



County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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December 31, 2013

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To: Supervisor Don Knabe, Chairman
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From: Philip L. Browning
Director, Department of Children and Family Services

Marvin J. Southard, DSW
Director, Department of Mental Health

**APRIL 28, 2009 AMENDMENT TO ITEM NO. 24: KATIE A. STRATEGIC PLAN,
TRI-ANNUAL REPORT ON THE MENTAL HEALTH SCREENING PROCESS**

On April 28, 2009, the Board ordered the Chief Executive Officer (CEO), the Department of Children and Family Services (DCFS) and the Department of Mental Health (DMH) to prepare a monthly report on the mental health screening process. On January 19, 2010, the Board ordered the CEO, DCFS and DMH to report on how to reduce the time between mental health screenings and the start of mental health services. In response, DCFS and DMH reviewed a sample of children's cases and on March 16, 2010 provided the Board with a plan that resulted in a redesign of the Coordinated Services Action Team (CSAT) and Referral Tracking System (RTS). On April 17, 2012, the Board Deputies approved the current format of the report and agreed that the report, dated April 30, 2012, would be the last monthly report and, going forward, the report will be submitted every four months on December 31, 2013 and April 30, 2014 and August 31, 2014.

This is the fifth tri-annual report updating your Board on the redesign of the CSAT implemented on October 1, 2010 and providing progress of all Service Planning Areas (SPAs) for the first quarter of Fiscal Year (FY) 2013–2014, (July 1, 2013 through October 31, 2013), as of December 16, 2013.

"To Enrich Lives Through Effective and Caring Service"

CSAT Process

The CSAT process (Attachment 1) requires expedited screening and response times based upon the acuity of a child's need for mental health services. Additionally, the CSAT process provides for the annual screening of children in existing cases with previous negative screens. Four tracks establish the process by which all DCFS children in new and currently open cases are screened and referred for mental health services.

Track	Screening Process
Track 1	Children in newly opened cases who are detained and placed in out-of-home care receive a mental health screening at case opening.
Track 2	Children in newly opened cases under Voluntary Family Maintenance, Voluntary Family Reunification or Court-supervised Family Maintenance case plans are screened at case opening.
Track 3	Children in existing cases opened before CSAT implementation are screened at the next case plan update.
Annual	Children in existing cases are screened 12 months after previously screening negative.

Referral Tracking System (RTS)

The RTS Summary Data Report (Attachment 2) includes 22 data elements providing the rate, number, timeliness, and acuity of mental health screenings, referral, and service response times to DCFS children in new and existing cases on a point-in-time basis.

The RTS Summary Data Report as of December 16, 2013 provides the progress of all SPAs for the first third of FY 2013–2014, from July 1, 2013 through October 31, 2013. This report reflects CSAT performance completed through December 16, 2013 and is a snapshot of work in progress. The following two charts depict the results to date for all three tracks associated with the screening and referral process:

Chart I shows that of 8,298 children, 8,081 children required screens (8,298 minus those currently receiving mental health services [19¹], in closed cases [170], who ran away or were abducted [28]):

- 6,849 (84.75%) children screened positive of all children requiring screens (8,081);
- 996 (12.33%) children screened negative of all children requiring screens (8,081);
- 236 (2.92%) children have screens pending of all children requiring screens (8,081).

