

**COUNTY OF LOS ANGELES
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
DEPARTMENT OF MENTAL HEALTH**

KATIE A. STRATEGIC PLAN

October 2, 2008

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**County of Los Angeles
Department of Children and Family Services
Department of Mental Health**

Katie A. Strategic Plan

Executive Summary

Background

In 2002, a class action lawsuit (Katie A.) was filed against the State and County alleging that children in contact with the County's foster care system were not receiving the mental health services to which they were entitled. In July 2003, the County entered into a Settlement Agreement resolving the County-portion of the lawsuit.

Under the terms of the Settlement Agreement, the County is obligated to make a number of systemic improvements in relation to screening and assessment practices to service delivery to better serve children with mental health needs. The Settlement Agreement also established an Advisory Panel (Panel) to assist the County in developing plans for meeting the obligations of the Settlement Agreement and to report to the Court on the County's progress in doing so.

Enhanced Specialized Foster Care Mental Health Services

On August 16, 2005, the Advisory Panel issued its Fifth Report concluding that the County had not developed a sufficient plan to meet the needs of the Katie A. Class and was not meeting the obligations of the Settlement Agreement. In response to this finding, the County developed the Enhanced Specialized Foster Care Mental Health Services Plan (Plan) which was approved by the Board on October 11, 2005.

The County Plan called for a number of systemic improvements to better meet the mental health needs of the plaintiff class. These improvements included expansion of the Medical Hubs, standardized mental health screenings for all children entering foster care, the co-location of mental health staff in DCFS offices, and increases in the County's capacity to provide intensive in-home mental health services.

The County Plan was intended to be implemented in two phases: Phase I covered Service Planning Areas (SPAs) 1, 6 and 7; and Phase II was intended to cover the remainder of the County. Phase I was launched and Phase II was being planned to incorporate lessons learned from Phase I implementation.

Corrective Action Plan

In November 2006, the Court in Katie A. ordered the County to make a number of modifications to the County Plan. Senior executive staff at DMH and DCFS worked to modify the County Plan in accordance with the Court order and produced the Board-

approved Corrective Action Plan for the Enhanced Specialized Foster Care Mental Health Services Plan (CAP) in August 2007. These modifications included the addition of systems for the screening and provision of mental health services to class members, greater expansion of intensive in-home mental health services including Wraparound and Treatment Foster Care services, transitioning children out of congregate care settings more quickly by utilizing intensive home-based mental health services models, and developing data systems to better track and monitor child outcomes.

Strategic Plan

Just prior to filing the CAP with the Board an implementation evaluation commissioned by the County to evaluate the effectiveness of Plan implementation in SPAs 1, 6, and 7 was released to guide future planning efforts concerning Countywide rollout of the Plan. Critiques cited in the implementation evaluation in conjunction with lessons learned from the two plans – Plan and CAP – and feedback obtained from the Katie A. Panel have resulted in and informed the development of a comprehensive Strategic Plan with an articulated vision for systematically screening, assessing, and providing children with an appropriate continuum of care to address their mental health needs in their own home or in the most homelike setting appropriate.

The screening and assessment portion of the plan developed a coordinated assessment and referral structure referred to as the Coordinated Services Action Team (CSAT) as a means to identify children and families needing mental health services, which can then expeditiously link children/families to the appropriate service. The CSAT will be piloted in SPAs 1, 6, and 7 (Phase I) before being rolled out in a staggered Countywide approach (Phase II). The mental health service delivery portion of the plan calls for the implementation of a Child and Family Teams (CFT) approach to service planning and the provision of individualized, intensive home-based mental health services. The newly created service capacity is planned to be rolled out Countywide over a five-year period. The combination of these two elements of the Strategic Plan – systematic screening and assessment of children and the timely provision of tailored and comprehensive mental health services – form the backbone of the Strategic Plan and are supported by important strategies related to training, tracking of performance indicators, caseload reduction for DCFS workers, and targeted funding initiatives. The successful implementation of the Strategic Plan is intended to fulfill the terms of the Katie A. Settlement Agreement and form the basis for an exit from Court jurisdiction.

Budget

The total projected cost for the Strategic Plan in FY 2008-09 is \$18 million, which includes revenues from Medi-Cal Early and Periodic, Screening, Diagnosis and Treatment (EPSDT), Title IV-E Training and Reinvestment revenues, Mental Health Services Act (MHSA) funding, and County General Funds. As Strategic Plan implementation approaches full capacity, the projected yearly cost is anticipated to reach \$119.9 million when fully implemented at full year cost in FY 2014-15.

**County of Los Angeles
Department of Children and Family Services
Department of Mental Health**

Katie A. Strategic Plan

Introduction

The Los Angeles County Departments of Children and Family Services (DCFS) and Mental Health (DMH) developed the following Strategic Plan to provide a single comprehensive vision for the current and planned delivery of mental health services to children under the supervision and care of child welfare, as well as for those at-risk of entering the child welfare system. This document provides a detailed road map for the implementation/delivery of mental health services Countywide, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, over a five-year period, and acts as the central reference for incorporating several planning efforts in this regard including the following:

Katie A. Settlement Agreement, 2003;
Countywide Enhanced Specialized Mental Health Services Joint Plan (Plan), 2005;
Findings of Fact and Conclusions of Law Order, 2006, issued by Federal District Court Judge Howard Matz regarding the County's Plan, and
The County's subsequent Corrective Action Plan (CAP), 2007, stemming from the deficiencies cited in the Court's Findings of Facts and Conclusions of Law.

The Strategic Plan includes reference to several systems-level enhancements, which are broad in scope and speak to the larger systems reform efforts that are underway in both Departments that will be of benefit not only to the members of the Katie A. class, but those who are served by either Department as well. Fundamental to both the Strategic Plan and the larger vision and missions of the two Departments is ensuring the systematic screening, assessment, and prompt delivery of mental health services to children in the custody of DCFS or in imminent risk of foster care placement. The service delivery approach will focus on the identification of child and family needs through a strengths-based model of assessment and the development of an array of clinical, direct support, and placement services to meet those needs within the home or the most homelike setting available. The development of these services will incorporate a holistic system of care approach, deeply rooted in best practice principles for both child welfare and children's mental health, by promoting multi-agency collaboration, cultural competence, improvements in utilization and access management, community network/provider development, and targeted finance strategies to maximize resources.

Background

In 2002, a class action lawsuit (Katie A.) was filed against the State and County alleging that children in contact with the County's foster care system were not receiving the mental health services to which they were entitled. In July 2003, the County entered into a Settlement Agreement resolving the County-portion of the lawsuit.

