# The Katie A. Advisory Panel
# Third Report to the Court
# September 30, 2004

**The Katie A. Advisory Panel**
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## I. INTRODUCTION

The following report outlines the evaluative efforts undertaken by the Panel since the last report, its conclusions about system performance to date and an update on performance indicators that can serve as an additional basis for determining the progress made by the Department in the future.

At this point in the Panel's work, we have a number of deep concerns about the Department's progress toward achieving the objectives of the settlement, which include:

- Except for a general plan for Wraparound improvement, which the Panel found insufficient to achieve the objectives of the plaintiff class, the Panel has not received plans related to the objectives that respond to the Panel's directive about plan specificity and depth;

- A lack of appropriate and accessible Wraparound and mental health services needed by the plaintiff class;

- Frequent placement changes, especially for older children and youth, without the provision of appropriate services to prevent such placements;

- Overuse of costly and unnecessary congregate placements, as opposed to family based placements, for younger children and youth;

- Lack of effective prevention services that avoid placement in foster care by helping families retain their children safely in their own homes;

- Lack of permanency for children;

- High workloads and caseloads among front line staff;

- Lack of appropriate training of staff to deal with the needs of the plaintiff class; and

- Front line practice that is unable to use engagement, assessment and individualized planning to consistently respond to the challenges experienced by children and their families.

## II. BACKGROUND

This is the third report to the court and addresses additional unmet needs of the plaintiff class, training, data and outcome indicator tracking and actions of the defendants to date.

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

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

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

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

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

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

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

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

- improve the consistency of DCF'S decision making through the implementation of Structured Decision Making;

- expand Wraparound Services;

- implement Team Decision Making at significant decision points for a child and his/her family;
- expand the use of Family Group Decision Making;
- ensure that the needs of members of the class for mental health services are identified and that such services are provided to them;

- enhance permanency planning, increase placement stability and provide more individualized, community-based emergency and other foster care services to foster children, thereby reducing dependence on MacLaren Children's Center (MCC). The County further agrees to surrender its license for MCC and to not operate MCC for the residential care of children and youth under 19 (e.g., as a transitional shelter care facility as defined by Health & Saf., Code,§ 1502.3). The net County cost which is currently appropriated to support MCC shall continue to be appropriated to the DCFS budget in order to implement all of the plans listed in this Paragraph 7.

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

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

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

- determine whether the County has carried out the plans;

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

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

Additionally, the Settlement directs that:

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

## III. PANEL ACITVITIES SINCE THE FIRST REPORT

Since the last report Panel activities have included:

A review of the placement of young children in group and congregate settings
A meeting between the Panel's consultant on data and outcome indicator tracking and DCFS staff
Conference call with training staff
Meetings with Dr. Sanders and staff
Interviews with D-Rate home providers
Review of DCFS documents about initiatives underway

Unsuccessful attempts to visit class members placed at Metro
Observation of New Initiatives
Organization of David Ambroz's interviews with class members

## IV. DCFS EFFORTS

The following section reflects the progression of Panel analysis that occurred over the past several months, concluding with Panel observations of some new, promising small initiatives, recently revealed to the Panel, and observed several weeks after the draft report was provided to the parties.

At the Panel meeting in July 2004, Dr. Sanders expressed surprise that the Panel had not been receiving reports about several DCFS initiatives relevant to the class. Specifically, he mentioned and said he would provide more information about (and that we should observe in DCFS offices):

Medical Hubs (on which $5 million in MacLaren funds are being spent)
Mental Health Assessment
Permanency for Teens ($1 million in MacLaren funds are being spent for older youth to seek families)
Concurrent Planning ("substantive, structural change to reduce time in care and increase stability")
Consistent use of SDM
Full implementation of TDM prior to detention
Strength-based training (to change the culture within DCFS about working with families; being demonstrated in SPA 4)

In a follow-up call with the Panel, Dr. Sophy indicated that the Medical Hubs and Mental Health Assessments were being implemented in several sites. We are still awaiting written descriptions of these initiatives. In a follow-up mailing to the Panel on July 30,2004, we were provided with reports in the following areas:

Family Unification
Permanency
Prevention
Permanency (AB408)
Wrap report

If Dr. Sanders' written response to this report is received before the report is mailed, it will be inserted as information.

### a. Report of the Family Reunification Committee of DCFS and the Commission (undated)

The committee said it focused on five areas of concern:

- Length of time in out-of-home care. Only a third of LA County are reunified with their families within one year of removal, in comparison to the national average of 76%; average time in out-of home care in LA is 24 months.
- Number of children in out-of-home care. (about 26,000) Necessity of DCFS to define reunification goals.
- Disproportionate number of African American and American Indian children in out of home care. About 10% of the population of LA county is African American but 45% of children in out-of-home care are African American.
- Necessity of enhancing the frequency and quality of visitation between children in care and their families
- An estimated 70-90% of all child welfare cases are impacted by substance abuse

What followed this list were procedural outlines although it was unclear whether they were being recommended or implemented: (1) Placement Decision-Making (using SDM and a Family Centered Team in each office to establish intensive care services in the first 90 days; regionalize emergency response); (2) Reunification (define DCFS goals; work with community resource specialist so reunification can happen); (3) Parent-Child Visiting (visit plan; immediate visits at least weekly; training); (4) Court (respect from judiciary; timely reports from DCFS including strengths and needs; non-adversarial approach by attorneys; training); (5) Community-Based Intensive Services (community resource specialist in each office; DMH should serve on Family Centered Teams and provide services for trauma, anger management, substance abuse, and young children; requirements for family preservation programs); and (6) a list of data elements.

This outline from Family Reunification Committee of DCFS and the Commission is not a plan. It consisted of ambitious general goals without any implementation strategy. The needs of class members were not indicated, and other than to say DMH should provide more services, the Community-Based Intensive Services section neither specifically defined what services, the amount or location nor what role DCFS contractors and DMH would play in expanding care for emotionally disturbed children). If any of these are seen by DCFS as compliance with Katie A., the Panel will have to review a specific plan with details on implementation.

**b. A Plan for Increasing Permanency for LA Foster Youth (3/18/04)**

Nearly 8,500 DCFS youth age 14 and older are in out-of-home care: 37% live in foster homes (FFAs-1652; county homes-1441), 34% with relatives (2892), 10% in guardian homes (867), and 18% in group homes (1489); an additional 224 are in adoptions caseloads. Of these DCFS youth age 14 and older in out-of-home care, 26% are from SPA 6, 21% are from SPA 3 and 16% are from SPA 8. For youth living with relatives, 37% had been in placement 10 years or more and 25% for 5-10 years. There is a backlog of 3000 children waiting for adoption. There is controversy about permanency definitional issues, but most agree that every foster youth needs a lifelong relationship

with a caring and committed adult. The "prevailing mindset," beliefs that youth don't want to be adopted or that families don't want to adopt them, was seen as a major barrier. The reduction in support services to foster parents and relatives who choose to adopt or become guardians was also a significant barrier. The importance of different strategies for achieving permanency for youth with relatives, foster homes, and group homes was recognized. MAPP goals include monthly transition to legal permanency 2% of children in foster care and adopt 15% of these children. A Youth Permanency Initiative was proposed, using retired case workers and others to assist in connecting youth with families, including doing intensive relative searches which have been successful elsewhere.

It is unknown to what extent this proposed plan for increasing permanency among DCFS teens is going to be implemented. It does not propose specifically how the "prevailing mindset" against permanent homes for teenagers will be changed. The needs of class members were not indicated, nor how sufficiently intensive services to support permanency for emotionally disturbed children and youth would be developed. If this plan for permanency for teens is seen by DCFS as compliance with Katie A., the Panel will have to review a specific plan with details on implementation.

**c. Plan for the Implementation of Assembly Bill 408 (caring connections for LA foster youth), 6/1/04.**

Described as complementing the findings contained in the above report, this document lists the intent and key provisions of AB 408. It defines the characteristics of a committed, caring person, the safeguards that should be considered in the selection or approval of this person, and the role of this person in the life of a DCFS youth. It spells out the obligations of DCFS if a caring, committed person is not identified for a young person. "Marketing strategies and funding and support options" are briefly described.

Perhaps of relevance to the Panel, this document lists seven general training requirements (apparently for DCFS staff, foster parents, judges, attorneys and mentors) so these individuals "believe that creating these opportunities and connections for children and older youth is possible, and that these connections could ultimately provide options for permanence."

If the definitions or training requirements are seen by DCFS as compliance with Katie A., the Panel will have to review a specific plan with details on implementation.

**d. Preventing Child Maltreatment: A Comprehensive Plan for a Continuum of Family-Centered Community-Based Prevention and Intervention Services for Children, Youth and Families in LA (7/19/04)**

This work group, convened by DCFS and the Commission at the request of the Board of Supervisors, convened representatives of over 60 organizations. The goal was "to develop a broad-ranging strategic plan to coordinate efforts to reduce child maltreatment and

assure the safety and well-being of children, youth and families." Its recommendations were:

1. Fund, organize and integrate first, second and third prevention resources in a neighborhood setting to focus on at least eight high-need geographic communities and on at least one other non-geographic community where children are at high risk for child maltreatment (e.g., American Indian; Asian/Pacific Islander; pregnant and parenting teens in foster care). Focus on communities where disproportionate numbers of children of color are involved with the child welfare system.

2. For families at risk of abuse and neglect who have not come to the attention of DCFS, build on existing community-based partnership coalitions to provide supports.

3. For families whose cases are determined to be "inconclusive," use a Team Decision making process that engages families in a family-centered approach to identify strengths and needs.

4. Develop a Family Unity approach to third level prevention to (1) reduce the cause for the separation; (2) achieve accountability for child abuse offenders; and (3) strengthen families who are at-risk. Enhance the existing interdependent multi-disciplinary approach based on early intervention via prosecution of cases involving physical and sexual abuse and severe neglect of children.

5. Develop a Charter Foster Home Development Program to improve the foster care program to develop specialized foster homes for children and youth who have exhibited behaviors that put them at high risk for recurrence of maltreatment, delinquency and homelessness.

6. Develop a plan for funding the Comprehensive Child Maltreatment Prevention Plan that includes: (1) identifying and linking existing public and private sector funding that can be used to provide the recommended preventative services and supports; (2) expanding the range of prevention solutions that can be funded through an approved Title IVE Waiver; and (3) pursuing policy and legislative changes at the local, state and federal level to enhance funding for prevention services.

The report describes prevention efforts adhering to "the principles of family support practice that now guide the delivery of health and human services to children and families in LA County [including] accountability, dignity and respect, cultural competency and training," although these are general goals which there is no evidence are actually being achieved. Furthermore, data to support Family Unity or the Charter Foster Home Development Program are not presented, and they are not compared to the nationally recognized evidence-based Treatment Foster Care or

Multisystemic Treatment methods the Panel has encouraged. If any of the six prevention recommendations are seen by DCFS as compliance with Katie A., the Panel will have to review a specific plan with details on implementation.

**e. Wraparound Services (6/16/04)**

This 5-page summary of recent Wraparound information clarifies that 68% of the referrals are from DCFS (it is unknown how many of the currently served 415 families are DCFS clients). Wrap is described as having a capacity of 466 families, but why it is not at capacity nor when that capacity is expected to be larger is not addressed. When two groups of children were compared six months after DCFS jurisdiction was terminated, 34 of the 46 children not receiving

Wrap had come back to the attention of DCFS while eight of the 46 children receiving Wrap had come back to the attention of DCFS (the comparison group were RCL 12 child with similar characteristics to the Wrap clients). In another follow-up, twelve children who graduated from Wrap were tracked for one year, during which time one came back to the attention of DCFS. In a review of 103 active Wrap cases, 40% had been in the program for more than 12 months. The mean stay of a group of 18 graduates in Wrap was 13 months, which was described as better than the national average (18 months in Wrap, no citation).

The Panel commended the Wrap program for compiling this information, which reflects some achievements by the program. Katie A. requires an expansion and improvement in quality in Wraparound services, so the Panel has to review a specific plan for expansion and staff training in Wrap. A breakdown of DCFS children and families in Wrap by SPA, the specific services they receive (including mental health and school placement), whether the child is living with parent, relative or foster home, and whether the child started and has remained in the home or Wrap supported a transition from residential to a home or from a foster home to a family home would be a more useful analysis for the court.

**f. Family Centered Team Decision Making**

At the end of May 2004, the Panel was emailed a 4-page draft entitled Implementing Family-Centered Team Decision Making, LA County. The document describes traditional Team Decision-Making as a placement disruption meeting of professionals with little or no input from the family (about which the Panel has raised concerns from the beginning because of the original DCFS plan to expand the use of TDMs). The document proposes instead a new approach for DCFS, Family-Centered Team Decision-Making, as a mixture of the strengths of the varied approaches to engaging families in Wraparound,

Children's System of Care, Family to Family and Family Group Decision Making. All of these efforts embrace the principles of being child focused, family centered, strength based, need driven, community based and culturally relevant. Distinct from these

approaches, however, the proposed DCFS Family-Centered Team Decision-Making avoids the use of an independent facilitator, which the Panel had cautioned reduces the number of meetings that can be held and the integration of the family engagement and strengths/needs-based principles to child welfare staff.