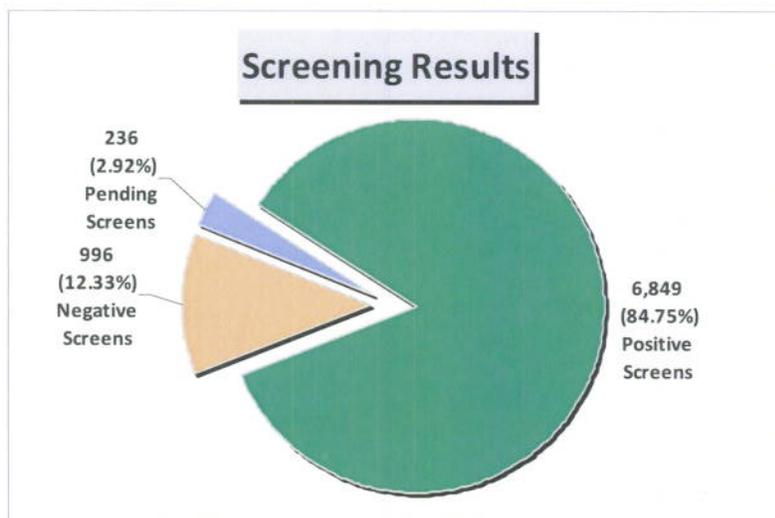
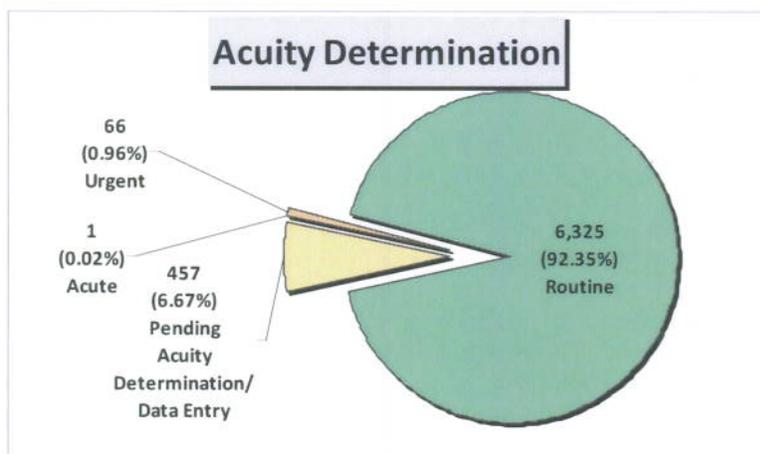


Chart II shows that of the 6,849 children who screened positive:

- 1 (0.02%) child was determined to have acute needs;
- 66 (0.96%) children were determined to have urgent needs;
- 6,325 (92.35%) children were determined to have routine needs;
- 457 (6.67%) children's acuity level was pending determination and/or data entry.



¹ The total number of children in all tracks currently receiving mental health services is 144. However, only children in existing cases (track 3 [19]) are subtracted from the total number of children requiring screens because all children in new cases (track 1 [18] and track 2 [107]) must be screened whether or not they are already receiving mental health services.

Acuity Referral Standards

Acute	Children presenting with acute needs are referred for mental health services on the same day as screening.
Urgent	Children presenting with urgent needs are referred for mental health services within one day of screening.
Routine	Children presenting with routine needs are referred for mental health services within 10 days of screening.

The average number of days between screening and referral to DMH for mental health services according to acuity for the first third of FY 2013-2014 as of December 16, 2013:

- Children with acute needs were referred to DMH in 0 days on average.
- Children with urgent needs were referred to DMH in 2 days on average.
- Children with routine needs were referred to DMH in 6 days on average.

Mental Health Service Activity Standards

Acute	Children presenting with acute needs begin receiving mental health service activities on the same day as the referral.
Urgent	Children presenting with urgent needs begin receiving mental health service activities within no more than three days of the referral.
Routine	Children presenting with routine needs begin receiving mental health service activities within no more than thirty days of the referral.

The average number of days between referral to and receipt of a mental health activity according to acuity in FY 2013-2014 as of December 16, 2013:

- The average number of days for receipt of a mental health service activity was 0 days for children with acute needs. (Attachment 2, line 19a);
- The average number of days for receipt of a mental health service activity was 0 days for children with urgent needs (Attachment 2, line19b); and
- The average number of days for receipt of a mental health service activity was 2 days for children with routine needs (Attachment 2, line19c).

The rate of children that received a mental health activity with required timeframes according to acuity in the first third of FY 2013-2014 as of December 16, 2013:

- 100 percent of children with acute needs received DMH services on the same day as the referral (Attachment 2, line 20a);
- 93.94 percent of children with urgent needs received DMH services within 3 days of the referral (Attachment 2, line 20b); and
- 97.11 percent of children with routine needs received DMH services within 30 days of the referral (Attachment 2, line 20c).