Under the terms of the Settlement Agreement, the County is obligated to make a number of systemic improvements to better serve children with mental health needs. Specifically, the County must ensure that class members:

- Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;
- Receive 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;
- Be afforded stability in their placements, whenever possible; and
- Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

The Settlement Agreement defines class members as all children who:

- Are in the custody of the Los Angeles County DCFS in foster care or who are at imminent risk of foster care placement by the Department;
- Are eligible for services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program;
- Have a mental illness or condition that is documented or, had an assessment been completed, could have been documented; and
- Need individualized mental health services to treat or ameliorate their illness or condition.

The Settlement Agreement also established an Advisory Panel (Panel) to assist the County in developing plans for meeting the obligations of the Settlement Agreement and to report to the Court on the County's progress in doing so. On August 16, 2005, the Advisory Panel issued its Fifth Report concluding that the County had not developed a sufficient plan to meet the needs of the plaintiff class and was not meeting the obligations of the Settlement Agreement. In response to this finding, the County developed the County Plan which was approved by the Board on October 11, 2005.

The County Plan called for a number of systemic improvements to better meet the mental health needs of the plaintiff class. These improvements included expansion of the Medical Hubs, standardized mental health screenings for all children entering foster care, the co-location of mental health staff in DCFS offices, and increases in the County's capacity to provide intensive in-home mental health services.

The County Plan was intended to be implemented in two phases: Phase I covered Service Planning Areas (SPAs) 1, 6 and 7; and Phase II will cover the remainder of the County. Phase I was launched and Phase II was being planned to incorporate lessons learned from Phase I implementation. However, in November 2006, the Court in Katie A. ordered the County to make a number of modifications to the County Plan. Senior executive staff at DMH and DCFS worked to modify the County Plan in accordance with the Court order and produced the Board-approved Enhanced Specialized Foster Care Mental Health Services CAP in August 2007.

These modifications included the addition of systems for the screening and provision of mental health services to class members, greater expansion of intensive in-home mental health services including Wraparound and Treatment Foster Care services, transitioning children out of congregate care settings more quickly by utilizing intensive home-based mental health services models, and developing data systems to better track and monitor child outcomes. A combination of these two plans, in concert with feedback obtained from the Katie A. Panel and an implementation evaluation conducted by Health Management Associates in 2007, have resulted in and informed the development of the comprehensive Strategic Plan that is described in this document. The screening, assessment, and linkage portion of the plan, which will be implemented through the use of a coordinated structure referred to as the Coordinated Services Action Team (CSAT), will identify children and families needing mental health services and link them expeditiously to the proper service. The CSAT will be piloted in SPAs 1, 6, and 7 (Phase I) before being rolled out in a staggered Countywide approach (Phase II). The mental health service delivery portion of the plan calls for the implementation of a Child and Family Teams (CFT) approach to service planning and the provision of individualized, intensive home-based mental health services. The newly created service capacity is planned to be rolled out Countywide over a five-year period. The combination of these two elements of the Strategic Plan – a systematic method for the screening, assessment, and linkage of children and the timely provision of tailored and comprehensive mental health services – form the backbone of the Strategic Plan and are supplemented by important strategies related to training initiatives, the tracking of service delivery, system and client-level performance indicators, reducing the caseloads of DCFS workers, and targeted finance strategies. These modifications, which include both a staggered rollout and full-scale Countywide implementation, are now being presented to your Board for review and approval. The successful implementation of these strategies is intended to fulfill the terms of the Katie A. Settlement Agreement and form the basis for an exit from Court jurisdiction.

Strategic Plan Timeline and Framework

The County, in collaboration with the Panel, has been meeting frequently to frame a holistic strategic plan that will provide a central reference and an overall vision for tying the Settlement objectives, Plan, and the CAP together, which will guide all future planning and implementation activities for delivering mental health services to children in foster care. A set of organizing principles centered around cultural competencies, implementing a strengths/child needs-based team approach to planning/service

delivery, integrated screening/assessment/service delivery processes, timeliness of response, etc. are informing the service delivery model for the provision of mental health services. The Strategic Plan merges components of the Plan and CAP into one document that will be organized into seven sections:

- Mental health screening and assessment;
- Mental health service delivery;
- Funding of services;
- Training;
- Caseload reduction;
- Data/tracking of indicators; and
- Exit criteria and formal monitoring plan.

A five-year Strategic Plan is envisioned to fully execute all of the components of the plan including the fulfillment of all the Settlement objectives and the completion of a Qualitative Services Review (QSR), which will be discussed in greater detail under Exit Criteria and Formal Monitoring Plan. The QSR provides a list of objective criteria for demonstrating compliance with the Settlement Agreement and generally encompasses two levels of review – child status indicators and system performance. QSRs have been used in other jurisdictions under similar child welfare court orders to improve qualitative performance and outcomes for children and families, and have become the standard for objectively documenting fulfillment of these orders.

The Strategic Plan will outline the requirements for each component of the plan, beginning with:

- Identification of the Settlement Agreement the section is addressing;
- Description of the goal and related strategies to achieve the goal;
- The implementation timeline;
- Staffing/funding required;
- County official with responsibility for the action;
- Interim benchmarks for tracking progress; and
- Tentative timeline for Countywide rollout (when applicable, if full-scale Countywide implementation is not proposed).

Overarching Values

DCFS and DMH share an interest in the safety, permanency, and well-being of children and families in Los Angeles County. The two Departments have committed to a collaborative undertaking, which entails substantive systemic change, to improve the lives of children and families consistent with the following overarching values.

Necessary reform will require the coordination and integration of Departmental initiatives in a manner that is mutually supportive and reinforcing:

In many cases, fundamental practice as well as a cultural change among staff will be required to achieve the goals of the Settlement Agreement;
Practice change should be informed by best practice and evidence-based practice standards, benefiting from significant learning in both the child welfare and mental health fields in recent years;
Planning, implementation, and modifications to practice should be based on the analysis of quantitative and qualitative data regarding client needs and strengths, service delivery approaches, and client outcomes; and
The financial supports for these reform efforts will require a redistribution of available funds and their deployment in a flexible and targeted fashion.

Ongoing Objectives

The County's efforts remain consistent with the objectives of the Settlement Agreement. The primary objectives of the Strategic Plan are:

Integration and coordination of the County's child welfare and children's mental health programs, policies, and practices which cumulatively provide a unified vision for delivering mental health services to children in foster care;
Prompt identification of the mental health needs of children served by the child welfare system and expedited service linkage;
Provision of Wraparound-like Child and Family Teams to those in need of treatment in order to reduce removals from family, promote permanency and stability of the child's living arrangement, and foster child and family well-being;
Reduced reliance on congregate care and out-of-home placements for foster youth;
Maximizing Title IV-E Waiver and MHSA funds to help advance systemic change in early intervention, caseload reduction, and permanency planning strategies; and
Development of a continuum of intensive in-home mental health services to promote family stability, reduce out-of-home placements, and provide an alternative to congregate care.

