

The Katie A. Advisory Panel
c/o 428 East Jefferson Street
Montgomery, AL 36104

Marty Beyer
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July 7, 2016

Honorable John A. Kronstadt
US District Court Judge
255 East Temple Street
Courtroom 750 - 7th Floor
Los Angeles, CA 90012-3332

Case No. CV02-05662-AMH (SHx), KATIE A. V. DIANA BONTA

Dear Judge Kronstadt,

The following Report to the Court outlines the County's progress toward achieving the objectives of the Katie A. Settlement Agreement and includes a description of its compliance with the current Joint DCFS/DMH Plan, Corrective Action Plan and the Strategic Plan. In the past the Panel has issued a report twice a year, covering January-June and July-December. However, for calendar year 2015, the Panel chose to report only after the close of 2015 to permit County initiatives beginning in the first reporting period to be addressed once implementation had begun in the second reporting period.

In late 2014, the County, plaintiffs and Panel began to discuss strategies to accelerate Katie A. implementation by undertaking an "immersion process" whereby the County would select two offices/regions per 18-month period in which there would be more intensive supports and resources invested to speed up implementation. The County adopted this approach because of limited progress to date and the large size of the County, which makes it difficult to bring intense resources to bear in each jurisdiction simultaneously. It also provides an environment where innovation can be tested prior to implementation throughout the County.

The first immersion offices are Compton and Van Nuys. The second two sites scheduled for immersion will begin the process 18 months following immersion initiation in the first sites. Current immersion plans involve expansion of DCFS staff and Intensive Home-Based Mental Health Services County-wide, with additional staff and service resources devoted to the immersion sites.

It is anticipated that the immersion process will continue, two offices at a time, until Katie A. is fully implemented system-wide. Implementation in non-immersion offices is expected to continue at the current pace until they are scheduled as an immersion site.

We would be happy to respond to any questions you may have about this report.

Sincerely,

A handwritten signature in blue ink that reads "Paul Vincent". The signature is written in a cursive style with a long horizontal flourish extending to the right.

Paul Vincent
Panel Chair

cc Panel Members
Dr. Mitchell Katz
Phillip Browning
Robin Kay
Laura Quinonez
Lauren Black
Ira Burnim
Antionette Dozier

**The Katie A. Advisory Panel
Report to the Court
Annual Report for 2015
July 5, 2016**

**The Katie A. Advisory Panel
c/o 428 East Jefferson Street
Montgomery, AL 36104
(334) 264-8300**

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Executive Summary

The following is a summary of the Panel’s Calendar Year 2015 findings regarding Los Angeles County’s implementation of the Katie A. Settlement Agreement, the Strategic Plan and progress toward meeting exit criteria within the Agreement.

System Progress

The Immersion Process

The County is undertaking a new initiative to accelerate and deepen implementation of the Katie A. Settlement. This process involves providing intensive resources and supports to two offices per 18-month period to fully implement the settlement in those locations and repeating the process until the entire County has completed implementation. The County refers to this approach as the Immersion process, which has been used successfully in several other child welfare systems involved in implementing class action settlements. The Compton and Van Nuys offices are the first Immersion sites chosen. The objectives in Immersion sites are to lower caseloads, fully implement the core practice model, expand intensive home-based mental health services, expand family foster care resources, reduce reliance on congregate care and of most importance, improve outcomes for children and families. Pre-immersion activities began in September 2015 and full immersion implementation began April 1, 2016.

The following table shows a number of initiatives planned for the initial sites.

Activity	Department Responsible		Process Measure (Tracking)	Outcome Measures
	DCFS	DMH		
Reduced Child Welfare Caseloads	X		<ul style="list-style-type: none"> ▪ Number of cases assigned to CSWs 	<ul style="list-style-type: none"> ▪ Lower number of cases per CSW
Safely Preventing Removals	X		<ul style="list-style-type: none"> ▪ Number of VFM cases ▪ Number of cases referred to community supports (i.e., Family Preservation) 	<ul style="list-style-type: none"> ▪ Higher percentage of non-detained petitions ▪ Higher rate of retention ▪ Lower rate of subsequent substantiated referrals
Increase Placement Resource Capacity	X		<ul style="list-style-type: none"> ▪ Number of placements in community of origin ▪ Number of placements outside County ▪ Number of placements in RCL 10 and higher ▪ Number of group home placements 	<ul style="list-style-type: none"> ▪ Higher percentage of children/youth placed with family ▪ Higher percentage of children/youth placed in County ▪ Higher percentage of children being placed within their SPA ▪ Lower percentage of children/youth placed outside of County ▪ Lower percentage of children/youth placed in RCL 10 and higher

Improved Access to Mental Health Services		X	<ul style="list-style-type: none"> ▪ Identify potential class members ▪ Identify potential sub-class members 	<ul style="list-style-type: none"> ▪ Increase number of children/youth receiving ICC and IHBS
Increased Training and Coach Capacity	X	X	<ul style="list-style-type: none"> ▪ Number of CSWs/SCSWs trained ▪ Number of DMH community providers trained 	<ul style="list-style-type: none"> ▪ Higher percentage of CSWs practicing CPM, every day with fidelity, on a majority of their cases ▪ Higher percentage of SCSWs guiding the practice of CPM, every day with fidelity, on a majority of the cases of the CSWs they supervise ▪ Higher percentage of DMH providers trained in Shared CPM
Enhanced Quality Improvement Process	X	X	<ul style="list-style-type: none"> ▪ Number QSRs completed per cycle 	<ul style="list-style-type: none"> ▪ Higher number of cases with improved QSR scores in status and performance practice indicators
Quality Improvement	X	X	<ul style="list-style-type: none"> ▪ Number of children in home-of-parent 	<ul style="list-style-type: none"> ▪ Increased number of children/youth receiving ICC/IHBS services ▪ Demonstration that IHBS/ICC is resulting in the needs of each class member being met ▪ Increased number of children/youth placed with kin or in home-like setting ▪ Decreased number of child/youth replacements ▪ Increased number of children/youth in home-of-parent

The Panel believes that effective use of this approach will lead to significant progress in fully implementing the settlement agreement.

Expansion of Intensive Home-Based Mental Health Services

DMH has announced a major expansion in its promising initiative, Intensive Field Capable Clinical Services. This approach provides for immediate availability of tailored, intensive home-based mental health services for children with high mental health needs. DMH plans to expand this resource from approximately 100 slots currently to 1,000 slots in 2016 and to 1500 slots in 2017. The expansion serves the entire County. If this plan is fully implemented, it will significantly improve system responsiveness to children with the greatest mental health needs.

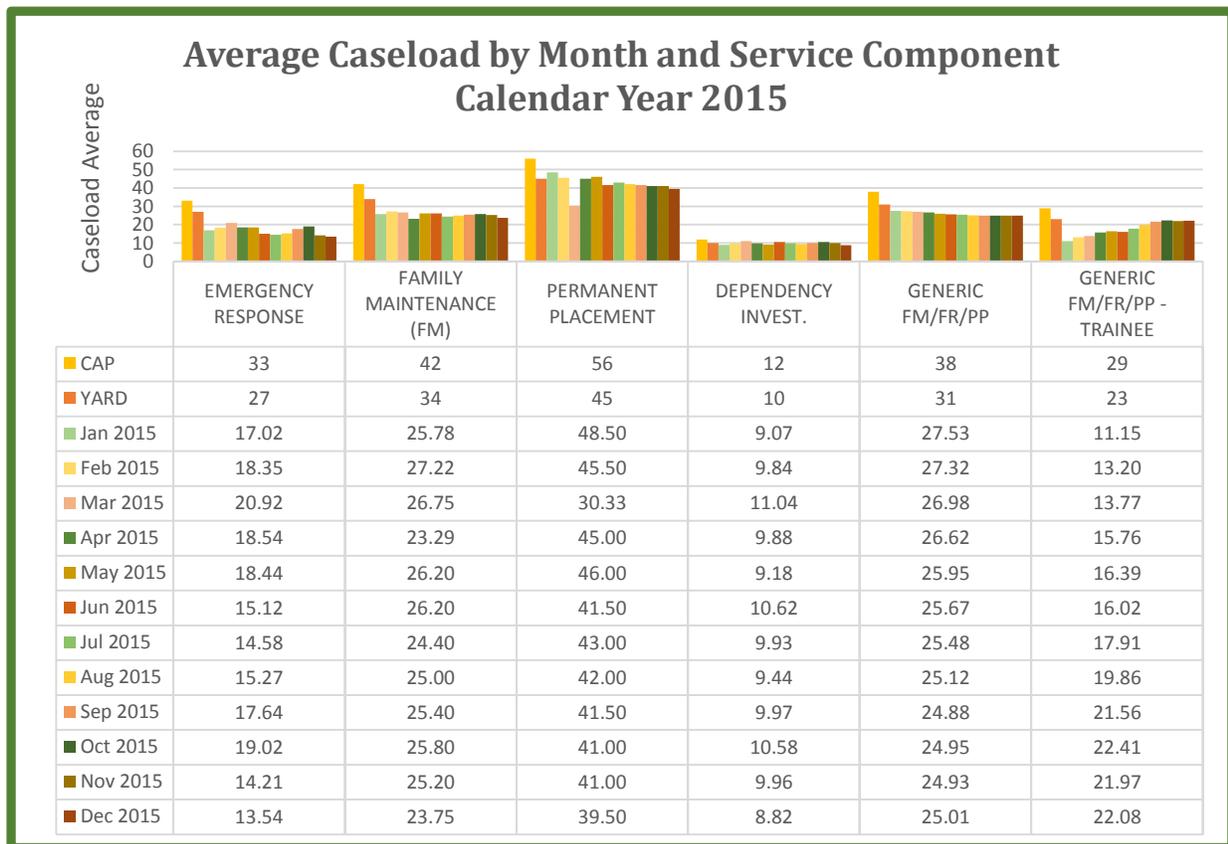
DCFS Workload Reduction

High DCFS caseloads have been a significant constraint to implementing the settlement agreement. However, as a result of the commitment of the County Board of Supervisors, DCFS has added approximately 1,000 new staff. Some of these staff are still in training and will have smaller caseloads until they have gained experience. When they assume full caseloads, the high County-wide DCFS workloads and caseloads should be materially reduced. However, they will remain above the DCFS goal for caseload size. Caseloads in the immersions sites are now close to an average of 20 cases.

The following table shows the trend in total agency caseload from 2003-2015.

Year End Count as of December 31	Emergency Response (Number of children involved in Abuse and Neglect In-Person investigations)	Family Maintenance (Service to children living in their own homes)	Out-of-Home (Children receiving Family Reunification or receiving PP Services)
2003	9,642	8,915	27,638
2008	9,928	10,678	20,813
2009	10,043	10,847	20,588
2010	10,005	12,933	19,956
2011	10,186	14,648	19,401
2012	10,269	13,945	18,943
2013	10,099	13,817	20,209
2014	10,782	13,112	20,282
2015	9,845	11,937	19,992

The table below shows current average caseloads not actual caseloads. Caseloads among seasoned staff carrying a full caseload are usually much higher.



Data Source: DCFS The SITE: 2/22/2016

NOTE: Excludes CSWs with zero caseloads. Excludes Adoption Caseload.

CAP: Maximum number of cases /Referrals that can be assigned to the primary CSW.

Yardstick: The optimal target number of cases assigned to the primary CSW.

Development of Additional Family Foster Homes

The Panel has consistently raised concerns about the insufficient number of foster homes available. DCFS has recently undertaken some new initiatives to address recruitment and retention that may positively impact the problem. They include:

- In some offices where the number of children most significantly exceed foster home beds, DCFS is considering providing specialized training and a stipend to selected foster parents to hold vacancies open for children removed within the catchment area. Currently, because of the placement shortage, children are often placed in the first available setting, even if it is located many miles away. This new concept supports the principle of placing children in close proximity to their family and community, preferably because they do not have to change schools. The Panel has encouraged the County to utilize this approach in all immersion sites.
- DCFS is also exploring expanding the availability of Emergency Aid Requisition funds to cover a broader array of foster parent needs not covered by other sources.
- DCFS is permitting specialized payments to initiate or maintain placement for special needs children.
- DCFS is implementing Emergency Placement Stipends of \$400 for relative and non-related caregivers to cover the costs of incidentals at time of placement. A total of \$1.8 million will be available.
- DCFS plans to raise the rates paid for respite care from \$3.00 per hour to \$10.00 per hour.
- DCFS is piloting a program in Compton to supply new caregivers with initial supports for young children at placement, such as diapers, strollers, blankets, etc.
- Many Counties believe that the lack of subsidized child care for foster parents and relative caregivers who work is a major barrier to recruitment and retention. Although the State has denied the request for funding of this cost for all 23 Counties which requested such funding in applications for State support for child care, DCFS has initiated a pilot program in SPA 2 to provide limited child care supports.

The Panel believes that the lack of accessible subsidized child care for foster parents remains a significant barrier. Without additional state support of child care expansion, the County will not be able to meet this need.

System Challenges

Quality Service Review Findings

The County's performance relative to implementation of the Core Practice Model remains modest, based on Quality Service Reviews. In analyzing QSR Practice Scores overall and comparing the baseline and the second cycle, system performance improved in the following indicators: Engagement, Voice and Choice, Teamwork, and Long-Term View. In Overall Practice, scores improved modestly from 47% in the baseline to 51% in the second cycle. The most significant gains were observed in the practices of Engagement, Voice and Choice, and Long-Term View, which improved during the second cycle by 14%, 12%, and 12% respectively. Although Teamwork practice improved from 18% to 25% acceptable, it continues to be the lagging indicator.

Current 2015 performance, which reflects scores only from the Belvedere, Pomona, Compton and San Fernando Valley offices, indicates that:

- 39% of children are not making acceptable progress toward permanency
- 25% of children are considered not to have acceptable emotional well-being
- 58% of families are not making acceptable progress toward adequate functioning
- 86% of children do not have a functioning family team
- 47% of cases do not have an overall adequate assessment
- 58% of cases do not have a long-term view of child and family goals and strategies
- 58% of cases do not have plans adequate for achievement of case goals
- 26% of cases are not adequately tracked toward achievement of goals

The County continues to consistently fall short of reviewing all 12 cases in the sample for each office. Even 12 cases represent an extremely small sample size, so reviewing only 10 or fewer, which is common, lessens confidence in the representativeness of the sample.

The Quality Assurance Office, which conducts the reviews, is understaffed. Recently, it had to supplement the QA team with staff from the Utah child welfare system, which has long experience with the QSR. The County must ensure that the QA unit is properly staffed for results to have consistent reliability.

DCFS and DMH Training and Coaching

DCFS has been implementing an organized effort to train their supervisory staff to coach caseworkers in the child and family team (CFT) process. It has prepared a cadre of "coach developers" who train supervisors as coaches and developed a growing number of front-line staff as facilitators of child and family team meetings. As the Panel has mentioned previously, the Department faces a significant barrier in that the union has been unwilling for caseworkers to make the CFT process a routine part of their work with all children and families due to caseload and workload constraints. In a June 2016 Panel meeting, the Panel met with representatives of the union, who stated that they had agreed to the DCFS policy directing the regular use of the CFT process

with all families, which represents progress in resolving this workload barrier. The additional staff DCFS has been permitted to hire was a major contributor to this achievement.

However, the union states that the lower caseloads are not yet low enough for staff to fully implement this new policy and that a gradual phase-in process will be necessary. The Panel realizes that implementation will take time, however we remain unclear about how long this will take and if the DCFS goal of caseloads of 15 for continuing service workers (who provide case management to children served in-home and in foster care) must be realized before all families have their own child and family team. The use of the CFT process among mental health providers occurs in a modified form by Wraparound providers and IFCCS providers, but is not in frequent use in other mental health settings. DMH has little capacity to develop frequent use of the process in the larger mental health community.

While DCFS has been aggressive about building coaching capacity for CFT implementation, attention to developing staff to address child and family underlying needs has not matched efforts to develop CFT facilitators. Identification of underlying needs is a foundational element of the Core Practice Model, but is not well understood by many staff in DCFS or by many DMH providers. DMH has planned some training for providers, but in the view of the Panel, does not have the resources for in-depth implementation.

Treatment Foster Care

There has been no meaningful progress in expanding treatment foster care resources.

Recommendations

Expansion of Intensive Home-Based Mental Health Services

DMH should develop a clear, operational definition of IHBS for providers that will provide clarity about expectations and performance.

The Panel recommends that the County track achievement of outcomes for IFCCS providers and utilize provider outcome achievement and QSR performance as a basis for continued funding.

Training and Coaching

The County should develop 6 central office staff to serve as full-time Core Practice Model coaches in immersion offices to speed up implementation. Once the first site has completed immersion, these staff can be deployed to the next immersion sites to accelerate progress there as well. These staff should have a full range of core practice model skills and should give primary focus to underlying needs and service crafting (especially of IHBS), supported by effective child and family teams. These coaches will need development beyond the training and coaching process now in place. The Panel is willing to assist in the development of these coaches.

The County should develop a simple supervisory process whereby supervisors routinely review the strengths/needs identification that are developed by CSWs and included in case plans and

MAT assessments and provide feedback. The process should include a rating structure that can be employed as an internal QA measure and accountability support. The Panel is willing to assist in developing this process, which it suggests be piloted in the immersion sites.

Workload

DCFS states that it has recently achieved a major milestone in discussions with the union about implementation of the core practice model, including the use of child and family teams. According to the Department, the union has agreed to the issuance of policy setting expectations about the responsibility of staff to employ the core practice model. However the next challenge may be finding agreement about the pace at which caseworkers will begin using core practice model with families. This issue will still have caseload implications.

The Panel recommends that the County continue to seek resources to permit the standard for emergency response workers to be 13 new cases per month and for continuing services workers, 15 cases per month.

The Immersion Process

The previous recommendation to develop full-time immersion coaches also relates to strengthening the immersion process. Currently there are 713 children from other regions placed in foster homes in Compton and 289 children from other regions placed in Van Nuys. The Panel supports a recent DCFS initiative to begin limiting the use of immersion office foster homes by other offices, which intended to keep children in or near their homes and communities in immersion sites.

Group Care

The Panel recommends that the County ensure that a primary focus of IFCCS expansion is to prevent placement in group care and transitioning children and youth from group care to family-based settings.

The Quality Service Review Process

The Panel recommends that the County adopt the plan to raise sample sizes in immersion sites from 12 to 15, a strategy now under consideration and ensure that 12 cases are consistently reviewed in non-immersion sites. The QSR review team vacancies should be filled quickly, as the vacancies are limiting the sample size. The review team also needs additional staff.

The Panel recommends that the County contact the Panel when it plans to drop a case out of the review sample.

The Panel recommends that the County provide the Panel copies of the most recent needs statements contained in case files for each case reviewed.

The Panel recommends that in the DMH QSR sample for IFCCS, the sample size be expanded to greater than one per site and that the program's sample size be relevant to the number of children served.

The Panel also recommends that DMH be provided sufficient additional QA resources to permit the QSR process to be used to evaluate the quality of IHBS.

**Katie A. Advisory Panel
Report to the Court
Annual Report for 2015
July 5, 2016**

I. Introduction

The following Report to the Court outlines the County's progress toward achieving the objectives of the Katie A. Settlement Agreement and includes a description of its compliance with the current Joint DCFS/DMH Plan, Corrective Action Plan and the Strategic Plan. In the past, the Panel has issued a report twice a year, covering January-June and July-December. However, for calendar year 2015, the Panel chose to report only after the close of 2015 to permit County initiatives beginning in the first reporting period to be addressed once implementation had begun in the second reporting period.

In late 2014, the County, plaintiffs and Panel began to discuss strategies to accelerate Katie A. implementation by undertaking an "immersion process" whereby the County would select two offices/regions per 18-month period in which there would be more intensive supports and resources invested to accelerate implementation. The County adopted this approach because of limited progress to date and the large size of the County, which makes it difficult to bring intense resources to bear in each jurisdiction simultaneously, and to provide an environment where innovation can be tested prior to implementation throughout the County. The first immersion offices are Compton and Van Nuys. The second two sites scheduled for immersion will begin the process 18 months following immersion initiation in the first sites. Current immersion plans involve expansion of DCFS staff and Intensive Home-Based Mental Health Services County-wide, with additional staff and service resources devoted to the immersion sites.

It is anticipated that the immersion process will continue, two offices at a time, until Katie A. is fully implemented system-wide. Implementation in non-immersion offices is expected to continue at the current pace until they are scheduled as an immersion site.

II. Current Implementation Plan Status

The Immersion Implementation Process

As was mentioned in the introduction, the County is undertaking a new initiative to accelerate and deepen implementation of the Katie A. Settlement. This process involves providing intensive resources and supports to two offices per 18 month period to fully implement the settlement in those locations and repeating the process until the entire County has completed implementation. The Compton and Van Nuys offices are the first Immersion sites. This approach has proved successful in other jurisdictions, including those implementing settlement agreements. The objectives in Immersion sites are to lower caseloads, fully implement the core practice model, expand intensive home-based mental health services, expand family foster care resources, reduce reliance on congregate care and of most importance, improve outcomes for

children and families. Pre-immersion activities began in September 2015 and full immersion implementation began April 1, 2016.

The following table shows a number of initiatives planned for the initial sites.

Activity	Department Responsible		Process Measure (Tracking)	Outcome Measures
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Increase Placement Resource Capacity	X		<ul style="list-style-type: none"> ▪ Number of placements in community of origin ▪ Number of placements outside County ▪ Number of placements in RCL 10 and higher ▪ Number of group home placements 	<ul style="list-style-type: none"> ▪ Higher percentage of children/youth placed with family ▪ Higher percentage of children/youth placed in County ▪ Higher percentage of children being placed within their SPA ▪ Lower percentage of children/youth placed outside of County ▪ Lower percentage of children/youth placed in RCL 10 and higher
Improved Access to Mental Health Services		X	<ul style="list-style-type: none"> ▪ Identify potential class members ▪ Identify potential sub-class members 	<ul style="list-style-type: none"> ▪ Increase number of children/youth receiving ICC and IHBS
Increased Training and Coach Capacity	X	X	<ul style="list-style-type: none"> ▪ Number of CSWs/SCSWs trained ▪ Number of DMH community providers trained 	<ul style="list-style-type: none"> ▪ Higher percentage of CSWs practicing CPM, every day with fidelity, on a majority of their cases ▪ Higher percentage of SCSWs guiding the practice of CPM, every day with fidelity, on a majority of the cases of the CSWs they supervise ▪ Higher percentage of DMH providers trained in Shared CPM
Enhanced Quality Improvement Process	X	X	<ul style="list-style-type: none"> ▪ Number QSRs completed per cycle 	<ul style="list-style-type: none"> ▪ Higher number of cases with improved QSR scores in status and performance practice indicators
Quality Improvement	X	X	<ul style="list-style-type: none"> ▪ Number of children in home-of-parent 	<ul style="list-style-type: none"> ▪ Increased number of children/youth receiving ICC/IHBS services ▪ Demonstration that IHBS/ICC is resulting in the needs of each class member being met ▪ Increased number of children/youth placed with kin or in home-like setting ▪ Decreased number of child/youth replacements ▪ Increased number of children/youth in home-of-parent

One of the most immediate challenges for the sites and the County as a whole is increasing the number of available family foster homes in close proximity to children’s community of origin. The following table shows the distribution of foster homes in Compton and Van Nuys. During the same period there were 419 children in out-of-home care in Compton and 350 children in Van Nuys.

OFFICE SERVICE AREA	ZIP	FFA CERTIFIED HOME *	FOSTER FAMILY HOME	GROUP HOME	SMALL FAMILY HOME	GRAND TOTAL
Compton	90059	11	10		1	22
	90061	13	8			21
	90220	26	24	2	1	53
	90221	12	9			21
	90222	16	5			21
	90262	14	7			21
	90723	14	4			18
Compton Total		106	67	2	2	177
Van Nuys	91040		1	1		2
	91042	2	1			3
	91331	20	5	2		27
	91352	7	3			10
	91401	3	2			5
	91402	6	2			8
	91403	4	2			6
	91405	2	3	3		8
	91411	2	1			3
	91423	6	2			8
	91601	5				5
	91602	2				2
	91604	5	1			6
	91605	2	3			5
	91606	5	3	1		9
91607	5				5	
Van Nuys Total		76	29	7		112
GRAND TOTAL		182	96	9	2	289

The following table shows the challenge faced by the County, where the number of available homes dropped from 8,713 in 1999 to 3,941 in 2015. It is important to note that the number of children in out-of-home care also dropped significantly during this period.

