

**The Katie A. Advisory Panel  
Report to the Court  
First Reporting Period of 2011  
March 26, 2011**

**The Katie A. Advisory Panel  
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## **Executive Summary**

In reviewing the County's performance relative to Katie A. implementation expectations, the Panel has observed a number of areas where progress is occurring. These include:

- Strong collaborative leadership by the management teams of DCFS and DMH – In fact the cross-system collaboration is the strongest in the Panel's experience
- Development of Multidisciplinary Assessment Teams (MAT), where 83% of MAT eligible newly detained children are referred for a MAT
- For 2009-2010, 80% of newly detained children received an initial medical examination at a Medical Hub
- Relative to mental health screening, of 923 children in new and open cases, children requiring screens were screened at a 95% screening rate
- Also related to screening, of the children who were screened and referred for mental health services, 96% received a mental health activity
- The County is ahead of schedule implementing Tier Two Wraparound (Wraparound for less intensive cases) serving 1325 children in November 2010
- The County is implementing the Qualitative Service Review (QSR) effectively, having now reviewed five offices
- DCFS and DMH have worked together in an exemplary fashion to integrate child welfare staff and mental health staff into QSR review teams

### **Challenges**

Clearly the County is making progress in implementing Katie A. provisions and the accomplishments cited above are noteworthy and commendable. However, there are remaining challenges that need to be addressed that the Panel and parties continue to work on collaboratively. The Panel and County plan to devote the majority of time in the March 2011 Panel meeting to strengthening County plans in the areas outlined below.

#### ***Home-Based Service Expansion***

Most services mental health services continue to be delivered in office based settings and the County has not yet developed a comprehensive strategy for building provider capacity to deliver home-based mental health services.

### ***Treatment Foster Care***

Although the Corrective Action Plan ordered by the court sets the expectation for development of 300 treatment foster care homes, to date the County has only developed 76 certified homes with 51 children in placement.

### ***Medical Hubs***

While the County's recent performance rate of 80% of newly detained children receiving an initial medical examination at a Medical Hub does represent a consistent achievement, it falls short of the County's goal of 100% - additional work is needed to ensure that the remaining 20% of children are properly medically assessed.

### ***Children in Group Care***

The number of children placed in group care is growing, from 100 in 2009 to 163 currently, in spite of expansion of Tier Two Wraparound and Wraparound vacancies.

### ***Training and Coaching***

The Panel continues to have concern about the scope and intensity of the County's strategy for preparing staff to practice consistent with the LA Practice Model. Both training and coaching capacity (meaning developing coaches and supervisors who can show DCFS and DMH staff how to employ new practice by modeling practice in actual cases) are not adequate to meaningfully change practice. The degree to which additional effort in the area is needed is clearly revealed by QSR findings, which the Panel will present in its next report.

## **Panel Recommendations**

### ***1. Training and Coaching***

The County has a well-articulated and ambitious Practice Model, has begun introductory training of staff in the practice model and with the implementation of the Qualitative Service Review, is identifying the areas of practice that need strengthening to achieve the objectives of the decree. However, there is not yet a detailed formal plan for strengthening practice. The County does face challenges in this regard. Los Angeles County is one of the largest systems in the Country with approximately 35,000 children in-home and out-of-home. DCFS alone has 2,276 case carrying staff and the mental health provider community is large as well. The County has few trainers and mentors yet capable of developing practice capacity. So improving front-line practice quality and outcomes will be a multi-year process.

Understanding the challenge provided by the system's scale and limited capacity, the Panel has a concrete recommendation. Because the County cannot yet support a broad implementation effort across multiple regions simultaneously, the County should select one or a few promising offices in terms of leadership quality and current performance and begin intensive training and coaching

in one site. The process will permit the development of additional trainers and coaches who can observe initial training and coaching, master the needed skills and begin the process in an additional office. The multiplying expansion of available training and coaching capacity as each new office is developed can speed the creation of internal resources needed to address practice across the entire system. Put simply, the Panel's advice is to start somewhere.

## ***2. Development of Treatment Foster Care Beds***

The County should quickly complete its recruitment strategy, including removing the requirement for dual adoption and foster care certification of providers, to make this critical family based therapeutic alternative to group care available to class members.

## ***3. Availability of Home-Based Mental Health Services***

The County should develop a specific strategy for transitioning providers from reliance on low-intensity office based mental health services to the provision of home-based mental health services with greater frequency. This plan should be linked to the strategy for training and coaching, since the child and family plan should govern the type of mental health services provided, their intensity and the setting in which they are provided.

There is value to central office analysis of data regarding mental health services received by children in care on a regular basis. An analysis of services delivered in the four intensive programs and outpatient service by frequency and service *by provider* would also be useful. In addition, more analysis of information about the mental health services being delivered to other class members is warranted. There are children with significant mental health needs who are residing with relatives or in group care (not in FFAs or D-Rate homes) for whom a similar analysis should be done. The Panel would like to explore this further in its upcoming meeting with the County.

## ***4. Medical Hubs***

The Panel requests that the County provide additional information about what would be required to significantly increase the percent of newly detained children receiving an initial examination at a Hub.

## ***5. Children in Group Care Settings***

The County should assess why the number of children in group homes is rising and provide a plan to more appropriately place children in home-based settings. This may need to include attention to Wraparound vacancies and the lack of treatment foster homes as well.

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**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. Background**

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

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

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

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

- o immediately address the service and permanence needs of the five named plaintiffs;
- o improve the consistency of DCFS decision making through the implementation of Structured Decision Making;

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

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

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

Additionally, the Settlement directs that:

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

The Department prepared a Joint DCFS/DMH Mental Health Plan to describe its strategy for implementing the provisions of the settlement agreement. The Panel and plaintiffs identified issues in the Plan they believed needed additional attention and in a subsequent court hearing, plaintiffs and defendants proposed submitting a joint finding of facts that would identify areas of agreement and disagreement. The court issued an order directing the County to revise its plan and submit the revision for review. That Corrective Action

Plan was completed and provided to the Court. In subsequent discussions with the Panel, the County concluded that additional strategies were necessary to achieve the objectives for the plaintiff class and committed to developing an overarching Strategic Plan that would address remaining system design needs. The County has now completed its Strategic Plan and received County Board approval for implementation.

### **III. Panel Activities Since the Last Report**

Since the last report the Panel has met twice with County staff about emerging issues including:

- Provision of training and coaching to DCFS and DMH staff (including discussions with CIMH)
- Delivery of mental health services to children in FFAs and D-Rate Homes
- Exit conditions for the QSR process
- Strategies for expansion of Treatment Foster Care
- Expansion of home-based mental health services
- Encouraging the use of findings in cases reviewed in the QSR for guiding improvements in practice
- Children in DCFS custody placed out of county
- The case rate and Medicaid utilization

Panel members have also participated in several week-long Qualitative Service Reviews.