I. MENTAL HEALTH SCREENING AND ASSESSMENT

A. Identification of Settlement Agreement being fulfilled

The Settlement Agreement obligates the County to provide necessary mental health services to all class members. On November 6, 2006, the Court directed the County to better describe how it would provide such services to class members and to specifically address certain focal populations of class members who have not been removed from their homes. In order to fulfill the obligation to provide mental health services, the County must identify the individual children who need them. This will be accomplished through the screening and assessment programs described below.

B. Description of the Goal and related strategies to achieve the Mental Health Screening/Assessment of 100 percent of children formally and informally entering foster care, as well as those already receiving child welfare services

To fulfill the obligations of the Settlement Agreement the County must screen and/or assess, and as needed provide appropriate mental health services to all children entering court-ordered foster care, those already receiving court-ordered child welfare services, and those at “imminent risk of foster care placement.”

It has been difficult for the County to operationalize programs to address the “imminent risk” population. However, the County is committing to screen and/or assess and as needed provide mental health services to all children where there is an ongoing relationship with DCFS even where this relationship has not yet resulted in placement of the child in the foster care system. This means, that children who are receiving Voluntary Family Maintenance (VFM) or Voluntary Family Reunification (VFR) services will be screened and, as needed, assessed when a voluntary services agreement is reached with the family.

To provide an example of the volume of children referred to DCFS each year, the Department investigated approximately 156,810 emergency response referrals¹ from May 2007 to April 2008. In comparison to the same period last year (May 2006 to April 2007), the Department investigated approximately 149,781 emergency response referrals, a 4.5 percent increase of 7,029 children.

On average, the Department detains approximately 7 percent of children for whom an investigation has been conducted, with the largest ratio of children being detained by the Department’s after-hours Emergency Response Command Post (ERCP). Of the approximately 124,672 children investigated for abuse or neglect from May 2007 to April 2008 by the day-time DCFS regional offices, 8,841 children or 7.1 percent were detained; while ERCP detained 2,553 children or 8.0 percent of the 32,048 referrals handled by them after-hours for the same period. A large portion of detained children or youth are placed with relatives or other temporary parent surrogates, and their cases are handled as Family Reunification (FR) cases, including Voluntary Family Reunification (VFR).

While a large number of children are placed outside of the parent's care, a significant number of children who are the subject of a child abuse or neglect investigation each month are not removed from their home but accepted for services under a Voluntary Family Maintenance (VFM) or court-ordered Family Maintenance (FM) case plan. Of the 34,284 children currently receiving child welfare services from DCFS, 14,728 children are receiving Permanent Placement (PP) services, 8,980 are receiving Family Reunification (FR) services (voluntary and court-ordered) and 10,576

¹ In most scenarios, LA County DCFS referral and case numbers represent the number of children served, instead of families, in line with California Statewide methods. Current DCFS research determined there to be an average rate of 1.8 children per family so numbers provided by child count can be calculated into a family count as needed.

children are receiving Family Maintenance (FM) services (voluntary and court-ordered).

The magnitude of children needing to be screened at any given time is substantial, given that 34,284 children were under the supervision of DCFS with an open case as of June 2008. This target is constantly moving given that anywhere from a low of 11,400 to a high of 16,940 new referrals are received depending on the month.

In regards to hotline referrals, DCFS accepted approximately 173,824 total referrals to investigate from May 2007 to April 2008. Of those, 156,810 were accepted for in-person investigation and 17,014 were evaluated out for a variety of reasons. Of the 156,810 referrals accepted for investigation, 136,868 (or 87 percent) of the referred children were determined to be unharmed and/or safe from child abuse or neglect. These referrals were closed by DCFS and no further contact with the family routinely occurred.² Conversely, in 13 percent of the investigations completed from May 2007 – April 2008, a total of 19,942 new children and families were accepted for on-going case management services. For those children under the care and supervision of the Department, the County agrees to ensure timely screening and/or assessment and as needed the provision of appropriate mental health services for any DCFS-involved child with a new or existing court-ordered or voluntary case plan. To accomplish this goal, the following methods subsequently discussed will be organized into three categorical tracks to better guide the screening and assessment processes.

Children Newly Detained Under Court-Ordered Family Reunification (FR) Case Plan³

All newly detained children will receive a comprehensive mental health assessment and linkage to mental health treatment through the Multidisciplinary Assessment Team (MAT) Program.⁴

² If an investigation reveals no evidence of current or imminent risk of abuse or neglect, but conditions exist to indicate a child or family member requires mental health services, DCFS CSWs will provide families with community-based referrals (e.g., differential response) and/or other assistance (e.g., alternative response) to link the family member to services, including mental health treatment, as a means of prevention. However, as the Department does not maintain contact or any other formal relationship with the family, ensuring the child and/or family member receives on-going and appropriate mental health treatment becomes the responsibility of the family.

³ The Appendix A. flow chart entitled “CSAT/Referral Tracking System Pathways for Emergency Response Referrals” provides a visual representation of the case flow process for screening, assessment, and service linkage for newly detained children and children newly open and non-detained under a Voluntary Family Maintenance (VFM), Voluntary Family Reunification (VFR), or Court-ordered Family Maintenance (FM) case plan.

⁴ A mental health screening becomes unnecessary for this population of children given the policy decision that all newly detained children will automatically receive a comprehensive mental health assessment through the MAT Program.

MAT Background

In 2004, DCFS, DMH and mental health contract providers began assigning and forming Multidisciplinary Assessment Teams (MATs) to ensure all newly detained children in SPAs 3 and 6 are thoroughly assessed and appropriately linked to services in a timely manner. Within 45 days, each newly detained child undergoes a thorough child-specific MAT assessment by a DMH contracted community service provider. The comprehensive MAT assessment focuses on the following key areas: mental health, physical health, developmental milestones, hearing/language development, caregiver and family of origin, educational and vocational needs. Once the assessment is completed, the assessor puts together a multi-faceted comprehensive report entitled the Multidisciplinary Assessment Team (MAT) Summary of Findings (SOF). The MAT SOF Report is then presented to the MAT team made up of the MAT Coordinator, the MAT service provider assessor, any mental health provider involved in the case, the parents, the current caregiver, the child, the public health nurse, the current case worker, the dependency investigator and any other pertinent service provider or DCFS staff involved with the case. The report is reviewed by the team members at the meeting in order to gain consensus over the needs of the family and the suggested services to meet the identified needs. The report is also validated for factual accuracy and documentation. Key persons are identified to follow-up with the family's needs and help ensure appropriate service linkages. Finally, the document is signed and the report is finalized and presented to Court as an attachment to the Jurisdictional Report. Its findings are utilized by the Court for appropriate child specific case planning recommendations.

