

**The Katie A. Advisory Panel
Twelfth Report to the Court
August 18, 2010**

**The Katie A. Advisory Panel
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Table of Contents

Executive Summary	Page 3
I. Introduction	Page 6
II. Background	Page 6
III. Panel Activities Since the Last Report	Page 8
IV. Current Implementation Plan Status	Page 8
V. Analysis of Strategic Plan Implementation	Page 18
VI. Katie A. Outcome Indicators/Exit Conditions	Page 24
VII. Panel Recommendations	Page 34
VIII. Glossary of Terms	Page 35
IX. Appendix	Page 37

Executive Summary

This report addresses the progress by the County in implementing the Katie A. Strategic Plan and Corrective Action Plan, along with relevant elements of the Countywide Enhanced Specialized Foster Care Mental Health Services Plan.

The County has continued to work intensely on implementation of the Strategic Plan since the Panel's last report. Among the progress the Panel has observed is:

- Thanks to the support of the County Board and progress made by DCFS and DMH, Katie A. resources have been protected during challenging economic times for the State
- An improvement in the percentage of newly detained children receiving an initial medical examination at a Hub from 75 percent in 2008-2009 to 82 percent currently
- Achievement of a 96 percent mental health screening rate for children appropriate for screening
- Of children with positive mental health screens, 95 percent were referred for mental health services
- Of children referred for mental health services, 94 percent received a mental health service activity (future reports will address timeliness)
- The County reached 101 percent of the targeted number of slots allocated for Tier II Wraparound Services (887) in May 2010
- The County has met all nine of the outcome indicator targets agreed to by the parties and Panel
- The County successfully developed a County Qualitative Service Review (QSR) protocol and piloted the process in June 2010

County Challenges

The County is now working on additional implementation steps and challenges that must be addressed to achieve the objectives of the settlement.

Training and Coaching of Staff

Foremost among these is training and mentoring the many DCFS supervisors and caseworkers and mental health practitioners so that their practice is faithful to the County's new model of practice. That model focuses on the strengths of children and families, not just their deficits. It

expects staff to be engaged with families and involve them fully in planning and decision-making about the services they receive and how they are delivered. The County practice model focuses on the underlying needs of children and families, not just the symptoms of underlying conditions and responds to those needs individually. Services are expected to be responsive to past trauma in the lives of children and their families. These expectations represent a big shift in practice for many child welfare and mental health professionals in the County. Successfully implementing this change in practice will require extensive training and mentoring of new and existing staff.

The biggest challenges for the County in this area are threefold: 1) designing training content that adequately addresses the shift in values needed, provides opportunities to develop some basic practice model skills and prepares staff for coaching; 2) providing enough coaching support so that supervisors can be developed to coach their supervisory units in the practice model and 3) ensuring that trainers and coaches have experience in practice within the County practice model prior to training and mentoring DCFS and mental health staff.

Resource Development

The County is currently assessing options for addressing two areas of resource development: 1) the lower than anticipated percent of children in D-rate homes receiving mental health services and expanding treatment foster care. D-rate homes are designed to serve children with emotional/behavioral needs. The County, plaintiffs' and Panel all expected that the percentage of D-rate children receiving mental health services would be higher than 81 percent. The County plans to follow up in this area to determine the reasons for this somewhat low incidence. The Panel has also asked the County to attempt to determine what percentage of children in D-rate homes were receiving home-based mental health services.

The County committed to developing 300 treatment foster care beds using two different program models by December 2012. To date, 43 beds have been developed and 21 children are in placement. The County recognizes that progress is much slower than desired and has tried several strategies to hasten capacity development, but progress remains slow. A more complete discussion of this issue is discussed later in this report, including a description of the barriers the County is trying to overcome.

Panel Recommendations

Training The Panel commends the work performed by the County in translating the practice model into appropriate training modules related to child and family engagement, teaming, assessment, and planning and incorporating content related to trauma into each module. We believe that such content will help prepare staff for subsequent coaching which incorporates hands-on mentoring of staff in work with actual children and families.

However the Panel believes that the training strategy is insufficient to fully prepare staff for coaching and actual practice. At two training days for each module, the training is too brief to do much more than describe the practice desired and appears to provide little opportunity for trainers to model the practice and allow participants to demonstrate skills in the classroom. The

Panel also does not believe that the County yet has a clear strategy to prepare trainers for training delivery. Most other systems successfully implementing practice change of this nature employ a process of first training and coaching the trainers in the new practice before they begin a training of trainers effort.

The County correctly notes that the scale of the system and volume of work limit the number of days staff can spend in training; however other systems have found a way to commit more time to this process. For smaller systems the challenge of scale and volume of work is of the same proportion as LA given the comparative differential in resources available in LA.

The Panel is unaware of any County Plan to train mental health providers in team-based strengths and needs-based practice, despite the fact that such providers play a major role in serving the plaintiff class. The training described above is designed for DCFS staff. The Panel has previously recommended that the County cross-train DCFS and mental health staff, but the current County Strategic Plan is largely silent on provider training. Recently the County has shared a conceptual approach for using the California Institute for Mental Health to provide some of the mental health training, but it is not yet sufficiently detailed to assess its viability.

The Panel recommends that training permit more time for skill development and that the County develop a credible plan for trainer development. The Panel also recommends that the County develop a plan for provider training.

Coaching The Panel and County are in agreement that intensive coaching needs to follow practice model training; however, the County does not have a plan for developing coaches other than a brief training module on coaching. The Panel has no confidence that coaches can be developed through classroom training alone. The County plans to rely primarily on line supervisors as coaches, a strategy the Panel concurs with in part. However, the Panel recommends that the County utilize experienced practice experts to develop supervisors as coaches, mentoring them in actual work with children and families.

Development of Treatment Foster Care Beds The County is making little progress in fulfilling its commitment to create 300 treatment foster care beds, (220 Intensive Treatment Foster Care Beds and 80 Multidimensional Treatment Foster Care Beds). The Panel recommends that the County intensify its efforts to complete this task and consider recruiting external technical assistance to achieve this effort.

D-Rate Homes and FFAs The Panel's primary recommendation is that the County determine if it is possible to gather additional detail about the reasons for the lower than expected numbers of children receiving mental health services in these placement settings and what percentage of those receiving mental health services are receiving home-based services.

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I. Introduction

The following Twelfth 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):

- immediately address the service and permanence needs of the five named plaintiffs;
- 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, several Panel members spent two days with the County's Qualitative Service Review design team. The design team provided feedback to Human Systems & Outcomes, the technical assistance organization helping the County design its unique version of the QSR protocol, on protocol content.

On May 11, 12 and 13, 2010 the full Panel held a regular Panel meeting in Los Angeles. Included in the agenda were:

- Updates on budget issues facing the County and both DCFS and DMH
- An update on the Katie A. Strategic Plan implementation
- An update on practice model training plans
- Information about Trauma-Informed Strengths/Needs Based Services
- Discussions with service providers about implementation of the practice model
- Information about County evidenced-based practices
- An update on mental health services provided to children in D-Rate homes and FFAs
- Discussion with attorneys for children served by DCFS
- Overview of the Child Steps Project (related to the efficacy of a combination of evidenced-based services)
- A meeting with a group of Multidisciplinary Assessment Team (MAT) provider staff (a case record review of a small sample of MAT cases is also being conducted by Panel members and County staff)

IV. Current Implementation Plan Status

Co-location of DCFS and DMH Staff

The County has hired 80 of the 81 positions allocated to DCFS. According to the County, it has allocated a total of 316 positions to DMH to support Katie A. related activities, 94 percent of which are filled.

Additional staffing for the DMH ACCESS Hotline

One of 3 positions is filled. The County continues to explore opportunities to improve the coordination of activities and information related to calls to the ACCESS hotline. In an effort to reliably identify DCFS children referred to the Hotline and provide a timely response, the County is proposing to add four additional positions.

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

The Panel and County are in agreement on the indicators that will reflect outcomes, efficiency and Practice quality. The list of outcome indicators, which measure safety and permanency performance are included in a later section of this report. The parties are currently working on exit goals for the efficiency indicators, which primarily deal with timeliness of mental health screening, assessment and service revision. The parties are also in agreement about qualitative indicators, which address areas such as emotional well-being, teamwork and planning. The tool which will be used to measure these indicators, the Qualitative Service Review (QSR), has been completed and was piloted during the last week in June.

Development of Multidisciplinary Assessment Teams (MAT)

The County's goal for the Multidisciplinary Assessments is completing a MAT for 100% of all MAT-eligible children. As of the Panel's January 2010 report, 63% of MAT-eligible children were screened. As of April 2010, the most current month for which data is available, 83% (395 children) of newly detained children countywide received a MAT Assessment. The County reports that the lack of Spanish speaking MAT staff continues to be a barrier to timely assessment. Also, some agencies had fully utilized their MAT funding by the end of the Fiscal Year, June 30. They receive a new allocation July 1.

The Panel and County are currently conducting a review of 20 MAT cases to identify the strengths and challenges of the MAT process.

Implementation of the DMH Behavioral Health Information System

Completion of the DMH information system (IBHIS), first projected for completion in June 2008, is now projected for completion in September 2013. DMH is current reviewing proposals from vendors.

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

The parties have agreed to utilize the Qualitative Service Review to achieve this objective and will begin the assessment of practice quality in June 2010. It will take two years to review all Service Planning Areas. Two hundred cases will be reviewed.