### **IV. Current Implementation Plan Status**

#### **Co-location of DCFS and DMH Staff**

The County reports that all 81 Katie A. positions have been filled. Of the 316 positions allocated to DMH to support Katie A. related activities, 96 per cent are filled.

#### **Additional staffing for the DMH ACCESS Hotline**

The DMH Access Center was designed to respond to calls from DCFS staff and the public regarding mental health services for children served by DCFS. The County has found it difficult to recruit hotline staff to the three allocated positions due to evening and weekend work assignments. Experience has also proven that demand does not necessitate filling all three positions, so only one position has been filled for this function. The County believes that the single position is adequate.

#### **Selection by DMH and DCFS of Selected Performance Indicators to be Tracked**

The parties have agreed upon the outcome and Qualitative Service Review (QSR) indicators that will be used to measure performance. Those outcome indicators and relevant performance targets have previously been identified to the court. The parties expect to have agreement on performance targets for the Qualitative Service Review by the end of April 2011.

## Development of Multidisciplinary Assessment Teams (MAT)

In January 2011, 91 percent of all newly eligible detained children were referred for a MAT assessment. In the Panel’s prior 2010 report, 83 percent of eligible newly detained children were referred. The County’s goal is a 100 percent referral rate. The performance of individual Service Planning Areas for September 2010 is reflected in the following table.

<b>Table 2: MAT Compliance</b>	<b>MAT Eligible</b>	<b>MAT Referred</b>	<b>Percent</b>
SPA 1	41	31	76%
SPA 2	91	77	85%
SPA 3	116	100	86%
SPA 4	24	23	96%
SPA 5	13	13	100%
SPA 6	107	78	73%
SPA 7	55	49	89%
SPA 8	61	52	85%
Total number of DCFS MAT referrals:	<b>508</b>	<b>423</b>	<b>83%</b>

\*Cumulative includes all September 2010 MAT referrals within each DCFS office and SPA.

This high referral rate is commendable and reflects improvement over the past six months. While referral rates are high, QSR results and small reviews by the Panel reveal that the assessments are generally service based, (i.e. youth needs mental health counseling) rather than needs based (which would describe the causes of the need for mental health services) and child and family plans are frequently not individualized. The County has begun to address this challenge by providing some training and revising its written guidance to MAT providers; however substantial work remains in changing the practice culture within DCFS and the mental health provider community.

## Implementation of the DMH Behavioral Health Information System (IBHIS)

The County provided the following specific update relative to IBHIS. This explanation was also provided to the court in response to the court’s order of October 25, 2010.

*The County initiated the Request For Proposal (RFP) process to select a vendor to*

*develop the Integrated Behavioral Health Information System (IBHIS) in 2008. After the receipt of the RFP proposals, the State of California issued new rules that significantly impacted the claiming process. Therefore, the RFP had to be cancelled and a new RFP process was initiated and is near the end of the procurement process. Once a vendor is selected, full implementation is expected to take approximately two years. Due to unexpected delays with the IBHIS, the Panel's eighth report to Court in April 2008 explained that IBHIS would be delayed and subsequently revised that estimate again in the Panel's tenth report to Court in July 2009. Since July 2009 the Panel reports to Court have consistently indicated that IBHIS is scheduled to be completed in 2013. In the interim, DMH developed a Katie A. Cognos Cube which has enabled DMH and DCFS to share client information, therefore, no longer requiring the use of the IBHIS system for this purpose. While the IBHIS system will improve the County's ability to capture clinical information related to those children who receive mental health services, the Cognos Cube does provide an ability to track service levels and associated costs of mental health services for Katie A. class members.*

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

The parties and Panel consider the County's adoption of the Qualitative Review Process as meeting the intent of this commitment. The County has developed the instrument design, continues to train staff in its use, piloted its use and now is regularly conducting reviews in local offices. The County plans to review all regions using this tool by June 2012.

### **Training for Staff Providing Intensive In-Home Services to Children Needing Mental Health Services**

In the Panel's last report, it noted the lack of a detailed strategy for training mental health providers and specifically addressed concern about the limitation of plan to have the California Institute for Mental Health provide brief conceptual training rather than more intensive practice-model based training.

In updating the Panel about current plans, the County reported the following.

*The California Institute for Mental Health, in collaboration with DMH, co-sponsored a one day kick off conference for the Core Practice Model training on February 10<sup>th</sup>. The meeting was attended by key DMH and contract provider staff from each of the County's eight Service Areas. Keynote speakers included Marleen Wong who spoke about the importance of a trauma-informed system and Frank Rider who shared his experience regarding collaboration between mental health and child welfare systems based upon his involvement in the J.K. v. Eden lawsuit in Arizona. The conference was well attended and the feedback was very positive.*

*CIMH has planned a series of half-day training events for mental health providers, with each of the eight Service Areas to be scheduled for four half day modules. CIMH will be employing a train the trainers approach and will also be following up the training with a series of conference calls and meetings related to the coaching and mentoring approach used to support implementation of the Core Practice Model.*

In addition, CIMH reported that 1,000 mental health staff in LA County have been trained in Trauma-Focused Cognitive Behavior Therapy (TF-CBT), and there has been additional training for other evidence-based practices.

DCFS reported that the 3-day coaching fundamentals curriculum is being provided on an ambitious schedule for Emergency Response supervisors. There is a plan for monthly ER case conferencing with master coaches. At least one service area has implemented monthly group coaching of workers using a reflective supervision approach. In addition, 90 MAT assessors were trained on identifying children's needs and the new MAT format.

While these steps constitute a useful introduction to Practice Model implementation, given the significant shift in DCFS and mental health practice needed for fidelity to the County's case practice model, the Panel continues to believe that training plans are not sufficient in scope or intensity to permit mental health providers and DCFS to meet the needs of class members. The Panel plans to again make that subject a major topic for discussion in its March meeting with the County and believes that a more detailed and comprehensive training and coaching strategy is required.

### **Expansion of Funding**

The County reports the following relative to budget issues.

*The FY 2009-10 Katie A. budget closed with \$22 million in net County cost savings. The savings are primarily due to vacant Wraparound slots. If the upward trajectory of filling Wraparound slots continues, the proportion of Katie A. savings should decline in the out years. As we have done with prior year savings, CEO has rolled the FY 2009-10 savings into a Provisional Financial Uses to offset fiscal commitments in FY 2010-11 and FY 2011-12 in support of the incremental rollout of the Strategic Plan.*

The County reports that it does not expect any shortfall in the current fiscal year.

