

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

Marty Beyer
Paul Vincent
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June 29, 2015

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 Second Reporting Period of 2014. The Panel will be following up with a bound copy for your use.

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

Sincerely,



Paul Vincent
Panel Chair

cc Panel Members
Phillip Browning
Marvin Southard
Laura Quinonez
Ira Burnim
Antionette Dozier

**The Katie A. Advisory Panel
Report to the Court
Second Reporting Period of 2014
June 23, 2015**

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c/o 428 East Jefferson Street
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Executive Summary

System Progress

The County continues to refer newly detained children to Medical Hubs for an initial medical examination at a high rate. Eighty-eight percent of newly detained children were referred during the current monitoring period. Mental health screening of newly detained children is also a positive accomplishment of the system. Of 12,685 children appropriate for screening, 12,384 were screened. Eighty-six percent of these children screened positive. Children screened positive received a mental health activity and at least one mental health service promptly. Also, a greater number of youth have received IHBS an ICC since December 2013.

A Panel review of a sample of Multidisciplinary Assessment Team cases indicated progress in the identification of children’s strengths and needs. The DMH pilot of the Intensive Field Capable Clinical Services continues to function well and DMH states that it is seeking funds for expansion.

System Challenges

Workload

The following table shows historical changes in the overall DCFS workload. In more recent months there has been a gradual decrease in Family Maintenance cases and a gradual increase in children placed out-of-home.

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 (July)	13,551	13,328	20,726
2014 (December)	12,896	13,112	20,809

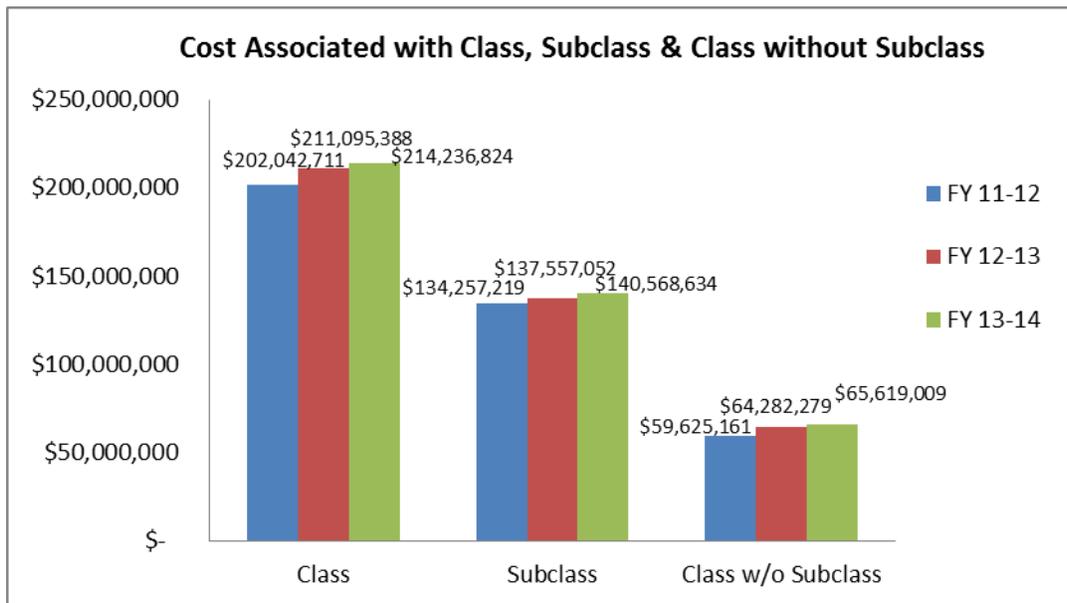
The average caseload for Emergency Response Workers increased during the monitoring period from 17.72 to 18.7. The average caseload for Continuing Service Workers decreased slightly during the monitoring period from 30.64 to 29.3. That caseload is almost double the standard of 15 cases per worker established by the Child Welfare League of America. Caseload size remains a significant barrier to implementation of the County’s Practice Model.

DCFS and DMH Training and Coaching - Core Practice Model Implementation

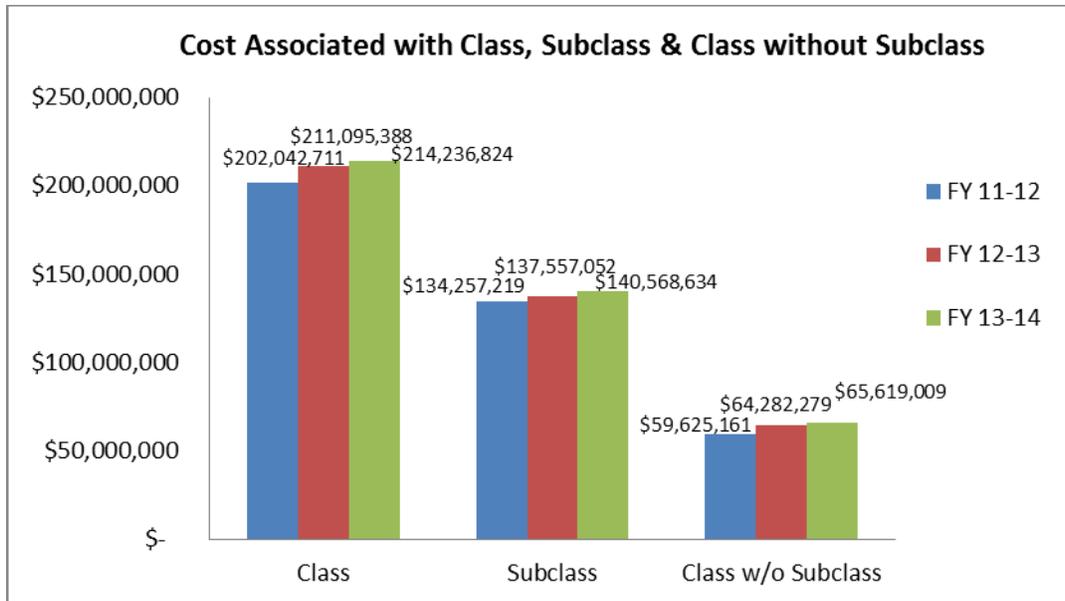
DCFS is continuing with its strategy of developing practice model coaches across the system. It is increasing the number of coaches certified to develop other staff: however that effort is not yet reflected in any significant improvement in practice performance as reflected in Quality Service Review results. DMH is providing Core Practice Model training to its co-located staff and to some providers. It is also providing child and family team coaching in a small number of group homes and through the Los Angeles Training Consortium, providing coaching to 12 Wraparound providers. DMH training and coaching capacity is still modest.

Expansion of Home-Based Mental Health Services

The following table shows the number of class members and subclass members by year. The overall number of class members has grown slightly, while the number of subclass members dropped slightly in FY 13-14.



The table below shows the costs for class members and subclass members. Total costs have risen slightly between FY 2012-2013 and FY 2013-2014.



The analysis of DMH data about the class show:

- A small decrease in the number of subclass members
- The mental health needs of the subclass have increased
- Average mental health costs for subclass members have increased steadily and exceed those of the class
- There has been no increase in home-based services for the subclass in FY 13-14, but less services are office-based. Further analysis of this trend is planned by DMH.
- There remains a large amount of the subclass not receiving intensive services

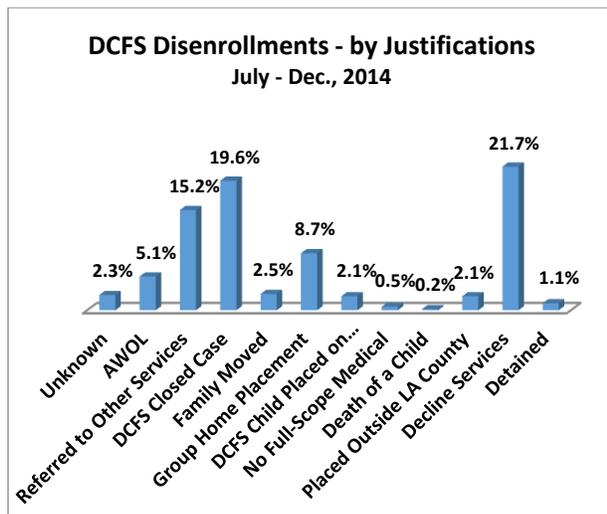
Wraparound

The following table shows the growth of Wraparound since FY 2009-2010.

	2009-10	2010-11	2011-12	2012-13	2013-14	YTD 2014-15
By Fiscal Year						
<u>Beginning Active Cases</u>						
Tier I	1,033	1,043	967	885	899	793
Tier II	41	778	1,070	1,283	1,434	1,461
Total Beginning Active (1)	1,074	1,821	2,037	2,168	2,333	2,254
<u>New Enrollments</u>						
Tier I	1,040	1,070	1,048	1,091	1,061	639
Tier II	985	1,235	1,475	1,723	1,751	1,106

Total New Enrollments (2)	2,025	2,305	2,523	2,814	2,812	1,745
Case Served						
Tier I	2,073	2,113	2,015	1,976	1,960	1,432
Tier II	1,026	2,013	2,545	3,006	3,185	2,567
Total Case Served = (1)+(2)	3,099	4,126	4,560	4,982	5,145	3,999

The County continues to work toward increasing Wraparound capacity. It also continues to experience a high number of cases where youth do not graduate from Wrap. Of the 1582 children/youth who enrolled in Wraparound in the monitoring period, 510 graduated. The table below shows the reasons for DCFS disenrollments.



Treatment Foster Care (TFC)

The number of children receiving treatment foster care in at the end of the monitoring period, 80, is only 4 higher than the number served at the end of the prior monitoring period. The County is essentially making no progress in reaching the target of 300 beds required in the Corrective Action Plan.

Foster Home Recruitment

There has been little change in the availability of foster homes. DCFS recruitment and retention efforts have not materially affected the shortage of homes.

Qualitative Review Findings

QSR Baseline Practice Indicators – Percent Acceptable

The QSR results provide a measure of the effectiveness of Core Practice Model implementation. The following table shows some gains in practice indicators compared to prior year performance.

However scores for the crucial indicators of Teamwork, Assessment, Long-Term View, Planning and Tracking remain quite low.

	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Overall 2011-2012	60%	52%	18%	50%	39%	41%	66%	52%	45%	47%
Overall 2012-2013	74%	64%	25%	46%	51%	46%	62%	53%	44%	51%

Multidisciplinary Assessment Teams

For the current monitoring period DCFS referred newly detained children to MAT at a high rate, 99.27%. MAT completion rates were lower, with 55 percent of cases completed within the target period of 45 days. Unless deadlines are met, the assessment may not be available to the court by the hearing to address the case plan.

Panel Recommendations

Workload

DCFS continues to experience high workloads, despite the hiring of additional staff. The County states that the slow development process of hiring and training the additional approximately 700 staff authorized by the Board has delayed the anticipated reduction in workloads. The Panel asks that the County provide a report of the impact on caseloads of new staff being fully productive in the field.

Expansion of Intensive Home-Based Mental Health Services

The Panel strongly supports the expansion of IFCCS. New strategies are needed to expand Treatment Foster Care. The Panel will schedule a call with the County to explore plans to fully comply with this provision of the Corrective Action Plan.

DCFS and DMH Training and Coaching

The current DMH limited coaching capacity and strategy are not significantly expanding the use of Core Practice Model approaches outside of specialized programs. DMH is hoping to expand the number of coaches to approximately 20 staff, if funding can be found; however the County needs to develop a plan to extend coaching to the broader DMH and provider work force.

Family Foster Home Recruitment

The Panel is unaware of any further DCFS efforts to expand the number of urgently needed family foster homes.

Katie A. Implementation

During this monitoring period the County and plaintiffs began a discussion about what the parties agreed was a slowing of implementation progress. During the First Reporting Period of 2015, January – June, 2015, these discussions continued, also involving the Panel. The status of these discussions, which were extensive and promising, will be described more fully in the next monitoring report.

**Katie A. Advisory Panel
Report to the Court
Second Reporting Period of 2014
June 23, 2015**

I. Introduction

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

II. Panel Activities Since the Last Report

During the monitoring period the Panel met with the County twice, provided consultation to the County Quality Assurance team on the Qualitative Service Review process, participated in a quality review and participated in a follow-up MAT study.