	1999	2001	2003	2005	2007	2009	2011	2012	2013	2014	2015
Foster Homes	3026	2861	3043	3305	1880	1143	814	540	586	650	723
FFA Homes	5553	5008	5096	4656	4577	4290	3102	2979	3016	3148	3163
Small Fam Homes	134	172	172	154	104	85	69	62	59	59	55
TOTALS	8713	8041	8311	8115	6561	5518	3985	3581	3661	3857	3941
	↑	↓	↑	↓	↓	↓	↓	↓	↑	↑	↑

Number of Children in Foster Home Placements in Los Angeles County

	1999	2001	2003	2005	2007	2009	2011	2012	2013	2014	2015
Foster Home	5136	3819	4,052	2,054	1,548	1,228	1,173	1,212	1,392	1,402	1,332
FFA Homes	8139	7720	6,741	5,971	5,950	6,022	4,987	4,901	5,108	5,157	5,045
Small Fam Homes	286	231	220	156	126	96	53	37	36	40	34
Grand Total	13,561	11,770	11,013	8,181	7,624	7,346	6,213	6,150	6,536	6,599	6,411

The following table shows the “readiness” of the two sites for immersion in terms of caseload size, size of the class, placement trends and preparation of staff in the case practice model. Compton, for example, has a much lower caseload average for continuing service workers than Van Nuys.

COMPTON	# CLASS & SUBCLASS	# W/O MH SVCS	# IN GHs	AVG ER CASELOAD [Optimal: 17]	AVG CS CASELOAD [Optimal: 20]	# CERT FAC		# CERT COACHES		# CERT COACH DEV		# OF CHILDREN WHO ENTERED CWC	# OF YOUTH WHO ENTERED YWC
						CSW	SCSW	CSW	SCSW	CSW	SCSW		
2015													
AUGUST	536	148	56	19	21	4	27	0	1	0	2	9	17
September	--	--	55	19	21	7	27	0	2	0	2	9	8
October	--	--	56	22	20	9	27	0	3	0	2	9	11
November	--	--	58	15	20	12	28	0	3	0	3	9	11
December	--	--	61	15	20	15	28	0	3	0	3	3	11
2016													
January	--	--	63	17	20	16	29	0	3	0	3	5	10
February	526	65	64	--	--	16	30	0	3	0	3	6	8
SOFT LAUNCH VARIANCE	-10	-83	+8	-2*	-1*	+12	+3	0	+2	0	+1	N/A	N/A

*Variance calculated based on initial five months of soft launch period.

VAN NUYS	# CLASS & SUBCLASS	# W/O MH SVCS	# IN GHs	AVG ER CASELOAD [Optimal: 17]	AVG CS CASELOAD [Optimal: 20]	# CERT FAC		# CERT COACHES		# CERT COACH DEV		# OF CHILDREN WHO ENTERED CWC	# OF YOUTH WHO ENTERED YWC
						CSW	SCSW	CSW	SCSW	CSW	SCSW		
2015													
AUGUST	440	105	54	16	29	0	18	0	2	0	3	4	2
September	--	--	55	20	28	0	18	0	2	0	3	1	3
October	--	--	57	21	26	0	18	0	2	0	3	0	4

November	--	--	56	14	27	0	18	0	2	0	3	0	4
December	--	--	53	14	26	3	18	0	4	0	3	0	5
2016													
January	--	--	50	15	24	3	22	0	7	0	3	0	0
February	584	60	49	--		5	21	0	8	0	3	0	0
SOFT LAUNCH VARIANCE	+144	-45	-5	-1*	-5*	+5	+3	0	+6	0	0	N/A	N/A

*Variance calculated based on initial five months of soft launch period.

The County has an interim goal of achieving an average caseload of 20 cases for continuing services and 17 for emergency response workers. The County recognizes that caseloads may need to be lower than the interim targets to permit full implementation of the case practice model. The following table and data were provided by the County as a caseload status report. It is important to note that average caseloads include some staff with significantly elevated caseloads, as newly hired staff are given reduced caseloads for a period after beginning work and some caseloads will be vacant for a period after resignations and transfers.

Office	Caseload (Average Referrals/Cases)							
	ER	CS						DI
	ER	GN	ST	GT	FF	PP	Total	DI
Belvedere	13.5	23.9	23.7	21.2			23.7	10.6
Compton	15.7	19.2	17.6	20.3			19.4	6.7
El Monte	20.0	23.6	29.0				23.9	7.6
Glendora	13.5	25.0	22.6	22.0	28.0		24.7	8.1
Lancaster	11.7	27.3	28.0	23.7			26.4	5.9
Metro North	14.1	29.1	18.0	22.5			26.8	8.3
Palmdale	18.9	27.2	26.5	24.8		38.0	26.5	9.0
Pasadena	15.2	19.7	20.0		19.0		19.7	9.4
Pomona	13.9	24.6	24.3				24.6	14.6
S F Springs	14.8	24.2	24.5		22.5		24.1	7.2
Santa Clarita	12.5	24.6	18.8				24.1	4.5
South County	15.9	25.9	28.6	21.3			25.2	9.2
Torrance	18.3	25.1	27.0	24.0		40.0	25.4	4.4
Van Nuys	14.0	24.6	15.8	18.3			22.8	17.2
Vermont Corridor	11.0	22.3	25.2	20.6			22.0	5.2
Wateridge	9.8	28.0	20.5	21.9			25.7	7.7
West LA	14.7	21.0	21.0				21.0	7.3
West San Fernando Valley	15.2	20.8	20.0	22.3			21.1	8.6
Department	14.0	24.3	22.4	21.7	23.0	39.0	23.8	8.6

1. The report includes regional offices only.
2. The report includes GN, GT, FF, PP, ER and DI file types only.
3. CS includes case that are open and active on the last day of reporting month.
4. No. of Referrals are child-based count.

These are average caseloads. The averages include staff with caseloads of one or more.

Attributable to the 1,300 Children's Social Workers newly-hired over the last two years, from January 2014 to January 2016:

- The Countywide average Continuing Services caseload has reduced from 31.0 to 23.8;
- The Countywide average Emergency Response Caseload has reduced from 17.4 to 14.0; and
- The Countywide average Dependency Investigations caseload has reduced from 9.9 to 8.6.

To enable successful Immersion implementation countywide, DCFS targets caseloads of:

- 20 for Continuing Services Workers;
- 17 for Emergency Response Workers; and
- 10 for Dependency Investigators.

With continued hiring of additional Children’s Social Workers and their 52-week DCFS Academy completions, DCFS projects reaching these targets countywide by *March, 2017*.

Expansion of Home-Based Mental Health Services

Intensive Field Capable Clinical Services (IFCCS)

IFCCS is an approach which provides an array of individualized intensive home-based mental health services, organized through a child and family team, which are quickly available to respond to children’s needs. Currently, approximately 100 slots are available. Five providers were selected to pilot this approach and as will be discussed later in this report, the County is poised to implement a major expansion of the IFCCS model by expanding to 1,000 slots in 2016.

According to DMH, from January 2015 through December 2015, referrals were from the following sources:

Psychiatric Hospital Discharges – 64%

Children and Youth Welcome Centers – 11%

Exodus Urgent Care Centers – 2%

DMH Field Response Operation Team – 0.5%

Administrative Exceptions (Children/youth whose circumstances fall somewhat outside IFCCS criteria) – 23%

The average length of services is six months, with the median length of services also at six months. DMH has piloted a qualitative tool to assess program quality, based on the QSR tool. According to this small evaluation pilot, provider strengths were found in the areas of Engagement, Intervention, Supports and Services, Assessment and Family Voice and Choice. Program improvement was noted as needed in Case Planning, Supportive Documentation, Teamwork and Long-Term-View. DMH is in the planning process to strengthen its quality assurance and quality improvement capacity to be able to evaluate and manage the anticipated growth of IFCCS.

Using Mental Health Services Act funding, DMH plans to expand IFCCS to 1,500 slots by 2017. This positive step by DMH will significantly expand intensive home-based mental health services for the plaintiff class. It will also present significant challenges in the training, coaching and evaluation of mental health providers.

DMH Service Provision to Class Members

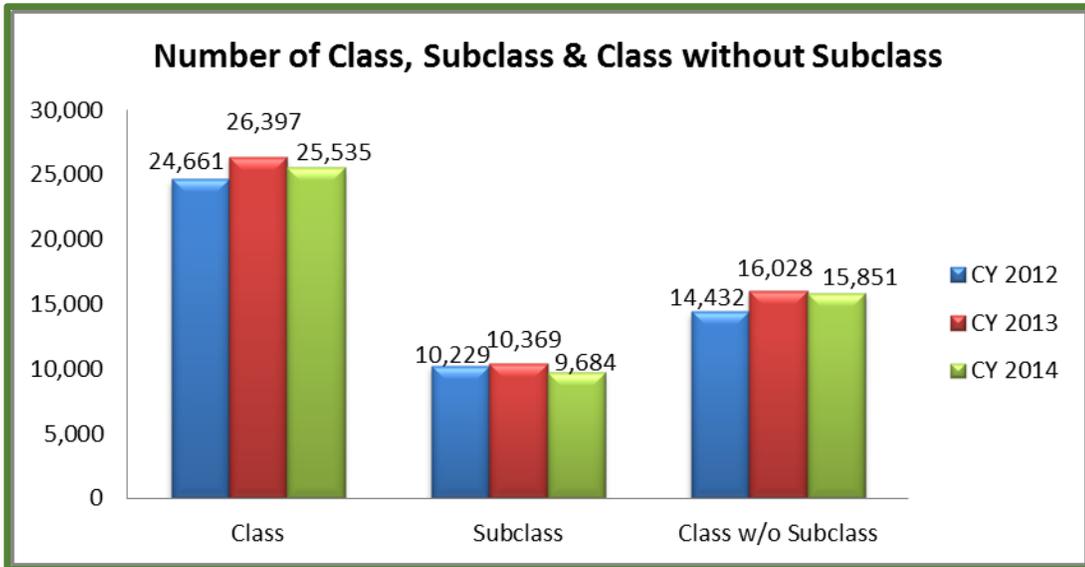
DMH provided the following data and analysis on its overall services to class members. The Department points out that there are some limitations on the accuracy and comprehensiveness of these data; however, the Panel believes that the data provide a useful overall view of mental health service provision in the County.

- 1) From the total amount of DCFS clients (60,962), 42% were Katie A. classⁱ members during calendar year 2014, slightly lower than the previous calendar year (CY 2013, 43%). Of the 25,535 class members in CY 2014, 15,851 (62%) belonged to a category identified as class members that does not include subclass members (Class w/o Subclass). During CY 2014, about 38% of the Katie A. class were subclassⁱⁱ members and received more intensive mental health services, a decrease from CY 2013 (39%) and CY 2012 (41%). The data shows that the number of subclass members increased from calendar year 2012 to 2013 and decreased in 2014 (CY 2014: 9,684; CY 2013: 10,369; CY 2012: 10,229). This decrease in subclass members seems to be largely due to a decrease in the number of youth that received three or more placements within 24 months. It should be noted that DCFS and DMH have difficulties in accurately capturing placement changes due to behavioral needs and the departments are currently refining processes to improve this data. The following graph shows the breakdown of the class, subclass and class without subclass for CYs 2012-2014.

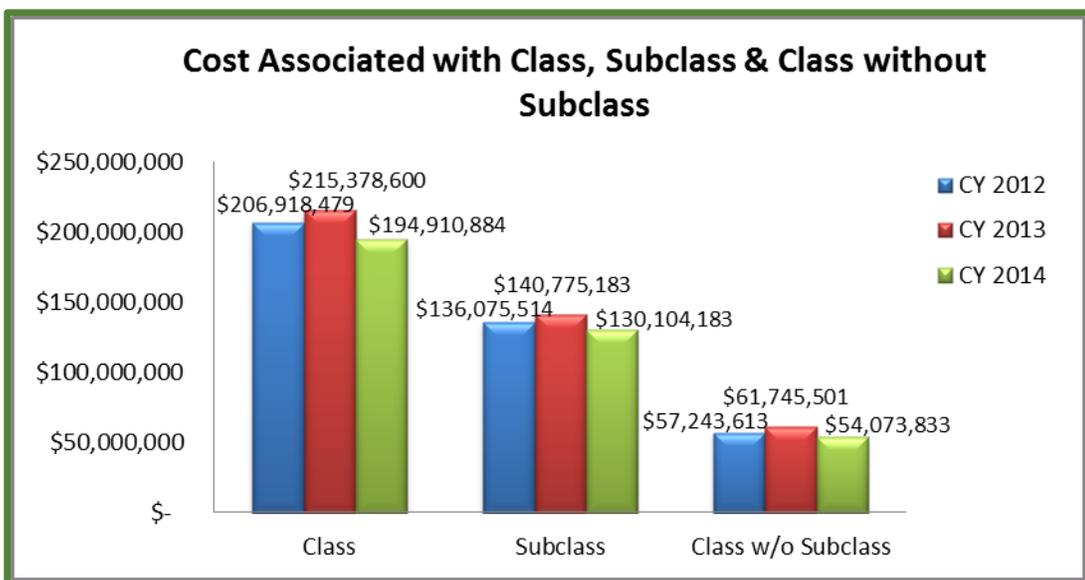
¹ Exodus: An outpatient Psychiatric Urgent Care Center that provides individuals in crisis with voluntary crisis stabilization services for up to 23 hours.

² Class: Children/youth who meet all of the following criteria: 1) Have an open child welfare services case; 2) Have full scope medi-cal; 3) Meet medical necessity for mental health services; and 4) Received a mental health service or were considered for Intensive treatment.

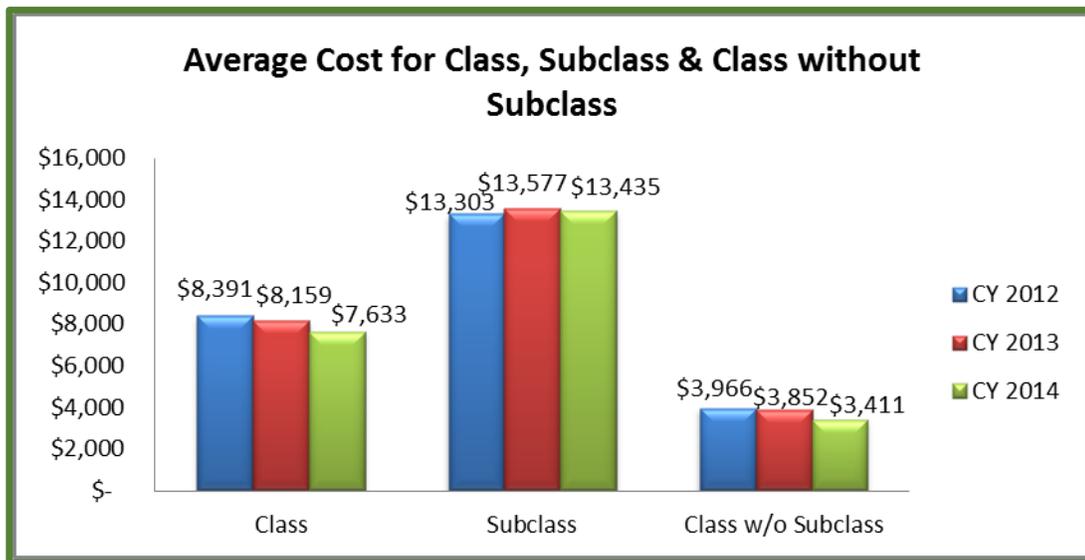
³ Subclass: Children/youth who meet criteria # 1-3 for the class above *and*: 4) Considered for or received *intensive* treatment, i.e., one or more of the following: a) Wraparound(Wrap), b) Intensive Field Capable Clinical Services (IFCCS), c) Full Service Partnership (FSP), d) Treatment Foster Care (TFC), e) Therapeutic Behavior Services (TBS), f) Had a psychiatric hospitalization, g) Received services through Exodus, h) Resided in a Community Treatment Center (CTF), i) Placed in a Group Home RCL 10 and above and/or j) Had 3 or more placement changes in 24 months due to behavioral needs.



2) The cost associated with providing mental health services to the Katie A. class increased in CY 2013 and then decreased in CY 2014 (CY 2014: \$195 million; CY 2013: \$215 million; CY 2012: \$207 million). The percentage of subclass costs slightly decreased in 2013 and slightly increased in 2014 (CY 2012, 66%; CY 2013, 65% and CY 2014, 67%). In 2014, while the subclass made 38% of the class, it made up about 67% of the total costs. While the percentage of subclass to class members has decreased over the past three calendar years, the percentage of the subclass costs increased from 2013 to 2014. This data show that the number of class members meeting the subclass criteria has decreased in the last two years, but this group has had more intensive mental health needs based on the services provided to them. The mental health costs associated with providing services to this group is still more than half of the total costs provided to the class.



- 3) Upon closer look at the costs for mental health services that were provided to subclass members, the CY 2014 data shows the average mental health cost associated with subclass members (\$13,435) has decreased slightly compared to CY 2013 (\$13,577) and is still much higher than the average cost of mental health services for class members who are not part of the subclass (\$3,411). The average cost for the class without subclass category has decreased in the last three years (CY 2014: \$3,411; CY 2013: \$3,852; CY 2012: \$3,966). More specifically, subclass members are receiving more services than the average class member not belonging to the subclass.



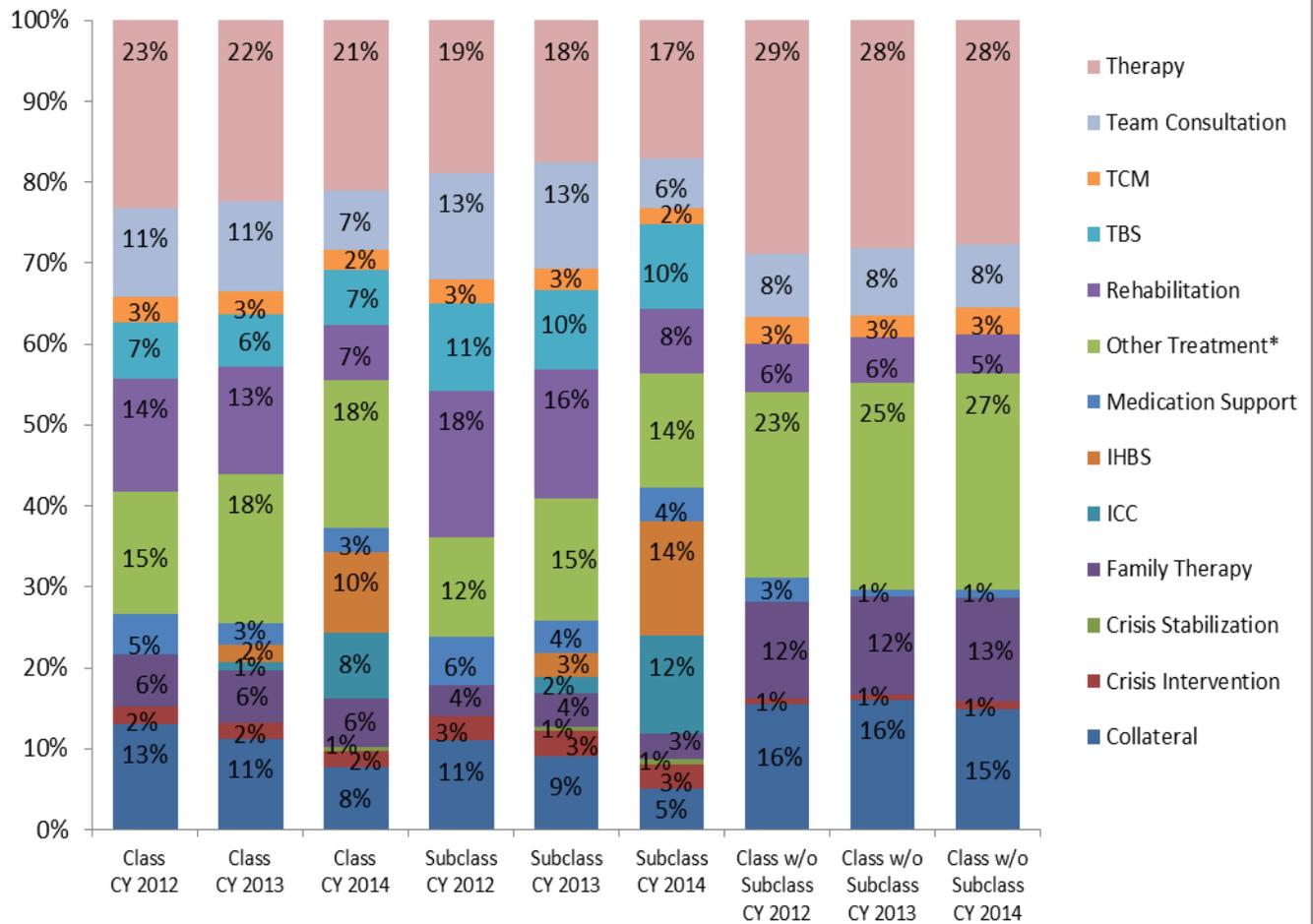
- 4) The mental health service array also varies between class and subclass members. For CY 2014, subclass members received less individual therapy (17%) than class without subclass members (28%). Subclass members also received more targeted case management (TCM) including team consultation (TC) and ICC (subclass: 20%; class without subclass: 11%), and more rehabilitation services including TBS, collateral and IHBS (subclass: 37%; class without subclass: 20%). ICC and IHBS were also introduced in 2013 for subclass members and specifically made up about 12% and 14% of the service array in 2014, respectively. In addition, within the last two calendar years, individual therapy for subclass members has decreased (CY 2014: 17%, CY 2013: 18%), TCM including TC and ICC has increased (CY 2014: 20%; CY 2013: 18%) and rehabilitation including TBS, collateral and IHBS has decreased (CY 2014: 37%; CY 2013: 38%).
- 5) The mental health service array for subclass members is more in line with the intensive services subclass members would be expected to receive. DMH hypothesizes that this type of service array would contribute to higher success rates for this population. During calendar year 2014, DMH expected the amount of

rehabilitation services and targeted case management to decrease with the implementation of ICC and IHBS. The data does support a decrease in targeted case management (CY 2014: 2%; CY 2013: 3%) and in rehabilitation services (CY 2014: 8%; CY 2013: 16%). DMH also states that it expected an increase in collateral services; specifically, collateral work with caregivers (CY 2014: 5%; CY 2013: 9%). Some of the collateral services may also be captured within IHBS and contribute to the decrease in collateral services being billed. DMH expects ICC, IHBS and collateral services to continue to increase as providers become more familiar with providing these intensive services to subclass members.

Team Consultation (TC) is a case consultation or case conference, with or without the client present, with the purpose of plan development. It must include discussion of the client's progress, or lack thereof, in treatment and/or discussion of the client's plan for mental health treatment.

Therapeutic Behavioral Services (TBS) is an intensive, individualized, one-to-one behavioral coaching program available to children/youth who are experiencing a current or emotional behavioral challenge or a stressful life transition.

