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December 23, 2011

To: Supervisor Zev Yaroslavsky, Chairman
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From: William T Fujioka
Chief Executive Officer

KATIE A. IMPLEMENTATION PLAN SEMI-ANNUAL UPDATE

On October 14, 2008, your Board approved the Katie A. Strategic Plan (Strategic Plan), a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare as well as those children at-risk of entering the child welfare system. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system in fulfillment of the objectives identified in the Katie A. Settlement Agreement.

The Strategic Plan describes a set of overarching values and ongoing objectives, offers seven primary provisions to achieve these objectives, and lays out a timeline by which these strategies and objectives are to be completed. The seven primary provisions include:

KATIE A. STRATEGIC PLAN OBJECTIVES	
1. Mental Health Screening and Assessment	2. Mental Health Service Delivery
3. Funding of Services/Legislative Activities	4. Training
5. Caseload Reduction	6. Data and Tracking of Indicators
7. Exit Criteria and Formal Monitoring Plan	

Implementation Support Activities

DATE	DESCRIPTION
May - December 2011	The Departments of Children and Family Services (DCFS) and Mental Health (DMH) completed implementation planning on the joint Field Response Operations Expedited Response Pilot (FRO ERP),which included hiring, development of DCFS policy and procedures, DMH practice guidelines, training, and a tracking system. A formal process has been established to provide for the timely notification, identification, and response to DCFS children/youth experiencing acute and/or urgent mental health needs to ensure better individualized safety plans for children. This protocol ensures communication between FRO and DCFS when the FRO team responds in person to a child, but does not hospitalize the child. All efforts will be tracked and evaluated for efficacy and improved outcomes for children.
August 2011	DMH and DCFS initiated a protocol to ensure the rapid sharing of information for children and youth who are identified as having "urgent" mental health needs. The protocol requires that services for these referrals are initiated in no longer than three days. The mental health provider is also required to complete a form describing the services provided and plans for future services, and fax this to DCFS within no more than seven days. This form is then uploaded into the client's case record in the Child Welfare Services/Case Management System (CWS/CMS). The protocol also emphasizes the need for ongoing communication on shared child welfare and mental health cases for the purposes of coordinating care.
September 2011	Enhanced Skill-Based Training (ESBT) has been rolled out to 95 percent of Line Supervisors and by May 1, 2012 over 60 percent of Children's Social Workers (CSWs) will have been trained. A training and coaching pilot in the Compton Office is scheduled to begin in November with complete rollout by January 2012. The pilot will emphasize the importance of both formal and informal teaming.
November 2011	The Directors of DCFS, DMH, and Probation issued a joint letter to all staff formally endorsing the Core Practice Model developed in consultation with the Katie A. Panel.

December 2011	A Policy Memo from the Interim Director of DCFS was released to all staff specifically addressing the increase of young children in group homes and reinforcing the department's efforts to reduce the number of children and youth in group home care.
December 2011	DCFS implemented a data tracking report through the interface between DHS' E-mHub System. This will enable DCFS to track on a child-specific basis the population of newly detained children who are referred and not referred, to a Medical Hub (Hub) for an Initial Medical Exam, and which child-specific children are being seen, and not seen, at the Hub.
December 2011	The State's Katie A. Settlement Agreement as well as the County's Exit Conditions were approved by the Federal Court. The County began participating in state workgroup meetings in early October to operationalize the key objectives of the state settlement agreement.
December 2011	DCFS, DMH, County Counsel, the Chief Executive Office (CEO), and children's mental health providers met with Tim Penrod from Arizona's Child and Family Support Services to discuss intensive home-based mental health services and lessons learned from Arizona's class-action lawsuit and the development of their mental health system.

OBJECTIVE NO. 1
Mental Health Screening and Assessment

Medical Hubs

Since the Countywide implementation of the E-mHub System, DCFS has developed a data tracking report through the interface between the E-mHub System on the priority population of newly detained children being served at the medical hub(s). Once this report is finalized, it will be generated monthly and will provide child and office specific tracking/compliance data on DCFS newly detained children who are referred to and have received an initial medical exam at a hub. The E-mHub System provides scheduling detail and reports the results of the initial medical exam, forensic exam, mental health screening results, and referral form status in real-time back to the CSW. The system will enable the department to track the medical hub compliance rates much more effectively than the manual process used in the past.