III. Current Implementation Plan Status

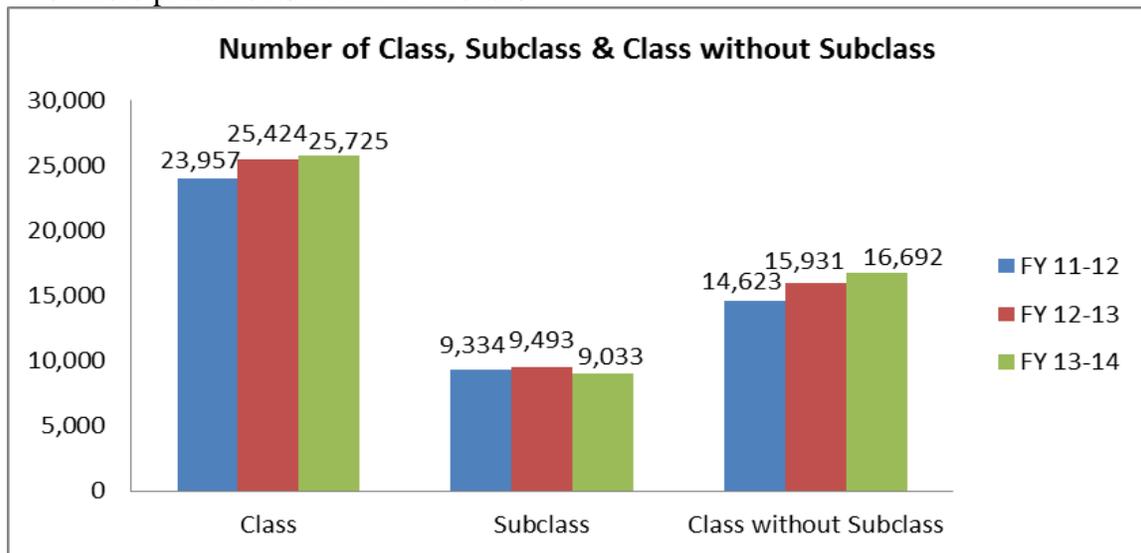
Expansion of Home-Based Mental Health Services

Utilization of Evidence-Based and Promising Practices for Class Members

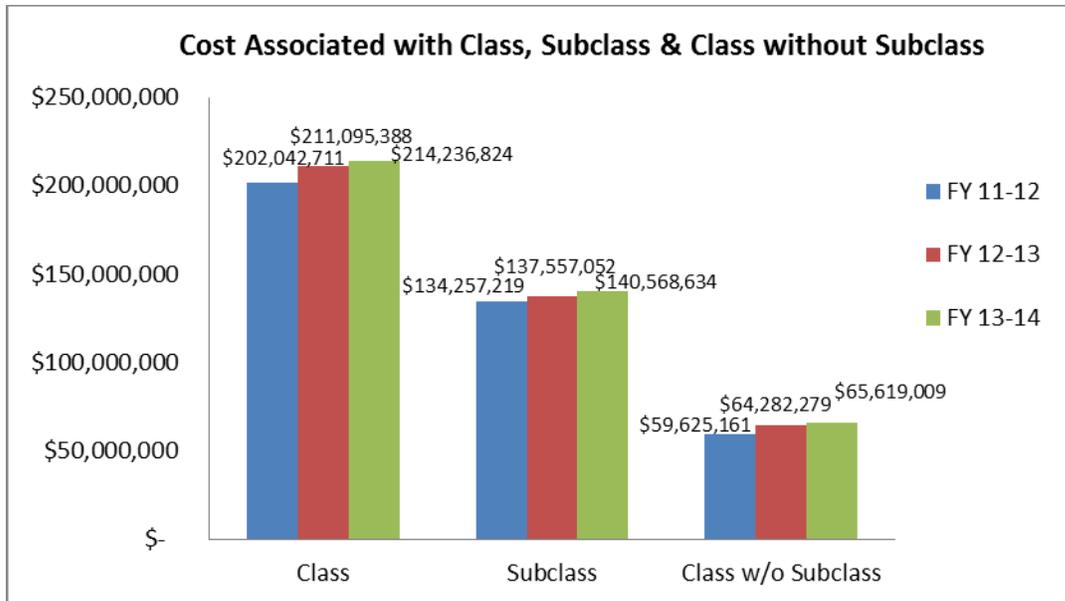
DMH provided the following report regarding efforts to expand home-based mental health services:

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 the DMH data set: 1) There are a number of providers that have begun claiming using IBHIS and this data is also included; however, there have been some problems with the loading of some of the tables needed for these reports in our data warehouse and some of this data may not be reflected; 2) DMH used a different analysis to capture the number of youth that were psychiatrically hospitalized due to limited DCFS and DMH data available; 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:

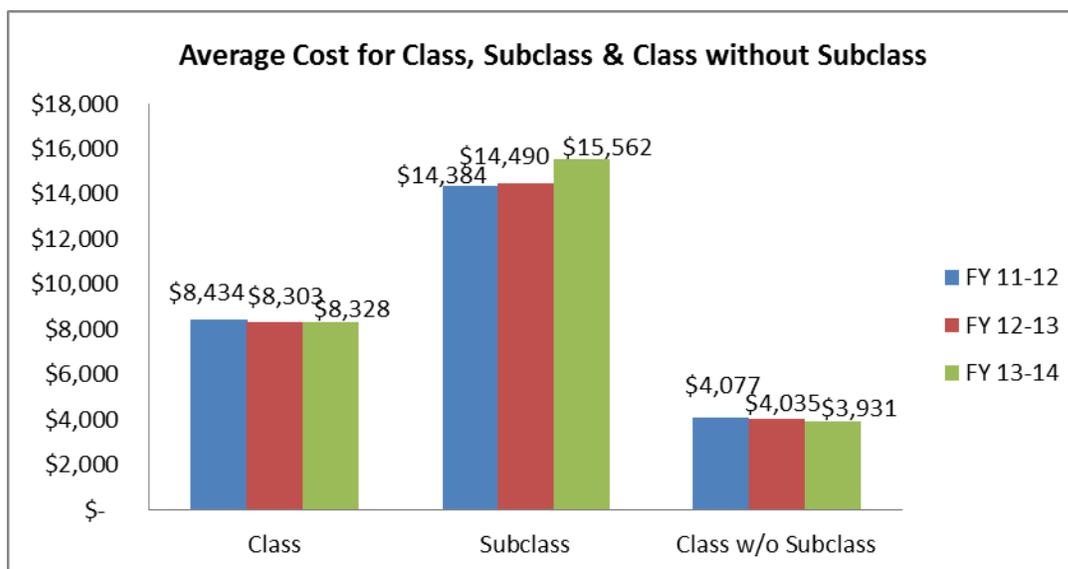
1) From the total amount of DCFS clients (60, 283), 43% were Katie A. class members during FY 13-14, slightly higher than previous fiscal years (FY 12-13 42%; FY 11-12 42%). During FY 13-14, about 35% of the Katie A. class were subclass members and received more intensive mental health services, a slight decrease from FY 12-13 (37%) and FY 11-12 (40%). 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. The data shows that the subclass has decreased since FY 11-12 making up a smaller percentage of the Katie A. class. In addition, while the percentage of subclass members has decreased, the number of subclass members has also slightly decreased from 9,493 (FY 12-13) to 9,033 (FY 13-14). This seems to be largely due to a decrease in the number of youth that received three or more placements within 24 months.



2) The cost associated with providing mental health services to the Katie A. class continues to increase for the last three fiscal years (FY 11-12 - \$202 million; FY 12-13- \$211 million; and FY13-14 - \$214 million). The percentage of subclass costs has remained steady during FY13-14 (66%) and FY 12-13 (65%). In FY 13-14, while the subclass made up about 35% of the class, it made up about 66% of the total class cost. While the percentage of subclass to class members has slightly decreased over the past three fiscal years, the percentage of the subclass cost has remained the same. This data shows that the number of class meeting the subclass criteria has slightly decreased in recent years but this group has had more intensive mental health needs. The mental health costs associated with providing services to this group is still more than half (66%) of the total costs provided to the class.

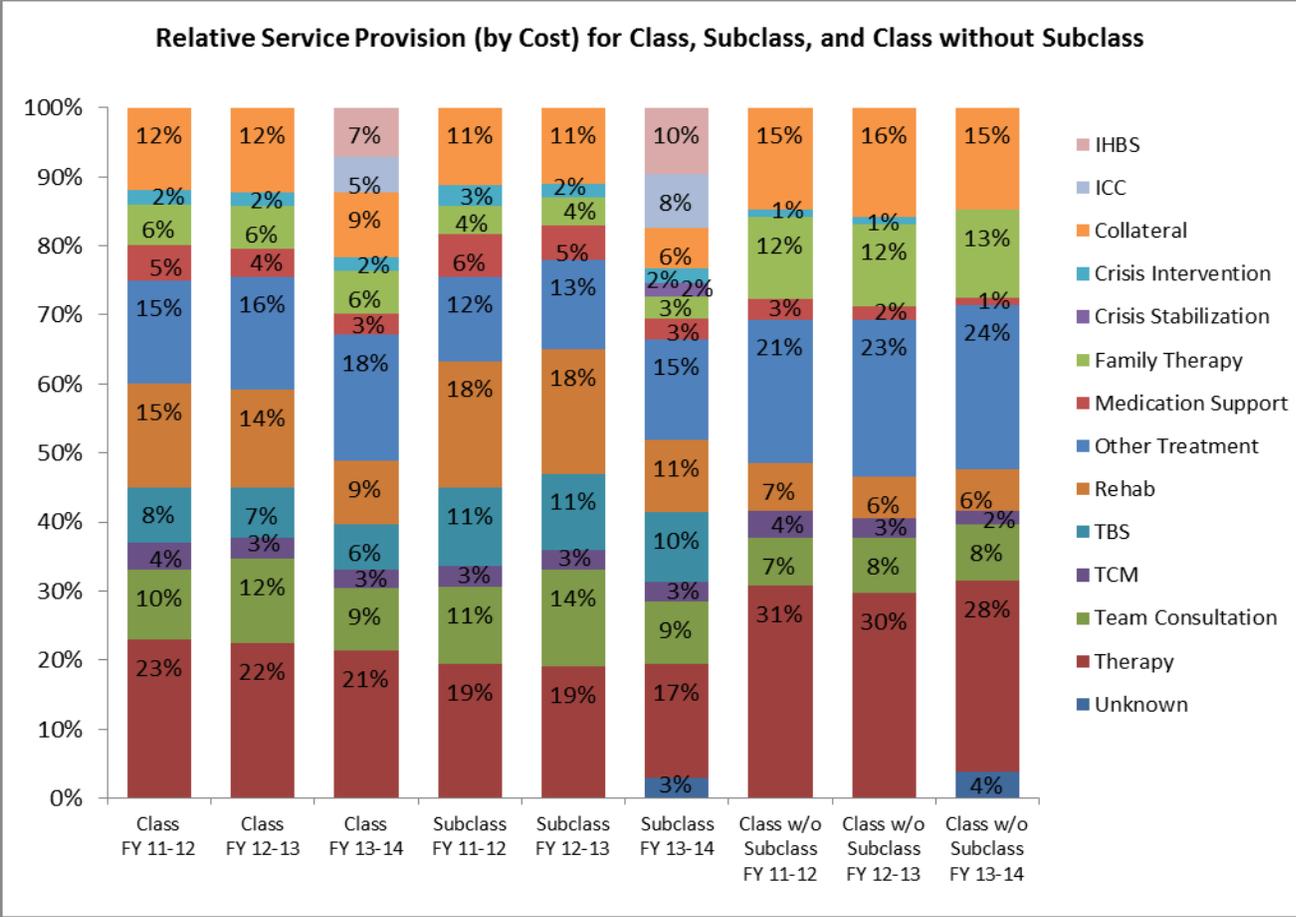


3) Upon closer look at the mental health service costs that were provided to subclass members, the FY 13-14 data shows the average mental health cost associated with subclass members (\$15,562) has increased compared to FY 12-13 (\$14,490) and is still much higher than the average cost of mental health services for class members who are not part of the subclass (\$3,931). The average cost for the class w/o subclass category remained steady (FY 13-14 \$3,931; FY 12-13 \$4,035). More specifically, subclass members are receiving more services than the average class member not belonging to the subclass.