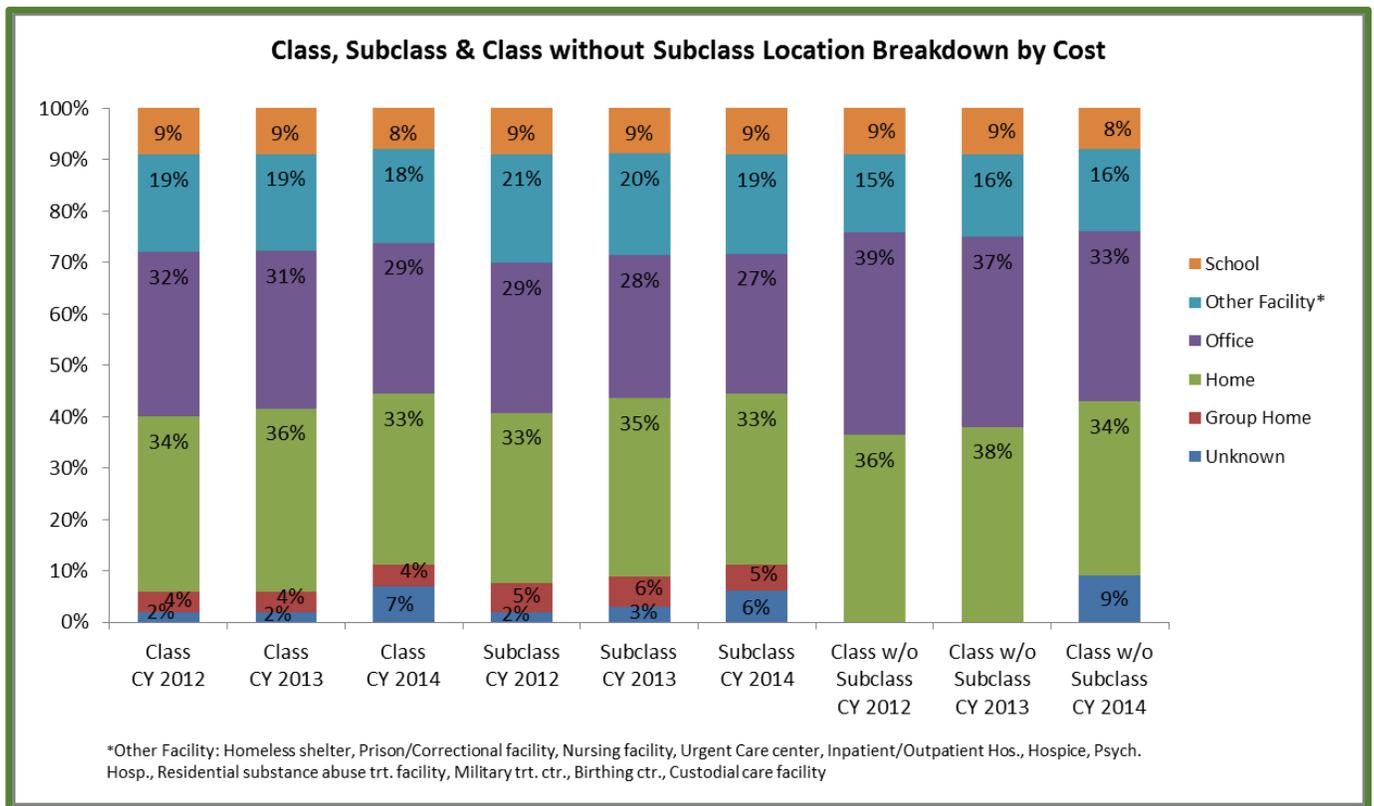
Relative Service Provision (by Cost) for Class, Subclass, and Class without Subclass



*Other Treatment includes: Assessment, Psych testing, Report writing, Record review, Day Treatment and Psych Hospitalization

- 6) There has been little change in the setting in which services have been provided (home and community-based vs. office) within the last two calendar years. There are still more services being provided in the office for class without subclass members (CY 2014: 33%; CY 2013: 37%) than for subclass members (CY 2014: 27%; CY 2013: 28%). In addition, more services seem to be provided in other facilities (including Group Homes) for the subclass (CY 2014: 5%; CY 2013: 6%) than for the class without subclass (CY 2014: 0%; CY 2013: 0%). This may be partly due to subclass members being in need of more intensive mental health services within other types of facilities like psychiatric hospitals, group homes RCL 10 and above, and urgent care centers. While DMH expected to see subclass members receiving more services in the home during calendar year 2014 than 2013, there was a decrease in services provided in the home (CY 2014: 33%, CY 2013: 35%). In addition, there were more services offered in the home for class without subclass members than for subclass members in 2014 (Class without subclass: 34%, Subclass: 33%). This trend is also

consistent with data from 2013. While there does not seem to be a trend in more services provided in the home for subclass members, subclass members do seem to be receiving less services in the office (CY 2014: 27%) than class without subclass members (CY 2014: 33%). It should be noted that for CY 2014, the location of services was unknown for the service claims of 7% of the Class, 6% of the Subclass and 9% of the Class without Subclass. DMH believes that this is most likely the result of the transition of billing and claims submittal from the Integrated System (I.S.) to the Integrated Behavioral Health Information System (IBHIS). As time progresses, and the two billing systems are better synchronized, the unknown data percentage should decrease.

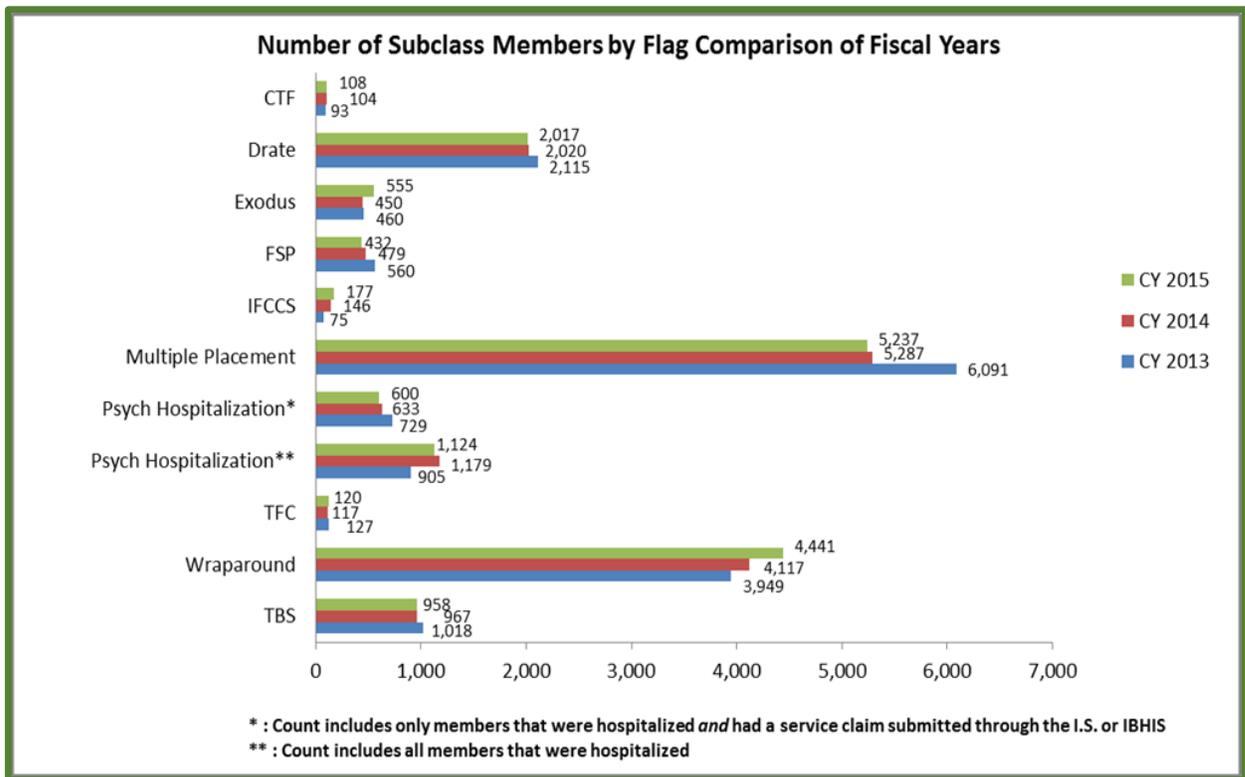


7) Based on the subclass definition, DMH developed the following chart of the criteria or programs youth were in that contributed to them being in the subclass. In CY 2015, the majority of youth had three or more placements (5,237), were in Wraparound (4,441), or placed in a D-Rate home (2,017). Furthermore, many of the youth fell into multiple categories below.

A) In addition, from CY 2014 to 2015, more youth were enrolled in TFC (from 117 to 120), in Wraparound (from 4,117 to 4,441) and admitted to Exodus (from 450 to 555). There were fewer subclass members enrolled in TBS (from 967 to 958), FSP (from 479 to 432) or had three or more placements within 24 months (from 5,287 to 5,237). The decrease in the multiple placement category continues to be

refined in an effort to be in line with the State’s definition of this category (due to behavioral reasons). DMH states that it is working to get a clear count of the number of youth that fall into this category. The data also shows that the number of youth placed in a psychiatric hospital has decreased; however, it is important to note that DMH continues to have difficulty gathering data regarding psychiatric hospitalizations and much of the data is missing or not accurately reported (hospital staff can bypass the I.S. and IBHIS and bill services directly to the State). The graph below includes two hospitalization counts: 1) Psychiatric Hospitalization: This count only includes members that were hospitalized *and* had a service claim submitted through the I.S. or IBHIS*; 2) Psychiatric Hospitalization: This count includes all members that were hospitalized (regardless of whether a claim was submitted through the I.S. or IBHIS).**

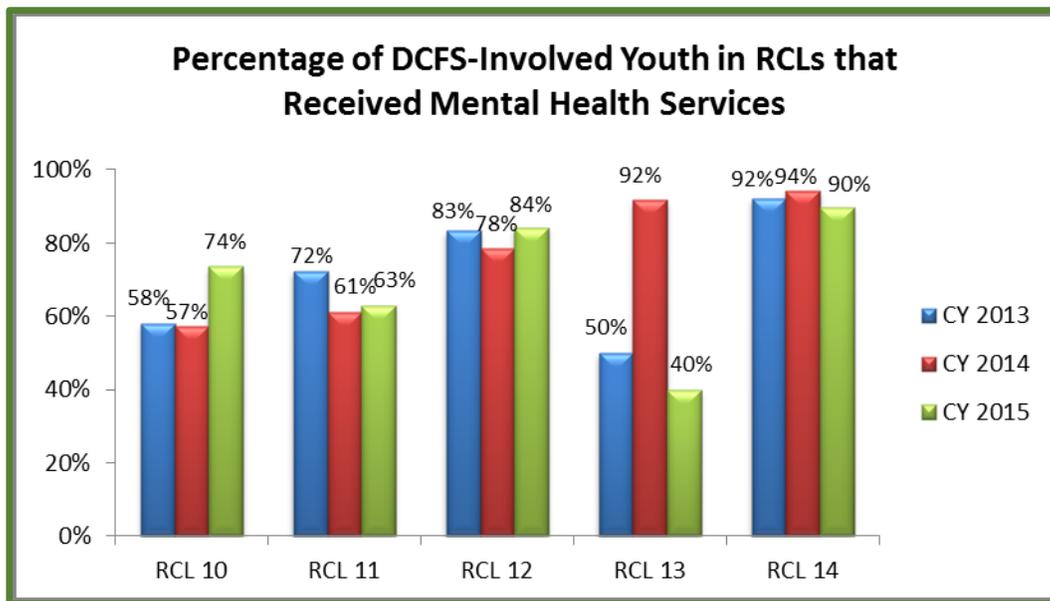
[The subclass criteria below include Full Service Partnership (FSP), clients that have had three or more placements within 24 months (Multiple Placement), Treatment Foster Care (TFC), Community Treatment Facility (CTF), D-Rate placement, Rate Classification Levels 10-14 (RCL 10–14), Psychiatric Hospitalization (Psych Hospitalization), Wraparound, Exodus, and/or Therapeutic Behavioral Services (TBS)].



8) In the following data, DCFS’ calendar year placement numbers were compared to DMH clients who received a mental health service while in Rate Classification Level (RCL) 10 and above. Many of the children placed in the RCLs may in fact be

receiving mental health services from the Group Home staff members and/or Fee-for-Service Providers, which is not reported to our mental health database. Additionally, some of these children may have been placed in facilities located outside of the County and/or State; therefore, in these instances, their mental health information would not be reported to DMH because of their technical “unmatched” label. DMH and DCFS will continue to explore possible reasons why some of the children in these placements did not reportedly receive any mental health services.

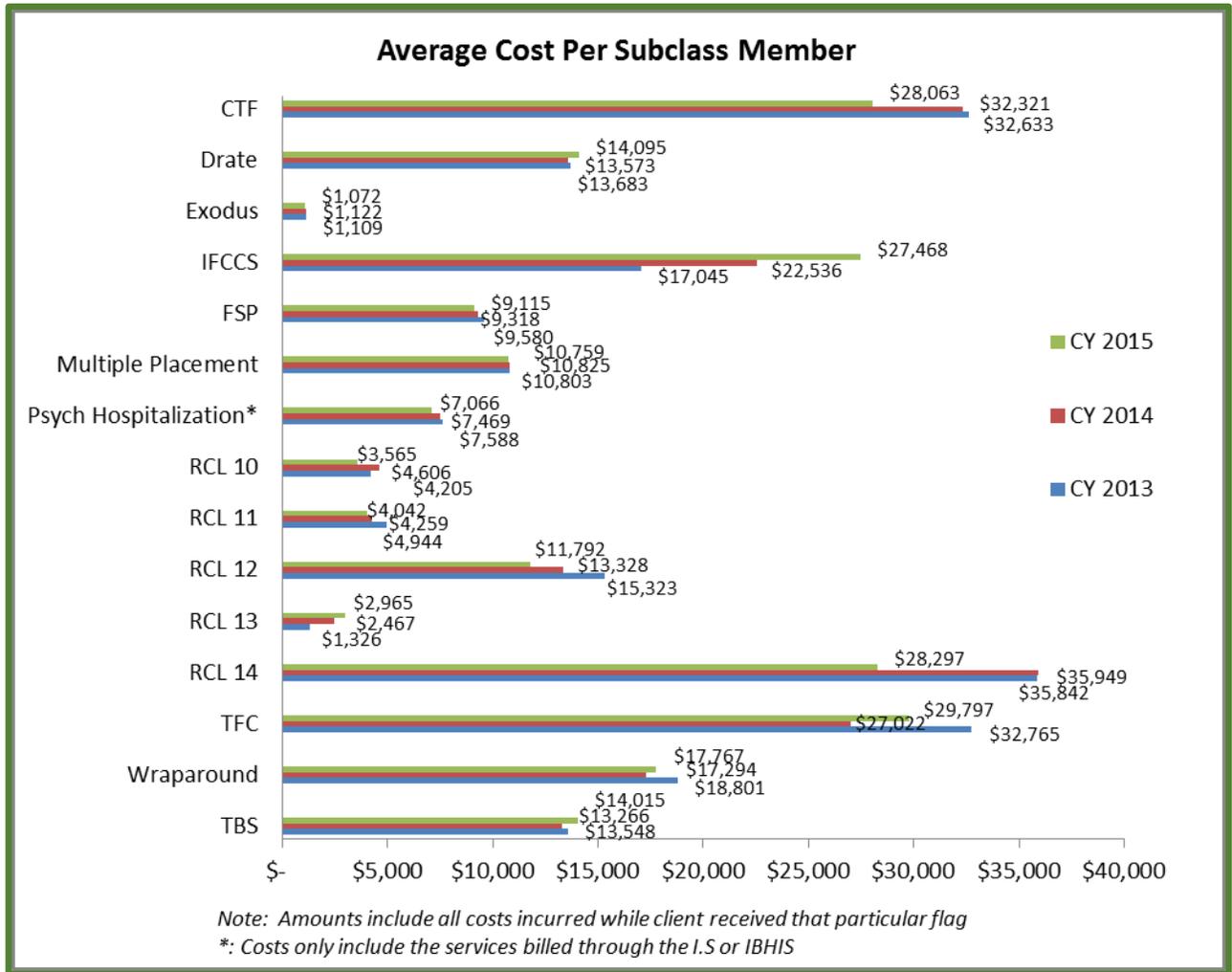
The graph below shows the percentage of DCFS-involved youth in RCLs 10 and above that received mental health services through DMH. The data shows that within the last three calendar years, the percentage of youth that received mental health services through DMH has remained somewhat steady in RCL 14 (CY 2015: 90%; CY 2014: 94%; CY 2013: 92%). The percentage of DCFS-involved youth in RCL 10, RCL 11 and RCL 12 who received mental health services through DMH has increased from CY 2014 to CY 2015. The youth in RCL 13 who received mental health services increased significantly from CY 2013 to CY 2014 and then decreased in CY 2015 (CY 2015: 40%; CY 2014: 92%; CY 2013: 50%). However fewer children/youth reside in RCL 13s compared to other RCLs (CY 2013: 2 residents, 2014: 12 residents, CY 2015: 10 residents).



- 9) The average cost associated with the identified criteria or programs varies greatly, with costs associated with Treatment Foster Care (CY 2015: \$29,797), Rate Classification Level 14 (CY 2015: \$28,297), and Community Treatment Facilities (\$28,063) being the programs with the highest costs for subclass members in calendar years 2013, 2014 and 2015 (see chart below). However, the costs of Psychiatric Hospitalizations only include the costs for claims that were submitted through the I.S. or IBHIS and do not include costs for services that the hospitals may have billed directly to the state. The costs only include services billed under one of the procedure code groupers: Therapy, Family Therapy, Collateral, Crisis Intervention, Targeted Case Management (TCM),

Therapeutic Behavior Services (TBS), Team Consultation, Rehabilitation, Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), Medication Support, Crisis Stabilization, Other Treatment (Assessment, Psychological Testing, Report Writing, Record Review, Day Treatment and Psychiatric Hospitalization).

10)



Utilization of Evidence-Based and Promising Practices for Class Members

DMH reports that for 2014, 8325 class members received treatment using an evidence-based or promising practice. This reflects a decrease from 10,044 in 2013 and 9,033 in 2012. Most received Trauma-Focused – Cognitive Behavioral Therapy, Managing and Adapting Practice, Seeking Safety and Child Parent Psychotherapy.

TF-CBT is an early intervention for children/youth ages 3-18 who may be at risk for symptoms of depression and psychological trauma, subsequent to any number of traumatic experiences, particularly those individuals who are not currently receiving mental health services. Services are

specialized mental health services delivered once a week for 12 to 16 sessions by clinical staff, as part of multi-disciplinary treatment teams.

MAP is designed to improve the quality, efficiency, and outcomes of mental health services for children and youth ages 0-21 by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. MAP as implemented in L.A County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.

SS is a present-focused therapy provided once a week for 5-6 months for individuals ages 13 and older. SS helps the individual attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.

CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach. CPP is provided once a week for 50 weeks and is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. CPP is intended as an early intervention for young children ages 0-6 that may be at risk for acting-out and experiencing symptoms of depression and trauma.

I. EBPs By Calendar Year

Evidence Based and Promising Practices	Number of Clients Served (All Ages)			Number of Legal Entities (All Ages)			Number of Clients Served (Ages 0-5)			Number of Legal Entities (Ages 0-5)		
	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014
Multisystemic Therapy (MST)	32	25	25	15	10	12	5	2	1	2	1	1
Functional Family Therapy (FFT)	257	268	143	16	13	11	11	8	5	5	3	2
Brief Strategic Therapy	53	43	20	10	14	6	11	7	5	5	6	3
Child Parent Psychotherapy (CPP)	954	1,258	1,050	40	47	43	882	1,166	990	38	44	41
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	45	15	5	7	5	3	2	4	1	2	2	1
Incredible Years (IY)	279	305	168	15	16	17	113	149	86	11	13	13
Parent-Child Interaction Therapy (PCIT)	200	262	421	13	28	36	134	199	352	11	24	35
Strengthening Families	48	42	21	7	3	2	3	0	1	2	0	1
Trauma Focused - Cognitive Behavioral Therapy (TF-CBT)	4,066	4,370	3,277	82	86	84	601	690	488	61	59	54
Triple P Positive Parenting Program	579	496	310	37	42	35	188	183	138	26	29	28
UCLA Ties Transition Model	22	32	41	2	3	3	13	20	25	2	2	2
Aggression Replacement Training (ART)	562	487	315	26	23	15	17	23	4	4	5	2
Alternatives for Families - Cognitive Behavioral Therapy (AF - CBT)	74	141	80	6	7	9	14	14	10	4	3	3
Managing and Adapting Practice (MAP)	2,503	3,023	2,693	79	82	84	320	396	397	53	59	60
Seeking Safety	1,268	1,385	1,107	54	63	61	16	54	20	9	6	5

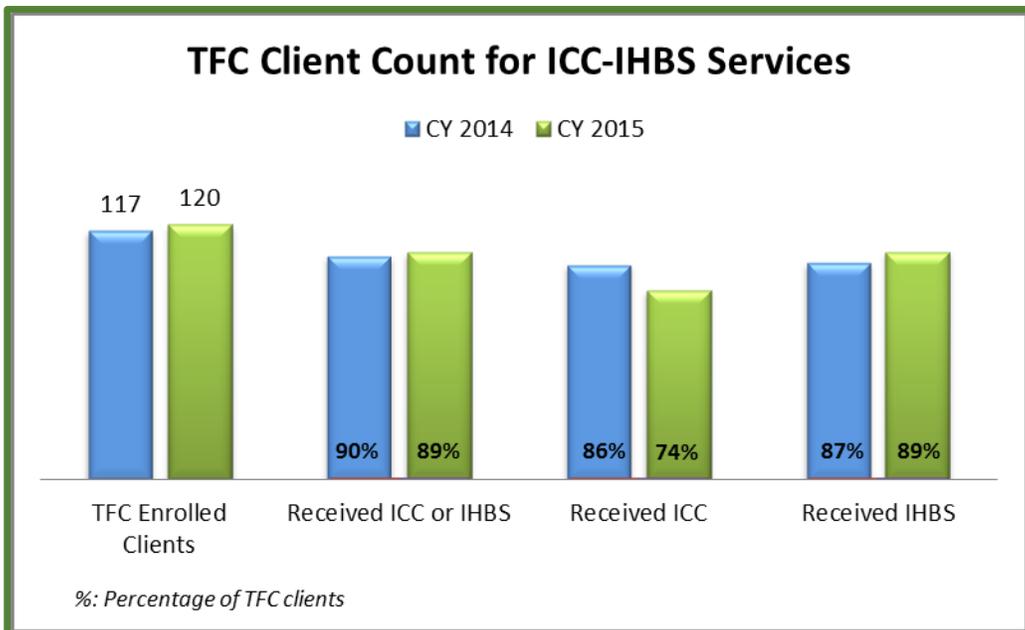
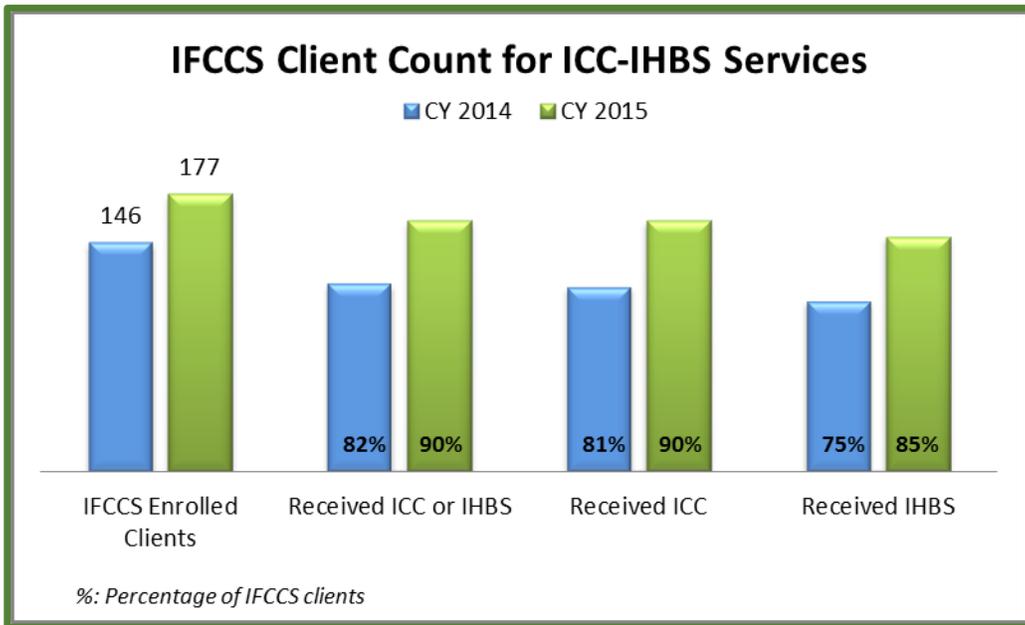
II. EBPs by Service Area

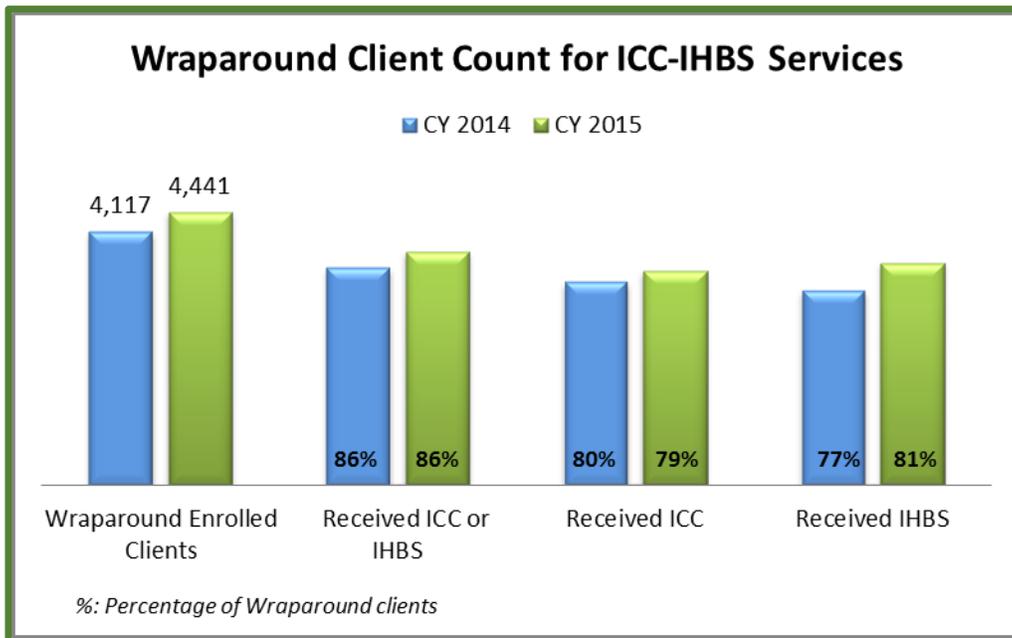
Evidence Based and Promising Practices	SA 1 Client Count	SA 2 Client Count	SA 3 Client Count	SA 4 Client Count	SA 5 Client Count	SA 6 Client Count	SA 7 Client Count	SA 8 Client Count	SA 9 (Out of County) Client Count	Distinct Client Count per EBP
Aggression Replacement Training (ART)	10	49	59	1	1	15	5	2	0	142
Alternatives for Families – Cognitive Behavioral Therapy (AF - CBT)	0	0	0	0	0	28	10	11	0	47
Brief Strategic Therapy	1	2	3	2	0	2	1	0	0	11
Child Parent Psychotherapy (CPP)	123	135	59	107	29	134	70	198	2	849
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	0	0	0	1	0	1	0	2	0	4
Functional Family Therapy (FFT)	6	4	0	11	0	56	6	17	0	99
Incredible Years (IY)	2	2	17	36	0	80	5	5	0	147
Managing and Adapting Practice (MAP)	431	456	614	267	84	274	297	347	0	2,737
Multisystemic Therapy (MST)	0	4	1	2	0	6	1	4	1	19
Parent-Child Interaction Therapy (PCIT)	36	70	49	35	10	67	34	119	0	418
Seeking Safety	41	165	262	69	6	64	25	19	33	670
Strengthening Families	0	7	0	0	0	0	0	0	0	7
Trauma Focused - Cognitive Behavioral Therapy (TF-CBT)	408	352	309	190	21	414	240	376	0	2,289
Triple P Positive Parenting Program	32	57	38	30	3	84	43	18	0	304
UCLA Ties Transition Model	0	0	3	0	21	0	0	3	0	27
Distinct Client Count per SA	980	1,134	1,262	698	161	1,158	685	1,065	36	
Legal Entity Distinct Count per SA	11	20	22	27	7	20	18	19	3	
<i>Note: 1) CY 2015 Data. 2) There were 7,179 children/youth that received one or more EBPs with one or more of the 89 Legal Entities.</i>										

Intensive Home-Based Services and Intensive Care Coordination

The County has been phasing in ICC and IHBS since FY 12-13 in three phases. As mentioned previously, DMH will expand to 1,000 IFCCS slots in May 2016 and add another 500 slots in FY 16-17.

