ROBERT D. NEWMAN, SBN 86534
RICHARD A. ROTHSCHILD, SBN 067356
ANTIONETTE DOZIER, SBN 244437
WESTERN CENTER ON LAW & POVERTY
3701 Wilshire Boulevard, Suite 208
Los Angeles, CA 90010
Telephone: (213) 487-7211
Facsimle: (213) 487-0242
Emails: rnewman@wclp.org
rrothscild@wclp.org
adozier@wclp.org

Attorneys for Plaintiffs
[Additional counsel appear on next page]

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

KATIE A. by and through her next friend Michael Ludin; **MARY B.** by and through her next friend Robert Jacobs; **JANET C.** by and through her next friend Dolores Johnson; **HENRY D.** by and through his next friend Gillian Brown: AND **GARY E.** by and through his next friend Michael Ludin; individually and on behalf of others similarly situated,

Plaintiffs,

v.

DIANA BONTA, Director of California Department of Health Services; **LOS ANGELES COUNTY; LOS ANGELES COUNTY DEPARTMENT OF CHILDREN AND FAMILY SERVICES**; **ANITA BLOCK**, Director of the Los Angeles County Department of Children and Family Services; **RITA SAENZ**, Director of the California Department of Social Services, and DOES 1 through 100, Inclusive

Defendants.

Case No. CV-02-05662-JAK (SHx)

ADVISORY PANEL'S REPORT TO THE COURT - FIRST REPORTING PERIOD OF 2014

The Hon. John A. Kronstadt
Courtroom: 750

(CONTINUED ATTORNEYS FOR PLAINTIFFS)

MARK D. ROSENBAUM, SBN 59940
AMERICAN CIVIL LIBERTIES UNION
OF SOUTHERN CALIFORNIA
1313 W. 8th Street
Los Angeles, CA 90017
(213) 977-9500 Fax: (213) 977-5297
Email: mrosenbaum@aclu-sc.org

MARILYN HOLLE, SBN 61530
MELINDA BIRD, SBN 102236
DISABILITY RIGHTS CALIFORNIA
350 South Bixel Street, Suite 290
Los Angeles, CA 90017
(213) 213-8000 Fax: (213) 213-8001
Email: marilyn.holle@disabilityrightsca.org
melinda.bird@diabilityrightsca.org

IRA BURNIM (pro hac vice)
BAZELON CENTER FOR MENTAL
HEALTH LAW
1101 Fifteenth Street, NW, Suite 1212
Washington, DC 20006
(202) 467-5730 Fax: (202) 223-0409
Email: irab@bazelon.org

JOHN O'TOOLE, SBN 62327
LEECIA WELCH, SBN 208714
FIZA A. QURAISHI, SBN 252033
NATIONAL CENTER FOR YOUTH LAW
405 14TH Street, 15th Floor
Oakland, CA 94612
(510) 835-8098 Fax: (510) 835-8099
Email: fquraishi@youthlaw.org
jotoole@youthlaw.org
lwelch@youthlaw.org

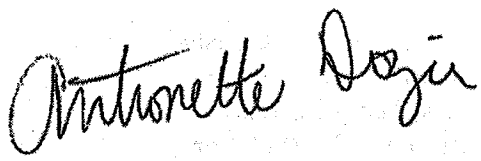
KIMBERLY LEWIS, SBN 144879
NATIONAL HEALTH LAW PROGRAM
3701 Wilshire Boulevard, Suite 750
Los Angeles, CA 90034
(310) 204-6010 Fax: (310) 204-0891
Email: lewis@healthlaw.org

PATRICK GARDNER, SBN 208119
YOUNG MINDS ADVOCACY CORP.
115 Haight Street
Menlo Park, CA 94025
(650) 494-4930 Fax: (650) 494-4930
Email: patrick@youngmindsadvocacy.org

Pursuant to this Court's Order, Plaintiffs are filing the Advisory Panel's Report to the Court - First Reporting Period of 2014. A true and correct copy of the Advisory Panel's Report to the Court is attached hereto.

DATED: January 21, 2015

Respectfully submitted,
WESTERN CENTER ON LAW AND POVERTY



By:_____
Antionette Dozier,
Attorneys for Plaintiffs

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

Marty Beyer
Paul Vincent
Edward Walker

December 18, 2014

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,

Attached is a copy of the Katie A. Panel's Report to the Court for the First Reporting Period of 2014. This report was delayed due to a more extensive period of review and comment between the Panel and the County.

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

Sincerely,

Paul Vincent

Paul Vincent
Panel Chair

cc Panel Members
Phillip Browning
Marvin Southard
Kim Lewis
Ira Burnim
Antionette Dozier
Brandon Nichols

The Katie A. Advisory Panel Report to the Court First Reporting Period of 2014 December 18, 2014

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

Marty Beyer
Paul Vincent
Edward Walker

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Executive Summary

System Progress

The County continues to make progress in a number of areas. One of the strengths of the County's approach to Katie A. implementation has been the creation of a principle-driven model of child welfare practice that is designed to shape the approach to families and children, the services developed to serve them and the case planning and decision-making mechanisms adopted to operationalize the principles. In addition, the joint planning and coordination between DCFS and DMH at the system level continues to be frequent, intensive and coordinated. The two organizations function as committed partners in implementing Katie A.

In terms of individual initiatives, the percentage of newly detained children referred to Medical Hubs for initial medical assessment has risen from 85.5 percent to 88 percent since the last reporting period. The County's performance in providing mental health screening to newly detained children is consistently high, with almost 97 percent of children eligible for screening receiving a screen. Over 96 percent of children who were screened and referred for mental health services received some form of mental health services within required time frames. The focus of Core Practice Model coaching has been sharpened and work is underway to build practice coaching capacity within DMH and DCFS. The Wraparound program has grown significantly. The County's pilot of Intensive Field Capable Clinical Services is showing progress and the County is seeking addition funds to support expansion. And the County's implementation of the Qualitative Service Review to measure the quality of practice, achievement of outcomes and provide feedback on performance is producing valuable insights about the effectiveness of practice change efforts.

System Challenges

Katie A. implementation in a number of key areas, however, is not progressing, or is at best making slight progress. The following key elements of the Strategic Plan need additional work to fulfill their role in meeting the goals and objectives of the settlement.

Workload

Part of the strategy in the County's plan is to lower workloads so Core Practice Model implementation can proceed. Currently, caseloads are rising for Emergency Response and Generic Caseworkers despite workload reduction efforts. The high caseload size is compounded by the fact that staff transfers and vacancies mean that remaining staff must assume the vacant caseloads, which means that caseloads of 30 or more are not unusual.

DCFS and DMH Training and Coaching - Core Practice Model Implementation

The County is facing significant challenges in implementing the Core Practice Model. One of the core elements of practice in the County's practice model is the regular use of child and family team meetings with children and families. The teams, which are expected to consist of the family, their informal supports, professionals, foster parents (in cases where children are

placed out-of-home) and others should be the locus of case assessment, planning, decision-making and coordination. The strength and needs-based individualized plans anticipated by the practice model, are expected to be developed by the child and family team. Unfortunately, workload barriers are preventing the implementation of the Child and Family Team process despite the County's efforts to build coaching capacity. As a result, only a fraction of line staff are convening and facilitating family teams – the object of the coaching efforts – because their caseloads are so high. Most of them have not had significant coaching support yet, although the County is working on building supervisory coaching capacity. Recent Qualitative Service Review findings, which have improved since baseline data were collected, reflect the need for considerable additional progress.

Indicator	Voice & Choice	Teamwork	Assessment	Long-term View	Planning	Supports and Services	Tracking & Adjustment
Percent of Scores in Acceptable range	65%	29%	53%	58%	53%	64%	51%

It is unlikely that the Department will meet exit targets unless workload issues are addressed and coaching capacity is expanded significantly.

Expansion of Home–Based Mental Health Services

A number of mental health initiatives are supporting Katie A. implementation. The co-location of mental health staff in DCFS offices, mental health screening of newly detained children, expansion of Wraparound and the pilot of Intensive Field Capable Clinical Services have increased the availability of mental health services to class members. However, only a modest number of class members are receiving in-home mental health services and fewer still, intensive services. For those children not served in specialized programs like Wraparound, Full Service Partnership and Intensive Field Capable Clinical Services, for example, service delivery is likely to be office-based. Coaching of mental health staff in Core Practice Model approaches is at its earliest stages, currently focused on a small number of group homes.

Information gathered by the Panel indicates that even with the development of more specialized mental health programs, the County struggles to meet the needs of children requiring intensive mental health services, especially those whose placements are unstable.

Treatment Foster Care (TFC)

The implementation of Treatment Foster Care continues to be stalled. In fact, fewer children were receiving TFC at the end of the reporting period than at the time of the last Panel report. Recruitment of new foster caregivers is lower than the number of caregivers leaving the program. The number of children receiving TFC at the end of the current monitoring period was lower, at 76, than the number served at the time of the Panel's prior report At that time 85 children were receiving TFC. Currently, the County remains far short of achieving the 300 beds required in the Court's prior Corrective Action Plan.

Foster Home Recruitment

The Panel has been unable to determine the number of family foster homes needed to meet the needs of the class. The County has frequently reported that it does not have enough family foster homes needed to meet demand, which is why some children experienced overstays in the Welcome Center in the past, why the number of children initially placed in group homes for emergency shelter is growing and why there remains a shortage of homes for young children. The Department has undertaken multiple initiatives to improve recruitment and retention, but to date any net gains have been modest. The Panel has sought to determine the gap between entries into care and exits from care to assess the number of homes needed; however, the County has been unable to extract such data from its data systems at this point. The County continues to work on this task. The Panel expects to provide further analysis of this challenges in its next report.

Panel Recommendations

The following recommendations are made by the Panel to foster implementation of the strategic plan and achieve the goals of the settlement.

Workload

The Panel noted earlier in this report that high DCFS caseloads are preventing Core Practice Model training and coaching, especially related to the Child and Family Team process, which is far from being fully implemented at the front line. Procedural efficiencies such as those described by DCFS in its workload reduction strategies will not be sufficient to provide the reduction in workloads needed to provide staff time to implement these new practice approaches. This is evident based on the fact that caseload size is growing in both Emergency Response and Generic caseloads, despite workload reduction efforts and increases in staff allocations. The County needs to significantly increase its work force beyond the 470 additional staff authorized to be able to implement the Strategic Plan successfully and meet the exit criteria of the settlement.

Treatment Foster Care

The County has made continuous efforts to increase the number of TFC beds with little success in the last few years and now faces a significant foster parent recruitment and retention problem. Using the expertise of its external consultants, the County should develop a revised plan to expand the availability of TFC beds by significant numbers each year. The plan should also include strategies to improve the focus and/or intensity of services for children served in TFC to reduce the number discharged to more intensive settings. The Panel would like to schedule a conference call with appropriate County representatives and its consultant advisors to learn more about strategies the County reports it is developing before the next Panel meetings

Expansion of Intensive Home-Based Mental Health Services

The Wraparound policy that requires children to be in a stable placement to be eligible for Wraparound presents a major barrier to serving the plaintiff class, especially those children with high mental health needs. Since instability is often the result of unmet mental health needs, the Wraparound design seems to be preventing services to some of the children it was created to serve. The County should revise its procedures to permit Wraparound to respond quickly to unstable children and in doing so, also join the placement-finding process as a team member.

The relatively high number of Wraparound vacancies is a lost resource to members of the plaintiff class. The County should assess the referral and admission process to identify opportunities to shorten the time period needed for admission to Wraparound. It should also assess the reasons children are rejected for service to determine if eligibility standards are an unnecessary barrier to serving children with high mental health needs.

The lack of clinical focus in some Wraparound cases was identified years earlier in a Qualitative Service Review targeting children served by Wraparound. This issue was also recently identified in interviews with CSWs and SSWs (line caseworkers and supervisors). Because of their mental health needs, children served by Wraparound have significant needs for clinical support. To address this need, the County should develop a strategy to increase the clinical focus with children served by Wraparound. The County should also review and interview a sample of the families whose children do not graduate from Wraparound to identify solutions to the pattern of children disenrolling from the program.

Beyond Wraparound, the County should explore the possibility of additional expansion of Intensive Field Capable Clinical Services (IFCCS). This flexible, high service intensity pilot, designed to serve children with high mental health needs, is showing considerable promise in meeting the needs of this population.

DCFS and DMH Training and Coaching

The County should develop a training and coaching plan that fully describes the steps to be taken to implement the use of Child and Family Teams throughout each DCFS office and in agencies providing services to children with mental health needs. The plan should be at a level of detail that describes the number of coaches needed, when they will begin and complete coaching in each setting and when CSWs and mental health practitioners will regularly employ child and family teams with the families they serve.

Family Foster Home Recruitment

The County added a modest number family foster homes during the monitoring period. In an effort to learn how foster home growth compared with trends in out-of-home care, the Panel requested that the County provide information about the rate of entry and exit from foster care during the reporting period. The County has been unable to produce those data at this point. As a result, to enable the Panel to analyze child welfare population trends, the Panel requests that the County provide data that identifies an array of data characteristics addressing such areas of out-

of-home care entries and exits, children exiting foster care at age 18 or older without permanency and estimated numbers of foster homes needed, for example. These data will be used to assist in tracking the status of Katie A. Implementation. The Panel and County should confer to identify the specific data needed.

Katie A. Advisory Panel
Report to the Court
First Reporting Period of 2014
December 18, 2014

I. Introduction

The following Report to the Court outlines the County's progress toward achieving the objectives of the Settlement Agreement and includes a description of its compliance with the current Joint DCFS/DMH Plan, Corrective Action Plan and the Strategic Plan.

II. Panel Activities Since the Last Report

The Panel met with the County in March and June, 2014. In addition, the Panel participated in several Qualitative Service Reviews (QSR) and provided a day of training on QSR fidelity practice to DCFS and DMH quality assurance staff. In each of the Panel's two meetings during this reporting period, the Panel met with local DCFS and DMH staff to discuss Strategic Plan implementation status, progress and system barriers. These discussions provided valuable insights into front-line practice. During the June Panel meeting, the Panel also met with representatives of agencies providing Intensive Field Capable Clinical Services (IFCCS), Full Service Partnership and Wraparound services. The Panel has focused more intensively on the system's capacity to respond to the needs of children with a high level of mental health needs in these stakeholder interviews.

At the request of Association of Community Human Service Agencies (ACHSA), the Panel met with a group of their representatives to listen to concerns about the County's new Wraparound contract. The Panel also met with a group of childrens' attorneys.

The Panel heard a number of consistent themes in the meeting with DCFS and DMH staff. They included the following:

The County struggles with serving children and youth in crisis. "This population bounces between offices, the Welcome Center, hospitals and group homes – constant crisis and constant movement (placement changes). By the time Wraparound is connected, children have moved again and the process starts over." Complicating this is the fact that Wraparound will not serve children without a stable placement, so for many youth, Wraparound is not considered a good match at this stage. Concerns were also expressed about the lack of clinical mental health focus in Wraparound, which handicaps the program's ability to address the high number of children with trauma needs. Staff mentioned the difficulty in getting parents and foster parents to consent to Wraparound services (DMH is now piloting a process whereby Wraparound secures the consents rather than the CSW). One office found Full Service Partnership services more effective with unstable children than Wraparound because instability was not a programmatic bar to services.

III. Current Implementation Plan Status

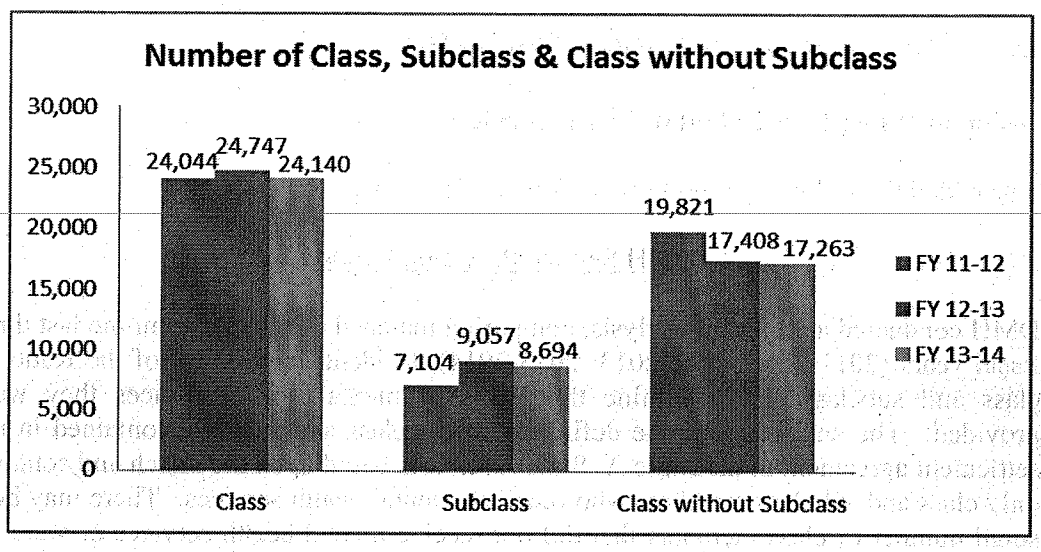
Expansion of Home-Based Mental Health Services

DMH provided the following report on service provision to class members.