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

The County has provided the Panel copies of an initial draft of training curricula, which the Panel is reviewing. The County also provided a draft of revisions to its practice model. Issues of interest to the Panel are the depth of training, number of staff to be trained over what time frame, expertise of trainers, involvement of mental health staff in training and the coaching plan. Training (and coaching) will be discussed further in a separate section of the report.

Expansion of Funding

To date the Board has continued to protect the additional funding provided to DCFS and DMH for Katie A. Implementation from the reductions that threatened other social service programs. In regard to the larger budget challenges facing DCFS, DMH and the State, the County reports the following:

Senate Democrats on Monday (June 21, 2010) unveiled their plan to give counties greater control of state programs, potentially shedding \$3 billion to \$4 billion in ongoing costs to the state budget. Many of the programs are already delivered by counties but paid for through state coffers. Senate Democrats see their changes as a more appropriate "realignment" of services and costs over the next four years. Their plan would not cut taxpayer costs but give counties new forms of revenues to pay for the added responsibilities. The state would approve a tax on oil production, permanently extend the state's higher vehicle license fee rate and delay corporate tax breaks. It would also give counties greater authority to seek local tax hikes from voters. "If you're going to plant your flag around some reasonable revenue, plant it next to a long-term plan to restructure government in California," said Senate President Pro Tem Darrell Steinberg, D-Sacramento. Republicans said they were willing to work with Democrats on a "realignment" plan, but they opposed the idea of using new taxes to pay for county costs. "Raising taxes to pay for the shift of programs isn't shrinking government, it's just avoiding the inevitable: State government has to get smaller and more efficient in this day and age," said Senate Republican leader Dennis Hollingsworth in a statement. The biggest component of the Democrats' plan involves shifting as much as \$2.6 billion in annual welfare-to-work costs to counties – making them responsible for 25 percent of CalWORKs grants, compared to 2.5 percent today. Counties also would become responsible for CalWORKs child care – more than \$1 billion annually – and take over more administrative duties. The plan borrows some ideas from Gov. Arnold Schwarzenegger's May budget proposal by shifting state juvenile parole services and low-level inmates to counties. It makes counties responsible for drug-related Medi-Cal programs, offender treatment services and the state's Drug Court. Counties also would take over Adult Protective Services and Department of Aging programs. Steinberg said the plan would cut the state's current \$19.1 billion deficit, but it is not yet clear by how much. In 2010-11, the state would offload \$3.1 billion in costs, the plan says.

One area the Panel, County and plaintiffs are interested in exploring further is the belief that some providers of MediCal eligible services chose to bill the case rate for Wraparound-like services, which shifts costs to the County rather than claiming fully for MediCal eligible services. This occurs because case rate claiming is simpler and less exposed to audit exceptions than MediCal claiming and as a result, service availability for indigent non-EPSDT eligible children with mental health needs can be diminished. The outcome of discussions between the State Katie A. parties facilitated by the Special Master regarding the State Katie A. case has major implications for helping resolve this claiming issue. The County is working with a workgroup of providers on the issue. This issue will be a topic of discussion at the September Panel meeting with the parties.

Expansion of Staff Resources for Multidisciplinary Medical Hubs

The County has a goal of providing 100% of all newly detained children an initial exam from a Medical HUB. The County reports that from July 2009 to February 2010, 82% of newly detained children received an initial medical exam, compared with 75% reported from August 2008 to July 2009. Currently, the County does not collect data on the timeliness of administering an initial medical exam for newly detained children.

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

In April 2010, the County completed 1461 Team Decision Making meetings, compared with 1640 in March. The County has increased the number of TDM facilitators from 76 to 82. In future reports, it would be helpful to have a specific breakdown on the percentage of TDMs held in cases of removal, replacement and reunification.

DCFS reports that it has completed 4,427 TDMs from January-March 2010, an increase of 208 TDMs over the prior three months.

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

Screening – The County is currently working on a revision to the mental health screening tool to respond to issues raised by a Board of Supervisors motion and a case review of 51 cases from the Santa Fe Springs Office. As of May 2010, County data was provided for SPAs 1, 6 and 7 and covers the period May 2009 – March 2010 for SPA 7, August 2009 – March 2010 for SPA 6 and September 2009 – March 2010 for SPA 1.

- A total of 1,084 individual Children's Social Workers (CSWs) completed mental health screens to date.
- Out of 17,169 children potentially requiring a screen, 11,679 children were screened at a 96% screening rate.

(Note: The number of children that required screens is defined as a) the number of newly detained children (Track 1) with a case opening in the month; b) the number of newly open non-detained children (Track 2) with a case opening in the month; c) the number of children in an existing open case (Track 3), not currently receiving mental health services, with a case plan update due or a behavioral indicator identified requiring the completion of a CIMH/MHST within the month. Out of the total number of children reported, the number of children that required screens was reduced by the number of children in cases (Tracks 1, 2, and 3) that were closed during the screening, referral and service linkage process.)

- Out of the 5,156 children who screened positive, 4,805 children were referred for mental health services at a 95% referral rate.
- Out of 4,805 children referred for mental health services, 4,529 children received a mental health service activity at a 94% access rate.
- The average number of days between the case opening or case plan due date and completion of a mental health screen was 20 calendar days. The average number of days between a positive mental health screen or Multidisciplinary Assessment Team (MAT) referral and referral for mental health service was 7 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 case opening and start of mental health services totaled 30 days.

This represents notable progress for the County in mental health screening. Data are not yet available to describe the timeliness of screening, referral and receipt of a mental health service in greater detail according to agreed upon standards. The work on the efficiency indicator data should ultimately describe the numbers and percent of children that met an agreed upon timeliness standard, such as receipt of a mental health service. Information on average performance is useful but incomplete.

Coordinated Services Action Team – The Coordinated Services Action Team (CSAT) aligns and coordinates DCFS and DMH staff 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 & 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 rollout of the Coordinated Services Action Team in coordination with the revised MHST is as follows:

<i>Table 1: CSAT Redesign Training and Roll-Out Schedule</i>				
<i>DCFS Office</i>	<i>Training Month</i>	<i>Trial Month</i>	<i>CSAT Roll Out</i>	<i>Referral Tracking System Report to Board</i>
Belvedere, SFS	Aug. 2010	Sept. 2010	Oct. 2010	Dec. 2010

Compton, Wateridge, Vermont Corridor	Aug. – Sept. 2010	Oct. 2010	Nov. 2010	Jan. 2011
Palmdale, Lancaster	Sept. – Oct. 2010	Nov. 2010	Dec. 2010	Feb. 2011
Pomona, El Monte, Pasadena, Covina Annex (Asian Pacific & American Indian Units Only)	Oct. – Nov. 2010	Dec. 2010	Jan. 2011	Mar. 2011
Glendora	Nov. – Dec. 2010	Jan. 2011	Feb. 2011	Apr. 2011
Metro North	Dec. – Jan. 2011	Feb. 2011	Mar. 2011	May 2011
West Los Angeles (and Deaf Services)	Jan. – Feb. 2011	Mar. 2011	Apr. 2011	June 2011
Lakewood, Torrance	Feb. – Mar. 2011	Apr. 2011	May 2011	July 2011
San Fernando Valley, Santa Clarita	Mar. – Apr. 2011	May 2011	June 2011	Aug. 2011
Medical Case Mgmt. Services	May 2011	June 2011	July 2011	Sep. 2011
Emergency Response Command Post	May 2011	June 2011	July 2011	Sep. 2011

The County reports that in May 2010 17,169 children were reviewed for screening eligibility compared with 15,587 in April 2010. The County has identified a need for crisis stabilization as an additional mental health resource for DCFS children with acute or urgent mental health needs.

Referral Tracking System (RTS) – The redesigned RTS and CSAT implementation process designed to distinguish DCFS children who screen positive for mental health services according to acute, urgent and routine presenting mental health needs is expected to be completed in all Service Planning Areas by September 2011.

Expansion of Mental Health Services

In previous plans, the County committed to provision of the following discrete services:

- Intensive In-Home Mental Health Services
- Early Intervention Foster Care
- Multidimensional Treatment Foster Care (MTFC)
- MTFC “Lite” (ITFC)
- Multisystemic Therapy
- Functional Family Therapy
- Incredible Years
- Trauma-Focused Cognitive Behavioral Therapy

More recently, the County has reported that it has identified five evidence-based modalities from the list above to implement. These are Multidimensional Treatment Foster Care (MTFC), Multisystemic Therapy (MST), Functional Family Therapy, Incredible Years and Trauma Focused Cognitive Behavior Therapy.

The County also committed in the Corrective Action Plan to develop 220 Intensive Treatment Foster Care (ITFC) beds and 80 Multidimensional Treatment Foster Care (TFC) beds. These are two different models of care. As of June 12, 2010, the County has 24 certified ITFC beds and 17 children are in placement. Nineteen MTFC beds have been developed with 15 in process. The number of trained MTFC clinical teams has recently increased from two to seven, expanding the geographic availability of this program. In addition, two of the five new teams were trained to treat middle aged children (ages 6-11), further broadening MTFC service capacity. Four children are placed in MTFC beds.

The County has had considerable difficulty in recruiting providers and foster parents for these models. Only 21 children out of the 300 projected are in placement. This very likely results in children being placed unnecessarily in congregate settings or remaining in them for a longer period of time than would be necessary if treatment foster care beds were available. While the pace of development of MTFC normally proceeds more slowly than other models, the County's slowness in developing these family-based treatment resources has been much slower than many other systems which have been able to expand treatment foster care more quickly.