This MAT program shares consistent practice principles with the Child and Family Team (described later in Section III) in that:

1. Services are driven by the needs of the child and preferences of the family and are addressed through a strengths-based approach;
2. The locus and management of services should occur in a multi-agency collaborative team and are grounded in a strong community base; and
3. The services offered, the agencies participating, and programs generated are responsive to cultural context and family characteristics.

The MAT assessment process is led by an independent community service partner and finalized by the collaborative efforts of the entire team. Due to the structure and organization of MAT, community service partners and the family play a greater role in the decision-making process right from the start. The MAT agency often becomes the mental health provider to serve the child/family they have assessed, simultaneously completing the intake process and typically reducing the wait for receipt of service. In cases that require the service of another agency, the MAT provider accepts shared responsibility to ensure timely service linkage to the appropriate agency.

The MAT teaming process allows for multidisciplinary collaboration with family members, caregivers, service providers and case managers and holds parties accountable to meet the needs of the child and family.

MAT Program Integration with Medical Hubs

Medical information is collected from the evaluation completed by either the Medical Hub or community medical provider to be integrated into the MAT assessment. Currently, 61 percent of newly detained children are served by one of the Medical Hubs, an interdepartmental initiative of DCFS, DMH, and the Department of Health Services (DHS). There are currently six Hubs in operation throughout the County and consist of the following: Harbor/UCLA Medical Center; High Desert Health System; LAC/USC Medical Center; Martin Luther King; Valleycare Olive View; and Childrens Hospital Los Angeles. A seventh Hub the San Gabriel Valley (MacLaren) Satellite Hub is scheduled to open the first quarter of 2009.

The Medical Hub program ensures that children at high-risk for health problems receive a thorough and comprehensive initial medical examination and forensic evaluation, if deemed appropriate, when there is an allegation of physical or sexual abuse. The goal of the Department is to work towards ensuring that 100 percent of the newly detained population is served by one of the Medical Hubs. However, until such time, any child not seen at a Hub will be evaluated by a community medical provider per current DCFS policy that requires all newly detained children to receive a comprehensive medical evaluation within 72 hours of detention, if high-risk, and 30 days for all others.

MAT Progress

More than 1,400 MAT cases have been completed to date with high-model fidelity and customer satisfaction ratings. More than 600 MAT cases in SPA 6 and 450 in SPA 3 will be completed by the end of Fiscal Year (FY) 2007-08. Fifteen SPA 6 and ten SPA 3 Specialized MAT Providers are completing assignments within the 45 day time frame and maintaining their capacity to respond to all referred children in a timely manner. Significant referral and capacity gains occurred within fiscal year FY 2007-08, almost doubling the number of MAT children served over the previous FY 2006-07. Also, SPA 6 ERCP cases are now being incorporated into the MAT case assignment process.

MAT Expansion

Countywide implementation of the MAT Program is planned for FY 2008-09 to ensure 100 percent of all newly detained children are assessed through the MAT program. Ten SPA 7 and five SPA 1 providers have begun MAT contract amendment activities to be completed by October 2008 with MAT assignments to commence no later than November 2008. Training has begun in SPA 1 while SPA 7 training dates are pending. SPAs 4 and 5 are forecast to begin MAT provider

selection, contract amendments and joint MAT orientation training in December 2008. SPAs 2 and 8 are slated to begin implementation activities in November 2008. Countywide implementation of the MAT program is projected to be completed by January/February 2009.

Children Newly Open and Non-Detained under a Voluntary Family Maintenance (VFM), Voluntary Family Reunification (VFR), or Court-Ordered Family Maintenance (FM) case plan

All new DCFS referrals resulting in a VFM, VFR or court-ordered FM case plan will receive a mental health screening using the California Institute for Mental Health (CIMH) Mental Health Screening Tool (MHST). Two separate tools exist for children ages 0-5 and 5-18 years of age. This tool was developed for use by non-clinicians, requires little formal training to use, and can be completed within a short period of time. The Department plans to implement procedures for the case-carrying Children's Social Workers (CSW) to complete the tool for all newly open children under a VFM, VFR or court-ordered FM case plan. If the tool indicates a mental health need, the child will be referred for a mental health assessment and treatment as needed. If the child is EPSDT-eligible, the referral for an assessment/treatment will be handled by a DMH Specialized Foster Care (SFC) staff person. DMH SFC staff will either link the child to the most appropriate contract provider or will complete the assessment him/herself. If the child is not EPSDT-eligible, the referral and service linkage for an assessment/treatment will be handled by the DCFS Service Linkage (SL) Specialist, a new position discussed in more detail below.

Plan for Implementation of the MHST

In October 2007, DCFS Management met with members of Local SEIU 721 Union to present the Department's plan for CSWs to complete the MHST for newly open cases. A comprehensive plan for the implementation of the MHST was not presented to the Union at the time, only the proposed concept. Union members raised significant concerns regarding the concept related to workload and liability. As a result, DCFS management agreed to postpone implementation of the MHST until a thoughtful plan was developed and subsequent discussion could be held between DCFS Management and the Union. Since that time and in direct response to Union concerns, DCFS Management formulated a comprehensive plan currently known as the Family Centered Services (FCS) Coordinated Services Action Team (CSAT) and Referral Tracking System. Described in detail below, the CSAT and Referral Tracking System encourages fundamental change beyond mental health service access and utilization to incorporate every aspect of DCFS service delivery by simplifying service referrals/linkages for social workers. Although not specifically required by the Katie A. lawsuit, experience has demonstrated that all Katie A. related program and practice change must be systematically integrated with all other service planning processes. By not doing so, workload is increased for all involved, service delivery remains less effective and fragmented, and positive outcomes are diminished. DCFS management hopes to build consensus and implement the

MHST in partnership with the Union, which will provide some of the infrastructure and beginning momentum for achieving the additional program and practice change required to fulfill Katie A.

Children in Existing Open Cases under all Court-Ordered or Voluntary FM, FR, and PP Case Plans⁵

For existing cases, both court-ordered and voluntary, the case-carrying CSW will complete the CIMH MHST when the next case plan update is due, in order to systematically ensure that all children currently served by the Department receive a mental health screening. The exceptions to this rule are for children with a previously completed MHST, for children already receiving mental health services, and/or for children currently receiving the specialized D-rate.