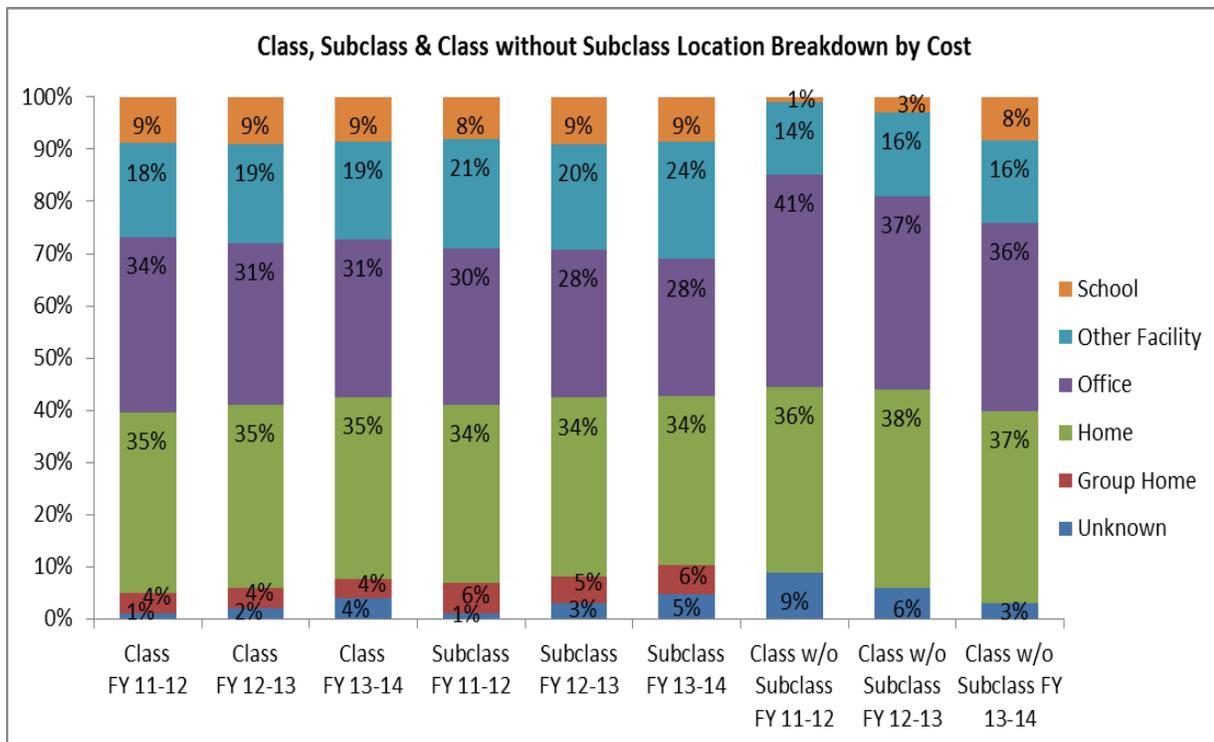


4) The mental health service array also varies slightly between class and subclass members. For FY 13-14, subclass members received less individual therapy (17%) than

class w/o subclass members (28%). Subclass members also received more targeted case management (TCM) including team consultation (TC) and ICC (subclass: 20%; class w/o subclass: 10%), more rehabilitation services including TBS, collateral and IHBS (subclass: 37%; class w/o subclass: 21%). 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 has decreased (FY 13-14: 17%; FY 12-13: 19%), TCM including TC and ICC has increased (FY 13-14: 20%; FY 12-13: 17%) and rehabilitation including TBS, collateral and IHBS has slightly decreased (FY 13-14: 37%; FY 12-13: 40%). The mental health service array for subclass members is more in line with the intensive services subclass members would be expected to receive. Theoretically, 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. While the data supports an increase in targeted case management, it does not support an increase in rehabilitation services, specifically collateral work with caregivers (FY 13-14: 6%, FY 12-13: 11%). Some of the collateral services may also be captured within IHBS and contribute to the decrease in collateral services being billed. DMH expects 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 service data has not changed much within the last two fiscal years. There are still more services being provided in the office for class w/o subclass members (FY 13-14: 36%; FY 12-13: 37%) than for subclass members (FY 13-14: 28%; FY 12-13: 28%). In addition, more services seem to be provided in other facilities (including Group Homes) for the subclass (FY 13-14: 30%; FY 12-13: 25%) than for the class w/o subclass (FY 13-14: 16%; FY 12-13: 16%). This may be partly due to subclass members being in need of more intensive mental health services within other types of facilities like psychiatric hospitals, group homes and urgent cares centers. While DMH 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 w/o subclass members (FY 13-14: 37%) than for subclass members (FY 13-14: 34%). These percentages are also consistent with data from last year. While there does not seem to be a trend in more services provided in the home for subclass members, subclass members do seem to be receiving less services in the office (FY 13-14: 28%) than class w/o subclass members (FY 13-14: 36%).

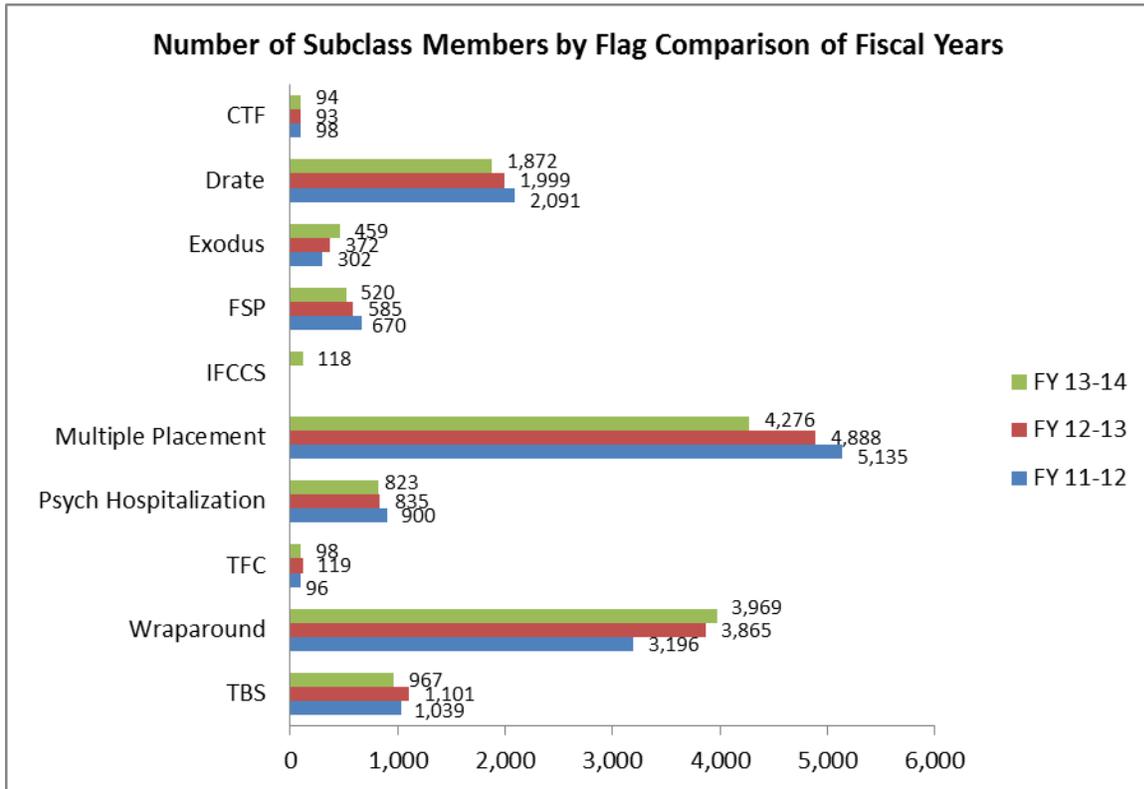


Using the last three fiscal years 2013-2014, 2012-2013 and 2011-2012 data, we identified some of the mental health services that were provided to subclass members that we identified as being similar to services provided within ICC and IHBS.

- 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 service, frequency of services and services more often provided in the youth's home or most home-like setting. Based on the subclass definition, DMH developed a chart below of the criteria or programs youth were in that contributed to them being in the subclass. Consistent with FYs 11-12 and 12-13, in FY 13-14 the majority of youth had three or more placements (4,276), Wraparound (3,969) or were placed in a D-Rate home (1,872). 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 (119 to 98), TBS (1,101 to 967), FSP (585 to 520), or had three or more placements within 24 months (4,888 to 4,276) and more were in Wraparound (3,865 to 3,969) and Exodus (372 to 459). The decrease in the multiple placement category continues to be refined in an effort to be in line with the State's definition of this category (due to behavioral reasons). DMH is working to get a clear count of the number of youth that fall into this category. The data shows that the number of youth enrolled in a psychiatric hospital has decreased (FY 13-14: 823; FY 12-13: 835); however, it is important to note that DMH continues to have difficulty gathering data regarding psychiatric hospitalizations and much of the data is missing or not accurately reported. *[The subclass criteria below include Full Service*

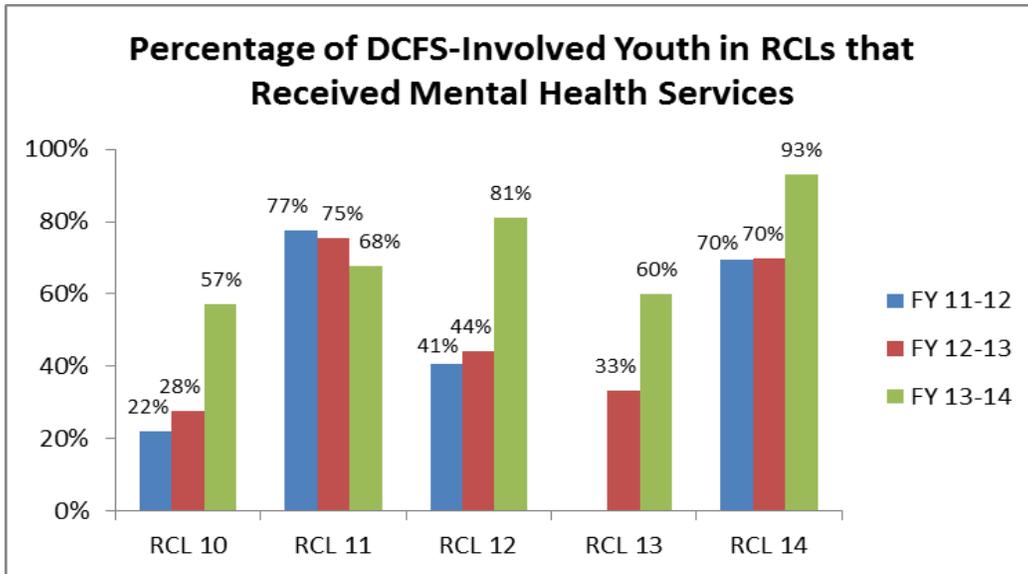
Partnership (FSP), clients that have had three or more placements within 24 months (Multiple Placement), Treatment Foster Care (TFC), Community Treatment Facility (CTF), D-Rate placement, Rate Classification Levels 10 -14 (RCL 10 – 14), Psychiatric Hospitalization (Psych Hospitalization), Wraparound,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