The graphs below show the number of clients within Intensive Field Capable Clinical Services (IFCCS), Treatment Foster Care (TFC), and Wraparound that have received ICC and IHBS during CY 2014 and CY 2015. The percentage of youth in IFCCS that received ICC and IHBS increased.



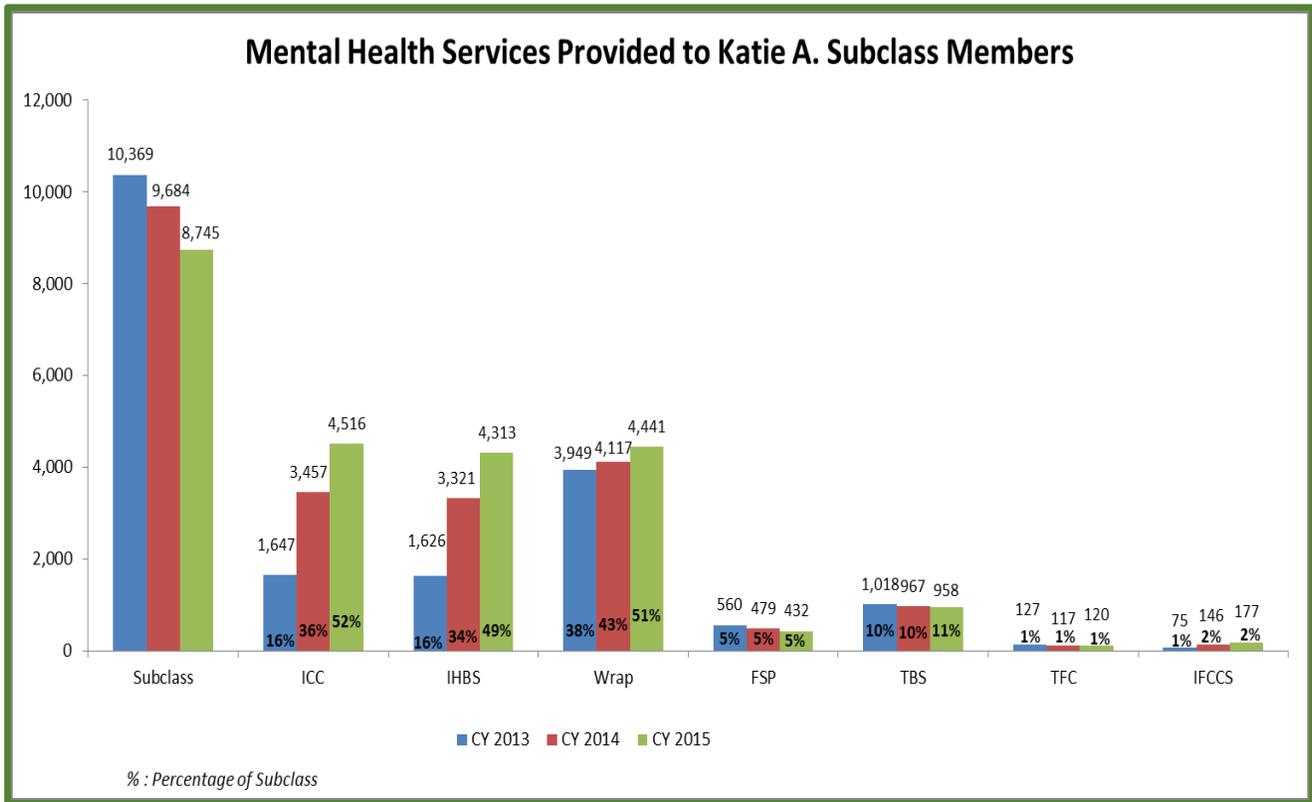


Mental Health Services Provided to Katie A. Subclass Members

The following graph provides a breakdown of the number and percentages of subclass members during calendar years 2013 through 2015 that have received ICC, IHBS and other intensive services (Wraparound, FSP, IFCCS, TFC and TBS). Some subclass members received more than one service and/or were enrolled in one or more programs during the CY. Actually, while TBS may be delivered within the home, it is not really an IHBS as defined by Katie A. IBHS services are more similar to Rehabilitation services than the specialty mental health services.

The following graphs also indicate the types of mental health services subclass members enrolled in Wraparound, TFC and Group Homes RCL 10 and above received in CY 2015. Some children/youth received more than one service and/or were enrolled in one or more programs during the CY. The percentage indicates that percent of clients in the program that received the service.

In Wraparound, the majority of clients received therapy (85%), Other Treatment (76%), and Team Consultation (75%). In TFC, the majority of clients received Therapy (69%), IHBS (66%), Team Consultation (59%) and Other Treatment (59%). In Group Homes RCL 10 and above, the majority of clients received Other Treatment (82%), Team Consultation (70%), and Therapy (66%). Some children/youth in the group homes may have received services directly by group home staff or a private mental health provider.



Based on the previous data, there are a number of points that are worth highlighting:

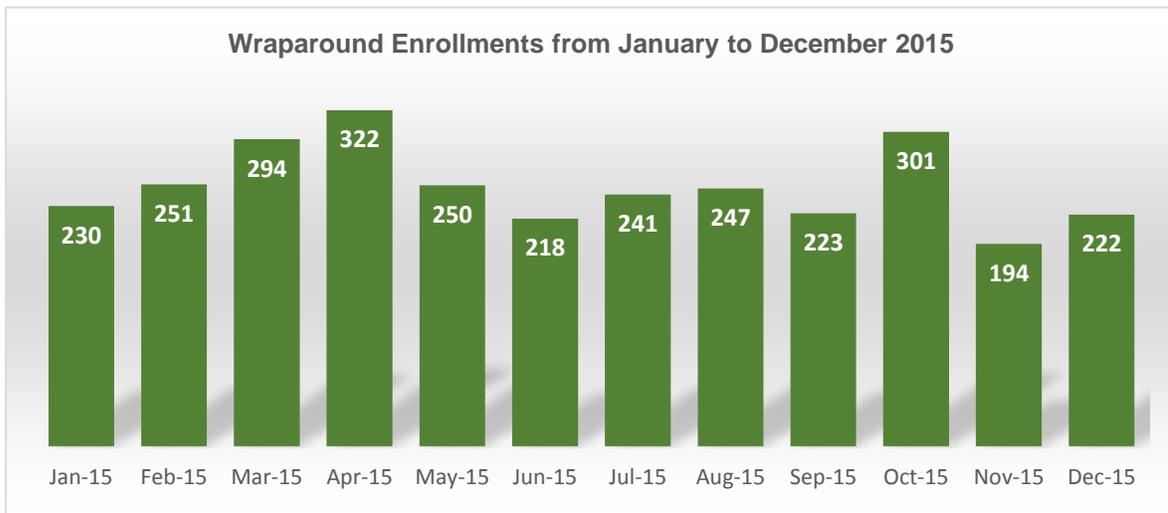
1. The data show that the number of subclass members has decreased in recent years making up a smaller percentage of the Katie A. Class. According to DMH, this may be partly due to the decrease in the number of youth that had three or more placements (as subclass indicator) within the last 24 months.
2. While the subclass made up about 38% of the Class during CY 2014, the Subclass made up about 67% of the total Class cost.
3. The average mental health cost associated with Subclass Members has remained steady over the last three calendar years and is much higher than the average cost of mental health services for class members who are not part of the subclass.
4. DMH reports that it had expected to see Subclass Members receiving more services in the home during calendar year 2014 than in calendar year 2013, but there was a decrease (CY 2014: 33%; CY 2013: 35%). While there does not seem to be a trend in more services provided in the home for Subclass Members, they are receiving less services in the office (CY 2014: 27%; CY 2013: 28%).

5. Consistent with previous years, the majority of youth in the subclass had either three or more placements, were enrolled in Wraparound or were placed in a D-Rate home.
6. Within RCLs, the number of youth that received mental health services through DMH has remained steady in RCL 14. In addition, the percentage of DCFS-involved youth in RCL 10, RCL 11 and RCL 12 who received mental health services through DMH increased from CY 2014 to CY 2015 while the percentage of youth in RCL 13 decreased. It is important to note that fewer children/youth reside in RCL 13 when compared to the other RCLs (CY 2014: 12 residents, CY 2015: 10 residents).
7. For the last three calendar years, 33% to 38% of class members received an Evidence-Based Practice or Promising Practice and the majority of those youth received Trauma Focused-Cognitive Behavioral Therapy (TF-CBT).
8. From CY 2014 to CY 2015, the percentage of youth that received ICC and IHBS in IFCCS increased, while only the percentage of youth who received IHBS increased in Wraparound and TFC.
9. In Wraparound and TFC, the majority of subclass members received therapy in CY 2015 (Wrap 85%, TFC 69%), while in group homes RCL 10 and above, the majority received Other Treatment (82%). Some children and youth in group homes may have received services directly by the group home staff or a private mental health provider.

Wraparound Services

At the direction of the Board of Supervisors, DMH is taking over management of the Wraparound Program from DCFS no later than June 30, 2016. The two agencies are working on a transition plan to address key components of system operations. There are 48 Wraparound service providers, which DMH refers to as legal entities, at 64 sites throughout the County. The new Wraparound contract replaced the former two-tier system with one Case Rate/Medi-Cal payment. According to DMH, one of the advantages of this payment structure is the financial feasibility of providers being able to serve children in residential facilities (with no identified caregiver), as they no longer are required to deduct the placement cost. DMH believes that the new approach enhances and highlights the Mental Health and Intensive Care Coordination/Intensive Home-Based Services (ICC/IHBS) mandated by the State's settlement of the Katie A. lawsuit that is inclusive of the Shared Core Practice Model.

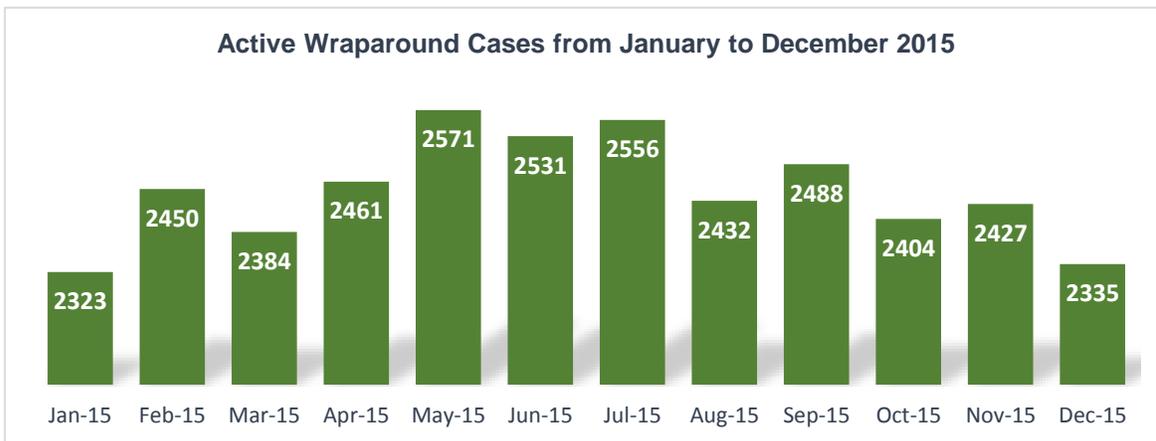
From January through December, 2015, a total of 2,993 children/youth were enrolled in Wraparound. The following table shows monthly enrollments.



Data

Source-DCFS Wraparound System -2/11/2016

From January through December, 2015, there was an average of 2,447 monthly active Wraparound cases:



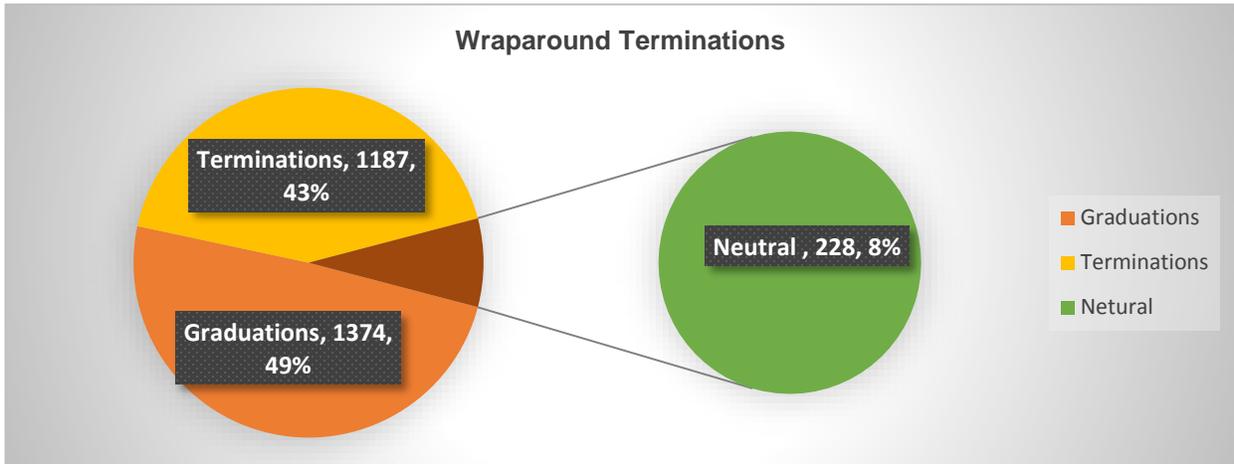
Data

Source-DCFS Wraparound System -2/11/2016

Wraparound Graduations, Neutral Terminations and Terminations by Category

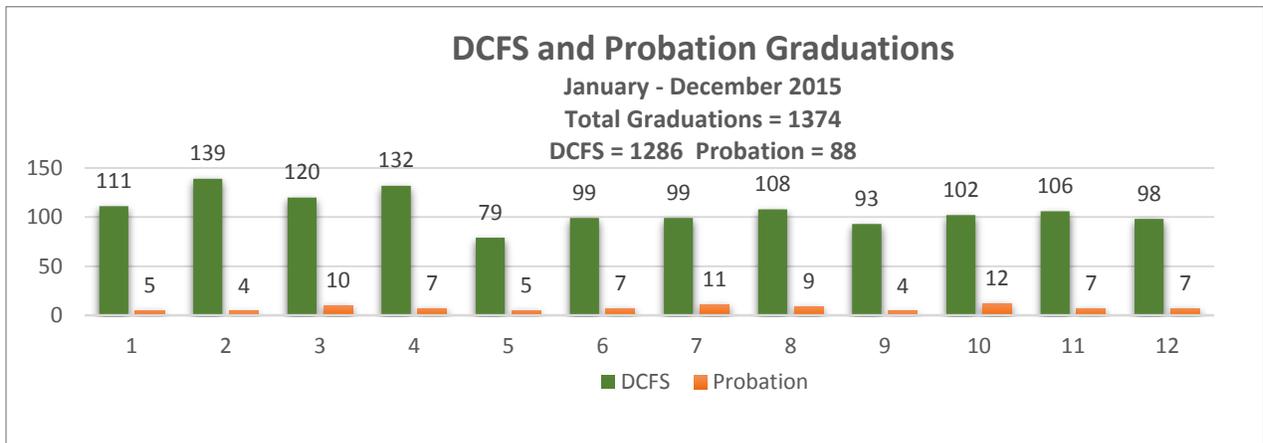
Wraparound terminations from both DCFS and the Department of Probation totaled 2,789:

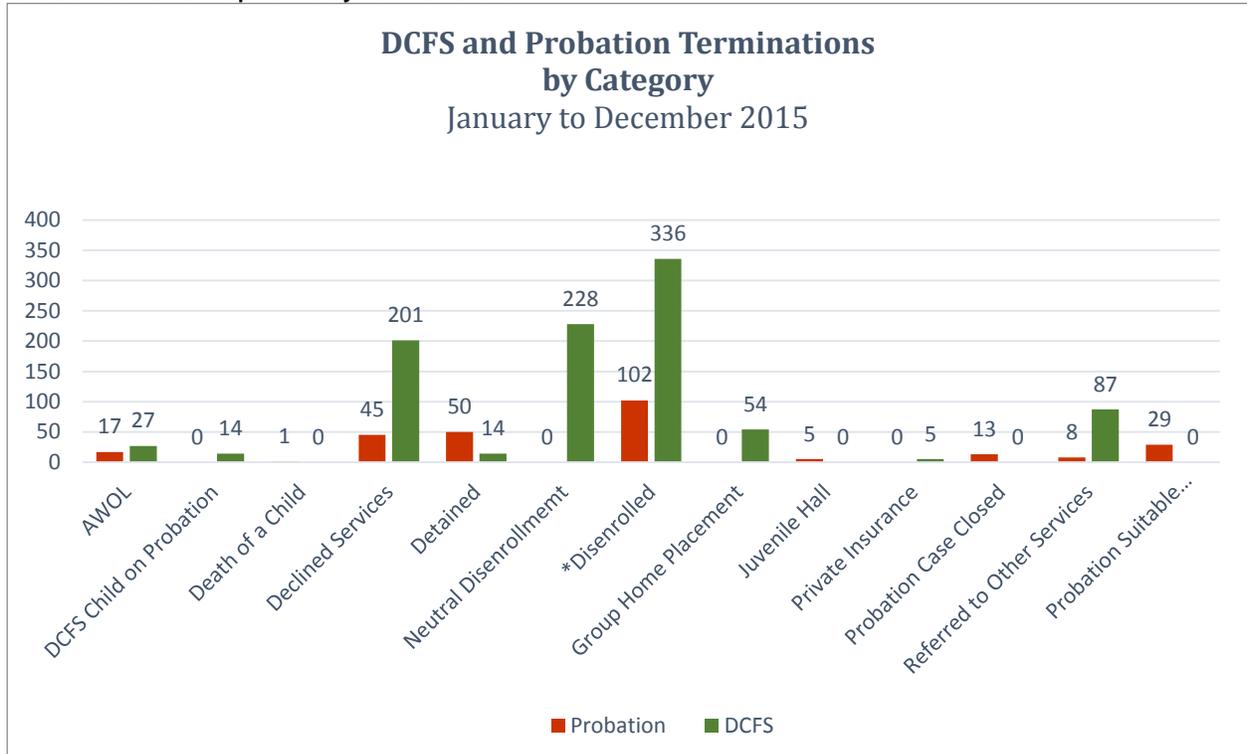
- Graduations for both departments totaled 1,374
- Terminations for both departments totaled 1,187 (Please note graphs below for various termination reasons)
- Neutral Terminations totaled 228 (Please note that Neutral Terminations are DCFS/Probation case closures and families moving outside of Los Angeles County)



Data Source-DCFS Wraparound System -2/11/2016

Wraparound Graduations & Terminations





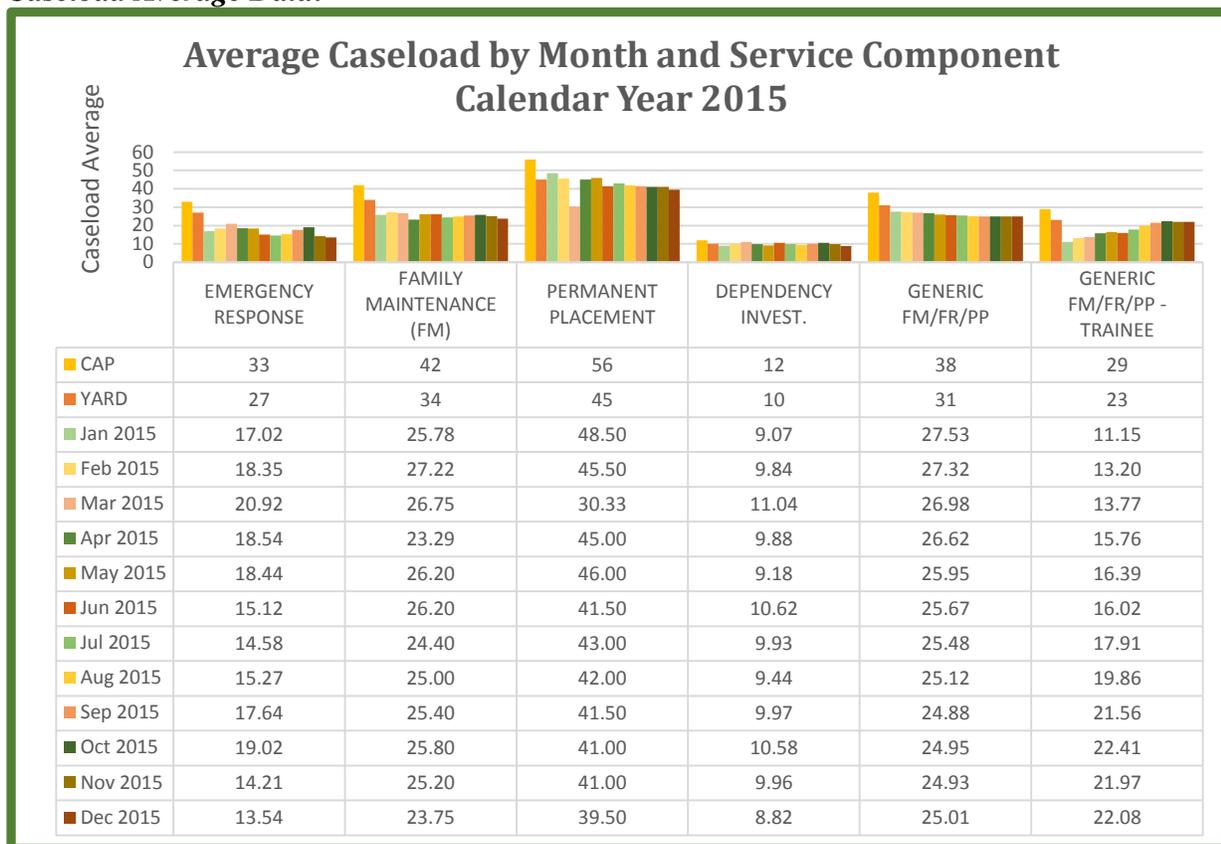
DCFS Staffing: Caseload/Workload Reduction

Workload constraints in DCFS are a major barrier to implementation of the case practice model. As previously mentioned, until DCFS reaches agreement with the union about caseworkers incorporating child and family team meetings and other core practice model approaches into their work, an action contingent upon lower caseloads, the County will continue to be unable to implement the core practice model or meet QSR exit standards. In the past year, the County Board has approved the addition of 586 DCFS CSW staff, a remarkable demonstration of commitment to children and families, DCFS and the Katie A. Settlement. Many of these new staff are in the process of being trained and when they can assume a full caseload, the overall workload should decline considerably. DCFS views an average of 20 cases for continuing services staff as an interim goal and hopes to lower caseloads even further. National standards and the standards in a number of other class action child welfare settlements establish a caseload size of 15 children in foster care and/or in-home as the recommended average. Caseload standards for Emergency Response caseloads are lower than for continuing services because of the intensive and time-constrained nature of investigations.