### **Expansion of Staff Resources for Multidisciplinary Medical Hubs**

For FY 2009-2010, the County reports that 80 percent of newly detained children received an initial assessment examination at a Medical Hub. The performance rate provided in the Panel's previous report was 82 percent. The County's goal is 100 percent of newly detained children. The Panel requested that the County provide additional information about what would be required to significantly increase the percent of newly detained children receiving an initial examination.

The County replied as follows:

*Due to insufficient tracking capabilities, the performance percentage rates do not tell the entire story. Since the start of the Medical Hub Program, DCFS and DHS have jointly only been able to implement a very limited tracking effort of comparing the monthly total number of newly detained children against the monthly total of Initial Medical Exams completed by the Hubs. Unfortunately, the current tracking mechanism does not report on a child specific basis, i.e., to determine if a specific newly detained child was referred to a Medical Hub and if the child was served by the Hub through the provision of a medical exam, including the month the child was referred and the month the child was served.*

*Most recently, with the implementation of DHS' E-mHub System, (a web-based patient information system at the DHS Medical Hubs) along with a real time interface with DCFS, there exists the opportunity to develop more effective tracking mechanisms that include child specific data.*

*The most recent DCFS/DHS Medical Hub Report that presents data for December 2010 (FY 10/11) highlights that 73 percent of the newly detained children received an Initial Medical Exam at a Medical Hub. It is recognized that this is a lower percentage than the previously reported 80 percent for FY 09/10. If child specific data were available, the percentage may very well be higher since strong efforts and activities have continued towards ensuring that the priority population is referred to the Hubs. Upon the conclusion of the roll out within the DHS Medical Hubs and the DCFS interface and resolution of any outstanding issues to fully implement the E-mHub System, DCFS and DHS will actively address implementing child specific tracking efforts.*

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

DCFS reports a decrease in Team Decision Meetings from July-September 2010 due to temporary reassignments to Emergency Response. There was an increase of 114 Team Decision Meetings for youth entering or exiting a group home and youth changing placement. Some temporary reassignments of TDM facilitators continue.

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

#### ***Screening***

The County reported the following performance related to the revised mental health screening tool and associated rollout as of January 31, 2011.

Newly Detained and Newly Opened Non-Detained Cases:

- A total of 254 individual Children's Social Workers (CSWs) completed mental health screens to date.
- Out of 923 children in new and open cases, 883 children required screens and 838 children were screened at a 94.9% screening rate.
- Out of the 501 children who screened positive, 59.79% received positive screens; 0% identified as having acute mental health needs, 5.01% as urgent, and 51.91% as routine.
- Out of the 501 children who screened positive, 478 children were referred for mental health services at a 95.79% referral rate.
- Out of the 478 children who were referred for mental health services, 461 children received a mental health service activity at a 96.44% service access rate.
- The average number of days between the case opening or case plan due date and completion of a mental health screen was 15 calendar days.
- The average number of days between an acute mental health screen and referral for mental health service was 0 calendar days; the average number of days between an urgent screen and referral for services was 5 days; and the average number of days between a routine screen and referral was 3 days.
- The average number of days between a referral for mental health service and the first mental health service activity was 3 calendar days.
- Out of 364 children, 281 children required annual screens, and 117 children were screened for routine mental health needs at a 41.64% screening rate.
- Out of the 11 children who screened positive, 9.4% received positive screens; 0% were identified as having acute mental health needs, 0% as urgent, and 9.4% as routine.
- Out of the 11 children who screened positive, 11 children were referred for mental health services at a 100% referral rate.
- Out of 11 children referred for mental health services, 10 children received a mental health service activity at a 90.91% service access rate.
- The average number of days between the annual re-screening due date and completion of a mental health screen was 0 calendar days.

- *The average number of days between a positive mental health screen and referral for mental health service was 6 calendar days.*
- *The average number of days between a referral for mental health service and the first mental health service activity was 3 calendar days.*
- *The average number of days between an acute mental health screen and referral for mental health service was 0 calendar days; the average number of days between an urgent screen and referral for services was 0 days; and the average number of days between a routine screen and referral was 6 days.*

The County reports that it is revising the screening report to provide more data that the information above.

***Coordinated Services Action Team (CSAT)***

According to the County, the Coordinated Services Action Team (CSAT) aligns and coordinates DCFS and DMH staffs to ensure that DCFS served children receive timely screening, assessment and linkage to mental health services. The CSAT members will provide office-based expertise to expedite and ensure service linkage by managing or directly handling tasks associated with the completion of the following:

- Timely referral and follow-up to the Medical Hub;
- Completion of the California Institute for Mental Health (CIMH) Mental Health Screening Tool (MHST), as required;
- Establishment of consent, authorization for release of information and determination of existing financial eligibility;
- Referral/Linkage for Assessment and Treatment as needed;
- Resource Management

The implementation schedule for countywide roll-out is as follows.

<b><i>Table 1: CSAT Redesign Training and Rollout Schedule</i></b>				
<b>DCFS Office</b>	<b>Training Month</b>	<b>Trial Month</b>	<b>CSAT Roll Out</b>	<b>RTS Report to Board</b>
Belvedere, Santa Fe Springs	Aug. 2010	Sept. 2010	Oct. 2010	Dec. 2010
Compton, Wateridge, Vermont Corridor	Aug. – Sept. 2010	Oct. 2010	Nov. 2010	Jan. 2011

Palmdale, Lancaster, Pomona, El Monte	Oct. 2010	Nov. 2010	Dec. 2010	Feb. 2011
Covina Annex (Asian Pacific/American Indian Units only), Metro North	Nov. 2010	Dec. 2010	Jan. 2011	Mar. 2011
ERCP	Dec. 2010	Jan. 2011	Feb. 2011	Apr. 2011
West Los Angeles, Deaf Services, Pasadena	Jan. 2011	Feb. 2011	Mar. 2011	May 2011
Lakewood	Feb. 2011	Mar. 2011	Apr. 2011	June 2011
Glendora	Mar. 2011	Apr. 2011	May 2011	July 2011
Medical Case Management Services, Torrance	Apr. 2011	May 2011	June 2011	Aug. 2011
San Fernando Valley, Santa Clarita, West San Fernando Valley	May 2011	June 2011	July 2011	Sep. 2011

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The County reports that it has also implemented two small Multi-Agency Response Team units to be implemented in June 2011 that will work exclusively with law enforcement cases.

### **Expansion of Mental Health Services**

#### ***Treatment Foster Care (TFC)***

The court's Corrective Action Plan required the County to develop 300 treatment foster care homes by January 2008. Developing TFC homes has been a challenge for the County. The County now reports having 75 certified homes and 51 children in placement. Twenty-two homes are now in the process of certification. A total of 104 youth have received TFC services. Developing 300 treatment foster care beds requires several complex steps, each of which has presented problems. The County had to contract with providers. The providers had to recruit and train staff and recruit and train therapeutic foster homes. The County had to improve methods for identifying children who would benefit from therapeutic homes, which required encouraging staff to make referrals and having a workable referral system. Referred children then are matched with a therapeutic home that fits the unique needs of the child.