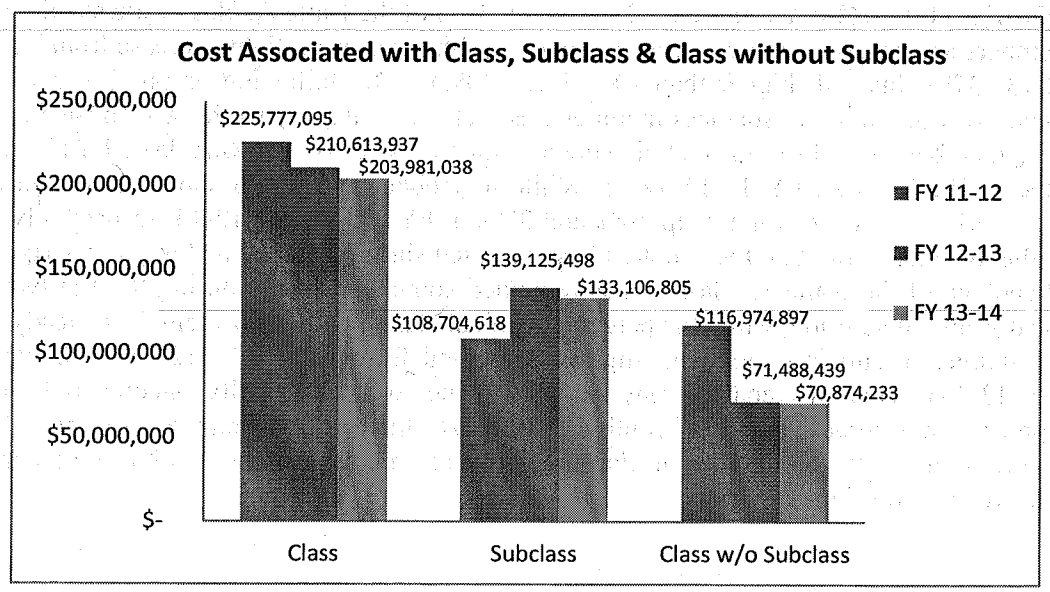
DMH Service Provision Report

DMH conducted an updated analysis, comparing matched client data from the last three fiscal years (2011-2012, 2012-2013, 2013-2014), to identify members of the Katie A. class and subclass and determine the levels of mental health services they were provided. The analysis used the definition of the class and subclass contained in the settlement agreement in the Katie A. State case. It is based upon the match and contains only class and subclass members who received mental health services. There may be a small number of class members that did not receive mental health services or were at-risk and these youth are not reflected in the numbers below. In addition, there were other restrictions with our data set: 1) there are a number of providers that have begun claiming using IBHIS but the data in this report only includes Integrated System (IS) data, as data from both systems has not yet been combined; 2) DMH used a different analysis to capture the number of youth that were psychiatrically hospitalized due to limited DCFS and DMH data available; and 3) this report may not fully reflect all class members and mental health services provided as providers have up to 18 months to submit claims. With this in mind, this analysis revealed the following:

1) From the total amount of DCFS clients (approximately 59,000), 41% of them were Katie A. class members during FY 13-14, similar to previous fiscal years (FY 12-13 42%; FY 11-12 42%). During FY 13-14, about 36% of the Katie A. class were subclass members and received more intensive mental health services, a slight decrease from FY 12-13 (37%) but still higher than FY 11-12 (30%). The following graph shows the breakdown of class and subclass members, as well as a category we have identified as class members that does not include subclass members (Class w/o Subclass: FY11-12 82%; FY12-13 70%; FY 13-14 72%). While the subclass made up about 30% of the class during FY11-12, it made up 36% and 37% in FYs 13-14 and 12-13, respectively. While the data shows that the subclass has increased since FY 11-12 making up a larger percentage of the Katie A. class, it has remained somewhat steady during the last two fiscal years. In addition, while the percentage of subclass members has remained steady, the number of subclass members slightly decreased from 9,057 (FY 12-13) to 8,694 (FY 13-14). This discrepancy may be partly due to the difficulty encountered in capturing an accurate number of youth that were psychiatrically hospitalized during FY 13-14. As a result, the number of class and subclass members may be slightly higher than we are reporting.

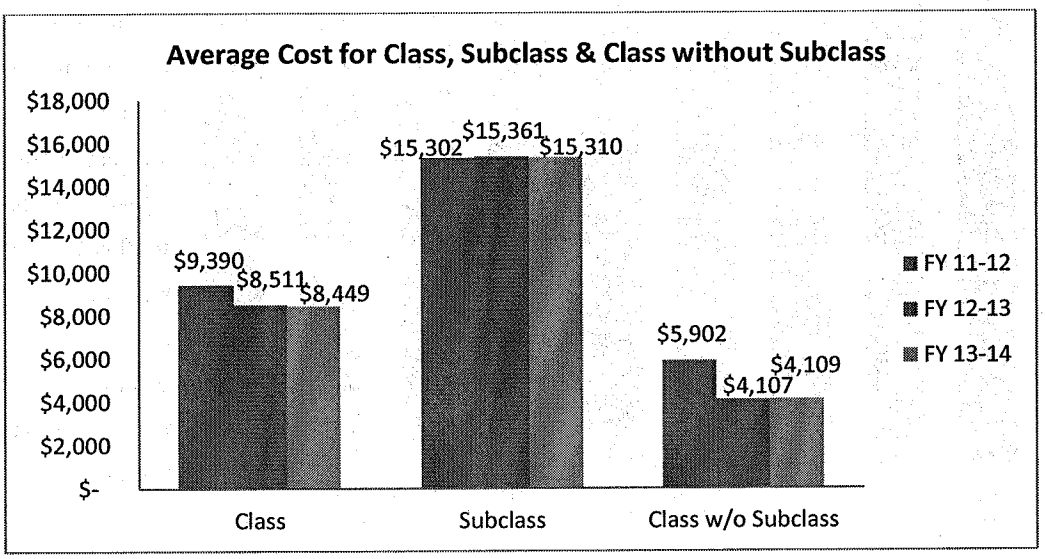


2) The cost associated with providing mental health services to the Katie A. class decreased within the last three fiscal years (FY 11-12 - $225 million; FY 12-13- $210 million; and FY13-14 - $204 million). The percentage of subclass costs has remained steady during FY13-14 (65%) and FY 12-13 (66%). In the last two fiscal years, while the subclass made up about 37% of the class, it made up about 65% of the total class cost. This is a big change from FY 11-12 when the subclass made up about 30% of the class and only 48% of the total cost. The data shows that the number of class meeting the subclass criteria has increased in recent years with more intensive mental health needs. The mental health costs associated with providing services to this group is still more than half (65%) of the total costs provided.

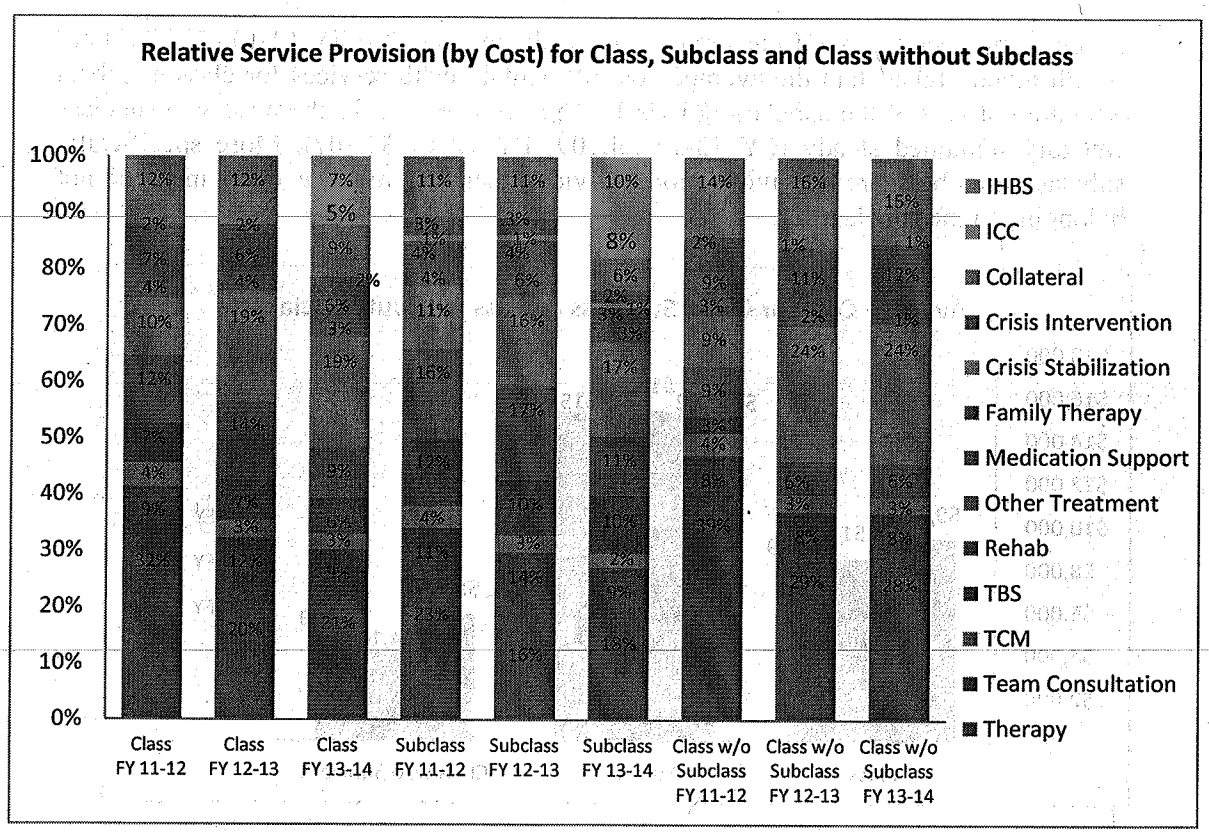


3) Upon closer look at the mental health service costs that were provided to subclass members, the FY 13-14 data shows the average mental health cost associated with

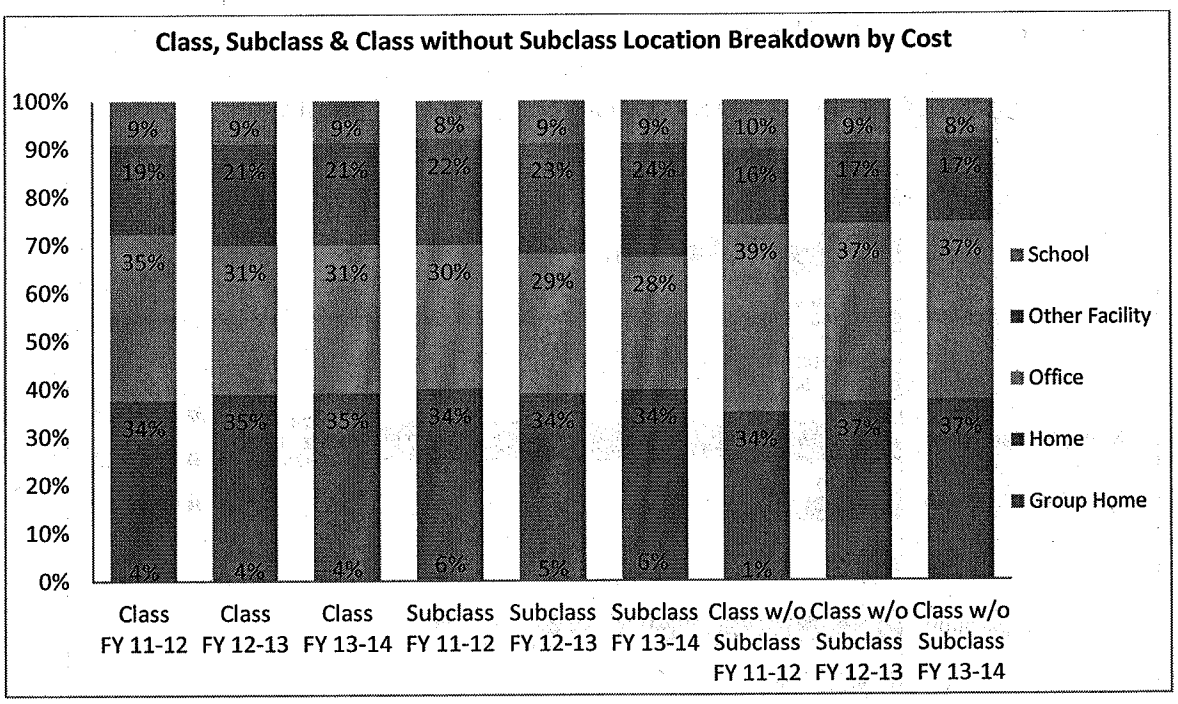
subclass members ($15,310) has remained steady compared to FY 12-13 ($15,361) but is still much higher than the average cost of mental health services for class members who are not part of the subclass ($4,109). The average cost for the class w/o subclass category remained steady (FY 13-14 $4,109; FY 12-13 $4,107). 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 slightly between class and subclass members. For FY 13-14, subclass members received less individual therapy (18%) than non- subclass class members (28%). Subclass members also received more targeted case management (TCM) including team consultation (TC) and ICC (subclass: 19%; class w/o subclass: 11%), more rehabilitation services including TBS and IHBS (subclass: 31%; class w/o subclass: 6%). ICC and IHBS were also introduced during FY 13-14 for subclass members and specifically made up about 8% and 10% of the service array, respectively. In addition, within the last two fiscal years, individual therapy (FY 13-14: 18%; FY 12-13: 16%), TCM including TC and ICC (FY 13-14: 19%; FY 12-13: 17%) and rehabilitation including TBS and IHBS (FY 13-14: 31%; FY 12-13: 27%) has slightly increased. The mental health service array for subclass members is more in line with the intensive services we would expect subclass members to receive and hypothesize that this type of service array would be more equivalent to ICC and IHBS and thus contribute to higher success rates for this population. During the last fiscal year, DMH expected the amount of rehabilitation services and targeted case management to increase with the implementation of ICC and IHBS and this data supports this. We expect these types of services to continue to increase as providers become more familiar with providing these intensive services to subclass members.



5) The location of services data has not changed much within the last two fiscal years. During the last two fiscal years, there are still more services being provided in the office for class w/o subclass members (FY 13-14: 37%; FY 12-13: 37%) than for subclass members (FY 13-14: 28%; FY 12-13: 29%). In addition, more services seem to be provided in other facilities for the subclass (FY 13-14: 24%; FY 12-13: 23%) than for the class w/o subclass (FY 13-14: 17%; FY 12-13: 17%). 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 and urgent cares centers. While we expected to see subclass members receiving more services in the home during FY 13-14 (34%) as compared to FY 12-13 (34%), there was no change noted. In addition, more services were offered in the home for class non-subclass class members (FY 13-14: 37%) than for subclass members (FY 13-14: 34%). These percentages are also consistent with data from last year.

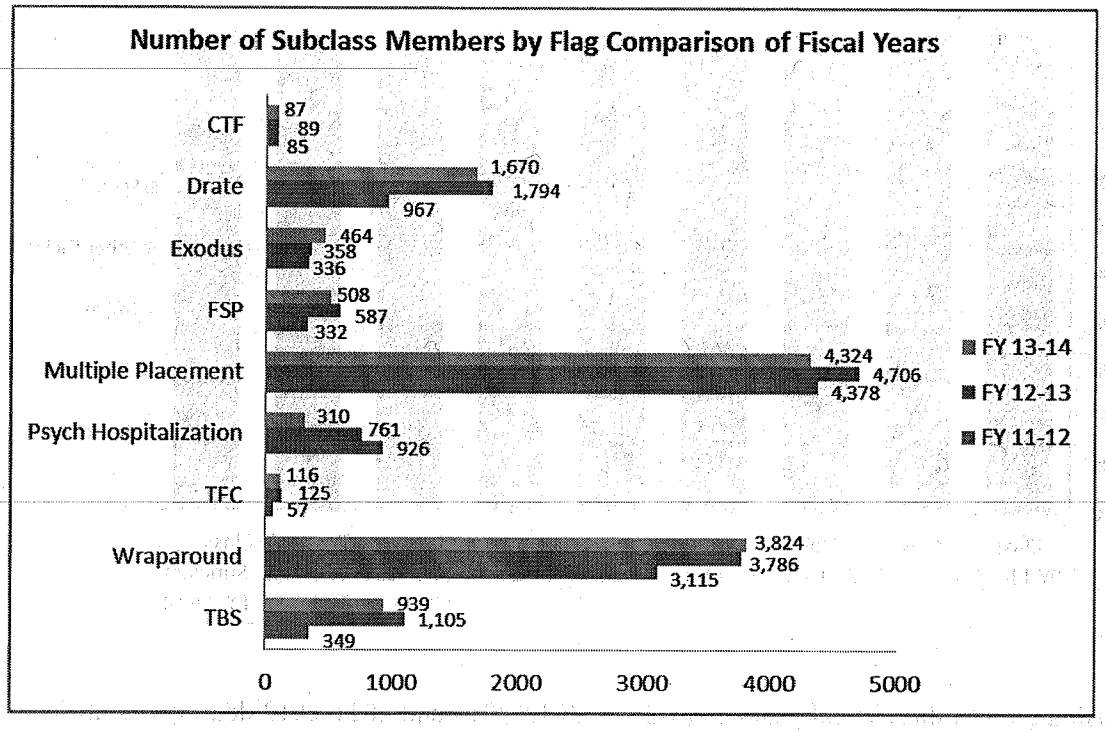


Using the last three fiscal years 2013-2014, 2012-2013 and 2011-2012 data, we identified some of the mental health services that were provided to subclass members that we identified as being similar to services provided within ICC and IHBS.