The document encourages the use of team decision-making by anyone, including Emergency Response workers, Family Maintenance/ Family Reunification workers, community based partners and family members: "FTDM is intended to become a routine method of assessing needs and planning for all children and families, beginning from the first call into the hotline and throughout the life of the case. Further, FTDM meetings should not be used only for placement disruptions or emergencies, but rather as a routine practice of continuously engaging the family to help anticipate and resolve crisis situations..."

The Panel supports this proposed definition of the new DCFS Family-Centered Team Decision-Making and description of its function throughout the life of the case. It is the experience of Panel members who have assisted child welfare systems in changing practice to include family meetings of this type that the rewards for families and workers are immediate, but helping case workers and supervisors have the confidence they can facilitate strengths/needs-based service planning meetings requires an enormous training and coaching effort. The training must be done by an individual who has led these meetings. Each worker must be coached as they lead a meeting. In the process, staff learn the complicated skill of how to identify the underlying needs connected to child safety, attachment and behavior. They also learn how to help a family and professionals collaborate in designing individualized services that will support the family and foster family in meeting the child's needs and building on the strengths of the family.

Has the draft concept paper been finalized since May? Is the DCFS Family-Centered Team Decision-Making being implemented? Is there an implementation plan for training and supporting staff to use FTDMs in their cases?

**Observation of Pilots and New Initiatives**

***Mental Health Assessment***

DCFS is piloting Multi-disciplinary Assessment Teams (MAT), designed to provide mental health assessments of children within 30-45 days of removal for use in case plan development. DCFS is collaborating with DMH and community mental health providers to do these assessments, in consultation with social workers and family members, to identify a child's mental health needs and recommend placement, treatment plans and educational strategies to address them. With the assistance of the medical/mental health hubs, the MAT provider would then be expected to identify and link the family to the appropriate treatment resources.

The Panel met with a private provider, Shield for Families, that operates numerous substance abuse and family service centers as well as family preservation program, a vocational center, and many units of low income housing. They described their mental health/substance abuse assessment done on a laptop computer by a social worker in the home as the DCFS worker is deciding on whether to remove the child. To date in this pilot project in Wateridge, they have seen many removals prevented by the assessment and immediate referrals of the family to services. They are also working with the MLK Hub and in the Point of Engagement project in Compton where they emphasize a family-centered approach to identifying needs and family-preservation hybrid of mental health and substance abuse services. Shield was described as a unique agency in offering a continuum of care using a variety of child and adult sources of funding. DCFS is waiting to study the outcomes of the mental health assessment pilot in several sites before deciding whether and how to expand it.

The Panel was quite encouraged by the outcomes Shields has been able to achieve. It appears that this agency, through strong leadership, has been able to implement the family-centered practice model with a high degree of fidelity. When asked what differentiates Shield from the other agency, which are not doing so well, the following characteristics of practice were identified: (1) They join the clients' world rather than forcing the client to join theirs; (2) They stand beside the client rather than above or behind; (3) They are culturally responsive and relevant by hiring clients as service providers; (4) They develop partnership with the client in developing the service - high levels of voice and choice for the client; (5) They promote services that are meaningful and practical to everyday life; (6) They go to where the client is rather than ask the client to come to them; (7) They ask they client what they need and let the family drive the process; and (8) They focus on meeting needs rather than pathology. Taking these principles to scale will be very difficult as the department does not currently have a resource plan or an articulated robust model. There is no training plan, quality review process, or utilization process to ensure uniformity and consistency across agencies.

***The Hubs***

Medical/Mental Health Hubs: DCFS has identified five medical centers located throughout the County that will serve as medical/mental health hubs for DCFS children. Each hub will provide forensic medical and mental health assessments 24 hours per day, 7 days per week in order to better inform us about a child's medical and mental health needs prior to making placement or services recommendations. The first hub has started, and DCFS is negotiating with other sites.

DCFS arranged a visit to the impressive Hub at County-USC Medical Center

that DCFS is funding to expand mental health care for children especially in group care, foster homes, and at the point of removal (they operate a 24 hour forensic medical assessment for children). They intend to blend up-front assessment with ongoing mental health services. They now have five pediatricians and an enlarging mental health staff and DCFS will be co-located.

While at Shield for Families, the Panel heard from a DMH staff person about the vision for the MLK Hub's front end assessment process to direct DCFS children to the appropriate mental health services in a timely manner. The HUB concept appears to focus management, provide a central location for coordination of multi-agency efforts, and has the potential to ensure continuity of model development. Like other efforts it is in pilot stage and there is no systems plan for bring the initiative to scale. This effort has tremendous potential but it is dubious to the panel how it will be support without it being linked to a large system reform effort aimed at redeploying financial resources from other parts of the system.

***Compton Project***

Eric Martz is a dynamic and inspiring DCFS leader in Compton and the admiration and respect that staff have for him and for each other is exceptional. His leadership team and front line personnel are enthusiastic about the Point of Engagement Service Delivery System. They are excited about their success at serving children and families in the home in lieu of utilizing placement: removals in one recent month were reduced by 90%, from an average of 40 to 4. Family engagement, through Child Safety Conferences, at the earliest possible stage of a case, and throughout its life, is a shared value and consistent practice in their project. Cases are transferred between workers quickly and seamlessly by imparting, in person, as much information as possible about the family and children, usually in their presence. A new initiative is finding family-based solutions for the children who have been in foster care for extended periods of time. The leadership at Compton is committed to engaging the community in its work, such as the agency's development of a network of community supports, including significant contributions by many dozen "faith-based" communities, and a community-based steering committee.

***Progress with DMH***

The Panel requested a meeting with Susan Kerr at the Department of Mental Health. She and Dr. Sophy (the DCFS Medical Director) described collaborative work to improve mental health services for children: (1) a weekly task force of DCFS and DMH planning co-location of staff, mental health staff going out with emergency response workers, and specialized caseloads of DCFS/DMH children for caseworkers in both systems; (2) efforts to improve services for children in D-Rate foster homes; (3) joint training is being planned; (4) discussions of whether the DMH child clinics in each SPA could provide additional services for DCFS children; (5) improved

mental health assessments; and (6) joint monitoring of the performance of community treatment facilities by both agencies.

DMH promised the Panel more statistical information on mental health services being provided to DCFS children which has not yet been provided. Given our concerns about mental health medications being authorized for children in DCFS custody, they encouraged us to meet with the staff at the court and discuss the medication protocol they are utilizing.

A week later, a Panel member met again with DCFS and Mental Health. The panel has consistently voiced its concern about the lack of participation of the Department of Mental Health in joining with DCFS to plan strategies for meeting the needs of the member class. DMH appears ready and able to focus its resources on removing the billing barrier facing the Assessment HUBS and the Multi-disciplinary Assessment pilots, revising the psychotropic medication authorization tracking system, supporting a more thorough and quality mental health reporting process to the court, resolving issues of sharing information and removing HIPPA as a confidentiality barrier, focusing energy on joint training to better understand each others systems, exploring services for emancipating youth, and developing a joint process for monitoring the group home placement system. These discussions are only in their early stages but the Department of Mental Health appears fully engaged and the panel is looking forward to more details about how these efforts will impact the member class and assist DCFS in meeting the settlement objectives.

These initiatives by DCFS are very promising. DCFS has provided little written documentation of these initiatives or descriptions of how they are specifically intended to improve services for class members. These initiatives are small; yet appear to be changing the front-end of the DCFS system that is very important. There are many class members who have been in DCFS care for years whose needs the Panel has documented and who also require DCFS planning and intervention. The challenge for DCFS is to take the mental health assessment and Compton model to scale and move forward on the Hubs and collaboration with mental health with written plans detailing sufficient system-wide staffing and staff training to assure that the Settlement Agreement's commitments to Katie A. class members are fulfilled.

***Panel Meeting with Joan Smith (DCFS Finance) and Claudine Crank (CAO) on September 23, 2004***

The Panel has been quite concerned about the lack of a comprehensive strategic plan for re-directing financial resources and requested a meeting with the CIO's office to better understand the fiscal policies impacting system reform. To date, the vast majority of DCFS efforts have been aimed at the front end of the system and redirecting/deflecting children entering into care. This has resulted in two very promising initiatives for front-end assessment (i.e.,

Assessment Hubs and Multi-disciplinary Assessment Teams). These efforts have been limited to small pilot projects yet have produced very good results in redirecting children with mental health needs to appropriate and timely mental health services. While significant results have been obtained for a very small number (20) of children there does not appear to be sufficient amount of resources to bring these initiatives to scale in any meaningful manner. The Panel recommended that these front end initiatives must be thought about in the context of broad systems reform aimed at the most expensive end of the system so that cost saving could be redirected to expansion of front end services initiatives and providing mental health services to children in foster care, kinship care, or other needed areas. When proposed, a lack of support for redirecting savings was provided as the reason for not developing a broader reform plan.

The CAO's office indicated that no one has said that savings on the maintenance side could not be utilized/redirected. The strategy has been to require that cost savings be obtained first and then to discuss how they would be utilized. Promising in this discussion was the CAO's willingness to engage in a proactive discussion about investing early if a competent plan and financial strategy could be presented by the Department that could reasonably be expected to achieve savings. This has not been done yet.

***Panel meeting with Wraparound service provides September 23, 2004***

Panel members attended a regularly scheduled collaboration meeting with DCFS and the Wraparound providers. The panel was pleased to see a focus in the meeting on measuring outcomes, the need for infrastructure development to support the growth of Wraparound, the need to greatly enhance parent involvement and partnership, the emphasis on how to improve the model to get more kids home with their families. Even in the face of the suspension of federally eligible referrals (approximately 85% of all eligible children) there was optimism about continuation.

While the Wraparound effort has expanded from 115 to 415 children it has does so without sufficient infrastructure to sustain quality. Half of the providers present were not receiving any referrals and there was no systematic gate keeping and referral process in place to manage the system across the department. Additionally, most of the DCFS Liaisons who were focused on coordination of this activity and on resolving service delivery issues at the SPA level have been withdrawn from the Wraparound effort and redeployed elsewhere without transition plans or commitments to back fill these positions. As a result, there is a lack of consistency in the implementation of the model, little focus on systematic change to support family-centered practice and the principles of Wraparound, and in some case no DCFS support for the Child and Family Team processes.

Additionally, the Local Interagency Operations Network (LION), a key SPA infrastructure component of the model has not been systemically implemented and

supported by the Department. As a result the model has moved to a reactive case-by-case caseworker service model that varies greatly depending on the training, knowledge, caseloads, and general support given the change effort by individual CSW's. Where the model has been working well the local Regional Administrator has individually supported the implementation of the LION. Further hindering the development of the effort is the lack of a comprehensive training plan for providers, DCFS management, and CSWs.

It is strongly felt that the lack of a detailed and comprehensive strategic plan is contributed significantly to the current infrastructure, support, and quality issues readily apparent and voiced by the county and providers alike. Without a detailed plan it is difficult to monitor progress and communicate to administration the resource needs for the plaintiff class.

## V. SUMMARY APPRAISAL OF PROGRESS TO DATE ON KATIE A. IMPLEMENTATION

As the content of this report will support, the Department continues to operate with many barriers to meeting the needs of plaintiff class members. This report and prior reports document that:

- Access to effective mental health services for class members is inadequate;
- The quality of Wraparound services is not adequate to meet the needs of the plaintiff class, many class members that need Wraparound support cannot access it and new regulatory decisions by the State and federal government have closed access to Wraparound enrollment for new children;
- Young class members are placed inappropriately in group and congregate settings because appropriate therapeutic family based services are not available to them;
- Class members have unacceptably high levels of placement instability and teen class members disproportionately experience overly restrictive placements in congregate settings, leading to further emotional harm; and
- The Department has consistently failed to develop the formal plans required in the settlement agreement and at the level of detail specified by the Panel, for achieving the objectives of the settlement.

In the face of these serious system problems that were major contributors to the conditions experienced by the named plaintiffs and the genesis of the Katie A. lawsuit, the Panel has highlighted system barriers, documented inadequate treatment for class members and made numerous recommendations for system improvement. A summary of these recommendations is provided in this section. To date, the Department has not responded formally to the Panel on any of these findings and to only a few of the recommendations, even when they were included by the Panel in a formal report to the court.

Nor has the Department provided the Panel with formal plans responsive to its requested level of detail and specificity for implementation of remedies to systemic barriers that impact the plaintiff class, as anticipated in the settlement agreement, with the exception of a brief Wraparound plan. The Panel raised serious concerns about the viability and scope of that plan and made specific recommendations, which did not result in any significant revisions.

Early in the Panel's work, we informed the Department that plans needed to provide enough detail that the efficacy of the plan could be evaluated. The Panel asked that plans be detailed at the task level, identify the personnel and financial resources committed to them and set deadlines for both task and plan completion. The Panel has yet to receive any plan detailed enough to determine its likelihood of success.

What the Department has done is launch a number of very broad system change efforts that it hopes will ultimately improve outcomes for all children and families served. The Panel often learns of these efforts only by specific inquiries that it initiates.

For example, most recently, on Saturday, September 25, 2004, five days before this Panel report is due, the Panel received from the Department a set of System Improvement Plans required by the State as part of the Child and Family Services Review. The Panel has not been involved in the development of these plans, as evidenced by the absence of the Panel among more that forty organizations listed as the planning body. The Panel will not have time to fully examine these plans prior to the report's deadline, but a preliminary review found them to be lacking in detail, description of financial resources committed and deadlines and accountability for completion. Many of them are "plans to plan" rather than a clear commitment to specific tasks. They have little specific reference to the plaintiff class.