Beginning in December, DCFS will implement a recommendation from the Katie A. Panel's October report requesting that a small sample of newly detained children not referred to the hubs be reviewed more closely to determine reasons for non-referral. The study will focus on interviewing CSWs and/or Supervising CSWs (SCSWs) to better understand the reasons why

newly detained children were not referred to a hub for an initial medical exam. Based on the findings from the study, a corrective action plan will be developed by March 2012 to address the newly detained, non-referrals to the hubs.

Coordinated Services Action Team - Redesign

The Coordinated Services Action Team (CSAT) process requires expedited screening and response times based upon the urgency of a child's needs for mental health services. As a result of a January 2010 Board Motion and subsequent case review, the Child Welfare Mental Health Screening Tool (MHST), the CSAT Screening and Assessment Policy, and the related DMH practice guidelines were revised to ensure the timely screening for, referral to, and provision of mental health services according to acute, urgent, and routine mental health needs identified. All CSAT previously trained offices have been retrained and are now implementing the CSAT redesign. CSAT has been implemented in all 19 Regional Offices and each CSAT Team is currently coordinating regular CSAT monthly meetings to promote teaming among all DCFS and DMH resource staff to better serve the needs of families. These CSAT meetings will serve as an open forum for each resource staff to troubleshoot and address challenges that hinder the timely delivery of services (i.e., mental health, medical, placement, family finding, Medi-Cal eligibility, etc.) to families. Additionally, many CSAT teams are working with the DMH D-rate and Family Preservation (FP) program managers to develop processes to streamline and prevent a duplication of mental health service delivery when a child is referred to DMH Specialized Foster Care co-located staff and also accepted by a FP provider agency for a D-rate placement.

Multidisciplinary Assessment Team

In September 2011, 97 percent of all eligible newly detained children Countywide were referred to the Multidisciplinary Assessment Team (MAT). From July 2010 to September 2011, there were 6,352 MAT referrals and 4,775 MAT assessments completed.

Table 1: MAT Compliance	MAT Eligible	MAT Referred	Percent
SPA 1	20	17	85%
SPA 2	77	74	96%
SPA 3	83	80	96%
SPA 4	51	51	100%
SPA 5	5	5	100%
SPA 6	75	70	93%
SPA 7	80	80	100%

SPA 8	51	51	100%
Total number of DCFS MAT referrals:	**442**	**428**	**97%**

In an effort to address a long standing provider capacity deficit in SPA 1, DMH successfully negotiated with two additional MAT providers who have agreed to provide MAT assessments in Service Planning Area (SPA) 1. Specialized Foster Care (SFC) staffs in all SPAs continue to prepare a comprehensive mental health assessment, if necessary, when a child is not eligible or capacity lacks to conduct a MAT Assessment.

From July 2010 through August 2011, the average timeline from MAT referral acceptance to completion of the final Summary of Findings (SOF) report was 45 days. The expected timeline for completion is 45 days. The percentage completed in 45 days or less was approximately 61 percent. The percent completed by the 50th day was 78 percent. DCFS MAT Administration is currently creating a process to directly e-mail the MAT SOF Reports to the court and attorneys to reduce the time lag in receiving timely MAT reports.

In terms of completing the MAT assessment by case disposition, DCFS MAT Coordinators report approximately 70 percent of MATs are completed prior to disposition. The remaining 30 percent are delayed for numerous reasons including:

1. Variance in timelines to disposition within the court process. While DMH MAT providers have 45 days to complete the assessment, disposition can occur prior to the 45 days;
2. CSW compliance in obtaining consent/referral documents delayed some initial MAT referrals, thereby delaying the timeline to completion;
3. Benefits establishment, including verifying/troubleshooting Medi-Cal and Medi-Cal applications; and
4. Toward the end of the fiscal year, there were provider capacity issues in several SPAs, which delayed the acceptance of referrals.

On November 21, 2011, DMH hosted the First Annual Countywide MAT Provider's Meeting, providing a forum to discuss MAT history, progress and information with all MAT providers. DMH is also in the process of updating the CSW Interview Guide and Quality Assurance (QA)/Quality Improvement (QI) Checklist to align with Core Practice Model (CPM) values and Quality Service Review (QSR) indicators. DMH plans to conduct audits on MAT charts in the near future using these tools to measure the SOF Reports. DMH will also be providing Strengths and Needs-based Trainings to further assist MAT providers with improving the quality of their SOF reports.

