the RMP and CANS process related to staff capacity? How does current capacity compare with expected demand?

County Response: *We did a projected analysis based on the current placement moves and number of children in residential care. Both DMH and DCFS hired additional staff to handle*

the projected use of RMP and believe we have the appropriate staffing and infrastructure to handle the need. We will be utilizing all of the Department's TDM staff (76) for the RMP.

4. Mental Health Service Delivery

DCFS and DMH are collaborating to ensure that thousands of children with mental health needs will be provided with intensive home-based services and their families/kin/foster/adoptive families will receive the support they require to meet the children's needs and prevent them from being removed. Much of this new expansion is directed toward class members needing intensive services, targeting a population identified by the County, plaintiffs and Panel as conservatively estimated at 2,500 children. The Panel believes that this initiative, while only based on a conservative estimate of need, will constitute an important step in implementing the Settlement Agreement. If the attention to screening and assessment outlined in the Plan is effectively accomplished, the Panel expects that process will identify additional children who need both intensive and less intensive mental health services.

In regard to the approach proposed for mental health service expansion, the Panel has the following questions and concerns.

- The Panel believes that the Plan should clarify the link between the intensive home-based mental health services expansion and new resources like Treatment Foster Care, the Comprehensive Children's Services Program, MTFC and others.

County Response: *The Plan does discuss the connection, albeit briefly, on page 39 of the Plan. Several of the Evidence Based Programs (EBPs) such as MTFC, MST, and CCSP do not employ a CFT as described in the plan. At this point in the planning process, the CFT would take a secondary role with respect to treatment planning/delivery if it was decided that an EBP would best meet the needs of the child rather than the CFT service provision. The CFT is only being employed for Tiers 1-3 Wraparound services using the SB 163 Wraparound program (tier 1), the new step-down service provision slots (tier 2), and the lowest acuity level service provision within the continuum (tier 3) consisting of 749 augmented Full Service Partnerships (FSP) slots.*

- While the three tiered approach will rely on Wraparound and Full Service Partnership providers as a starting point for expanding services, the Panel sees no strategy to transition the large numbers of providers engaged in conventional office-based therapy to practice consistent with the proposed home-based mental health practice approach. It appears to us that you risk operating in two practice cultures which have different perspectives about child and family needs. Additional description of the strategy for changing provider practice for children with less intensive needs is essential.

County Response: *While the focus of the Plan is clearly on more intensive-level services, the Plan establishes a fundamental culture shift in the County's approach to providing services to class members. Both specific features of the Plan, such as universal screening and assessment, and less quantifiable features, such as training of staff in core values and the co-location and informal teaming of DCFS and DMH staff, should help promote*

consistency of service philosophies across the existing and newly planned service spectrums. Additionally, as the Plan will embody a more clearly articulated philosophy and vision for the provision of children's mental health services, it will control the County's other work in this area. Specifically, the Plan's service approach will guide the upcoming expansion of less intensive services under MHSA, (such as field capable clinical services, prevention and early intervention services, and activities associated with the Workforce Education and Training (WET) initiative), refinements to the County's performance-based contracting process, changes to the County's service of probation youth and the infusion of training, coaching, and mentoring opportunities that embody the vision of mental health service delivery contained in the Strategic Plan as well as a trauma-focused perspective. (We plan to provide you with an opportunity to discuss some of these other initiatives when you next visit the County.) Last, many of the same agencies who will be funded to provide the three tiers of intensive services, or have significant relationships with agencies that provide these services, should impact the less-intensive services. Therefore by working with, and training these agencies on the provision of intensive services, the philosophies of such services should be extended to the provision of less-intense services.

- We encourage you to include specific strategies to create an effective response to the trauma needs of children and supports required by their families and caregivers throughout the service delivery system. We only see a reference to this regarding FSP programs, not the rest of the service network.

County Response: *Trauma based services are incorporated in the CFT continuum and will be available across all tiers. Discussions are underway with CIMH to contract for curriculum development pertaining to a holistic system of care for children and families, as well as one for trauma-based services. DCFS, DMH co-located staff, and providers will receive training in these two arenas, which will be integrated into the overall CFT training as well as across the mental health service delivery continuum.*

- Additional description of the intent to develop CFT/practice model coaching capacity is needed. Developing internal coaching capacity is a complicated and intensive process and it would be helpful to know how you have conceptualized it. Financially, what level of resources do you plan to commit to training and coaching development in this area?