While some of the Department's new initiatives could over the next decade, produce general improvements at some level, the plaintiff class has received only superficial attention from the Department. The plaintiff class cannot wait to be assisted in the hope that ultimately the entire system will be better.

At this point in the implementation of Katie A. provisions, the Panel has no confidence that the objectives of the settlement will be achieved for the plaintiff class or that the Department has made any meaningful effort to fulfill it obligations to the class. Of lesser importance, the Panel feels that its efforts, advice and time are not only unwelcome to the Department, but largely ignored.

**Status of the Panel's Findings and Recommendations**

The Panel has provided DCFS with a series of findings from its evaluation of child and family status and system performance. It has also made various recommendations to DCFS regarding the development and implementation of its obligations under the settlement agreement. These recommendations were based on the experience of the Panel members, individually and collectively, and represent best practices in child welfare.

They were carefully considered and took into account the other initiatives that the Department is undertaking. As indicated at the beginning of this report, the Agency has been largely unresponsive to these findings and recommendations, especially in the form of formal written replies. Findings and recommendations have included:

Report on the outcomes for a sample of children discharged from MacLaren – No DCFS response;

Report on the problem and effect of multiple placements on class members – No DCFS response;

Report and recommendations on Emergency Response staff – No DCFS response;

Report on the functionality, depth and utility of case plans – No DCFS response;

Recommendation on the content expected in mandatory plans under the settlement agreement – No plans submitted by DCFS consistent with the recommendation;

Recommendations on improving the functionality, depth and utility of reports to the court - No DCFS response;

Recommendations on the creation of a DCFS practice model – DCFS developed a draft, but its application has not been observed;

Feedback on the content of the Department's plan for Wraparound services – No DCFS revision provided;

Recommendations on data outcome indicators – Relative agreement by DCFS;

Recommendation that DCFS adopt a qualitative review process to identify the strategies needed to assist the plaintiff class – DCFS declined, preferring to use a peer review approach already underway;

Request for the required plan on implementing Structured Decision Making – No plan provided;

Request for the required plans for implementing team decision making models – No plans provided;

Recommendation to combine the multiple team decision making models into one effective approach – Draft concept paper provided;

Recommendation of a working definition of class members – DCFS responded with a definition excluding large numbers of children with significant mental health problems;

Recommendation to create home-based mental health services for the plaintiff class – No DCFS response:

Recommendations on serving developmentally disabled class members – No DCFS response;

Recommendation on assigning an adoption specialist to each unit – No DCFS response;

Recommendation to move placement decisions closer to the worker with case management responsibilities – No DCFS response;

Recommendation to provide significant re-training and coaching to front line staff in strength based practice – DCFS initiated group training of one-day content on strength based practice for front line staff; and

Recommendations on named plaintiffs – DCFS accepted some (including hiring an expert consultant to assist them) and failed to adopt others;

We recognize that Los Angeles DCFS is a huge and otherwise unique environment and that Dr. Sanders is relatively new to an enormous job, and it is not our intent to be hypercritical about the Agency. Many of the staff have been very responsive to our requests and suggestions and interested in improving performance. Neither are we disgruntled that our advice has not been followed. If DCFS had viable alternative plans for achieving the objectives of the settlement agreement, we would be happy to inform the court of our support for these steps. Instead we feel obligated to inform the Court and the community that the promise of the Settlement Agreement has not been achieved and indeed, will not be at the present pace of change.

## VI. DCFS CHILDREN AT METROPOLITAN STATE HOSPITAL

At the end of July, 2004, DCFS reported that there were 19 DCFS children at Metropolitan State Hospital. In mid-August, Panel member Marty Beyer requested that DCFS re-schedule for September 9, 2004 the tour of Metro which had been approved but then canceled due to a court hearing months before. Three attorneys concerned about their clients' placements at Metro asked that Dr. Beyer interview them, and she subsequently requested that DCFS arrange for her to participate in a treatment team meeting for each of these children in addition to the tour of Metro. In the first week of September, DCFS county counsel was told that the Attorney General had to approve Dr. Beyer's visit. After days of discussion, the tour and participation in team meetings were denied. On September 9, Dr. Beyer went to Metro with the attorney for one DCFS child who asked that Dr. Beyer participate in her legal visit, with the approval of the DCFS staff who met them at Metro, and was told that only the individual(s) named on the minute order from the court could visit. Later that day, the conservator/relative of another child requested that Dr. Beyer participate in her visit during regular visit hours with the child, and Metro staff said that Attorney General Sandra Goldsmith had instructed them

that Dr. Beyer was not permitted on the unit even with the approval of DCFS to interview the child who is in their custody. County Counsel later reported that with sufficient notice in the future, a Metro tour would be set up.

The 19 DCFS children at Metro in July, 2004 were as young as 12 years old and on average they have been at Metro for 16 months; four have been there more than two years. Dr. Beyer has reviewed the court reports and placement history for the DCFS children at Metro. Panel members also met with a large group of children's lawyers to discuss their concerns about conditions at Metro and lack of services for their clients there. The Panel will include a report about Metro in its next report to the court, assuming that Dr. Beyer is permitted to visit.

## VII. DATA AND OUTCOME INDICATOR TRACKING

The Katie A. Panel requested a brief review by its data consultant of the statistical indicators that the Panel plans to use as one part of an effort to establish baseline data that can be used to assess trends and progress toward the successful implementation of the settlement agreement. The first information provided by the Los Angeles County Department of Children and Family Services (DCFS) involved nineteen indicators that DCFS was able to readily produce from existing computer files. Previously, the Panel and DCFS reached consensus on the collection of part of a larger list of indicators the Panel viewed as potentially useful and relevant to the assessment of important outcomes for class members. At the time of the consensus, DCFS declined to provide data on five additional indicators due to the absence of direct access to the information within existing departmental computer files. Subsequently, DCFS has also declined to provide a qualitative review process consistent with the Panel's recommendations; and has proposed to substitute an existing peer review.

A brief general summary of the report is provided below, followed by the complete report located in the Appendix as Attachment 1. Discussions between the Panel and the Department are ongoing about the scope and detail of the data tables requested. It is hoped that the baseline data will be available for the Panel's next report in December. It will not be possible to provide data on the plaintiff class specifically until there is agreement between the Panel and the Department about a working definition of the plaintiff class.

### General Summary of Data Report Findings

The Katie A. Panel requested a brief review of the statistical indicators that the Panel plans to use as one part of an effort to establish baseline data that can be used to assess trends and progress toward the successful implementation of the Settlement Agreement reached in May, 2003 and approved by the Court in July, 2003. The initial report, submitted to the Panel in mid-August, addressed three topics. The first topic involved

general considerations regarding the use of data to assess progress within the Settlement Agreement. The second involved specific observations and recommendations regarding the nineteen indicators currently being collected. The third involved the proposed substitution of the existing peer review process for the qualitative review process proposed by the Panel.

**a. General considerations regarding the use of data to assess progress within the Settlement Agreement:** The collection and utilization of baseline data relevant to the Settlement Agreement is an essential step toward being able to assess progress beyond statements of intentions or efforts. At any point in a system as large as the DCFS, there will be ample fodder for dueling anecdotes of success or failure. Standardized collection of data is one way to provide evidence of progress, or the lack thereof, which can be broadly recognized as transparent and balanced. It is important to note from the outset that there are constraints on the utility of any data and, particularly, the type of data represented in the nineteen agreed-upon indicators. It may be helpful to identify some of these constraints so that there is a shared understanding about what information the indicators can and cannot provide.

Perhaps the most important limitation on the baseline data currently available is that the Los Angeles County data represents very large numbers of children and families. Class members and their families are essentially embedded in these larger numbers. As a result, examining trends for the larger population essentially "dilutes" what happens for class members and their families. <u>This situation puts a premium on defining the class, and on being able to extract data on the class from the larger body of data in which it is embedded.</u> <u>At this point, the Panel's recommendation for a working definition of the class has been rejected by the Department in favor of a narrower class.</u> Other general considerations include the needs to examine percentages rather than absolute numbers alone, to be able to graph trends and to annotate context events, to use retrospective data to correct for late data entry, to be constantly aware of data collection conventions that may introduce unintentional bias, to consider the use of cohort data to more easily examine interventions, and to recognize the limitations of descriptive data that may indicate what happened, but not why. Periodic tests of the statistical significance of observed changes should be considered.

**b. Specific observations and recommendations regarding the nineteen current indicators:** Most of the general observations noted above are applicable to all of the indicators. The DCFS data staff provided helpful notes beneath the tables and graphs of some indicators that gave information about what the table includes or excludes, and about the methodology for data collection. Knowing that a particular table excludes such non-foster care placements as psychiatric hospitalizations, or that the number of placements are counted based on only the last entry into care and upon twelve continuous months in placements provide important cues for interpretation. Providing similar notes for all of the indicators would be useful.

The full report provides observations and recommendations relevant to each of the nineteen current indicators. An example, addressing Indicator 4: Number and Type of

Referrals on Active Cases for the Past 12 Months, noted: *This indicator needs additional context. To understand whether or not the rate of re-referral is changing, the percentage of active cases with multiple referrals is required. Even with the percentage of active cases falling into the columns of different numbers of multiple referrals, it would be difficult to interpret what the data might suggest about practice without more, and sometimes different information. For example, examining the interaction between re-referral rates and whether or not the initial case was substantiated might point to useful information about the accuracy of assessments. Other interactions with data about services provided might provide useful information about the effectiveness of different interventions. Examination of re-referral rates, apart from interactions with other (reportedly available) data, is likely to be a sterile enterprise. Fortunately, DCFS data staff indicates that the examination of such interactions can be accomplished with requests from the Panel and reasonable lead time.*

**c. The DCFS proposal to substitute an internal peer review process for the Panel's recommended qualitative review.** The July 20, 2004 response to the Panel from the office of the County Council, indicating the DCFS decision not to follow the Panel's recommendation regarding a qualitative review was examined. Also reviewed were the supporting documents accompanying the response. The DCFS proposal to substitute an internal peer review process for the Panel's recommended qualitative review offers a process that lacks the quality and depth of information the Panel seeks.

The DCFS Peer Quality Case Review (PQCR) has many substantive limitations. It has no established history or methodology, it has a narrow internal perspective, and it does not consistently define what is being measured or how it will be measured (in terms of outcomes for children and families or specific aspects of system performance). Perhaps of greatest concern, it is not a case specific review process. It is only by having the ability to connect specific aspects of system performance with specific outcomes for a particular case that it is possible to correctly assess what has to change to improve outcomes. Without this ability, assessment of what has to change becomes little more than a matter of opinion.

It would be useful to revisit the Panel's recommendations to DCFS regarding the role of a qualitative review. <u>It seems unlikely that the process with which DCFS is currently involved will ever produce the sort of case specific qualitative assessment of practice that the Panel has recommended.</u>

## VIII. YOUNG CHILDREN IN DCFS GROUP CARE

In October 2003 DCFS reported that there were 2,159 children in group homes. DCFS prepared a 62-page spreadsheet of children in group homes at the end of February 2004 (2,160 children). There were a total of 405 children under age 12 in group homes: a shocking 122 of them were age 8 and under.

The different types of group homes in the county are not clearly defined. There are 14 Rate Classification Levels (RCLs) that were established by the California Department of

Social Services, Foster Care Funding and Rates Bureau Division in 1990. The levels are based on a point system quantifying intensity of care in: child care and supervision; social work activities; mental health treatment services (number of hours per child per month); levels of staff; and staff education. These levels were described by DCFS as being based upon the home's ability to deliver services rather than on the child's need for the service. The term "group home" does not mean either a small number of children or a house on a residential street. Most have six children or more under one roof and at least the RCL 12 and 14 programs are residential facilities where children live in 6-10 bed cottages or units.

There are more than 120 group homes housing DCFS children, with the following number of group homes at each level:

| | |
|---|---|
| RCL 2 - 0 | RCL 9 - 12 |
| RCL 3 - 0 | RCL 10 - 14 |
| RCL 4 - 1 | RCL 11 - 17 |
| RCL 5 - 1 | RCL 12 - 42 |
| RCL 6 - 1 | RCL 13 - 0 |
| RCL 7 - 9 | RCL 14 - 6 |
| RCL 8 - 20 | |

In addition, one home is grandfathered, one home is a Regional Center home and two homes are community treatment facilities.

According to the January, 2004 report, most children are in level 12 group homes:

| | |
|---|---|
| RCL 2 - 2 children | RCL 9 - 160 children |
| RCL 3 - 2 children | RCL 10 - 146 children |
| RCL 4 - 2 children | RCL 11 - 247 children |
| RCL 5 - 3 children | RCL 12 -1126 children |
| RCL 6 - 16 children | RCL 13 - 0 |
| RCL 7 - 60 children | RCL 14 - 149 children |
| RCL 8 - 237 children | |

Most of the DCFS offices used group homes for children under age 12 at a rate slightly lower than the percentage of overall children in care from that office. Exceptions were:

| | | |
|---|---|---|
| Metro N | 6% of LA children in care | 13% of GH children < 12 |
| Lakewood | 13% of LA children in care | 18% of GH children < 12 |
| Pasadena | 5% of LA children in care | 11% of GH children < 12 |

SPA 6 (Century, Hawthorne and Wateridge) had substantially fewer children under 12 in group homes (a total of 13%) than its proportion of children in care (a total of 19%).