In its comments in response to the Panel's draft report, the County states:

Both ITFC and MTFC have had successful graduations. Some systems barriers: MTFC has had a very low volume of referrals. One reason for this is that CSWs are often unaware of the existence of a potential permanent caregiver who may be available once the youth's behaviors are more manageable; In cases where the CSW is aware of a permanent caregiver, they may still not refer the youth to MTFC because of the CSW's low confidence in the caregiver's capacity (which is a major focus of MTFC interventions), or because the youth is currently "stable" in their group home and not in need of MTFC; CSW not understanding TFCs are treatment driven rather than placement driven; CSW not understanding the program to refer appropriate candidates (still getting kids who need psychiatric hospitalization rather than treatment foster homes).

In the process of commenting on the Panel's draft report, the County has identified the following strategies to support a more rapid expansion of treatment foster care resources.

- a. *Increase in number of TFC bed development has begun since the first 9 contracts were fully executed on April 21, 2010; that is, since that time 19 new MTFC foster parents were certified and are beginning the matching process and 34 new ITFC homes were recruited and are in the process of certification and training.*

- b. *Organize two half-day conferences to maximize outreach to DCFS and CSW line staff and TFC providers on the specific topic of treatment-driven vs. placement-driven foster care programs.*
- c. *Consider finding funding to bring in outside experts in ITFC programs in California to consult with LA County ITFC providers and foster parents.*
- d. *Begin a pilot project to decrease the number of pre-placement visits for potential ITFC placements.*
- e. *Continued outreach to existing DCFS foster families and Kinship Services to increase awareness of TFC programs for possible recruitment.*

In addition to the feedback provided above, please note that DCFS has just now received official notification from the California State Department of Social Services (CDSS) that the 3 newly contracted ITFC agencies (Ettie Lee, Hathaway-Sycamores, and Vista Del Mar) were given state approval, and have been emailed the amended Rate Letter. The DCFS Contracts section has been notified, and can now send out the Start Work Letter for these three agencies. So, in total there are now 12 agencies contracted to deliver 12 ITFC programs and 7 MTFC programs.

The Panel endorses these strategies and will continue to work with the County to encourage the commitment of additional resources to enable full implementation.

Expansion of Wraparound by 500 Slots

The County projected achieving a total of 1400 Wraparound slots by the end of FY 2009-2010 and as of May 2010 had filled 1,027 slots. As was discussed in the Panel's recent meeting with the County, there appears to be a need to more efficiently allocate unused slots and fill them quickly. As of June 1, 2010 the County revised the referral policy to allow Wraparound agency providers to make referrals directly. Referrals have improved as a result. The county has approved a small pilot to allow mental health wraparound agency providers to make these referrals directly, which has been an improvement. The county should continue to monitor efforts to streamline access to these services. The County has also set up a committee with providers to review the case rate (county General funds used to pay for some of the Wraparound services) to determine if more of those services can or should be covered by EPSDT. The state litigation also has an impact on this current practice as the Panel understands there are not clear state rules or guidance about Medi-Cal /EPSDT coverage of these services.

In the Court's most recent order related to the County Katie A. Settlement Agreement, the County was asked to elaborate on a description of Wraparound effectiveness mentioned by the Panel in its Eleventh Report. The County reports the following:

The County agreed to increase the number of Tier 1 Wraparound slots to a total of 1400 at the time of the development of the Strategic Plan in October 2008. As of April 30, 2010 the County had filled 1,048 Tier 1 slots, For the first time ever since the roll out of Tier II, 887 children are enrolled in Tier II Wraparound as of May 2010, exceeding the

cumulative target by 12 slots. All together point in time enrollments for April and May 2010 for Wraparound tiers 1 & 2 reached 1,935.

An analysis of out-of-home placements and associated financial costs was conducted comparing two groups (Wraparound vs. RCL 12 and 14 children) from FY 2007-2008 whose cases remained open for at least 12 months. One-hundred ninety-four cases were reviewed. The findings were:

- Children who graduated from Wraparound were more likely to have their cases terminated within 12 months compared to children from RCL 12-14 (almost 59% vs. almost 17%).*
- 41% of the Wraparound graduates had no placement costs or subsequent out-of-home placements compared to just over 6% of the RCL 12-14 group.*
- Wraparound graduates spent fewer days in placement than did children from RCL 12-14 (202 vs. 308 days).*
- Wraparound graduates were generally placed in less restrictive placements with foster families, relatives, or guardians compared to more restrictive settings such as group homes or FFA-certified foster homes for the RCL 12-14 group.*
- Wraparound graduates had substantially less average placement costs than the RCL 12-14 group (\$9,627 versus \$15,872).*

Intensive Home-Based Service Delivery

A major part of home-based mental health service development is the creation of what the County defines as Tier II Wraparound, which is a somewhat less intensive and more flexible form of Wraparound appropriate for less intensive cases. The County projected ultimately creating 2,800 slots and reports the following for March – May, 2010. The County projects to fill all 2,800 slots by FY 2014-2015.

Tier II Enrollment/Target Analysis			
Month-Year	Target	% of Target Achieved (D /B)	CUM (DCFS+FSP Child+FSP TAY)*
Mar-10	725	93%	677
Apr-10	800	97%	778
May-10	875	101%	887

Targeted Mental Health Services for D-Rate Homes

This task has been fully implemented. The County and Panel are now exploring the utilization of mental health services by children in D-Rate homes and FFAs. Preliminary data indicates that as of a November 30, 2009 placement date in which children received mental health services 90 days prior to or after the November 30, 2009 placement date, out of 1,570 children in D-Rate homes, 1,270 or 81% were receiving mental health services. The County wants to explore why a higher percentage of participation in mental health services was not found, as D-rate homes are specifically used for children with mental health/behavioral needs. Using the same data parameters, of 6,106 children placed in FFAs, 2,922 or 49% were receiving mental health services.

For children in D-Rate homes, the type of mental health service coded was “Other” for 60%. In FFAs the percentage of children coded as receiving “Other” mental health services was 83%. Further exploration is needed by the County to determine what portion of the “Other” category includes home-based mental health services.

Caseload/Workload Reduction

As part of its workload reduction strategy, the County projected reducing the generic caseload average from 26 to 24 by June 2010. Currently the average caseload is 24.94 cases. The County also projecting its emergency response average caseload from 24 to 18. Currently the average caseload is 19.72. Further reductions in caseload are challenged by heightened emergency response demand, necessitating shifting staff with generic caseloads to emergency response responsibilities.

There was a 2 percent decrease in the out-of-home caseload from May 2009 to may 2010. Due to an increase in children receiving in-home services, the total DCFS caseload went up by 1.2 percent.

Young Children in Group Homes

As mentioned in the Panel’s January 2010 report, the County has steadily reduced the number of children age 12 and under from nearly 600 in 2003 to slightly over 100 at the end of 2009. The following chart shows the number of young children currently in group homes by age and provider. The current total of 163 is somewhat higher than six months ago.

GROUP HOME REPORTS FOR CHILDREN 0 TO 12 BY FACILITY FOR THE MONTH OF MAY 2010

GROUP HOME FACILITY	0	1	2	3	4	5	6	7	8	9	10	11	12	TOTAL
BAYFRONT YOUTH AND FAMILY SERV	0	0	0	0	0	0	0	0	0	0	0	0	1	1
BOYS TOWN CALIFORNIA	0	0	0	0	0	0	0	0	0	0	0	0	1	1
BRUCE & NELSON RES FACILITY	0	0	0	0	0	0	0	0	0	0	1	0	0	1
CAMACHO CHILDREN'S CENTER II	0	0	0	0	0	0	0	0	1	0	0	0	0	1
CANDLELIGHT HOMES	0	0	0	0	0	0	0	0	0	0	0	0	1	1

CHILDEHELP	0	0	0	0	0	0	2	1	1	3	2	6	8	23
CHILDREN'S HOMES OF SOUTHERN C	0	0	0	0	0	0	0	0	0	0	0	0	1	1
DAVID & MARGARET HOME, INC.	0	0	0	0	0	0	0	0	0	0	0	0	2	2
DREAM HOME CARE	0	0	0	0	0	0	0	0	2	1	0	1	0	4
FIVE ACRES THE BOYS' AND GIRLS	0	0	0	0	0	0	3	5	7	7	8	10	8	48
GARCES RESIDENTIAL CARE SERVIC	0	0	0	0	0	0	0	0	0	0	1	0	1	2
HATHAWAY-SYCAMORES CHILD AND F	0	0	0	0	0	0	0	0	0	0	0	0	1	1
HILLSIDES	0	0	0	0	0	0	0	0	0	2	2	2	1	7
HOPE 4 U	0	0	0	0	0	0	1	0	0	0	0	0	0	1
HOPE HOUSE	0	0	0	0	0	0	0	0	0	0	0	0	2	2
JUNIOR BLIND OF AMERICA	0	0	0	0	0	0	0	0	0	1	1	0	0	2
LEROY HAYNES CENTER CHILDREN &	0	0	0	0	0	0	0	0	0	0	3	3	4	10
LITTLE PEOPLE'S WORLD	0	0	0	0	0	0	1	0	1	1	1	6	5	15
MARYVALE	0	0	0	0	0	0	0	0	1	4	5	5	4	19
MCKINLEY CHILDREN'S CENTER INC	0	0	0	0	0	0	0	0	1	0	0	5	4	10
MOZELL PENNINGTON BOYS CENTER	0	0	0	0	0	0	0	0	0	0	0	0	1	1
O'CONNOR AND ATKINS GROUP HOME	0	0	0	0	0	0	0	0	0	0	2	0	2	4
ORANGE COUNTY CHILDREN'S FOUND	0	0	0	0	0	0	0	0	0	0	0	1	1	2
PARADISE OAKS YOUTH SERVICES	0	0	0	0	0	0	0	0	0	0	0	0	1	1
PENNACLE FNDATN INC	0	0	0	0	0	0	0	0	0	0	0	0	1	1
PENNY LANE CENTERS	0	0	0	0	0	0	0	0	0	0	0	0	1	1
STARVIEW CHLDRN & FMLY SER CTF	0	0	0	0	0	0	0	0	0	0	0	0	1	1
TOTAL	0	0	0	0	0	0	7	6	14	19	26	39	52	163

Qualitative Service Review

The Qualitative Service Review began in late June 2010 and will take two years for application to all SPAs. More information about this process will be provided later in this report.