1) Subclass members are receiving a variety of services to meet their mental health needs. DMH has identified these services and programs as providing a high intensity of services, frequency of services and services more often provided in the youth's home or most home-like setting. Based on the subclass definition, we have developed a chart below of the criteria or programs youth were in that contributed to them being in the subclass. Consistent with FY 12-13, in FY 13-14 the majority of youth had three or more placements (4,324), Wraparound (3,824) or were placed in a D-Rate home (1,670). During FY 11-12, however, the majority of youth had three or more placements (4,378), Wraparound (3,115) or were placed in a RCL 12 (1,077). It is important to note that many youth fell into multiple categories below.

2) In addition, from FY 12-13 to FY 13-14, fewer youth were enrolled in TFC (125 to 116), TBS (1,105 to 939), and FSP (587 to 508), and more in Wraparound (3,786 to 3,824) and Exodus (358 to 464). The data shows that the number of youth enrolled in a psychiatric hospital greatly decreased (FY 13-14: 310; FY 12-13: 761); however, it is important to note that we had difficulty gathering accurate data regarding psychiatric hospitalizations and much of the data is missing or not accurately reported. *[The subclass criteria below include Full Service Partnership (FSP), clients that have had three or more placements within 24 months (Multiple Placements), Treatment Foster Care (TFC), Community*

Treatment Facility (CTF), D-Rate placement, Rate Classification Levels 10 -14 (RCL 10 – 14), Psychiatric Hospitalization (Psychiatric), Wraparound, Exodus, and/or Therapeutic Behavioral Services (TBS)].

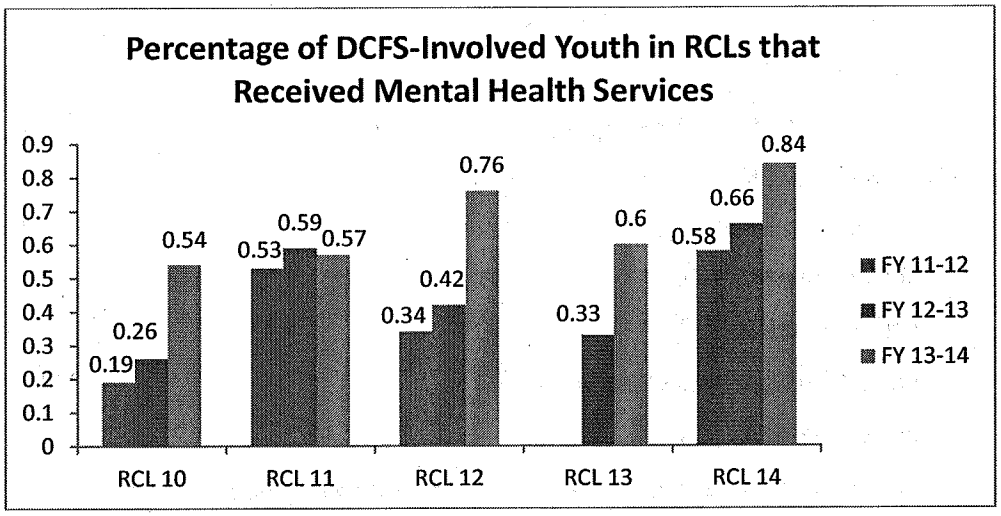


In the data provided below, DCFS' fiscal year placement numbers were compared to DMH's clients that received a mental health service while in Rate Classification Level (RCL) 10 and above. It is important to note that many of the children placed in the RCLs may in fact be receiving mental health services from the group homes' staff members and/or Fee for Service Providers which is not reported to our mental health database. DMH will investigate the feasibility of retrieving fee for service data for children placed in group homes and conducting a survey of group homes to determine mental health services provided to children which was not reported in DMH Information System (IS). DMH expect that these tasks could be completed for the next panel report to court.

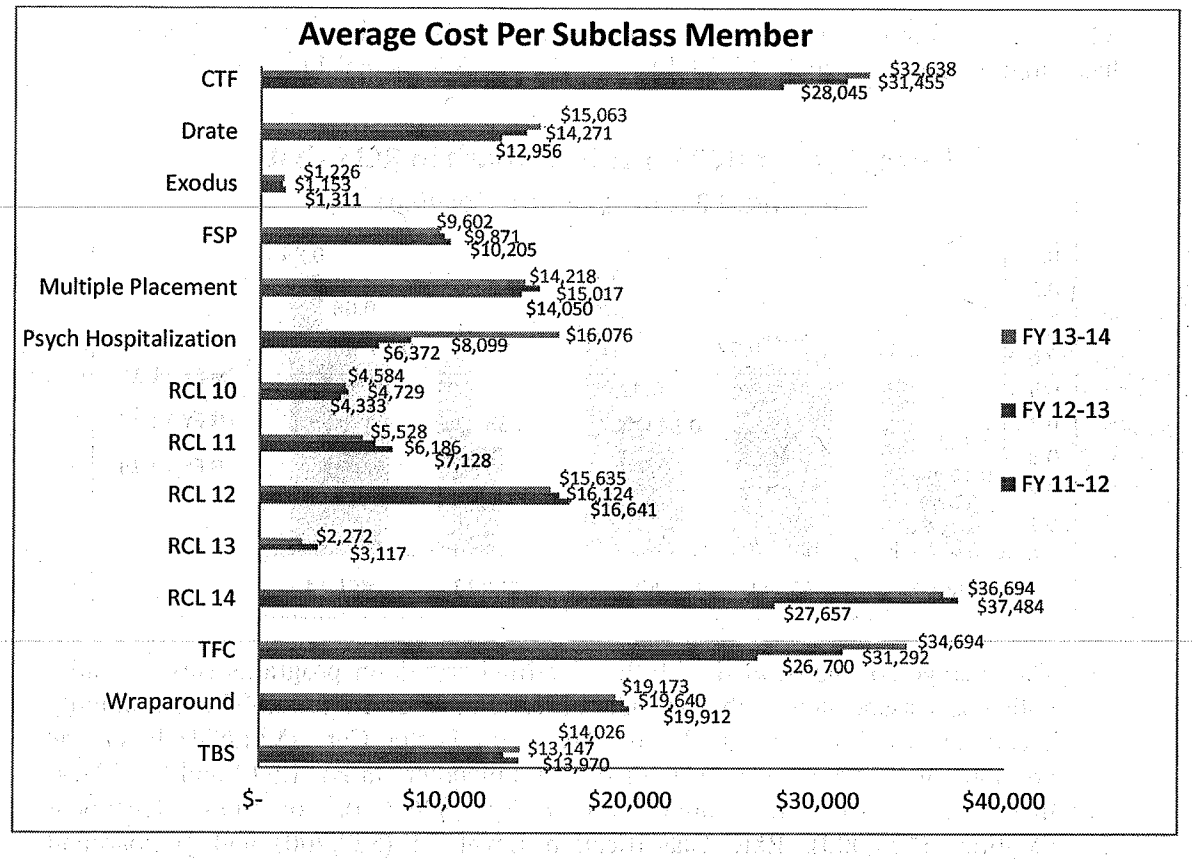
3) Additionally, some of these children may be placed in facilities located outside of the County and/or State; therefore, in these instances, their mental health information would not be reported to DMH because of their technical "unmatched" label. DMH and DCFS will continue to explore possible reasons 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 fiscal years, the number of youth that received mental health services through DMH has steadily increased in RCL 10 (FY13-14 54%; FY 12-13 26%; FY 11-12 19%), RCL 12 (FY13-14 76%; FY 12-13 42%; FY 11-12 34%), and RCL 14 (FY13-14

84%; FY 12-13 66%; FY 11-12 58%). The number of DCFS-involved youth in RCL 11 has remained fairly constant (FY13-14 57%; FY 12-13 59%; FY 11-12 53%).



4) The average cost associated with the identified criteria or programs varies greatly, with costs associated with Rate Classification Level 14 ($36,694), Community Treatment Facilities ($32,638) and Treatment Foster Care ($34,694) being the programs with the highest costs for subclass members in FY 12-13 and FY 13-14. In FY 11-12, however, Treatment Foster Care ($26,700), Community Treatment Facilities ($28,000), Rate Classification Level 14 ($27,700) and Wraparound ($20,000) were programs associated with the highest costs for subclass members (see chart below).



From the Panel's perspective, these data are useful descriptors of IHBS expansion, but not yet fully evaluative. Highlights of the data include:

- Class members make up 41% of the 59,000 DCFS clients, similar to the prior year
- During FY 2013-2014, 36 % of class members were sub-class members, similar to the prior year
- The percent of sub-class member costs relative to class member costs grew from 30% in FY 2011-2012 to 65% in FY 13-14
- Average annual class member's mental health costs for class members not in the sub-class were $4,019 compared to $15,310 for sub-class members in FY 2013-2014
- Service delivery in office-based settings (as opposed to home, community settings, other) is 9% higher (37%) for non-subclass members than sub-class members (28%) – both percentages are low, considering the goal of providing home-based services

Utilization of Evidence-Based and Promising Practices for Class Members

Evidence-Based and Promising Practices

Using data from the last three fiscal years, DMH identified the Evidenced-Based and Promising Practices that were delivered to class members. DMH reports below the number of class members that received these services and the number of legal entities in Los Angeles County that

provided these services to class members. The chart also breaks out the number of Birth to Five class members that were served by these modalities.

> The County reports that for FY 13-14, about 9,000 DCFS-involved youth received treatment using an evidence-based or promising practice at a service cost of about $40 million. This is a decrease from FY 12-13 when almost 10,000 youth were served through this modality with a service cost of $43 million. FY 13-14 data is consistent with data for FY 11-12. For the last three fiscal years, the majority of youth received Trauma Focused-Cognitive Behavioral Therapy (3,726), Managing and Adapting Practice (2,715), Child Parent Psychotherapy (1,163), and Seeking Safety (1,118).

The County states that to understand the reasons for the decrease in youth being served, it is important to understand the data reporting systems. The County explains this decrease as follows.

> Since the initial release of the Integrated Behavioral Health Information System earlier this year, DMH information technology staff had to pull the similar data from this new system and integrate it with the existing Integrated System data. However, due to the significantly different data structure, the effort to merge the data has not been a simple effort and required support from the vendor as well as other key IT staff. This effort was further hindered with numerous power and server infrastructure issues arising during the summer month which led to repeated system shutdowns and server recoveries. Recently, a version of the combined data sources has been made available for the IT staff to leverage, which should help to resolve these issues. Furthermore, plans are in place to move the database servers to another more stable location. Given these problems with the database, it may well be that the reduced number is simply an artifact of the missing data.

	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)		
Evidence Based and Promising Practices	FY 11-12	FY 12-13	FY 13-14	FY 11-12	FY 12-13	FY 13-14	FY 11-12	FY 12-13	FY 13-14	FY 11-12	FY 12-13	FY 13-14
Multisystemic Therapy (MST)	39	31	20	13	14	7	5	7	0	4	2	0
Functional Family Therapy (FFT)	334	272	216	14	15	12	15	11	11	8	4	2
Brief Strategic Therapy	42	54	31	9	11	9	7	17	11	2	6	6
Child Parent Psychotherapy (CPP)	773	1,124	1,163	37	43	41	711	1,189	1,102	35	40	38
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	47	36	6	9	6	3	4	3	3	2	2	3
Incredible Years (IY)	263	324	221	16	16	16	104	165	100	14	12	14
Parent-Child Interaction Therapy (PCIT)	220	194	310	15	12	31	159	160	265	13	10	28
Strengthening Families	43	53	35	6	5	2	3	1	1	2	1	1
Trauma Focused - Cognitive Behavioral Therapy (TF-CBT)	4153	4,271	3,726	79	83	81	549	690	609	56	60	59
Triple P Positive Parenting Program	658	548	373	37	38	32	210	205	168	25	25	25
UCLA Ties Transition Model	39	37	40	2	2	3	28	33	25	2	2	2
Aggression Replacement Training (ART)	606	524	409	26	23	20	17	25	9	5	6	3
Alternatives for Families - Cognitive Behavioral Therapy (AF - CBT)	52	133	116	4	7	7	6	19	13	3	5	4
Managing and Adapting Practice (MAP)	2476	2,859	2,715	76	79	82	301	395	363	52	53	60
Seeking Safety	1433	1,233	1,118	56	56	59	17	28	3	8	8	5

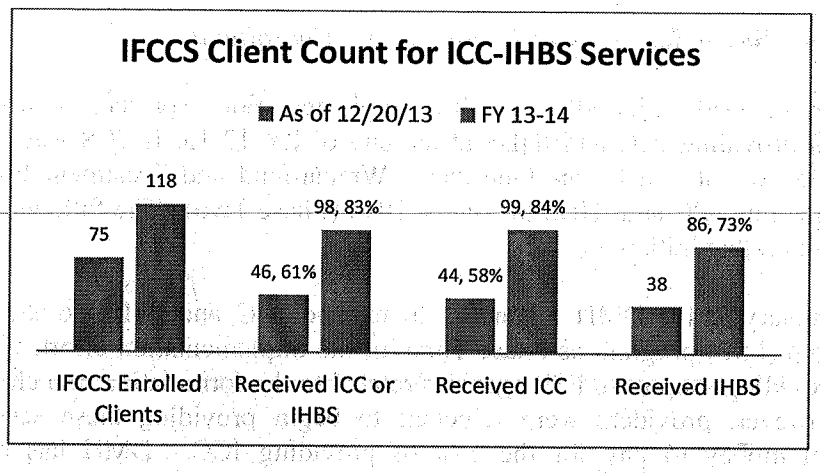
The Panel has the following observations about these data:

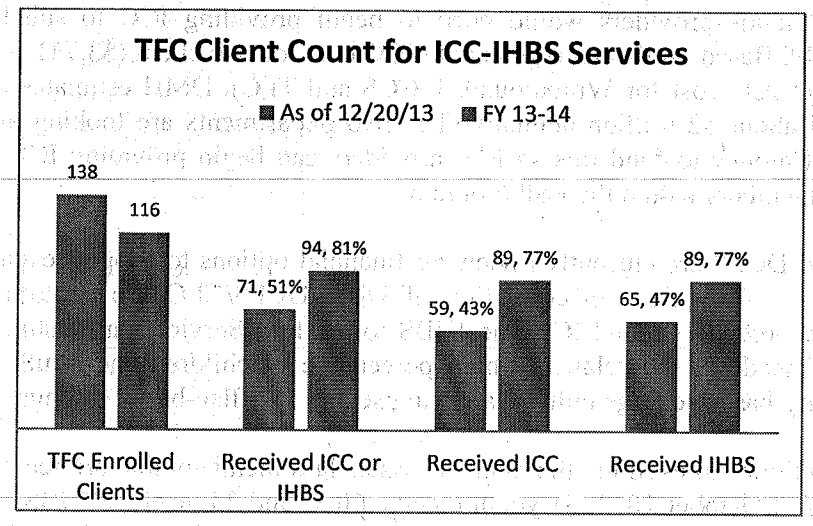
- The reported in-home services for class members is not growing as rapidly as expected –DMH plans to explore further
- Additional funds are needed to expand ICC and IHBS to the Full Service Partnership program – Both DCFS and DMH are said to be exploring other funding sources
- In IFCCS, IHBS and Wraparound, the percent of youth that received IHBS and ICC increased 30% since December 2013

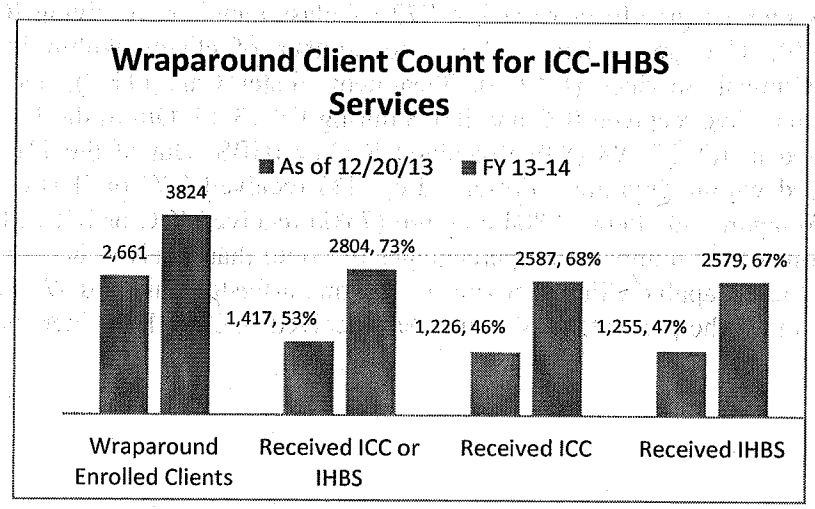
Intensive Home-Based Services and Intensive Care Coordination

The County developed a phased approach to implementation expansion in which Los Angeles County began providing ICC and IHBS at the end of FY 12-13. IFCCS was Phase One of the ICC and IHBS rollout and began June 2013. Wraparound and Treatment Foster Care (TFC) began implementing ICC and IHBS in August 2013 (Phase Two). The following is the County's progress report on that initiative.