Two offices had disproportionately large numbers of children age 8 and under in group care--Lakewood, with 22, and Metro N, with 20. Lakewood accounts for 13% and Metro N. for 6% of overall children in care, yet together they have almost 40% of the youngest children in group homes. Pomona, with 6% of children in care, has 5% of children under

12 in group homes and no children 8 or under in group homes; Century, with 5% of children in care, has 4% of children under 12 in group homes, but only one child under 8 in group homes: was this a management decision in those offices?

# Children Age 8 and Under in Group Homes (2/04)

| | |
|---|---|
| A. Valley East-1 | N. Hollywood-9 |
| A. Valley West-3 | Pasadena-12 |
| Belvedere-3 | Pomona-0 |
| Century-1 | SF Springs-3 |
| Covina-3 | Santa Clarita-3 |
| Hawthorne-4 | Torrance-5 |
| Lakewood-22 | Wateridge-8 |
| Metro N-20 | West LA-11 |

The adoption unit has six and the BSP units total eight children age 8 and under in group care. Eight of the youngest children were in a group home called Caring for Babies with AIDs.

Children ages 9-11 were in 48 group homes, many of which had only one or two young children; the group homes with the largest number of 9-11 year olds were Five Acres and Hollygrove (with McKinley, Leroy, Maryvale, Manna Manor and Child Help having 12 or more children in this age group):

| | |
|---|---|
| Ava Lyn-2 | Heritage-1 |
| Bright Horizon-1 | Hillsides-10 |
| Canyon Acres-1 | Hollygrove-32 |
| Caring for Babies with AIDS-2 | Hope House-3 |
| Child Focus-3 | Hudson Lindsey-6 |
| Child Help-12 | Jean Lores-1 |
| Children Are Our Future-1 | Jeeb Children Foundation-4 |
| Cleos-2 | Leroy Boys Home-16 |
| Crittenden-7 | Little People World-8 |
| CRJ-1 | Manna Manor-13 |
| Dangerfield-1 | Maryvale-15 |
| Devereux-2 | McKinley Boys Home-21 |
| DGI-1 | O'Conner & Athens-5 |
| Dream Home care-3 | Olive Crest-1 |
| Drice-1 | P & J's Children's |
| Foundation-2 | |
| Emilys-1 | Pennacle Foundation-1 |
| Ettie Lee-4 | Pioneer Boys Ranch-2 |
| Father Flanagan Boystown-2 | San Gabriel-6 |
| Five Acres-42 | St. Paul-2 |
| Foundation for Jr. Blind-1 | Sycamores-8 |
| Greater Hope Society-3 | Washington Hemlock-2 |
| Green Home for Boys-7 | West Covina-3 |

Harriet-1
Hathaway-7
West Residential-1
Westside-4

Young children were in high rate classification level homes. The majority of the children age 8 and under are in RCL 12 homes. Seven percent of children in RCL 12 group homes are under age 8 (80 out of the total of 1126 children in RCL 12). Children age 8 and under were in 23 group homes, many of which had only one or two young children; the group home with the largest number of children age 8 and under was Bienvenidos, with 39 most of whom were under 5 (Five Acres, Westside and Hollygrove had 16, 14 and 11 respectively):

Bienvenidos-39
Caring for Babies with AIDS-8
Child Focus-1
Child Help-2
Crittenden-1
Dangerfield-2
Five Acres-16
Green Home for Boys-1
Hillsides-1
Hollygrove-11
Hope House-2
Hudson Lindsey-1
Jeeb Children Foundation-2
Leroy Boys Home-4
Little People World-3
Manna Manor-3
Maryvale-4
McKinley Boys Home-3
O'Conner & Athens-1
P & J's Children's Foundation-2
San Gabriel-1
Sycamores-1
Westside-14

The majority of children age 8 and under were placed in these group homes in 2003 or 2004. Exceptions were 16 8-year olds in 11 homes since 2002: McKinley Boys Home has a 6-year old and a 3 year old there since 2002, Westside has a 5-year old and 7-year old there since 2002, Bienvenidos has a 6-year old and two 3-year olds there since 2002, and Caring for Babies with AIDS- has a 6-year old, a 3-year old and a 2-year old there since 2002.

**Study of a Sample of DCFS Children Under 8 in Group Care**

Thirty children under age 8 in group homes were studied by reviewing their placement histories and most recent court reports. In the spring of 2004, the 20 males and 10 females ranged in age from 4 to almost 8 (average=6.5 years old); almost half were African-American (African American-14; Hispanic-9; Caucasian-7). They were in nine group homes: Bienvenidos (12), Child Focus (1), Five Acres (5), Hollygrove (3), Hope House (1), Manna Manor (1), Maryvale (3), P and J (1) and Westside (3). They came from 12 DCFS offices (A. Valley E., Covina, Hawthorne, Lakewood, Metro N., N. Hollywood, Pasadena, Santa Clarita, S.F. Springs, Torrance, Wateridge and West LA).

*These children were placed in group homes as young as age 3;* their average age at the time of this group home placement was 5.7 years. It is surprising that group care would be considered for such young children, for example:

> A 4-year old African-American boy from Lakewood who has had seven placements. He was born positive for marijuana; when he was an infant, he and his siblings were placed with their maternal grandmother after they were physically abused and exposed to domestic violence. His father is deceased. In 2003 his grandmother could no longer care for the children; the report indicates it is hoped she will adopt them in the future although she is being treated for depression. He was placed in 9/03 at age 3 at Bienvenidos where he remains with one of his siblings.
>
> A 5-year old Caucasian boy from N. Hollywood who entered care due to neglect and exposure to domestic violence in 6/03, was placed the next day at Bienvenidos and has been there ever since. His older sister is a second grader who "longs to return home" although their family is not visiting and no relatives have been identified as placement possibilities. The two of them were placed at the facility at the same time, while their infant sister went to a foster home. The court report does not indicate why he was placed in group care at age 4 or why he and his sister remain there a year later.

*These 30 children under age 8 in group care had an average of five placements.* Only seven had one placement and nine had seven or more placements, including:

> A 6-year old African-American boy from Santa Clarita who has had 14 placements. At 8 months old he was placed with a relative for four months, followed by a nine-month foster home placement, and a return to his father for three months. He re-entered care in 9/99 (age 2) and was in nine foster homes in two FFAs in less than two years. Then he spent two years at Bienvenidos before being placed at Hollygrove in 7/03 where he remains. His court report was a blank form.
>
> A 5-year old African-American boy from Pasadena who has had 12 placements, including two years at Westside before being moved to Bienvenidos in 3/04 where he remains. He was removed at three months old after being left alone and exposed to domestic violence; he was returned home at age 2 for four months. He is in special education in kindergarten, was diagnosed with Oppositional Defiant Disorder and Bipolar Disorder and is prescribed Risperdal. Two siblings have moved back home, while two others remain in foster homes. The court report does not indicate what progress has been made in meeting the needs that drive his aggression nor what steps are being taken to ensure permanency for him.

In contrast, four of the 30 children were placed directly at Bienvenidos and were moved within a few months, including:

> A 4-year old Hispanic boy from N. Hollywood who entered care due to sexual and physical abuse by his father and was placed in 1/04 with his sibling at Bienvenidos and then placed in a foster home in 3/04. His mother was frightened of his father (but repeatedly returned to him), was reluctant to accept services, and had not visited at the time of the 2/04 court report

> A 5-year old Hispanic boy from Metro North who entered care due to neglect and exposure to domestic violence and was placed directly in 10/03 at Bienvenidos with his three siblings. He was diagnosed with autism, and his mother, who is depressed, had not followed through with the children's doctor and other appointments. After four months at Bienvenidos, the children were placed with their maternal grandparents in Mexico.

Most of the children were placed in group homes in 2003 and had been there for half a year or longer; *their average length of stay in their current group home was nearly nine months.* Some have very long stays, especially considering their age:

> A 7-year old African-American girl from Hawthorne who was removed at age 5 with her four siblings after being sexually abused by her stepfather. She had four placements, including four months at Bienvenidos before she was placed two years ago with one of her siblings at Maryvale. Their two youngest siblings are in the process of being adopted. Her plan is long term foster care, although her father and his girlfriend are being considered as a placement. The court report is uninformative except to describe her as often acting out.

For some, these long group home stays appear to be built into the group home program despite the risks for children of institutionalization:

> A 6-year old African-American girl from Lakewood who was removed at age 3 after being physically abused. She lived with her grandmother for eight months and then was abused and removed from her home. She was asked to leave three foster homes due to aggression, including being suspended from kindergarten. She has been at Five Acres since 11/03--they projected a 12-18 month stay (for a 5-year old). She is described as a "permanent planning" case: her mother has disappeared, her father is a substance abuser, and her younger sister's foster parent wants to adopt her sister.

It is unacceptable for such young children to have long term foster care as their goal, yet few of the court reports for these 30 children reflected progress toward permanency, including:

> A 7-year old Hispanic girl from Santa Fe Springs who was returned to her mother at age two months, removed at age 1 due to domestic violence and placed with her grandmother, and then had seven foster home placements before age 4 when she was placed for two years at Bienvenidos where her two younger siblings still reside. She moved to Five Acres at age 6 in 7/03 where she remains. She is making progress in her special education kindergarten. Her mother lives out-of-state and has phone contact; she and her siblings do not interact much during visits. Her plan is long-term foster care. The court report does not describe the behavior for which she is being medicated, the reasons for her change in group home placement, treatment goals at Five Acres, or the steps being taken to ensure permanency for her.
>
> A 6-year old Hispanic boy from West LA who was physically abused by his parents and was removed at age 5 when he was hit by a car after being left with his great grandmother; he was described as ADHD, but his parents had not arranged a continuation of his medication when they moved to LA from another state. He was placed at Bienvenidos for 7 months before being placed at age 5 in 9/03 at Westside with his 2-year old sister where he remains; his disruptive behavior has decreased. His parents disappeared and seldom visit, and a search for a pre-adoptive home is being considered.
>
> A 7-year old African-American boy from West LA diagnosed with fetal alcohol syndrome who entered care at age 2 with two siblings due to medical neglect and an unsanitary home; two years before they had been removed for physical abuse and then returned to their mother (two older siblings were adopted). He has had 8 placements, including 18 months with a relative when he was 5 from whom he was removed because of his behavior problems. He has been at the P & J Foundation group home for more than year; one older brother is in group care and another is in a foster home. His mother has been repeatedly arrested, and he and his brother are taken to visit his grandmother although it appears she is not well enough to care for them. In 2003 he was referred to Wraparound, but it was full; he was referred to System of Care which rejected him because he was not in a foster home.

Twenty-six of the children had siblings in care, but only 10 had a sibling placed with them in the group home. Especially after being removed from their families, separation from a sibling can be a serious loss for young children:

> A 5-year old Hispanic boy from N. Hollywood who was born to a teen mother who was in care. He was placed in a foster home for almost two years; he was in another foster home before being returned to his mother at age 2 1/2; he re-entered care due to physical abuse and was moved three times because of his sexualized behavior before being placed at age 4 in

> 7/03 at Bievenidos where he remains. The 32-page 5/03 court report repetitively states the allegations, but provides no information about his treatment in group care, his relationship with his sibling in foster care or their mother, or what efforts are being made to arrange intensive services to ensure that a placement with his great aunt is successful.
>
> A 7-year old Hispanic girl from West LA who was placed with her sibling at age 5 when her stepfather sexually abused her. She had a placement in 2003 at College Hospital although it is unknown whether this was a psychiatric unit. The court report says that she does not like visiting with her mother who apparently still lives with the perpetrator. She has been at Hollygrove since 9/03 and the court report does not indicate what steps are being taken to ensure permanency for her or her sister who remains in a foster home.

It is not known what the rationale behind eight of the children having been previously placed in another group home before being moved to this group home is:

> A 5-year old Caucasian girl from West LA who has had 8 placements since entering care when she was 18 months old due to physical abuse and domestic violence. She spent nine months at Bienvenidos before being placed at age 4 at Westside in 8/03 where she remains. She is labeled as hyperactive and aggressive and was moved to a special education kindergarten, yet is described as "thriving in placement." She is medicated for anxiety and receives TBS. Her sibling is in a foster home where she has an overnight visit once a month. The court report indicates that, at age 5, "long term foster care is the best plan" for her.
>
> A 7-year old Caucasian boy from Pasadena who had five placements, including 10 months at Bienvenidos, before he arrived at Five Acres in 2/03 where he remains. He was removed at birth for 16 months with a relative; he was returned to one parent for 20 months; he returned to care for a month and apparently was placed with the other parent for 15 months. He was described as aggressive, with abandonment issues, and only "slowly responding" in the group home. The court report does not indicate what progress has been made in meeting the needs that drive his aggression. In 9/03 recruitment for an adoptive home for him began, while visits with his mother and sister continued, and the court report observes, "his behavior reflects his confusion about going home."