Exit Criteria

The parties and Panel have reached agreement on exit conditions for Safety and Permanency outcome indicators. Additional information on this task will be provided in a separate section. Discussions continue on exit conditions for efficiency indicators and the Qualitative Service Review.

V. Analysis of Strategic Plan Implementation

Training and Coaching

In May 2010, the County provided the Panel with four curricula to review:

Trauma-Informed Child Welfare System
Enhancing Strengths/Needs-Based Practice
Engaging to Meet the Needs of Children and Families

Strengths-Based Teaming

This training for DCFS staff is essential for implementing the Core Practice Model. As the County said, “Development and delivery of skill based training, supported by coaching and mentoring of direct service social work staff and supervisors, are critical components of the Katie A. Strategic Plan and directly relates to key Quality Service Review benchmarks that are a part of exit criteria for the Settlement agreement.” The Trauma-Informed Child Welfare System” was initially a stand-alone one-day training, but now has been integrated into the other three modules. The other three modules (Strength/Needs Practice, Engagement and Teaming) are each two-day sessions which DCFS staff attend each week for three weeks and are scheduled to be piloted beginning in July, 2010. The County expects to complete all the Core Practice Model Training by June 2011. A copy of the training schedule is found in Appendix B. The following is a summary of the comments on the training provided to the County by the Panel June 10, 2010.

1. Trauma-Informed Child Welfare System

Training on the effects of trauma on children's behavior and adjustment in foster care is crucial, and this curriculum contained important information. But the presentation appeared too academic, and our feedback suggested how to make it more specifically applied to the needs of children in DCFS. For the child welfare population, trauma includes loss as well as abuse and exposure to family or community violence, so most children in care have been traumatized (although many would not meet PTSD criteria): (a) most children are upset for a long time after being placed in foster/relative care; (b) some children in foster care have been traumatized by physical or sexual abuse or exposure to violence prior to entering care; (c) each child has unique reactions to trauma; and (d) children show their unique reactions to separation and other trauma in visits. Many children in care have trauma-related behavior problems in the foster home, school and visits which is why so many more mental health services and more trauma-informed teamwork are necessary. DCFS staff, clinicians, parents, teachers, foster parents, and group care staff have to be able to look behind the behaviors to figure out what the child needs and this should be the context of training on a trauma-informed child welfare system.

2. Effectively Assessing Behaviors to Meet the Unmet Needs of Children and Families

The county's summary of this module is:

A two-day training for social workers provides an overview of the Katie A. Strategic Plan, and the Core Practice Model/Shared Practice Principles. A strength-based framework will be presented for identifying, assessing and addressing the unmet needs of children and families. Through a variety of skill based activities, social workers will incorporate the principles of Advanced Strength-Need Based Practice to identify and address the link between the child's behaviors and underlying unmet needs of children and families. Social workers will be introduced to Child Trauma based needs and the importance of maintaining focus on the underlying needs that are often manifested in challenging behaviors. Social Workers will also learn the importance of crafting individualized services, which support the family and

caregivers in shifting their focus from family deficits to mobilizing family strengths, to meet their children's underlying needs. Last, workers will develop strategies to enhance their ability to effectively work with diverse cultural groups towards gaining a better understanding of each child's and/or families needs in order to develop meaningful case plans that incorporate a family's unique culture and strengths.

Panel feedback attempted to help the training developers get more specific in the examples they use of children's needs. For example, the Panel suggested modeling in training the kind of thinking social workers would do about a child's needs behind a problem behavior, such as: "I need to feel not stupid." "I need to learn to read better." "I need to be listened to." "I need to be part of decisions about my future." "I need to know my Dad and brothers are all right." "I need attention from my Mom." "I need to feel proud of something I do in school." A possible activity was proposed to help training participants discuss their hunches about the needs behind a child's behaviors, and those of parents and foster parent, making sure that each child's attachment, trauma-related, and developmental needs are considered.

3. Engaging Families to Identify Their Children's Underlying Needs

The county's summary of this module is "a two day training for social workers focuses on enhancing practice skills which focus on building effective working relationships with children, families and community partners, with the purpose of identifying a child's unmet needs and ensuring that those needs are met in a timely, comprehensive manner. Engaging families is the foundation to developing meaningful partnerships between family members, social workers and their community. At its core, engagement requires that the child/youth and family be active participants in mobilizing family strengths towards identifying and addressing a child's needs, while maintaining a solution focused approach to those family issues and concerns that impact child safety. Engagement also involves working to understand a family's needs within the unique culture of each family and effectively address barriers or stigmas related to seeking help to get those needs met, particularly when a mental health need has been identified. Effective engagement helps the child and family to engage with their community (formal and informal supports) so that families can develop long lasting support systems to help sustain positive changes."

Our feedback on this important module was to emphasize that reaching agreement with families about the needs of their children is an important part of engagement, from the first day of contact, during visits, and in team meetings. The training developers were encouraged to use visits as a key element teaching engagement, and to connect this engagement training to the teaming training and to how the first contacts with a family are presented.

4. Strength Based Teaming

The county's summary of this module is "a two-day training for workers continues to build on Enhancing Strengths/Needs Based Practice and Engaging Families by incorporating the principles offered there into the teaming process. Whether teams are short or long term, family planning for achieving safety, permanency and well being can be more effective with genuine teamwork. Teamwork includes working collaboratively with families and community partners to

help identify a child and/or family's unmet needs and together develop an effective plan that addresses those needs. Additionally, workers will learn how to help their families identify and build teams of formal and informal supports so that families feel connected and supported in the change process. This training is designed to help enhance the worker's knowledge of team dynamics, including an understanding of what makes teams successful, the steps and skills necessary for successful team outcomes, and the skills to facilitate the teaming process, including strategies for negotiating conflict.”

Our feedback encouraged more specific focus on effective teams in day-to-day child welfare practice, specifically the challenges of helping parents, foster parents and providers reach agreement about the needs of a child. The Panel gave feedback that the needs of children are not primarily identified by formal professional assessment, but by the individuals on the team putting their heads together. Furthermore, making sure that trauma is presented in the teaming training as teams will discuss their different perspectives on the trauma-related behaviors of children is important.

5. Training Design

The Panel believes that the County has identified the appropriate core topics relevant to practice within the system model of practice. There are three areas of the design process that remain a Panel concern; the brevity of training time provided in each module, the limited trainer guidance about content within the trainer guides/handbooks and the challenge of developing a sufficient number of trainers to deliver the content with fidelity to the model of practice.

Regarding the length of training, as the Panel has advised previously, effective training should do more than just provide descriptions of the skills needed. It should also include opportunities for trainers to model the skills needed and for participants to demonstrate skills and receive feedback on performance. Given the breadth of practice content covered in training, two-day modules do not seem likely to cover the content adequately.

A significant part of training content contains Power Point presentations that trainers are to elaborate on. For example, in the module on Strength-Based Teaming, the section on Individualized Planning Strategies lists:

- Begin with family objective
- Identify mobilized strengths
- Explore hunches, clarify
- Understanding with family
- Identify and address needs

The trainer guidance for this list is “discuss each in detail”. Such curriculum design places a large responsibility upon trainers to communicate the correct detail to ensure that the explanation is faithful to the model of practice; however no further trainer guidance is provided on the trainer’s guide. The Panel believes that given the limited experience of professionals in the County’s model of practice, more fully documented written guidance is needed in the trainer’s guides/handbooks to assure fidelity and consistency.

Because the number of training professionals that have practiced within the environment of the LA practice model is modest, the Panel believes that the training of trainers to deliver the training is a critical step. To competently deliver this training, for example, trainers should have experience in engaging families, facilitating team meetings, assessing child and family strengths and underlying needs with family members, individualized planning and individualized service crafting. Additional County planning seems needed to ensure that trainers are able to model the skills which are taught. What is the County's plan for training of trainers?

6. Training of Mental Health Providers

The draft training content seems primarily directed at DCFS staff. The Panel has inquired previously about the training plan for providers and suggested that mental health and DCFS staff be trained jointly on core issues. This is important to ensure that the approach of DMH and DCFS to serving children is aligned and Departments understand the role and perspective of each other. The County needs to provide additional information about plans for training and coaching provider staff. The brief conceptual approach relative to the CIMH role in training providers provided by the County doesn't provide enough detail to judge its viability. In addition, after meeting with CIMH staff about training consistent with the LA Practice Model, the Panel would like more information about their training experience in building skills in cross-system team-based strengths and needs-based practice.