However, once an initial MHST is complete, no additional screenings will be required unless certain “behavioral indicators” are observed or come to the attention of the case-carrying CSW. A MHST **shall be completed** when a mental health “behavioral indicator” has been identified, whether or not a mental health screening has been completed in the past, the child is currently receiving mental health services, or the child is receiving the D-rate.

Cross-Over Youth

In many ways, children in foster care who are at risk of entering the juvenile justice/probation system (“cross-over”) present special challenges. And, the county is working on a number of initiatives apart from those of Katie A to address the needs of this population. But, the County also acknowledges that steps must be taken to insure a service culture that is sensitive to the possibility that apparently criminal behaviors may be symptomatic of unmet mental health needs and that satisfaction of those needs is often a more effective and less costly alternative to the option of juvenile-justice involvement.

Importantly, cross-over children under the care and supervision of the Department of Children and Family Services are full recipients of the screening, assessment, and service programs provided for in this Strategic Plan. And, full implementation of the features of this plan will promote the early identification of mental health needs and the avoidance of criminal behavior through management of those needs. Implementation will also provide social workers with assessment tools such as the CIMH MHST and the behavioral indicator chart discussed below to better understand the context in which cross-over issues arise and to access appropriate mental health services when they do.

⁵ Appendix B. “CSAT/Referral Tracking System Pathways for Open Cases” provides a visual representation of the case flow process for screening, assessment, and service linkage for children in existing open cases under all court-ordered or voluntary FM, FR, and PP case plans.

Behavioral Indicators

During the life of a case, a child may experience many situations that may impact his/her mental health. The following is a chart of behavioral indicators, of which the presence of just one indicator would require a new mental health screening. The chart is not exhaustive, but is meant to serve as a guide in identifying concerning behavioral indicators. The worker will be encouraged to seek an assessment for any child who is demonstrating behaviors that are markedly different from his/her prior functioning.

Behavioral Indicator Chart

Children under the age of 5

| 0 – 18 months | |
|---|--|
| Crying that is excessive in intensity or duration | Persistent arching |
| “Floppiness,” or stiffening when held or touched | Persistent and excessive feeding problems |
| Cannot be consoled by caregiver | Makes or maintains no eye contact |
| Does not vocalize (e.g. “coo”), cry or smile | Does not respond to caregiver |
| Does not respond to environment | Interaction with others does not appear to be pleasing |
| Cannot initiate or maintain sleep without extensive assistance in the absence of Stressors such as noise or illness | |

| 18 – 36 months | |
|--|---|
| <i>Any of the behaviors for 0-18 months</i> | |
| Extremely destructive, disruptive, dangerous or violent behavior | Excessive or frequent tantrums |
| Excessive or repetitive self-injurious behavior (e.g. rocking, masturbation) | Appears to have an absence of fear or awareness of danger |
| Persistent and intentional aggression despite reasonable adult intervention | Does not seek caretaker/adult to meet needs |
| Fails to initiate interaction or share attention with others with whom s/he is familiar | Unaware or uninvolved with his/her surroundings |
| Does not explore environment or play; does not seek caretaker/adult to meet needs (e.g. solace, play, object attainment); few or no words; fails to respond to verbal cues | Few or no words; fails to respond to verbal cues |

| 3-5 Years | |
|--|---|
| <i>Any of the behaviors for 0-18 months and 18-36 months</i> | |
| The child experiences frequent night | Excessive preoccupation with routine, objects |

| | |
|---|--|
| terrors | or actions (e.g. hand washing – becomes distraught if interrupted, etc.) |
| Extreme hyperactivity, excessively “accident-prone” | Does not use sentences of 3 or more words |
| The child is excessively withdrawn | Speech is unintelligible |
| Clear and significant loss of previously attained skills | does not play or interact with peers |
| Persistent, extremely poor coordination of movement (e.g. <i>extremely clumsy</i>) | Unusual eating patterns (e.g. refuses to eat, overeats, repetitive ingestion of nonfood items) |

| 5 Years to Adult | |
|---|---|
| The child/youth has been a danger to him/herself or to others in the last 90 days | The child/youth has experienced severe physical or sexual abuse or has been exposed to extreme violent behavior in his/her home in the last 90 days |
| Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaulted other children or adults; reckless and puts self in dangerous situations; has come to the attention of the juvenile justice system through either the traffic court and/or being charged with a misdemeanor or felony; attempts to or has sexually assaulted or molested other children, etc. | Subjected to or witnessed extreme physical abuse, domestic violence or sexual abuse, e.g., severe bruising in unusual areas, forced to watch torture or sexual assault, witness to murder, etc. |
| The child has behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy. Such as: | |
| Persistent chaotic, impulsive or disruptive behaviors; daily verbal outbursts; requires constant direction and supervision in all activities; overly jealous of caregiver’s other relationships; excessive truancy; fails to respond to limit setting or other discipline, etc. | excessive noncompliance; constantly challenges the authority of caregiver; requires total attention of caregiver; disruptive levels of activity; wanders the house at night |
| The child/youth has exhibited bizarre or unusual behaviors in the last 90 days | The child has an immediate need for psychotropic medication consultation and/or prescription refill |
| History or pattern of fire-setting; cruelty to animals; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including alcohol or drug induced); repetitive body motions (e.g., head banging) or vocalizations (e.g., echolalia); smears feces; etc. | Either needs immediate evaluation of medication or needs a new prescription |

All Ages

| | |
|---|---|
| Child/youth has been a victim of physical and/or sexual abuse and or severe neglect while under DCFS supervision | Child/youth has been exposed to extreme violent behavior or trauma while under DCFS supervision |
| The child has returned from being a runaway or a victim of child abduction | The child/youth has been in two or more placements in the last 90 days |
| The child has experienced a major life event in the last 90 days (e.g., death of a family member or friend; marriage/divorce of a parent; parent's arrest and incarceration; birth of a sibling, etc. | The child/youth has experienced a school expulsion or suspension |
| Child/youth is removed from the home of a parent due to a failed VFM or Court-ordered FM | |

Family-Centered Services (FCS) Coordinated Services Action Team (CSAT) and Referral Tracking System

The Family-Centered Services (FCS) Coordinated Services Action Team (CSAT) and Referral Tracking System was largely developed as a result of the deficiencies cited in the Health Management Associates (HMA) 2007 Report in relation to the implementation of the Enhanced Specialized Foster Care Mental Health Services Plan and the lack of a coordinated vision guiding the systematic mental health screening, assessment, and receipt of appropriate services. The CSAT seeks to coordinate, structure, and streamline existing programs and resources to expedite mental health assessments and service linkage, once a positive mental health screen or mental health trigger has been presented. While the CSAT and Referral Tracking System originated from the Katie A. planning process, it is encouraging fundamental change beyond mental health service access and utilization to incorporate every aspect of DCFS service delivery by simplifying service referrals/linkages for social workers.