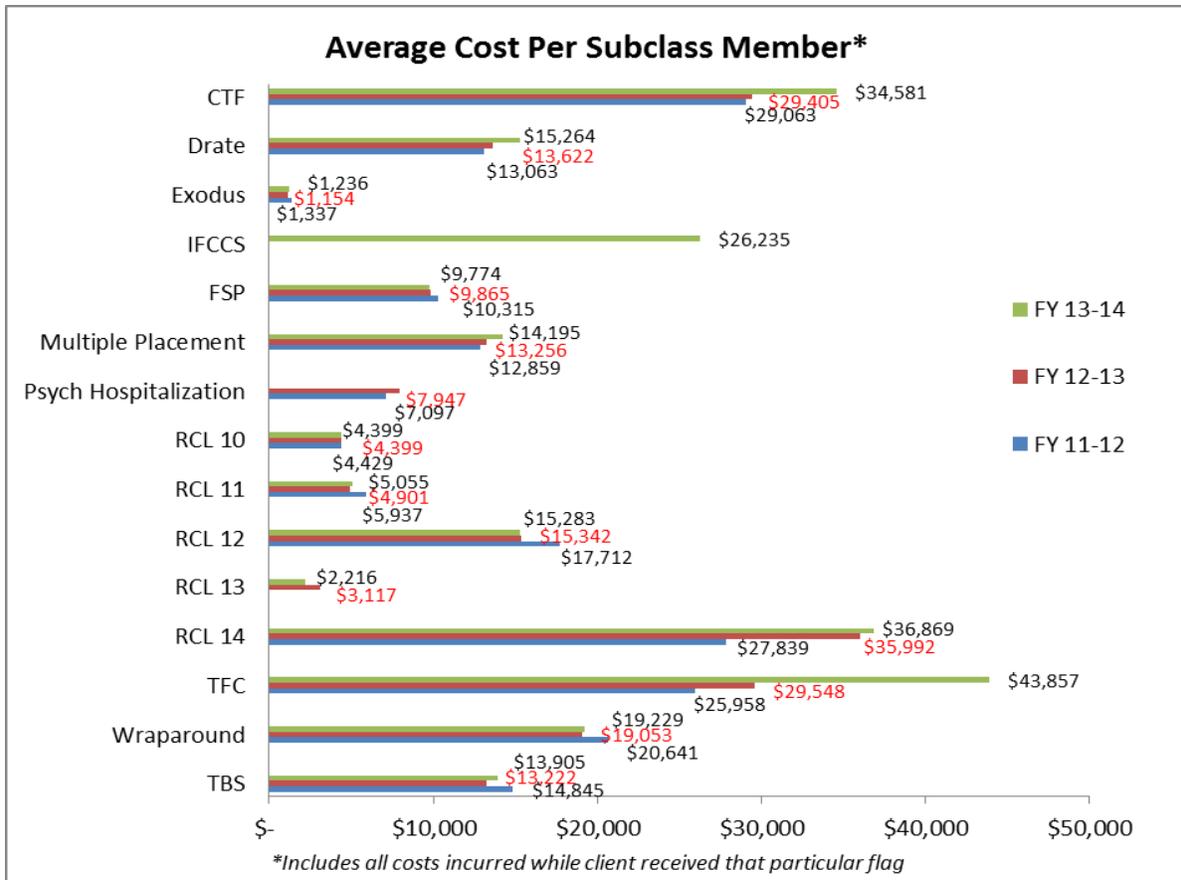
- 3) In the data provided below, DCFS’ fiscal year placement numbers were compared to DMH’s clients that received a mental health service while in Rate Classification Level (RCL) 10 and above. It is important to note that many of the children placed in the RCLs may in fact be receiving mental health services from the group homes’ staff members and/or Fee for Service Providers which is not reported to the mental health database. 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 percentage of youth that received mental health services through DMH has steadily increased in RCL 10 (FY13-14: 57%; FY 12-13: 28%; FY 11-12: 22%), RCL 12 (FY13-14: 81%; FY 12-13: 44%; FY 11-12: 41%), and RCL 14 (FY13-14: 93%; FY 12-13: 70%; FY 11-12: 70%). The percentage of DCFS-involved youth in

RCL 11 that received mental health services through DMH has decreased (FY13-14: 68%; FY 12-13: 75%; FY 11-12: 77%).



- 4) The average cost associated with the identified criteria or programs varies greatly, with costs associated with Rate Classification Level 14 (\$36,869), Community Treatment Facilities (\$34,581) and Treatment Foster Care (\$43,857) being the programs with the highest costs for subclass members in FYs 11-12, 12-13 and 13-14 (see chart below).



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 services.

The County reports that for FY 13-14, about 9,200 DCFS-involved youth received treatment using an evidence-based or promising practice. This is a decrease from FY 12-13 when about 9,800 youth were served through this modality but an increase compared to 8,300 during FY 11-12. For the last three fiscal years, the majority of youth received Trauma Focused-Cognitive Behavioral Therapy, Managing and Adapting Practice, Child Parent Psychotherapy, and Seeking Safety.

	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)		
	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
Evidence Based and Promising Practices												
Multisystemic Therapy (MST)	34	30	22	11	14	7	6	6	0	4	2	0
Functional Family Therapy (FFT)	290	276	219	14	15	12	13	11	11	8	4	2
Brief Strategic Therapy	38	54	31	8	11	9	6	17	11	2	6	6
Child Parent Psychotherapy (CPP)	711	1,157	1,196	41	45	42	660	1,384	1,130	39	42	39
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	43	36	6	8	6	3	5	4	3	3	2	3
Incredible Years (IY)	233	329	227	16	16	16	92	179	107	12	12	14
Parent-Child Interaction Therapy (PCIT)	192	197	320	15	12	33	142	187	274	12	10	30
Strengthening Families	38	52	36	6	5	2	3	1	1	2	1	1
Trauma Focused - Cognitive Behavioral Therapy (TF-CBT)	3,827	4,356	3,811	83	83	83	520	796	633	58	60	60
Triple P Positive Parenting Program	562	556	387	38	40	35	193	229	171	25	26	25
UCLA Ties Transition Model	27	32	37	2	2	3	16	31	23	2	2	2
Aggression Replacement Training (ART)	552	526	419	27	23	21	16	28	10	5	6	4
Alternatives for Families - Cognitive Behavioral Therapy (AF - CBT)	42	134	116	4	7	7	5	20	13	3	5	4
Managing and Adapting Practice (MAP)	2,172	2,916	2,806	79	80	84	269	452	386	50	53	61
Seeking Safety	1254	1,325	1,176	56	58	64	15	52	12	8	9	4

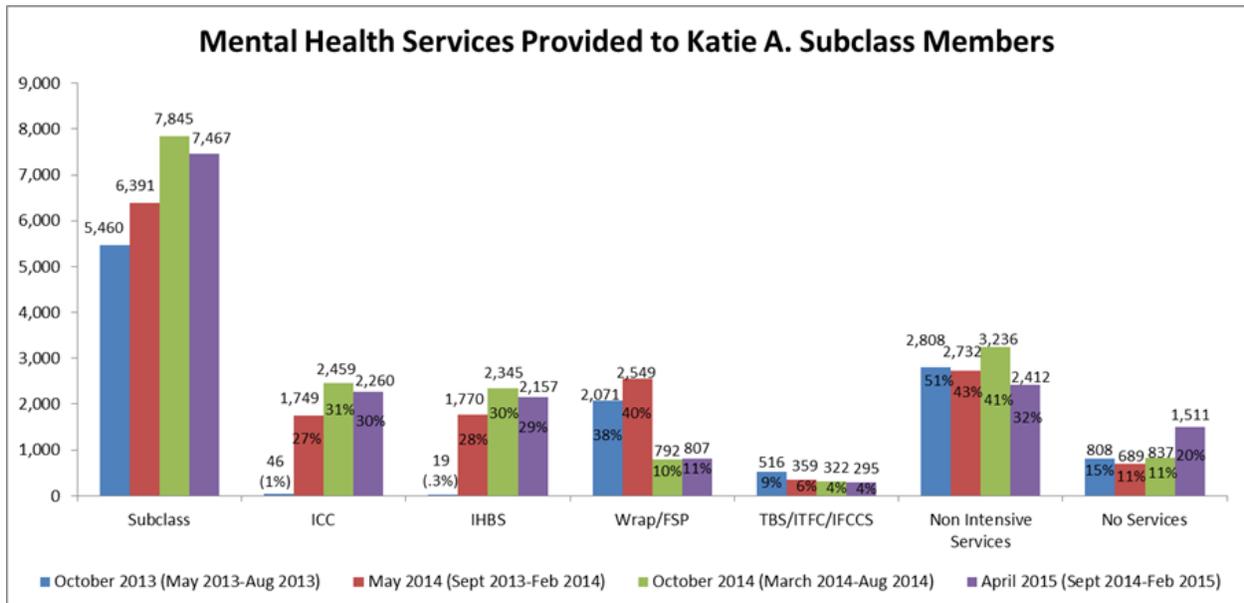
Intensive Home-Based Services and Intensive Care Coordination

The County reports that it has 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).

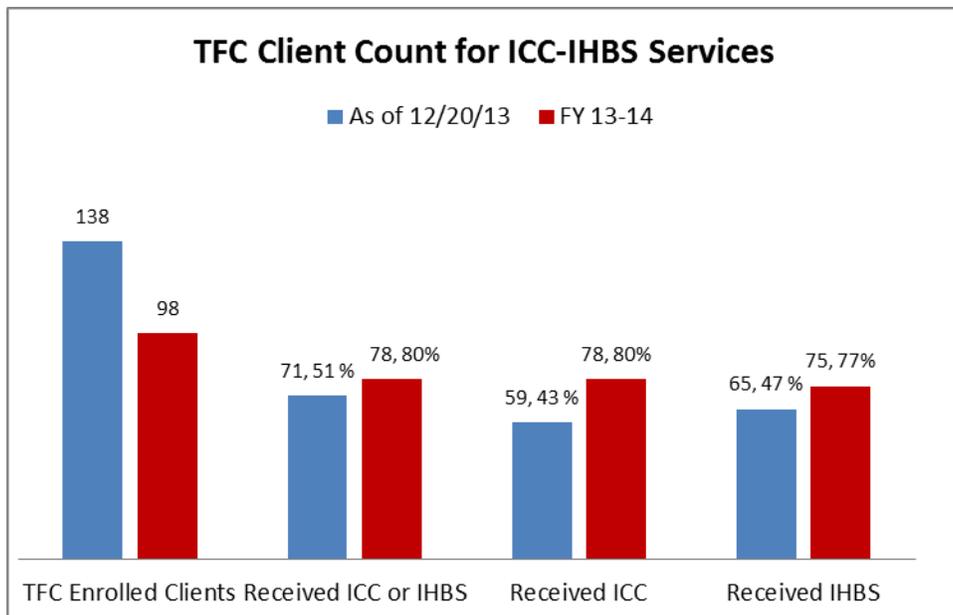
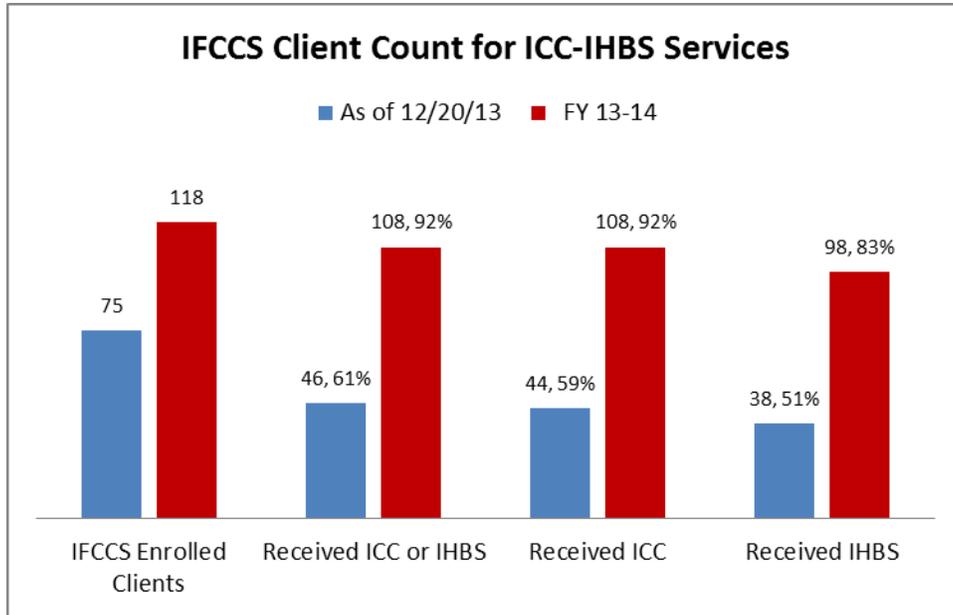
DMH states:

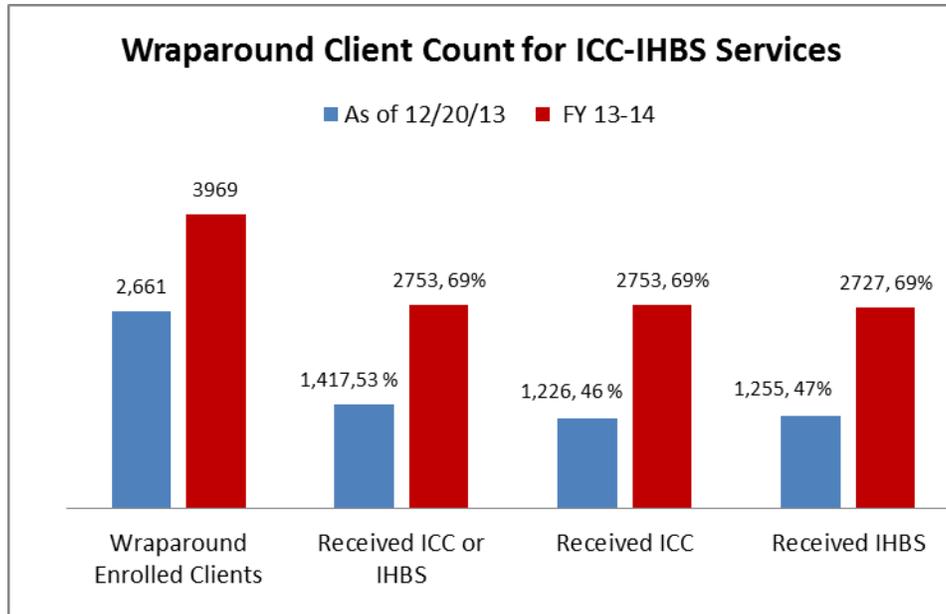
As of January 2014, DMH attempted to expand ICC and IHBS to the Full Service Partnership (FSP) program as Phase Three of the implementation effort. DMH coaches began providing support to FSP agencies related to the formulation of a child and family team; however, providers were reluctant to begin providing these services without additional money to pay for the cost of providing ICC. DMH has computed the estimated costs 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 continues to examine the number of subclass members that are receiving ICC and IHBS. The graph below is a breakdown of the numbers and percentages of subclass members during the specified enrollment period that have received ICC, IHBS, other intensives services (Wraparound, FSP, IFCCS, ITFC, TBS), non-intensive services, or no mental health services. This data is also reported to the State on a semi-annual basis.