7. Coaching

The Panel and County agree about the need for training of staff to be accompanied by skilled coaching in actual cases. The recent pilot QSR should provide some indication of the degree of mentoring staff will need in engagement, family/youth participation in planning, team formation and functioning, strength/needs based assessment and individualized planning. We suggest that trainers interview the County staff that were mentored as QSR reviewers by experienced reviewers in the Pilot Review to gain their impression of the extent of coaching needed to build appropriate practice.

The Panel and County also agree that practice coaching is an appropriate role for supervisors. An unanswered question for the Panel is how the County will prepare supervisors to provide necessary coaching. Developing this hands-on mentoring capacity with actual children and families cannot be successfully provided in classroom settings alone. The County should provide the Panel a plan that describes the formal training and mentoring of supervisors as coaches.

The County provided a lengthy response to the Panel's appraisal of training plans for DCFS staff. A copy can be found in Appendix C. Appendix D contains the County's response to Panel questions about training for mental health providers. The Panel appreciates the explanations provided, but its concerns about the design of DCFS training and lack of cross training between DCFS and DMH remain.

Multidisciplinary Assessment Team Implementation

Based on the joint Panel and County review of 20 MAT cases, the Panel has provided the County with recommendations about strengthening the effectiveness of the MAT process. The Panel plans to conduct a larger review of new MAT cases at a future date.

Qualitative Service Review (QSR) Implementation

The County successfully implemented a pilot review of the QSR process and County protocol in the Belvedere office the week of June 28, 2010. Fourteen cases were reviewed. The review involved six experienced reviewers who were paired with County staff, most of whom are in training to become independent reviewers themselves. Two Panel members were also present and reviewed two cases. For several more reviews, experienced external QSR reviewers will continue to mentor County reviewers to develop their ability to utilize the protocol and review objectively. For the intermediate future, at least one Panel member will review two cases in each review to observe the collection of information about the experience of class members, to learn from the cases they reviewed and to assess the fidelity of the process to the QSR model.

The aggregate of cases reviewed provides rich information about the quality of practice in the County and the progress in fully implementing the practice model in the strategic plan. A case summary or story is developed for each case reviewed, providing a narrative description of the challenges and successes of the children and families reviewed. The Panel expects to provide both scores from the QSR and examples of case stories in future reports to the court. The following tables reflect the areas reviewed and the pattern of performance over time in the QSR reviews in the Salt Lake Region in Utah, a state where the QSR helped it successfully exit from a class action settlement in child welfare. Similar data will be provided for the Los Angeles County reviews.

Utah DCFS Salt Lake Valley Region QCR Score Progression

Salt Lake Region Child Status-Combined								
	FY00	FY01	FY02	FY03	FY04	FY05	FY06	FY07
Safety	86.7%	91.2%	94.4%	97%	94%	89%	94%	97%
Stability	69.0%	76.5%	72.2%	73%	83%	56%	61%	77%
Approp. Of Placement	90.6%	95.5%	90.3%	96%	99%	96%	94%	97%
Prospect for Permanence	64.3%	74.6%	59.7%	61%	77%	52%	59%	74%
Health/Physical Well-being	97.6%	95.6%	95.8%	99%	99%	93%	100%	97%
Emotional/Behavioral Well-being	76.2%	89.7%	75.0%	81%	87%	86%	83%	86%
Learning Progress	88.1%	88.1%	79.2%	77%	88%	90%	85%	89%
Caregiver Functioning	100%	95.2%	95.6%	100%	100%	98%	98%	96%
Family Resourcefulness	60.0%	75.0%	56.8%	51%	86%	58%	55%	62%
Satisfaction	86.4%	80.9%	84.5%	81%	91%	80%	89%	91%
Overall Score	86.7%	89.7%	87.5%	89%	90%	88%	92%	97%

Salt Lake Region System Performance-Combined								
	FY00	FY01	FY02	FY03	FY04	FY05	FY06	FY07
Child & Family Team Coordination	36.7%	29.4%	34.7%	54.3%	78.3%	80.3%	75.0%	89.0%
Child & Family Assessment	26.6%	36.8%	33.3%	54.3%	71.0%	52.1%	69.0%	69.0%
Long-Term View	33.3%	36.8%	31.9%	41.4%	69.6%	53.5%	56.0%	71.0%
Child & Family Planning Process	47.6%	30.9%	48.6%	60.0%	75.4%	71.8%	68.0%	91.0%
Plan Implementation	69.6%	67.6%	56.9%	71.4%	87.0%	85.9%	79.0%	80.0%
Tracking & Adaptation	69.0%	54.3%	56.9%	57.1%	82.6%	77.5%	75.0%	80.0%
Child & Family Participation	64.3%	50.0%	44.4%	62.3%	78.3%	80.3%	80.0%	91.0%
Formal/Informal Supports	86.7%	76.5%	73.6%	82.9%	94.2%	94.4%	80.0%	94.0%
Successful Transitions	68.6%	52.9%	49.3%	63.8%	80.6%	68.2%	70.0%	74.0%
Effective Results	73.2%	64.7%	66.7%	72.9%	88.4%	81.7%	82.0%	83.0%
Caregiver Support	92.0%	88.1%	91.1%	97.9%	97.7%	92.2%	94.0%	96.0%
Overall Score	47.6%	52.9%	48.6%	58.6%	85.5%	83.1%	76.0%	86.0%

VI. Katie A. Outcome Indicators and Exit Conditions

The parties have reached agreement on the outcome indicators by which Katie A. Performance can be measured as well as proposed exit targets relative to each indicator. Exit targets will also be proposed for efficiency indicators and Qualitative Servicer Review performance.

This section will describe the outcome indicators, summarize current performance for each and identify the exit target proposed.

Background

Some of the indicators are based on definitions determined by the federal Children's Bureau, by which it monitors state child welfare performance and holds states accountable to federal performance standards. Others were developed solely for application to Katie A. class members. To enable the parties and court to track the experience of Katie A. class members separate from children who do not have mental health needs, for purposes of outcome tracking, the following definition of class membership is being used. A Katie A. class member is a child being served by DCFS that is receiving a mental health service or who has received a mental health service between 12 months before and up to 12 months after the DCFS case start date. This definition is narrower than the settlement agreement's definition and does not capture all of the "at risk" population. However, to track outcomes across the entire population of children served through the case management system, there must be an open case and identified need for mental health services. DCFS children not yet screened for mental health services and not receiving a mental health service, for example, would not be counted. The methodology chosen, however, seems to the Panel likely to provide a representative picture of the results of the settlement related to child outcomes.

The County has agreed to a methodology for tracking class members that represents a meaningful advance in outcome evaluation. The parties and Panel were assisted in developing the evaluation methodology by Dr. Fred Wulczyn of the Chapin Hall Center for Children and Barbra Needell of UCLA Berkley. Their assistance was invaluable in creating an effective process for tracking progress over time.

Most of the indicators reflect County performance based on what are called entry cohorts. Rather than tracking performance by capturing data on all children served in a single point in time, such as the last day of the year, most indicator data in this report reflect the year in which children enter out-of-home care or otherwise had their case opened. The problem caused by only tracking point-in-time data annually is that the experience of children who may have entered foster care years ago and experienced many moves is combined with that of children who only entered foster care in the prior month, for example. So a measure of length of stay in foster care traditionally involves an average. What's deceptive about this approach is that the progress made in a reform effort would be distorted by poor practice in past years, including older children who had poor outcomes and remain in the system. Assuming that reform efforts have been successful in shortening length of stay, the progress in achieving permanency experienced by children entering care in the past year would be masked by averaging the two subpopulations.

In tracking outcomes by entry cohort, all children entering care in each year would be tracked separately over time from those entering care in other years. As a result, it would be possible to determine if children entering care after the reform began had a different experience than those who entered care prior to reform efforts.

Entry cohort tracking is employed in all of the indicators except the stability indicators, where both entry cohort data and exit cohort data (children who exited in a given year) are used to ensure that the experience of all children is captured.

Tracking data begins with 2002-2003, the year in which the Settlement Agreement was signed and extends to the most current period in which complete annual data are available. For each indicator, the status of non-class members (children without DMH services) is better than class-members.

Outcome Exit Targets

The parties have agreed to exit targets for each indicator. There is a minimum level of performance target and an aspirational target assigned to each indicator. The aspirational target is an improvement goal unrelated to exit. Minimum Performance Levels were set only after these data became available and essentially assure that current performance will be a floor that the County does not fall below.

Overview of the System Population

The table below is informational. This table reflects that a slightly higher percent of class members initially entered foster care in the year their case was opened in 2007-2008 (57.54%) than in 2002-2003 (54.46%). The inverse happened with non-class members.

Initial Removal Patterns

Population of FY 2002-2003 to FY 2007-2008

Fiscal Year	With DMH Services – Class Members					Without DMH Services – Non-Class Members				
	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total
2002-2003	1,624	45.54%	1,942	54.46%	3,566	8,075	58.68%	5,685	41.32%	13,760
2003-2004	1,830	46.68%	2,090	53.32%	3,920	8,551	62.07%	5,226	37.93%	13,777
2004-2005	2,364	48.93%	2,467	51.07%	4,831	9,575	62.89%	5,649	37.11%	15,224
2005-2006	2,421	46.64%	2,770	53.36%	5,191	9,211	62.86%	5,442	37.14%	14,653
2006-2007	2,486	40.79%	3,609	59.21%	6,095	8,738	61.57%	5,455	38.43%	14,193
2007-2008	2,845	42.46%	3,856	57.54%	6,701	8,078	63.72%	4,600	36.28%	12,678

**Safety Indicator 1.
Repeated Reports of Abuse and Neglect**

This indicator tracks the degree to which children that are the subject of a substantiated abuse or neglect report (referrals) but are not removed from home, do not experience another substantiated report during the case open period up to 12 months. The goal would be to assess risk and provide supportive services effectively enough that maltreatment would not reoccur. Data shows that the County’s performance on this indicator has improved from 80% of class

members having no subsequent referrals within 12 months for 2002-2003 to 82.8% of class members having no subsequent referrals within 12 months in 2007-2008.