County Response: *The financial commitment for training and coaching is roughly \$1 million a year, which would have to be approved each budgeting cycle by the Board of Supervisors. As discussed on pages 51- 53 of the Strategic Plan, the coaching and mentoring portion is the cornerstone and most ambitious aspect of the overall training plan. The four integral phases for the CFT process will be consistent with the four Wraparound phases of: 1) engagement and team preparation; 2) initial plan development; 3) implementation; and 4) transition. The coaching/mentoring curriculum has not been conceptualized in detail as the County intends to contract for this service as discussed on page 53 of the Plan.*

- The Plan references the difficulty of claiming some vital support services under Medi-Cal rules and regulations. We are pleased to see that you have approached the State about creating more flexibility in the California Title XIX Plan and/or State regulations. In the event you are not successful, we would like to see a provision for the use of flexible funds to cover some of these costs.

County Response: *As you can understand, the County is constrained in providing additional flexible dollars as the proposed investment for intensive mental health services is substantial as discussed on page 46 of the Plan. We will continue to work closely with the plaintiffs' attorney in the case against the State, as well as develop our own legislative, regulatory, and administrative proposals to seek greater flexibility from the State to maximize Medi-Cal funding. We recently received a response from the State that they are willing to meet with DMH to address the funding issues raised in the Department's July 17, 2008 letter.*

5. Financing

Making maximum allowable use of available Medi-Cal dollars will be important to the implementation of the CFT approach. The County has referenced additional training of providers in Medi-Cal claiming, intended to clarify claimable activities and provide guidance in how claimable activities should be described and documented. Has this effort increased Medi-Cal claiming for Wrap providers who were found to be under-claiming? If not, what action will the County take to address this issue?

County Response: *DMH recently concluded Wraparound training in June of this year and another training is planned for October 29th with the providers. At this point, it is too early to ascertain the impact on billing practices. However, a 6-month pre and post-test training comparison could be conducted to determine provider billing for a period of time prior to and after the trainings. Based on the results of this exercise, corrective actions could be formulated, if warranted, to enhance eligible billing practices.*

6. Training

The County has described a model for the content of its practice and the training to support it that is very consistent with the Panel's past recommendations. The Plan has an expanded focus for preparing DCFS staff on their role in responding to the needs of class members and also acknowledges the need for hands on coaching of staff in the field. Panel recommendations to the County on training have emphasized the need to develop staff skills in core areas needed for class members, including strength-based approaches, team-based practice, the assessment of underlying needs, and individualized planning.

The Panel hopes that the County training approach, which is at this point described only generally, is highly focused on practice skills. At the moment, much of the training proposed seems focused on procedural matters, such as the functioning of CSAT. The Plan provides little description of how providers will be trained to serve children in the home-based approach, either

through formal training or coaching. Almost no attention is paid to training related to providers serving children who don't need intensive services.

The Panel has recommended that DCFS describe how its training will be coordinated or linked to DMH training, particularly in relation to the Mental Health Services Act component, Workforce Employment and Training. Such linkage is a strategic opportunity to achieve and sustain the level of skill development of County and contract agency providers who will deliver the mental health services to class members.

County Response: *The financial commitment for training and coaching is roughly \$1 million a year, which would have to be approved each budgeting cycle by the Board of Supervisors. As discussed on pages 51- 53 of the Strategic Plan, the coaching and mentoring portion is the cornerstone and most ambitious aspect of the overall training plan. The four integral phases for the CFT process will be consistent with the 4 Wraparound phases of: 1) engagement and team preparation; 2) initial plan development; 3) implementation; and 4) transition. The coaching/mentoring curriculum has not been conceptualized in detail as the County intends to contract for this service as discussed on page 53 of the Plan.*

7. Caseload Reduction

The County states in its Plan that while caseload reduction is not a mandated component of the Settlement Agreement, the County and Panel “view reduced caseloads as a vital objective necessary to execute the objectives of the Katie A. Settlement Agreement and subsequent orders.” Recently, the County has provided more detail about its caseload reduction efforts, which the Panel was pleased to see. In that plan the County projects reducing Emergency response and generic caseloads by fifteen percent in a three year period.