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.





Based on the data above, DMH highlights the following points:

1. The data shows that the number of subclass members has decreased in recent years making up a smaller percentage of the Katie A. class. This may be partly due to the decrease in the number of youth that had three or more placements within the last 24 months.
2. While the subclass made up about 35% of the class during FY 13-14, it made up about 66% of the total class cost. The data shows that while the number of class members that meet the subclass criteria has decreased in recent years, their mental health needs has increased.
3. The average mental health cost associated with subclass members has steadily increased and is much higher than the average cost of mental health services for class members who are not part of the subclass.
4. While DMH expected to see subclass members receiving more services in the home during FY 13-14, there was no change noted. However, the data shows less services being provided in the office for subclass members. 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, were enrolled in Wraparound or were placed in a D-Rate home.
6. Within RCLs, the number of youth that received mental health services through DMH has steadily increased in RCL 10, RCL 12, and RCL 14 while the number of youth that received mental health services by DMH in RCL 11 has decreased.

7. 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.
8. There has been a greater number of youth that received IHBS and ICC since December 2013; however, there are still a large amount of subclass members that are not receiving intensive services.

Evidence-Based and Promising Practices

Implementation of Behavioral Health Information System (IBHIS)

DMH implemented IBHIS in 102 directly operated programs as of 2/17/2015, with the remaining programs to be completed by June 30, 2015. The one exception is programs located in Sheriff Department or Probation Department facilities. DMH states that there are discussions underway regarding system integration with Sheriff and Probation hospital information systems that could lead to streamlined workflow for Mental Health employees at these sites and improved data quality for client records. Transitioning contract providers to submitting claiming through IBHIS has been substantially delayed. Four Legal Entity (LE) contract providers were brought into production use of IBHIS for claims submission in February 2014. Processing those claims has proven labor intensive. DMH and Netsmart are working on system changes and work process improvements to reduce the amount of manual labor in the process. Fee-for-Service providers will be brought onto IBHIS only after there is another successful rollout of LE providers to IBHIS claims processing. While no firm date has been established for the next LE rollout, progress to-date suggests it may be possible by June 30, 2015.

Intensive Field Capable Clinical Services (IFCCS)

IFCCS is one of the County's most promising initiatives in serving class members with intensive mental health needs. Through December 2014, the IFCCS program has served a total of 142 youth. IFCCS providers provide an array of individualized intensive home-based mental health services, organized through a child and family team that are quickly responsive to children's needs. In its update, DMH reports the following.

Of all referrals received, 67% came from Psychiatric Hospitalization discharges, 23% came from Children and Youth Welcome Centers, 6% came from Exodus Urgent Care Centers, and 3% came from Psychiatric Mobile Response Teams. The program continues to provide Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS), as well as the full array of Specialty Mental Health Services to children and youth with intensive mental health needs that have contributed to multiple placement disruptions. The average length of stay in the program is approximately 5.4 months with a range of 2 weeks to 1 year. The program utilizes a Program Improvement Review process, which is an adaptation of the Quality Services Review (QSR), to ensure quality of service provision and evaluate fidelity to the Shared Core Practice Model. Reviews of all five service providers were completed by the year's end of 2014. Strengths were noted in the areas of Engagement, Planning and Intervening, and Tracking and Adapting. Areas that require continued training, support, and development include Assessment of Underlying Needs, Teaming, and

Long Term View. DMH Program Administration provides technical assistance and support through monthly roundtable meetings and telephone conferences when needed and will be incorporating a series of clinical trainings to support development in these areas.

Treatment Foster Care (TFC)

The County reports that since its inception in April 2008 the Treatment Foster Care (TFC) program served a total of 361 children/youth. During the period of July 1, 2014 through December 31, 2014, 31 children/youth entered; 19 children/youth graduated; and 3 children/youth disenrolled from the ITFC and MTFC programs. Furthermore, 13 TFC foster parents were newly-recruited; and 9 TFC foster parents left the programs. As of December 31, 2014, there are a total of 98 active TFC homes; and 80 children/youth placed in them. As of December 31, 2014, there were 18 certified homes at the end of the month that were not filled, 5 due to being on respite; 11 electing to take a break; and 2 being “on hold” pending investigations of allegations against them.

At the end of the current monitoring period, there are were 98 TFC beds and 80 children served, only four children higher than reported in the prior Panel report.

**Treatment Foster Care
July-December 2014**

Youths

Month	Youth in Program at end of month	Youths Entered	Youths Graduated	Youths Disenrolled
July 2014	69	1	6	1
August 2014	63	3	6	0
September 2014	62	3	4	0
October 2014	69	7	0	0
November 2014	72	7	2	1
December 2014	80	10	1	1
Total		31	19	3

Foster Parents

Month	Certified Homes at end of month	Certified FPs Gained	Certified FPs Lost
July 2014	95	2	1
August 2014	94	4	5
September 2014	92	0	2
October 2014	95	4	1
November 2014	96	1	0
December 2014	98	2	0
Total		13	9

DCFS does not report any new recruitment and retention strategies that would produce a growth in capacity which would lead to achievement of the 300 beds specified in the Corrective Action Plan.

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

DMH Training and Coaching

DMH Training

DMH reports the following about its Core Practice Model (CPM), Child-Family Teams (CFT), and Trauma Informed Practice (TIP) trainings:

DMH Trainings from June 1, 2014 to December 30, 2014

Training	Date of Training	Hosted by	Participants included:
Introduction to SCPM/ CFT/ ICC/ IHBS	6/4/2014	DMH CWD Staff	Pasadena DMH SFC Co-located Staff (SA 3)
Introduction to SCPM/ CFT/ ICC/ IHBS	6/10/2014	DMH CWD Staff	Vermont Corridor DMH SFC Co-located Staff (SA 6)
Shared Core Practice Model	7/9/2014	DMH Coaches	Children's Providers County Wide
Introduction to Child and Family Teaming	8/12/2014	DMH Coaches	Children's System of Care Admin Staff
Introduction to SCPM/ CFT/ ICC/ IHBS	8/20/2014	DMH CWD Staff	West Los Angeles DMH SFC Co-located Staff (SA 5)
Shared Core Practice Model	9/17/2015	DMH Coaches	Children's Providers County Wide
Shared Core Practice Model	9/24/2014	DMH Coaches	Children's Institute Mental Health Staff
Introduction to SCPM/ CFT/ ICC/ IHBS	9/30/2014	DMH CWD Staff	Service Area 7 DMH SFC Co-located Staff
Introduction to SCPM/ CFT/ ICC/ IHBS	10/2/2014	DMH Coaches	Service Area 4 DMH SFC Co-located Staff
Shared Core Practice Model	10/22/2014	DMH Coaches	Children's Providers County Wide
Introduction to SCPM/ CFT/ ICC/ IHBS	10/30/2014	DMH CWD Staff	Service Area 8 DMH SFC Co-located Staff
Introduction to Child and Family Teaming	11/12/2014	DMH Coaches	Children's System of Care Admin Staff
Trauma Informed Practice	11/13/2014	DMH CWD	Children's Providers County Wide
Introduction to SCPM/ CFT/ ICC/ IHBS	11/18/2014	DMH CWD Staff	Compton DMH SFC Co-located Staff (SA 6)
Introduction to SCPM/ CFT/ ICC/ IHBS	11/19/2014	DMH CWD Staff	Wateridge DMH SFC Co-located Staff (SA 6)
Introduction to SCPM/ CFT/ ICC/ IHBS	12/2/2014	DMH CWD Staff	Pomona, El Monte, Covina DMH SFC Co-located Staff
Shared Core Practice Model	12/3/2014	DMH Coaches	Children's Providers County Wide
Trauma Informed Practice	12/4/2014	DMH CWD	Children's Providers County Wide

DMH Coaching

DMH has three designated DMH coaches are working in conjunction with an external consultant to implement coaching, specifically with the Group Home providers, RCL 12-14 (See Table 1). This process is concentrated on developing Child and Family Team Meeting facilitation skills within group homes.

Table 1. From 6/2014 through 12/2014, four group homes have been trained in the CFT process in SA 3, 5, and 8. A total of 10 facilitators have been developed and 21 CFTs have been conducted.

SA	Group Home	Start Date	End Date
3	Five Acres	8/4/2014	8/21/2014
5	Vista Del Mar	6/9/2014	06/25/2014
8	Starview	9/22/2014	10/9/2014
8	Bayfront	11/3/2014	11/20/2014

The Los Angeles Training Consortium (LATC) has partnered with DMH to implement a county-wide coaching program. This program provides on-site coaching to LA County Wraparound providers to assess and strengthen fidelity. LATC completed coaching in targeted Service Areas (SA) 3, 6, and 8 (See Table 2).

Table 2. From June 2014 to December 2014, a total of 12 Wraparound providers were trained in the coaching modules. The modules include Coaching Overview; CFT Prep; Debriefing; Case Coaching; CFTM; and Booster sessions.

SA	Wraparound Provider	Start Date	End Date
3	Hillsides	6/5/14	8/19/14
3	Five Acres	6/11/14	6/11/14
3	Bienvenidos	6/12/14	6/18/14
3	D'Veal	6/13/14	6/13/14
3,6,8	Crittenton	6/13/14	12/10/14
3	Foothill	8/28/14	8/28/14
6,8	Children's Institute	6/9/14	8/11/14
6	Personal Involvement Ctr.	6/6/14	6/30/14
6	LA Child Guidance	7/11/14	8/26/14
8	Vista Del Mar	6/10/14	6/10/14
8	Bayfront	6/11/14	11/18/14
8	Masada Homes	11/7/14	11/7/14

DCFS Training and Coaching

DCFS is working with external consultants to implement the Core Practice Model. Most of the training and coaching focus has been on developing internal coaches for the Child and Family DCFS reports the following coaching activities for the period of July 1, 2014 through December 31, 2014:

- Since August 5, 2014, the reconfigured Central CPM Implementation Team continued coordinating and staging all aspects of overall CPM implementation during monthly meetings.
- To maintain ongoing and increased training capacity in all DCFS Regional Offices, Coaches were certified to provide in-office delivery of the CPM training modules. Modules included a specific focus on skill development in the formation and facilitation of CFTs to develop individualized plans to meet needs. Referred to as "just in time" training, these modules are delivered in relatively small groups, at office sites with participants who are specifically scheduled to participate in active CPM unit and field based coaching following training. CFTs serve as a primary but not exclusive environment where CPM skills are modeled and coached.
- Each DCFS Regional Office and the Sensitive Case Unit gained capacity to facilitate CFT Meetings.
- 8 out of 18 DCFS Regional Offices include certified CPM Coaches who can, in turn, certify SCSWs and CSWs in CPM practice through training, coaching and observation of the coach trainee's capacity to facilitate CFT meetings.
- 42 repurposed TDM Facilitators were certified in CPM practice as CFT Facilitators; and continue in the process of being certified as CFT Coaches.
- Newly-hired CSWs received training in CPM practice basics as part of the DCFS New Hire Training Academy. In the future, the DCFS New Hire Training Academy will include enhanced training on "underlying needs;" and will integrate increased CFT and CPM skill-based training into its curriculum.
- Refresher CPM training was provided to all SCSWs as part of the Introduction Session for the SCSW Training Academy.
- The QSR Tool was integrated within all CPM coaching and training as a point of reference for DCFS staff, families and teams.
- Due, in part, to the release of departmental performance goals, by June 30, 2015, each DCFS Regional Office projects having:
 - 100% of existing Coach Facilitators (formerly known as TDM facilitators) trained at the CPM Coach Developer level.
 - 50% of Emergency Response and Continuing Services SCSWs will be trained in CPM and CFT facilitation in order to coach, train and equip their CSWs. 50% of those will also be certified as Coaches in all aspects of the CPM.