Some of the children did not go to a foster home, but were placed in this group home directly (ten of the children were placed in this group home within two months entering care). It was apparent that their relatives were not receiving sufficient support themselves and/or child services to continue to care for a SED child. Many of them appear dedicated to the children, which is a reason to ask whether intensive services provided in the relative's home could have prevented placement:

> A 5-year old African-American boy from Torrance who was removed before he was 2 due to domestic violence and lived with a relative for three years. He was returned to his mother, removed again in three months, returned to the relative for a few months before being placed due to abuse at Westside in 12/03 where he remains. He is diagnosed with ADHD and mild MR, is prescribed Risperdal, "has transformed into a different child," and recently did not qualify as needing special education. Nevertheless, his plan is long-term foster care.
>
> A 5-year old Caucasian girl from Pasadena whose grandmother started caring for her in 2002 because of her mother's methamphetamine addiction. In 10/03 she was placed directly at Bienvenidos because her grandmother could not manage her tantrums and she is still there; two siblings remain with her grandmother. She is diagnosed with PTSD and reactive attachment disorder and is prescribed Risperdal. Her grandmother visits her, but says she is not ready for overnight visits. The court report does not indicate how a group placement could help a child with attachment difficulties or what steps are being taken to ensure permanency for her.
>
> A 7-year old African-American boy from Antelope Valley E. who entered care due to physical abuse by his maternal grandmother who was caring for him and his 8 siblings (with birthrates ranging from 1989 to 2001). Their mother, who had medically neglected the children, was in and out of her mother's home and continued to use marijuana; there was domestic violence between mother and grandmother. He was aggressive at school and his attendance was poor. He was placed directly at Five Acres in 2/04 and remains there; his siblings are in relatives' homes. The 28-page court report repetitively states the allegations, but does not contain a plan for him.

Other children were placed in the group home from a foster home, often after several foster home disruptions, and the same question must be asked: whether intensive services provided in their foster home could have prevented placement in group care:

> A 6-year old African-American boy from Lakewood who was placed when he was born positive for cocaine; he was in this foster home (where his sibling remains) for almost three years. Parental rights were terminated when he was 2. He was in a second foster home for more than a year before being placed at age 6 in 7/03 at Hollygrove where he remains. He is prescribed Zoloft for depression and Adderall for ADHD. The court report does not explain whether his rejection by his first home was due to behavior attributed to his prenatal substance exposure or whether his current diagnosis of PTSD is the result of the loss of his two homes. He has weekly visits with his brother and former foster parent who is adopting his brother and is willing to have him return to her home.

> A 7-year old African-American boy from Wateridge who was removed at age 4 after being abused by his stepfather. He has had 7 placements, including with a relative (a D-rate home). He was placed at Bienvenidos at age 7 in 8/03 due to his severe tantrums while his two brothers remained with the relative. Both his last foster parent and his maternal grandmother have visited and expressed a willingness to be a permanent home, but his plan is long-term foster care.

Whether or not placement could have been prevented, it is apparent from the court reports that the children are so challenging to manage that relatives are not seen as able to care for them. Consequently, the children get stuck in group care even though intensive support for foster parents or relatives could be designed to ensure that discharge placements would be successful:

> A 5-year old Hispanic boy from Pasadena who was removed at age 3 after he was injured in a car accident when his mother was drunk. His father is incarcerated; it is unknown where his four siblings are. He had 7 placements before being placed at Bienvenidos at age 4 due to his aggression and depression. Two family group decision making meetings were held in an effort to identify a relative placement for him. The 10/03 court report indicated he still has behavior problems, and his mother is making progress and visiting regularly. Nevertheless, "DCFS cannot request more time for either parent. It is very unfortunate, mother is very close, but not close enough. He is in a safe place. It is very difficult to consider other options for him due to his behavior." The recommendation was to leave him in the group home until DCFS could set up another placement.
>
> A 6-year old Caucasian girl from Lakewood who was removed at age 3 after being physically abused. She lived with a foster parent/guardian for almost two years with her younger sibling who still lives there. She was placed at Maryvale in 10/03 due to unmanageable behavior. The court report does not indicate progress; her guardian wants her to return but DCFS says she cannot handle her.
>
> A 7-year old African-American boy from Wateridge who was removed at age 6 after being physically abused and exposed to domestic violence. Two months later (2/03) he and two siblings were placed in different homes within Manna Manor and they have been there ever since. He is aggressive and distractible and is prescribed Depakote and Risperdal. Three younger siblings are in foster homes. Their mother visits consistently, but the court report indicated no steps toward permanency.

<u>Visit to Hollygrove</u>

Hollygrove is a Level 12 program, with a capacity of 68 children ages 6-13 living in 10-bed houses on a small campus in a city block surrounded by a fence which also contains a nonpublic school, 8-bed (30-day) Assessment Center, a medical/mental health unit, swimming pool and recreational areas. Average stay is 18 months. It was once an orphanage (started in 1880) where Marilyn Monroe lived, reportedly looking across the street at Paramount Studios. The buildings have been renovated and are bright and modern, although many of the bedrooms are for four children. Apparently much of these improvements are the result of an endowment and capital campaign. Their Assessment Center has two children to a bedroom, with motion detectors to prevent sexualized behaviors. They emphasized their mental health services and described the process of having given up the level system. They now operate with "Healthy Values," which the interviewed children articulated well. Hollygrove also is an FFA, with 30 children living in foster homes. There appears to be almost no connection between the foster homes and the group home--they would like to be able to discharge children with continuity of services from the group home to their foster homes, but the foster homes are kept full by DCFS all the time. They said they have asked to operate Wraparound and therapeutic foster care, but so far are not. They indicated that most of the time in their program there are several children who could be discharged if they had their own Wrap services. They find it frustrating that children are too often discharged by the court from the group home to a foster home not operated by Hollygrove without adequate mental health and school services and then are readmitted to the group home. They described the program as being in a "very needy" neighborhood and they would like to serve children from that community rather than being countywide. But they have no control over admissions to either program and typically have few children from SPA 4. They complained they often are told to discharge children with little warning without time to arrange necessary mental health and educational services.

They indicated that most children come to them after a series of placements and the child is viewed as too emotionally disturbed to be handled in a D-rate foster home. They reported that children are housed in shelters waiting until they turn 6 years old so they can be sent to Hollygrove. They were proud of a no-eject history and only rare resorting to psychiatric hospitalization.

Hollygrove recently closed down one of their cottages because of a reduction in referrals (they operated with a loss of over $500,000 before the closure). Although they seemed to have thought of a variety of ways to use staff and facility differently, it was difficult to tell how seriously they have pursued these ideas with DCFS (or DMH), in part because they are stuck with the cost of the physical plant and DCFS will not pay for empty beds.

Visit to Bienvenidos

Bienvenidos is a Level 12 program in Altadena, with a capacity of 46 children in the four-acre "village" of attractive newly constructed buildings with large outdoor play areas. It has the largest number of children under age 8. Four co-educational cottages each house eight children (two to a room) and are bright and cheerful with child-friendly furniture and space to play. Staff ate at a table in each cottage with the children as if they

were a family. Mental health staff could be observed walking on the campus to pick up the next child they were to see, greeting and being affectionate toward other children along the way. The play therapy space is ideal. Children are referred for a mental health interview soon after arrival. A pediatrician and a child psychiatrist are each there one day a week. They have three social workers for 46 children. They have a 1:3 staff:child ratio.

Bienvenidos frequently has sibling groups who are typically not housed in the same cottage but arrangements are made for them to see each other almost daily. Social work staff assist families in visits that include all the children. Bienvenidos is considered an emergency shelter: they are able to do intakes 24 hours a day. The "Mother Goose" unit at Bienvenidos houses up to 12 children under 2. At the time of the visit there were five staff caring for eight little ones, including several infants. Asked why such young children would be placed there instead of a foster home, they indicated the baby might be the youngest in a sibling group placed together. In addition, they are able to manage medically fragile youngsters with awake staff all night--they said they are known for doing well with infants with failure to thrive, for example. The youngest children are typically there the shortest time, usually less than three months. Bienvenidos has a special unit for 2-3 year olds, with four beds in each bedroom. Bienvenidos previously operated a therapeutic day school, but now the educational building is used as a center where children are involved in various activities in the morning and afternoon--it is well-stocked with toys, crafts, music, games and play equipment. Older children go off grounds to one of three schools in the area.

Bienvenidos averages two restraints a week. Typically there is no more than one hospitalization a year. Staff turnover is only 10%. Bienvenidos is also an FFA, and sometimes they are able to place children from the group home into one of their own foster homes. They seldom are able to get children accepted by Wraparound. They work especially hard to get siblings to safely return home or be placed together. They prefer these carefully orchestrated discharges, but they are not always given the time for a planned discharge. Bienvenidos also is a mental health agency, with offices in four communities--how much continuity of care occurs after discharge is unknown.

**Conclusions**

- <u>Group care should be avoided for young children (below age 11)</u>

Almost all children can have their needs assessed and intensive individualized supports constructed for them without taking them out of a family home. Even in the best residential care, children will receive less individualized care than in a family home, multiple placement cannot be avoided, and permanency may be harder to achieve. The concepts of "stabilizing" children and residential multidisciplinary assessment primarily serve administrative convenience. The principle that a child's first placement should be his/her only placement applies to children with severe emotional problems: an average of five placements for very young children is bound to inflict system-caused harm that could be avoided. That two offices had disproportionately large numbers of children age 8 and under in group care while two others had almost none

suggest that staff training and coaching could lead to alternatives being consistently created for these children. Group homes, some of which are providing excellent care, are offering what they believe DCFS wants, and they might be responsive to a planned process of diversifying what their programs offer young children.

---> Comprehensive care for SED children in family homes

The cases described demonstrate the urgent need for intensive home-based services for children and their caretakers (family, foster family, relatives) designed specifically to prevent placement in group care. This requires early assessment of needs and efficient matching of children to services to address trauma reactions and other causes of aggressive and uncontrollable behavior, as well as highly trained TBS workers, crisis assistance and respite. Home-based providers would have to have both the skill to teach the child effective coping methods and the caretaker new management strategies. These services should be provided to a family that may become the child's permanent home to avoid moving the child--as the child progresses, the intensity of services can be reduced. These intensive services will be costly (although not as expensive as group homes) and will require specialized training for clinicians and one-on-one staff and foster parents/relatives. Given the limitations of outpatient providers, clinicians trained in working with traumatized young children might have to be recruited.

---> Effective arrangements for sibling groups

Group homes are being utilized because of the lack of relatives and foster homes for sibling groups. Placing sibling groups together is an important goal, and the high rate of two-thirds of this small sample being separated from their siblings must be avoided. How can siblings be placed together while avoiding institutional placement? In other communities, homes designated for sibling groups have been rented by the agency and foster parents have been moved into them. Possibly some of the group home buildings could be used for sibling groups living together with staff or a combination of staff and foster parents. If the children also require treatment or the family would benefit from therapeutic visitation and/or family treatment, facility clinicians could provide it. If DCFS encouraged group homes to diversify their services to include a homelike environment for large sibling groups, this would achieve the goal of not splitting siblings especially when one or more children have high needs, but (a) how would this cost compare to foster care and to what the group home is now paid and (b) since sibling groups come into care unpredictably, what would they do to cover their costs between groups? The preferred situation is for sibling groups to be placed together and not move until they return home or to a relative or to another permanent home. An advantage of utilizing trained foster parents in a group home building instead of staff (with staff perhaps providing day time childcare assistance and/or awake night capacity) is that the foster parents might move with the sibling group into a permanent home if reunification does not work out.

• <u>A system of care for young children</u>

In the rare situation of a young child who cannot be safely cared for with supports in a family home, effectively clustering intensive school and clinical services

around them might happen best through one program operating its own array of individualized services from temporary residential to treatment foster care to home-based supports at home. To avoid the frequent phenomenon of an SED child waiting for a relative to "get ready" to provide care, a system of care provides intensive assistance to the relative to meet the needs of the child. Residential staff might provide respite from the foster home or family home or as one-on-one coaches for children or families. In addition to funding, the effectiveness of such a program would rely on careful control that only the neediest children entered and good collaboration with DCFS and Mental Health to ensure continuity of care.

---> Long stays in "temporary" non-family environments must be avoided for young children

An average group home stay of nine months is a high percentage of a young child's life; placement for years in a group home interferes with normal development, formation of attachments and future adjustment in normalized living situations. A well-supported permanent home is therapeutic for a traumatized child. The younger the child, the sooner a regular review process for an alternative to group care and a permanent home should begin: to prevent a 5 year old having been in group care for two years, for example, a consistent review process across all offices should begin after three months in a group home. These children should be at the top of the list for Wraparound, System of Care or other home-based services in relative or foster homes.

---> Specializing group home care for young SED children

Caring for traumatized children requires trained staff. That young children are mixed with older children in more than 40 group homes, many of which may not have special training in the care of SED children, is unacceptable. As the number of young children placed in group care is reduced, a few well-prepared group homes should be designated for young children and DCFS should clarify its expectations for treatment, visits and permanency planning for these children. The practice of placing young children in other group homes should stop.

---> Placements in one group home and then another should be avoided

These children are at risk of being institutionalized.