From August 2011 through October 2011, DMH MAT Coordinators completed a total of 97 MAT QA Checklists and 52 MAT CSW Interview Surveys. Overall, 95 percent of the QI

Checklist's eight domain ratings were positive and 84 percent of the MAT CSW Interview Survey's seven domain ratings were positive. Areas rated positive include improved ability to work effectively with MAT assessors, satisfaction with their participation in the SOF meeting, useful information provided in the SOF meetings to aid CSWs in the development of service plans for children and families, and learning about and utilizing resources. Areas rated challenging included difficulty scheduling meetings due to time constraints, problems clarifying roles and responsibilities of team members, and difficulties when court orders specific modalities of treatments.

D-rate

As of September 30, 2011, a total of 1,313 children placed in out-of-home care received the D-rate. DMH and DCFS have continued to review the needs of D-rate children and the mental health services offered to them in an effort to better identify the programmatic needs of this population and to make reforms to the D-rate program that could offer more defined service provisions on the DCFS/DMH spectrum of care.

In addition, DCFS and DMH have created a workgroup that meets to discuss the enhanced coordination between Wraparound services and Treatment Foster Care (TFC) utilizing D-rate certified foster parents and relative caregivers. Although these discussions are preliminary in nature, DCFS and DMH are exploring the increased level of intervention available to D-rate children and the degree to which D-rate caregivers are able to receive additional support and guidance from Wraparound providers cross-trained in the TFC model, which could provide a more flexible and robust continuum of services.

Team Decision-Making/Resource Management Process

DCFS has completed 8,219 Team Decision-Making (TDM) meetings from March 2011 through August 2011 - a 12 percent increase from the previous report. Additionally, DCFS has completed a total of 1,026 Resource Management Process (RMP) TDMs on 66 percent of youth entering a group home, 69 percent of youth replaced, and 54 percent of youth exiting a group home. This was an increase of 14 percent for group home entry TDMs, 16 percent for replacement TDMs, and a 9 percent increase for group home exits from the last report.

DCFS has developed stricter gate-keeping provisions to mitigate the number of children 0-12 entering group homes. The provisions consist of the following:

- Placement of children age eight years and younger in a group home will no longer be permitted without the approval of the Chief Deputy or Director.

- For any group home placement packet to be generated, the signatures of the CSW, SCSW, Assistant Regional Administrator (ARA), and Regional Administrator (RA) must be obtained confirming that an RMP team meeting has occurred prior to placement or within one week of placement when an RMP cannot take place in advance.

- For any youth approved for placement in a group home, a mandatory referral to the department's family finding program, called Permanency Partners Program (P3), must be made at the time of placement (except for those enrolled in Residentially Based Services (RBS), which has its own family finding component).

- For any youth placed in a group home, a regular family team meeting coordinated and facilitated by the case carrying CSW or SCSW should occur on a monthly basis at minimum.

- For any child age 12 years or younger, a Permanency Planning Conference (PPC), a family team meeting coordinated and facilitated by a PPC Facilitator, should occur once every four months. The signature of the CSW, SCSW, ARA and RA is required on the PPC plan. Additionally, a monthly tracking report will be coordinated and produced by the Resource Management Division, with an assignment to RAs to update the report with the current status and plan for transitioning to the community.

OBJECTIVE NO. 2
Mental Health Service Delivery

Specialized Foster Care

The DMH Specialized Foster Care (SFC) co-located staffs respond to requests for consultation from CSWs, provide referral and linkages to community-based mental health providers, offer treatment services when necessary, and participate in the CSAT process in those offices where CSAT has rolled out. Currently, DMH has 178 co-located staff in 18 DCFS regional offices. In addition, DMH is working with its provider community to improve capacity and utilization of mental health services, particularly among those providers not fully utilizing their Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) contracts, now totaling 64. These contracts now provide for over $120 million of targeted mental health services for DCFS children, including Wraparound, TFC, MAT and enhanced mental health services.

DMH continues to see improvements in the utilization of mental health services by DCFS-involved children. At present, 60 percent of the children and youth who are the subject of an open DCFS case are either receiving mental health services or have received mental health services during their current DCFS case.

Wraparound

As of November 11, 2011, 1,128 Tier I and 1,398 Tier II slots were filled, which is 60 percent of the targeted 4,200 slot rollout. Tier I enrollments have increased due to the increase in the Adoptions Assistance Program (AAP) utilization, the ongoing suspension of the RMP enrollment requirement to Tier I, and the implementation of the RBS program.