> As of January 2014, DMH attempted to expand ICC and IHBS to the Full Service Partnership (FSP) program as Phase Three of the implementation effort. DMH coaches began providing support to FSP agencies related to the formulation of a child and family team; however, providers were reluctant to begin providing these services without additional money to pay for the cost of providing ICC. DMH has computed the estimated funds providers would need to begin providing ICC to subclass members within FSP. Based on the average annual ICC cost for one client ($3,741 – using FY 13-14 average ICC cost for Wraparound, IFCCS and TFC), DMH estimates that providers will need about $2 million annually. The two departments are looking at ways to get additional money to fund this so FSP providers can begin providing ICC and IHBS to subclass members within the FSP program.
>
> DMH and DCFS are currently reviewing financial options to support expansion of ICC and IHBS. A workgroup consisting of DMH/DCFS/CEO are exploring alternative funding sources to expand ICC and IHBS to the Full Service Partnership program and meet the needs of the relatively high percentage of children and youth in home and community-based settings rather than being served in office-based settings.
>
> DMH continues to examine the number of subclass members that are receiving ICC and IHBS. As of October 2013, 51 youth received ICC and 23 received IHBS. As of January 2014, this number greatly increased to 772 subclass members receiving ICC (653) and IHBS (669). The graphs below show the number of clients within Intensive Field Capable Clinical Services (IFCCS), Treatment Foster Care (TFC), and Wraparound (WRAP) that have received ICC and IHBS during FY 13-14. Out of the 118 children that were served in IFCCS, 98 (83%) received ICC or IHBS. Out of the 116 children that were served within Treatment Foster Care, 81% received ICC or IHBS. Out of 3,824 enrolled Wraparound clients 2,804 children (73%) received ICC or IHBS. Below are the comparisons of the numbers and percentages of youth that received ICC or IHBS within Intensive Field Capable Clinical Services, Treatment Foster Care and Wraparound. In all three programs, the percentage of youth that received ICC or IHBS increased by at least 30%.


IFCCS Client Count for ICC-IHBS Services
As of 12/20/13
FY 13-14
75
118
46, 61%
98, 83%
44, 58%
99, 84%
38
86, 73%
IFCCS Enrolled Clients
Received ICC or IHBS
Received ICC
Received IHBS


TFC Client Count for ICC-IHBS Services
As of 12/20/13
FY 13-14
138
116
71, 51%
94, 81%
59, 43%
89, 77%
65, 47%
89, 77%
TFC Enrolled Clients
Received ICC or IHBS
Received ICC
Received IHBS


Wraparound Client Count for ICC-IHBS Services
As of 12/20/13
FY 13-14
2,661
3824
1,417, 53%
2804, 73%
1,226, 46%
2587, 68%
1,255, 47%
2579, 67%
Wraparound Enrolled Clients
Received ICC or IHBS
Received ICC
Received IHBS

The County summarizes these data as follows.

1) While the data show that the number of subclass members has increased in recent years making up a larger percentage of the Katie A. class, it has remained somewhat steady during the last two fiscal years. In addition, while the percentage of subclass members has remained steady, the number of subclass members slightly decreased. This may be partly due to a) the difficulty DMH encountered in capturing an accurate number of youth that were psychiatrically hospitalized; b) IBHIS data not being accounted for in DMH numbers; and c) claims that have not yet been submitted. As a result, the number of class members and mental health services they received may be slightly higher than we are reporting.

2) In the last two fiscal years, while the subclass made up about 37% of the class, it made up about 65% of the total class cost. The data shows that the number of class members that meet the subclass criteria has increased in recent years, as well as, their mental health needs.

3) The average mental health cost associated with subclass members ($15,000) has remained steady in recent years but is still much higher than the average cost of mental health services for class members who are not part of the subclass ($4,000).

4) While the County expected to see subclass members receiving more services in the home during FY 13-14, there was no change noted. In addition, more services were offered in the home for class members (37%) than for subclass members (34%). DMH intends to take a closer look at the types of services being provided in the office and home in order to get a better understanding of the data.

5) Consistent with the previous year, the majority of youth in the subclass had either three or more placements, was enrolled in Wraparound or was placed in a D-Rate home.

6) The data shows that the number of youth enrolled in a psychiatric hospital greatly decreased by more than half; however, DMH is concerned with the accuracy of the hospitalization data and is working toward developing a better way to track this information.

7) Within RCLs, the number of youth that received mental health services through DMH has steadily increased in RCL 10, RCL 12, and RCL 14 while the number of youth in RCL 11 has remained fairly constant.

8) For the last three fiscal years, almost 40% of class members received an EBP or Promising Practice and the majority of those youth received Trauma Focused-Cognitive Behavioral Therapy.

9) There has been a greater number of youth that received IHBS and ICC since December 2013. Within IFCCS, 83% of the youth received ICC or IHBS, 81% in

Treatment Foster Care and 73% in Wraparound. In all three programs, the percentage of youth that received ICC or IHBS increased by at least 30%.

A workgroup consisting of DMH/DCFS/CEO is exploring alternative funding sources to expand ICC and IHBS to the Full Service Partnership program and meet the needs of the relatively high percentage of children and youth in home and community-based settings rather than being served in office-based settings.

Treatment Foster Care (TFC)

As a result of previously slow progress in the County's efforts to expand therapeutic foster care, the County was directed by the court in its Corrective Action Plan order to expand therapeutic foster care to 300 beds.

The following table displays growth and exit outcomes over time and reflects the continuing slow progress in complying with the court's order.

	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13	FY 13-14
New Intakes	26	30	68	62	85	42
Youth Exiting TFC	14	27	36	49	63	58
Exit to Higher Level of Care (GH, Hosp)	9 (64%)	12 (44%)	17 (47%)	14 (29%)	23 (37%)	19 (33%)
Exit to a Lower Level of Care (HOP, LG)	5 (36%)	15 (55%)	19 (53%)	35 (71%)	40 (63%)	39 (67%)
Youth Receiving TFC Services in FY	30	41	81	95	107	136

At the end of FY 2013-2014, the County had a total of 97 certified foster homes with a total bed capacity of 110—the larger number accounts for homes where TFC siblings are placed together. Of the 110 beds, 76 were filled, nine were vacant working on a match, eleven were respite only, twelve were taking a break, and two were on hold awaiting outcome of an investigation. During this time period only 13 new homes were certified and 28 foster parents left TFC. The primary reasons given for the attrition was to return to regular foster care (39%) or to leave foster care all together (32%). Despite these losses and the lower number of intakes, the successful outcome rate rose.

DCFS began tracking the Foster Parent attrition rates in June 2012. The data that follows is for the time period of June 2012 through September 2014.

DCFS is reporting all outcome reasons and not just adoptions to better understand the complete picture and context. Since the inception of TFC tracking, six (6) children have been adopted. One (1) family transitioned from TFC to an adoptive placement in FY 2013-2014 (see below).

Reason for leaving TFC	Number	Comments
TOTAL number since June 2012:	155	
1. Left Foster Care Completely	74	
a. Chose to leave all Foster Care with explanation	*38*	*These are always for stated personal reasons such as retirement, illness, change in household, moved out of state, ask to be voluntarily decertified, and so forth.*
b. Left Foster Care with no explanation	*36*	*This is very common that the foster parents state that they want to take a break and then do not respond to any follow up contact by the FFA staff. This in many ways should be added to those that choose to leave foster care.*
2. Chose to return to Regular Foster Care	38	*They usually report not wanting to continue providing care for this TFC population or they want to have more foster youth in their homes.*
3. Chose to do Respite Only	8	
4. Were involuntarily decertified	15	*These were either due to DCFS investigations or, most commonly, by the FFA who found the caregivers unsuited to foster care.*
5. Became certified TFC for a specific child	20	*The reason is for some sort of permanency. They either (a) continued to care of the youth at a lower level of care as regular foster parents or (b) continued as an adoptive placement.*
a. Continued with youth to lower level of care	*14*	*(a) After the youth leaves TFC, we do not track the final outcome whether or not they continue for guardianship, adoption, or just continue as foster caregivers for the youth.*
b. Continued as adoptive placement	*6*	*(b) After the youth leaves TFC, we do not track the final outcome whether or not they finalize an adoption. However DCFS adoptions workers are part of the transition for this group. [Note only 1 of the 6 transitioned to the adoptive home in FY 2013-2014. Other 5 were before 2013.]*

The County reports the following efforts to expand TFC during the reporting period.

> Since the last reporting period, Los Angeles County has hired an additional staff person to assist the TFC contract providers in developing resources and an infrastructure around targeted recruitment for the program. The County has formed a Recruitment and Retention workgroup that meets monthly to develop strategies and action plans that empower the agencies to take the steps necessary to grow the pool of Certified TFC Parents. As a result of these efforts, eleven of the twelve agencies formed a collaborative and hosted a large recruitment event on June 21st. The event was well-attended, with a panel of current TFC Foster Parents, former TFC foster youth, and distinguished speakers, such as DCFS Director Philip Browning and State Senator Carol Liu. Overall, there were approximately 30 potential foster parents who expressed interest in becoming certified with TFC.

In May, the Child Welfare Initiative (CWI) approached the Director of DCFS with a proposal to provide technical assistance to the LA County TFC-contracted agencies for foster parent recruitment. CWI had been providing technical assistance to six of the twelve LA County TFC-

contracted Foster Family Agencies. The chief consultant for CWI has had over 25 years of experience in the field of foster care including the development of TFC for the State of North Carolina. Since the first proposal, LA County DCFS and DMH managers have been working with CWI to forge a plan that would best fit the needs of LA County TFC and adhere to the County and State contractual requirements. Los Angeles County has contracted with the 12 TFC Foster Family Agencies in their efforts to recruit and oversee Treatment Foster Care homes. Using the expertise of external consultants, the County hopes to increase the number of TFC homes by expanding the recruitment beyond the confines of the Foster Family Agencies and include State licensed foster parents and relative caretakers with TFC equivalent training and support.

Clearly, the County continues to struggle with expanding TFC. In the previous Panel report, the Panel reported that the County had 92 TFC beds serving 85 children. Fewer children were being served at the end of the previous Fiscal Year and the turnover of foster parents was exceeding the recruitment of new homes. The use of external consultants may be helpful in expanding TFC capacity, but at this stage the County is still working on a plan to address TFC development. Based on experience to date, the Panel has no evidence that further progress is likely.

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

DCFS Training and Coaching

The implementation of DCFS training and coaching tied to the Core Practice Model continued during this reporting period. In addition to ongoing broader training in practice areas of the CPM, DCFS focused on capacity building with DCFS supervisors and workers being trained and coached in Child and Family Team (CFT) practice to facilitate their own CFT meetings with families. In addition to certifying seven coach developers, DCFS re-purposed 42 former TDM facilitators and initiated their training and coaching cycle in CPM, CFT facilitation and coaching. From the overall pool of former TDM facilitators, an additional contingent was re-purposed to oversee case-carrying units due to the influx of new hires being brought in as part of the Department's Caseload Reduction efforts. The County reports that lower caseloads and reasonable spans of control for supervisors continue to be critical areas of focus for the Department in order to create conditions for staff to learn and apply the CPM skills tied to improved outcomes and improved QSR results.

Coach Developers are completing the process of certifying the 42 Coach Facilitators in all offices; utilizing in-office training and direct practice in facilitating CFTs with staff and supervisors as the means by which the teaming practice is learned and applied and CPM skills are reinforced. DCFS has also continued to utilize external technical assistance to assist in this process and to advise leadership on strategies for continued CPM and CFT implementation.

Since the end of the reporting period, DCFS has gone further in its implementation planning related to CFTs, setting achievement targets and clarifying expectations. The Panel will describe these efforts in the next Panel report.

DMH Training

DMH reports the following about its Core Practice Model and CFT training.

> DMH has continued training staff and mental health provider agencies in the Shared Core Practice Model (SCPM). The SCPM trainings are facilitated by the DMH Coaches and are held one time per month. The trainings are experiential and highlight each practice element while weaving in coaching principles and a strength-based approach.
>
> To ensure and maintain consistency with the implementation of the Child and Family Team's (CFT) and meetings, DMH has developed a CFT Overview Training. The training is an in-depth overview of the CFT process developed to familiarize DMH staff with the practice implementation. The CFT Overview Training facilitates strategies on how to apply the SCPM to the CFT Meetings while increasing an understanding of the CFT process and facilitation efforts throughout the county. DMH has trained Children's Systems of Care staff including Quality Service Reviewers, Multidisciplinary Assessment Team administrative staff and Wraparound administrative staff.
>
> DMH coaches and the Intensive Field Capable Clinical Services (IFCCS) program have partnered and developed an introductory training to the Katie A. Class and Subclass, SCPM, CFT, ICC, IHBS to support the efforts of the CFT and Practice Model implementation. The trainings have targeted DMH Co-Located staff, supervisors and managers. The goals of the training are: to review the Katie A. Class and Subclass eligibility, to review the SCPM, to understand the role of Co-Located staff in the CFT meetings and to gain knowledge of ICC and IHBS services.

DMH Coaching

The DMH Coaches have continued to work with the DCFS external consultants in implementing the training and testing phase of the Child and Family Team (CFT) model. This training process includes the observation and application of the CFT model which consists of a four step process:

(1) Coach & Case Review;
(2) Child & Family Team Engagement (Preparation);
(3) Child & Family Team Meeting; and
(4) Debrief

CFT coaching has specifically targeted group home staff, in addition to other elements of the DMH service delivery system. The Los Angeles Training Consortium is also assisting with training and coaching.

Expansion of Wraparound

In fiscal year 2012-2013 a combined total of 2,814 children were enrolled in Tier I and Tier II Wraparound. In fiscal year 2013-2014 the number of new enrollments in Tier I and Tier II Wraparound totaled 2,812 children. According to the County, new enrollments for the past two

years have been the highest since the inception of Wraparound. The County provided the following update on next steps in the Wraparound Re-design implementation.

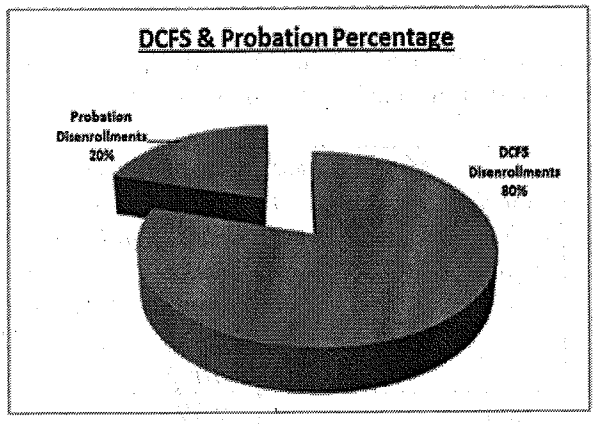
> The County continues to focus on ways to increase the number of children served by the Wraparound Program. Strategies to support these efforts include the following:
>
> - Reinstating a Management Appraisal and Performance Plan (MAPP) goal for DCFS Regional Administrators and Program Administration that includes a 25% increase in new enrollments to the Wraparound Program
> - Implementation of an automated Wraparound Referral System that allows social workers a more user friendly and time efficient method to refer children
> - Expedited Wraparound consent process has expanded countywide, whereby Wraparound providers obtain written consents from families upon referral from the social worker.

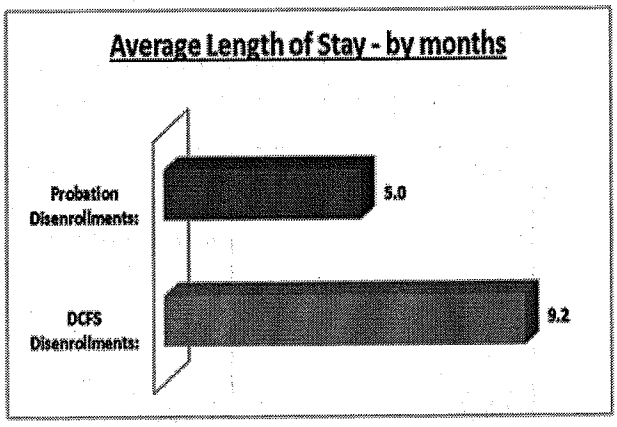
The County provided the following status report for Wraparound.