The caseload trends described below provide some context about the overall agency workload. The following figures are updated with point-in-time data for each point in year referenced.

Year End Count as of December 31	Emergency Response (Number of children involved in Abuse and Neglect In-Person investigations)	Family Maintenance (Service to children living in their own homes)	Out-of-Home (Children receiving Family Reunification or receiving PP Services)
2003	9,642	8,915	27,638
2008	9,928	10,678	20,813
2009	10,043	10,847	20,588
2010	10,005	12,933	19,956
2011	10,186	14,648	19,401
2012	10,269	13,945	18,943
2013	10,099	13,817	20,209
2014	10,782	13,112	20,282
2015	9,845	11,937	19,992

Caseload Average Data:



Data Source: DCFS The SITE: 2/22/2016

NOTE: Excludes CSWs with zero caseloads. Excludes Adoption Caseload.

CAP: Maximum number of cases /Referrals that can be assigned to the primary CSW.

Yardstick: The optimal target number of cases assigned to the primary CSW.

Emergency Response:

The average caseload per ER CSW showed a 28% decrease from 18.7 referrals per CSW in December, 2014 to an average of 13.54 referrals per CSW in December, 2015. Caseload numbers for Emergency Response Workers fluctuate and are based on the calls received at the Hotline that generate the referrals. The target caseload for ER CSWs in immersion offices is 17 referrals

Continuing Services:

Generic CSW caseloads showed a 15% decrease in the average caseload per CSW from 29.3 in December 2014 to 25.01 in December 2015. This is a direct result of the influx of newly hired CSWs who have completed their training and are now carrying full caseloads. The target caseload for continuing services CSWs in immersion offices is 20 cases.

Placement of Children and Youth in Group Homes and Residential Facilities

The following table shows the monthly group home census, by age range and purpose of placement for 2015. The County reports that the average census was 953 children for that period. Additional data reflects:

- Average of 65 children per month age 12 and under placed for therapeutic stabilization, which includes crisis intervention, clinical evaluation and the identification of a treatment plan.
- 65 newly placed children in group care each month
- Average of 45 children per month age 12 and under placed for emergency shelter purposes
- Average of 766 children per month age 13-17 ½ placed for therapeutic stabilization
- Average of 53 children per month age 13-17 ½ for placed for emergency shelter purposes
- Average of 124 non-minor dependents (age 18+) placed for therapeutic stabilization
- Length of stay data are not available, but DCFS is working on these calculations

Monthly Group Home Census
(Excluding Adoptive, Guardian Home, and Non-Foster Care Placement)
January 2015 to December 2015

Group Home	Jan 2015	Feb 2015	March 2015	April 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	TOTAL
0-12	54	54	64	74	87	67	65	71	36	73	69	65	779
13-17	785	782	799	789	801	799	778	760	737	715	722	720	9187
18 Plus	134	140	132	116	126	125	129	126	115	117	121	112	1493
TOTAL	973	976	995	979	1014	991	972	957	888	905	912	897	11,459
ESC													
0-12	43	44	47	32	42	38	36	47	41	48	59	60	537
13-17	42	45	32	34	34	62	67	58	70	67	66	65	642
18 Plus	0	0	0	0	0	0	4	6	6	5	3	6	30
TOTAL	85	89	79	66	76	100	107	111	117	120	128	131	1,209
Medical (MCMS)													
0-12	9	8	6	6	7	6	6	6	36	73	69	5	237
13-17	22	24	23	22	21	19	19	18	737	715	722	15	2357
18 Plus	8	10	8	5	7	10	10	11	115	117	121	7	429
TOTAL	39	42	37	33	35	35	35	35	888	905	912	27	3,023
MCMS ESC (Medical)													
0-12	0	0	1	0	0	0	0	0	0	0	0	0	1
13-17	0	0	0	0	0	0	0	0	0	0	0	0	0
18 Plus	1	1	0	0	0	0	0	0	0	0	0	0	2
TOTAL	1	1	1	0	0	0	0	0	0	0	0	0	3

Note:

1. Data source: 0-12 ESC Count from High Risk Services Division; Ages 13-17 and 18 Plus: CWS/CMS History Database.

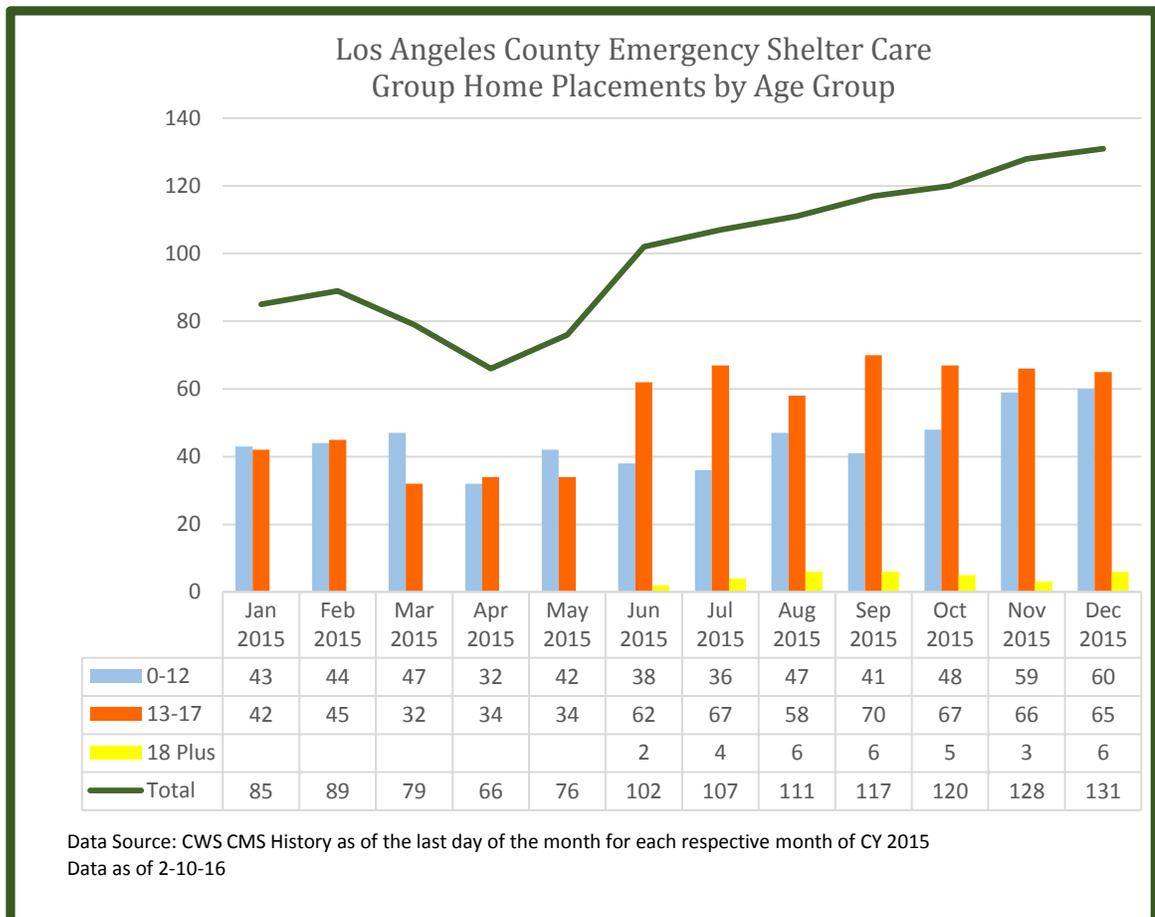
2. MCMS: Medical Case Management Services are children placed in congregate care in order to sufficiently meet their medical needs.

3. ESC: Emergency Shelter Care: Children who are placed in congregate care on an emergent basis, until placements that meet their needs are located.

The County reported the following update.

Of the 19,992 DCFS youth reported to be in out-of-home care on December 31, 2015, 4.5% (897) were placed in a Group Home in order to meet their behavior needs, until a suitable alternative was identified. The County has had to rely on Group Home placements due to the paucity of appropriate foster and therapeutic foster home resources. The data above lists that, on average, 953 children and youth were in Group Home care per month during calendar year 2015. DCFS is working on length of stay data.

The County has invested a considerable amount of resources to work with the State on its Continuum of Care Reform efforts scheduled to become effective January 1, 2017. Given the depth and breadth of these proposed reforms (most of which have yet to be drafted into proposed regulations), the likely impact upon the rates paid, deliverables offered, and performance-based contracting objectives, the County continues its efforts to reduce Group Home stays on a case-by-case basis while waiting for the State to roll out the budget, laws and regulations required to implement these reforms a year from now.



Treatment Foster Care (TFC)

In providing updates for this report, the County informed the Panel that it can report no new recruitment and retention strategies that would produce a growth in capacity which would lead to achievement of the 300 TFC beds specified in the Corrective Action Plan. The County also noted that:

The State of California Health Care Services did receive approval (by the Center for Medicare and Medicaid Services) of their state plan amendment. This amendment will allow certain eligible Foster Family Agency resource parents to directly bill MediCal for specialized mental health services. This may reach a new pool of foster parents interested in providing care for high needs children. In addition, the County will be initiating a new solicitation for Intensive Treatment Foster Care contracts in October 2016, which will provide an opportunity to expand the number of TFC providers. The new solicitation will allow for crafting new statements of work for the providers, thereby strengthening requirements for efficient and comprehensive services for TFC youth and fuller support of TFC caregivers.

It appears that further clarification is needed from the State to permit the County to capitalize on this regulatory information. The Panel has no reason to expect additional growth in TFC in the upcoming reporting period. The Panel pointed out in its most recent meeting that provision of sufficiently intensive IHBS services to meet the needs of a child and support the needs of a caregiver to meet those needs could result in a foster home functioning as a treatment foster home (and the foster home could be able for a higher monthly rate. The Panel recommended that DCFS and DMH begin documenting these placements, their successes and costs.

Implementation of Behavioral Health Information System (IBHIS)

The Department of Mental Health states that it has implemented IBHIS in all directly operated programs with the exception of programs co-located with the Sheriff and Probation Departments. Providers are now submitting claims and a small group of fee-for-service providers will begin using IBHIS early in 2016.

Coaching of DCFS and DMH Staff in Core Practice Model Practice CPM)

DMH Training and Coaching

DMH is providing training and coaching to its co-located staff (staff placed in DCFS offices) and some providers. Training primarily includes content on the County's Shared Core Practice

Model (CPM), ICC and IHBS and Trauma Informed Practice. As the Panel has noted previously, training sessions tend to be relatively brief (less than a full day), involve large groups of participants (which limits participant involvement in training activities) and mostly conceptual (as opposed to being skill-based). DMH continues to have a modest training capacity and in the Panel’s opinion, capacity too small to adequately prepare staff and providers to fully and faithfully implement the CPM.

Currently, DMH is preparing training in IHBS for IFCCS providers and has enlisted the assistance of Dr. Marty Beyer, Panel member, to provide a day of training. DMH proposed 5 days of training for 80 participants from the 20 new IFCCS providers, spread over 2 months in the summer of 2016 as the new IFCCS contracts are scheduled to begin. Feedback from the Panel revolved around increasing the training on trauma, trauma-related needs, crafting IHBS services individually to meet needs and support caregivers in meeting needs, and the role of the IHBS clinician on the team and as a clinical supervisor for IHBS staff. Service crafting is not guaranteed even when underlying needs are identified or there is a team in place. It is a way of thinking that has to be taught and encouraged through coaching and supervision. A challenge for crafting needs-based individualized intensive services is that providers will continue to prepare a diagnosis-driven treatment plan and Medi-Cal claiming for unconventional IHBS services.

The Panel recommended that DMH develop a purposeful plan for ensuring fidelity in actual practice for each provider, including a clinical supervision method that will be utilized, with direct feedback from quality service reviews and the role of coaching in conjunction with clinical supervision in the provider agencies.

DMH coaching has been primarily focused on teaching staff in a small number of group homes to facilitate team meetings. DMH has very modest coaching resources with which to develop its work force to engage in CPM practice. It is difficult to see how DMH can meaningfully improve IHBS practice within the core practice model in the planned expansion of IFCCS.

DMH provided the following calendar of training sessions for 2015.

Training	Date of Training	Trained by	Participants included:
Trauma Informed Practice	1/22/15	Jeanette Yoffe, MFT	DMH Staff and Children’s Providers Countywide
Shared Core Practice Model	2/18/15	DMH Coaches	DMH Staff and Children’s Providers Countywide
Trauma Informed Practice	3/12/15	Jeanette Yoffe, MFT	DMH Staff and Children’s Providers Countywide
Shared Core Practice Model	3/26/15	DMH Coaches	DMH Staff and Children’s Providers Countywide
Shared Core Practice Model	4/7/15	DMH Coaches	DMH Staff and Children’s Providers Countywide
Trauma Informed Practice	4/9/15	Jeanette Yoffe, MFT	DMH Staff and Children’s Providers Countywide

Training	Date of Training	Trained by	Participants included:
Shared Core Practice Model	4/14/15	DMH Coaches	Bayfront Family Services
Sensory Integration in School Aged Children & Youth	4/23/15	Kimberly Rice, ODT, OTR/L, SWC	Children's Wraparound and Intensive Field Capable Clinical Service Providers Countywide
Trauma Informed Practice	5/14/15	Jeanette Yoffe, MFT	DMH Staff and Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	5/14/15	Jessica Walters, PhD	Children's Providers Meeting
Best Practice Interventions with Complex Trauma Victims	5/18/15	Ken Schwartznberger, LCSW, RPT-S	DMH Staff and Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	5/20/15	Jessica Walters, PhD	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	5/21/15	DMH Coaches	DMH Staff and Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	5/21/15	Jessica Walters, PhD	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	6/2/15	DMH Coaches	SA 5 DM Staff and Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	6/4/15	Jessica Walters, PhD	Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	6/9/15	Jessica Walters, PhD	DMH Staff and Children's Providers Countywide
Trauma Informed Practice	6/11/15	Jeanette Yoffe, MFT	DMH Staff and Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	6/16/15	Jessica Walters, PhD	Children's Providers Countywide
Shared Core Practice Model	6/18/15	DMH Coaches	DMH Staff and Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	6/23/15	Jessica Walters, PhD	Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	7/2/15	Jessica Walters, PhD	Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	7/7/15	Jessica Walters, PhD	Children's Providers Countywide
Shared Core Practice Model	7/8/15	DMH Coaches	Personal Involvement Center
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	7/9/15	Jessica Walters, PhD	Children's Providers Countywide

Training	Date of Training	Trained by	Participants included:
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	7/14/15	Jessica Walters, PhD	Children's Providers Countywide
Shared Core Practice Model	7/16/15	DMH Coaches	Child and Family Center
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	7/20/15	Jessica Walters, PhD	Children's Providers Countywide
Shared Core Practice Model	7/20/15	DMH Coaches	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	7/24/15	DMH Coaches	D'Veal Family and Youth Services
Shared Core Practice Model	7/28/15	DMH Coaches	The Village Family Center
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	7/27/15	Jessica Walters, PhD	Children's Providers Parent Partners
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	7/28/15	Jessica Walters, PhD	Children's Providers Parent Partners
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	8/11/15	Jessica Walters, PhD	Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	8/12/15	Jessica Walters, PhD	Children's Providers Countywide
Shared Core Practice Model	8/12/15	DMH Coaches	Aviva Family & Children's Services
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	8/25/15	Jessica Walters, PhD	Children's Providers Countywide
Shared Core Practice Model	8/26/15	DMH Coaches	DMH Staff and Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	9/15/15	Jessica Walters, PhD	Children's Providers Countywide
Shared Core Practice Model	9/15/15	DMH Coaches	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	9/21/15	DMH Coaches	Bayfront
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	9/28/15	Jessica Walters, PhD	Children's Providers Countywide
Shared Core Practice Model	9/29/15	DMH Coaches	El Centro del Pueblo
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	9/30/15	Jessica Walters, PhD	Children's Providers Countywide

Training	Date of Training	Trained by	Participants included:
Shared Core Practice Model	9/30/15	DMH Coaches	Ettie Lee Youth and Family Services
Shared Core Practice Model	10/7/15	DMH Coaches	Ettie Lee Youth and Family Services
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	10/14/15	Jessica Walters, PhD	Children's Providers Countywide
Shared Core Practice Model	10/20/15	DMH Coaches	DMH Staff and Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	10/21/15	Jessica Walters, PhD	Children's Providers Countywide
Trauma Informed Practice	10/29/15	Jeanette Yoffe, MFT	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	11/12/15	DMH Coaches	DMH Staff and Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	11/17/15	Jessica Walters, PhD	Children's Providers Countywide
Trauma Informed Practice	11/19/15	Jeanette Yoffe, MFT	DMH Staff and Children's Providers Countywide
Culturally Sensitive Practice: Integration of Shared Core Practice Concepts	11/19/15	Dr. Barbara Stroud	DMH Staff and Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	12/7/15	Jessica Walters, PhD	Children's Providers Countywide
Shared Core Practice Model	12/16/15	DMH Coaches	DMH Staff and Children's Providers Countywide

DCFS Training and Coaching

DCFS has primarily employed training and coaching staff in the Child and Family Team process as a means of implementing the Core Practice Model. In doing so, the main focus has been on developing internal coaches who are coaching supervisors and some caseworkers to facilitate team meetings. The County reports that to date, 575 staff have been certified as child and family team coach developers, coaches or practitioners (facilitators). Forty supervisors were certified as coach developers, 73 supervisors were developed as coaches and 339 supervisors and 102 caseworkers were developed as practitioners (facilitators). DCFS primarily uses the CFT process as a setting in which staff are taught to identify and respond to child and family underlying needs. Unfortunately, this strategy is too brief and is without sufficient intensive focus on strength/needs-based practice, which results in staff being unprepared to fully implement the core practice model. With the Panel's encouragement DCFS has recently begun adding crafting individualized services with sufficient intensity to its training and coaching. DCFS and DMH have relied on consultants to develop training and coaching, and the Panel has

encouraged both Departments to integrate strengths, needs (especially trauma-related needs), service crafting and teaming into a single Shared Core Practice Model training and coaching approach that belongs to the county and is led by county staff.

While the Department has made significant progress in developing the capacity to teach staff the CFT process, having certified 575 staff, the team meetings held were largely a means to develop staff skills in the process. Few caseworkers are employing child and family teams with cases on an ongoing basis, partly because of resistance by the union to adding the CFT workload to a workforce it already considers overloaded. This stalemate has existed for several years and has stalled this core initiative. Basically, the majority of children and families are not experiencing significantly different practice than they were a year ago. This view is supported by the Qualitative Service Review performance, where system performance on many key practice indicators, especially the CFT process, remains quite low.

DCFS believes that because the County has increased front-line staff by approximately 1,231 staff since August 2013, an improvement of great significance for this system, and because of recent promising discussions with the union about caseload size, that caseworkers will soon be able to fully incorporate the CFT process into their ongoing work with children and families. The union leadership has stated that it concurs with the DCFS policy to fully implement the CFT process; however they remain cautious about staff capacity to employ the CFT process in all cases unless caseloads are lowered further. The Panel has been unable to determine exactly when full implementation might occur.

Qualitative Service Reviews (QSR)

Settlement Standard

Each Service Planning Area can exit individually by meeting the passing standards for both the Child and Family Status Indicators and the System Performance Indicators (85 percent of cases with overall score of acceptable respectively and 70 percent acceptable score on Family Engagement, Teamwork and Assessment). Once the targets have been reached, at the next review cycle the regional office must not score lower than 75 percent respectively on the overall Child and Family Status and System Performance Indicators, and no lower than 65 percent on a subset of System Performance indicators respectively (engagement, teamwork, and assessment). The County will continue the QSR process for at least one year following exit and will post scores on a dedicated Katie A website.

Consistent with its strategic plan, the County continues to conduct Qualitative Service Reviews (QSR). The QSR is an interview-based evaluation of the quality of frontline practice involving a sample of cases in each office. The QSR permits an examination of the quality of services (not just whether the service was delivered) as well as an assessment of the child's current status. Each DCFS office is reviewed on an 18-month cycle. QSR performance is an element of the Katie A. Settlement Agreement's exit criteria for the County.

The QSR Baseline was completed in August 2012 and the corresponding QSR Baseline Report was completed and issued in 2013. The second QSR Review cycle was completed in October 2014, with finalized scores completed in December 2014. The third QSR cycle began in February

2015. The offices that have had reviews thus far are Belvedere, Pomona, Compton, San Fernando Valley and Vermont Corridor. The early 2016 reviews will be for the following offices: El Monte (January, 2016), Metro North (March, 2016) and Glendora (April, 2016).

The QSR provides a basis for measuring, promoting, and strengthening the Shared Core Practice Model and the protocol includes two domains: Child and Family Status Indicators measure how the focus child and the child's parents/caregivers are doing within the last 30 days. The Practice Indicators measure the core practice functions being provided for the focus child and the child's parents/caregivers during the most recent 90-day period. The team consists of trained DCFS and DMH reviewers who conduct a case review and interviews with key players in the life of the child and family's case within a two-day period. The team assesses status and performance indicators to be able to determine facts such as:

Child and Family Status

- Is the focus child safe?
- Is the focus child stable?
- Is the focus child making progress toward permanency?
- Is the focus child making progress emotionally and behaviorally?
- Is the focus child succeeding in school?
- Is the focus child healthy?
- Are the focus child's parents making progress toward meeting the focus child's safety, developmental and emotional needs?

Practice Performance

- Are the focus child and family meaningfully engaged and involved in case decision making, referred to as Family Voice and Choice?
- Is there a functional team made up of appropriate participants?
- Does the team understand the focus child and family's strengths and underlying needs?
- Is there a functional and individualized plan?
- Are necessary services available to implement the plan?
- Does the plan change when family circumstances change?
- Is there a stated and shared vision of the path ahead leading to safe case closure and beyond (Long-Term View)?

Overall, scores are reflective of the aggregate scores of each of the indicators for each case reviewed in the sample. Opportunities for organizational learning and practice development include providing the CSW and their supervisor face-to-face feedback on findings in the cases reviewed. In addition, oral case presentations are made in group debriefings called "Grand Rounds" and a written case report for each case reviewed is produced to provide context for the scores and to enhance learning.

The QSR scores are subject to an exit standard approved by the court. The QSR Exit Standard is stated as follows:

Each Service Planning Area is expected to individually meet passing standards for both the Child and Family Status Indicators and the System Practice Indicators (85 percent of cases with overall

score of acceptable, respectively; and 70 percent acceptable score on Family Engagement, Teamwork and Assessment). Once the targets have been reached, at the next review cycle the regional office must not score lower than 75 percent, respectively, on the overall Child and Family Status and System Practice Indicators; and no lower than 65 percent on a subset of System Practice indicators respectively (Engagement, Teamwork, and Assessment). The County will continue the QSR process for at least one year following exit and will post scores on a dedicated Katie A website.