The Wraparound program is undergoing a major redesign process in preparation for the new contract in 2014. Five workgroups were created to address the different focal areas: fiscal; contracts; program; practice; and quality improvement/assurance. The first phase of the Wraparound redesign process (workgroup recommendations) is complete and now the Wraparound Administration is preparing for the second phase (analysis of the recommendations from the workgroups). The fiscal workgroup is finishing up and is expected to complete their analysis in December.

Once the Wraparound Administration compiles all the recommendations, they will be discussed with the existing Wraparound providers. The Wraparound Administration will analyze the recommendations and start the draft of the Statement of Work (SOW) by March 2012. The SOW will then be posted for public comment and finalization by the end of 2012.

Treatment Foster Care

The target population for TFC is the most emotionally or behaviorally challenged youth in, or at risk of placement in, group homes or psychiatric facilities. TFC provides an alternative to group home care for these children by providing intensive in-home therapeutic and behavior management services in a foster home with a limit on the number of children placed in that home. Although TFC program placements and contracts have increased, program growth was slowed due to time consuming and costly requirements placed on foster parents. Potential foster homes were required to obtain approval for foster as well as adoptive care. As a result, DCFS executive management has now waived this requirement for all TFC foster parents and will begin the process for modifying existing contracts with the Board of Supervisors.

Table 2: TFC Placement and Capacity ***(as of November 30, 2011)***

	No. of Placed Children	Certified Homes	Certified Home Vacancies	Inactive Homes	Upcoming Beds
Intensive Treatment Foster Care (ITFC)					
	40	62	9	13	15
Multidimensional Treatment Foster Care (MTFC)					
	20	39	7	11	7
Grand Total	***60***	***101***	***16***	***24***	***22***

Overall, a total of 156 youth have received TFC services. Of the 94 youth that have transitioned out of the program, 55 percent graduated to a lower level of care (i.e., home of parent, legal guardian, relative and/or foster home) while the remainder recidivated to a higher level of care. The success of TFC is also evidenced by those 62 youth who currently remain stable in their TFC homes. These youth are supported by a unique team dedicated to the provision of their needs and are now successfully moving towards permanency and pro-social stability. It was additionally determined that this program presents the County with a significant annual fiscal savings of approximately $1.8 million in fiscal year (FY) 2010-11, as a result of meeting youth needs in community settings when compared to congregate care services.

In June 2011, DCFS and DMH TFC staff established a workgroup comprised of managers and supervisors from CEO, DCFS, and DMH to increase the delivery of intensive treatment services to DCFS-involved youth (particularly those youth in D-rate homes) as well as to identify resources for targeted recruitment and fine-tune foster parent retention strategies. The Workgroup will also review and analyze the differences between those youth who have recidivated versus those who graduated from the TFC program. Both departments are collectively preparing for an upcoming TFC foster parent training/recruitment event planned for February 17, 2012.

Another effort that is underway to address TFC is a D-rate/TFC pilot project proposal that would effectively cross train contracted provider staff who manage TFC contracts and Wraparound Programs on TFC principles. In efforts to move forward with the pilot project, both departments have encountered barriers related to contracting, solicitation, and regulatory issues. The Workgroup consulted with other municipalities who currently operate successful TFC programs to discuss best practices and how they use multiple funding streams to finance their TFC programs. The goal has been to increase the viability and sustainability of the County's TFC program. The departments are continuing to meet to discuss and identify possible solutions to these barriers, participating on two related State Workgroups, as well as consulting with County Counsel.

OBJECTIVE NO. 3
Funding of Services/Legislative Activities

Currently, the FY 2011-12 Katie A. budget depicts approximately $11.3 million in net County cost savings. The savings are primarily due to vacant Wraparound slots.

In December 2011, settlement negotiations with the State concluded and the Federal Court formally approved the State Settlement at the December 1, 2011 Fairness Hearing. Leadership staff from both DCFS and DMH has been participating on the Katie A. State Settlement Implementation Workgroup since early October to operationalize the key objectives of the settlement agreement. The Workgroup is comprised of state and County Katie A. leadership,

legal representation and several other Katie A. stakeholders. One of the focal areas this group is working on is to develop a billing manual that will provide guidance on billing issues for care and supervision that fall under Title IV-E as well as mental health services that should be captured under EPSDT.

Other promising news to report is that the Federal Court approved the County's Exit Conditions in December 2011. This is a huge step forward for the County in developing measureable exit criteria to demonstrate compliance with the County's settlement agreement, which eventually will advance the County's exit from Court oversight.