Currently, scores of programs and services exist throughout the County and across our system to address the diverse needs of DCFS involved children and families, but the implementation of those programs within DCFS lacks an overarching vision and approach to connect our service delivery. Staffing resources and services are fragmented and exist in silos. CSWs spend much of their time attempting to navigate diverse eligibility and gate-keeping requirements rather than attending directly to the needs of children and families. Moreover, they spend considerable time completing numerous and diverse referral forms, each containing much of the same demographic and needs-assessment information. Additionally, CSWs are required to attend a variety of meetings to gain the child's acceptance into the program and/or placement. Lack of a centralized referral management structure limits the Department's ability to track service capacity, utilization rates and trends, and to make rapid adjustments as needed. Due to the above barriers, existing programs and services may be under-utilized in direct opposition to the goals of child safety, permanency and well-being. Further, the needs of children and families may

go unnoticed and/or untreated by an over-reliance on individual CSWs to ensure prompt and appropriate services. In order to comply with the Katie A. Settlement Agreement, DCFS and DMH are working together to create a single referral and tracking system to support the CSWs linkage to the existing and newly created programs to address the mental health needs of children. In order to accomplish, there needs to be a user-friendly means of linking children to the service that most effectively and cost-efficiently meets their needs.

The CSAT and Referral Tracking System will accomplish the following specific objectives:

- 1) Utilize a single, referral process regardless of the entry point by which children and families enter the child welfare system, be it court-ordered or voluntary;
- 2) Condense existing forms into one standardized, universal screening application/form;
- 3) Implement an automated referral and tracking system to track referrals, capacity, utilization and service need by geographic location;
- 4) Integrate existing staff and program resources into unified management and navigation teams that work efficiently in consultation with the CSW, child, family, and their team;
- 5) Remove unnecessary bureaucratic layers of service authorization (i.e., DCFS Wraparound Liaisons will link children approved through the TDM process directly to Wraparound providers, eliminating the need for CSWs to attend a separate meeting to gain service authorization);
- 6) Increase ability to rapidly and thoroughly identify needs and deploy resources/services; and
- 7) Maximize utilization of existing and future resources and programs.

Coordinated Services Action Team (CSAT)

The CSAT will be organized to accomplish the following: ensure the consistent, effective, and timely screening and assessment of mental health needs across all populations of children served by DCFS; coordinate staff who currently link children to services within and across offices; and to systematically review capacity, access and utilization to current and future services. For the most part, existing resources within each Regional Office will form CSATs and be organized to electronically receive needs-based referrals, link children and families for appropriate services, and enter the results into the FCS Referral Tracking System. The creation of the CSAT aligns existing DCFS and DMH regional, non-line staff to rapidly receive referrals through the FCS and to coordinate with the case-carrying CSW to ensure the most appropriate service linkage. The CSAT will be located in each regional office and will be the primary system experts or navigators assisting CSWs to rapidly link children and families to needed services providing a strong complement to Intensive Services Workers (ISWs) and the Points of Engagement (POE) model. Again, while the CSAT and Referral Tracking System originated from the Katie A.

work, it has helped to promote the larger systems change effort required to effectively screen, assess, provide, and track services to children in foster care. Each CSAT team will also collect, manage and analyze data to provide local DCFS and DMH managers reports that will track trends and utilization patterns. The CSAT Lead will provide aggregate data for all of Los Angeles County to central DCFS and DMH management that will identify global and local trends, capacity issues, service gaps and successful innovations. This centralized data will also be used as a means of quickly identifying and tracking problems with specific providers, types of services, and the CSAT Referral Tracking System itself.

After a CSW completes the FCS Universal Referral Form, the Service Linkage Specialists (SL Specialists), a newly created CSA I position, will act as the CSAT Lead (with DCFS MAT Coordinator as their back-up). The SL Specialists become the system navigators and resource coordinators for the regional offices. They oversee, direct, coordinate, and link staff. The SL Specialist will hold regular team meetings between all members of the CSAT, ensure timely assignments to members of the team, arbitrate conflicts within the team, act as consultant to team members, and communicate policy and institutional barriers to service delivery to both Regional Administration and the Office of the Medical Director. They will also assume responsibility for tracking all activities of the CSAT, gathering, analyzing and producing data reports to the local DMH and DCFS managers.

The CSAT Lead will forward each new referral to the most appropriate CSAT member for follow-up and service linkage. Upon receipt of the referral, the CSAT member documents the result of their work in the Referral Tracking System. The following staff who already exist in DCFS regional offices will work in collaboration with the CSAT Leads:

- DCFS MAT Coordinators;
- DCFS RMP Team Decision Making and Resource Management Program Staff;
- DCFS Resource Utilization Management (RUM) Co-located Staff;
- DMH Specialized Foster Care (SFC) and RMP Co-located Staff;
- DCFS D-rate Clinical Evaluator;
- Wraparound/System of Care Liaison;
- Department of Public Social Services Co-located Staff (Linkages);
- DCFS and DHS Nurse;
- DCFS Educational Consultant;
- DCFS Youth Development Coordinator;
- DCFS Permanency Partners Program (P3) Staff;
- DCFS Adoption and Safe Families Act (ASFA) and co-located staff.

CSAT Leads will, as needed, draw upon all staff listed above when necessary to facilitate delivery of specific services to the child and family.

Cases in need of services administered through DMH, that are not appropriate D-rate, MAT or Wrap/SOC, will primarily be assigned to the DMH SFC co-located staff. CSAT members will document their work to link children and family with appropriate services and document their efforts into the FCS Referral Tracking System and into the child's case. CSWs, administrators and program managers will have access to the tracking system and can monitor aspects of service delivery such as which children were referred, how many referrals were made, CSAT staff responsible for arranging services, number of cases served by each agency, and number of slots available in various programs. The CSAT and FCS Referral Tracking System will provide the necessary infrastructure and systems navigation to ensure that children are systematically screened, assessed, and linked to the appropriate mental health services in a timely manner.