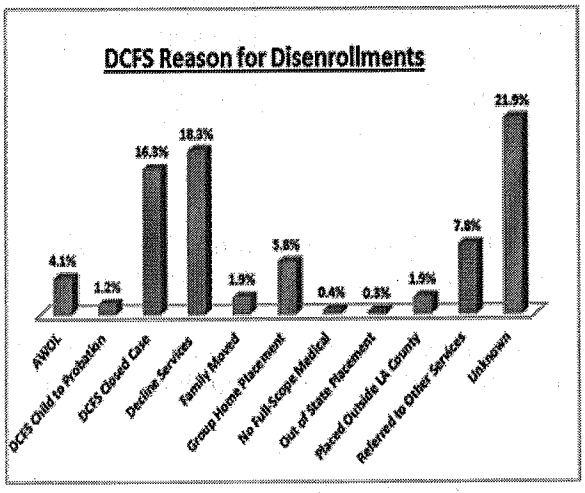
> There were forty-nine agencies that submitted proposals for the upcoming contract. These proposals are currently being evaluated and scored. In the coming months, selected agencies will receive notification of a tentative contract offer. It is anticipated that the new contracts will be underway by May 2015. The County is proposing that the first year of the contract include a "Transitional Year" whereby the contractors will receive a higher case rate during this first year with the expectation that they will be prepared to provide a more mental health focused approach to services and maximize their EPST funding allotment beginning in the second year of the contract. Recent analysis has shown that Wraparound Agencies, as a group, are claiming approximately 50% of their costs to EPSDT and 50% to case rate. However, there are some Wraparound Agencies that are outliers in this regard, claiming a larger proportion of their costs to their case rate dollars. Over the course of the next several months, DMH and DCFS will work together to improve the claiming practices of these agencies to bring them into line with the 50/50 ratio that is envisioned in the new Wraparound contracts.
>
> Up until now, children in emergency shelter care group homes are referred for Wraparound upon transition to a community based placement (i.e. foster care, relative care). DCFS and DMH are currently working with several of the Wraparound providers in developing the protocols and structure to support initiating Wraparound services for children while in emergency shelter. It is expected that this referral process will be implemented in November.
>
> From the time period of March 2014 to August 2014, Wraparound services terminated for a total of 1270 children. Forty-six percent (46%) of these children graduated while fifty-four percent (54%) were disenrolled from the Wraparound Program. The charts below provide comparison information on graduations and disenrollments.

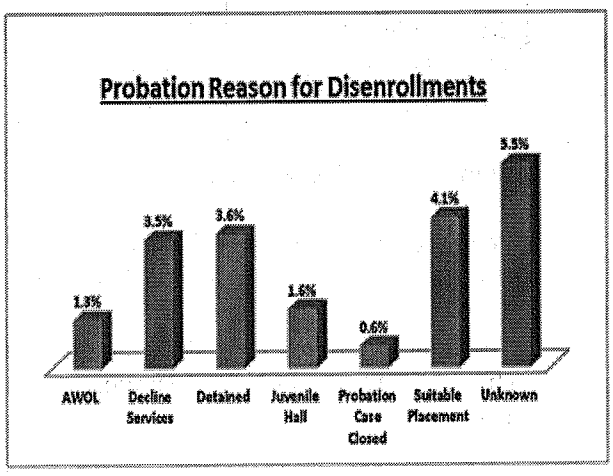
Wraparound Disenrollments

Mar. to Aug., 2014









Wraparound also has a high percentage of youth who do not graduate, meaning they do not complete the full Wraparound intervention. The disenrollment rate was 55.27% as compared to the graduation rate of 44.73%. The County is currently compiling the data for the past 6 months; however it is likely that the percentage will be generally consistent with what was found in the reported period above.

While Wraparound has become a sizable program, it faces a number of challenges in responding to the needs of the Katie A. class. There are approximately 400 vacancies in the program, which appears to be a relatively constant number. These slots could serve substantially more children and families if they could be filled quickly. Feedback from line DCFS staff and the results of a Qualitative Service Review of Wraparound cases indicated that the program is often lacking clinical focus, which impairs its ability to address the large number of children with trauma

histories. As the County mentioned in its update, Wraparound has a high number of children that do not graduate, reflecting lost opportunities to meet the needs of class members. Further evaluation is needed by the County to determine the reasons for disenrollments and improve graduation rates.

Caseload/Workload Reduction

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	*Emergency Response (Abuse and neglect investigations)*	*Family Maintenance (Service to children living in their own homes)*	*Out-of-Home (Children placed in foster family, kinship, group home, adoption, guardian home and other settings)*
2003	*13,348*	*9,341*	*29,595*
2008	*13,246*	*10,766*	*22,278*
2013 (July)	*13,129*	*13,847*	*20,036*
2013 (December)	*12,143*	*13,817*	*20,629*
2014 (June)	*13,449*	*13,539*	*20,682*

Summary of Caseload Data:

For Emergency Response: the average caseload per ER CSW decreased from 19.70 to 17.27 (from FY 09-10 to FY 12-13); then increased from 17.27 to 17.82 (from FY 12-13 to FY 13-14).

For Continuing Services: the average caseload per Generic CSW increased from 23.37 to 29.06 (from FY 09-10 to FY 12-13); then increased again from 29.06 to 30.64 (from FY 12-13 to FY 13-14).

DCFS reported the following efforts to reduce caseload and workload.

> The safe management and decrease of caseload and workload continue as a key Departmental challenge and priority. Near term actions taken and planned to address caseload and workload reduction in support of practice improvement include but are not limited to:
>
> - Hiring and training up to 470 new CSWs in addition to ongoing hiring to address attrition and assigning staff to the communities in greatest need.
>
> - Implemented a Caseload Equity Analysis that has been incorporated into staffing allocation methodologies in order to support offices with higher and more complex caseload related needs and allocate new and existing staff accordingly.

- Reducing the number of staff on "return to work" or "partial caseload" status, providing additional staff capacity in the offices and in other critical programs.

- Re-allocating and re-deploying vacant position from support programs to more critical line functions in the offices including the re-allocation of needed supervisor (SCSW) items and individuals to unit based responsibilities.

- Continued to explore the means to streamline front-line operations workload to free additional time for critical casework tasks in engaging families.

- Fully implemented a new policy system that replaced 6,000 pages of policy with a revised, web-based, user friendly policy manual; reducing the time it takes for staff to access procedural information and increasing the available time they have with children and families.

- Implemented a joint labor-management Caseload Accountability Workgroup to develop, vet and implement strategies to safely reduce caseloads and referral loads across time, allowing more time for front line staff to learn and practice new skills consistent with the Department's Core Practice Model.

Placement of Children and Youth in Group Homes and Residential Facilities

Placement of Young Children in Group Homes

DCFS notified the Panel that it has been including some children who receive short-term emergency shelter (ESC) in group care facilities in its reporting of children 0-12 placed in group homes and residential facilities. DCFS discovered this in discussions with the Panel about trends related to overstays in the Welcome Centers. As a result, DCFS reports that it has fewer younger children in group settings for therapeutic reasons than previously reported. After reviewing each child in this data set, DCFS states that it is able to accurately report on the population of children in group homes. DCFS clarifies the group home census as follows.

> Information on all children in GH placement is represented in the data below. It reflects the total number of children under DCFS supervision who were in placement at the end of the month, for January through June 2014. Of the Total number of children in GH placement (1078) in January, thirty-three (33) children were receiving Medical Case Management services and One Hundred and Fifty-Three (153) were in Emergency Shelter Care placements. This yields a total of Nine Hundred and Twenty-Five (925) children placed in Group Home care. Of the 925 children in GH placements, Sixty-Eight (68) were ages 0-12. In comparison, the data reflects that the efforts that DCFS is making to reduce the use of congregate care are having an impact, in that there was a decrease in the number of children in GH placements from Jan to Jun 2014 by 8%, from Nine Hundred Twenty-Five (925) to Eight Hundred Fifty-Six (856) for all non-ESC GH and a decrease for the youngest population of Ages 0-12 from 68 to 65. There was, however, an increase in the use of GH Emergency Shelter Care, from One Hundred Fifty-Three (153) to Two Hundred Fifty-Five (255) during the same period. Increasing the

overall GH placement use from One Thousand Seventy-Eight (1078) in January to One Thousand One Hundred and Eleven (1111) in June 2014. The use of ESC care represents DCFS efforts to place children in temporary shelter until the more suitable placement home can be found to meet their needs.

County of Los Angeles
Department of Children and Family Services
End-Month Group Home Placements for
Medically Fragile Children and all other Group Home Placed Children
Emergency Shelter Care vs. Non-Emergency Shelter Care
January 2014 to June 2014

Facility Type	Office	Age Group	1/31/2014 ESC Yes	1/31/2014 ESC No	1/31/2014 Total	2/28/2014 ESC Yes	2/28/2014 ESC No	2/28/2014 Total	3/31/2014 ESC Yes	3/31/2014 ESC No	3/31/2014 Total	4/30/2014 ESC Yes	4/30/2014 ESC No	4/30/2014 Total	5/31/2014 ESC Yes	5/31/2014 ESC No	5/31/2014 Total	6/30/2014 ESC Yes	6/30/2014 ESC No	6/30/2014 Total
Group Home	MCMS	0-12	1	3	4	1	4	5	1	4	5	1	4	5	1	5	6	1	8	9
		13-17	3	23	26	3	25	28	2	24	26	2	26	28	2	26	28	3	25	28
		18 Plus	0	7	7	0	6	6	0	7	7	0	5	5	0	7	7	0	6	6
	MCMS Total		*4*	*33*	*37*	*4*	*35*	*39*	*3*	*35*	*38*	*3*	*35*	*38*	*3*	*38*	*41*	*4*	*39*	*43*
	Other	0-12	10	68	78	19	65	84	25	69	94	26	64	90	25	61	86	27	65	92
		13-17	129	711	840	143	692	835	164	664	828	165	668	833	178	662	840	211	635	846
		18 Plus	10	113	123	10	112	122	12	116	128	12	120	132	13	120	133	13	117	130
	Other Total		*149*	*892*	*1,041*	*172*	*869*	*1,041*	*201*	*849*	*1,050*	*203*	*852*	*1,055*	*216*	*843*	*1,059*	*251*	*817*	*1,068*
Group Home Total			153	925	1,078	176	904	1,080	204	884	1,088	206	887	1,093	219	881	1,100	255	856	1,111

Source: CWS/CMS History Database

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

ESC: Emergency Shelter Care: Children who are placed in congregate care on an emergency basi, until palcements that meet their needs are located.

After frequent discussions with the County about the composition of group homes, County data appear to have clarified the reasons children are placed there – therapeutic purposes vs. short-term shelter care. However, several significant issues remain. First, the confusion about the group home census is one of several examples of County difficulties with data. Another important data trend the Panel has been seeking is the ratio of admissions to out-of-home case vs. exits from out-of-home care. This basic measure of foster care trends is necessary to assess the demand for placement resources and effectiveness of permanency efforts, however the County is not currently able to report this information at this time.

Also, group homes are not an appropriate setting for children entering out-of-home care. Group homes are not family-based settings, have transient populations and often have staff on shifts, reflecting an unstable environment for children already traumatized by removal from their families. Not only is the setting undesirable, but the number of children exposed to it for purposes of emergency shelter grew by 100 to 255 in the current reporting period. This trend clearly reflects the lack of placement and family stabilizing capacity by the County.

Qualitative Service Review (QSR)

The County committed to implementing a process to measure the quality of its casework practice performance using the Qualitative Service Review (QSR) process. The Qualitative Service Review is an interview-based quality assurance method that 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 early 2013. The second QSR Review cycle began the first week of December 2012, with the DCFS Belvedere office followed by the Santa Fe Springs, Compton, Vermont Corridor, Wateridge, Pomona, Glendora, El Monte, San Fernando Valley, Lancaster, Metro North, Pasadena, Santa Clarita, Torrance, West Los Angeles, South County and West Los Angeles offices.

The QSR provides a basis for measuring, promoting, and strengthening the Shared Core Practice Model and the protocol includes two domains. These are child and family status indicators which measure how the focus child and the child's parents/caregivers are doing within the last 30 days and practice indicators which measure the core practice functions being provided with and for the focus child and the child's parents/caregivers for the most recent 90-day period. The team consists of trained DCFS and DMH reviewers who conduct a case review, and conduct interviews within a two-day period with key players in the life of the child and family's case.

The team assesses status and performance indicators to be able to determine facts such as:

Child and Family Status
Is the child safe?
Is the child stable?
Is the child making progress toward permanency?
Is the child making progress emotionally and behaviorally?
Is the child succeeding in school?
Is the child healthy?
Are the child's parents making progress toward acquiring necessary parenting skills and capacity?

Practice Performance
Are the child and family meaningfully engaged and involved in case decision making (called Voice and Choice)?
Is there a functional team made up of appropriate participants?
Does the team understand the child and family's strengths and 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?

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 CSW 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 story 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:

Description:
Each Service Planning Area will 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.

Overall Score: Passing Score (Status): 85% Passing Score (Practice): 85%
The following tables reflect the performance for Belvedere, Santa Fe Springs, Compton, Vermont Corridor, Wateridge, Pomona, Glendora, El Monte and San Fernando Valley offices during the second cycle as compared to their QSR Baseline results. Immediately below each section are the corresponding baseline results for comparison purposes. The Wateridge, El Monte, Glendora and Pomona offices were reviewed during the July-December 2013 monitoring period.

QSR Scores for the past 12 months are identified in the following period.

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%**
Overall	**93%**	**79%**	**70%**	**96%**	**95%**	**79%**	**73%**	**56%**	**97%**	**70%**	**87%**

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

	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%
Overall	**78%**	**67%**	**26%**	**49%**	**56%**	**51%**	**63%**	**54%**	**47%**	**54%**

QSR 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 QSR scores for the past year, the following indicators need significant improvement. Data represent 9 office reviews.

Indicator	Voice & Choice	Teamwork	Assessment	Long-term View	Planning	Supports and Services	Tracking & Adjustment
Percent of Scores in Acceptable range	65%	29%	53%	58%	53%	64%	51%

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

The County committed in its strategic plan to provide mental health screening to all newly detained children in DCFS. The County submitted the following information about its initiative 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 upon the acuity of a child's need for mental health services. Additionally, the CSAT process provides for the annual screening of children in existing cases with previous negative screens. Four tracks establish the process by which all DCFS children in new and currently open cases are screened and referred for mental health services. The process of screening is described in the table below.

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 implementations 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 County reports the following performance about screening and follow up.

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

The RTS Summary Data Report as of August 8, 2014 provides the progress of all SPAs for the FY 2013–2014, from July 1, 2013 through June 30, 2014. This report reflects CSAT performance completed through August 8, 2014 and is a snapshot of work in progress. The

following two charts depict the results to date for all three tracks associated with the screening and referral process activity from July 1, 2013 through June 30, 2014.

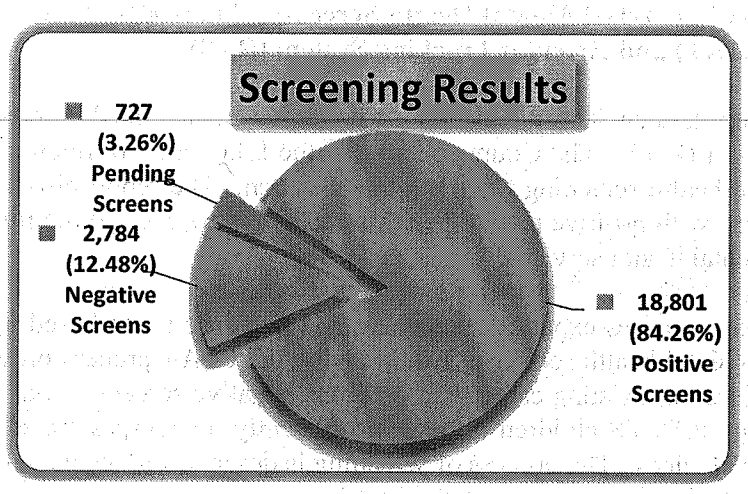
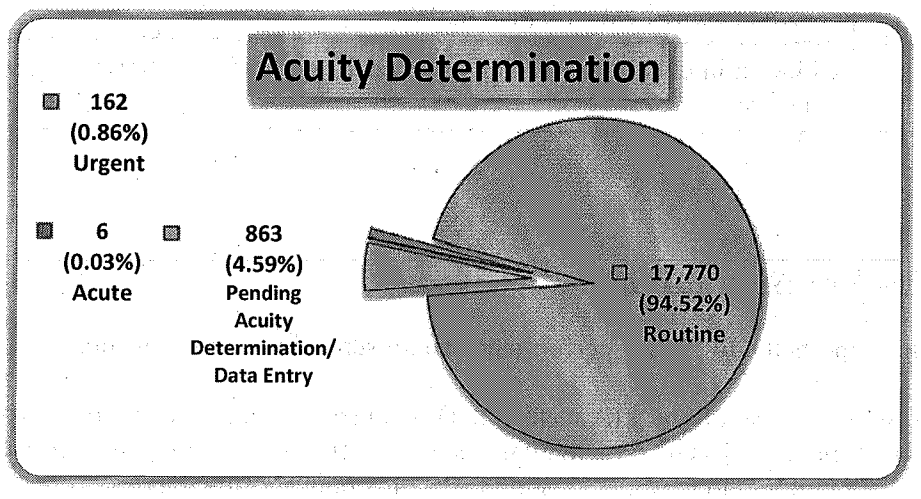


Chart I shows that of 22,844 children, 22,312 children required screens. **(22,844 minus those currently receiving mental health services [36[1]], in closed cases [439], who ran away or were abducted [57]):**

Of the 22,312 children who required screens:

- 18,801 (84.26%) children screened positive of all children requiring screens (22,312);
- 2,784 (12.48%) children screened negative of all children requiring screens (22,312);
- 727 (3.26%) children have screens pending of all children requiring screens (22,312).



[1] The total number of children in all tracks currently receiving mental health services is 312. However, only children in existing cases (track 3 [36]) are subtracted from the total number of children requiring screens because all children in new cases (track 1 [40] and track 2 [236]) must be screened whether or not they are already receiving mental health services.