Overall Score: Passing Score (Status): 85% Passing Score (Practice): 85%

The first set of three tables reflects the Status Indicators for the Third, Second and Baseline QSR Cycles. The second set of three tables reflects the Practice Indicators for the same three QSR Cycles.

The first table reflects the percentage of cases scoring within the acceptable range for Status Indicators in the Belvedere, Pomona, Compton and San Fernando Valley (now Van Nuys) offices during the third cycle, followed by the overall scores combined.

QSR Third Cycle Status Indicators (2015) – Percent Acceptable

NOTE: Fewer reviews occurred in 2015 because of competing priorities in the QSA unit

CHILD AND FAMILY STATUS INDICATORS		SAFETY OVERALL	Safety: Exposure to harm				Safety: Risk to self/others	
			Home - Parent	Caregiver Home	School /child care	Other settings	Risk to self	Risk to others
BELVEDERE	Unacceptable	0%	0%	0%	0%	0%	0%	0%
	Acceptable	100%	100%	100%	100%	100%	100%	100%
POMONA	Unacceptable	22%	0%	0%	0%	0%	0%	29%
	Acceptable	78%	100%	100%	100%	100%	100%	71%
COMPTON	Unacceptable	11%	33%	0%	0%	0%	0%	0%
	Acceptable	89%	67%	100%	100%	100%	100%	100%
San Fernando Valley	Unacceptable	0%	0%	0%	0%	0%	0%	0%
	Acceptable	100%	100%	100%	100%	100%	100%	100%
OVERALL	Unacceptable	11%	10%	0%	0%	0%	0%	10%
	Acceptable	92%	92%	100%	100%	100%	100%	93%

CHILD AND FAMILY STATUS INDICATORS		STABILITY OVERALL	Stability		Perm.	Liv Arr OVERALL	Living Arrangements	
			Stability: home	Stability: School			Parent home	Caregiver
BELVEDERE	Unacceptable	0%	0%	0%	0%	0%	0%	0%
	Acceptable	100%	100%	100%	100%	100%	100%	100%

POMONA	Unacceptable	33%	33%	29%	33%	0%	0%	0%
	Acceptable	67%	67%	71%	67%	100%	100%	100%
COMPTON	Unacceptable	33%	33%	0%	67%	0%	0%	0%
	Acceptable	67%	67%	100%	33%	100%	100%	100%
San Fernando Valley	Unacceptable	11%						
	Acceptable	89%	89%	86%	44%	89%	100%	100%
OVERALL	Unacceptable	19%	19%	11%	39%	3%	0%	0%
	Acceptable	81%	81%	89%	61%	97%	100%	100%

CHILD AND FAMILY STATUS INDICATORS		Health/ Physical Well-being	Emot. Well-being	Learning & Develop.	Family Funct.	Caregiver Funct.	Family Con.	Overall Child & Family Status
BELVEDERE	Unacceptable	0%	11%	0%	0%	0%	40%	0%
	Acceptable	100%	89%	100%	100%	100%	60%	100%
POMONA	Unacceptable	0%	33%	33%	50%	25%	43%	33%
	Acceptable	100%	67%	67%	50%	75%	57%	67%
COMPTON	Unacceptable	11%	44%	56%	83%	17%	38%	44%
	Acceptable	89%	56%	44%	17%	83%	63%	56%
San Fernando Valley	Unacceptable	22%	11%	22%	75%	14%	56%	11%
	Acceptable	78%	89%	78%	25%	86%	44%	89%
OVERALL	Unacceptable	8%	25%	28%	58%	12%	45%	22%
	Acceptable	92%	75%	72%	42%	88%	55%	78%

Note: Overall percentages have been rounded to the nearest full percent.

QSR Second Cycle Status Indicators (2012-2013) – Percent Acceptable

Office	Safety Overall	Stability	Permanency	Living Arrangements	Health	Emotional Well Being	Learning & Development	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
Belvedere	100%	83%	92%	100%	100%	92%	75%	57%	100%	67%	100%
Santa Fe Springs	92%	83%	58%	100%	100%	83%	75%	50%	100%	67%	83%
Compton	92%	67%	67%	92%	100%	83%	67%	63%	100%	38%	75%
Vermont Corridor	100%	91%	82%	100%	91%	100%	64%	60%	100%	88%	100%
Wateridge	92%	75%	75%	83%	100%	75%	67%	38%	90%	78%	83%
Pomona	100%	91%	80%	100%	100%	73%	82%	86%	100%	71%	100%
Glendora	90%	80%	60%	90%	80%	70%	90%	50%	88%	75%	90%
El Monte	100%	80%	80%	100%	100%	90%	70%	100%	100%	88%	90%

San Fernando Valley	100%	89%	56%	100%	100%	78%	78%	40%	100%	67%	78%
Lancaster	100%	63%	50%	100%	100%	63%	88%	43%	100%	67%	88%
Metro North	89%	78%	78%	89%	89%	78%	78%	40%	100%	67%	89%
Pasadena	67%	89%	56%	100%	89%	67%	56%	50%	100%	67%	78%
Santa Clarita	78%	56%	67%	89%	78%	67%	67%	50%	86%	71%	78%
Torrance	90%	70%	40%	100%	100%	90%	70%	29%	100%	67%	80%
West LA	90%	100%	80%	100%	100%	90%	60%	57%	100%	71%	80%
South County	90%	90%	60%	100%	80%	90%	70%	71%	100%	75%	90%
Palmdale	90%	90%	40%	80%	80%	60%	60%	43%	100%	43%	60%
Overall	92%	81%	66%	95%	94%	80%	71%	55%	98%	69%	85%

Note: Overall percentages have been rounded to the nearest full percent.

QSR Baseline Status Indicators (2011-2012) - Percent Acceptable

Office	Safety Overall	Stability	Permanency	Living Arrangements	Health	Emotional Well Being	Learning & Development	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
Overall	99%	80%	57%	95%	97%	70%	80%	61%	96%	71%	88%

QSR Third Cycle Practice Indicators (2015) - Percent Acceptable

Practice Indicators	Engagement	Voice & Choice	Teamwork	Assessment Overall	Assessment Child	Assessment Family	Assessment Caregiver	Lon Term View	Planning	Supports & Services	Intervention Adequacy	Tracking & Adjustment	Overall Practice
BELVEDERE	89	67	0	78	100	50	86	78%	56	78	89	78	78
POMONA	100	78	44	56	67	57	60	44%	67	89	78	78	78
COMPTON	89	56	0	33	44	22	67	22	22	56	33	56	44
San Fernando Valley	44	56	44	44	89	0	71	22	22	56	44	44	44
OVERALL	81	64	14	53	75	31	72	42	42	69	61	64	61

QSR Second Cycle Practice Indicators (2012-2013) - Percent Acceptable

Office	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Belvedere	92%	64%	33%	58%	67%	50%	67%	55%	58%	67%
Santa Fe Springs	75%	67%	8%	50%	50%	42%	67%	58%	50%	58%
Compton	75%	67%	17%	42%	50%	50%	58%	58%	50%	58%
Vermont Corridor	55%	45%	9%	36%	55%	27%	36%	36%	27%	45%
Wateridge	58%	75%	58%	67%	67%	75%	58%	58%	50%	58%
Pomona	91%	73%	55%	45%	64%	64%	73%	55%	55%	73%
Glendora	80%	70%	40%	70%	60%	60%	70%	70%	40%	60%

El Monte	90%	70%	20%	70%	60%	50%	70%	70%	50%	60%
San Fernando Valley	89%	56%	22%	33%	44%	56%	78%	67%	78%	56%
Lancaster	88%	75%	25%	50%	50%	38%	63%	50%	50%	50%
Metro North	100%	78%	11%	44%	56%	44%	44%	22%	22%	33%
Pasadena	78%	67%	22%	33%	44%	56%	44%	44%	33%	33%
Santa Clarita	44%	67%	11%	33%	56%	44%	89%	56%	44%	44%
Torrance	50%	50%	30%	40%	20%	30%	60%	50%	30%	30%
West LA	70%	70%	20%	30%	50%	30%	60%	60%	40%	50%
South County	50%	50%	20%	40%	20%	30%	70%	60%	40%	50%
Palmdale	70%	50%	20%	30%	40%	30%	50%	30%	20%	30%
Overall	74%	64%	25%	46%	51%	46%	62%	53%	44%	51%

OSR Baseline Practice Indicators (2011-2012) – Percent Acceptable

	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Overall	60%	52%	18%	50%	39%	41%	66%	52%	45%	47%

Analysis of QSR Findings

In analyzing the 2015 QSR Practice Scores for the first four offices and comparing the baseline and the third cycle, system performance improved in the following indicators: Engagement, Voice and Choice, Overall Assessment, and Planning. In Overall Practice, scores improved from 47% in the baseline to 61% in the third cycle.

The most significant gains were observed in the practices of Engagement, Voice & Choice, and Tracking & Adjustment, which improved during the third cycle by 21%, 12%, 19% respectively. Long Term View is slightly up by 3%. Teamwork practice continues to be the lagging indicator. Overall Practice increased by 14% from baseline during the third round of reviews.

In analyzing QSR Practice Scores overall and comparing the baseline and the second cycle, system performance improved in the following indicators: Engagement, Voice and Choice, Teamwork, and Long-Term View. In Overall Practice, scores improved modestly from 47% in the baseline to 51% in the second cycle. The most significant gains were observed in the practices of Engagement, Voice and Choice, and Long-Term View, which improved during the second cycle by 14%, 12%, and 12% respectively. Although Teamwork practice improved from 18% to 25% acceptable, it continues to be the lagging indicator.

Current 2015 performance, which reflects scores only from the Belvedere, Pomona, Compton and San Fernando Valley offices, indicates that:

- 39% of children are not making acceptable progress toward permanency

- 25% of children are considered not to have acceptable emotional well-being
- 58% of families are not making acceptable progress toward adequate functioning
- 86% of children do not have a functioning family team
- 47% of cases do not have an overall adequate assessment
- 58% of cases do not have a long-term view of child and family goals and strategies
- 58% of cases do not have plans adequate for achievement of case goals
- 26% of cases are not adequately tracked toward achievement of goals

The County continues to consistently fall short of reviewing all 12 cases in the sample for each office. Even 12 cases represent an extremely small sample size, so reviewing only 10 or fewer, which is common, lessens confidence in the representativeness of the sample.

Implementation of the DMH Mental Health Screening Tool (MHST), Coordinated Services Action Team (CSAT) and Referral Tracking System (RTS)

The County committed to provide mental health screening to all newly detained children in DCFS in its strategic plan. The County provided the following information on its efforts to provide mental health screening to all eligible children. The report also provides data on the referral of children with positive mental health screens to services and the timeliness of delivery of subsequent mental health services.

The CSAT process requires expedited screening and response times based on the acuity of a child’s need for mental health services. Additionally, the CSAT process provides the opportunity for an annual screening of children in existing cases who had previous negative screens. The process by which all DCFS children in new and currently open cases are screened and referred for mental health services has four tracks. The table below identifies the screening process by track.

Track	Screening Process
Track 1	Children in newly opened cases who are detained and placed in out-of-home care receive a mental health screening at case opening.
Track 2	Children in newly opened cases under Voluntary Family Maintenance, Voluntary Family Reunification or Court-supervised Family Maintenance case plans are screened at case opening.
Track 3	Children in existing cases opened before CSAT implementation are screened at the next case plan update.
Annual	Children in existing cases are screened 12 months after previously screening negative.

Referral Tracking System (RTS)

The RTS Summary Data Report (Attachment 1) includes 22 data elements providing the rate, number, timeliness, and acuity of mental health screenings, referrals, and service response times to DCFS children in new and existing cases on a point-in-time basis.

The previous reporting period reflected the CSAT progress for the first half of Fiscal Year 2014-15. The RTS Summary Data Report provides the progress of all SPAs for Calendar Year 2015, (January 1, 2015 through December 31, 2015). This report reflects CSAT performance and data entries as of January 13, 2016 and continues to be a snapshot of work in progress. The following two charts show the results to date for all three tracks associated with screening and referral process activity.

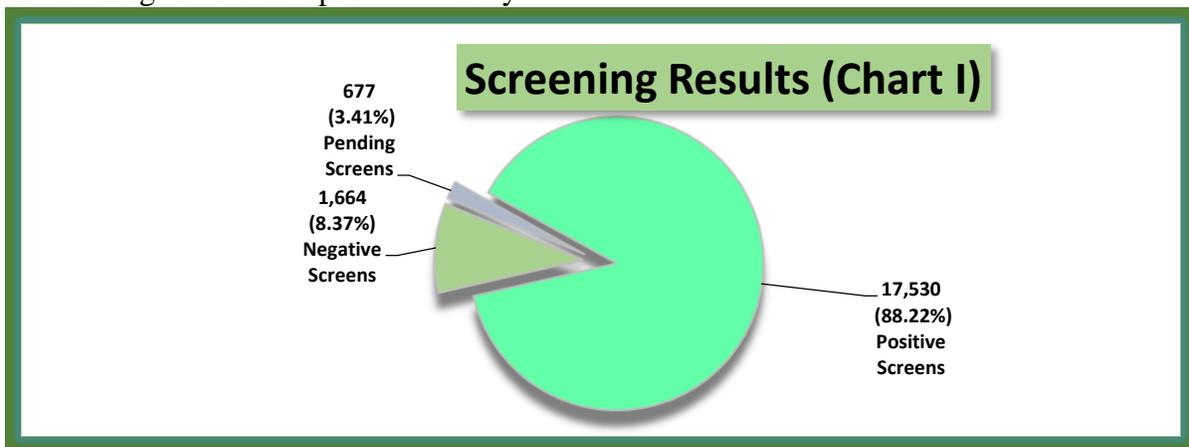


Chart I (above) shows that out of 20,348 children, 19,871 children required screens.

(20,348 minus those currently receiving mental health services [¹³], in closed cases [395], or who ran away or were abducted [70]):

Of the 19,871 children who required screens:

- 17,530 (88.22%) children screened positive;
- 1,664 (8.37%) children screened negative;

¹ The total number of children in all tracks currently receiving mental health services is 138. However, only children in existing cases (track 3 [13]) are subtracted from the total number of children requiring screens because all children in new cases (track 1 [12] and track 2 [113]) must be screened whether or not they are already receiving mental health services.

- 677 (3.41%) children have screens pending.

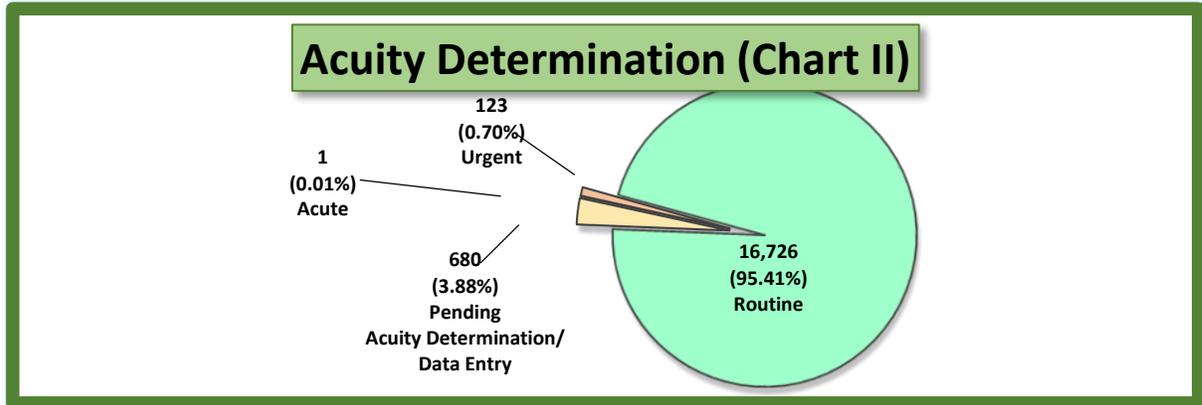


Chart II (above) shows that out of the 17,530 children who screened positive:

- 1 (0.01%) child was determined to have acute needs;
- 123 (0.7%) children were determined to have urgent needs;
- 16,726 (95.41%) children were determined to have routine needs;
- 680 (3.88%) children’s acuity level was pending determination and/or data entry.

Acuity Referral Standards

Acute	Children presenting with acute needs are referred for mental health services on the same day as screening.
Urgent	Children presenting with urgent needs are referred for mental health services within one day of screening.
Routine	Children presenting with routine needs are referred for mental health services within 10 days of screening.

The average number of days between screening and referral to DMH for mental health services, according to acuity, for Calendar Year 2015, as of January 13, 2016, is as follows:

- Children with acute needs were referred to DMH on the same day on average.
- Children with urgent needs were referred to DMH on the same day on average.
- Children with routine needs were referred to DMH in four days on average.

Mental Health Service Activity Standards

Acute	Children presenting with acute needs begin receiving mental health service activities on the same day as the referral.
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Urgent	Children presenting with urgent needs begin receiving mental health service activities within no more than three days of the referral.
Routine	Children presenting with routine needs begin receiving mental health service activities within no more than thirty days of the referral.

The average number of days between referral to and receipt of a mental health activity, according to acuity for Calendar Year 2015, as of January 13, 2016, is as follows:

- Children with acute needs received a mental health service activity within the same day of the referral, on average. (Attachment 2, line 19a);
- Children with urgent needs received a mental health service activity within one day of the referral, on average (Attachment 2, line 19b); and
- Children with routine needs received a mental health service activity within two days of the referral, on average (Attachment 2, line 19c).

The rate of children who received a mental health activity within required timeframes according to acuity; for Calendar Year 2015, as of January 13, 2016, is as follows:

- 100 percent of children with acute needs received DMH services on the same day as the referral;
- 86.99 percent of children with urgent needs received DMH services within three days of the referral; and
- 98.38 percent of children with routine needs received DMH services within 30 days of the referral.

CSAT MH Screening Achievements

As of January 13, 2016, for those children served in Calendar Year 2015, the average timeline from case opening/case plan update to the start of mental health service activities is 16 days.

DCFS and DMH continue to collaborate in order to sustain the improvements made in mental health screening, assessment and service delivery:

- 96.59 percent of children who were eligible for screening were screened for mental health needs;
- 97.59 percent of children who screened positive were referred to mental health services; and
- 96.78 percent of children referred for services received mental health service activities within the required timelines.

Historical CSAT Trend Data

From Fiscal Year 2012-13 through Calendar Year 2015, CSAT data has been very stable. This stability has been evidenced in the following ways:

Acuity Determination:

- Between 10 and 16 percent of cases have screened “negative” or determined not to need mental health services
- Between 84 and 90 percent of cases have screened “positive” or determined to have a need for mental health services.
- Of the positive screened cases, 0.1 percent or less were found to have “acute” service needs.
- Of the positive screened cases, 1.0 percent or less were found to have “urgent” service needs
- Of the positive screened cases, between 90 and 95 percent were found to have routine service needs.

Responsiveness to Need:

- Number of days from acute screening to referral ranged from same day to one day.
- Number of days from urgent screening to referral ranged from same day to two days.
- Number of days from routine needs to referral ranged from four days to six days.

Screening, Referral and Services:

- The rate of mental health screenings has ranged between 95 and 98 percent.
- The rate of referral for mental health services has ranged between 95 and 98 percent.
- The rate of receipt of a mental health activity within the required timeframe has ranged between 94 and 96 percent.

DMH states that the next calendar year report for 2016 will align to the new State-mandated data requirements in CWS/CMS. Additionally, the next report will provide information on the number of Developmental Screenings completed of young children and the recommended intervention choices determined by mental health service providers, as required by the State and reported by the Department of Mental Health.

County Multi-Disciplinary Assessment Team (MAT) Update

At the time of the completion of the prior Panel Report, 100 percent of newly detained children were referred for a MAT Assessment. During this reporting period, 99.57 percent of newly detained children were referred to the various 51 MAT assessment agencies throughout Los Angeles County. From January 1, 2015 through December 31, 2015, there were 5,846 MAT referrals and 4,694 MAT assessments completed. Of those referred, approximately 20 percent were not completed, compared to 22 percent reported as not completed in the prior report. During the month of December, 2015, the County reports 100 percent compliance with MAT referrals, which are listed by SPA in the following chart.

Table 1: MAT Compliance December 2015	MAT Eligible	MAT Referred	Percent
SPA 1	24	24	100
SPA 2	64	64	100

SPA 3	60	60	100
SPA 4	52	52	100
SPA 5	3	3	100
SPA 6	81	81	100
SPA 7	83	83	100
SPA 8	42	42	100
Total number of DCFS MAT referrals:	343	343	100

MAT Timelines

From January, 2015, to December 31, 2015, the average timeline from MAT referral acceptance to completion of the final Summary of Findings (SOF) report was 44 days, two days less than reported in the prior report. Data regarding the number and percent of cases received by the court prior to disposition are not available; however DCFS is exploring the development of such a report. Approximately 66 percent were completed in 45 days or less, 82 percent were completed by the 50th day; and, 93 percent were completed by the 60th day.

Approximately 20 percent of children referred to MAT did not have completed assessments as of the end of December, 2015. Of this 20 percent, 10 percent of children were in the process of receiving a MAT assessment, so those could not be counted as complete at the time data was collected. The remaining 10 percent were initially referred to MAT, but did not have completed assessments due to various reasons including lack of capacity with the MAT providers, runaways, and cases where children were returned home or whose cases were closed.

Summary of MAT Outcome Study

In December, 2014, DCFS' Bureau of Clinical Resources and Services conducted data analysis on the effectiveness of the MAT Assessments. The findings had not been submitted to the Panel during the previous period. The purpose of this study was to determine whether the MAT Assessment process helped achieve positive child-based outcomes. This study analyzed the 2009-10 entry cohort of over 1,500 children who received the MAT Mental Health Assessment compared to a control group of over 1,500 children who did not receive the MAT Assessment. Data looked at the outcomes for over four years post-entry to DCFS supervision. The study revealed that children who completed the MAT Assessment process had better outcomes than those children who did not receive the MAT Assessment. The study looked at four outcome indicators: 1) length of time in care; 2) placement stability; 3) re-entry, and 4) permanency.

The outcomes of the study revealed that children ages birth to five years who go through the MAT assessment process have significantly fewer placements ($p < .001$). The outcomes also revealed that children who go through the MAT assessment process are significantly more likely to achieve permanency ($p < .01$) than those who do not. Re-entry rates were not shown to have a statistically significant reduction at this time; but children who received a MAT assessment do have a lower average of re-entries than children that did not receive a MAT Assessment. Finally, children that

receive MAT assessments are more likely to spend a statistically significant longer amount in care on average than those who do not receive the assessment. This finding may be reflecting that with detained children, it may be best to ensure a slower but more secure planning process to ensure long-term positive outcomes.

MAT Training and Development

Beginning in January, 2015, the DMH Child Welfare Division has collaborated with MAT Contracted Providers and DCFS MAT staff to set up a schedule of MAT 101 trainings across all Service Areas within Los Angeles County. The MAT 101 training has been updated to incorporate features of the Shared Core Practice Model, Trauma-Informed Mental Health Practices, Underlying Needs, as well as specific features of the Birth-5 ICARE assessment and identification of underlying needs within the birth to five year population.

The targeted staff for these trainings are MAT assessors, MAT supervisors, administrators overseeing MAT programs for their agencies, and DCFS staff involved with the MAT program. The MAT 101 training sessions will be co-sponsored by a number of MAT Contracted Providers, who have volunteered to provide training venues.

The MAT 101 trainings began in August, 2015 and were held on an as-needed across multiple Service Areas. Trainings occurred as follows:

Service Area	Training Date	Number of Attendees
1	8/17/15	16
2	10/20/15	32
4	9/14/15	4
6	10/8/15	21
8	10/23/15	6

MAT 101 trainings will be provided on a continual basis, as needed, by the MAT contracted providers.

Over the course of 2015, many MAT providers received specific training on the identification of underlying needs, including a “train-the-trainer” training. These trainings were provided by Dr. Marty Beyer, Ph.D., Panel member, in collaboration with DCFS and DMH. Dr. Beyer contributed to the production of a “Formulating Underlying Needs” video through Los Angeles County DCFS and the University Consortium for Children and Families.

In addition to the MAT 101 and Underlying Needs trainings offered to MAT providers during calendar year 2015, a MAT Best Practices Workgroup meeting was held on October 27, 2015. Attendees included DCFS and DMH MAT administrators as well as MAT DMH staff and MAT provider representatives from each Service Area. The workgroup discussed potential updates to MAT policy and procedures, and worked to standardize the implementation of MAT practices across all of Los Angeles County.