OBJECTIVE NO. 4
Training

DCFS Training

DCFS and DMH have developed curricula that encompass training for CSWs, co-located DMH staff, and community mental health providers to "Enhance Practice Skills". Enhanced Skill-Based Training (ESBT) offers an overview and rationale of the content as well as training towards strengths-needs based practice, engagement, and teaming.

To date, ESBT has been rolled out to 95 percent of DCFS Supervisors and by May 1, 2012, over 60 percent of CSWs will have received ESBT. In addition, along with the Los Angeles Training Consortium (LATC), DCFS has implemented coaching for supervisors to reinforce the ESBT in all DCFS offices.

Additional "Coaching to Child Welfare" Seminars are being planned for TDM facilitators, other line DCFS SCSWs, co-located DMH staff and others who have an opportunity to consistently model a strengths–needs based approach to working with families.

Finally, to further enhance the quality and knowledge base of Coaches from September 8, 2011 to November 9, 2011 over 60 DCFS, DMH, Inter-University Consortium and LATC coaches have taken QSR training. The goal is to have the majority of coaches participate as QSR Reviewers by the end of FY 2011-12.

DMH Training

In September 2011, DMH completed the two-day Core Practice Model (CPM) training provided by California Institute for Mental Health (CIMH) for the DMH SFC co-located staff, DMH directly operated clinics and children's mental health contract providers. This four-module

training used a train-the-trainer approach with a specific focus on clinical supervisors and clinical leads.

Training was completed Countywide and approximately 78 contract providers, seven directly operated children's clinics, and 18 DMH SFC co-located sites were trained. A total of 382 supervisors and lead clinicians were trained Countywide. In addition, training has been provided to SFC, MAT and Wraparound providers in the key practice areas of: cultural competency, needs-based assessment, family engagement, dual diagnosis, crisis management and mental health interventions with the birth to five population and their families.

Integration of Coaching Efforts

On September 29th DMH and DCFS met with the LATC to contract for delivery of coaching services to the Compton DCFS office which is considered the pilot office. DCFS and LATC have provided coaching to Compton for the last six months. The contract with LATC will augment coaching capacity from a two-hour session per month to three full days of coaching per week and will include coaching to DMH staff and contract providers. A total of 18 "external" coaches will be assigned to the Compton office, comprised of eight DCFS training staff, eight LATC staff, and two DMH staff.

The current DCFS, DMH and LATC coaches have participated in the Enhanced Skills Based Training and the QSR training. These coaches have a good foundation to communicate and demonstrate the core practice model expectations for the Compton office. Coaches and staff will be assigned one family to follow from case inception to termination. Coaches will prepare mental health providers separately from DCFS staff, but will integrate mental health providers when necessary to meet the needs of the family. Coaches will work with mental health providers on clarifying their roles and expectations during child and family team meetings.

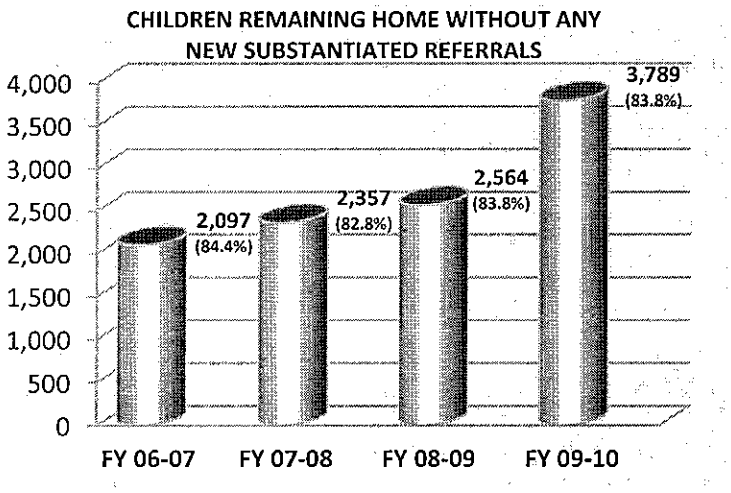
OBJECTIVE NO. 5
Caseload Reduction

The DCFS total out-of-home caseload has been reduced from 15,429 (April 2011) to 15,390 (September 2011). Under the Title IV-E Child Welfare Waiver Capped Allocation Demonstration Project, the Department is allowed to redirect dollars to much needed services to strengthen families and achieve safety, permanency, and well-being.