The County now has contracts with 12 providers trained in two different therapeutic foster care approaches (TFC and MTFC).

The County's contracted therapeutic foster care providers have particularly struggled with recruitment of therapeutic foster families, although there is some gradual progress at this point. The County reports that it can take from two to six months to complete the home study and pre-

service training required once a therapeutic foster home has been recruited. At this point, there are 75 therapeutic foster home beds. The County reports that offices are now referring children for therapeutic foster home placement at a rate that fits the providers' capacity to match them to homes.

One barrier that seems to have been problematic is a DCFS policy requiring that TFC providers be dually approved as foster and adoptive homes, which is an effort to speed permanency. However, some prospective TFC providers do not wish to become adoptive resources and decline to apply. The intent of this policy for conventional foster homes is sound, but it may be ineffective for treatment homes. The Panel is recommending that the County reconsider the application of this policy to treatment foster homes as it develops new recruitment and certification strategies.

The table below describes the current status of TFC development by provider.

<i>Table 3: TFC Placement and Capacity (as of 11/30/2010)</i>					
Agency	No. of Placed Children	Certified Homes	Certified Homes Vacancies	**Inactive Homes	Upcoming Beds
<i>Intensive Treatment Foster Care (ITFC)</i>					
Five Acres	10	15	2	3	5
ChildNet	6	7	1	0	1
Olive Crest	2	2	0	0	1
Penny Lane	2	3	2	0	6
Aviva	0	0	0	0	0
Rosemary's Children Serv.	0	1	1	0	0
The Village	3	3	0	0	4
CII	0	1	1	0	1
David and Margaret	0	0	0	0	1
Vista Del Mar	1	1	0	0	1
Hathaway-Sycamore	0	0	0	0	0
Ettie Lee	2	2	0	0	0
<i>SUB TOTAL</i>	26	35	7	3	20

<i>Multi-dimensional Treatment Foster Care (MTFC)</i>					
CII	5	7	0	0	0
Penny Lane	8	17	0	10	6
ChildNet	2	5	3	0	0
David and Margaret	3	5	0	2	0
<i>SUB TOTAL</i>	18	34	3	12	6
<b>GRAND TOTAL</b>	<b>44</b>	<b>69</b>	<b>10</b>	<b>15</b>	<b>26</b>

\*\*Per Agency Request

The County wants to formally extend the deadline for achieving 300 therapeutic foster home beds and the Panel and parties are discussing a set of strategies and proposal to request such an extension. The Panel believes that significant urgency needs to be given to expanding TFC resources for class members and that new strategies are needed to accelerate the pace of development

#### **Expansion of Wraparound by 500 Slots**

Enrollment in what the County refers to as Tier I (traditional) Wraparound is 1,015. The County continues to have difficulty in promptly refilling Wraparound slots that have been vacated. For comparison, in May 2008 1217 slots were filled, which conformed to the court's requirement that 500 slots be added to existing capacity. Given the fact that there has been an increase in the number of children in group care, referenced elsewhere in this report, the Panel does not understand why vacant slots could not have been made available for children at-risk of entering group care.

#### **Intensive Home-Based Service Delivery**

Tier II Wraparound is a somewhat less intensive and more flexible form of Wraparound for less intensive cases. The County committed to developing 2,800 slots by FY 2014 – 2015 and currently 1,652 children were enrolled as of January 31, 2011. The following table shows the County's performance vs. projections.

<b>Tier II Enrollment/Target Analysis</b>			
<b>Month-Year</b>	<b>Target</b>	<b>Cumulative</b>	<b>% of Target Achieved</b>
<b>Jun-10</b>	950	1023	108%
<b>Jul-10</b>	1025	1122	109%

<b>Aug-10</b>	1100	1212	110%
<b>Sep-10</b>	1175	1312	112%
<b>Oct-10</b>	1250	1396	112%
<b>Nov-10</b>	1325	1459	110%

### **Mental Health Services for Children in D-Rate and FFA Settings**

It is commendable that the county can now report on the quantity of mental health services being provided to DCFS children. Staff has continued the process of matching the names of children in D-rate homes and FFA homes from the DCFS information system to billing for mental health services in the DMH information system. It appears that most of the 1,500 children in D-Rate homes and almost two-thirds of the 6,000 children in FFA homes received mental health services (taking out the 1,920 children age 4 and under in FFA homes, this percentage goes up to 73% for the children over 4 in FFA homes receiving mental health services). In response to concerns that several hundred D-Rate children were identified as not receiving mental health services, a follow-up study was done that found that half of a sample of these children were receiving mental health services (through DMH contracted providers, fee-for-service or private practitioners) that did not show up on the DMH database; several children had refused services and for others mental health service referrals were made as a result of the follow-up.

Children in D-Rate and FFA homes primarily rely on regular outpatient mental health services, not the four specialized mental health programs (Wraparound, Intensive In-Home, Full Service Partnership, and System of Care): 67% of D-Rate and 84% of FFA children receiving mental health services had outpatient services (“other enrollment”). In three of the four specialized mental health programs, about half the enrolled D-Rate and FFA children receive six or more mental health services a month. But questions about the intensity of Wraparound, Intensive In-Home, Full Service Partnership, and System of Care are raised by finding that about a quarter of the D-Rate and nearly a third of the FFA children receive three or fewer mental health services a month in those four programs. Of the children not in the four programs, nearly a fifth of the D-Rate children receiving regular outpatient mental health services get only one service a month and half the D-Rate and FFA children get three or fewer outpatient services a month.

#### D-RATE Placement

Total Clients in Placement 1,570  
 Clients Receiving Mental Health Services 88%

	<u># clients</u>	<u>Specialized MH Programs Enrollment*</u>	<u>Other Enrollment**</u>
Receiving Mental Health Services	1,374	33%	67%

FFA Placement

Total Clients in Placement 6,106  
 Clients Receiving Mental Health Services 63%

	<u># clients</u>	<u>Specialized MH Programs Enrollment*</u>	<u>Other Enrollment**</u>
Receiving Mental Health Services	3,875	16%	84%

\* Client found to be a concomitant client of DCFS and DMH. Client is also enrolled in one of the following Mental Health Service Programs: Wraparound, Intensive In Home Behavioral Services, Full Service Partnership, Children's System of Care.

\*\* Client found to be a concomitant client of DCFS and DMH who is not enrolled in one of the four above named mental health programs, but may be enrolled in another Mental Health Service Program provided by Los Angeles County Department of Mental Health.