Expansion of Staff Resources for Multidisciplinary Hubs

As previously reported, the County committed to providing a comprehensive medical examination for all newly detained children in its Strategic Plan. These assessments are completed by the Medical Hubs, located in hospital settings. The County, through a partnership among the Departments of Children and Family Services and Health Services and Mental Health, continues to implement efforts to ensure that newly detained children are referred to and served by the Medical Hubs.

For calendar year 2015, the County reports that 89.3% of newly-detained children were referred to a Medical Hub for an Initial Medical Examination (IME). In the prior reporting period, 88% of children had been referred. During 2015, there were 3,551 Medical Hub referrals submitted by DCFS for IMEs. The percentage of newly-detained children being referred to the Medical Hubs for the mandated IME continues to increase. On a regular basis, the County reviews and implements opportunities to increase the percentage of all newly-detained children being referred to the Medical Hubs to 100%. These efforts include conducting presentations at the DCFS regional offices as well as sending monthly reports to all regional offices regarding the mandate to refer all newly-detained children to the Medical Hubs per DCFS policy. While there continues to be a high percentage of Medical Hub referrals submitted for the IMEs, the timeframe for the submission, based on DCFS policy, requires continued attention. The County implements all opportunities to strengthen compliance with policy in its commitment to having newly detained children referred to the Medical Hubs in a timely manner.

Outcome Data Performance

A series of child outcomes in the areas of safety and permanency have been identified to be tracked over time to show progress. As part of this process, the parties agreed to exit targets for each indicator, meaning that the targets would have to be met as one of several conditions for ending court oversight. There is a “minimum level of performance” target and an “aspirational” target assigned to each indicator. The aspirational target is an improvement goal unrelated to exit from Court oversight. Minimum Performance Levels were set only after these data became available and essentially assured that current performance, at that time, would be a baseline below which the County does not fall.

Overview of the System Population

The table below provides data for all newly opened cases, by fiscal year, as the methodology has not yet been modified to reflect the current Calendar Year. The table sorts data by DCFS initial case plans of Family Maintenance (Children Remained Home) or Family Reunification (Children Removed from Home), each of which is further sorted according to whether or not DMH services are in place. This table reflects that the number of open cases has recently dropped from 23,315 (FY 2012-2013) to 22,597 (FY 2013-2014). The number of cases that were provided Family Maintenance Services as the initial case plan decreased slightly over that period of time, as did the number of Family Maintenance cases receiving services from DMH.

Department of Children and Family Services
Katie A. Data Analysis Report
FY 2002-2003 to FY 2013-2014

Population: FY 2002-2003 to FY 2013-2014

Fiscal Year	All Children					With DMH Services					Without DMH Services				
	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total
2002-2003	9,699	56.0%	7,627	44.0%	17,326	1,624	45.5%	1,942	54.5%	3,566	8,075	58.7%	5,685	41.3%	13,760
2003-2004	10,381	58.7%	7,316	41.3%	17,697	1,830	46.7%	2,090	53.3%	3,920	8,551	62.1%	5,226	37.9%	13,777
2004-2005	11,939	59.5%	8,116	40.5%	20,055	2,364	48.9%	2,467	51.1%	4,831	9,575	62.9%	5,649	37.1%	15,224
2005-2006	11,632	58.6%	8,212	41.4%	19,844	2,421	46.6%	2,770	53.4%	5,191	9,211	62.9%	5,442	37.1%	14,653
2006-2007	11,224	55.3%	9,064	44.7%	20,288	2,486	40.8%	3,609	59.2%	6,095	8,738	61.6%	5,455	38.4%	14,193
2007-2008	10,923	56.4%	8,456	43.6%	19,379	2,845	42.5%	3,856	57.5%	6,701	8,078	63.7%	4,600	36.3%	12,678
2008-2009	10,370	56.2%	8,071	43.8%	18,441	3,060	40.8%	4,433	59.2%	7,493	7,310	66.8%	3,638	33.2%	10,948
2009-2010	13,393	60.1%	8,906	39.9%	22,299	4,521	42.4%	6,131	57.6%	10,652	8,872	76.2%	2,775	23.8%	11,647
2010-2011	15,007	64.7%	8,182	35.3%	23,189	5,849	49.2%	6,031	50.8%	11,880	9,158	81.0%	2,151	19.0%	11,309
2011-2012	14,359	66.8%	7,126	33.2%	21,485	6,390	52.8%	5,703	47.2%	12,093	7,969	84.8%	1,423	15.2%	9,392
2012-2013	15,076	64.7%	8,240	35.3%	23,316	7,085	51.1%	6,778	48.9%	13,863	7,991	84.5%	1,462	15.5%	9,453
2013-2014	14,463	64.0%	8,134	36.0%	22,597	6,057	48.6%	6,412	51.4%	12,469	8,406	83.0%	1,722	17.0%	10,128

Notes:

1. Entry cohort includes children whose DCFS case started in the Fiscal Year indicated.
2. Children with DMH services are those who received the DMH services between 12 months before and 12 months after the case start date.
3. Data Source is CWS/CMS DataMart as of 08/10/2015.

Safety Indicator 1.
Repeated Reports of Abuse and Neglect

This indicator tracks the degree to which children who are the subject of a substantiated referral for abuse or neglect, but are not removed from home, do not experience another substantiated report during the subsequent 12 months. The goal is to assess risk and provide supportive services effectively enough that maltreatment does not reoccur. Data shows that the County’s performance on this indicator has improved from 80% of class members having no subsequent substantiated referrals within 12 months for FY 2002-2003 to 87.2% of class members having no subsequent referrals within 12 months in FY 2013-2014.

The parties agreed to a Minimum Performance Level of 82.8% and the County aspires to a goal of 83.3%. The County currently exceeds both the Minimum Performance Level goal and the aspirational goal.

Safety Indicator 1:
 Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period up to 12 months

Fiscal Year	All Children			With DMH Services			Without DMH Services			Minimum Performance Level 82.8%
	Children initially remained home	Children without any substantiated referrals	%	Children initially remained home	Children without any substantiated referrals	%	Children initially remained home	Children without any substantiated referrals	%	
2002-2003	9,699	8,759	90.3%	1,624	1,300	80.0%	8,075	7,459	92.4%	Aspire to 83.3%
2003-2004	10,381	9,368	90.2%	1,830	1,510	82.5%	8,551	7,858	91.9%	
2004-2005	11,939	10,785	90.3%	2,364	1,980	83.8%	9,575	8,805	92.0%	
2005-2006	11,632	10,457	89.9%	2,421	2,020	83.4%	9,211	8,437	91.6%	
2006-2007	11,224	10,161	90.5%	2,486	2,097	84.4%	8,738	8,064	92.3%	
2007-2008	10,923	9,843	90.1%	2,845	2,357	82.8%	8,078	7,486	92.7%	
2008-2009	10,370	9,369	90.3%	3,060	2,564	83.8%	7,310	6,805	93.1%	
2009-2010	13,393	11,970	89.4%	4,521	3,789	83.8%	8,872	8,181	92.2%	
2010-2011	15,007	13,685	91.2%	5,849	5,105	87.3%	9,158	8,580	93.7%	
2011-2012	14,359	12,932	90.1%	6,390	5,533	86.6%	7,969	7,399	92.8%	
2012-2013	15,076	13,654	90.6%	7,085	6,245	88.1%	7,991	7,409	92.7%	
2013-2014	14,463	13,108	90.6%	6,057	5,280	87.2%	8,406	7,828	93.1%	

Notes:

1. Intent of indicator: Of those children who initially remained home in the Fiscal Year, how many did not experience any new (First occurrence of re-abuse) substantiated referrals during the case open period, up to 12 mos?
2. The table above excludes evaluated-out referrals.
 1. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.
 4. Data Source is CWS/CMS DataMart as of 08/10/2015.

**Safety Indicator 2.
Incidence of Maltreatment by Foster Parents.**

This indicator reflects the incidence of maltreatment of children by their foster parents. The incidence is small and the County's performance for class members has been consistently in the 99 percentile range, meaning that over 99% of class members in foster home settings experienced no substantiated maltreatment by their foster parents. In FY 2013-2014, 99% of all children and 99% of class members experienced no substantiated foster parent maltreatment. The indicator does not include the experience of class members in group home and residential settings due to a feature in the design of automated reporting that does not identify the specific alleged perpetrator in congregate care settings. This continues to reflect a gap in performance tracking.

The parties agreed to a Minimum Performance Level of 98.4% and the County aspires to a goal of 98.6% for this indicator. The County FY 2013-2014 performance, as measured, exceeds the Minimum Performance Level goal and the aspirational goal.

Safety Indicator 2. Of all children served in foster care in the Fiscal Year, how many did not experience maltreatment by their foster care providers?

Fiscal Year	All Children			With DMH Services			Without DMH Services			Aspire to 98.6%
	All children served in foster care in Fiscal Year	Children with no maltreatment	%	All children served in foster care in Fiscal Year	Children with no maltreatment	%	All children served in foster care in Fiscal Year	Children with no maltreatment	%	
2002-2003	32,822	32,398	98.7%	10,798	10,529	97.5%	22,024	21,869	99.3%	
2003-2004	30,239	29,817	98.6%	10,762	10,495	97.5%	19,477	19,322	99.2%	
2004-2005	28,843	28,498	98.8%	11,025	10,815	98.1%	17,818	17,683	99.2%	
2005-2006	27,749	27,490	99.1%	11,272	11,120	98.7%	16,477	16,370	99.4%	
2006-2007	28,250	27,933	98.9%	12,479	12,280	98.4%	15,771	15,653	99.3%	
2007-2008	27,247	26,911	98.8%	13,166	12,956	98.4%	14,081	13,955	99.1%	
2008-2009	25,031	24,763	98.9%	13,637	13,460	98.7%	11,394	11,303	99.2%	
2009-2010	24,255	23,879	98.4%	15,647	15,340	98.0%	8,608	8,539	99.2%	
2010-2011	23,191	22,908	98.8%	16,232	15,995	98.5%	6,959	6,913	99.3%	
2011-2012	21,981	21,680	98.6%	16,117	15,864	98.4%	5,864	5,816	99.2%	
2012-2013	23,207	22,950	98.9%	17,566	17,344	98.7%	5,641	5,606	99.4%	
2013-2014	24,296	24,064	99.0%	18,011	17,826	99.0%	6,285	6,238	99.3%	

Notes:

1. The table above excludes children with abuse/neglect in group homes and guardian homes.
2. Children placed in group homes are not included in this data due to inability of correctly identify and accurately code alleged perpetrator information for these placements.
3. Children placed in guardian homes are not included because DCFS policy identifies legal guardianships as permanent placements and not as out-of-home placements.
4. The table is based on "Soundex" match of perpetrator's name and substitute care provider's name.
5. All children served in foster care includes: children already in foster care on the first day of the Fiscal Year, children who initially entered foster care in the Fiscal Year and children who entered foster care as a result of a FM disruption.
6. Children with DMH services are: children already in foster care on the first day of the fiscal year - those who received DMH services between 12 months before and 12 months after the first day of the fiscal year, children who initially entered foster care in the fiscal year and children who entered foster care as a result of an FM disruption -those who received the DMH services between 12 months before and 12 months after the DCFS case start date.
7. Data Source is CWS/CMS DataMart as of 08/10/2015.

DCFS provided a separate report of maltreatment of children in group homes, which is included below.

Safety Indicator 2b: Of all children placed in Group Homes in the Fiscal Year, how many did not experience maltreatment by their foster care providers?

Fiscal Year	All Children			With DMH Services			Without DMH Services		
	All children served in group home in fiscal year	Children with no maltreatment	%	All children served in group home in fiscal year	Children with no maltreatment	%	All children served in group home in fiscal year	Children with no maltreatment	%
2009-2010	3,106	3,077	99.1%	2,541	2,518	99.1%	565	559	98.9%
2010-2011	3,287	3,266	99.4%	2,791	2,775	99.4%	496	491	99.0%
2011-2012	3,388	3,373	99.6%	2,922	2,908	99.5%	466	465	99.8%
2012-2013	3,561	3,543	99.5%	3,046	3,029	99.4%	515	514	99.8%
2013-2014	3,940	3,930	99.7%	3,399	3,392	99.8%	541	538	99.4%

Notes:

1. Table includes children placed in group home during any time in the reporting period.
2. Table includes group home placement count. If children were placed in the two different group homes, it was counted twice.
3. The maltreatment is based on Non Protecting Parent Code indicator on CWS/CMS.

Safety Indicator 3.

Recurrence of Maltreatment within 6 Months

This indicator measures the percentage of all children who were victims of a substantiated abuse and neglect referral who were not victims of another substantiated referral within six months. It provides some evidence of the effectiveness of efforts to prevent subsequent abuse and neglect. Class members are not identified separately in this indicator. The data shows improvement in reducing subsequent substantiated referrals between FY 2002-2003, when 90.4% of children did not experience subsequent substantiated referrals within six months, and in FY 2013-2014 when 92.6% of children did not experience a subsequent substantiated referral.

The parties agreed to a Minimum Performance Level of 92.3% and the County aspires to a goal of 92.8% for this indicator. The County FY 2013-2014 performance meets the Minimum Performance Level goal.

Fiscal Year	Time Period	No Maltreatment	Total	Percent
2002-2003	Jul 2002 - Dec 2002	11,649	12,950	90.0%
	Jan 2003 - Jun 2003	11,179	12,328	90.7%
2003-2004	Jul 2003 - Dec 2003	10,118	11,062	91.5%
	Jan 2004 - Jun 2004	11,013	12,025	91.6%
2004-2005	Jul 2004 - Dec 2004	10,174	11,111	91.6%
	Jan 2005 - Jun 2005	10,715	11,664	91.9%
2005-2006	Jul 2005 - Dec 2005	9,337	10,145	92.0%
	Jan 2006 - Jun 2006	9,767	10,530	92.8%
2006-2007	Jul 2006 - Dec 2006	8,848	9,558	92.6%
	Jan 2007 - Jun 2007	9,314	9,983	93.3%
2007-2008	Jul 2007 - Dec 2007	8,734	9,394	93.0%
	Jan 2008 - Jun 2008	9,732	10,534	92.4%
2008-2009	Jul 2008 - Dec 2008	9,743	10,485	92.9%
	Jan 2009 - Jun 2009	9,461	10,199	92.8%
2009-2010	Jul 2009 - Dec 2009	11,795	12,762	92.4%
	Jan 2010 - Jun 2010	12,326	13,527	91.1%
2010-2011	Jul 2010 - Dec 2010	12,845	13,878	92.6%
	Jan 2011 - Jun 2011	13,700	14,702	93.2%
2011-2012	Jul 2011 - Dec 2011	12,371	13,259	93.3%
	Jan 2012 - Jun 2012	12,995	13,934	93.3%
2012-2013	Jul 2012 - Dec 2012	12,279	13,194	93.1%
	Jan 2013 - Jun 2013	12,786	13,755	93.0%
2013-2014	Jul 2013 - Dec 2013	10,530	11,345	92.8%
	Jan 2014 - Jun 2014	10,511	11,391	92.3%

Minimum Performance Level **92.3%**

Aspire to **92.8%**



Notes:

1. Intent of indicator: Of all children who come into contact with DCFS and were victims of a substantiated maltreatment referral during the 6-month time period, what percent were victims of another substantiated maltreatment referral within the next 6 months?
2. The table includes children who had a substantiated referral in the 6-month time period indicated.
3. The table above excludes allegations of 'at risk, sibling abused' and 'substantial risk'.
4. No maltreatment includes children who were not victims of another substantiated maltreatment referral within 6-months of the initial substantiated referral of maltreatment.
5. This is a referral based report and DMH match is not applicable

6. Data Source is CWS/CMS DataMart as of 08/10/2015.

**Permanency Indicator 1.
Median Length of Stay in Out-of-Home Care**

This indicator measures the median number of days that Class members are in out-of-home care, grouped by the year they entered care. The County has reduced the median length of stay for Class members from 656 days in FY 2002-2003 to 221 in FY 2012-2013.

The parties agreed to a Minimum Performance Level of 409 days and the County aspires to a goal of 383 for this indicator. The decline over time reflects a sustained improvement, and exceeds both the Minimum Performance Level and the Aspirational Performance Level.

Permanency Indicator 1. Median length of stay for children in foster care

Fiscal Year	All Children			With DMH Services			Without DMH Services			Minimum Performance Level 409 days
	Children initially removed from home	No. of children who exited foster care	Median Days	Children initially removed from home	No. of children who exited foster care	Median Days	Children initially removed from home	No. of children who exited foster care	Median Days	
2002-2003	7,627	7,208	578	1,942	1,759	656	5,685	5,449	549	Aspire to 383 days 
2003-2004	7,316	6,887	522	2,090	1,893	596	5,226	4,994	475	
2004-2005	8,116	7,460	444	2,467	2,145	531	5,649	5,315	423	
2005-2006	8,212	7,292	429	2,770	2,297	518	5,442	4,995	394	
2006-2007	9,064	7,354	389	3,609	2,778	442	5,455	4,576	284	
2007-2008	8,456	5,755	295	3,856	2,364	409	4,600	3,391	231	
2008-2009	8,071	6,668	293	4,433	2,740	401	3,638	2,706	199	
2009-2010	8,906	5,667	328	6,131	3,591	417	2,775	2,076	140	
2010-2011	8,182	5,113	325	6,031	3,470	427	2,151	1,643	77	
2011-2012	7,126	3,945	277	5,703	2,921	298	1,423	1,024	113	
2012-2013	8,240	4,584	290	6,778	3,601	304	1,462	983	146	
2013-2014	8,134	4,553	180	6,412	3,425	221	1,722	1,128	50	

Notes:

1. Intent of indicator: Of all the children who were initially placed into foster care within the fiscal year, what is the median number of days that the children remained in foster care?
2. Median days from FY 2002-2003 to FY 2011-2012 utilized SAS survival analysis that provides a Kaplan-Meier estimate of the number of days that half of the children will exit foster care and half will remain in foster care. This survival analysis includes both open and closed placement episodes. Starting FY 2012-2013 only closed placement episodes are included and removal date and placement episode end date are used to calculate median days.
3. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.
4. Data Source is CWS/CMS DataMart as of 08/10/2015.

**Permanency Indicator 2.
Reunification within 12 Months**

This indicator reflects the County’s success in quickly returning children to their parents. The County continues to be challenged with its reunification achievement, although the percentage of Class children who were returned home within 12 months increased slightly from 31.7% in FY 2012-2013 to 32% in FY 2013-2014.

The parties agreed to a Minimum Performance Level of 36.4% and the County aspires to a goal of 45.6% for this indicator. The County currently does not meet the Minimum Performance Level for Class and Non-Class children.

Permanency Indicator 2. Reunification within 12 months

Fiscal Year	All Children			With DMH Services			Without DMH Services			Minimum Performance Level 36.4%
	Children initially removed from home	Children reunified within 12 months	%	Children initially removed from home	Children reunified within 12 months	%	Children initially removed from home	Children reunified within 12 months	%	
2002-2003	7,627	1,509	19.8%	1,942	281	14.5%	5,685	1,228	21.6%	Aspire to 45.6% 
2003-2004	7,316	1,667	22.8%	2,090	384	18.4%	5,226	1,283	24.6%	
2004-2005	8,116	2,401	29.6%	2,467	639	25.9%	5,649	1,762	31.2%	
2005-2006	8,212	2,481	30.2%	2,770	713	25.7%	5,442	1,768	32.5%	
2006-2007	9,064	3,135	34.6%	3,609	1,120	31.0%	5,455	2,015	36.9%	
2007-2008	8,456	3,306	39.1%	3,856	1,402	36.4%	4,600	1,904	41.4%	
2008-2009	8,071	3,089	38.3%	4,433	1,633	36.8%	3,638	1,456	40.0%	
2009-2010	8,906	3,310	37.2%	6,131	2,313	37.7%	2,775	997	35.9%	
2010-2011	8,182	3,015	36.8%	6,031	2,281	37.8%	2,151	734	34.1%	
2011-2012	7,126	2,271	31.9%	5,703	1,820	31.9%	1,423	451	31.7%	
2012-2013	8,240	2,610	31.7%	6,778	2,152	31.7%	1,462	458	31.3%	
2013-2014	8,134	2,546	31.3%	6,412	2,052	32.0%	1,722	494	28.7%	

Notes:

1. Intent of indicator: How successful is DCFS at reunifying all children under its supervision quickly?
2. The table includes all children who exited foster care through reunification within 12 months of removal from home.
3. The table is based on removal date and episode end date.
4. The table includes placement episodes with 8 days or longer.
5. % equals children reunified within 12 months divided by children initially removed from home.
6. Children with DMH services are those who received the DMH services between 12 months before and 12 months after the DCFS case start date.
7. Data Source is CWS/CMS DataMart as of 08/10/2015.

Permanency Indicator 3
Adoption within 24 Months

This indicator reflects the County’s success in quickly moving children to adoption who cannot return home. Data reveal a recent decrease in the percentage of Class members adopted within 24 months from 3.3% in FY 2012-2013 to 2.7% in FY 2013-2014.

The parties agreed to a Minimum Performance Level of 2% and the County aspires to a goal of 2.9% for this indicator. The County currently exceeds the Minimum Performance Level, but does not exceed the aspirational performance goal for Class members.

Permanency Indicator 3. Adoption within 24 months

Fiscal Year	All Children			With DMH Services			Without DMH Services			Minimum Performance Level 2.0%
	Children initially removed from home	Children adopted within 24 months	%	Children initially removed from home	Children adopted within 24 months	%	Children initially removed from home	Children adopted within 24 months	%	
2002-2003	7,627	230	3.0%	1,942	12	0.6%	5,685	218	3.8%	Aspire to 2.9%
2003-2004	7,316	250	3.4%	2,090	20	1.0%	5,226	230	4.4%	
2004-2005	8,116	382	4.7%	2,467	36	1.5%	5,649	346	6.1%	
2005-2006	8,212	373	4.5%	2,770	58	2.1%	5,442	315	5.8%	
2006-2007	9,064	359	4.0%	3,609	71	2.0%	5,455	288	5.3%	
2007-2008	8,456	352	4.2%	3,856	84	2.2%	4,600	268	5.8%	
2008-2009	8,071	305	3.8%	4,433	111	2.5%	3,638	194	5.3%	
2009-2010	8,906	255	2.9%	6,131	167	2.7%	2,775	88	3.2%	
2010-2011	8,182	281	3.4%	6,031	185	3.1%	2,151	96	4.5%	
2011-2012	7,126	262	3.7%	5,703	188	3.3%	1,423	74	5.2%	
2012-2013	8,240	243	2.9%	6,778	184	2.7%	1,462	59	4.0%	

Notes:

1. Intent of indicator: How successful is DCFS at moving children under its supervision into finalized adoption quickly?
2. The table includes all children who exited foster care through adoption within 24 months of removal from home.
3. The table is based on removal date and placement episode end date.
4. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.
5. % equals children adopted within 24 months divided by children initially removed from home.
6. Data Source is CWS/CMS DataMart as of 08/10/2015.

***Permanency Indicator 4.
Reentry into Foster Care***

This indicator reflects the County’s success in ensuring that children returned to their parents remain in their care for at least 12 months after reunification. The data indicates that Class members re-entered foster care at a rate of 11.9% in FY 2013-2014, which represents an improvement from FY 2012-2013, when the rate was 13.0%. Evaluating reentry rates requires sensitivity to the fact that the more intensely an agency is focused on reunification, the more likely it is that rates will be higher than systems without a reunification priority. The County has had greater success with Non-Class members, which is to be expected.

The parties agreed to a Minimum Performance Level of 13.9% and the County aspires to a goal of 12.9% for this indicator. For the FY 2012-2013, the County did meet the Minimum Performance Level as well as, the aspirational goal.