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

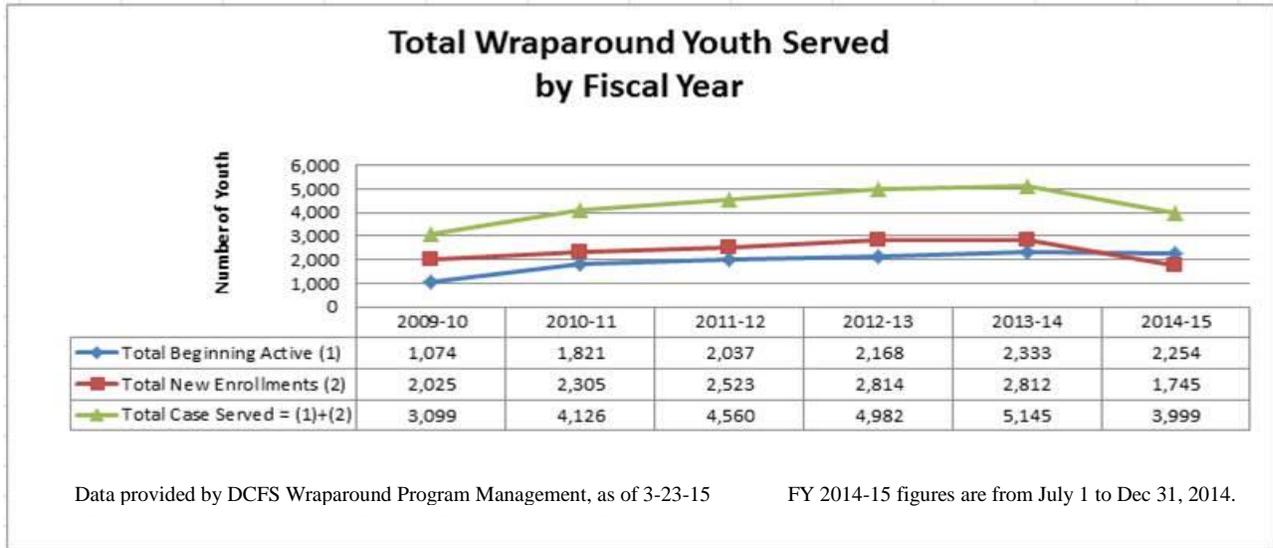
Because DCFS has replaced the TDM process with a focus on Child and Family Team process, using former TDM facilitators as coaches to broaden facilitation skills among more staff, updates are no longer provided. Descriptions of team meetings will be reflected in sections on CPM implementation and Qualitative Service Review performance.

Wraparound Services

According to the County, LA County has 34 Wraparound Service providers with 64 sites. Ninety-five percent of these agencies have full wraparound teams and continue working on increasing their capacity to serve a greater number of children/youth.

During the reporting period of July 1, 2014 through December 31, 2014 a total of 3,999 youth were provided Wraparound services.

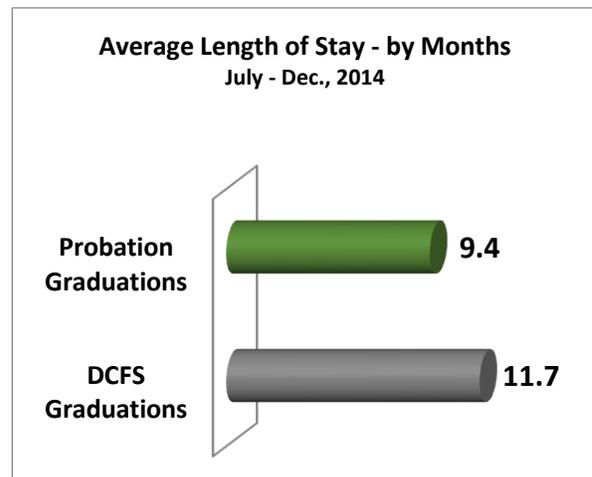
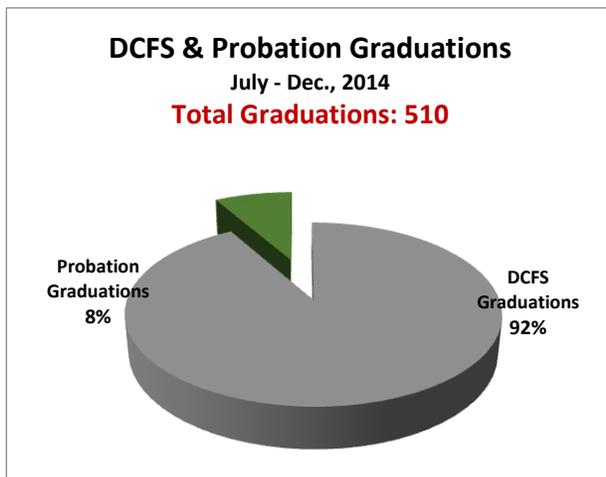
	2009-10	2010-11	2011-12	2012-13	2013-14	YTD 2014-15
By Fiscal Year						
<u>Beginning Active Cases</u>						
Tier I	1,033	1,043	967	885	899	793
Tier II	41	778	1,070	1,283	1,434	1,461
Total Beginning Active (1)	1,074	1,821	2,037	2,168	2,333	2,254
<u>New Enrollments</u>						
Tier I	1,040	1,070	1,048	1,091	1,061	639
Tier II	985	1,235	1,475	1,723	1,751	1,106
Total New Enrollments (2)	2,025	2,305	2,523	2,814	2,812	1,745
<u>Case Served</u>						
Tier I	2,073	2,113	2,015	1,976	1,960	1,432
Tier II	1,026	2,013	2,545	3,006	3,185	2,567
Total Case Served = (1)+(2)	3,099	4,126	4,560	4,982	5,145	3,999



During the period of July 1, 2014 through December 31, 2014 there was an average of ? ongoing Wraparound cases.

- Enrollments totaled 1,582 children/youth (for an average of 73 children/youth per week in Tier I, Tier II and AAP-Tier I Wrap);
- Terminations totaled 1,076 children/youth:
 - ✓ Graduations totaled 510 children/youth – 92% from DCFS and 8% from Probation;
 - ✓ Dis-enrollments totaled 566 children/youth - 81% from DCFS and 19% from Probation (please note graphs below for various dis-enrollment reasons).

Wraparound Graduations

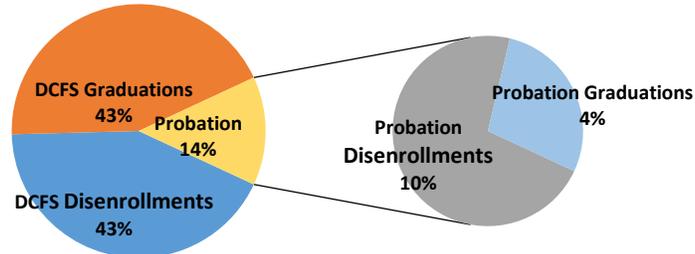


Wraparound Terminations

Wraparound Terminations

July - Dec., 2014

Total Disenrollments & Graduations: 1076
(566/53% Disenrollments & 510/47% Graduations)

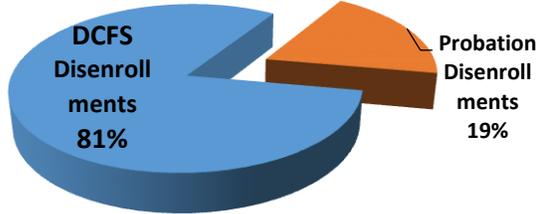


Wraparound Dis-enrollments

DCFS & Probation Disenrollments

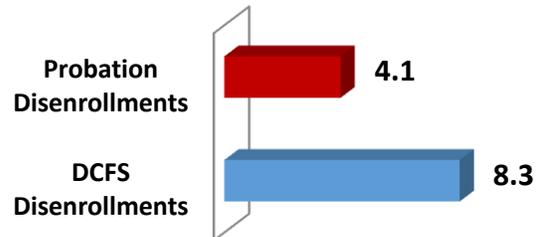
July - Dec., 2014

Total Disenrollments: 566



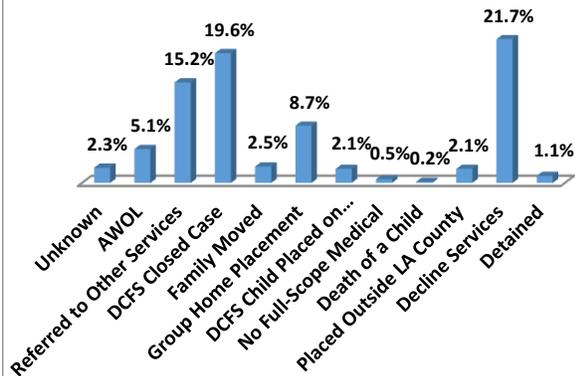
Average Length of Stay - by Months

July - Dec., 2014



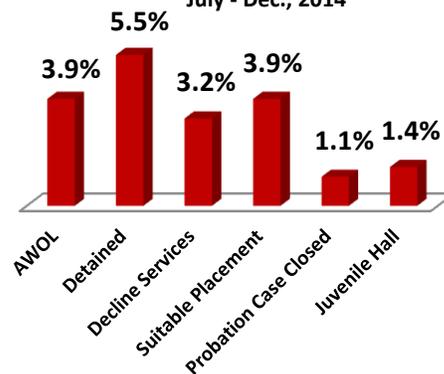
DCFS Disenrollments - by Justifications

July - Dec., 2014



Probation Disenrollments - by Justifications

July - Dec., 2014



These data show that disenrollments exceed graduations. While some disenrollments from LA County programs are unavoidable, such as a placement out of county, others raise questions about program quality and family engagement. These data suggest a need to better understand why children and youth are not completing their wraparound interventions.

Expansion of Wraparound

The County provided the following update on Wraparound expansion.

For the past two years, new wraparound enrollment rates have been the highest since the inception of the Wraparound program in 1996. Continued efforts to increase wraparound enrollment include:

- Reinstating a Management Appraisal and Performance Plan (MAPP) goal that includes a 25% increase in new enrollments to the Wraparound Program;
- Implementing an automated Wraparound Referral System enabling an easy and time-efficient referral process for social workers;
- Establishing an expedited Wraparound consent process, whereby Wraparound providers obtain written consents from families upon Inter-agency Screening Committee (ISC) case assignment.

New Wraparound Contracts

Forty-nine (49) agencies submitted proposals for new wraparound contracts which will be effective in May 2015. The County states that the first year of the new contracts will be a “Transitional Year,” during which contractors can receive a higher case rate, up to 50% of their service costs. Recent analysis revealed that Wraparound agencies, as a group, are claiming approximately 50% of their costs to EPSDT and 50% to case rate. Some Wraparound agencies are outliers in this regard, claiming a larger proportion than 50% of their costs to their case rate dollars. Over the course of the next several months, DMH and DCFS plan 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 first year of the new Wraparound contracts. In so doing, the County expects an increase in clinical services thereby maximizing their EPSDT funding allotment by the second year of the new contract.

Placement of Children and Youth in Group Homes and Residential Facilities

As requested, the County has provided the Panel data regarding the entries and exits into congregate care. Between July and November 2014, the number of group home entries exceeded group home exits. In December 2014, the trend reversed, in that, more children exited than entered group homes. The County continues to rely on group home placements most frequently due to the inadequacy of appropriate foster and therapeutic foster home resources. The below chart details the monthly entry/exit data for group homes.

Group Home Placements July- December 2014						
Month	July	August	September	October	November	December
Entries	307	240	273	299	235	226
Exits	292	238	262	294	233	231
Variance	+16	+2	+11	+5	+2	-6

The County states that during the previous reporting period of January 2014 through June 2014, the County’s reliance on Emergency Shelter Care (ESC) group home placements increased, from 100 to 255. During the current reporting period of July 2014 through December 2014, the County’s reliance on ESC Group Home placements remained steady, ranging from 73 to 113 with an average of 98 youth residing in ESC Group Homes per month. In December 2014, only 73 children/youth were placed in ESC Group Homes. The below chart itemizes and trends of the use of Medical Facility and Emergency Shelter Group Home placements.

Sum of CNT	LENGTH_OF_STAY			Grand Total
	Within 6 Months	6 - 12 Months	Over 12 Months	
AGE_GROUP				
13-17	483	176	129	788
18 Plus	50	26	58	134
Grand Total	533	202	187	922

Source: CWS/CMS History Database

NOTE:

1. Data reflect non-MCMS children who were in a non-ESC Group Home placement as of 12/31/2014.
2. Length of Stay is based on the number of months from the placement start date in the current group home up to December 31, 2014.

13-17

- 61.3% stayed between 0-6 months;
- 22.3% stayed between 6-12 months; and
- 16.3% stayed over one year.