Average Mental Health Services Per Month

	<u># clients</u>	<u>1 service</u>	<u>D-RATE</u> <u>2-3 services</u>	<u>4-5 services</u>	<u>6-9 services</u>	<u>10+ services</u>
WRAPAROUND	200	6%	14%	19%	34%	28%
INTEN IN-HOME	38	11%	33%	27%	21%	8%
FULL SERV PART	46	7%	18%	22%	33%	20%
SOC	47	7%	18%	23%	34%	17%
SERVICES IN OTHER ENROLLMENT +	782	18%	35%	30%	15%	3%

	<u># clients</u>	<u>1 service</u>	<u>FFA</u> <u>2-3 services</u>	<u>4-5 services</u>	<u>6-9 services</u>	<u>10+ services</u>
WRAPAROUND	170	8%	19%	22%	29%	22%
INTEN IN-HOME	59	11%	32%	31%	22%	4%
FULL SERV PART	67	7%	19%	26%	31%	16%
SOC	36	8%	16%	21%	36%	20%
SERVICES IN OTHER ENROLLMENT +	1,729	14%	35%	33%	15%	3%

+ Client found to be a concomitant client of DCFS and DMH who is not enrolled in one of the four above named mental health programs, but may be enrolled in another Mental Health Service Program provided by Los Angeles County Department of Mental Health and is receiving one of the following outpatient services: Collateral, Individual, Medication Support, Targeted Case Management

When the 782 D-Rate and 1,729 FFA children not enrolled in the intensive programs are examined in more detail, the following outpatient services were provided:

	<u>D-Rate</u>	<u>FFA</u>
<u>Individual Therapy</u>		
1 session/month	23%	20%
2-3 sessions/month	48%	46%
4-5 sessions/month	22%	26%

Medication

Support

<i>1 session/month</i>	85%	80%
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Collateral Contacts

(with foster family, school, etc.)

<i>1 contact/month</i>	67%	61%
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<i>2-3 contacts/month</i>	30%	33%
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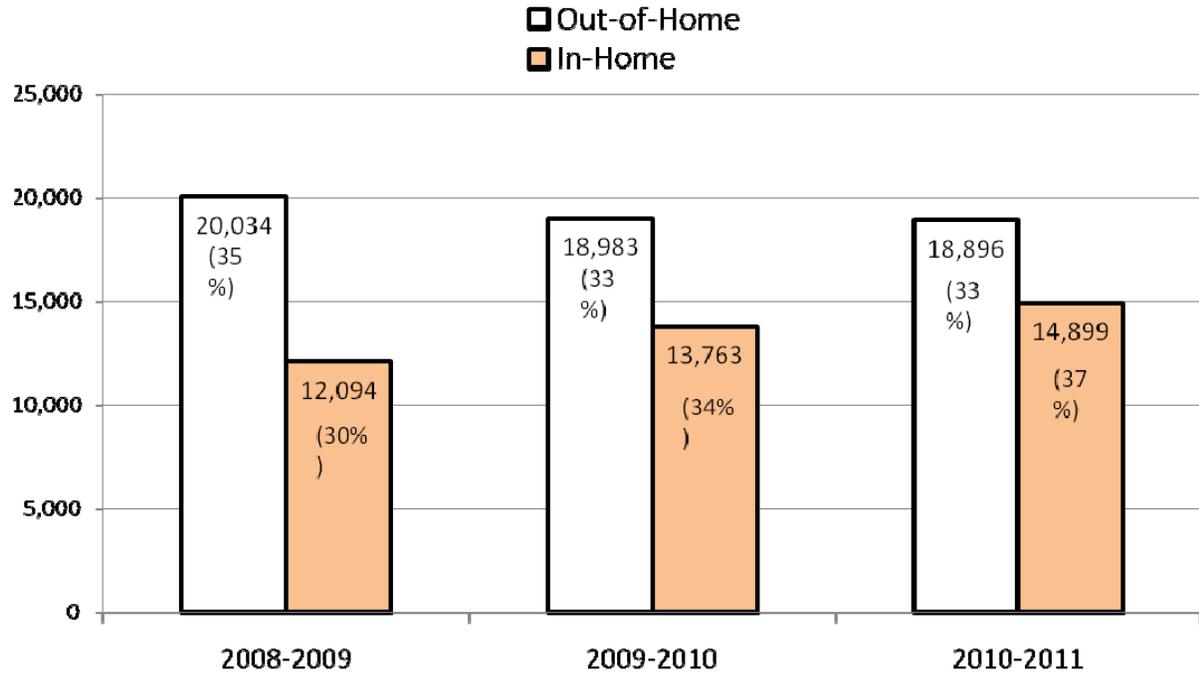
This information reflects traditional outpatient services at the minimal level, with almost a quarter of the children receiving only one therapy session a month and many of their caregivers receiving only one clinical contact a month. On the one hand, the findings indicate that D-Rate and FFA children are receiving outpatient services. Phone interviews with D-Rate caregivers found high levels of satisfaction with the services that are being provided. On the other hand, a substantial number may not be receiving sufficiently intensive services, given their challenging behaviors.

Defining the intensity and frequency of mental health services to address needs is complex. Once/weekly individual therapy and once/monthly caretaker guidance is not an intensive level of services and may not be sufficient to meet the needs of high needs children. Quality of services is not defined by quantity. While in-home service delivery is not necessarily a higher quality than office-based services, intensive services in the home reduces absences and more effectively addresses the caretakers' concerns about how to meet the complex mental health needs of these children. In other communities, intensive home-based services would include weekly caretaker guidance and, in addition to weekly in-home therapy for the child, as much as daily assistance to the child under the therapist's direction (similar to TBS but more clinical).

**Caseload/Workload Reduction**

As of January 2011, the average CSW generic caseload increased slightly from 25.27 in July 2010 to 25.76 in January 2011. As the following chart shows, total caseloads have been relatively stable for the past two years. In-home cases have grown by three percent.

## Children in Out-of-Home and In-Home Placements



**Notes:**

1. The table includes active cases as of the last month of the reporting fiscal year.
2. **Out-of-Home Placement:** FFA Certified Homes, Relative Homes, Foster Family Homes, Small Family Homes, Guardian Homes, Group Homes, Court Specified Homes and others (County Shelter, Medical Facility, and Tribe -Specified Homes, also includes children in Adopted Homes and Non-Foster Care (hospitalized) **In-Home:** Children who reside with parents receiving Family Maintenance Services (Child is not in placement).
3. Data source is CWS/CMS History as of the last month of the reporting fiscal year.
4. Data in fiscal year 10-11 is as of December 31, 2010.
5. Percentages are by type of placement across all three fiscal years.

### *Young Children in Group Homes*

#### **GROUP HOME REPORTS FOR CHILDREN 0 TO 12 (by facility) NOVEMBER 2010**

In the Panel's last report, it reported that the number of young children in group homes was just over 100 by the end of 2009. That number is 163 at the time of the report. The Panel is asking the County to assess and report on why this number is rising, especially with the Wraparound expansion and Tier II Wraparound growing.