Minimum Performance Level – 82.8%

Aspire To – 83.3%

The County currently meets the Minimum Performance Level goal.

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

Fiscal Year	With DMH Services – Class members			Without DMH Services – Non-Class Members		
	Children initially remained home	Children without any substantiated referrals	%	Children initially remained home	Children without any substantiated referrals	%
2002-2003	1,624	1,300	80.0%	8,075	7,459	92.4%
2003-2004	1,830	1,510	82.5%	8,551	7,858	91.9%
2004-2005	2,364	1,980	83.8%	9,575	8,805	92.0%
2005-2006	2,421	2,020	83.4%	9,211	8,437	91.6%
2006-2007	2,486	2,097	84.4%	8,738	8,064	92.3%
2007-2008	2,845	2,357	82.8%	8,078	7,486	92.7%

Safety Indicator 2.

Incidence of Maltreatment by Foster Parents.

This indicator reflects the incidence of maltreatment of children by their foster parents. The incidence is small and the County’s performance for class members has been consistently in the 98% range, meaning that over 98% of class members in foster home settings experienced no substantiated foster parent maltreatment. Unfortunately the indicator does not include the experience of class members in group home and residential settings due to a feature in the design of automated reporting that does not identify the specific alleged perpetrator in congregate settings. This reflects a significant gap in performance tracking.

Minimum Performance Level – 98.4%

Aspire To – 98.6%

The County meets the Minimum Performance Level exit target.

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

(Federal CFSR Measure: Methodology specific to Katie A)

Fiscal Year	With DMH Services			Without DMH Services		
	All children served in foster care in Fiscal Year	Children with no maltreatment	%	All children served in foster care in Fiscal Year	Children with no maltreatment	%
2002-2003	10,798	10,529	97.5%	22,024	21,869	99.3%
2003-2004	10,762	10,495	97.5%	19,477	19,322	99.2%
2004-2005	11,025	10,815	98.1%	17,818	17,683	99.2%
2005-2006	11,272	11,120	98.7%	16,477	16,370	99.4%
2006-2007	12,479	12,280	98.4%	15,771	15,653	99.3%
2007-2008	13,166	12,956	98.4%	14,081	13,955	99.1%

**Safety Indicator 3.
Recurrence of Maltreatment Within 6 Months**

This indicator measures the percentage of all children that came into contact with DCFS and were victims of a substantiated abuse and neglect referral without being victims of another substantiated referral within six months. It provides some evidence of the effectiveness of efforts to prevent subsequent abuse and neglect. Class members are not identified separately in this indicator.

The data show improvement in reducing subsequent substantiated referrals between 2002-2003, when 89.5% of children did not have subsequent referrals within six months, and 2007-2008, when 92.39% of children did not have a subsequent referral. It should be noted that the 2002-2003 data and 2007-2008 data for this indicator are only for the period of July – December, so caution should be used in comparing those years with others.

Minimum Performance Level – 92.3%

Aspire To – 92.8%

The County is meeting the Minimum Performance Level.

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

Fiscal Year	Time Period	No Maltreatment	Total	Percent
2002-2003	Jul 2002 - Dec 2002	11,649	12,950	89.95%
	Jan 2003 - Jun 2003	11,179	12,328	90.68%
2003-2004	Jul 2003 - Dec 2003	10,118	11,062	91.47%
	Jan 2004 - Jun 2004	11,013	12,025	91.58%
2004-2005	Jul 2004 - Dec 2004	10,174	11,111	91.57%
	Jan 2005 - Jun 2005	10,715	11,664	91.86%
2005-2006	Jul 2005 - Dec 2005	9,337	10,145	92.04%
	Jan 2006 - Jun 2006	9,767	10,530	92.75%
2006-2007	Jul 2006 - Dec 2006	8,848	9,558	92.57%
	Jan 2007 - Jun 2007	9,314	9,983	93.30%
2007-2008	Jul 2007 - Dec 2007	8,734	9,394	92.97%
	Jan 2008 - Jun 2008	9,732	10,534	92.39%

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

This indicator measures the median number of days class members are in out-of-home care, grouped by the year they entered care. The County has reduced the median length of stay for class members from 656 days in 2002-2003 to 409 in 2007-2008. The fewer days in care in 2007-2008 are to be expected for children entering care this recently, but the decline over time does reflect meaningful improvement.

Minimum Performance Level – 409 Days
Aspire To – 383 Days

The County is meeting the Minimum Performance Level.

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

Fiscal Year	With DMH Services			Without DMH Services		
	Children initially removed from home	No. of children who exited foster care	Median Days	Children initially removed from home	No. of children who exited foster care	Median Days
2002-2003	1,942	1,759	656	5,685	5,449	549
2003-2004	2,090	1,893	596	5,226	4,994	475
2004-2005	2,467	2,145	531	5,649	5,315	423
2005-2006	2,770	2,297	518	5,442	4,995	394
2006-2007	3,609	2,778	442	5,455	4,576	284
2007-2008	3,856	2,364	409	4,600	3,391	231

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

This indicator reflects the County’s success in returning children to their parents quickly. The County has improved its reunification achievement from 14.5% of class members being returned within 12 months in FY 2002-2003 to 36.4% in 2007-2008.

Minimum Performance Level – 36.4%
Aspire To – 45.6%

The County currently meets the Minimum Performance Level.

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

Fiscal Year	With DMH Services			Without DMH Services		
	Children initially removed from home	Children reunified within 12 months	%	Children initially removed from home	Children reunified within 12 months	%
2002-2003	1,942	281	14.5%	5,685	1,228	21.6%
2003-2004	2,090	384	18.4%	5,226	1,283	24.6%
2004-2005	2,467	639	25.9%	5,649	1,762	31.2%
2005-2006	2,770	713	25.7%	5,442	1,768	32.5%
2006-2007	3,609	1,120	31.0%	5,455	2,015	36.9%
2007-2008	3,856	1,402	36.4%	4,600	1,904	41.4%

**Permanency Indicator 3
Adoption Within 24 Months**

This indicator reflects the County’s success in quickly moving children under its supervision that cannot return home to adoption quickly. Data reveal improvement, showing that the percent of children adopted within 24 months rose from 0.6% in 2002-2003 to 2.0% in 2007-2008. The table also reveals that the County is more successful in achieving adoption for children without mental health needs (non-class members) than for children with them.

Minimum Performance Level – 2.0%
Aspire To – 2.9%

The County is meeting the Minimum Performance Level.

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

Fiscal Year	With DMH Services			Without DMH Services		
	Children initially removed from home	Children adopted within 24 months	%	Children initially removed from home	Children adopted within 24 months	%
2002-2003	1,942	12	0.6%	5,685	218	3.8%
2003-2004	2,090	20	1.0%	5,226	230	4.4%
2004-2005	2,467	36	1.5%	5,649	346	6.1%
2005-2006	2,770	58	2.1%	5,442	315	5.8%
2006-2007	3,609	71	2.0%	5,455	288	5.3%
2007-2008	N/A	N/A	N/A	N/A	N/A	N/A

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

This indicator reflects the County’s success in ensuring that children returned to their parents remain with them after reunification. The following table indicates that the County’s success rate declined from 7.7% of class members reentering care in 2002-2003 to 13.9% reentering care in 2007-2008. Evaluating reentry rates requires sensitivity to the fact that the more intensely an agency is focused on reunification the more likely it is that rates will be higher than systems without a reunification priority. The County has much greater success with non-class members, which is to be expected.

Minimum Performance Level – 13.9%

Aspire To – 12.9%

The County is meeting the Minimum Performance Level.

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

Fiscal Year	With DMH Services			Without DMH Services		
	Children who were reunified	Children who re-entered foster care	%	Children who were reunified	Children who re-entered foster care	%
2002-2003	1,528	118	7.7%	4,084	170	4.2%
2003-2004	1,733	144	8.3%	3,957	149	3.8%
2004-2005	2,068	195	9.4%	3,857	165	4.3%
2005-2006	2,485	385	15.5%	4,221	338	8.0%
2006-2007	2,737	379	13.8%	4,243	362	8.5%
2007-2008	3,335	464	13.9%	4,303	366	8.5%

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

This indicator measures, “Of those children in foster care less than 12 months, how many remain in their first or second placement?” The County’s performance has improved from 74.0% of class members having no more than two placements in their first year of care in 2002-2003 to 82.5% in 2007-2008.

Minimum Performance Level – 82.5%

Aspire To – 84.1%

The County meets the Minimum Performance Level.

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

Fiscal Year	With DMH Services			Without DMH Services		
	Children in foster care less than 12 months	Children with 2 or less placements	%	Children in foster care less than 12 months	Children with 2 or less placements	%
2002-2003	385	285	74.0%	1,549	1,417	91.5%
2003-2004	490	384	78.4%	1,575	1,435	91.1%
2004-2005	775	601	77.5%	2,083	1,894	90.9%
2005-2006	851	683	80.3%	2,038	1,834	90.0%
2006-2007	1,257	1,028	81.8%	2,263	2,088	92.3%
2007-2008	1,530	1,263	82.5%	2,111	1,888	89.4%

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

This indicator measures the experience of class members in foster care for 12 months but less than 24 months without a third or more placements in year two. The County’s performance has remained essentially the same since 2002-2003. In that period, 89.5% of class members did not experience a third or more moves compared to 89.2% not experiencing a third or more moves in 2007-2008.