Chart II shows that of the 18,801 children who screened positive:

- 6 (0.03%) children were determined to have acute needs;
- 162 (0.86%) children were determined to have urgent needs;
- 17,770 (94.52%) children were determined to have routine needs;
- 863 (4.59%) 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 FY 2013-2014 as of August 8, 2014:

- Children with acute needs were referred to DMH on same day on average.
- Children with urgent needs were referred to DMH in 1 day on average.
- Children with routine needs were referred to DMH in 5 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.
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 in FY 2013-2014 as of August 8, 2014:

- Children with acute needs received a mental health service activity within the same day of the referral, on average;
- Children with urgent needs received a mental health service activity within 1 day of the referral, on average and
- children with routine needs received a mental health service activity within 2 days of the referral, on average.

The rate of children that received a mental health activity with required timeframes according to acuity FY 2013-2014 as of August 8, 2014:

- 100 percent of children with acute needs received DMH services on the same day as the referral;
- 96.30 percent of children with urgent needs received DMH services within 3 days of the referral; and
- 96.93 percent of children with routine needs received DMH services within 30 days of the referral.

CSAT MH Screening Achievements

As of August 8, 2014 for children served in the FY 2013-2014, the average timeline from case opening/case plan update to the start of mental health service activities is 14 days.

- **DCFS and DMH continue to collaborate in order to sustain improvements made in mental health screening, assessment and service delivery:**
  - 96.74 percent of children who were eligible for screening were screened for mental health needs;
  - 95.91 percent of children who screened positive were referred to mental health services; and
  - 96.32 percent of children referred for services received mental health service activities within the required timelines.

- During this review period MAT Assessors in 6 of 8 SPAs have received Strengths and Needs trainings in order to improve the development of a common language around the underlying needs and strengths of children and families that are served by our community providers. The two remaining SPAs will be trained by October 2014.

The following chart provides a breakdown of timeliness from screening to referral for FY 2013-2014 as of August 20, 2014.

FY2013 - 2014

Days of number of children from screening to referral for mental health services.

Acuity	0 - 3 days	%	4 - 7 days	%	8 - 13 days	%	14 - 20 days	%	20 - 30 days	%	31 days or over	%	Total
Acute	6	100.00											6
Urgent	126	77.30	20	12.27	11	6.75	3	1.84			3	1.84	163
Routine	10,375	59.36	2,748	15.72	1,821	10.42	1,120	6.41	740	4.23	675	3.86	17,479
Total	10,507	59.54	2,768	15.68	1,832	10.38	1,123	6.36	740	4.19	678	3.84	17,648

Days of number of children from screening to receipt of a mental health activity.

Acuity	0 - 3 days	%	4 - 7 days	%	8 - 13 days	%	14 - 20 days	%	20 - 30 days	%	31 days or over	%	Total
Acute	6	100.00											6
Urgent	161	98.77	2	1.23									163
Routine	14,112	81.43	902	5.20	957	5.52	668	3.85	420	2.42	271	1.56	17,330
Total	14,279	81.60	904	5.17	957	5.47	668	3.82	420	2.40	271	1.55	17,499

Note: Data as of August 20, 2014

The County reports that it has completed its work with the University of Southern California to have the MHST evaluated in terms of reliability and validity. The County believes that the preliminary results are very positive, and show that the MHST is in fact an effective mental health screening tool. Additional mental health resources are now coming on-line for young children (ages 2-5). DCFS, First 5 LA and DMH have recently collaborated to begin a twenty-two (22) million dollar County-wide expansion of Parent Child Interaction Therapy (PCIT).

Important factors in the delivery of client-focused mental health services are three-fold: identifying the specific type of service provided to meet the unique needs of the client, service intensity and the setting in which the service was delivered (home, school, office, congregate setting). The IS/IBHIS reporting system cannot yet generate reports reflecting these data. This prevents more precise reporting on the growth of intensive mental health services. However, the County has demonstrated significant progress in the provision of mental health screening and initial follow-up.

Development of Multidisciplinary Assessment Teams (MAT)

The County committed to implement Multidisciplinary Assessment Teams that would assess the needs of all newly detained children. The County provided the following report on implementation of the Multidisciplinary Assessment Team (MAT) process, which establishes a commitment to provide a multidisciplinary assessment of all newly detained children within 45 days of entry.

County MAT Update

At the time of the completion of the prior Panel Report, 98.5 percent of newly detained children were referred for a MAT Assessment. During this reporting period, 100 percent of newly detained children were referred to the various 51 MAT assessment agencies throughout Los

Angeles County. From November 2013 through June 2014, there were 3768 MAT referrals and 3195 MAT assessments completed. Of those referred, approximately 15 percent were not completed, compared to 23 percent reported not completed in the prior monitoring report. MAT referrals by SPA are listed below.

Table 1: MAT Compliance June 2014	MAT Eligible	MAT Referred	Percent
SPA 1	38	38	100
SPA 2	69	69	100
SPA 3	84	84	100
SPA 4	27	27	100
SPA 5	6	6	100
SPA 6	93	93	100
SPA 7	95	95	100
SPA 8	73	73	100
Total number of DCFS MAT referrals:	**485**	**485**	**100**

From November 2013 through June 2014, the average timeline from MAT referral acceptance to completion of the final Summary of Findings (SOF) report was 51 days, a few days more than reported in the prior panel report. This was due to this report reflecting the end of the fiscal year where there is less provider capacity and it takes longer to refer children. Approximately 37 percent were completed in 45 days or less, 60 percent were completed by the 50th day and 83 percent were completed by the 60th day.

As indicated above, approximately 15 percent of children referred to MAT did not have completed assessments as of the end of June 2014. Of this 15 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 5 percent were initially referred to MAT, but did not have completed assessments due to the following "MAT Cancellation Reasons:"

- Children are returned home soon after the MAT referral and are no longer MAT eligible.
- Children are referred to MAT but they have private insurance and are therefore no longer MAT eligible.
- Children who run away are not available to complete the assessment. These children are referred for mental health services when they return from AWOL but many of them do not receive the MAT assessment.
- Children who are in psychiatric hospitals or juvenile detention have billing and access issues that prevent the completion of the MAT process.
- Children move out of county or state.
- Children lose Medi-Cal eligibility after referral.

Psychiatric Hospitals and Juvenile Halls have their own mental health staff to conduct internal assessments and linkage to mental health services. In lieu of the MAT assessment, children in these institutions are referred to Co-located Mental Health staff to help ensure that they are receiving mental health treatment in their current locations.

DCFS provides interim Medi-Cal eligibility to all detained children for the first 30 days until DCFS determines the services for which the child actually qualifies for. At the end of the initial 30 days it is possible that some children lose their initial eligibility due to a number of reasons, including but not limited to having private insurance or being found ineligible for Full-Scope Medi-Cal due to Federal eligibility requirements. Children and their caregivers who are found to be Federally ineligible, are referred to DPSS for Non-Needy Dependent Care AFDC.

The Panel is currently conducting a review of a sample of MAT cases to assess the degree to which child and family strengths and underlying needs are identified and plan recommendations are individualized and appropriately matched to needs.

Expansion of Staff Resources for Multidisciplinary Medical Hubs

As previously reported, in its Strategic Plan the County committed to providing a comprehensive medical examination for all newly detained children. These assessments are delivered by a series of Medical Hubs, located in hospital settings. As of the prior monitoring report, the County was referring 85.5 percent of newly detained children to a Medical Hub. In the current reporting period, the County is referring 88 percent of newly detained children to a Hub, which is continuing commendable progress.

HUB Referrals Timeliness for Newly Detained Children FFA Placements

Age of Child	0-3 years old or High Risk Child	4-18 years old
Referral Submission Timeline Standards	**3 Calendar Days**	**5 Business Days**
Jan / Feb 2014 N= 336	135 (40%)	201(60%)
CSW Referral Submission timeliness	9.3 Calendar Days	9.4 Business Days

The above data is focused only on children whose placement was in certified FFA homes during January and February 2014, DCFS is working to expand this analysis to include all children in all Out-of-Home Care placement types. During this period, of the 336 newly detained children placed in Foster Family Agency (FFA) certified homes, 135 were between the ages of 0-3 years old. The remaining 201 children were between the ages of 4 to 18 years old. The available data reveals that the average length of time for submission of the Medical Hub Referral for children ages 0 to 3 was 9.3 calendar days from the date of the initial placement. The average length of referral time for children between 4-18 years of age was 9.4 business days after their initial placement.

DMH Staffing

The County's plan includes the co-location of mental health staff in DCFS offices. The County has maintained the level of DMH staffing in support of Katie A. Implementation at the same overall levels reflected in the last Panel report. Current staffing levels are shown below.

LOCATION	MENTAL HEALTH POSITIONS
Child Welfare Division	51
D-Rate	12
Service Area 1	29
Service Area 2	24
Service Area 3	33
Service Area 4	17
Service Area 5	4
Service Area 6	84
Service Area 7	39
Service Area 8	23
MHSA	3
TOTAL	319

The total staffing level is unchanged from the last Panel report.

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

There is agreement between the parties about the outcome indicators to be tracked and reported to the parties and the court. Outcome tracking and reporting occurs routinely and is reported annually by the Panel.

IMPLEMENTATION OF BEHAVIORAL HEALTH INFORMATION SYSTEM (IBHIS)

The County committed to implementing a new DMH Behavioral Health Information System early in the Katie A. planning process, assuming that the State DMH development of a statewide Behavioral Health Information System would support County Katie A. needs. This system is intended to enhance tracking and reporting on the status of children served, the services they receive, and various other elements of the provision of mental health care. Frequent delays at the State level have significantly delayed the original completion date. Regarding this Panel Report, DMH reports that it has implemented an aggressive planning and testing process to design and bring up an information system that will integrate clinical, administrative and fiscal data. DMH has adjusted the target production date to October 2015.

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

Consistent with its strategic plan, the County continues to conduct Qualitative Service Reviews (QSR), an interview-based evaluation of the quality of frontline practice involving a sample of

cases in each office. Additional detail on current QSR review findings are provided in a subsequent section of the Panel's report.

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

In its initial strategic plan the County committed to employing Team Decision Making meetings, involving the family, as a setting for case decision-making. These meetings are designed to be led (facilitated) by a trained, full-time facilitator. The County's implementation of TDMs targeted the TDM process at key decision points (initial removal, re-placement and re-unification) and also to address the needs of special populations and or children/youth with specialized need. However, the County never had enough facilitators to provide TDM meetings consistently beyond initial removal. The number of TDM facilitators has been downsized in part due to the need for supervisory coverage of line units.

The County has worked with the Panel to deepen teaming practice through the implementation of Child and Family Teams (CFT) as a means of engaging and supporting families and to support Practice Model implementation. The CFT meeting is designed to be led by trained CSWs and supervisors and serve as the locus of family engagement, assessment, planning, coordination and tracking. As a result, these family meetings will be held continually as circumstances demand, rather than only at a few key decision points. The transition plan to move from the TDM model to the development of CFTs for children and families is underway. Elements of this plan and actions taken include:

- Providing training to staff in the CFT process
- Re-purposing 42 of the TDM Supervisory positions (SCSW) to convert these facilitators to coaches, who will develop County staff to facilitate team meetings

Currently, the County reports the following TDM performance:

- Calendar Year 2012: 1st Quarter - 3,975 TDM meetings completed and 2nd Quarter – 1,664 TDM meetings completed, for a total 5,639 TDM meetings completed through May 9, 2013.
- Calendar Year 2013 July 1, 2013 to Dec 31, 2013 - 7088 TDMs completed (Note, this does not incorporate CFT meetings that have occurred in the previously identified pilot offices for CPM implementation).
- July 2013-May 2014 9,384 Team Meetings including TDMs (or TDMs in related formats) were completed.

Outcome Data Performance

The parties identified a series of child outcomes in the areas of safety and permanency that would be tracked to reflect progress over time. 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 exit

targets that are a condition of 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. Minimum Performance Levels were set only after these data became available and essentially assured that current performance at that time would be a baseline that the County does not fall below.

Overview of the System Population

The table below provides data representation for all newly opened cases sorted by fiscal year. The table presents the DCFS initial case plans of either Family Maintenance (Remained in Home) or Family Reunification (Detained); Each of which is further sorted by with and without DMH Services. This table reflects that the number of open cases has dropped from 23,189 (2010-2011 FY) to 21, 485 (2011-2012 FY), however has increased in FY 2012-2013 to 23,315 cases. The number of cases that were provided Family Maintenance Services as the initial case plan increased in the same period of time, suggesting that DCFS is increasing efforts to work with the families and the children in their home setting with resources in place. 2013-2014 Fiscal Year is on target for similar results.

Population of FY 2002-2003 to FY 2012-2013

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	55.98%	7,627	44.02%	17,326	1,624	45.54%	1,942	54.46%	3,566	8,075	58.68%	5,685	41.32%	13,760
2003-2004	10,381	58.66%	7,316	41.34%	17,697	1,830	46.68%	2,090	53.32%	3,920	8,551	62.07%	5,226	37.93%	13,777
2004-2005	11,939	59.53%	8,116	40.47%	20,055	2,364	48.93%	2,467	51.07%	4,831	9,575	62.89%	5,649	37.11%	15,224
2005-2006	11,632	58.62%	8,212	41.38%	19,844	2,421	46.64%	2,770	53.36%	5,191	9,211	62.86%	5,442	37.14%	14,653
2006-2007	11,224	55.32%	9,064	44.68%	20,288	2,486	40.79%	3,609	59.21%	6,095	8,738	61.57%	5,455	38.43%	14,193
2007-2008	10,923	56.37%	8,456	43.63%	19,379	2,845	42.46%	3,856	57.54%	6,701	8,078	63.72%	4,600	36.28%	12,678
2008-2009	10,370	56.23%	8,071	43.77%	18,441	3,060	40.84%	4,433	59.16%	7,493	7,310	66.77%	3,638	33.23%	10,948
2009-2010	13,393	60.06%	8,906	39.94%	22,299	4,521	42.44%	6,131	57.56%	10,652	8,872	76.17%	2,775	23.83%	11,647
2010-2011	15,007	64.72%	8,182	35.28%	23,189	5,849	49.23%	6,031	50.77%	11,880	9,158	80.98%	2,151	19.02%	11,309
2011-2012	14,359	66.83%	7,126	33.17%	21,485	6,390	52.84%	5,703	47.16%	12,093	7,969	84.85%	1,423	15.15%	9,392
2012-2013	15,076	64.66%	8,240	35.34%	23,316	7,085	51.11%	6,778	48.89%	13,863	7,991	84.53%	1,462	15.47%	9,453

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 7/25/2014.

Safety Indicator 1.
Repeated Reports of Abuse and Neglect

This indicator tracks the degree to which children that are the subject of a substantiated abuse or neglect report (referrals) but are not removed from home, do not experience another substantiated report during the case open period up to 12 months. The goal would be to assess risk and provide supportive services effectively enough that maltreatment would 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 2002-2003 to 88.1% of class members having no subsequent referrals within 12 months in 2012-2013.

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

Minimum Performance Level 82.8%

Aspire to 83.3%

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 to12 months.
2. The table above excludes evaluated-out referrals.
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 7/25/2014.

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% range, meaning that over 99% of class members in foster home settings experienced no substantiated foster parent maltreatment. FY 2012-2013, 98.9% of all children and 98.7% of class members experienced no substantiated foster parent maltreatment. While originally, the County and State reporting system for this did not accurately capture the experience of class members in group home and residential settings due to a feature in the design of automated reporting that, reporting mechanism has now been updated to capture such data. Given recent implementation in this reporting and tracking methodology, the data below should not be viewed as yet as fully reflecting all reports of incidence of maltreatment in out of home care.

The parties agreed to a Minimum Performance Level of 98.4% and the County aspires a goal of 98.6% for this indicator. The County currently 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?
(Federal CFSR Measure: Methodology specific to Katie A)

Fiscal Year	All Children			With DMH Services			Without DMH Services		
	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%

Minimum Performance Level 98.4%

Aspire to 98.6%

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 7/25/2014.

Safety Indicator 3.
Recurrence of Maltreatment Within 6 Months

This indicator measures the percentage of all children that came into contact with DCFS and were victims of a substantiated abuse and neglect referral without being 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 show improvement in reducing subsequent substantiated referrals between 2002-2003, when 89.5% of children did not have subsequent referrals within six months, and 2012-2013 when 92.96% of children did not have a subsequent referral.

The parties agreed to a Minimum Performance Level of 92.3% and the County aspires a goal of 92.8% for this indicator. The County 2012-2013 FY performance exceeds the Minimum Performance Level goal and the aspirational goal.