The County provided the following chart relative to provider census.

<b>GROUP HOME FACILITY</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>TOTAL</b>
BRUCE & NELSON RES FACILITY	0	0	0	0	0	0	0	0	0	0	<u>1</u>	0	0	<u>1</u>
CANDLELIGHT HOMES	0	0	0	0	0	0	0	0	0	0	0	0	<u>1</u>	<u>1</u>
CASA EDITHA FOUNDATION, INC. D	0	0	0	0	0	0	0	0	0	<u>1</u>	0	0	0	<u>1</u>
CHILDHELP	0	0	0	0	0	0	0	<u>3</u>	<u>6</u>	<u>5</u>	<u>7</u>	<u>3</u>	<u>2</u>	<u>26</u>
CHILDREN'S HOMES OF SOUTHERN C	0	0	0	0	0	0	0	0	0	0	0	0	<u>1</u>	<u>1</u>
DREAM HOME CARE	0	0	0	0	0	0	0	0	<u>1</u>	0	<u>1</u>	0	<u>2</u>	<u>4</u>
FIVE ACRES THE BOYS' AND GIRLS	0	0	0	0	0	0	<u>2</u>	<u>6</u>	<u>8</u>	<u>3</u>	<u>12</u>	<u>8</u>	<u>12</u>	<u>51</u>
GARCES RESIDENTIAL CARE SERVIC	0	0	0	0	0	0	0	0	0	0	<u>1</u>	<u>1</u>	<u>2</u>	<u>4</u>
HARRIET HOUSE	0	0	0	0	0	0	<u>1</u>	0	0	0	0	0	0	<u>1</u>
HATHAWAY-SYCAMORES CHILD AND F	0	0	0	0	0	0	0	0	0	0	<u>1</u>	0	<u>2</u>	<u>3</u>
HILLSIDES	0	0	0	0	0	0	0	<u>2</u>	0	<u>1</u>	<u>2</u>	<u>2</u>	<u>1</u>	<u>8</u>
HOPE HOUSE	0	0	0	0	0	0	0	0	0	0	0	0	<u>1</u>	<u>1</u>
JUNIOR BLIND OF AMERICA	0	0	0	0	0	0	0	0	0	0	0	<u>1</u>	<u>1</u>	<u>2</u>
LEROY HAYNES CENTER CHILDREN &	0	0	0	0	0	0	0	0	0	<u>1</u>	0	<u>3</u>	0	<u>4</u>
LITTLE PEOPLE'S WORLD	0	0	0	0	0	0	0	<u>3</u>	<u>1</u>	<u>3</u>	<u>1</u>	<u>8</u>	<u>3</u>	<u>19</u>
MARYVALE	0	0	0	0	0	0	<u>1</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>16</u>
MCKINLEY CHILDREN'S CENTER INC	0	0	0	0	0	0	0	<u>1</u>	<u>2</u>	0	<u>1</u>	<u>3</u>	<u>5</u>	<u>12</u>
MURRELL'S FARM AND BOYS HOME	0	0	0	0	0	0	0	0	0	0	0	0	<u>1</u>	<u>1</u>
O'CONNOR AND ATKINS GROUP HOME	0	0	0	0	0	0	0	0	0	0	<u>1</u>	<u>3</u>	0	<u>4</u>
PARADISE OAKS YOUTH SERVICES	0	0	0	0	0	0	0	0	0	0	0	0	<u>1</u>	<u>1</u>
PENNACLE FNDATN INC	0	0	0	0	0	0	0	0	0	0	0	0	<u>1</u>	<u>1</u>
PENNY LANE CENTERS	0	0	0	0	0	0	0	0	0	0	0	0	<u>2</u>	<u>2</u>
PERFECT IMAGE YOUTH CENTER	0	0	0	0	0	0	0	0	0	0	0	0	<u>2</u>	<u>2</u>
PHOENIX PROGRAMS INC	0	0	0	0	0	0	0	0	<u>1</u>	0	0	0	0	<u>1</u>
STARVIEW CHLDRN & FMLY SER CTF	0	0	0	0	0	0	0	0	0	0	0	0	<u>1</u>	<u>1</u>
THE DANGERFIELD INSTITUTE	0	0	0	0	0	0	0	0	0	0	0	0	<u>1</u>	<u>1</u>
VISTA DEL MAR CHILD AND FAMILY	0	0	0	0	0	0	0	0	0	0	0	0	<u>2</u>	<u>2</u>
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4</b>	<b>16</b>	<b>21</b>	<b>17</b>	<b>30</b>	<b>35</b>	<b>48</b>	<b>171</b>

In the future, it would be useful to analyze the 7 offices that have more than 10 young children in group care, presented as a percentage of the total number of children under 12 in that office. Questions to answer include the following. Have these 7 offices been provided by DCFS and DMH central office assistance in doing a strengths/needs look at each of their young children in group care to consider where else their needs might be met? One of the County's hopes has been that instead of going to group care or remaining in group care, young children with high needs would be placed in therapeutic foster care. To what extent is this happening? Does referral to therapeutic foster care require a TDM facilitator?

### Qualitative Service Review (QSR)

The Department has done a stellar job of implementing the QSR. Its work is faithful to the intended design of the process and offices reviewed have conscientiously attended to feedback about the quality of practice. Office in the Belvedere, Santa Fe Springs, Compton and Vermont Corridor location have been reviewed to date the with Wateridge office scheduled for March,

2011. Reviews for remaining offices are scheduled over the next eighteen months. The Panel will report on results to date in its next report, when enough cases will have been reviewed to provide definitive trend data.

A copy of the definition of each QSR indicator is included in the Appendix.

### **Exit Criteria**

The remaining exit criterion to be agreed to relates to the QSR. The parties have a tentative agreement that they hope to present to the court for review by late April.

## **V. Analysis of Strategic Plan Implementation**

### **Training and Coaching**

One of the Panel's greatest concerns about Strategic Plan implementation is the modest plan for provision of training and coaching of DCFS and DMH providers in the practice model. Early feedback from the QSR process indicates that the areas of child and family and assessment, teamwork among service providers, DCF and the family, involvement of youth and family in decision making and service planning need considerable improvement. These reviews make clear that strengthening practice in these areas is critical to assisting parents in gaining necessary caregiving capacity, addressing children's emotional and behavioral needs and achieving permanency. The Panel will be discussing these issues with the County in the upcoming Panel meeting.