Achievements

As of December 16, 2013, for children served in the first third of FY 2013-2014, the average timeline from case opening/case plan update to the start of mental health service activities is 11 days.

DCFS and DMH continue to sustain improvements made in mental health screening, assessment and service delivery:

- 97.08 percent of children who were eligible for screening were screened for mental health needs;
- 95.19 percent of children who screened positive were referred to mental health services; and
- 95.04 percent of children referred for services received mental health service activities within the required timelines.

Quality Service Review

The Quality Service Review (QSR) process is the central strategy adopted by the County, in collaboration with the Katie A. Advisory Panel and plaintiff attorneys, to assess the quality of the services delivered to members of the Katie A. class. The QSR is an action-oriented learning process used to improve practice and service delivery for children and families. The QSR is also a measure of how well DCFS and DMH are implementing the Core Practice Model, the primary framework for practice expectations. Findings from case reviews are used to guide next steps to support practice and enhancing efforts that will lead to better outcomes for the families served.

The QSR measures both systems performance and outcomes for children and families. It reflects the quality of services in such areas as family engagement, teaming among service providers, and children and families, as well as the ability to assess the needs that bring families to DCFS' attention, and provide timely and adequate services and supports. The QSR evaluates outcomes such as safety,

permanency, well-being, school performance, and the ability to form appropriate social relationships.

Nine DCFS offices have completed a second QSR. The following provides a sample of historical and the most recent QSR data results, narrative findings, and a QSR story. The focus is on those indicators that are most essential to improving the work. As a point of reference, the higher the scores achieved, the better the practice and outcomes. Benchmarks targeted for systems performance and child status are noted in the table below. Definitions of these indicators are found at the end of the following section.

QSR Results:

Service Area	Regional office	Date of QSR	Overall Child/ Youth Status*	Overall Practice Performance*	Engagement**	Teamwork**	Assessment**	Long-term View	Supports and Services	Adequacy of Intervention
7	Belvedere	Baseline 7/1/2010	85%	31%	46%	16%	45%	23%	62%	38%
7	Belvedere	Second Round 12/1/2012	100%	67%	92%	33%	71%	67%	67%	55%
7	Santa Fe Springs	Baseline 8/1/2010	71%	35%	79%	29%	52%	36%	57%	43%
7	Santa Fe Springs	Second Round 1/1/2013	83%	58%	75%	8%	59%	50%	67%	58%
6	Compton	Baseline 10/18/10	77%	31%	38%	0%	59%	23%	69%	54%
6	Compton	Second Round 3/4/13	75%	58%	75%	17%	53%	50%	58%	58%
6	Vermont Corridor	Baseline 1/24/11	86%	21%	36%	7%	30%	36%	57%	43%
6	Vermont Corridor	Second Round 4/8/13	100%	45%	55%	9%	52%	55%	36%	36%
6	Wateridge	Baseline 3/14/11	93%	14%	43%	0%	32%	21%	43%	21%
6	Wateridge	Second Round 5/13/13	83%	58%	58%	58%	67%	67%	58%	58%
3	Pomona	Baseline 7/11/11	92%	42%	58%	8%	35%	25%	67%	50%
3	Pomona	Second Round 6/24/13	100%	73%	91%	55%	45%	64%	73%	55%

3	Glendora	Baseline 8/22/11	83%	50%	58%	25%	52%	58%	67%	58%
3	Glendora	Second Round 8/5/13	90%	60%	80%	40%	70%	60%	70%	70%
3	El Monte	Baseline 10/4/11	93%	71%	79%	29%	50%	71%	79%	79%
3	El Monte	Second Round 9/16/13	90%	60%	90%	20%	70%	60%	70%	70%
2	San Fernando Valley	Baseline 1/17/12	92%	50%	67%	8%	67%	42%	50%	50%
2	San Fernando Valley	Second Round 10/21/13	78%	56%	89%	22%	33%	44%	78%	67%
DEPARTMENT WIDE OVERALL BASELINE		7/2010- 8/2012	88%	47%	60%	18%	50%	39%	66%	52%
NINE OFFICES OVERALL SECOND ROUND		12/1/12 - 10/2013	88%	60%	78%	29%	58%	57%	64%	59%