Safety Indicator 3. No recurrence of maltreatment within 6 months (Federal CFSR Measure)

Fiscal Year	Time Period	No Maltreatment	Total	Percent
2002-2003	Jul 2002 - Dec 2002	11,649	12,950	89.95%
	Jan 2003 - Jun 2003	11,179	12,328	90.68%
2003-2004	Jul 2003 - Dec 2003	10,118	11,062	91.47%
	Jan 2004 - Jun 2004	11,013	12,025	91.58%
2004-2005	Jul 2004 - Dec 2004	10,174	11,111	91.57%
	Jan 2005 - Jun 2005	10,715	11,664	91.86%
2005-2006	Jul 2005 - Dec 2005	9,337	10,145	92.04%
	Jan 2006 - Jun 2006	9,767	10,530	92.75%
2006-2007	Jul 2006 - Dec 2006	8,848	9,558	92.57%
	Jan 2007 - Jun 2007	9,314	9,983	93.30%
2007-2008	Jul 2007 - Dec 2007	8,734	9,394	92.97%
	Jan 2008 - Jun 2008	9,732	10,534	92.39%
2008-2009	Jul 2008 - Dec 2008	9,743	10,485	92.92%
	Jan 2009 - Jun 2009	9,461	10,199	92.76%
2009-2010	Jul 2009 - Dec 2009	11,795	12,762	92.42%
	Jan 2010 - Jun 2010	12,326	13,527	91.12%
2010-2011	Jul 2010 - Dec 2010	12,845	13,878	92.56%
	Jan 2011 - Jun 2011	13,700	14,702	93.18%
2011-2012	Jul 2011 - Dec 2011	12,371	13,259	93.30%
	Jan 2012 - Jun 2012	12,995	13,934	93.26%
2012-2013	Jul 2012 - Dec 2012	12,279	13,194	93.07%
	Jan 2013 - Jun 2013	12,786	13,755	92.96%

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 7/25/2014.*

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

This indicator measures the median number of days 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 2002-2003 to 304 in 2012-2013.

The parties agreed to a Minimum Performance Level of 409 days and the County aspires a goal of 383 for this indicator. The decline over time reflects a maintained 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		
	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
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

Minimum Performance Level 409 days

Aspire to 383 days

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. The table used 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.

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 7/25/2014.

Permanency Indicator 2.
Reunification Within 12 Months

This indicator reflects the County's success in returning children to their parents quickly. The County continues to have its challenges with its reunification achievement which dropped from 36.8% of all children being returned within 12 months in FY 2010-2011 to 31.7% in FY 2012-2013. This drop in performance level continues to be impacted by several other measures not derived from this data set, suggesting other systemic issues influencing the outcomes.

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

Permanency Indicator 2.
Reunification within 12 months (Federal CFSR Measure: Methodology specific to Katie A)

Fiscal Year	All Children			With DMH Services			Without DMH Services		
	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%
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%

Minimum Performance Level 36.4%

Aspire to 45.6%

Note:

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 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 7/25/2014.

Permanency Indicator 3
Adoption Within 24 Months

This indicator reflects the County's success in quickly moving children under its supervision that cannot return home to adoption quickly. Data reveal improvement, showing that the percent of children adopted within 24 months rose from 0.6% in 2002-2003 to 3.1% in 2010-2011FY and 3.7% for 2011-2012.

The parties agreed to a Minimum Performance Level of 2.0% and the County aspires a goal of 2.9% for this indicator. The County currently exceeds the Minimum Performance Level and the Aspirational performance goal.

NOTE Data is 11/12 FY

Permanency Indicator 3.
Adoption within 24 months (Federal CFSR Measure: Methodology specific to Katie A)

Fiscal Year	All Children			With DMH Services			Without DMH Services		
	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%
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%

Minimum Performance Level 2.0%

Aspire to 2.9%

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 7/25/2014.*

Permanency Indicator 4.
Reentry Into Foster Care

This indicator reflects the County's success in ensuring that children returned to their parents remain with them after reunification. The following table indicates that the County's success rate had an overall decline from 7.7% of class members reentering care in 2002-2003 to 13.0% reentering care in 2012-2013. As seen in the table, the reentry rates fluctuate from year to year, and have hovered between 13 and 15 percent for the last 8 years. 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 much 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 a goal of 12.9% for this indicator. For the FY 2012-2013 the County did meet the Minimum Performance Level, and are nearly at their aspirational goal of 12.9%.

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

Fiscal Year	All Children			With DMH Services			Without DMH Services		
	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%
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%

Minimum Performance Level 13.9%

Aspire to 12.9%

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 according to 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.*
4. *Data source is CWS/CMS Datamart as of 7/25/2014.*

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 has improved again from 74.0% of class members having no more than two placements in their first year of care in 2002-2003 to 87.8% in 2012-2013.

The parties agreed to a Minimum Performance Level of 82.9% and the County aspires a goal of 84.1% for this indicator. The data reflects great improvement as the performance indicators for the FY 2012-2013 far exceeds the minimum and aspirational goals.

Permanency Indicator 5a.
Children in foster care less than 12 months with 2 or less placements (Federal Measure: Methodology specific to Katie A)

Fiscal Year	All Children			With DMH Services			Without DMH Services		
	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%
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%

Minimum Performance Level 82.5%

Aspire to 84.1%

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 7/25/2014.*

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

This indicator measures the experience of class members in foster care for 12 months but less than 24 months without a third or more placements in year two. In 2002-2003, 89.5% of class members did not experience a third or more moves compared to a high of 92.8% not experiencing a third or more moves in 2009-2010. The data reflects that there was another increase in percentage points to 93.6 for the 2012-2013 FY Performance Indicators. The increase in foster home stability exceeds the Minimum Performance Levels and above the Aspirational Performance Levels.

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	%
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%

Minimum Performance Level 89.2%

Aspire to 89.7%

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 7/25/2014.*

The County met all the performance targets but one for this reporting period, reunifications within 12 months.

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. The County performance has improved with this indicator, with 45.2% of class members in care more than 24 months or more experiencing no more than two moves in 2002-2003 compared with 69.9% for FY 2012-2013.

The parties agreed to a Minimum Performance Level of 58.8% and the County aspires a goal of 61.7% for this indicator. The data continues to reflect consistent improvement as the performance indicators for FY 2012-2013 are 69.9% which far exceeds the minimum and Aspirational goals.

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			DMH Services		
	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%
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%

Minimum Performance Level 58.8%

Aspire to 61.7%

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*
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 7/25/2014.*

Exit Criteria

The County Board concurred with the County's proposal for exit conditions and the Court subsequently approved them.

IV. Panel Analysis of Strategic Plan Implementation

Workload

ER and Generic CSW caseloads are somewhat higher than in the previous reporting period. In fact it is not uncommon for caseloads to be considerably higher than the average due to staff vacancies. The use of caseload averages fails to communicate the extent of high caseloads experienced by a significant number of staff. Based on the County's update on workload

reduction, the workload reduction strategies referenced are not materially affecting the impact of the County's high caseloads. The Panel plans to follow up on caseload size to assess actual caseloads at the unit level during future reporting periods.

Treatment Foster Care (TFC)

Efforts to expand the availability of TFC beds beyond the current modest level are not producing increased numbers of children served in this resource. Currently, only 76 children are placed in TFC homes. The County also has a significant TFC caregiver turnover challenge. There have been improvements in reducing the high number of children discharged to higher level settings, but a third of children are still being discharged to more intensive and restrictive placements. This is an indication that either the TFC intervention is not succeeding in appropriately meeting these child's needs or that children are being placed in TFC may not be appropriate for the setting.

Expansion of Home-Based Mental Health Services

There has been a meaningful expansion of home-based mental health services. The County's Wraparound programs serve approximately 2300 children and families at any one time and the IFCCS pilot shows promise of being a successful model of individualized service delivery. The County is working diligently on the implementation of ICC and IHBS. The use of home-based services is growing, but still reaches only a modest portion of the Katie A. class.

Despite the development of home-based mental health services, the County is not yet able to consistently and adequately serve the child population with high mental health needs. There have been problems with procedural rules within Wraparound programs that according to line-staff, impede service to children who are in unstable placements. Since instability is a frequent characteristic of children with high needs, this practice presents a major barrier to helping children in crisis.

In its prior report, the Panel noted that the Wraparound design requires that CSW's obtain family consent for Wraparound participation and due to their high workloads and sometimes strained relationships with families, CSWs were not consistently successful if securing those consents. To its credit, the County addressed this barrier so that now the Wraparound team approaches the family for consent.

Wraparound continues to experience a surprising level of vacancies, meaning that despite the need for supports to children in crisis, Wraparound services go unused. Currently, there are 400 Wraparound vacancies. Also, as mentioned previously, Wraparound experiences a significant number of children and youth that do not complete the Wraparound process.

DCFS and DMH Training and Coaching

DCFS and DMH are providing training and coaching in support of the Core Practice Model, particularly related to the CFT process. The level of training and coaching is modest and has not yet materially affected the practice skills of significant numbers of front-line mental health staff. In DCFS, few if any CSW's are facilitating CFTs and in DMH, CFT training and coaching is

currently directed mostly at a small number of group homes. The County's QSR scores provide a sobering picture of practice performance among key practice indicators, as reflected in the table below.

Indicator	Average Acceptable Score
Teaming	26%
Assessment	49%
Long-Term-View	56%
Planning	51%
Tracking and Adjustment	47%

The QSR Process

The Qualitative Service Reviews are providing useful information about the strengths and challenges of Katie A. Implementation. QSR scores are identifying areas of improving performance, like family engagement and permanency, as well as challenges like those referenced above.

The QSR case narratives (called case stories), prepared for each case reviewed and the QA unit analyses of office performance provide important facts about current outcomes and system challenges. One recent office report, for example, mentioned that the practice of balancing caseloads among staff so that there is relative equity of caseload size was causing children and families to lose contact with caseworkers they had developed a positive relationship with. Such transfers interrupt the continuity of caseworker-family relationships and can affect casework progress. While it is reasonable for the County to seek balance in caseload size among staff, it is possible that the process is having a disruptive effect on child and family progress in some cases. This example illustrates the value of the QSR in identifying system barriers as well as practice development needs. The QSR process is a valuable tool for the County and results should receive consistent attention from managers and decision-makers to be able to identify barriers such as this.

Use of Short-Term Shelter Placements and Foster Family Recruitment

The Panel will not be able to fully analyze the status of this issue until further data is received (see recommendations).

V. Panel Recommendations

The following recommendations are made by the Panel to foster implementation of the strategic plan and achieve the goals of the settlement.

Workload

The Panel noted earlier in this report that high DCFS caseloads are preventing Core Practice Model training and coaching, especially related to the Child and Family Team process, which is far from being fully implemented at the front line. Procedural efficiencies such as those described by DCFS in its workload reduction strategies will not be sufficient to provide the

reduction in workloads needed to provide staff time to implement these new practice approaches. This is evident based on the fact that caseload size is growing in both Emergency Response and Generic caseloads, despite workload reduction efforts and increases in staff allocations. The County needs to significantly increase its work force beyond the 470 additional staff authorized to be able to implement the Strategic Plan successfully and meet the exit criteria of the settlement.

Treatment Foster Care

The County has made continuous efforts to increase the number of TFC beds with little success in the last few years and now faces a significant foster parent recruitment and retention problem. Using the expertise of its external consultants, the County should develop a revised plan to expand the availability of TFC beds by significant numbers each year. The plan should also include strategies to improve the focus and/or intensity of services for children served inTFC to reduce the number discharged to more intensive settings. The Panel would like to schedule a conference call with appropriate County representatives and its consultant advisors to learn more about strategies the County reports it is developing before the next Panel meetings

Expansion of Intensive Home-Based Mental Health Services

The Wraparound policy that requires children to be in a stable placement to be eligible for Wraparound presents a major barrier to serving the plaintiff class, especially those children with high mental health needs. Since instability is often the result of unmet mental health needs, the Wraparound design seems to be preventing services to some of the children it was created to serve. The County should revise its procedures to permit Wraparound to respond quickly to unstable children and in doing so, also join the placement finding process as a team member.

The relatively high number of Wraparound vacancies is a lost resource to members of the plaintiff class. The County should assess the referral and admission process to identify opportunities to shorten the time period needed for admission to Wraparound. It should also assess the reasons children are rejected for service to determine if eligibility standards are an unnecessary barrier to serving children with high mental health needs.

The lack of clinical focus in some Wraparound cases was identified years earlier in a Qualitative Service Review targeting children served by Wraparound. This issue was also recently identified in interviews with CSWs and SSWs (line caseworkers and supervisors). Because of their mental health needs, children served by Wraparound have significant needs for clinical support. To address this need, the County should develop a strategy to increase the clinical focus with children served by Wraparound. The County should also review and interview a sample of the families whose children do not graduate from Wraparound to identify solutions to the pattern of children disenrolling from the program.

Beyond Wraparound, the County should explore the possibility of additional expansion of Intensive Field Capable Clinical Services (IFCCS). This flexible, high service intensity pilot, designed to serve children with high mental health needs, is showing considerable promise in meeting the needs of this population.

DCFS and DMH Training and Coaching

The County should develop a training and coaching plan that fully describes the steps to be taken to implement the use of Child and Family Teams throughout each DCFS office and in agencies providing services to children with mental health needs. The plan should be at a level of detail that describes the number of coaches needed, when they will begin and complete coaching in each setting and when CSWs and mental health practitioners will regularly employ child and family teams in the families they serve.

Family Foster Home Recruitment

The County added a modest number family foster homes during the monitoring period. In an effort to learn how foster home growth compared with trends in out-of-home care, the Panel requested that the County provide information about the rate of entry and exit from foster care during the reporting period. The County has been unable to produce those data at this point. As a result, to enable the Panel to analyze child welfare population trends, the Panel requests that the County provide data that identifies an array of data characteristics addressing such areas of out-of-home care entries and exits, children exiting foster care at age 18 or older without permanency and estimated numbers of foster homes needed, for example. These data will be used to assist in tracking the status of Katie A. Implementation. The Panel and County should confer to identify the specific data needed.

VI. 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.

DMH – Department of Mental Health

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

ER – Emergency response

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

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

Intensive Care Coordination (ICC) – 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.

Intensive Field Capable Clinical Services (IFCCS) – 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.

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

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

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

VII. Appendix

County Multidisciplinary Assessment Team (MAT) Quality Assurance Report

A total of 739 MAT Quality Assurance (QA) Checklists and 446 MAT Children's Social Worker (CSW) Interview Surveys were submitted from December 2013 through June 2014. The QA Checklists ask DMH MAT Psychologists and Coordinators as well as DMH Contract Provider Supervisors to check a Yes or No response for each of the questions on the tool. The CSW Interview Guides as the DMH MAT Psychologist or Coordinator to interview the DCFS CSW after the Summary of Findings (SOF) Meeting to provide feedback on the MAT Process. Below is a box of each domain and the positive response rate for both the QA Checklist and the CSW Interview Guide.

QA Checklist Domain #	Positive Response Rate (% of responders who checked yes)
#1 / Reasonable Efforts were made to engage all stake holders	97%
#2/ SOF adequately addressed all MAT Domains of functioning (ie. medical, dental, developmental, speech/language, education, vocation, mental health, family/caregiver).	98%
#3/ Strengths of child, family & caregivers adequately described	99%
#4/ Underlying needs of child, family & caregivers adequately described	98%
#5/ Child's, family's and caregiver's voice taken into account in decision making process.	97%
#6/ Recommended services and supports made in SOF were consistent with assessment information and specific enough to be implemented	98%
#7/ If mental health needs identified, is appropriate linkage being pursued.	97%

QA Checklists & CSW Interview Guides revealed strengths and needs in the MAT process and Summary of Findings meeting. Specifically, the MAT Summary of Findings and MAT process was most beneficial when there were parents or extended family members participating at the SOF meeting. Several respondents commented on the helpfulness of

CSW Interview Checklist Domain #	Positive Response Rate (% of responders who checked yes)
#1/ CSW experienced positive **team work** with MAT assessor that allowed **effective collaboration**	95%
#2/SOF meeting helped CSW **in developing service plan** for case plan participants	96%
#3/CSW found SOF meeting to be helpful in making **recommendations to the court**	89%
#4/SOF meeting assisted CSW in identifying the **underlying needs** of case plan participants	96%
#5/SOF meeting assisted CSW in identifying **strengths** of case plan participants	98%
#6/ CSW felt MAT assessor made **reasonable attempts to engage** all necessary individuals	98%
#7/ CSW felt all **meeting participants actively involved** in meeting & **voice and choice** were taken into account in decision-making process	98%

translators being present for family members and caregivers at the meeting.

Some barriers to parent involvement included incarceration, parent whereabouts unknown, and parents who were not able to return phone calls of MAT assessors. Additionally, some foster caregivers had multiple foster children they needed to care for, which made it difficult for a few foster parents to participate in the SOF meeting due to child care needs. The Summary of Findings meeting was also helpful as it provided a time for MAT assessors to provide psycho-education on trauma, the child's strengths and needs, and the child's trauma symptoms to the child's family and caregivers, treatment providers, and DCFS CSW. DCFS CSWs shared that they found the meeting helpful when the MAT assessors provided specific resources and referrals for the family and child, identified the strengths and needs of the child and family members, and provided mental health linkages for the child (if needed). DCFS CSWs noted that the SOF meeting was especially relevant when the SOF meeting occurred before the disposition hearing or when the DCFS CSW was new to the case. At times linking children with mental health services could be challenging when the child's placement was pending or the child was placed out of the county.

One new systemic change in the DMH MAT program is an updated tracking log and revised fax notification form were implemented on July 1, 2014. The tracking system is similar to past MAT tracking systems, but will allow CWD to monitor the number of MAT children who receive MAT assessments after they are placed out of county and the number of Katie A Subclass children. Additionally, the new log contains formulas to highlight the length of time spent to submit the Final SOF and to link the child after the SOF meeting. The updated MAT tracking system will now allow Service Areas and DMH Child Welfare Division to monitor the timelines for the SOF Completion and Linkage process.