The Team Decision Making Process

TDM is a collaborative meeting process designed to produce the best decision concerning a child's safety and placement through the joint contributions of family members, community partners, service providers, caregivers and other support networks. TDM staff provide a vital link to the CSAT in connecting children and families to mental health services and other supportive resources, particularly in the case of replacements, reunifications, and returns to home. TDMs operate on the premise that the well-being of a child is best served by an inclusive collaboration and consensus of shared ideas and opinions in support of the child and their family.

Los Angeles County currently has 76 full-time TDM Facilitators Countywide. They conducted over 10,000 TDMs last year (7/1/06 to 6/30/07), impacting over 21,000 families. The TDM process has not yet been integrated into Emergency Response Command Post (ERCP), therefore, additional staffing is being requested to provide TDMs at ERCP or within 72 hours of taking a child into temporary custody. This will enable TDMs to occur on weekends, holidays, and after-hours resulting in reduced wait time to connect children/families to needed services. The additional staffing needs will be met with Title IV-E Waiver Capped Allocation funds.

Removal TDMs are the only TDMs that are mandatory at this time. The Department and the union continue to work together to reach an agreement regarding replacement and reunification TDMs. Everyone agrees that TDMs are "best practice", however, the union's contention is that caseloads are too high and places a strain on the case-carrying CSW and their Supervising Children's Services Worker (SCSW). Therefore, the Department continues to plan its increase in the rate of TDMs in conjunction with caseload and workload reduction.

The Family Centered Services (FCS) Referral Tracking System

The FCS Referral Tracking system will be designed as a local system by which CSWs can identify client needs and make requests for services to meet those needs. The array of services will ultimately include all services offered within and by

DCFS, as well as services offered by DMH, DPSS, DHS and other Community Based Organizations. The Referral Tracking system will be user-friendly for the CSW in that much of the information needed to refer families to programs will be populated automatically from CWS/CMS. At this time, DCFS is working with DMH, DHS and DPSS regarding the interface between programs so that the referral tracking application can receive real-time information.

The minimum data elements required to transmit an effective referral, populated from CWS/CMS and Single Index, to generate a request for services on an open referral/case include:

- 1) Child's basic information (CWS/CMS Case No., State ID No., name, DOB, gender, ethnicity, language);
- 2) Child's case information (service component, removal date, court status, date of detention, next court date);
- 3) Child's education information (school name, grade, special education status);
- 4) Parent's information (name, phone, language);
- 5) Primary SCSW and CSW information (name, phone);
- 6) Child's placement information (caregiver name, address, phone, facility type); and
- 7) Medi-Cal eligibility status.

In the event that Federal legal restrictions governing the Statewide Automated Child Welfare Information System (SACWIS) and confidentiality concerns preempt the development of an automated referral tracking system, less reliable manual procedures would have to be put in place. For example, through the generation of CSW/CMS forms some case-identifying and demographic information for a client could be pre-populated in a form, while the rest would have to be manually filled out. The CSW would then be able to print the form and submit it to the CSAT for assistance, but automated efficiencies would be minimal. CSAT staff would be required to consult manual logs to determine the status of cases where service needs have been identified and requested. Although the delivery and procurement of such services would occur in the same manner, the ability for the CSWs, administrators and program managers to monitor aspects of this service delivery system would be limited and labor intensive. In order to track the process of service delivery to a child or family, a centralized manual tracking log would need to be considered.

DCFS, DMH and legal counsel are in close consultation to determine the best means whereby DCFS can track the initiation and disposition of requests for services. The following possibilities are being researched:

1. DCFS creates a Universal Referral Form to be generated through CWS/CMS as described above. Children required to be screened/assessed will be identified in CWS/CMS using special projects. The necessary data elements will be identified and directly downloaded to a DMH database.

2. DMH Chief Information Office Bureau (CIOB) management staff can, within a couple months, match the children from DCFS special projects against data in the DMH/DCFS client-cube (already in existence from the existing Federal Court Order) to provide a one-line dispositional report on an individual client's service linkage. This would not allow DCFS and DMH staff to case manage clients, but would provide data to measure progress on quantitative outcomes.
3. DMH may build a database/tracking application to directly download data from the DCFS CAD or CWS/CMS database to provide a more comprehensive tracking and case management system if SACWIS violations preempt the development on the DCFS end. This would require DMH management staff to conduct systems analyses and develop programming tasks, which cannot be completed with existing resources.
4. Additionally, DCFS and DMH are exploring the possibility for DMH staff to enter documentation of their work with DCFS clients into CWS/CMS which, regardless of the tracking system, would be ideal.

The Resource Utilization Management Process

RMP addresses the Court's November 2006 recommendations of developing a system to transition children out of congregate care settings by developing a better system to utilize and monitor resources/outcomes for children. All RMP members will also be members of the CSAT and will receive referrals through the FCS Referral Tracking System.

The RMP is a family centered, multi-departmental, integrated approach to identifying, coordinating and linking appropriate resources/services to meet the needs of children currently in, or at risk of a RCL 6 through 14 placement. The RMP will consist of four major elements. First, it will enhance the TDM process for children at risk of a potential placement move. Second, the child's strengths and needs will be assessed using the Child and Adolescence Needs and Strengths (CANS) tool by a Resources Utilization Management (RUM) staff member and a DMH clinical psychologist. Third, the family will be informed of the services available to them before the meeting and are encouraged to help make the decision. Fourth, the services identified by the family and the team will be approved and linked by a team member and the CSW.

The RMP will utilize existing and planned DMH intensive in-home mental health services programs, including Multidimensional Treatment Foster Care (MTFC), Multisystemic Treatment (MST), Comprehensive Children's Services Program (CCSP), and DCFS' intensive services, including Wraparound, Intensive Treatment Foster Care (ITFC) and RCL 6 and above group home care. Additionally, the RMP will link children and families with intensive mental health service needs to planned Child and Family Teams and intensive home-based services programs.

The RMP will be integrated into the TDM process, so whenever a child (who is currently in a RCL 6 through 14 placement or at risk of such placement) is identified

as being at risk of a placement move, the CSW will call for a RMP TDM. The process will follow the current TDM policy by which the child's family, support staff, and treating agency staff will be invited to attend.

In order for the RMP to be effective, the information provided at the TDM is crucial. Thus, the RUM staff will be responsible for conducting the CANS before the meeting and will discuss the results of the CANS at the meeting.

The Child and Adolescence Needs and Strengths (CANS) is the universal assessment tool utilized by the RUM staff to identify the strengths and needs of children in their school, home, and community environments. The CANS evaluates the child or youth's functioning in terms of school performance, conduct and behavior, social relationships, moods and emotions, substance use, aggressive and self-harmful behaviors. The CANS also assesses the child's primary and substitute caregivers' ability to provide a safe and emotionally nurturing environment, including their ability and willingness to participate in recommended services. The CANS will help inform the decision about the level of intensity of services and/or the level of placement.