18+

- 37.3% stayed between 0-6 months;
- 19.4% stayed between 6-12 months; and
- 43.3% stayed over one year.

Group Home Utilization
Monthly Group Home Census - Emergency Shelter Care vs. Non-Emergency Shelter Care
(Excluding Adoptive, Guardian Home, and Non-Foster Care Placement)
July 2014 to December 2014

Office	Age Group	7/31/2014		Jul '14 Total	8/31/2014		Aug '14 Total	9/30/2014		Sep '14 Total	10/31/2014		Oct '14 Total	11/30/2014		Nov '14 Total	12/31/2014		Dec '14 Total
		ESC			ESC			ESC			ESC			ESC					
		Yes	No		Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
MCMS	0-12		9	9		11	11		10	10		10	10		9	9		8	8
	13-17		29	29		30	30		30	30		29	29		29	29		23	23
	18 Plus		7	7		7	7		9	9		9	9		10	10		10	10
MCMS Total			45	45		48	48		49	49		48	48		48	48		41	41
Other	0-12	26	68	94	38	69	107	48	66	114	36	73	109	43	73	116	42	63	105
	13-17	70	767	837	61	770	831	55	746	801	66	763	829	39	799	838	26	788	814
	18 Plus	4	129	133	7	127	134	10	128	138	5	132	137	6	133	139	5	134	139
Other Total		100	964	1,064	106	966	1,072	113	940	1,053	107	968	1,075	88	1,005	1,093	73	985	1,058
TOTAL GH Census		100	1,009	1,109	106	1,014	1,120	113	989	1,102	107	1,016	1,123	88	1,053	1,141	73	1,026	1,099

Source: CWS/CMS History Database

Number of Children residing in Group Homes

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 emergent basis, until placements that meet their needs are located.

Placement of Young Children in Group Homes (Ages 0-12)

The County reports that during the period of July 1, 2014 through December 31, 2014, group home placements for what the County calls “therapeutic stabilization” of (Non-MCMS and Non-ESC) children, ages 12 and under, averaged 69 children per month (a low of 63 and a high of 73 children each month), with a significant majority of those placements lasting six months or less. However, group homes as emergency temporary shelter (30 days or less) for children in this age range increased to an average of 39 children per month (a low of 26 and a high of 48 children). The ages of young children in both group homes and emergency temporary shelter ranged from ages 7 to 12.9 years.

As of December 2014, lengths-of-stay for young children placed in group homes for therapeutic stabilization follow:

- 46% stayed between 0-6 months;
- 26% stayed between 6-12 months; and
- 28% stayed over one year.

During the second half of 2014, there were several DCFS policy updates regarding group home use prompted by the State’s efforts to reduce the use of congregate care and reduce the duration of congregate care placements. These changes require case reviews for all youth in group home placement in excess of 365 days (including multiple group home placements); as well as additional court reporting requirements for the placement of youth six years or younger in group home care.

The court requires DCFS to document the reasons supporting a group home placement for a young child. In addition to these efforts, the County states that senior managers in the Department continually discourage the use of congregate care.

Placement of Children in Group Homes (Ages 13-17 ½)

According to the County, as demonstrated in the chart above, during the period of July 1, 2014 through December 31, 2014, which is the current monitoring period, children in this age range are the highest population served by group home placements for therapeutic stabilization (Non-MCMS and Non-ESC). During the previous reporting period a monthly average of 837 children resided in Group Homes. During the current reporting period a monthly average of 772 children resided in Group Homes (a low of 746 and a high of 799). This reporting period also included a significant reduction in the reliance on ESC Group Home use as emergency temporary shelter (30 days or less). In June 2014, the ESC Group Home census was 211. In July 2014, the ESC group home census was down to 70, representing a 66% decrease. During this reporting period, the average monthly ESC Group Home census for children ages 13-17 is 53.

Placement of Non-Minor Dependents in Group Homes (Ages 18 +)

The County re-ports that during the period of July 1, 2014 through December 31, 2014, the census of Non-Minor Dependents (NMDs) residing in Group Homes for therapeutic stabilization (Non-MCMS and Non-ESC) increased from an average of 116 to 130 (a low of 127 and a high of 134) per month. Youth who turn 18 and remain under DCFS supervision as well as NMDs who elect to return to DCFS supervision are included in this population. Also during this reporting period there was a 50% reduction in reliance on ESC Group Homes for this age group of dependents. During the previous reporting period, the average monthly ESC Group Home census was 12. During this reporting period, the average monthly ESC Group Home census was 6, representing a 50% reduction.

Qualitative Service Reviews (QSR)

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.

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 was completed at the end of October 2014, with the scores finalized in December 2014. (The third cycle has been scheduled to begin in February 2015.)

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 all 18 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 Torrance, West LA, South County, and Palmdale offices were reviewed during the July-December 2014 monitoring period. QSR Scores for the past 12 months are identified in the following chart.

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

Office	Safety Overall	Stability	Permanency	Living Arrangements	Health	Emotional Well Being	Learning & Development	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
Belvedere	100%	83%	92%	100%	100%	92%	75%	57%	100%	67%	100%
Santa Fe Springs	92%	83%	58%	100%	100%	83%	75%	50%	100%	67%	83%
Compton	92%	67%	67%	92%	100%	83%	67%	63%	100%	38%	75%
Vermont Corridor	100%	91%	82%	100%	91%	100%	64%	60%	100%	88%	100%
Wateridge	92%	75%	75%	83%	100%	75%	67%	38%	90%	78%	83%
Pomona	100%	91%	80%	100%	100%	73%	82%	86%	100%	71%	100%
Glendora	90%	80%	60%	90%	80%	70%	90%	50%	88%	75%	90%
El Monte	100%	80%	80%	100%	100%	90%	70%	100%	100%	88%	90%
San Fernando Valley	100%	89%	56%	100%	100%	78%	78%	40%	100%	67%	78%
Lancaster	100%	63%	50%	100%	100%	63%	88%	43%	100%	67%	88%
Metro North	89%	78%	78%	89%	89%	78%	78%	40%	100%	67%	89%
Pasadena	67%	89%	56%	100%	89%	67%	56%	50%	100%	67%	78%
Santa Clarita	78%	56%	67%	89%	78%	67%	67%	50%	86%	71%	78%
Torrance	90%	70%	40%	100%	100%	90%	70%	29%	100%	67%	80%
West LA	90%	100%	80%	100%	100%	90%	60%	57%	100%	71%	80%
South County	90%	90%	60%	100%	80%	90%	70%	71%	100%	75%	90%
Palmdale	90%	90%	40%	80%	80%	60%	60%	43%	100%	43%	60%
Overall	92%	81%	66%	95%	94%	80%	71%	55%	98%	69%	85%

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

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

<u>Office</u>	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

Office	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Belvedere	92%	64%	33%	58%	67%	50%	67%	55%	58%	67%
Santa Fe Springs	75%	67%	8%	50%	50%	42%	67%	58%	50%	58%
Compton	75%	67%	17%	42%	50%	50%	58%	58%	50%	58%
Vermont Corridor	55%	45%	9%	36%	55%	27%	36%	36%	27%	45%
Wateridge	58%	75%	58%	67%	67%	75%	58%	58%	50%	58%
Pomona	91%	73%	55%	45%	64%	64%	73%	55%	55%	73%
Glendora	80%	70%	40%	70%	60%	60%	70%	70%	40%	60%
El Monte	90%	70%	20%	70%	60%	50%	70%	70%	50%	60%
San Fernando Valley	89%	56%	22%	33%	44%	56%	78%	67%	78%	56%
Lancaster	88%	75%	25%	50%	50%	38%	63%	50%	50%	50%
Metro North	100%	78%	11%	44%	56%	44%	44%	22%	22%	33%
Pasadena	78%	67%	22%	33%	44%	56%	44%	44%	33%	33%
Santa Clarita	44%	67%	11%	33%	56%	44%	89%	56%	44%	44%
Torrance	50%	50%	30%	40%	20%	30%	60%	50%	30%	30%
West LA	70%	70%	20%	30%	50%	30%	60%	60%	40%	50%
South County	50%	50%	20%	40%	20%	30%	70%	60%	40%	50%
Palmdale	70%	50%	20%	30%	40%	30%	50%	30%	20%	30%
Overall	74%	64%	25%	46%	51%	46%	62%	53%	44%	51%

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 Practice Scores, comparing between the baseline and the 2nd cycle, system performance improved in the following indicators: Engagement, Voice & Choice, Teamwork, and Long-Term View. In Overall Practice, scores improved modestly from 47% in the baseline to 51% in the second cycle. The most significant gains were witnessed in the practices of Engagement, Voice & Choice, and Long-Term View, which improved during the 2nd cycle by 17%, 12%, and 12% respectively. Although Teamwork practice improved from 18% to 25% acceptable, it continues to be the lagging indicator.

While these modest gains show improvement, performance shows that:

- 43% of children are not making acceptable progress toward permanency
- 30 % do not have acceptable well-being (which is largely a mental health measure)
- 39% of families are not making acceptable progress toward adequate functioning
- 75% of children do not have a functioning family team
- 54 % of cases do not have an adequate assessment
- 61% of cases do not have a long-term view of child and family goals and strategies
- 69% of cases do not have plans adequate for achievement of agency goals
- 55% of cases are not adequately tracked toward achievement of goals

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 March 11, 2015 provides the progress of all SPAs for the FY 2014–2015, from July 1, 2014 through March 11, 2015. This report reflects CSAT Performance based on data entries made through March 11, 2015. It 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, 2014 through March 11, 2015.

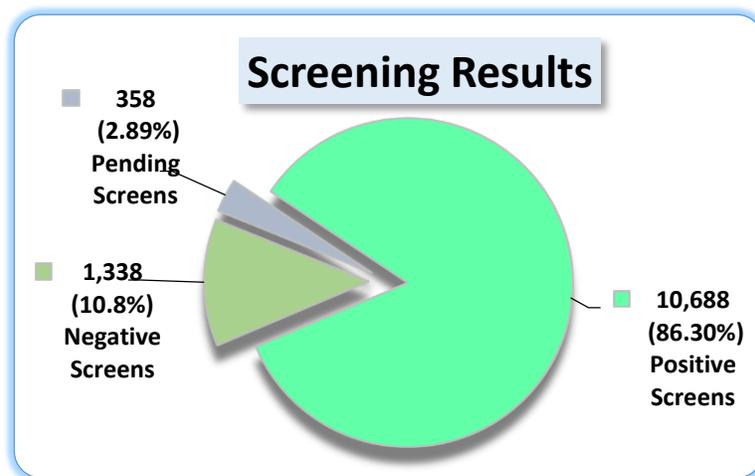


Chart I shows that of 12,658 children, 12,384 children required screens. (12,658 minus those currently receiving mental health services [8¹], in closed cases [217], who ran away or were abducted [49]):

Of the 12,384 children who required screens:

- 10,688 (86.30%) children screened positive of all children requiring screens;
- 1,338 (10.8%) children screened negative of all children requiring screens;
- 358 (2.8%) children have screens pending of all children requiring screens.

¹ The total number of children in all tracks currently receiving mental health services is 100. However, only children in existing cases (track 3 [8]) are subtracted from the total number of children requiring screens because all children in new cases (track 1 [16] and track 2 [76]) must be screened whether or not they are already receiving mental health services.

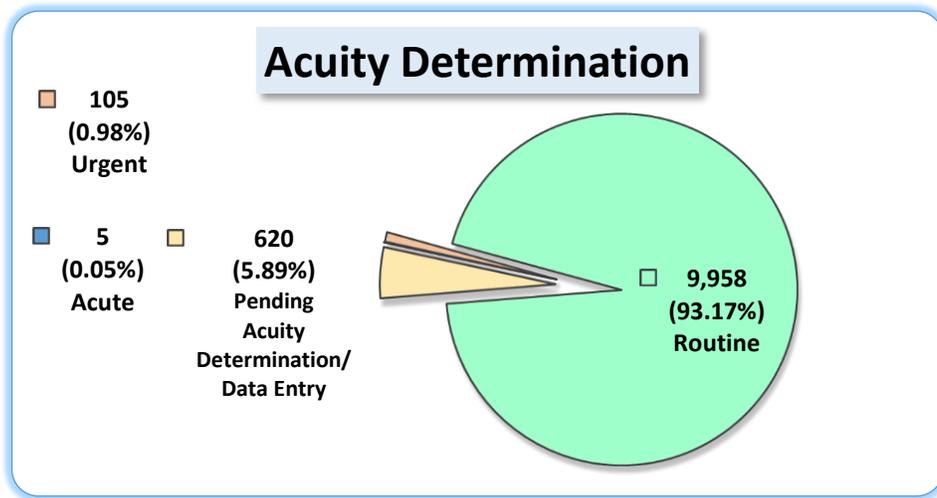


Chart II shows that of the 18,801 children who screened positive:

- 5 (0.05%) children were determined to have acute needs;
- 105 (0.98%) children were determined to have urgent needs;
- 9,958 (93.17%) children were determined to have routine needs;
- 620 (5.89%) 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 the first 9 months of FY 2014-2015 as of March 11, 2015:

- 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.
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Urgent	Children presenting with urgent needs begin receiving mental health service activities within no more than three days of the referral.
Routine	Children presenting with routine needs begin receiving mental health service activities within no more than thirty days of the referral.