• <u>Preventing labeling of young African American males</u>

DCFS should provide training to staff, mental health providers, and group care providers regarding the tendency to stigmatize the aggression and hyperactivity of African American males and to develop confidence in services that will meet the needs behind their trauma-related behavior. One outcome of providing this guidance to staff and providers will be serving these children in family homes and avoiding group care where their reactivity to provocation from other children tends to make their behavior worse.

• <u>Recognizing the dangers of medication for young children</u>

At least a third of the studied children under 8 in group care are prescribed psychotropic medication, including SSRIs and Risperdal which can have serious side effects and their safety for long-term use with children has not been demonstrated. DCFS and the court should reconsider the court's authorization of these medications.

- Making major improvements in court reports

These young children in group care are some of the children at greatest risk in DCFS, yet their court reports are not informative. They do not give a brief summary of the child's history. They do not state the child's needs or strengths. They refer to attached mental health reports or IEPs, but the conclusions are not reflected in the court report: vague statements of "progress in behavior" or "progress in therapy" do not help with planning for the child.

## IX. DCFS TRAINING

### Background and Operations

Los Angeles County DCFS has 2073 caseworkers and 302 front-line supervisors, plus many additional managers, administrators and support staff in its organization, a large population of professionals that is charged with achieving safety, permanency and well-being for the children and families in their caseloads. In selecting and preparing front line staff for their mission, LA County DCFS has developed a selection and training program that has the following characteristics.

Professional staff enter with a minimum of a BA degree, with many staff having a degree in a social services area. CSW 2 level staff must have a MA in psychology, counseling or social work plus experience. Additional experience may be substituted for an advanced degree.

A consortium of four local universities provides pre-service training and a significant amount of in-service training for DCFS. The internal DCFS training unit has traditionally had responsibility for more policy related training and training related to specific topics that tend to be driven by events, such a mandates by the Board of Supervisors (disaster preparedness, for example). The Panel has not reviewed the current pre-service curriculum itself, but the agenda for a prior offering, displayed in a later section, illustrates the content.

Internal training staff report that the pre-service training was not offered for a significant period of time following August 2003 because so few new staff were being hired. Training has resumed and four classes (called academies in the Department), totaling 136 new staff are soon to graduate and these new caseworkers will then assume a caseload.

Experienced staff are provided in-service training (enhanced training), some of which is mandatory and some of which is optional for workers and supervisors. There is specialized training for different classifications, such as training on writing court reports, testifying in court and adoption, for example. Community colleges provide the training for caregivers (foster parents) as well as independent living training.

In prior periods, there have been four university consortium training teams providing pre-service training for 200-300 new employees per year. A DCFS trainer (anchor) is a part of each team as a resource. There is some specialization among the universities regarding content. For example, USC delivers training on the legal aspects of child welfare. Cal State LA focuses on management training, Cal State Long Beach specializes in supervisory training and UCLA addresses adoptions. When delivering training, Universities rely heavily on outside presenters to deliver modules There is only a small full time consortium staff dedicated to training delivery at the universities.

The sequence of modules depends heavily on the presenter, but there is an effort to have a logical sequence followed. Trainers try to assure that case planning training occurs before the legal process, for example. There are quizzes on modules and a competency exam, which is not used for retention or promotion. A writing exam is also sent to the supervisor as information. Class sizes for pre-service training ranged from 25-60, with an average of 40. There is a training web site where participants can sign up for training.

The original pre-service concept was for staff to complete training prior to receiving a caseload. Training was 10-12 weeks with each week having a field experience opportunity. Workers were to go to a training unit first and gradually assume a full caseload throughout the probationary period. That changed five to six years ago when training units couldn't recruit enough training supervisors to deal with the high volume of new hiring at the time. There was increasing pressure due to rising caseloads to release workers quickly to assume full caseloads.

The ideal supervisory training model was for new supervisors to get 15 days of training over a four to five month period, addressing topics such as leadership, diversity, roles, teams and transfer of learning. There have been only a few deliveries recently due to decreased hiring/promotions. The current supervisory span of control is 8, with a goal of 6 through redeployment.

The training office developed a training plan (Business Plan) over two years ago to provide for more intensive development, more initial mentoring and an extensive use of training units. It was not implemented

Training has recently been delivered by in-house trainers for all staff in the areas of strength based family centered practice and concurrent/permanency planning. Each of these modules was a one-day delivery to participant groups of approximately 40. At present, approximately 1700 staff have received the training. Additional training in planning, visiting and teaming/conferencing is envisioned for future delivery, but is still in the planning stage.

The recent redeployment of central office staff to the field reduced the in-house training capacity by 75 percent, but trainers say they feel like they are still able to contribute to practice improvement with the resources they have. Following the initial redeployment decision, the training unit was able to retain a few additional staff, but the office remains quite small, totaling 14 professional positions, especially for a system of this size.

The training office, with support from the universities, recently provided training for approximately 187 staff that are being redeployed (61 supervisors and 126 line staff) from non case-carrying jobs to case-carrying responsibilities. Training was intended to reacquaint staff with front-line issues. The supervisors also were expected to go through supervisory core training. At the initial training, only 70-80 staff attended due to delays in redeployment action among some staff. The training for staff being redeployed is a sixteen-day curriculum, not counting supervisory training days.

The State does have training mandates for counties, but it appears that counties exercise flexibility in tailoring training content. At this point, State level training priorities are driven by the State's PIP. The State was criticized in the CFSR for its lack of attention to/influence on consistent training content and delivery. The State is working on standardizing new worker training. LA training staff that the State has begun to recognize that localities need flexibility to tailor their training and the County expects the State to prescribe a standardized core program mandating content in human development, risk and safety assessment, child maltreatment identification and case planning and permanency (which the State calls placement). The State will set expectations for competencies and objectives, permitting local flexibility around process.

There are four graduate social work programs in the county. DCFS funds up to 66 students each year to complete a MSW degree.

Trainers and university representatives were asked for their suggestions on strengthening training. Their responses were as follow.

- Implement the Training Business Plan
- Develop an effective mentoring structure
- Address resistance to training because of workload impact of being away from the office
- Find a practical way to train caregivers, resource families, providers
- Let new workers spend some time in the office, seeing the real world, before starting training

New training initiatives are in the planning stage. Forty additional staff have been allocated to focus on ASFA (permanency issues). Their primary focus will be on certification of relative caregivers, an ASFA compliance requirement. Pre-service training will be provided to this group.

There is planning work to create a new model for hiring and training that anticipates emerging needs, rather than reacting to it. This would be a positive step for the system. The pre-service curriculum is undergoing revision to make it more strength based, to integrate Structured Decision Making, to address mental health issues in children and families and to strengthen placement and permanency practice. In the future, the curriculum is to be further revised to address family teaming/decision making. This cannot move forward until policy makers have completed a clear conceptualization of the conferencing model to be employed. The Department is said to be looking at the possibility and challenges of integrating the several different conferencing/teaming models now in use into a common approach.

The training office has undertaken brief training on concurrent planning by SPA, training first supervisors and then workers. One Service Bureau has already been trained, involving 700-800 staff.

**Analysis**

The training leadership seems thoughtful about training needs and has identified a number of objectives to work on, specifically improving strength based practice, attending to skills needed to address mental health issues and improving child and family planning, for example. They recognize the importance of training being more skills based than procedural (a common complaint from the field about current training) and the necessity of skilled mentoring for new workers once they complete formal training.

Several years ago the training staff proposed an ambitious "Business Plan" that outlined a variety of initiatives to strengthen training, one of the more important of which was to create specialized mentor units in office to provide intensive mentoring to new staff before they assumed a full caseload. There is not an organized, well-supported mentoring effort of this type in place at present. A prior administration declined to adopt the plan. Lack of resources was the major reason for the failure to adopt the proposal.

However, if significant additional resources were available to strengthen training, spending more on the same or similar training approaches alone would not be a worthwhile investment. The current training design, which the Department training staff recognize needs improvement, is seriously flawed. First, the Panel is concerned about the design of the basic pre-service curriculum. Rather than being based on the foundations of good practice, which are engaging families, effective teaming and coordination, thorough assessments of strengths and needs, individualized planning and effective interventions, the curriculum is topical. Topical curricula focus on specific child and family conditions, programs, life events or behaviors rather than on the universal elements of practice.

The curriculum outline below is for pre-service training provided in 2003, still in use, and presents a variety of discrete topics for new workers to learn about.

| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
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|---|---|---|---|---|
| August 11<br><br>Housekeeping Intro to DCFS | August 12<br><br>**Physical Abuse**<br><br>Public Health Nurses | August 13<br><br>**Parenting**<br><br>Legal Foundations 1 | August 14<br><br>COPE | August 15<br><br>Writing Exam<br><br>Child Placement |
| August 18<br>Child Development 0-5<br><br>Legal Foundations II 1:30-4pm | August 19<br><br>Child Neglect<br><br>Gay & Lesbian Youth | August 20<br>_____ Retirement Planning<br><br>Kinship Placement<br>Care Seat Safety | August 21<br><br>Interviewing Skills | August 22<br>Perinatal Substance Abuse<br><br>Legal Information |
| August 25<br><br>OUTLOOK 9-4* | August 26<br><br>Social Work Values<br><br>Latency & Adolescence | August 27<br><br>CHOICES | August 28<br><br>**CWS/CMS DAY 1**<br>*9-4*<br>*DCGS Training Section@ Maclaren Center* | August 29<br>Law Enforcement and Drug Recognition |
| September 1<br><br>Labor Day Holiday | September 2<br><br>Case Planning<br><br>Kid Pix 3-4 | September 3<br>**CWS/CMS #2**<br>*9-4*<br>*DCFS Training Section @ Maclaren Center* | September 4<br>Strength Based Practice<br>CARL 1pm-3pm<br><br>Great West 3-4pm | September 5<br>Sexual Abuse Practicum 8:30-12<br><br>Attachment, Separation and Loss |
| September 8<br><br>Legal Permanence | September 9<br>Domestic Violence Application<br><br>Ethnographic Interviewing | September 10<br><br>Ritual & Emotional Abuse<br><br>Special Education | September 11<br>**CWS/CMS #3**<br>*9-4*<br>*DCFS Training Section @ Maclaren Center* | September 12<br><br>Court Writing |
| September 15<br>Transitional Independent Living Program<br><br>Junk in the trunk 1-3<br>Field Prep | September 16<br><br>FIELD DAY | September 17<br>**CWS/CMS #4**<br>*9-4*<br>**DCFS Training**<br>*Section @ Maclaren Center* | September 18<br><br>SSC<br><br>Test review<br>SSC | September 19<br>Test<br><br>Lunch<br>Termination<br>Graduation |

There is no evidence of a coherent framework of practice that underpins these course offerings, just individual subject presentations, provided by a variety of different

presenters in block of time ranging from a few hours to a half day. The priorities suggested by the amount of time devoted to topics seem in some instances unrelated to the importance of the subject. The only topic to which multiple full days are devoted relates to learning how to use the Department's computer system. The agenda seems to require that as much time be spent on writing court reports as on dealing with the effects of attachment, separation and loss and child placement issues. Case planning, a critical area of practice that the Department agrees needs improvement, appears to merit only a half day.

In these short blocks of time it is not possible for training, especially when delivered to group as large as forty participants, to actually teach skills. These sessions are inevitably information based, which is useful, but doesn't go far enough to actually help staff acquire discrete skills. A worker might learn to recognize the harm of a child's separation and loss from family, for example, but would not be given the skills to practice in a way to mitigate the harm, or avoid it.

Effective training begins with knowledge and information, but focuses most heavily on:

- Modeling the skills to be acquired
- Providing training activities that permit participants to demonstrate the skills
- Providing feedback to participants on their performance
- Coaching participants to improve their skills

Presenters in LA are often part-time, having duties in other organizations and may present only their one part of the curriculum. In the opinion of the Panel, without a structured training of trainers initiative, trainers often do not possess the ability to model the skills in a training environment. Such fragmented training delivery invites inconsistency with a common theme of practice and the interjection of personal views and philosophies into training content. Full time trainers can provide much greater fidelity to core training expectations and better integration of the content of the modules provided.

Beyond pre-service training, a bigger challenge is in-service training for the approximately 2500 DCFS staff that engage in direct practice daily – the same direct practice that the Department wants to change. The current in-service effort has been focused on strength based practice and concurrent planning, each one-day deliveries to large groups of staff. Future in-service plans involve training on teaming/shared decision making, case planning and visiting. It is anticipated that each of these three training deliveries will be brief as well.

The Panel sees no likelihood that brief, large group training in any of these topics will create lasting practice improvement, for the same reasons referenced in the discussion on pre-service training. With a maximum of fourteen training staff, the training unit does not have the capacity to expand these planned deliveries. Several systems familiar to the Panel that have achieved significant improvements in outcomes through re-training had to deliver multiple weeks of skill based re-training to the entire work force, not a few

days. All of the trainers were first carefully prepared to model and coach the required skills as a prerequisite.

## Recommendations

### *Pre-Service Training*

The Panel recognizes that training is perhaps the most important support that can be offered, especially for new staff. Pre-service training is often a one-time luxury, in that trainers can spend numerous consecutive weeks shaping attitudes and values about families and the skills needed to provide sustainable safety, stability, permanency and well-being. Training is expensive and it takes badly needed resources out of the work force, so this investment needs to be employed very strategically. Given the limitations of resources for training, the Panel does not support using core pre-service classroom training to teach procedure, such as policy, forms, process and technical content. That said, of course some level of exposure to policy and process is essential before assuming a caseload.