Minimum Performance Level – 89.2%

Aspire To – 89.7%

The County meets the Minimum Performance Level.

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

Fiscal Year	With DMH Services			Without DMH Services		
	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%
2002-2003	600	537	89.5%	1,730	1,647	95.2%
2003-2004	697	625	89.7%	1,595	1,533	96.1%
2004-2005	689	589	85.5%	1,528	1,453	95.1%
2005-2006	782	664	84.9%	1,407	1,315	93.5%
2006-2007	1,064	949	89.2%	1,251	1,190	95.1%
2007-2008	N/A	N/A	N/A	N/A	N/A	N/A

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

This indicator is similar to 5a. and 5b., except it applies to the stability of children in care more than 24 months. The County performance has improved with this indicator, with 45.2% of class members in care more than 24 months or more experiencing no more than two moves in 2002-2003 compared with 58.8% in 2007-2008. The differences between class members and non-class members are particularly striking in this indicator.

Minimum Performance Level – 58.8%

Aspire To – 61.7%

The County currently meets the Minimum Performance Level.

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

Fiscal Year	With DMH Services			Without DMH Services		
	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%
2002-2003	7,959	3,600	45.2%	10,986	8,016	73.0%
2003-2004	7,955	3,710	46.6%	9,084	6,749	74.3%
2004-2005	7,535	3,638	48.3%	7,424	5,605	75.5%
2005-2006	7,136	3,609	50.6%	6,000	4,593	76.6%
2006-2007	6,587	3,587	54.5%	5,173	4,122	79.7%
2007-2008	5,992	3,525	58.8%	4,553	3,760	82.6%

VII. Panel Recommendations

Training The Panel commends the work performed by the County in translating the practice model into appropriate training modules related to child and family engagement, teaming, assessment, and planning and incorporating content related to trauma into each module. We believe that such content will help prepare staff for subsequent coaching which incorporates hands-on mentoring of staff in work with actual children and families.

However the Panel believes that the training strategy is insufficient to fully prepare staff for coaching and actual practice. At two training days for each module, the training is too brief to do much more than describe the practice desired and appears to provide little opportunity for trainers to model the practice and allow participants to demonstrate skills in the classroom. The Panel also does not believe that the County yet has a clear strategy to prepare trainers for training delivery. Most other systems successfully implementing practice change of this nature employ a process of first training and coaching the trainers in the new practice before they begin a training of trainers effort.

The County correctly notes that the scale of the system and volume of work limit the number of days staff can spend in training; however other systems have found a way to commit more time to this process. For smaller systems the challenge of scale and volume of work is of the same proportion as LA given the comparative differential in resources available in LA.

The Panel is unaware of any County Plan to train mental health providers in team-based strengths and needs-based practice, despite the fact that such providers play a major role in serving the plaintiff class. The training described above is designed for DCFS staff. The Panel has previously recommended that the County cross-train DCFS and mental health staff, but the current County Strategic Plan is largely silent on provider training.

The Panel recommends that training permit more time for skill development and that the County develop a credible plan for trainer development. The Panel also recommends that the County develop a plan for provider training.

Coaching The Panel and County are in agreement that intensive coaching needs to follow practice model training; however, the County does not have a plan for developing coaches other than a brief training module on coaching. The Panel has no confidence that coaches can be developed through classroom coaching alone. The County plans to rely primarily on line supervisors as coaches, a strategy the Panel concurs with in part. However, the Panel recommends that the County utilize experienced practice experts to develop supervisors as coaches, mentoring them in actual work with children and families.

Development of Treatment Foster Care Beds The County is making little progress in fulfilling its commitment to create 300 treatment foster care beds, (220 Intensive Treatment Foster Care Beds and 80 Multidimensional Treatment Foster Care beds). The Panel recommends that the County intensify its efforts to complete this task and consider recruiting external technical assistance to achieve this effort.

D-Rate Homes and FFAs The Panel's primary recommendation is that the County determine if it is possible to gather additional detail about the reasons for the lower than expected numbers of children receiving mental health services in these placement settings and what percentage of those receiving mental health services are receiving home based services.

Encourage the County and First Five LA to collaborate, when possible, on securing funding to provide training to mental health providers to address the unique assessment and treatment needs of infants and pre-schoolers in the child welfare system. In order to promote best child welfare and infant mental health practices, additional training is needed to enhance the mental health service capacity for the most vulnerable age group the County serves - children 0-5.

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

Training Roll – Out Plan for: Providers, DCFS & DMH Staff, QSR and Coaching

DCFS and DMH have committed to roll-out Pilot Training for both Line-Staff and Community Mental Health Providers in July 2010. Coordinated Services Action Team (CSAT) training is on hold because the Mental Health Screening Tool (MHST) needed to be modified to include acuity measures so that children with critical and urgent mental health could be highlighted and given immediate attention. **Being sensitive to the demands placed on ER - a staggered approach is proposed where co-located DMH and Continuing Services DCFS staff receive Enhanced Skill-Based Training (EBST) in July, with a (3) month stagger before ER staff are trained.** EBST training will be held at the I.U.C. sites, exact dates are subject to revision – pending verification of schedules.

EBST Office-Based Roll-out starts with back-end and co-located DMH Staff ; * Coaching Pilot will be July 27-30 for Pilot offices only.

TRAININGS	Jul 2010	Aug	Sept	Oct	Nov	Dec	Jan 2011	Feb	Mar	Apr	May	Jun	Jul	Aug
CIMH Pilot Training for M.H. Providers	Providers to be selected by CIMH & DMH	Pilot finishes Aug Full Roll-out in Sept.												
Resume CSAT Training (w/ new MHST) - Coaching Pilot	* Coaching Pilot 7/27- 7/30	<u>Aug</u> Bel/SFS <u>Aug/Sept</u> Com, Wat, Vert.	<u>Sept/Oct</u> Pal, Lan, Pom, EI M	<u>Oct/Nov</u> Pas, Cov A, Gle	<u>Nov/Dec</u> Metro North	<u>Dec/Jan</u> WLA, Deaf Services	<u>Jan/Feb</u> Lakewood Torrance	<u>Feb/Mar</u> SFV, Santa Clarita	<u>Mar/Apr</u> MCMS		ERCP			
ESBT Pilot Training: one back-end staff per office DMH	July 14 &15 @ UCLA Strengths/Needs) July 21 &22 @ MCC (Engaging) July 28 & 29 @ CSULA (Teaming)	Pilot finishes Aug – Refine training – Full Roll-out in Aug/Sept.												
ESBT Full-Roll Out Training *2 Days pre week – for 3 weeks @ IUC sites		Sante Fe Springs	Belvedere Compton Wateridge	V.Corridor Palmdale Lancaster	Pomona Glendora Pasadena El Monte	M. North	W.LA Covina Annex	W.SF S.Clar	Torr Lake.					
ESBT Full Roll-Out for ER Staff					SFS, Bel	Com, Wat, Vert	Pal, Lan	Pom, Gle, Pas, EI M	MN,	WLA, Cov	WSF, Santa Clarita	Tor, LakW		
QSR Roll Out Schedule – Outline FY 2010/2011	<u>6/27-7/2</u> Belvedere	<u>8/9-8/13</u> Sante Fe Springs		<u>10/18-10/22</u> Compton			Vert	Wat	Lan	Pal		Pom		<u>Sep</u> EI M <u>Oct</u> Gle <u>Nov</u> Pas

Appendix C

County Response to Panel Comments on Training and Coaching

Department of Children and Family Services (DCFS) has continued to solicit Panel member input in the development of skills training and coaching components recently forwarding draft materials for their review and critique. Panel members have provided feedback regarding training/coaching for line staff, supervisors and providers. Responses to specific issues are listed below.

- 1) Panel Feedback: The six (6) days of Enhanced Skill-Based Training (ESBT) (three, two-day modules) on each of the key areas; Engaging, Teaming, and Strength/Needs do not fully cover all the areas staff needs to know regarding these core competencies. (p.21 of draft Panel report)

Development and implementation of skills based training in these areas will be an ongoing and developmental process as time commitments required for skill based training are carefully balanced against the needs/demands for direct service provision by line staff and supervisors. DCFS acknowledges that staff cannot necessarily learn everything needed to develop a full complement of all skills in Engaging, Teaming and Strength-Based techniques in six days of training. After discussion by DCFS Executive leadership; an initial pilot utilizing a six day format (two days a week for three weeks) was readied and completed. Participants included line staff, supervisors and co-located Department of Mental Health (DMH) staff. If the consensus of all feedback is that additional ESBT training days are needed, DCFS will increase the length and scope of formal training. Feedback from trainers, participants (DCFS, DMH) based on the pilot as well as Panel member perspectives will be factors in shaping future recommendations.

Concurrently, DCFS and DMH have been developing a model of follow up coaching and transfer of learning to increase opportunities for modeling, practice and feedback to occur in field units and with more direct case application. This will assist in building on and reinforcing key points in each module. Additionally, feedback from the trained Quality Service Review (QSR) reviewers will be solicited and incorporated based on their findings and recommendations regarding the training/coaching and skill development needs of staff and supervisors.