The Panel agrees that reducing caseloads will have an important impact on improving the provision of appropriate services to the plaintiff class. While data from the County on the plaintiff class are not yet available, in other systems, children in foster care with mental health needs have poorer outcomes than the child welfare population as a whole. Children with emotional/behavioral problems are more likely to experience placement disruptions, placement in restrictive congregate settings, poor school performance and longer stays in care. Serving such a population takes more time in monitoring progress, adjusting interventions and seeking resources. Children that are unstable are also likely to need more frequent contact and attention. While for children with intensive mental health needs the County's Plan projects the availability of services to be delivered by specialized providers, children whose needs do not rise to that level will still need more attention from DCFS staff.

The Panel has communicated some of its ideas for caseload reduction, which the County believes are not appropriate for Los Angeles County at this time. The Panel continues to doubt that County plans are expansive or intensive enough to provide sufficient time and cost savings to enable front line staff to adequately meet the needs of class members. At this point we recommend that the County provide regular updates on the impact of the proposed workload reduction strategies so we can mutually assess the results of this portion of the Plan and its effects on the plaintiff class. If additional approaches are found to be needed to generate

additional cost savings within the waiver or in County expenditures, the Panel will be happy to describe approaches found successful elsewhere.

County Response: *The County agrees to provide the Panel with regular updates evaluating the impact of the caseload reduction strategies articulated on pages 57-66 of the Strategic Plan.*

8. Data/Tracking of Indicators

The Panel is encouraged to see the development of an automated mental health tracking system that will provide important data about the utilization of mental health services by class members. However, completion is not expected until January 2009, meaning that the Panel and court must continue to wait to determine the extent to which implementation of the settlement is producing expanded mental health service delivery for class members and improving their outcomes. Data from the interim approach, tracking the progress of the Proxy Class, are not available either. Until the new automated system is complete, the Panel recommends that the County provide data on the Proxy Class in time for it to be included in its next report to the court.

County Response: *The County is in the process of preparing an update to the November 2007 data submission on the proxy class encompassing the Catherine Pratt indicators (with the possible exception of indicator 21 as data inconsistencies relating to psychiatric hospitalizations are being reconciled), however, the next data submission will be on the entire child welfare population and cover FYs 2002-03 through 2007-08. We anticipate having this data available for the upcoming Panel retreat in October.*

The Panel is also pleased to see recognition by the County that clinical treatment utilization management is a key component of monitoring and planning the overall system developments. Utilization Management is the vehicle through which the County ensures that children receive quality, cost effective services in the most appropriate treatment setting, in a timely manner and that there is an effective mechanism to manage the utilization of clinical/mental health treatment resources.

The description of the capacity and functioning of this system infrastructure is, however, lacking specificity and the service tracking information technology systems described under the Coordinated Service Action Team (CSAT) are not in place. Additionally, there needs to be a more explicit description of the relationship between the development of the Cognos Cube and the proposed service referral tracking system.

County Response: *SACWIS regulations have complicated the development of the Family Centered Services Referral (FCS) Referral Tracking System, and it appears that the development of the FCS system could likely be considered duplicative of CWS/CMS. Alternative solutions to the FCS are discussed on page 21 of the Strategic Plan. In order not to slow down the production of data, the short-term solution proposed (number 2) to track service receipt would entail uploading tagged special projects fields from CWS/CMS to DMH on a regularly scheduled basis, so as to provide one-line dispositional reports on an individual client's service linkage. While the longer term solution (number 3) would consist of building a tracking*

application and database on the DMH end, which would routinely download DCFS data to provide a more comprehensive tracking and case management system of class members.

Until the requested funding to hire contractors is in place and the business rules for developing such a system and IT architecture are developed, specific functionality cannot be articulated for the proposed system. At the point contractors are hired and the business specifications are being contemplated, then detailed discussions concerning functionality and capacity could occur. It's important to remember that the cube is a querying and reporting application; the cube provides for canned reports and would enable managers from both Departments, with some viewing restrictions dependent on each Department's respective confidentiality provisions, to conduct their own queries and data reports. The cube should be able to provide reporting capabilities for any given database as long as the basic IT requirements are present.