Training should equip staff to engage in practice that provides desired child and family outcomes. There is growing consensus in the field about a core set of principles that underpin good practice. These should be foundational in training design and include:

- Children and families are more likely to enter into a helping relationship when the worker or supporter has developed a trusting relationship with them.
- The quality of this relationship is the single most important foundation for engaging the child and family in a process of change.
- Children and families are more likely to pursue a plan or course of action that they have a key role in designing.
- When children and families see that their strengths are recognized, respected and affirmed, they are more likely to rely on them as a foundation for taking the risks of change.
- Children experience trauma when they are separated from their families. When children must be removed to be protected, their trauma is lessened when they can remain in their own neighborhoods and maintain existing connections with families, schools, friends and other informal supports.
- Assessments that focus on underlying needs, as opposed to symptoms, provide the best the best guide to effective intervention and lasting change.
- Plans that are needs based, rather than driven by the availability of services, are more likely to produce safety, stability and permanency.
- The family's informal helping system and natural allies are central to supporting the family's capacity to change. Their involvement in the planning process provides sustaining supports over time.
- Decisions about child and family interventions are more relevant, comprehensive and effective when the family's team makes them. Families should always be core members of the team.

- Coordination of the activities of case contributors is essential and works most effectively and efficiently when it occurs in regular face-to-face meetings of the family team.
- Reunification occurs more rapidly and permanently when visiting between parents and children in custody is frequent and in the most normalized environment possible (office based visits and supervised visits are the least normalized environment).
- Success in school is a reliable predictor of child well-being. When the direction of planning for safety, stability and permanency is fully integrated with school needs and plans, children are more likely to make progress in all of these areas.
- Children in foster care who are transitioning to adulthood are most successful in achieving independence when they have established relationships with caring adults who will support them over time.
- The service array should be sufficiently flexible to be adapted to the unique needs of each child and family. Services and supports best meet child and family needs when they are provided in the family's natural setting or for children in custody, the child's current placement. If services are limited to delivery in a particular place, children often have to move to receive them (Services should be flexible enough to be delivered where the child and family reside).
- Many of the services and resources that children and families find most accessible and responsive are those established in their own community, provided within their own neighborhoods and culture.

Pre-service training should embody these values and principles in a delivery of four to five classroom weeks, with an alternating week of structured OJT between each classroom week. The curriculum should be organized around the core elements of best practice, including engagement skills (which we call building trusting relationships), team building and facilitation skills, assessment skills, planning skills and intervention skills.

The design process should begin with agreement on and description of core competencies and enabling abilities, which drive the curriculum content. Each week should deal with universally needed skills, although where a vital form or process is crucial to content, such as a risk assessment instrument or case plan format, they can be integrated into the simulations and small group work so that skills as well as process can be taught. Likewise, family dynamics issues, like domestic violence or incest, are within the larger skills development activities, not free-standing topics. As part of the curriculum development process, the activities and exercises should be scripted in a detailed trainer's guide, so trainers deliver the content consistently and are supported in presenting the material. The design should include first modeling of skills by trainers, then practice of skills by participants and provision of feedback by the trainers to coach performance. Specialized content, such as computer training, should be presented in a follow up in-service training session.

In the engagement week, for example, where the interpersonal helping skills are introduced (often described as interviewing), the trainer would model in a role-play or actual interviews with a participant the use of reflection, clarification, reframing or questioning, for example, to demonstrate to participants what the skills look like. The process of change and dealing with resistance should also be a part of this module. In subsequent small group work, participants would have the opportunity to practice those skills and receive feedback and coaching from one of the trainers. Videotaping in such settings is helpful so staff can see their own performance. Readings as "homework" should be a part of the content as well.

In the assessment week, as another example, attention should be given to understanding the difference between needs and services. Workers practice writing needs statements that address underlying conditions, not just symptoms. These ultimately shape the child and family plan. There are also opportunities to introduce issues like substance abuse and domestic violence, although intensive attention to such topics probably works best as a separate in-service module.

The intervention week is the opportunity to address particular practice specialties, such as CPS or permanency. Workers who anticipate specializing in CPS or foster care, for example, will use exercises related to those areas, putting together all that has been learned in the prior modules.

For OJT, there should be a guide and training for the local supervisor, or optimally a staff member that mentors all new graduates for four to six weeks after completion of training. Each OJT week should address content areas presented the prior week. For example, OJT activities in OJT week 1 would focus on observing and coaching the use of interpersonal helping skills. In the OJT week following the planning module, attention would be given to plan development. To work optimally, a full-time OJT manager at the local level is desirable, given the many other duties carried by line supervisors. Every system struggles with the OJT phase. It will be essential to provide training for supervisors on delivering OJT content. There are opportunities for the use of web-based technology and computer based instruction in OJT that would be very effective in OJT.

The emphasis on modeling and coaching of skills by trainers assumes that trainers posses these skills. Because trainers often cannot model the needed skills, a major part of development work is training of trainers.

Brief, in-service training days can be valuable, but they are best suited for presenting information. Skills cannot be mastered in a group training setting in just one day. As a result, the Department should capitalize on the pre-service opportunity to build the core skills that all staff need and use other forums to provide most of the procedural information and more specialized information needed.

***In Service Training***

The Department wants their training to be more strength based, an approach the Panel supports. A major challenge of developing a different pre-service training design for new workers that creates strengths based individualized practice, is that this practice and the skills to employ it will not necessarily be shared by the peers and supervisors of new staff. Inevitably, new staff will be told by more experienced staff, "We don't do it that way here", resulting in the new practice being quickly extinguished. It is imperative that at least vital practice elements of the new pre-service training content, including engagement, teaming, assessment and planning skills, be delivered to existing staff so that they will support the change.

Such content cannot be mastered in short in-service training deliveries. Blocks of training time will be needed to prepare experienced staff to master these new skills.

***Resources and Recommendations***

The Department has a plan for improving training that has a number of sound ideas, including the creation of specialized mentoring units and protected, smaller caseloads for new workers. However, staffing these mentoring units would require that additional resources be made available for local coaching and mentoring.

The greatest training design and resource challenge facing the Department, however, is not pre-service training. The critical challenge is skill and practice development of the existing work force. It will not be possible for the small DCFS training unit to significantly impact the nature of practice in short one-two day sessions. Either a significant increase in the number of skilled internal trainers is needed to and/or the full time training staff within the universities needs to be expanded. A training of trainers initiative would also be required.

The Panel recommends:

- That mentoring units be established to serve new staff in local offices and that new staff carry a small, protected caseload during the initial months of field work;

- That the pre-service curriculum be designed to focus on skill building around the modules of engagement, teaming, assessment, planning and intervention;

- That both curricula include content specifically relevant to the needs of the plaintiff class;

- That in-service training for all staff be developed and delivered based on the same five practice areas:

- That full time staff or university trainers be developed to permit the modeling and coaching of core skills within the classroom setting; and

- That training resources be expanded to support this training development.

## X. Conclusion

The Panel would prefer to be describing the promising detailed plans by DCFS for achieving the objectives of the plaintiff class rather than criticizing the disappointing and inexplicable absence of clear strategies for achieving the settlement objectives. We hope that this report will result in DCFS recognizing that the needs of the plaintiff class are urgent and mounting an intensive focus on the strategies required to meet those needs. Toward that end, we remain available for additional discussions with DCFS about the content of this and former reports and next steps available for the Department.

# APPENDIX

# ATTACHMENT 1

## DATA AND OUTCOME INDICATOR TRACKING

**a. General considerations regarding the use of data to assess progress within the Settlement Agreement:** The collection and utilization of baseline data relevant to the Settlement Agreement is an essential step toward being able to assess progress beyond statements of intentions or efforts. At any point in a system as large as the DCFS, there will be ample fodder for dueling anecdotes of success or failure. Standardized collection of data is one way to provide evidence of progress, or the lack thereof, which can be broadly recognized as transparent and balanced. It is important to note from the outset that there are constraints on the utility of any data and, particularly, the type of data represented in the nineteen agreed-upon indicators. It may be helpful to identify some of these constraints so that there is a shared understanding about what information the indicators can and cannot provide.

- The Los Angeles County data represents very large numbers of children and families and very large numbers of staff and programs. Class members and their families are essentially imbedded in these larger numbers. As a result, examining

trends for the larger population essentially "dilutes" what happens for class members and their families. The question may arise that, if trends (positive or negative) are evident, do they accurately represent class members; or are the outcomes for class members better or worse than the trends? This situation puts a premium on defining the class, and on being able to extract data on the class from the larger body of data in which it is imbedded.

- Most of the nineteen indicators being tracked involve some reference number, which is subsequently divided into subgroups of interest. For example, indicator No. 2 divides the total number of children referred each month (the reference number) into four subgroups (substantiated, unfounded, inconclusive, and N/A). Most of the reference numbers vary from month to month. Part of this variation is random, but part is not. For example, the number of referrals may be affected by a single highly publicized case. For this reason, it is often more helpful to pay attention to proportions or percentages, than to absolute numbers when looking for trends. It is also extremely valuable to be able to annotate context events that may affect the numbers or the percentages (such as the highly publicized case, noted above, or a policy change redefining an appropriate referral). Because absolute numbers may affect collateral issues of interest, such as workload, it is helpful to know both the numbers and the percentages. Trends, though, are most likely to be visible through a careful examination of the percentages over time.

- Discussions with knowledgeable staff involved in the collection and presentation of DCFS data indicated that collecting information on the last day of the month provides a useful interval for the data; but it may also introduce a small, but reducible error. It is their experience that not all data due for entry at the end of the month is actually entered by the end of the month. Their experience is that it takes about three months for all of the late entry that is going to occur to take place. This suggests reporting data three months in arrears will produce the most accurate data.

- Discussions with the same knowledgeable staff indicated that while they believe that the indicator data provided (especially with the three months in arrears adjustment) is reasonably accurate; established data collection conventions may eliminate certain data of interest to the Panel. For example, on indicator No. 8, the number of placements for children in foster care excludes certain classes of placements such as adoptive placements, non-foster care placements and probation placements. According to the established data collection conventions, these are not foster care placements; but they may be of great interest in assessing outcomes for class members since they may include mental health hospitalizations or criminal justice interventions with mentally ill class members. This constraint potentially interacts with the first constraint noted above, because adverse results for class members may be "diluted" in the larger population and hidden because they may be subject to uncounted placements at a rate disproportionate to the larger population. There is a need both to be able to extract class specific data,

and to accurately examine potentially important data that is inadvertently hidden because of existing data collection conventions.

- One of the challenges to discerning changes within a large and complex population is that even successful interventions may be difficult to detect within a population that contains much accumulated evidence of the lack of success through prior interventions. This is a different manifestation of evidence being "diluted" or hidden. For example, if there are children in the system with long lengths to stay in foster care, many children will have to have relatively shorter lengths to stay to significantly reduce the median length of stay (indicator No. 11). Data collection by cohorts of children entering care may provide a more responsive measure of interventions being implemented. Both types of data are informative (population data and cohort data), and both should be considered for a number of indicators.

- A final and particularly troublesome constraint of the agreed-upon indicated data is that all of the information is only descriptive. Each of the indicators counts some event or outcome that is accessible through the DCFS automated system. The indicators essentially described some state of affairs -- that some percentage of foster children are separated from some or all of their siblings, for example. The indicators may accurately described these percentages, and changes in these percentages may be evident over time; but the indicators will never provide explanatory information about how or why the results came to be. Descriptive information is fundamentally important because it describes results reflecting the extent to which DCFS is able to fulfill its responsibilities described in the Settlement Agreement (paragraph 6). However, without additional information about the practice within DCFS that contributes to the results described in the indicators, the "how" and "why" may remain both speculative and contentious. Case based qualitative reviews are needed to provide the missing explanatory information.

**b. Specific observations and recommendations regarding the nineteen current indicators:** Several of the observations and recommendations regarding the nineteen current indicators noted above are applicable to all of the indicators. These would include clear indication of the reference number for each indicator, collection of data three months in arrears, the provisions of tables that indicate both numbers and percentages, and the careful annotation of significant context events. The DCFS data staff provided helpful notes beneath the tables and graphs of some indicators that gave information about what the table includes or excludes, and about the methodology for data collection. Knowing that a particular table excludes such non-foster care placements as psychiatric hospitalizations, or that the number of placements are counted based on only the last entry into care and upon twelve continuous months in placements provide important cues for interpretation. Providing similar notes for all of the indicators would be useful. <u>The ability to define the class and extract data relevant to class members from the larger population would clearly contribute to the usefulness of the indicator data.</u>

It would also be helpful to routinely provide graphing of the indicators over time. Graphing provides some of the most transparent opportunities for perceiving whether or not trends are emerging. It would also be helpful to regularly provide standard tests of statistical significance, where they are appropriate, to assist in determining whether or not changes in data are random or not. Determining an appropriate interval for tests of significance (perhaps quarterly or every six months), and the appropriate tests of statistical significance would involve further discussions between the Panel and the DCFS data staff.