*A score of 85 is our target score

**A score of 75 is our target score

Definition of Indicators:

INDICATOR	DEFINITION
Overall Child/Youth Status	The QSR Protocol provides ten qualitative indicators for measuring the current status of a focus child.
Overall Practice Performance	This measure is based on nine qualitative indicators measuring certain core practice functions being provided with and for the focus child and the child's parents and/or caregivers.
Engagement	Degree to which those working with the focus child and family are: Relating with the child/youth, biological family, extended family, primary caregiver, and other team members for the purpose of building a genuine, trusting and collaborative working relationship. Identifying a support system and/or finding family members who can assist with support and permanency for the focus child. Developing and maintaining a mutually beneficial trust-based working relationship with the child and family that involve having unconditional positive regard, respect for diversity, an inclusive planning process, and the ability to understand and work through resistance to participating in services. 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.
Teaming	Degree to which: (1) the "right people" for this child and family have formed a working Child and Family Team that meets, talks, and plans together. (2) The CFT has the skills, family knowledge, and abilities necessary to define the strengths and needs of this child and family and to organize effective service for this child and family, given the level of complexity of circumstances and cultural background of the child and family. (3) Members of the child and family's team collectively function as a unified team in planning services and evaluating results. (4) 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 to benefit the child and family.
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.
Assessment	Degree to which those involved with the child and family understand: (1) Their strengths, needs, 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.
Intervention Services and Supports	Degree to which the strategies, supports, and services planned for the child, parent or caregiver, and family are available on a timely and adequate basis to meet near-term child and family needs and to achieve the outcomes planned.
Adequacy of Services and Supports	Degree to which planned interventions, services, and supports being provided to the child and family have <i>sufficient power</i> (precision, intensity, duration, fidelity, and consistency) and <i>beneficial effect</i> to produce results necessary to meet near-term needs and achieve outcomes that fulfill the long-term view.

Most Recent Office QSR Results:

The most recent QSR was conducted during October 2013 within the San Fernando Valley DCFS Regional Office, Service Area 2. The key results are provided below:

Service Area	Regional office	Date of Last QSR	Overall Child/ Youth Status*	Overall Practice Performance*	Engagement**	Teaming**	Assessment**	Long-term View	Intervention Services and Supports	Adequacy of Services and Supports
2	San Fernando Valley	Baseline 1/17/12	92%	50%	67%	8%	67%	42%	50%	50%
2	San Fernando Valley	Second Round 10/21/13	78%	56%	89%	22%	33%	44%	78%	67%

Nine randomly selected cases were reviewed in the San Fernando Valley and 78 percent scored in the acceptable range with respect to overall child/youth status. This was a 14 percent decline compared to their previous baseline score. The cases scored 56 percent in the acceptable range with respect to overall practice performance. This score was 9 percentage points higher than the countywide baseline and 6 percentage points higher than their office's score during the first cycle.

Scores on the preponderance of practice indicators were notably higher in San Fernando Valley during the second cycle compared to the countywide baseline scores.

On "Engagement," 89% percent of cases scored favorably (compared to 60 percent in the countywide baseline); on "Long-Term View," 44 percent scored in the favorable

range (compared to 39 percent in the countywide baseline); on “Adequacy of Service Intervention,” 67 percent of the cases scored favorably (compared to 52 percent in the countywide baseline).

In addition, the San Fernando Valley Office scored higher on each of the practice indicators within their office during the second cycle when compared to their baseline scores, with one exception. San Fernando Valley improved their practice scores within their office during the second cycle when compared to their baseline cycle scores on the indicators of “Engagement” by 22%, “Teamwork” by 14%, “Long-Term View” by 2%, “Supports & Services” by 28%, and “Adequacy of Service Intervention” by 17%. Their practice score for “Assessment” declined by 34%.

The San Fernando Valley’s improved practice scores during the second cycle follows the positive trend seen in eight of the first nine offices, where overall practice improved by 36% in Belvedere, 23% in Santa Fe Springs, 27% in Compton, 24% in Vermont Corridor, 44% in Wateridge, 31% in Pomona, and 10% in Glendora when compared against their own baseline scores. (The El Monte Office posted a 71% acceptable in overall practice, the highest score in the baseline but dropped to an above average score of 60% in the second cycle.)