There is a current capability using the Cognos Cube to produce a comprehensive analysis of the mental health service delivery system for children in child welfare served by the mental health provider system. This analysis should be a priority and should be completed by January 1, 2009. This would provide the County and the Panel with a baseline for understanding the capacity and resource issues. Without this information, it is almost impossible to determine if the appropriate resources are being designed, developed and reconfigured to meet the needs of the member class.

County Response: *The data submission under development for the October Panel retreat, particularly the last three "Catherine Pratt" mental health indicators begin to address these concerns. Once this data is available, more earnest discussions concerning mental health capacity and resource issues can commence. DMH has recently hired two of the three staff requested to produce and analyze data on a regular basis. These staff members are currently being trained and will soon be able to create Cognos reports and analyze the data. Additionally, DMH has identified another staff member who will be able to assist part-time in the extraction of data from the cube and this service mapping task will be first priority.*

9. Exit Criteria and Formal Monitoring Plan

As mentioned previously, the Panel is pleased to see the County's commitment to using a qualitative review process as part of its quality improvement efforts and as an element of exit criteria. The Panel believes that use of a quality review process is vital to measuring not only if efforts to improve services to class members are working, and if they aren't, why not? For example, if a qualitative review process were in place, the County would have learned quickly if the MAT process was working as intended. Likewise, such a review process would inform the County about the effectiveness of other strategies, such as screening efforts and use of new mental health service approaches.

We are also pleased that the County agrees that a three-tiered process, qualitative measurement, completion of a Strategic Plan and positive outcome indicator trends, should be the basis for an exit design. We look forward to working with you to design that important task.

VII. Panel Recommendations

The Panel appreciates the County's attention and responses to the issues it raised in prior feedback about the Plan. The Panel notes that the County concurs with some of the Panel's recommendations and agrees to address them. However, several concerns about the Strategic Plan remain and those are expressed in the following recommendations.

Mental Health Screening The Panel continues to believe that the multiple layers of organizational units and processes involved in the screening and tracking process could increase miscommunication and delays in providing timely services. The Panel recommends that the County begin tracking the timeliness of service initiation from the date of screening to assess how quickly services are actually delivered. Once the QSR is implemented, it would provide valuable information about the issue of coordination and effective information sharing.

The Panel continues to have concern about the access class members living in their own homes will have to screening, given the impediment of the union's concern.

MAT The Panel is not convinced that an expanded infrastructure will solve the problem of delays in MAT completion. It will be critical for MATs to be completed in time for them available for consideration by the court prior to disposition if they are to add value to the development of child and family plans. The Panel recommends that the County report quarterly on the number and percent of MATs completed within 45 days and the number provided to the court prior to disposition. The Panel also plans to conduct periodic MAT reviews to assess qualitative issues, especially the confusion between needs and services and the tendency to limit identification of needed services to that currently available. This is another area where the QSR will provide valuable feedback.

Mental Health Service Delivery The Panel believes that more targeted strategies are needed to change the practice of traditional, office-based mental health practitioners and recommends that the County identify specific steps it will take to convert the practice of this group of mental health professionals to a "Whatever it Takes" approach.

Workload Since workload reduction strategies are now part of the Strategic Plan and since several other strategies are dependent on reduced workloads, such as employing TDM's in additional case events and using case managers to provide mental health screening, the Panel recommends that the County regularly track caseload ratios to determine the progress of proposed strategies and share these reports with the Panel.

Provider Practice and Training In its earlier comments about the Plan, the Panel noted that it saw little in the way of strategy to change provider practice and especially clinical practice outside of the intensive service initiatives that are at the heart of the Strategic Plan. Many children will continue to receive conventional office-based therapy, including children needing more intensive services. The County responds that efforts like universal screening and assessment, co-location, a more clearly articulated philosophy and vision for provision of services and other efforts will somehow affect provider approach and practice.

Data In the Panel’s November meeting with the County, further discussions were held about data issues. The County provided a recent trend data report that included information on the total DCFS caseload and mental health usage. This report is promising in demonstrating what the DCCS and DMH data systems can provide about the experience of children served by both systems. The Panel requested the same information relative to the proxy class. The Panel and County will meet again on December 18, 2008 to determine the specific data trend requirements necessary to assess progress of Katie A. class members. Pending that meeting, the Panel has no further recommendations at this time.

VIII. 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