DMH MAT Administration under the DMH Child Welfare Division has also continued to provide trainings to MAT Providers and DMH Community Partners, such as LA County Unified School District on foster care children, trauma, and trauma needs in birth to five children. Specifically, two trainings in February focused on Building Relationships and Observing Foster Care Children with their Caregivers, which was provided by several of the MAT psychologists who specialize in infant and early childhood mental health. The training provided updated activities and videos on how to observe young foster care children and actively engage their foster families, biological parents, and extended support systems in collaborating to meet the child's underlying trauma and developmental needs. Participants provided positive and enthusiastic feedback. Additional trainings included a training on Young Children and Trauma in January and a training on typical and atypical development in young children in April. Trainings on childhood trauma and foster care children were also provided to a school based collaborative with representatives from LA Unified School District and provided to Los Angeles Unified Preschool.

Additionally, in April, the 3rd Annual Countywide Provider meeting was held and nearly 300 staff members attended. The morning session focused on issues relevant to MAT Managers and Supervisors such as tracking Katie A Subclass Members, results from a MAT Language Capacity and Birth to Five Training Needs assessment, a review of the SOF meeting protocol, and a MAT Manager Panel comprised of managers from 3 MAT Providers who presented on trauma assessments, developmental screening of young children, and the use of

case managers in MAT. The afternoon portion focused on the needs of MAT Assessors and had panel of 3 professors from Cal State Los Angeles' Charter College of Education who provided an overview of educational accommodations for foster care children and case studies of successful educational interventions with foster care children. A MAT Assessor also shared about her own experiences of engaging school staff in order to assess MAT children in their day care or school environment during the MAT process.

Medical Hubs

Currently, the County reports that for the period of August 2013 to July 2014, 88% of the newly detained children were referred to the Medical Hubs for the required Initial Medical Examination. This percentage is noteworthy since it represents the highest percentage since DCFS implemented formal tracking and reporting to its management including regional operations. This is very good news, and the County continues to explore further mechanisms as opportunities arise, to ensure that this population of children are referred to the Medical Hubs towards achieving the goal of 100%. The user friendly reporting tool that highlights the percentages and that can be accessed by regional operations managers continues to be effective in determining the status in real time of the newly detained children being referred to a Hub for the Initial Medical Examination.

To ensure that the Initial Medical Examination results received from the Medical Hubs are documented into CWS/CMS to meet the required child welfare regulatory mandate and to ensure that the value of the results are maintained, DCFS continues to implement another user friendly tool, in real time, entitled, Medical Hub Exam Results Entered into CWS/CMS. Based on the percentages presented in the tool, the results are being entered albeit not consistently across regional operations. DCFS continues to address opportunities to highlight the mandate as they arise towards increasing the percentages.

The partnership to outstation DCFS Children's Social Workers (CSWs) and Public Health Nurses (PHNs) at the Medical Hubs, including at Children's Hospital Los Angeles, the private sector Hub, is considered to be extremely valuable. Children are referred more smoothly and served more effectively. The out-stationed CSWs are able to provide essential information to the Hub forensic medical examiners on the child's prior DCFS involvement and specifics of the current case that serve to inform the medical examination. Similarly, the out-stationed PHNs contribute in a significantly way to care coordination efforts by providing information from the child's previous medical history and assisting in coordinating services once the examination results and recommended treatment become available. For example, referrals to specialists are made more timely and efficiently.

Lastly, external stakeholders continue to value the contribution of the Medical Hubs in serving the needs of children under the care and supervision of the County. Most recently this has been demonstrated in the recommendations of the Blue Ribbon Commission (BRC) in its final Report. The BRC notes that, "Expansion of the Hub system will help save children's lives and enable DCFS to better evaluate and appropriately place children". Two BRC recommendations specific to the Medical Hubs are:

- All children entering placement and children under age one whose case is being investigated by DCFS should be screened at a Medical Hub;
- Children placed in out of home care or served by DCFS should have ongoing health care provided by physicians at a Medical Hub.

At this time, the County's CEO, DCFS and DHS and other stakeholders are working together to jointly address analyses of these recommendations.

DCFS Child and Family Team Training and Coaching

DCFS Coach Developers and Facilitator Coaches have continued to work with an external consulting team in implementing the Child and Family Team (CFT) model. DCFS is also initiating cross training and coaching for other Sections capable of serving to support CPM training and coaching and the implementation of CFTS in the offices including but not limited to: MAT/SLS and Youth Development Services (YDS). They have initiated their training sequenced with plans to initiate coaching in the first two quarters of 2015. This process for certification as a facilitator includes the observation and application of the 4-step CFT process:

(1) Coaching & Case Review;
(2) Child & Family Team Engagement (Preparation);
(3) Child & Family Team Meeting; and
(4) Debrief

The training and coaching cycle spans 2-3 weeks each month, and includes an overview training for all managers in an office, the SCSWs and CSWs that will be offering families to work with and those being trained in facilitating the work. The training and coaching cycle is experiential, case and field based and utilizes a "see one, do one" approach, allowing the participant to observe the consultant facilitate the CFTM process from beginning to end, and then facilitate an entire process on their own while being observed by their mentor coach. The training and testing phase of the model has required extensive coordination of logistical details. Consistent with the CPM and CFT values and principles, the focus has been to accommodate the schedules of the youth and families participating in the process.

43 facilitators have been exposed to the process and are in varying stages of field-based training. Fifteen facilitators (SCSW level) have been certified in the most advanced parts of the CFTM work. Six of the Coach Developers (CSA Is) have also been certified. The work continues through the end of 2014 where the goal is to certify an average of 15 facilitators per month with plans to carry this forward to the line unit (SCSW and CSW) level systematically in the next reporting period. A provisional policy regarding CFTMs is scheduled to be released in the first quarter of FY 2015. A full policy should be in effect in the second quarter of FY 2015. This will help address the ongoing concerns related to the continuing practice of TDM meetings in most regional offices.

Regular meetings with the Facilitator Coaches help address barriers and challenges in implementation towards strengthening the practice of CFTMs. They also serve as booster sessions so that everyone receives the same information

Additionally, a process is being discussed about how to capture all meetings in the existing database. One of the key components is to account for all four steps of a CFTM and to weight each piece so that if a family elects not to complete the process, the facilitator can receive credit for the parts that were completed.

In a continuing effort to establish uniformity and support the implementation process in all offices, the lead Coach Developers continue to deliver an overview training providing information on the CPM 23 Practice Behaviors, the fundamentals of coaching, and how to help sustain the practice in the regional offices. Several sessions have already been provided to Pomona and Wateridge (as CAPP offices) including support staff (PHNs and DPSS liaisons).

The following has been accomplished from January to October 2014:

- January & February – training of Coach Developers (CSA I level staff on CPM Team)
- March & April – first cohort of Facilitator Coaches (SCSW level from the regional offices)
- May, June, August, September and October – second, third, fourth, fifth and sixth cohorts of Facilitator Coaches.
- Module 3 training equips Coach Developers and Facilitator Coaches to train other SCSWs and CSWs in the CFTM process. Two 2-day sessions were held in June, July, September and October. There is one more session scheduled for November 2014. DMH staff have participated in a Module 3 training with DCFS staff to ensure continuity.

DMH Training and Coaching

The training spans over a period of 3 weeks, and consists of an overview of the teaming process with the agency staff that is expected to participate in the process. The training is experiential and utilizes a "see one, do one" approach, allowing the participant to observe the consultant facilitate the CFT process from beginning to end, and then facilitate an entire process on their own. The training and testing phase of the CFT model has required extensive coordination of logistical details. The focus has been to accommodate the schedules of the youth and families participating in the process.

On January 27, 2014, the DMH Coaches partnered with the Children's Systems of Care (CSOC) Administrative Staff to initiate the training process with the Full Service Partnership (FSP) program at Hathaway-Sycamores. Tricia Mosher Consulting trained a total of 2 DMH Coaches and 2 CSOC Staff to be Facilitators of the CFT process. Clinical staff from Hathaway-Sycamores participated in the training and received coaching on the CFT Model. Six youth and their families from the FSP program participated in the process resulting in 6 CFT Meetings.

On May 5, 2014, DMH Coaches partnered with the Group Home (GH) Administrative Staff to participate in this training with Hathaway-Sycamores GH. A total of 1 DMH Coach and 2 GH Administrative Staff were trained to be Facilitators of the CFT process. GH clinical staff from Hathaway-Sycamores was trained and coached on the CFT Model. Six youth and their families participated in the process resulting in 6 CFT Meetings.

On June 9, 2014, the training was initiated at Vista Del Mar Group Home. During this process 2 GH staff were trained to be Facilitators of the CFT process. Clinical staff from Vista Del Mar was also trained and coached on the CFT Model. A total of 3 youth and their families participated in the process resulting in 3 CFT Meetings.

On August 1, 2014 the training was initiated with Five Acres Group Home. The training is currently underway. Those that are being trained as Facilitators include 1 DMH Coach, 1GH Administrative Staff, and 2 Clinical Supervisors from Five Acres. Five Acres clinical staff is participating in the training process and is being coached on the CFT Model. We are expecting to hold 6 CFT Meetings at the conclusion of this process.

On September 22, 2014 the CFT Model training will be initiated at Starview Group Home. The plan is to train 1 DMH GH staff, 1 DMH FSP staff, and 1 staff person from Starview Group Home.

Los Angeles Training Consortium

During the Fiscal Year 2013-2014, Los Angeles Training Consortium (LATC) coaches provided 130 coaching modules (including the overview of coaching) in Service Areas 3, 6 & 8 with the Intensive Treatment Foster Care (ITFC) and Intensive Field Capable Clinical Services (IFCCS). Fiscal Year 2014-2015, LATC will begin coaching modules with Wraparound providers in Service Areas 4 & 5. These modules primarily include the following:

(1) Overview of Coaching;
(2) Case consultation;
(3) CFT meeting Prep;
(4) CFT meeting Debriefing; and
(5) Live coaching in a CFT

LATC coaches will continue to implement the coaching pilot with provider agencies in the identified Service Areas that work closely with DCFS and DMH to provide the needed therapeutic, mental health, rehabilitative and wraparound care to the children served by DCFS. The coaching will primarily focus on the Wraparound programs but will also offer booster sessions to the ITFC and IFCCS programs. A total of 18 Booster Coaching modules will be available in this new contract period.

The coaching will focus on the Shared Core Practice Model and the use of the CFT (Child and Family Team) as a vehicle for decision making and change. In addition, the coaching will also emphasize family ownership of CFT's, paralleling the model that is being implemented at DCFS and DMH through Tricia Mosher Consulting. The LATC will use the established coaching group to carry out this ongoing critical work.

Coaching Workgroup

The Coaches from DCFS, DMH, and LATC continue to participate in monthly support groups. The coaches met on the following dates during this past period: January 23rd, February 27th, March 27th, April 24th, June 26th, and July 31st, 2014. The Coaching Workgroup is scheduled to meet on the 4th Thursday of every month for the next fiscal year, 2014-2015. The next scheduled meeting is set for August 28th, 2014. The workgroup continues to provide a forum where coaches can receive and reciprocate support, strategize and problem solve, engage in self-reflective discussions, and enhance coaching skills. The coaches participated in the following activities during the monthly workgroup: presented case vignettes, engaged in role plays, participated in team building exercises, and exchanged resources such as scholarly articles and handouts. The workgroup continues to be a valuable resource that enhances interagency collaboration and support.

Attachment A : Child Welfare Division Trainings January - September 2014

Training	Date of Training	Hosted by	Number of Participants	Participants included:
Shared Core Practice Model	1/9/2014	Child Welfare Division	6	DMH Staff and MAT Providers
Shared Core Practice Model	2/13/2014	Child Welfare Division	30	DMH Staff and Providers
Shared Core Practice Model	3/13/2014	Child Welfare Division	39	DMH Staff and Providers
Shared Core Practice Model	4/10/2014	Child Welfare Division	32	DMH Staff DCFS and Providers
Best Practice Interventions with TFC Clients: Reaching Children Thru Play	4/14/2014	Child Welfare Division	90	TFC Contract Providers, DMH, DCFS Staff
Shared Core Practice Model ICC/ IHBS	4/14/2014	Child Welfare Division	53	SFC DMH Co-Located Staff
Child and Family Teaming Training Overview	4/23/2014	Child Welfare Division	11	DMH, DCFS QSR Reviewers
Shared Core Practice Model	4/25/2014	Child Welfare Division	26	Aviva Family and Children Services
Shared Core Practice Model	5/15/2014	Dr. Barbara Stroud	20	DMH Staff and Providers
An Introduction to Katie A. Class and Subclass SCPM/ CFT/ ICC/ IHBS	6/4/2014	Child Welfare Division	10	SA 3 SFC Co-Located Supervisors / Staff
Shared Core Practice Model	6/10/2014	Child Welfare Division	16	DMH Staff and Providers
An Introduction to Katie A. Class and Subclass SCPM/ CFT/ ICC/ IHBS	6/10/2014	Child Welfare Division	6	SA 6 SFC Co-Located Supervisors/ Staff
An Introduction to Katie A. Class and Subclass SCPM/ CFT/ ICC/ IHBS	6/19/2014	Child Welfare Division	21	SA 2 SFC Co-Located Supervisors/ Staff
Shared Core Practice Model	7/9/2014	Child Welfare Division	8	DMH Staff and Providers
Shared Core Practice Model	7/24/2014	Child Welfare Division	26	Aviva Family and Children Services
Shared Core Practice Model	8/6/2014	Child Welfare Division	47	DMH Staff and Providers
Child and Family Teaming Training Overview	8/12/2014	Child Welfare Division	23	DMH Staff
An Introduction to Katie A. Class and Subclass	8/20/2014	Child Welfare Division	TBD	SA 5 SFC Co-Located Supervisors/ Staff

SCPM/ CFT/ ICC/ IHBS				
Shared Core Practice Model	9/17/2014	Child Welfare Division	TBD	DMH Staff and Providers
An Introduction to Katie A. Class and Subclass SCPM/ CFT/ ICC/ IHBS	9/30/2014	Child Welfare Division	TBD	SA 7 SFC Co-Located Supervisors/ Staff

* Note the trainings shaded in gray are upcoming trainings; therefore, dates or attendance figures are not available

DCFS Young Children in Group Care

Of the young children placed in group home care as of July 31, 2014, 58.4% (45) were placed in group homes that had RBS programs; not all of these children were in RBS beds, but most of those who were not were waiting to move to an RBS bed within the program. Of the children 0-12 years old placed in group home care 48% (37) had been there 0-6 months, 23% (18) had been there 6-12 months, and 28% (22) had been there over one year. The very small number of young children admitted to group homes (77 out of 27,241 children ages 0-13 years) most often have had a history of significant trauma, prior open child protective services cases and behavioral disturbances prior to DCFS involvement, a history of multiple hospitalizations and a history of several prior relative or foster home placements, often with Wraparound, Full Service Partnership or IFCCS services. Due to a cycle of rapid replacement from one home (or hospital) to another, these youth are often placed inappropriately in school because they do not have an Individualized Educational Plan (IEP), or their current IEP does not adequately address their needs in the classroom; for the same reasons they have not had continuity of psychiatric and psychological care because their providers have changed as they have moved from one home to another. A group home setting, especially one with an on-grounds school, offers this small group of children an opportunity for academic and psychiatric reassessment so that IEPs and medication can be better targeted to address the youth's symptoms as the youth's underlying needs can be explored and identified while the youth's team is afforded the opportunity to shift its focus from crisis intervention to more proactive re-engagement, assessment, reassessment, planning and adjusting. Generally their team is able to use this time to explore family finding efforts and offer an identified prospective caregiver or parent some intensive, individualized training and engagement with the youth's team in order to prepare them to receive the youth for placement in their home.

PROOF OF SERVICE

Katie A., et al. v. Diana Bonta, et al.

Case No.V-02-05662 JAK (SHx)

I, the undersigned, say: I am over the age of 18 years and not a party to the within action or proceeding. My business address is 3701 Wilshire Boulevard, Suite 208, Los Angeles, California 90010.

On January 21, 2015, I served the foregoing documents described as:

ADVISORY PANEL'S REPORT TO THE COURT - FIRST REPORTING PERIOD OF 2014

on all interested parties in this action by placing copies thereof enclosed in a sealed envelope addressed as follows:

John F. O'Toole
National Center for Youth Law
405 14th St., 15th Floor
Oakland, CA 94612-2701

Kathleen R. Wolfe
US Department of Justice
950 Pennsylvania Avenue N W NYA
Washington, DC 20503

[X] BY MAIL - I deposited such envelope in the mail at Los Angeles, California, with first class postage thereon fully prepaid. I am readily familiar with the business practice for collection and processing of correspondence for mailing. Under that practice, it is deposited with the United States Postal Service on that same day, at Los Angeles, California, in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postage cancellation date or postage meter date is more than one (1) day after the date of deposit for mailing in affidavit; and/or

[ ] BY E-MAIL TRANSMISSION - I caused such document to be electronically transmitted to the offices of the addressee(s) listed above, using the above e-mail address, prior to 5:00 p.m. on the date specified above.

[ ] BY PERSONAL SERVICE - [ ] I delivered by hand, or [ ] I caused to be delivered via messenger service, such envelope to the offices of the addressee with delivery time prior to 5:00 p.m. on the date specified above.

I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 21, 2015, at Los Angeles, California.

Amanda Smith

Amanda Smith