The overall practice score for the countywide baseline cycle was 47% acceptable. In the nine offices during the second round, the cumulative overall practice score improved by 13% to 60% acceptable.

The two practice indicators that appear to have improved the most during the second cycle are “Engagement” and “Long-Term View,” and the San Fernando Valley also improved in these areas. This reflects that staff members within the system of care are developing positive rapport and effective working relationships with children/youth and families and their informal supports to bring them in as full participants in case planning and goal accomplishment. It also means that staff members within the system of care are developing increased understanding of safety, well-being, and permanency outcomes and functional life goals for the child and family that specify required protective capacities, desired behavioral changes, sustainable supports, and other accomplishments necessary for safe case closure.

The lagging practice indicator in both the baseline and second cycles continues to be “Teamwork.” The score for the countywide baseline cycle was 18% acceptable. In the nine offices during the second round, the cumulative “Teamwork” score modestly improved to 29% acceptable. The San Fernando Valley Office also demonstrated a modest improvement in their “Teamwork” score, with 22% of their cases falling within the acceptable range, compared with 8% acceptable in their first cycle, and compared with 18% in the countywide baseline. There are two Offices that have posted remarkably higher scores in “Teamwork” practice: Wateridge, 58%, and Pomona, 55%, respectively. It is noteworthy that both the Pomona and Wateridge offices are part of the California Partners for Permanency Grant (CAPP),

and these offices are using implementation science strategies to install the CAPP and Shared Core Practice Model. "Teamwork" improves the formation and function of the total support system (including the right informal as well as formal supports) around the family to unite, communicate, and coordinate actions toward the case plan goals and following case closure.

A QSR Story

D.R. is a 12-year-old boy who experienced eight placements since his family's case opened over six years ago. His mother is deceased due to a drug-related kitchen fire about two years ago. His biological father's whereabouts are unknown. During this time, the youth was placed into a prospective adoptive home. His younger brother accused him of inappropriate sexual behavior and his prospective adoptive mother reacted by asking him to be replaced and to be sent to a group home for children with sexualized behavior. When he successfully completed the program, his prospective adoptive home refused to take him back until he had a successful experience in another foster home, where he is now. His younger brother has since recanted his story, yet D.R. is not scheduled for visits nor does he receive calls from the prospective adoptive parents, and adoption with this family appears to be unlikely. D.R. is unaware of this. His total focus is on returning to the adoptive home. There has been a Wraparound team in place for four years. The team, which includes D.R., Wraparound staff, Children's Social Worker and caregiver, are looking for better ways to understand the youth. They are currently requesting a neuropsychological assessment and a cognitive-behavioral therapist to make recommendations so that D.R.'s treatment can be more effective. D.R.'s younger sibling is being adopted (in the same home where he previously lived), and he has an older sibling who resides in a group home.

The overall child status was low due to the multiple moves, lack of realistic permanency plans, and the limited assessment and understanding of D.R. In overall practice, this case scored in the refinement zone, with a passing score. There is ongoing team participation with regular meetings, which include the Wraparound mental health therapist. They have actively responded to the youth's needs for relationship. Each professional is very attached to him, and they have resolved several behavioral issues. They agree that including informal supports would help this team gain fresh solutions to the challenging issues that occur.

Summary

This is the fifth tri-annual report provided to your Board tracking mental health acuity and response rates since the redesign. CSAT processes, RTS business rules and programming, and the associated Summary Data Report are modified as lessons are learned. Similarly, our practice and service delivery system is being refined through the QSR process. Data covering the continuing period for FY 2013-2014 in the form of the Summary Data Report and updated QSR results will be included with the April 30, 2014 tri-annual report to your Board.

If you have any questions, please call us or your staff may contact Aldo Marin, DCFS Office of Board Relations, at (213) 351-5530.

PLB:MJS:
CJS:JB:SM

Attachment

c: County Counsel
Chief Executive Officer