### **Development of Home-Based Mental Health Services**

The Panel and County analyzed the pattern of mental health service utilization for the children served in D-Rate homes (foster homes receiving a higher payment rate for children with severe emotional problems) and children in family foster homes in foster care agencies (FFAs). Most of the children in D-Rate homes and approximately two thirds of children in FFAs were receiving mental health services. However most of the children in these programs receive conventional outpatient services, not the specialized services like Wraparound, Intensive In-Home, Full Service Partnership or System of Care supports.

While low service intensity patterns alone do not necessarily indicate insufficiency, it seems apparent that there is not yet sufficient capacity to provide intensive home-based mental health services for the percentage of this population likely to be in need of it. This highlights the urgency of needs to expand home-based mental health service capacity and ensure that adequate training and coaching is delivered to assist providers to serve children in this manner. There are also implications for standard setting by the County regarding expectations for mental health service delivery. If the County wants home-based mental health services provided, it should make that expectation clear to providers.

## **Development of Treatment Foster Care Capacity**

The Department has encountered a number of barriers in implementing treatment foster care in response to the court's corrective action order to develop 300 approved homes. Currently 76 homes have been developed and 51 children are in placement. In the Panel's December meeting with the County, the County agreed to develop a revised recruitment plan to address the need to create 224 more homes. The County reports that the plan is not yet complete, but expects to provide it to the Panel in April 2011.

## **VII. Panel Recommendations**

### ***Training and Coaching***

The County has a well-articulated and ambitious Practice Model, has begun introductory training of staff in the practice model and with the implementation of the Qualitative Service Review, is identifying the areas of practice that need strengthening to achieve the objectives of the decree. However, there is not yet a detailed formal plan for strengthening practice. The County does face challenges in this regard. Los Angeles County is one of the largest systems in the Country with approximately 35,000 children in-home and out-of-home. DCFS alone has 2,276 case carrying staff and the mental health provider community is large as well. The County has few trainers and mentors yet capable of developing practice capacity. So improving front-line practice quality and outcomes will be a multi-year process.

Understanding the challenge provided by the system's scale and limited capacity, the Panel has a concrete recommendation. Because the County cannot yet support a broad implementation effort across multiple regions simultaneously, the County should select one or a few promising offices in terms of leadership quality and current performance and begin intensive training and coaching in one site. The process will permit the development of additional trainers and coaches who can observe initial training and coaching, master the needed skills and begin the process in an additional office. The multiplying expansion of available training and coaching capacity as each new office is developed can speed the creation of internal resources needed to address practice across the entire system. Put simply, the Panel's advice is to start somewhere.

### ***Development of Treatment Foster Care Beds***

The County should quickly complete its recruitment strategy, including removing the requirement for dual adoption and foster care certification of providers, to make this critical family based therapeutic alternative to group care available to class members.

### ***Availability of Home-Based Mental Health Services***

The County should develop a specific strategy for transitioning providers from reliance on low-intensity office based mental health services to the provision of home-based mental health services with greater frequency. This plan should be linked to the strategy for training and coaching, since the child and family plan should govern the type of mental health services provided, their intensity and the setting in which they are provided.

There is value to central office analysis of data regarding mental health services received by children in care on a regular basis. An analysis of services delivered in the four intensive programs and outpatient service by frequency and service *by provider* would also be useful. In addition, more analysis of information about the mental health services being delivered to other class members is warranted. There are children with significant mental health needs who are residing with relatives or in group care (not in FFAs or D-Rate homes) for whom a similar analysis should be done. The Panel would like to explore this further in its upcoming meeting with the County.

### ***Medical HUBs***

The Panel requests that the County provide additional information about what would be required to significantly increase the percent of newly detained children receiving an initial examination at a HUB.

### ***Children in Group Care Settings***

The County should assess why the number of children in group homes is rising and provide a plan to more appropriately place children in home-based settings. This may need to include attention to Wraparound vacancies and the lack of treatment foster homes as well.

## **VIII. Glossary of Terms**

ADHD – Attention deficit hyperactivity disorder

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

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

Comprehensive Children’s Services Program (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.

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

DMH – Department of Mental Health

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

ER – Emergency response

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

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

FGDM – Family Group Decision Making

FM – Family maintenance services, provided for families with children living at home.

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

IEP – Individual Education Plan

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

MAT – Multi-Disciplinary Assessment and Treatment Team

PTSD – Post-traumatic stress disorder

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

RPRT – Regional Permanency Review Teams

TAY – Transitional Age Youth

## **IX. APPENDIX**

## Appendix A

### INDICATOR LISTING - LA DCFS Qualitative Service Review Protocol

The QSR Protocol provides reviewers with a specific set of indicators to use when examining the status of the child and caregiver and analyzing the responsiveness and effectiveness of the core practice functions prompted in the CPM. Indicators are divided into two distinct domains: *status* and *practice performance*.

□ **Status indicators** measure the extent to which certain desired conditions are present in the life of the focus child and the child's parents and/or caregivers—as seen over the past 30 days. Status indicators measure constructs related to *well-being* (e.g., safety, stability, and health) and *functioning* (e.g., the child's academic status and the caregiver's level of functioning). Changes in status over time may be considered the near-term outcomes at a given point in the life of a case.

□ **Practice indicators** measure the extent to which *core practice functions* are applied successfully by practitioners and others who serve as members of the child and family team (CFT). The core practice functions measured are taken from the CFT and provide useful case-based tests of performance achievement. The number of core practice functions and level of detail used in their measurement may evolve over time as advances are made in the state-of-the-art practice.

**QSR Child & Caregiver Status Indicators:** This version of the QSR Protocol provides nine possible qualitative indicators for measuring the current status of a focus child and the child's parent and/or caregiver. Status is determined for the most recent 30-day period, unless stated otherwise in the indicator. A status measure could be viewed as a desired outcome for a child, parent, and/or caregiver who, at an earlier time, may have experienced significant difficulties in the area of interest.

**1a. SAFETY - Exposure to Threats of Harm:** Degree to which: • The child is free of abuse, neglect, and exploitation by others in his/her place of residence, school, and other daily settings. • The parents and caregivers provide the attention, actions, and supports necessary to protect the child from known safety factors in the home.

**1b. SAFETY - Risk to Self/Others:** Degree to which the focus child: • Avoids self-endangerment. • Refrains from using behaviors that may put others at risk of harm. [*For a child age three years and older*]

**2. STABILITY PATTERN:** Degree to which: • The child's daily living, learning, and work arrangements are stable and free from risk of disruptions. • The child's daily settings, routines, and relationships are consistent over recent times. • Known risks are being managed to achieve stability and reduce the probability of future disruption. [*Timeframe: past 12 months and next 6 months*]

**3. PERMANENCY PROSPECTS:** Degree of confidence held by those involved (child, parents, caregivers, others) that the child/youth is living with parents or other caregivers who will sustain in this role until the focus child reaches adulthood and will continue onward to provide enduring family connections and supports in adulthood.