The individual CSW generic caseload average in October 2011 was 27.05, which is a very slight increase of .26 children per social worker since April 2011 (26.79). The ER caseloads also depict a slim increase in number of referrals from April 2011 (17.5) to October 2011 (17.10). These elevated caseload averages continue to reflect ongoing parallel ER over 60-day investigations. Both the generic and emergency response averages tend to increase with

the seasonal fall and early spring Child Protection Hotline referral peaks. These peaks also generate an increase in Emergency Response Command Post follow-up referrals, increased workload related safety measures in emergency response activities/investigations and caseload averages.

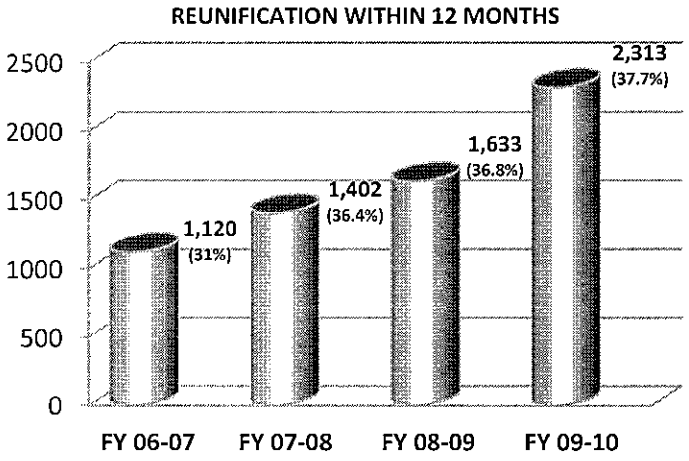
OBJECTIVE NO. 6
Data and Tracking of Indicators



Safety Indicator 1:

Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period while receiving mental health services, up to 12 months.

Since FY 2006-07, there has been an 81 percent increase in the number of children remaining home without any new substantiated referrals.



Permanency Indicator 1:

Reunification within 12 months for children receiving mental health services.

Improvements in reunification are evident since the number of children reunified has more than doubled since FY 2006-07.

OBJECTIVE NO. 7
Exit Criteria and Formal Monitoring Plan

Quality Services Review

The QSR provides an in-depth, case-based review of the front-line DCFS and system partners practice in specific locations and points in time. The QSR utilizes a combination of record reviews, interviews, observations, and deductions made from fact patterns gathered and interpreted by certified reviewers regarding children and families receiving services. To date, 128 cases have been randomly selected for review. An average of 10 children, youth, caregivers, family members, service providers and other professionals, per case, have been interviewed and the baseline results demonstrate consistent themes and patterns across the 11 DCFS regional offices reviewed: Belvedere; Santa Fe Springs; Compton; Vermont Corridor; Wateridge; Lancaster; Palmdale; Pomona; Glendora; El Monte; and Pasadena.

On average, 87 percent of the cases across the offices have scored acceptably on the Child and Family Status indicators while roughly 40 percent of the cases scored favorably on the System Performance Indicators.

Based upon the reviews conducted thus far the following practice lessons have been identified: engaging families and giving voice and choice to children, parents and caregivers in decision making enhances understanding and participation, leading to better outcomes; strength-based identification of needs helps gain understanding of underlying needs and treatment of trauma required for true and lasting change to occur; improved long-term view provides a clearly articulated vision and guides all the work toward safe closure; better teamwork improves the functioning of the total support system around the family to unite, communicate, and coordinate actions toward the case plan goals and following case closure. Review findings are currently being utilized by local DCFS leaders and practice partners to stimulate and support efforts to improve practice.

The remaining offices of the first QSR Cycle will be reviewed during the 2012 calendar year in the following order: San Fernando Valley (January 17th); West San Fernando Valley and Santa Clarita (February 22nd); Metro North (March 19th); West Los Angeles (April 22nd); Torrance (May 14th); and South County (June 4th).

SUMMARY HIGHLIGHTS

DATE	DESCRIPTION
Ongoing	CPM, ESBT, coaching and QSR training continues to roll out to both DCFS and DMH staff and mental health service providers to improve practice.
Ongoing	DMH and DCFS continue to enhance the implementation and coordination of the high-needs service delivery spectrum of TFC, Wraparound and D-rate.
December 2011	Katie A. Exit Conditions for the County were approved by the Federal Court and the Court approved the state's settlement agreement.

Please let me know if you have any questions regarding the information contained in this report, or your staff may contact Lesley Blacher, Manager, at (213) 974-4603, or via e-mail at lblacher@ceo.lacounty.gov.

WTF:BC
LB:lb:yw

c: Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Mental Health

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