With the direction and approval of the DCFS Executive Team; Casey Family Programs (CFP) is assisting by funding coaches who will provide regular reinforcement (modeling, feedback) in direct application to cases in both group and individual case conferencing and teaming sessions. In addition to utilizing licensed DCFS staff as coaches, DMH co-located staff will also be utilized to provide specific mental health expertise. With support from CFP, a foundational coaching pilot for approximately 40 staff has been completed (July 27-30, 2010) focused on coaching “basics”. The follow-up application of specific coaching to child welfare practice is scheduled to begin in (5) five pilot DCFS offices and; at the direction of the Executive Team, will be initiated in the Department’s Emergency Response

program/operation and subsequently expanded across the broader continuum of child welfare services. QSR standards and findings will serve as key anchor points in the development of this coaching model/approach. CFP has also agreed to assist in providing subject matter experts on a regular basis to ensure that staff are kept current with best social work practices from around the country.

- 2) *Panel Feedback: There is limited trainer guidance about the content within the trainer guide/handbooks. (p. 21 of draft Panel report)*

There's concurrence that, as curricula are refined based on pilot participant feedback, written training materials (Participant's and Trainer's Handbooks for each module) will need to have a greater degree of specificity and clarity so that trainers, staff and supervisors can refer back to specific activities in the modules to build on and reinforce key practice skills. As the pilot training concludes, DCFS continues to refine and sharpen the ESBT curricula based on line staff feedback, while ensuring that the core concepts still address the core competencies outlined in the QSR. DCFS will be meeting with the Inter-University Consortium to discuss expansion of the Trainer's and Participants' Handbooks and will be soliciting Panel member feedback and involvement both in reviewing participant/trainer feedback and in shaping finalization of the curricula, work products, tools and materials.

- 3) *Panel Feedback: The County needs to create a plan to develop a sufficient number of trainers to deliver the content of the training with fidelity to the model of practice. (p.21 of draft Panel report)*

In discussions/conference calls with Panel members on this issue; criteria for trainers, coaches as well as master trainers has been discussed. These criteria include but are not limited to: experience engaging families, facilitating team meetings, assessing child and family strengths and underlying needs with family members, trauma informed practice, individualized planning/service crafting, training/coaching, curriculum development experience and credibility/experience in direct child welfare practice, supervision and decision making. It's been acknowledged that finding individuals each of whom has this entire continuum/breadth of experience is challenging in any/all jurisdictions. As such, a team approach to curriculum development; training and coaching has been undertaken. The County has solicited individuals each of whom have a degree of experience in the several (but not necessarily all) aforementioned areas and instituted a collaborative process in curriculum development and training and co-training/facilitation in an effort to best attend to all the above referenced criteria.

Additionally, experienced local Wraparound providers (including the Los Angeles Training Consortium) have participated in the ongoing Training workgroup shaping training/coaching efforts and, to the extent they are available, can/will be called upon to assist in these efforts both with public agency staff as well as the provider community. Utilizing this team/collaborative approach, DCFS and DMH believe that there is adequate internal training capacity building within Los Angeles County and its provider community. Trainers, master trainers and coaches will also benefit from subject matter experts to be brought in on a regular basis by CFP to ensure all are kept current on best practices in child

welfare. The County will update panel members on our progress during their next visit (September 15 and 16, 2010) to Los Angeles.

- 4) Panel Feedback: The Panel suggests that the County staff who were mentored as QSR reviewers by experienced reviewers in the Pilot Review be interviewed to provide their impression of the extent of coaching needed to build appropriate practice. (p.22 of draft Panel report).

As stated, the County will consult with those staff who were recently trained as QSR reviewers as well as conduct intensive and in-depth interviews with staff who have just completed the ESBT Pilot training to ensure that all feedback about how to improve the training and coaching is captured.

- 5) The Panel has expressed concern about the lack of cross-training planned between DCFS and DMH.

DCFS continues to consult and share training curricula with DMH; its training contractor, CIMH; the provider community and others, to explore all relevant cross training needs and possibilities. With DMH, a careful and thorough evaluation of training roll-out schedules, resources and responsibilities will be conducted to ensure the most appropriate use of the Katie A. training budget, while also making sure that all parties who need to be trained receive quality instruction and follow up coaching support. Feedback regarding training curricula will also be solicited from the mental health provider community to review its ESBT to get their opinion as to whether it adequately trains line social workers and supervisors to be able to effectively engage and team with multi-problem class member families and their children.

Appendix D

County's Response to Panel Comments on Core Practice, Intensive In Home Services, and Trauma Informed Models: Training and Technical Assistance

Overview

Los Angeles County Department of Mental Health (LADMH) is interested in expanding their capacity to meet the mental health needs of children involved in the child welfare system (and in turn promote achievement of safety, permanence and well-being outcomes) through implementation of Home-Based Services (HBS), Core Practice and Trauma Informed models.

Target audiences, goals, content areas, and specific projects for training and technical assistance activities are described below.

Training activities would/could involve the following audiences:

- LADMH collocated clinicians
- LADMH contract providers
- Department of Child and Family Services (DCFS) social workers

Training activities would promote achievement of the following goals:

- Implementation of HBS intervention model
- Application of Core Practice Model principles and practices
- Incorporation of Trauma Informed practice
- Interagency coordination between LADMH clinicians, DCFS social workers, and community-based mental health providers

Deliverables

California Institute of Mental Health shall:

1. Develop training content that includes the following:

A. HBS Intervention Model

- o Primary principles (specific to child need and family preference, team based management, culturally specific and effective interventions)
- o Child and Family Team core practice elements (engagement and team preparation, initial plan development, implementation, transition)
- o Decision making framework (team-based decision making, ongoing evaluation of success, adjusting service plans)
- o Interagency collaboration strategies

B. Core Practice Model

- o Organizational Principle and Standards (engaging families, gathering information, service planning, tracking and adapting) all in the context of Child Protective Services context
- o Service elements (flexible, individualized, family focused, culturally specific, effective, 24 hour response capability)

- Service planning with a focus on working with stressed families including advanced formulation skill sets and guidelines for selecting, sequencing and accessing interventions for children and caregivers
 - Quality management (evaluating success and adjusting plans)
- C. Trauma Informed practice
- Articulation of issues commonly experienced by children involved in the child welfare system including disorders resulting from maltreatment, secondary problems associated with removal from home, and treatment models associated with achievement of permanency, safety and emotional/behavioral health
 - Service planning guidelines and practices specific to serving children involved in the child welfare system, including identification of suicide risk
2. Conduct Training projects that involve the following activities:
- A. HBS, Core practice and Trauma Informed curriculum and Practice Improvement Protocols addressing the content areas outlined above. Each curriculum (4 in total as outlined below) would consist of a set of presentation materials (i.e. slides, articles) and be expected to require 60-90 minutes to conduct.
- B. Introduction conference (1-day). One event countywide presenting an overview of the curriculum and training activities.
- C. SPA specific introduction training events consisting of 4 content areas (1/2 day each). Total of 32 events.
- D. Technical assistance focusing on SPA specific lead agency and DMH supervisor/lead clinicians (as detailed below). This would be an extension of the core (foundation) training described in #2 and would involve a series of consultation meetings or conference calls with supervisors/lead clinicians who would in turn coach/mentor their staff.
3. First Training (1/2 day training event)
- I. Assessment and clinical formulation – through a child welfare lens
- Overview of problems most commonly experienced by children and youth receiving child welfare services including the outcome(s) of child neglect and or abuse
 - Comprehensive Family-Focused Assessments – permits the identification and provision of services that are specifically targeted to address the family’s needs and problems and ensure the child’s safety, wellbeing and permanency.
 - Using assessment information to develop a picture that drives services – based on need and family and youth strengths that appreciates the cultural meaning of help-seeking
 - Developing individualized service plans
 - Strategies for monitoring service performance and child and family outcomes, and adjusting service plans accordingly

- II. Overview of programs and practices that have demonstrated effectiveness for children, youth and families served by the child welfare system
 - Parenting practices
 - Mental Health practices (i.e. depression, disruptive behaviors, anxiety, substance abuse)
 - Trauma practices
 - Parent support practices

4. Second Training (1/2 day training event)

I. Parent engagement – through a child welfare lens

Involvement with child welfare services brings families into contact with a complicated array of service systems including the legal, mental health and educational systems. Faced with complex demands parents and families in crisis are at a heightened risk of failing to meet court and service system requirements. Thus family support and engagement is paramount to aiding families through this complex system.

- Collaborative processes
- Engagement interventions to improve attitudes about and increase family retention in services
- Culturally informed engagement strategies

II. Engaging parents in the delivery of home based services

- Ethical, safety, administrative and supervision issues
- Strategies for effective home-based intervention

5. Third Training (1/2 day training event)

I. Trauma informed practice with children and youth in the child welfare service system

- Impact of childhood traumatic stress
- Strategies for mitigating the impact of traumatic stress
- Critical elements of trauma informed care

Distinction between trauma informed services and trauma specific interventions

6. Fourth Training (1/2 day training event)

I. Collaboration

- Levels and characteristics of collaboration
- Requisites for interagency collaboration
- Collaborative strategies
- Team-based decision making and management
- Collaborating with families

7. Technical Assistance

Technical assistance will be provided to small groups (clusters) of designated supervisors and lead clinicians, consisting of a series of 15 (1-hour) consultation calls per cluster, and 3 (2-hour) meetings, focusing on application of the IIHS, Core practice and Trauma Informed curriculum and Practice Improvement Protocols. Technical assistance activities will be designed to assist supervisors/lead clinicians in monitoring and supporting use of the curriculum and protocols by their clinicians.