- Indicator 1: Number of Children referred by Month. This indicator is helpful in its current form. It provides sufficient information to understand what the numbers represent and what reference number was used. The addition of a graph added helpful visual information that confirms both the variation in the number of referrals and the modest upward trend. A test of significance and annotation of any significant context events could add to the utility of subsequent presentations of this indicator.
- Indicator 2: Number of Children Referred by Disposition Type. This indicator would benefit from a number of adjustments. It is one of the indicators that would improve with the three months in arrears reporting of the data. This would reduce the number of cases allocated to "N/A", and the remaining "N/A" cases would primarily be comprised of evaluated-out referrals. This would permit a more accurate assessment of substantiation rates and related investigative issues. Interpreting this data is likely dependent on comparative data from other jurisdictions to provide even rough normative estimates of expected levels of substantiation. Without this context, little can be said about changes in the rate of substantiation. This is also an indicator that would clearly benefit from being presented with percentages (as well as numbers), allowing a more accurate assessment of rates of disposition to different categories. Graphing of the rates would be helpful.
- Indicator 3: Number of Referrals by Response Type. This indicator, when presented with percentages as well as numbers, would permit some assessment of the distribution of cases across different response priorities, and of the percentage of cases evaluated-out (often described in other systems as "unaccepted intakes"). Again, without some comparative context, it is difficult to say much about the percentages of cases allocated to different investigative priorities or evaluated-out.
- Indicator 4: Number and Type of Referrals on Active Cases for the Past 12 Months. This indicator needs additional context. To understand whether or not the rate of re-referral is changing, the percentage of active cases with multiple referrals is required. Even with the percentage of active cases falling into the columns of different numbers of multiple referrals, it would be difficult to interpret what the data might suggest about practice without more, and sometimes different information. For example, examining the interaction between re-referral rates and whether or not the initial case was substantiated might point to useful information about the accuracy of assessments. Other interactions with data about services provided might provide useful information about the effectiveness of different interventions. Examination of re-referral rates, apart from interactions

with other (reportedly available) data, is likely to be a sterile enterprise. Fortunately, DCFS data staff indicates that the examination of such interactions can be accomplished with requests from the Panel and reasonable lead time.

- Indicator 5: Number of Abuses/Neglects in Foster Care. Again, this data would be much more informative if it were provided in percentages of the cases in each type of placements. This would permit the rational comparison of abuse or neglect in different types of placements. The notes indicate a disturbing omission in the types of placements, with group homes being excluded as a placements type. The omission is the result of unfortunate data definition differences between foster homes and group homes, but results in another piece of "invisible" data, perhaps highly relevant to class members. This is another indicator where comparative data from other jurisdictions is essential for determining whether or not the 1 percent abuse rate reported in foster care is credible or reasonable.
- Indicator 6: Number of Children Entering Foster Care After Receiving FM Services. This is an interesting indicator, but it requires additional information for meaningful interpretation. First, there is a need to establish a timeframe defining "after receiving FM services". The timeframe is not likely to exceed 6 to 12 months, since the numbers represent open FM cases; but the interpretation of the data would differ for cases just referred for services and for cases that had been open for some number of months. DCFS data staff indicated that they could compare the number of children identified with the start data for FM services. The Panel could request whatever timeframe it deemed appropriate (examining, for example, children entering foster care after some number of months in FM services). Again, a reference number (the number of children entering foster care in the corresponding month) is necessary to calculate percentages that might indicate a trend at some point. Graphing the resulting data would be helpful.
- Indicators 7 and 17: Number of Children in Foster Care by Facility Type. These indicators examine the number of children in foster care by facility type. Again, percentages (as well as numbers) would be more informative; and percentages could be usefully graphed. It would be very helpful to break the "other" column into some of its component parts since the "other" category comprises about 9 percent of the total (and 9 percent of the total accounts for more than 2400 children). Some of the components of "other" would be interesting to examine separately. The DCFS data staff recommended leaving "medical facility" in the "other" category since this data is not entered reliably or accurately because many medical facilities are not considered foster care placements.
- Indicator 8: Number of Placements for Children in Foster Care for 12 Months. This indicator may provide useful information about trends over time once the numbers are supplemented by percentages, since the percentages will compensate for the varying numbers of children in care for 12 months. It is worth noting that this table excludes several placements of interest (such as adoptive placements, non-foster care placements, and probation placement); but since these cases are apparently not viewed as foster care placements, the accuracy and reliability of the available data may be no better than the medical facility data noted above.

  It is also important to note that the data includes a couple of definitional restrictions that minimize the perceived number of placements children may

experience: First, the table addresses only children in foster care for 12 consecutive months. Second, the table is based on the most recent removal date. This means that children who may have been in foster care for more than 12 months, but not consecutive months, are not represented; and that children with multiple entries into foster care have only the placements within the last 12 consecutive months represented. The data will be accurately comparable from month to month, since the definitional restrictions apply to all months measured; but it will be important to keep in mind that it is a minimal measure of placements for children in foster care.

Finally, to have a more nuanced understanding of placements in foster care, it would be helpful to have the rates for multiple placements for different durations of foster care experience. For example, the DCFS data staff indicated that they could produce the number of placements in foster care for children with 3,6, 12, 18, and 24 months in consecutive foster care. This would permit several useful analyses such as whether placement "accumulation" is linear or accelerates over time in care. This indicator is also an example of indicators that might be especially useful to examine through the use of cohorts of children entering care. This would permit a more sensitive assessment of whether or not various interventions or changes in the system were having an impact.

- Indicator 9: Number of Children Entering Foster Care with Previous Cases with DCFS. This indicator examines the number of children with previous cases with DCFS who enter foster care as the result of a substantiated referral. This is an interesting metric, but one that would benefit from a more precise definition of "previous case". The table currently counts children who have ever (within their lifetime) had a case with DCFS. It might be more informative to examine children who enter foster care within one, two, or five years of the closure of the previous case. As with other indicators, this indicator is more likely to produce useful analysis when it is considered in interaction with other variables such as age, the types of services previously completed, the type of case previously open (family maintenance vs. foster care, for example). As with most of the indicators, it would be helpful to have the data available as percentages -- to be able to see what percent of children entering foster care each month previously had cases with DCFS. A graph of the percentages would be helpful.
- Indicator 10: Number of Children Who Re-entered Foster Care within 12 Months of Reunification. Again, it is essential to know the number of reunifications per month to generate even a crude (crude, since the children exiting any month are generally not the same children reentering in the same month) percentage rate of re-entry. Cohort data, based on case closure date, would provide more accurate information. It would also permit more informative examination of interactions with other variables. As isolated numbers, it would be difficult to ever drawn meaningful conclusions from the data as it is currently reported.
- Indicator 11: Length of Stay in Median Days for Children in Foster Care. This indicator, when graphed, might provide useful information about the length of stay for the children included in the table. Indeed, there appears to be some decline in median stay over the period reported (no test of significance was applied). It is worth noting though, that some placements are excluded (the non-

foster care placements where the reliability and accuracy of data entry are suspect); and that in the future guardianship placements will be excluded since they are considered permanent placements. These excluded data may well be of particular interest with regard to class members. Finally, this is a metric particularly well-suited for cohort data reporting since any effects of interventions would be more evident with "fresh" cases than when their results are diluted in the whole foster care population.

- Indicator 12: Number of Children Adopted within 24 Months. This will likely be an informative indicator to track over time, but rates of adoption (the percentage children exiting foster care through adoption) will be more useful than raw numbers. Cohort data may be helpful in understanding any changes in the rate of adoption. Since the indicator is based on the child's last exit from foster care, information on children who may have entered and exited foster care numerous times will not be evident through this indicator.
- Indicator 13: Number of Children Reunified within 12 Months. Again, cohort data and percentages of cohorts would provide more accurate and more informative tables and graphs.
- Indicator 14: Number of Children Exiting Foster Care by Termination Reason Type. This data would be more informative if both numbers and percentages were provided. It might also be helpful to present the percentage data in a separate table focused on exit reasons that account for five or more percent of the total number exiting each month. This would make trends easier to spot, while leaving low frequency, but important reasons (such as abduction, medical facility, and adoption) in a larger numerical table.
- Indicators 15 and 16: Number of Siblings Placed Together in Foster Care. This is an important indicator that would be more informative as percentages. Graphing this data would provide a sobering reminder that substantial (consistently more than half in the current data) percentages of children are separated from some or all of their siblings.
- Indicator 19: Number of AWOL (Runaway) Children. This indicator could be more usefully tracked if it were represented as percentages of the appropriate reference number. The DCFS data staff thought that this indicator was "fairly accurate" since it is based on warrants issued, rather than reports of incidents that might be very transient in nature ("running off" vs. "running away").

**c. The DCFS proposal to substitute an internal peer review process for the Panel's recommended qualitative review.** The July 20, 2004 response to the Panel from the office of the County Council, indicating the DCFS decision not to follow the Panel's recommendation regarding a qualitative review was examined. Also reviewed were the supporting documents accompanying the response. These included documentation of the purpose, process and schedule for the DCFS Peer Quality Case Reviews (PQCR); two PQCR reports for SPA5 and SPA7; a summary of findings from the first two PQCRs (SPA 5 and SPA 7); additional PQCR reports from two offices in SPA8; and references to the supporting policies and codes.

There are significant challenges to assessing whether or not the DCFS proposal to substitute an internal peer review process for the Panel's recommended qualitative review is likely to be at all successful in providing the quality and depth of information the Panel seeks.

- First, the PQCR does not have an established history or methodology. It is candidly described as, *"The PQCR is a work in progress. Every month, we learn ways to improve the process. Below is the latest description of the process, and* [sic] *is subject to change, as we continue to conduct the reviews, and incorporate improvements"*. There are substantial differences in the depth, detail, and focus of the different reports provided to the Panel. It is difficult to determine when this process will begin to generate consistent, comparable information either between offices or over time.
- Second, the PQCR has a very narrow perspective; reflecting primarily an internal DCFS view about a system subject to varied (and sometimes conflicting) views from other perspectives such as those of children and families, other community agencies, service providers, and the court. The DCFS description of the purpose of the PQCR notes, *" Since CWS/CSM* [the computerized information systems] *cannot measure how we do on certain outcomes (such as 'How involved are families in case planning?', or 'Are families accessing the services they need?'), the PQCRs are a way to obtain this qualitative information from the CSW and SCSW perspective."* The PQCR process describes the only face-to-face interviews being with the CSW/SCSW, and families receiving a telephone interview. The Panel clearly envisioned broader representation of diverse perspectives within a qualitative review.
- Third, the PQCR is fundamentally different from the qualitative review process of interest to the Panel. The Panel has recommended a case specific review process that supports the sort of explanatory information referred to in the last point of **I.**, above. In its Second Report to the Court, May 30, 2004, the Panel stated, *"Until system practice and functioning at the case level is understood, is impossible to craft effective system change strategies to improve outcomes. The Panel believes that the completion of a qualitative review will provide DCFS essential data it needs to develop functional plans"*. This is quite different from the DCFS description of purpose for the PQCR*: "The interviews with the CSWs and SCSWs have less to do with the specific case, and more to do with the opinions and experiences of the CSW and SCSW"*. It is only by having the ability to connect specific aspects of system performance with specific outcomes for a particular case that it is possible to correctly assess what has to change to improve outcomes. Without this ability, assessment of what has to change becomes little more than a matter of opinion.
- Finally, the PQCR does not consistently define what is being measured or how it will be measured. Although the response to the Panel from the office of the County Council describes a connection to the state and, ultimately, the federal Child and Family Services Review (CFSR) outcomes of safety, permanence, and well-being; the PQCR does not appear to directly or consistently measure these outcomes. Perhaps of greater concern, the PQCR does not consistently define or

measure the specific aspects of system performance that might be expected to lead to the desired outcomes. To provide useful guidance for practice change, it is essential that there be consistent definitions of "inputs" (specific aspects of system performance) and "outputs" (the desired outcomes for children and families); and a consistent method of measuring and reporting findings. Otherwise, the ability to aggregate information, analyze the information, draw conclusions and specify appropriate changes is quite limited.

It would be useful to revisit the Panel's recommendations to DCFS regarding the role of a qualitative review. It seems unlikely that the process with which DCFS is currently involved will ever produce the sort of case specific qualitative assessment of practice that the Panel has recommended. Providing examples of the sort of qualitative assessment that the Panel envisions should be helpful in establishing more accurate communication about what the Panel's vision for a qualitative review would look like, how it would function, and how its results would be used to assist DCFS in developing functional plans to achieve the responsibilities described in the Settlement Agreement.

**Sources**

Primary sources for this initial report are:

Documents:

The Katie A. Settlement Agreement
The Katie A. Advisory Panel, First Report to the Court, January 13, 2004
The Katie A. Advisory Panel, Second Report to the Court may 30, 2004
The initial printout of the 19 agreed-upon indicators, tables and graphs
The DCFS response to the Panel regarding a qualitative review, July 20, 2004 with its associated supporting documents [noted in **III**, above]
Child Welfare Services(CWS/CMS) Reports, Performance Indicators Project, Child Welfare Research Center, University of California, Berkeley
California Child and Family Services Review, Los Angeles County Self-Assessment, 6/21/04 Final Draft

Interviews:

August 4, 2004, on site meeting with:
Lisa Sorensen, Katie A. Program Manager
Cecilia Custodio, Manager of Data Base, Web Development, Research, Measurement and GIS
Rae Hahn, Program Analyst
Les Beebe, Program Analyst (contract employee)