The average number of days between referral to and receipt of a mental health activity according to acuity for the first 9 months of FY 2014-2015 as of March 11, 2015:

- 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 3 days of the referral, on average.

The rate of children that received a mental health activity with required timeframes according to acuity for the first 9 months of FY 2014-2015 as of March 11, 2015:

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

CSAT MH Screening Performance

As of March 11, 2015, for children served in the first 9 months of FY 2014-2015, the average timeline from case opening/case plan update to the start of mental health service activities is 14 days (an activity does not necessarily mean treatment).

- 97.11 percent of children who were eligible for screening were screened for mental health needs;
 - 97.48 percent of children who screened positive were referred to mental health services; and
 - 94.90 percent of children referred for services received mental health service activities within the required timelines.
- During this review period MAT Assessors in all 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.

County MAT Update

At the time of the completion of the prior Panel Report, 100 percent of newly detained children were referred for a MAT Assessment. During this reporting period, 99.27 percent of newly detained children were referred to the various 51 MAT assessment agencies throughout Los Angeles County. From July 2014 through December 2014, there were 2877 MAT referrals and 2305 MAT assessments completed. Of those referred, approximately 20 percent were not completed, compared to 15 percent reported not completed in the prior monitoring report. MAT referrals by SPA are listed below.

Table 1: MAT Compliance Dec 2014	MAT Eligible	MAT Referred	Percent
SPA 1	46	46	100
SPA 2	57	57	100
SPA 3	55	55	100
SPA 4	42	42	100
SPA 5	7	7	100
SPA 6	94	94	100
SPA 7	73	73	100
SPA 8	50	50	100
Total number of DCFS MAT referrals:	424	424	100

MAT Timelines

From Jul-Dec 2014, the average timeline from MAT referral acceptance to completion of the final Summary of Findings (SOF) report was 46 days, a few days less than reported in the prior panel report. Approximately 55 percent were completed in 45 days or less, 74 percent were completed by the 50th day and 91 percent were completed by the 60th day.

As indicated above, approximately 20 percent of children referred to MAT did not have completed assessments as of the end of December 2014. Of this 20 percent, 13 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 7 percent were initially referred to MAT, but did not have completed assessments.

The Panel reviewed a sample of 19 MAT SOF reports, one from each DCFS office and 19 different MAT providers. The SOF meetings was convened between March 11, 2014 thru

May 2, 2014 the children ranged in ages from 3-17 at the time of the MAT SOF report. The MAT Study findings were discussed at the Katie A. Panel Retreat on March 5, 2015.

Summary of MAT Study

One MAT case from each of the 19 DCFS offices were studied. The MAT assessments were completed by 19 different providers, and the MAT SOF meetings were convened between 3/11/14-5/2/14 (the children had been removed from their families in January and February, 2014). DCFS and DMH staff collected the following on each of the 19 MAT Study cases: MAT Assessment, DCFS Detention Report, most recent DCFS court report (usually the Jurisdiction/Disposition Report), placement history, team meeting information from the CSW, mental health service information, DMH Provider assessment, Client Care Coordination Plans, and Discharge Summary (if discharged).

Since the previous MAT Study, MAT assessors have improved in listing strengths and needs. Both parent and child strengths are described at the beginning of MAT assessments. MAT assessments have a paragraph describing the child's trauma history. Examples of in-depth trauma histories from MAT assessments were given, as well as guidance for future MAT assessments to review thoroughly a range of trauma in the life of the child, connect the trauma to the child's feelings and behaviors, and suggest how caretakers can respond to trauma-related feelings and behaviors in this child. MAT assessments have a section typically listing three needs of the child. MAT assessors have been trained to identify underlying needs which is a challenge because children's behaviors are the focus of families, other caregivers, teachers and service providers. In the past there was a tendency to jump to a service to "fix" a child's problem behavior without considering the need driving it. Instead, MAT assessors ask questions such as "What is the child telling us about his/her needs with this behavior?" or "What is the need behind this behavior?" which then allows the design of more effective supports and services. Examples of strong needs in the studied MAT cases were given, along with guidance to MAT assessors to list needs that are: specific, not adult imperatives, not services disguised as needs, not in jargon, recognize the effects of trauma on behavior, and reflect voice and choice for the youth and family. The study suggested that MAT assessors identify supports are services that are likely to be effective in meeting each of the child's needs.

In the majority of the 19 studied children, there had been no Child and Family Team meeting (or Wrap family meeting or TDM) in the six months since the MAT Summary of Findings meeting. One of the goals of the MAT assessment is to use the MAT findings to encourage the important individuals in the child's life to have a shared understanding of the child's needs and commit to steps each one will take to meet those needs. This initiates the team for the child and family, and even if some participants will be replaced by others as services are put in place, the benefits of teaming will motivate them to have another team meeting after the MAT meeting. Teaming is a key component of the Core Practice Model and is a focus of training and coaching of DCFS and DMH staff. The MAT Study recommended that DCFS and DMH change the MAT Summary of Findings meeting into the first Child and Family Team meeting.

After the MAT assessment, 13 of the 19 MAT Study cases received mental health services including individual therapy, family therapy, individual rehabilitation services and/or TBS and these are summarized here. Two MAT Study cases received intensive services after the MAT assessment (with claiming documented in the DMH information system). Three other MAT Study cases received considerable mental health services after the MAT assessment. Only five MAT

Study cases received three or more individual therapy sessions per month for several months. Five of the 19 MAT Study cases received no DMH services after the MAT assessment and an additional one received only a one-time mental health service.

Six of the 19 children in the MAT Study had one placement and seven were placed with family within several months of removal. The MAT Study recommended that DCFS and DMH staff receive coaching to ensure that multiple placements in a short period of time result in an intensification of services.

The MAT Study also recommended that DCFS court reports should be an example of the Core Practice Model and be strengths- and needs-based, DCFS reports to the court after the detention hearing should present the child's needs, strengths, trauma history and proposed services and supports from the MAT assessment (since MAT Summary of Findings meetings are occurring within two months of the child's placement), and DMH Provider Client Care Coordination Plans should be consistent with the Core Practice Model and be strengths- and needs-based with specific trauma-related needs and services to meet them.

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. The County through the partnership between the Departments of Children and Family Services, Health Services and Mental Health, continues to implement efforts to ensure that newly detained children are referred and served by the Medical Hubs. The County provided the following update:

For the current reporting period of July 1, 2014 to December 31, 2014, the County continues to report that 88% of newly-detained children are being referred to a Medical Hub for an Initial Medical Examination. There were 2,368 Medical Hub Referrals submitted from July 1, 2014 to December 31, 2014. Based on a recent data run and analysis, out of 2,368 Medical Hub Referrals submitted, 845 were for children ages 0-3 and 1,523 were for children age 3 and older. The average length of time for submission of a Medical Hub Referral for children 0 to 3 year olds was 24 calendar days. The average length of referral time for children between 4 to 18 years of age was 24 business days. Current DCFS policy is that the Medical Hub Referral is to be submitted within 3 calendar days of the child's initial placement, for children under 3 years of age. For children above 3 years of age, the Medical Hub Referral is to be submitted within 5 business days of the child's placement.

Los Angeles County Staffing

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	58
D-Rate	12
Service Area 1	28
Service Area 2	24
Service Area 3	33
Service Area 4	17
Service Area 5	4
Service Area 6	81
Service Area 7	39
Service Area 8	22
MHSA	3

The total staffing level has increased to two additional staff from the last Panel report.

DCFS Staffing: 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 (July)	13,551	13,328	20,726
2014 (December)	12,896	13,112	20,809

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); then, increased from 17.82 to 18.7 (from FY 13-14 to July-December 2014).

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); then, decreased from 30.64 to 29.3 (FY 13-14 from July-December 2014).

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.

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.

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

Emergency Response caseloads rose from an average 17.86 cases to 18.7 in the current reporting period. Generic caseloads decreased slightly from an average 30.64 cases to 29.3. In actual front-line practice, Generic caseloads can be considerably above 30, making it extremely difficult for staff to engage in practice consistent with the Core Practice Model. Currently, high caseloads are a major barrier to implementing the Core Practice Model.

Treatment Foster Care (TFC)

The County has not added any more TFC bed capacity since the last report and at the end of the current monitoring period, increased the number served by only four children. The County seems to have no plan for increasing capacity at this point.

Expansion of Home-Based Mental Health Services

The County has made gains in expanding intensive home-based mental health services through Wraparound expansion and its new Intensive Field Capable Clinical Services (IFCCS) program. The County is now seeking additional funds to expand IFCCS. There is also growth in the incidence of ICC and IHBS, as defined in the State Katie A. Settlement. However, the Panel believes that a considerable portion of this growth is through increased claiming rather than through actual practice change as envisioned by the State's practice model. A considerable portion of the provider community's practice remains as traditional office based practice, with little use of the Child and Family Team process outside of specialized programs like Wraparound and IFCCS.

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 currently focused on developing former TDM facilitators as coaches, who will coach local supervisors. The local supervisory will have the primary responsibility for coaching CSWs. 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. DMH does have hopes of getting approval for adding additional CFR coaches. The County's QSR Practice Performance scores, below, reflect the gradual progress in improving Core Practice Model performance.

QSR Baseline Practice Indicators – Percent Acceptable

	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Overall 2011-2012	60%	52%	18%	50%	39%	41%	66%	52%	45%	47%
Overall 2012-2013	74%	64%	25%	46%	51%	46%	62%	53%	44%	51%

Use of Short-Term Shelter Placements and Foster Family Recruitment

While the use of group home settings as emergency shelter settings for dependent children has declined somewhat, the County has a continuing reliance on it. Use of these undesirable settings as an emergency shelter resource is further evidence that the County is unable to adequately expand family foster care to meet the needs of class members. The Panel is unaware of any further strategies by the County that are likely to solve this problem.

V. Recommendations

Workload

DCFS continues to experience high workloads, despite the hiring of additional staff. The County states that the slow development process of hiring and training the additional approximately 700 staff authorized by the Board has delayed the anticipated reduction in workloads. The Panel asks that the County provide a report of the impact on caseloads of new staff being fully productive in the field.

Expansion of Intensive Home-Based Mental Health Services

The Panel strongly supports the expansion of IFCCS. New strategies are needed to expand Treatment Foster Care. The Panel will schedule a call with the County to explore plans to fully comply with this provision of the Corrective Action Plan.

DCFS and DMH Training and Coaching

The current DMH limited coaching capacity and strategy are not significantly expanding the use of Core Practice Model approaches outside of specialized programs. DMH is hoping to expand the number of coaches to approximately 20 staff, if funding can be found; however the County needs to develop a plan to extend coaching to the broader DMH and provider work force.

Family Foster Home Recruitment

The Panel is unaware of any further DCFS efforts to expand the number of urgently needed family foster homes.

Katie A. Implementation

During this monitoring period the County and plaintiffs began a discussion about what the parties agreed was a slowing of implementation progress. During the First Reporting Period of 2015, January – June, 2015, these discussions continued, also involving the Panel. The status of these discussions, which were extensive and promising, will be described more fully in the next monitoring report.

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.

DCFS – Department of Children and Family Services

DMH – Department of Mental Health

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

ER – Emergency response

ESC – Emergency Shelter Care

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

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

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

FGDM – Family Group Decision Making

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

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

IEP – Individual Education Plan

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

IFCCS - Intensive Field Capable Clinical Services – phase one of the county’s implementation of ICC and IHBS. Target population is youth who are in DCFS’ Emergency Response Command Post, Exodus Recovery Urgent Care Center, discharging from a psychiatric hospitalization, or had a response by Field Response Operations or PMRT without a psychiatric hospitalization.

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

MAT – Multi-Disciplinary Assessment Team

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

PTSD – Post-traumatic stress disorder

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

RPRT – Regional Permanency Review Teams

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

TAY – Transitional Age Youth

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

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