**4. LIVING ARRANGEMENT:** Degree to which: • Consistent with age and ability, the focus child is in the most appropriate/least restrictive living arrangement, consistent with the child's needs for family relationships, assistance with any special needs, social connections, education, and positive peer group affiliation. • [If the child is in temporary out-of-home care] the living arrangement meets the child's needs to be connected to his/her language and culture, community, faith, extended family, tribe, social activities, and peer group.

**5. HEALTH:** Degree to which the focus child is achieving and maintaining favorable health status, given any disease diagnosis and prognosis that the child may have.

**6. EMOTIONAL WELL-BEING:** Consistent with age and ability, the degree to which the focus child is displaying an adequate pattern of: • Attachment and positive social relationships, • Coping and adapting skills, • Appropriate self-management of emotions and behaviors, • Resilience, • Optimism, • A positive self-image, and • A sense of satisfaction that his/her fundamental needs are being met.

**7a. EARLY LEARNING STATUS:** Degree to which: • The child's developmental status is commensurate with age and developmental capacities. • The child's developmental status in key domains is consistent with age- and ability-appropriate expectations. *[For a child under 5 years of age]*

**7b. ACADEMIC STATUS:** Degree to which the focus child [according to age and ability] is: (1) regularly attending school, (2) placed in a grade level consistent with age or developmental level, (3) actively engaged in instructional activities, (4) reading at grade level or IEP expectation level, and (5) meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent. *[For a child age 5 years or older]*

**7c. PREPARATION FOR ADULTHOOD:** Degree to which the youth [according to age and ability] is: (1) meeting academic requirements for annual promotion and course completion leading to a high school diploma or equivalent; (2) gaining life skills, developing relationships and connections, and building capacities for living safely, becoming gainfully employed, and functioning successfully upon becoming independent of child services; - OR - (3) becoming eligible for adult services and with the adult system being ready to provide (without waiting or disruption) continuing care, treatment, and residential services that the youth will require upon discharge from services.

**8. FAMILY FUNCTIONING & RESOURCEFULNESS:** Degree to which the parents or caregiver [with whom the child is currently residing or has a goal of reunification]: • Has the capacity to take charge of its issues and situation, enabling family members to live together safely and function successfully. • Take advantage of opportunities to develop and/or expand a reliable network of social and safety supports to sustain family functioning and well-being. • The

parent or caregiver is willing and able to provide the child with the protection, assistance, supervision, and support necessary for daily living.

**9. CAREGIVER FUNCTIONING:** Degree to which: • The substitute caregivers, with whom the child is currently residing, are willing and able to provide the child with the assistance, protection, supervision, and support necessary for daily living. • If added supports are required in the home to meet the needs of the child and assist the caregiver, the added supports are meeting the needs.

**QSR Practice Performance Indicators:** This version of the QSR Protocol provides nine qualitative indicators for measuring certain core practice functions being provided with and for the focus child and the child’s parents and/or caregivers. Practice performance is determined for the most recent 90-day period for cases that have been open and active for at least the past 90 days.

**1. ENGAGEMENT:** Degree to which those working with the focus child and family (parents and other caregivers) are: • Finding family members who can provide support and permanency for the focus child. • Developing and maintaining a culturally competent, mutually beneficial trust-based working relationship with the child and family. • Focusing on the child and family’s strengths and needs. • Being receptive, dynamic, and willing to make adjustments in scheduling and meeting locations to accommodate family participation. • Offering transportation and child care supports, where necessary, to increase family participation in planning and support efforts.

**2. VOICE & CHOICE:** Degree to which the focus child, parents, family members, and caregivers are active ongoing participants (e.g., having a significant role, voice, choice, and influence) in shaping decisions made about child and family strengths and needs, goals, supports, and services.

**3. TEAMWORK:** Degree to which:

• **TEAM FORMATION:** (1) The “right people” for this child and family have formed a working team that meets, talks, and plans together. (2) The team has the skills, family knowledge, and abilities necessary to define the strengths and needs of the child and family and to organize effective services for this child and family, given the level of complexity of circumstances and cultural background of the child and family.

• **TEAM FUNCTIONING:** (1) Members of the child and family’s team collectively function as a unified team in planning services and evaluating results. (2) The decisions and actions of the team reflect a coherent pattern of effective teamwork and collaborative problem solving that builds upon child and family strengths and needs and benefits the child and family—as revealed in present results.

**4. ASSESSMENT & UNDERSTANDING:** Degree to which those involved with the child and family understand: (1) Their strengths, needs, risks, preferences, and underlying issues. (2) What must change for the child to function effectively in daily settings and activities and for the family

to support and protect the child effectively. (3) What must change for the child/family to have better overall well-being and improved family functioning. (4) The *big picture* situation and dynamic factors impacting the child and family sufficiently to guide intervention. (5) The outcomes desired by the child and family from their involvement with the system. (6) The path and pace by which permanency will be achieved for a child who is not living with nor returning to the family of origin. [Need, as used in this indicator, is based on the *Framework for Assessing and Responding to Needs* presented in the introductory section of the practice performance domain.]

**5. LONG-TERM VIEW:** Degree to which there are stated, shared, and understood safety, well-being, and permanency outcomes and functional life goals for the child and family that specify required protective capacities, desired behavior changes, sustainable supports, and other accomplishments necessary for the child and family to achieve and sustain adequate daily functioning and greater self-sufficiency. [*Current goals guiding planning of interventions over the past 90 days*]

**6. PLANNING:** Degree to which a well-informed, well-reasoned, family centered, team-driven planning process is being used to direct strategies and resources for: (1) meeting near-term child and family needs; (2) achieving child safety, well-being, and permanency outcomes; and (3) supporting and sustaining the family or permanent caregiver.

**7. SUPPORTS & SERVICES:** Degree to which the strategies, supports, and services planned the child and family are available on a timely and adequate basis to meet near-term child and family needs and to achieve the outcomes planned.

**8. INTERVENTION ADEQUACY:** Degree to which planned interventions, services, and supports being provided to the child and family have sufficient power (precision, intensity, duration, fidelity, and consistency) and beneficial effect to produce results necessary to meet near-term needs and achieve outcomes that fulfill the long-term view.

**9. TRACKING AND ADJUSTMENT:** Degree to which those involved with the child and family are:

- Carefully tracking the child's/family's intervention delivery processes, progress being made, changing family circumstances, and attainment of functional goals and well-being outcomes for the child and family.
- Communicating (as appropriate) to identify and resolve any intervention delivery problems, overcome barriers encountered, and replace any strategies that are not working.
- Adjusting the combination and sequence of strategies being used in response to progress made, changing needs, and knowledge gained from trial-and-error experience to create a self-correcting intervention process.

## **Appendix B**