Permanency Indicator 4. Reentry into foster care during the Fiscal Year and reentry within 12 months of the date of reunification

Fiscal Year	All Children			With DMH Services			Without DMH Services			Minimum Performance Level 13.9%
	Children who were reunified	Children who re-entered foster care	%	Children who were reunified	Children who re-entered foster care	%	Children who were reunified	Children who re-entered foster care	%	
2002-2003	5,612	288	5.1%	1,528	118	7.7%	4,084	170	4.2%	Aspire to 12.9%
2003-2004	5,690	293	5.1%	1,733	144	8.3%	3,957	149	3.8%	
2004-2005	5,925	360	6.1%	2,068	195	9.4%	3,857	165	4.3%	
2005-2006	6,706	723	10.8%	2,485	385	15.5%	4,221	338	8.0%	
2006-2007	6,980	741	10.6%	2,737	379	13.8%	4,243	362	8.5%	
2007-2008	7,638	830	10.9%	3,335	464	13.9%	4,303	366	8.5%	
2008-2009	7,445	916	12.3%	3,793	597	15.7%	3,652	319	8.7%	
2009-2010	7,260	852	11.7%	4,294	596	13.9%	2,966	256	8.6%	
2010-2011	7,050	837	11.9%	4,781	649	13.6%	2,269	188	8.3%	
2011-2012	5,971	802	13.4%	4,248	644	15.2%	1,723	158	9.2%	
2012-2013	5,788	692	12.0%	4,250	551	13.0%	1,538	141	9.2%	
2013-2014	6,256	699	11.2%	4,663	556	11.9%	1,593	143	9.0%	

Notes:

1. Intent of indicator: How successful is DCFS at ensuring children successfully remain with their parents after being reunified with parents?
2. The numerator is children who re-entered foster care within 12 months of reunification.
The denominator is children who were reunified during the fiscal year. Placement episodes less than 8 days were included in accordance with the Federal Methodology.
3. Children with DMH services are those who received the DMH services between 12 months before and 12 months after the DCFS case start date.

***Permanency Indicator 5a
Placement Stability in First Year of Placement***

This indicator measures, “Of those children in foster care less than 12 months, how many remain in their first or second placement?” The County’s performance continues to improve, from 74.0% of Class members having no more than two placements in their first year of care in FY 2002-2003, to 89.1% in FY 2013-2014.

The parties agreed to a Minimum Performance Level of 82.5% and the County aspires to a goal of 84.1% for this indicator. The data reflects great improvement as the performance indicators for the FY 2013-2014 far exceeds the Minimum Performance Level and the aspirational goal.

Permanency Indicator 5a. Children in foster care less than 12 months with 2 or less placements

Fiscal Year	All Children			With DMH Services			Without DMH Services			Minimum Performance Level 82.5%
	Children in foster care less than 12 months	Children with 2 or less placements	%	Children in foster care less than 12 months	Children with 2 or less placements	%	Children in foster care less than 12 months	Children with 2 or less placements	%	
2002-2003	1,934	1,702	88.0%	385	285	74.0%	1,549	1,417	91.5%	Aspire to 84.1%
2003-2004	2,065	1,819	88.1%	490	384	78.4%	1,575	1,435	91.1%	
2004-2005	2,858	2,495	87.3%	775	601	77.5%	2,083	1,894	90.9%	😊
2005-2006	2,889	2,517	87.1%	851	683	80.3%	2,038	1,834	90.0%	
2006-2007	3,520	3,116	88.5%	1,257	1,028	81.8%	2,263	2,088	92.3%	
2007-2008	3,641	3,151	86.5%	1,530	1,263	82.5%	2,111	1,888	89.4%	
2008-2009	3,372	2,973	88.2%	1,769	1,504	85.0%	1,603	1,469	91.6%	
2009-2010	3,615	3,143	86.9%	2,475	2,096	84.7%	1,140	1,047	91.8%	
2010-2011	3,246	2,872	88.5%	2,398	2,083	86.9%	848	789	93.0%	
2011-2012	2,475	2,150	86.9%	1,952	1,669	85.5%	523	481	92.0%	
2012-2013	2,850	2,530	88.8%	2,325	2,041	87.8%	525	489	93.1%	
2013-2014	2,801	2,516	89.8%	2,216	1,974	89.1%	585	542	92.6%	

Notes:

1. Intent of indicator: Of those children who are in foster care for less than 12 months, how many remain in their first or second placement?
2. This table includes all types of placement moves.
3. This table includes children who were in foster care for at least 8 days, but less than 12 months.
4. Children in foster care less than 12 months is determined by placement episode end date and removal date.
5. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.
6. Data Source is CWS/CMS DataMart as of 08/10/2015.

***Permanency Indicator 5b
Placement Stability in Second Year of Placement***

This indicator measures children in foster care for 12 months but less than 24 months who did not experience a third or greater placement in the second year. In FY 2002-2003, 89.5% of Class members did not experience a third or greater placement, compared to 92.3% not experiencing a third or greater placement in FY 2012-2013.

The parties agreed to a Minimum Performance Level of 89.2% and the County aspires to a goal of 89.7% for this indicator. Foster home stability for class members currently exceeds Minimum Performance Level and the aspirational goal.

Permanency Indicator 5b. Children in foster care 12 months but less than 24 months, without a move to a third or greater placement(s) in the second year

Fiscal Year	All Children			With DMH Services			Without DMH Services		
	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%
									Minimum Performance Level 89.2%
									Aspire to 89.7%
2002-2003	2,330	2,184	93.7%	600	537	89.5%	1,730	1,647	95.2%
2003-2004	2,292	2,158	94.2%	697	625	89.7%	1,595	1,533	96.1%
2004-2005	2,217	2,042	92.1%	689	589	85.5%	1,528	1,453	95.1%
2005-2006	2,189	1,979	90.4%	782	664	84.9%	1,407	1,315	93.5%
2006-2007	2,315	2,139	92.4%	1,064	949	89.2%	1,251	1,190	95.1%
2007-2008	1,975	1,825	92.4%	961	865	90.0%	1,014	960	94.7%
2008-2009	1,879	1,683	89.6%	1,204	1,047	87.0%	675	636	94.2%
2009-2010	1,916	1,772	92.5%	1,574	1,460	92.8%	342	312	91.2%
2010-2011	947	869	91.8%	768	711	92.6%	179	158	88.3%
2011-2012	1,848	1,726	93.4%	1,618	1,515	93.6%	230	211	91.7%
2012-2013	2,123	1,956	92.1%	1,854	1,711	92.3%	269	245	91.1%



Notes:

1. Intent of indicator: Of those children in foster care for 12 months but less than 24 months, what percent did not move to a third or greater placement(s) in the second year?
2. This table includes all types of placement moves.
3. The denominator is children who were in foster care 12 months but less than 24 months.
The numerator is children who did not move to a third or greater placement in the second year.
4. Children in foster care 12 months but less than 24 months is determined by placement episode end date and removal date.
5. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.
6. Data Source is CWS/CMS DataMart as of 08/10/2015.

***Permanency Indicator 5c
Stability for Children in Care for More than 24 Months***

This indicator is similar to 5a and 5b, except it applies to the stability of children in care more than 24 months. County performance has dropped slightly in this indicator, with 64.2% of Class members in care 24 months or more not experiencing a third or greater move in FY 2012-2013, compared with 62.6% for FY 2013-2014.

The parties agreed to a Minimum Performance Level of 58.8% and the County aspires to a goal of 61.7% for this indicator. Foster home stability for Class members currently exceeds Minimum Performance Level and the aspirational goal.

Permanency Indicator 5c. Children in foster care on the first day of the Fiscal Year who have been in foster care for 24 months or more, and have not experienced a move to a third or greater placement(s) during the Fiscal Year.

Fiscal Year	All Children			With DMH Services			Without DMH Services			Minimum Performance Level 58.8%
	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%	
2002-2003	18,945	11,616	61.3%	7,959	3,600	45.2%	10,986	8,016	73.0%	Aspire to 61.7%
2003-2004	17,039	10,459	61.4%	7,955	3,710	46.6%	9,084	6,749	74.3%	
2004-2005	14,959	9,243	61.8%	7,535	3,638	48.3%	7,424	5,605	75.5%	
2005-2006	13,136	8,202	62.4%	7,136	3,609	50.6%	6,000	4,593	76.6%	
2006-2007	11,760	7,709	65.6%	6,587	3,587	54.5%	5,173	4,122	79.7%	
2007-2008	10,545	7,285	69.1%	5,992	3,525	58.8%	4,553	3,760	82.6%	
2008-2009	9,115	6,509	71.4%	5,376	3,332	62.0%	3,739	3,177	85.0%	
2009-2010	7,829	5,572	71.2%	4,980	3,076	61.8%	2,849	2,496	87.6%	
2010-2011	6,966	5,037	72.3%	4,432	2,846	64.2%	2,534	2,191	86.5%	
2011-2012	6,341	4,443	70.1%	4,002	2,514	62.8%	2,339	1,929	82.5%	
2012-2013	6,293	4,401	69.9%	3,916	2,515	64.2%	2,377	1,886	79.3%	
2013-2014	6,536	4,482	68.6%	3,827	2,394	62.6%	2,709	2,088	77.1%	



Notes:

1. Intent of indicator: Of those children in foster care for at least 24 months, what percent did not move to a third or greater placement(s) during the Fiscal Year?
2. This table includes all types of placement moves.
3. The denominator is children who were in foster care on the first day of the fiscal year and who have been in foster care for 24 months or more.
The numerator is children who have not experienced a move to a third or greater placement(s) during the fiscal year.
4. Children with DMH services are those who received DMH services between 12 months before and 12 months after the first day of each fiscal year.
5. Data Source is CWS/CMS DataMart as of 08/10/2015.

III. Panel Analysis of Strategic Plan Implementation

Expansion of Home-Based Mental Health Services

DMH is planning a major expansion of Intensive Field Capable Clinical Services (IFCCS) from the current 100 slots to 1,000 slots in 2016 and adding 500 more slots in the following year. The Panel views this expansion as a major step toward improving supports for class members and especially for sub-class members. DMH also has discussed utilizing the Qualitative Service Review process as a means of evaluating provider performance and class member outcomes, a strategy which the Panel strongly supports. However, DMH currently does not appear to have the staff resources to do so. DMH also is piloting a training and coaching concept in intensive home-based mental health services and service crafting (tailoring services to match child and family needs) for IFCCS providers. The Department has enlisted Panel member Dr. Marty Beyer to assist in this process.

The scale of this planned expansion is an ambitious and commendable initiative by the County and should provide a substantial improvement in the availability of intensive home-based mental health services. The Panel has several concerns about the implementation of this plan, however. First, there does not seem to be clarity within DMH and among its providers about exactly how high quality IHBS should differ from conventional home-based mental health services. Specifically, IHBS should be configured in response to each child and family's strengths and needs, a practice approach in which the LA County mental health provider community has little capacity to perform. The matching of services to needs also requires the capacity to tailor service supports in a creative and individualized manner, another practice largely absent in the county.

As a result of an All County Information Notice issued this year by the California Department of Health Care Services, DMH will need to explore how to make ICC and IHBS services available to all Medi-Cal beneficiaries under the age of 21 who meet the medical necessity threshold. This will require a significant investment in training and coaching resources.

Because the use of tailored, intensive home-based mental health services is not an integral part of mental health practice in the County, implementing the planned IFCCS expansion will require a major expansion of training and coaching for DMH staff and providers. Current DMH plans are modest in terms of numbers of staff to be trained, (160) and the time devoted to training (20 hours per participant).

Based on Panel interactions with Wraparound and Full Service Partnership providers and findings from Quality Service Reviews, the Panel believes that these providers also need training in the core practice model, including service tailoring.

The Department's contracts with its providers will need to be modified to include expectations for fidelity to the case practice model. DMH has completed a draft contract and discussions among the DMH, plaintiffs' and the Panel about content and the level of detail required are ongoing. The Panel believes that contracts need to establish expectations for actually improving outcomes for children and youth, not just procedural compliance.

To assess provider fidelity with the core practice model, DMH intends to utilize the QSR process to assess quality and performance, among other measures. The Panel commends this decision, but believes the strategy to use the QSR process to review one case per year per provider employs a sample size too small to provide representative data. The sample size should involve multiple cases per provider. To conduct even one review per provider, DMH will need additional quality assurance staff.

DCFS and DMH Training and Coaching

DCFS training and coaching has had a very limited effect on child and family outcomes. While the Department has been successful in developing a large number of coaching specialists and supervisors as facilitators and coaches of the child and family team process, high workloads have prevented caseworkers from utilizing the teaming approach in more than an incidental number of families. Unless workloads reach a level where the union will consent to permit widespread use of the approach, progress in employing the core practice model routinely with children and families will remain stalled. The Department believes that the issue will be resolved soon, but past hopes for a resolution have not been realized.

Another limitation to the DCFS training and coaching approach is that insufficient attention is given to helping staff identify the underlying needs of children and families in the coaching process. Coaching is primarily focused on the development of child and family team facilitation skills, meaning that attention to underlying needs is incidental and insufficient to enable staff to adequately assess needs.

DMH training and coaching has been very limited in scope. Limited staff resources have been a major barrier. As mentioned previously, the Panel believes DMH strategies for training and coaching IFCCS providers are not sufficiently robust to develop the clinical and intervention skills needed by children with a high level of mental health needs. DMH will need additional staff to provide the necessary staff development for these providers.

Quality Service Review scores reflect the limited effect DCFS and DMH training and coaching is having on system performance. In 2015 reviews, 14% of scores scored acceptably on teaming and 53% scored acceptably on assessment.

Workload

DCFS has experienced high workloads and caseloads since the beginning of the Katie A. Settlement. These high workloads have severely limited the ability of the system to implement the core practice model, which underlies the DCFS role in implementing the strategic plan. In the past 3 years, however, the Board of Supervisors has approved significant staff increases for the Department, as was described previously in this Report. The union has stated that it supports the DCFS policy on the use of the CFT process; however agreement on the pace of CFT implementation appears to be part of a continuing discussion. Until workload size permits the consistent use of the child and family team process with all families and children, meeting the settlement requirements will not be met.

The Immersion Process

The Panel strongly supports the County's strategy to utilize the Immersion process to implement the Kate A. Settlement. The County has developed a baseline of Immersion site performance against which to measure future performance, undertaken a preparation process in past months to prepare staff for new roles, communicated with partners in the two sites about Immersion strategies, mapped site resources and resource gaps, is considering expanding the QSR process in Compton and Van Nuys and continues efforts to strengthen the core practice model training and coaching process. The County has already identified the second set of Immersion sites, Belvedere and Pasadena, to facilitate their readiness for implementation.

The work of the leadership and supervisors in Compton and Van Nuys during the initial phase of immersion has been impressive. The enthusiasm for improving practice and provision of mental health services in the two large offices has been evident in Panel visits to the offices and quarterly review meetings.

The likelihood of success in the Immersion sites is heavily dependent on resolving a number of the system barriers addressed in this section of the report, which include reducing the workload and caseload; strengthening the training and coaching process; expanding the high-fidelity intensive home-based mental health services that are the core of IFCCS expansion; and significantly expanding family foster homes and Treatment Foster Care, especially within the Immersion sites.

Expansion of Family Foster Homes

As referenced previously in this report, DCFS continues to operate with a significant shortage of foster homes. This limitation makes it more difficult to match children with appropriate caregivers, impedes access to family-based settings for children experiencing an entry into care or placement disruption and causes children to be placed far outside of their home communities. This can overload caregivers with children and youth and can lead to use of inadequate or minimally acceptable settings because other options do not exist.

DCFS reports that a 2012 survey of the foster parent association and foster caregiver providers identified the following barriers to recruitment and retention:

1. The inability of caregivers to manage compliance with the frequency of court ordered visitation;
2. Poor to no access to child care;
3. The high costs of diapers and formula; and
4. Inadequate support to meet the medical and mental health needs of children in care.

In an effort to improve recruitment and retention of foster parents, DCFS states that it is exploring/implementing the following approaches.

- In some offices where the number of children most significantly exceed foster home beds, DCFS is considering providing specialized training and a stipend to selected foster parents to hold vacancies open for children removed within the catchment area.

Currently, because of the placement shortage, children are often placed in the first available setting, even if it located many miles away. This new concept supports the principle of placing children in close proximity to their family and community. The Panel has encouraged the County to utilize this approach in all immersion sites.

- DCFS is also exploring expanding the availability of Emergency Aid Requisition funds to cover a broader array of foster parent needs not covered by other sources.
- DCFS is permitting specialized payments to initiate or maintain placement for special needs children.
- DCFS is implementing Emergency Placement Stipends of \$400 for relative and non-related caregivers to cover the costs of incidentals at time of placement. A total of \$1.8 million will be available.
- DCFS plans to raise the rates paid for respite care from \$3.00 per hour to \$10.00 per hour.
- DCFS is piloting a program in Compton to supply new caregivers with initial supports for young children at placement, such as diapers, strollers, blankets, etc.
- Many Counties believe that the lack of subsidized child care for foster parents and relative caregivers who work is a major barrier to recruitment and retention. Although the State has denied the request for funding of this cost for all 23 Counties which requested such funding in applications for State support for child care, DCFS has initiated a pilot program in SPA 2 to provide limited child care supports.

Treatment Foster Care (TFC)

The County has reported that it has no new strategies with which expand the number of homes to 300. This limitation is reflected in the data which show no growth in homes for the past year. The County hopes the recent policy issuance by the federal Center for Medicare and Medicaid Services, permitting states to claim treatment foster care as a discrete service will expand federal claiming and permit an increase in provider rates. However at the present time, greater policy clarity is needed at the State level to permit the State to take full advantage of this ruling.

Placement of Children in Group Care

DCFS notes in its update that the County has had to rely on group care because of “a paucity of appropriate foster and therapeutic foster home resources.” The inclusion of Treatment Foster Care (TFC) in the Strategic Plan was an effort to relieve the reliance on group care for class members. Unfortunately, TFC has not become an effective alternative. If DCFS can develop a sufficient number of additional family foster homes and the IFCCS expansion is of high fidelity, supporting conventional foster homes for children with mental health needs with IFCCS involvement would permit considerable reductions in group care. This is particularly crucial for children 12 and younger.

The MAT Process

The County reported the findings of a 2009-2010 MAT study that suggested improved outcomes for children who had experienced a MAT. A summary of that study was included in a previous section of the report. The Panel provided some observations about the methodology of the study which raise questions about the accuracy of the conclusions. These observations are:

1. This methodology can be read to say that there was a retrospective review of 1500 kids who got MATs and 1500 who did not. The children were not selected randomly, which would have been the desired methodology.
2. It was unknown how the control group was selected. It appears that it consisted only of children that Department did not yet have the capacity to serve.
3. This is 2009-2010 data. There have been significant changes in the MAT process since that period.
4. It appears that an analysis of outcomes by age group would be necessary. Older children newly entering care are at higher risk for placement breakdown and LTFC. MAT and non-MAT groups were not matched by age, gender, race/ethnicity.

An important issue is the percent of MAT reports that reach the court (for support of judicial decision-making) prior to the dispositional hearing. DCFS is exploring ways to identify the percentage of cases reaching the court prior to disposition.

The QSR Process

Currently, the County is consistently reviewing fewer cases in each office than the goal of 12. Such a small sample undermines the representativeness of the reviews. The Panel does not understand why it is so difficult for the County to use replacement cases to maintain appropriate sample sizes when children and families unexpectedly become unavailable, decline to participate or otherwise cannot participate.

Panel members participating in the QSR have observed that the caseworker identification of child and family needs as expressed in agency files reflects a considerable inability to describe underlying needs accurately. Where needs statements are cited, they are frequently described as services or behaviors which children and families are expected to conform to or avoid. This fact is evidence that the core practice model training is having little effect on this element of practice.

The County is considering using the QSR to assess the fidelity and effectiveness of the IFCCS process and to increase the number of cases reviewed in the Immersion process to improve representativeness. The Panel also favors the use of a QSR-like process to assess the fidelity and effectiveness of Wraparound and Full Service Partnership. To achieve these goals, which the Panel endorses, DCFS and DMH will need additional quality assurance staff.

IV. Recommendations

1. Expansion of Intensive Home-Based Mental Health Services

DMH should develop a clear, operational definition of IHBS, Wraparound and Full Service Partnership for providers that will provide clarity about expectations and performance.

The Panel recommends that the County track achievement of outcomes for IFCCS providers and utilize provider outcome achievement and QSR performance as a basis for continued funding.

2. Training and Coaching

The County should develop 6 central office staff to serve as full-time Core Practice Model coaches in immersion offices to speed up implementation. Once the first site has completed immersion, these staff can be deployed to the next immersion sites to accelerate progress there as well. These staff should have a full range of core practice model skills and should give primary focus to underlying needs and service crafting (especially of IHBS), supported by effective child and family teams. These coaches will need development beyond the training and coaching process now in place. The Panel is willing to assist in the development of these coaches.

The County should develop a simple supervisory process whereby supervisors routinely review the strengths/needs identification developed by CSWs and included in case plans and MAT assessments and provide feedback. The process should include a rating structure that can be employed as an internal QA measure and accountability support. The Panel is willing to assist in developing this process, which it suggests be piloted in the immersion sites.

3. Workload

DCFS states that it has recently achieved a major milestone in discussions with the union about implementation of the core practice model, including the use of child and family teams. According to the Department, the union has agreed to the issuance of policy setting expectations about the responsibility of staff to employ the core practice model. However the next challenge may be finding agreement about the pace at which caseworkers will begin using core practice model with families. This issue will still have caseload implications.

The Panel recommends that the County continue to seek resources to permit the standard for emergency response workers to be 13 new cases per month and for continuing services workers, no more than 15 cases...

4. The Immersion Process

The previous recommendation to develop full-time immersion coaches also relates to strengthening the immersion process. Currently there are 713 children from other regions placed in foster homes in Compton and 289 children from other regions placed in Van Nuys. The Panel supports a recent DCFS initiative to begin limiting the use of immersion office foster homes by

other offices, intended to keep children in immersion sites in or near their homes and communities.

Group Care

The Panel recommends that the County ensure that a primary focus of IFCCS expansion is to prevent placement in group care and transitioning children and youth from group care to family-based settings.

The Quality Service Review Process

The Panel recommends that the County adopt the plan to raise sample sizes in immersion sites from 12 to 15, a strategy now under consideration and ensure that 12 cases are consistently reviewed in non-immersion sites. The QSR review team vacancies should be filled quickly, as the vacancies are limiting the sample size.

The Panel recommends that the County contact the Panel when it plans to drop a case out of the review sample.

The Panel recommends that the County provide the Panel copies of the most recent needs statements contained in case files for each case reviewed.

The Panel also recommends that DMH be provided sufficient additional QA resources to permit the QSR process to be used to evaluate the quality of IHBS.

The Panel recommends that DMH expand the QSR sample size for IFCCS to greater than one per site and make each program's sample size relevant to the number of children served.

V. Glossary of Terms

ADHD – Attention deficit hyperactivity disorder

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

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

Coaching - Coaching is supportive; solution focused; skillfully listening to others; sensitively asking questions; self-reflective; and strengths-needs driven.

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

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

CFT – A Child and Family Team Meeting

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

DCFS – Department of Children and Family Services

DMH – Department of Mental Health

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

ER – Emergency response

ESC – Emergency Shelter Care

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

FFS – Fee for Services is a network of individual clinicians who provide mental health services to individuals in the county as distinct from those directly operated and contracted agencies who provide such services.

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

FGDM – Family Group Decision Making

FM – Family maintenance services, provided for families with children living in the home of either of his/her parent or LG.

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

IEP – Individual Education Plan

ICC - Intensive Care Coordination – ICC is similar to the activities routinely provided as Targeted Case Management (TCM); however, they must be delivered using a Child and Family Team Process to guide the planning and service delivery process. Service Components and Activities are related to the elements of the Core Practice Model.

IFCCS - Intensive Field Capable Clinical Services – phase one of the county’s implementation of ICC and IHBS. Target population is youth who are in DCFS’ Emergency Response Command

Post, Exodus Recovery Urgent Care Center, discharging from a psychiatric hospitalization, or had a response by Field Response Operations or PMRT without a psychiatric hospitalization.

IHBS - Intensive Home-Based Mental Health Services – IHBS are intensive, individualized, and strength-based, needs-driven intervention activities that support the engagement of the child and family in the intervention strategy. IHBS are medically necessary, skill-based interventions.

MAT – Multi-Disciplinary Assessment Team

PCIT – Parent Child Interaction Therapy is an evidence base practice for ages 2 to 5 children with externalized acting out behaviors.

PTSD – Post-traumatic stress disorder

RCL – Rate Classification Level (levels of group home care, with RCL 14 being considered residential treatment; about 2,332 children are in 83 group homes

RPRT – Regional Permanency Review Teams

SCPM - Shared Core Practice Model is a practice model adopted by the Department of Children and Family Services and the Department of Mental Health to focus our work on identifying and addressing the underlying strengths and needs of children and families.

TAY – Transitional Age Youth

TFC – Treatment Foster Care – DMH will provide additional information about TFC.

Wraparound - Wraparound is a family-centered, strengths-based, and needs driven planning process for children, youth, and families that take place in a team setting