In addition to reducing the number of subsequent meetings, paperwork and linkage work for the CSW, the RMP will shorten the timeframe to services for the family. Currently, a CSW attends the TDM and then must fill out another referral form for the service recommended in the TDM. They then need to attend a subsequent meeting to determine if the child meets referral criteria. The RMP will eliminate second "screening" meetings. The TDM will "authorize" services so the CSW will not need to attend another meeting for approval⁶. Additionally, no services can be provided without going through the RMP (DCFS finance will not process payment for any new group home placement, or Specialized DMH/DCFS service unless it has the appropriate documentation/signatures from the RMP). The DMH intensive in-home mental health services will require a parallel process, integrated into the RMP via the DMH staff member, to provide authorization and enrollment through the DMH Child Welfare Division for tracking purposes.

The RUM and DMH staff will also be responsible for bringing a current list of all services and placements in the County. If the decision is to place the child, it will be within the family's community, as appropriate. Once a service/placement is identified, the RUM and/or assigned DMH staff will support the CSW with the recommended service/placement linkages. All Structured Decision Making (SDM), HUB, MAT, education, medical and other relevant information will also be provided at the TDM to make the best possible decision.

⁶ For children being referred to an RCL 14, or Community Treatment Facility (CTF), there is an additional screening after the RMP for authorization.

C. Implementation Timeline for SPAs 1, 6, and 7

Pending Board approval of the Strategic Plan and associated staffing requests, the following timeline will guide the implementation of the CSAT and coordinated supports necessary to initiate the systematic screening and assessment of Katie A. class members in SPAs 1, 6, and 7. The regional offices in these SPAs will pilot the CSAT and FCS Referral Tracking System and provide additional insight regarding where revisions need to be made before launching a Countywide rollout. Additionally, MAT and D-rate currently require additional staffing augmentations due to the number of enhancements within each program in addition to the proposed work that will be required to carryout the first year of this Strategic Plan. The major activities include:

- Finalizing policies and procedures for the CSAT by December 2008;
- Hiring for key CSAT positions (positions discussed in more detail in Section D.) commences in October 2008 pending Board approval;
- Training curriculum finalized by February 2009, in order to begin the training and rollout of the CSAT in the following regional offices:
 - SPA 7 – Belvedere and Santa Fe Springs are trained in March 2009;
 - SPA 6 – Wateridge and Vermont Corridor are trained in April 2009;
 - SPA 6 – Compton is trained in May 2009; and
 - SPA 1 – Palmdale and Lancaster are trained in June 2009.

Implementation in the regional offices will be closely monitored for 6 months, and adjustments/corrections will be made as necessary to inform the Countywide rollout of the CSAT.

Preparations for FCS development are currently underway. Should SACWIS issues halt the development of the FCS system, described above under Referral Tracking System, other opportunities will be evaluated to facilitate, if at all possible, an electronic (instead of a manual) interface for the exchange of referral data between DCFS and DMH.

D. Staffing/Funding Required

The following DCFS positions will be required to staff the CSAT in SPAs 1, 6, and 7, the D-rate and MAT programs currently being rolled out Countywide, and to provide the necessary central administration for oversight and implementation:

- 1 Children's Services Administrator (CSA) III – Katie A. Division to provide central administration oversight for Service Linkage Specialist, D-rate and MAT;
- 1 Secretary III for the Katie A. CSA III;
- 1 CSA II – SLS to act as central systems navigator administrator over the CSA Is;
- 1 Supervising Typist Clerk (STC) for CSA II – SLS;
- 1 CSA II – D-rate to act as central administrator for the D-rate program;
- 1 STC for CSA II – D-rate;
- 2 STCs for D-rate reclassified from existing ITCs needed to carryout addition duties related to Psychotropic Medication Authorization Process;

- 1 STC for D-rate needed to carryout additional duties related to Psychotropic Medication Authorization Process;
- 2 Children's Services Worker (CSW) IIIs – D-rate needed to carryout additional duties related to Psychotropic Medication Authorization Process;
- 7 CSA I –SLS to act as system navigator leads for the CSAT;
- 1 CSA I – MAT to provide additional central administration oversight;
- 3 CSA Is MAT Coordinators for SPA 1 and 3;
- 8 SCSWs to act as TDM Facilitators for ERCF;
- 1 CSA II – TDM to act as central administrator;
- 1 Principal Application Developer (to perform highly specialized and complex information systems analysis and programming tasks and act as the technical expert for development or maintenance of one or more major systems);
- 2 Senior Information Systems Analysts to conduct systems analysis; gathering business and user requirements; establishing and documenting functional specifications; and user test planning and execution; and
- 2 Senior Application Developers to perform a wide range of application development related duties including analysis, design, evaluation, coding, testing and maintenance of complex application systems; and gather business data from different sources to create database objects for data reporting.

The total number of new positions requested, 34, and reclassified positions, 2, would be filled on an urgent basis to provide critical staffing to implement the CSAT and pilot this model in SPAs 1, 6, and 7 for 6-months before rolling out Countywide. Several other positions are also needed at this time to complete the rollout of MAT and D-rate in line with the implementation plans currently being rolled out Countywide, and to provide the necessary central administration for oversight and implementation.

Phase II staffing, which is inclusive of the complete Countywide rollout, would include the following positions for DCFS and would primarily start in FY 2009-10, except for the MAT Coordinators which would be hired concurrently with the MAT Coordinator in SPA 1, since MAT is going Countywide before the implementation of the CSAT:

- 10 ITC Screening Clerks for SPAs 2, 3, 4, 5, and 8 (Phase II);
- 10 CSA I – SLS for SPAs 2, 3, 4, 5, and 8 (Phase II);
- Total DCFS positions requested for Phase II rollout of CSAT – 20.

DMH staffing support for the CSAT will be required for Phase II Countywide rollout and will require an additional 31 line staff, management and secretarial support positions consisting of:

- 5 Mental Health Clinical Program Heads for SPAs 2, 3, 4, 8, and Headquarters;
- 5 Secretary IIIs to support the Clinical Program Heads;
- 1 Mental Health Analyst II will provide data management support;
- 10 Clinical Psychologist IIs for SPAs 2, 3, 4, 6, and 8; and

10 Psychiatric Social Workers for SPAs 2, 3, 4, 6, and 8

It should be noted that in addition to the positions requested to support Mental Health Screening and Assessment in Phase II, DMH will be requesting additional Net County Cost (NCC) dollars to support these new positions along with a subset (approximately 54) of Plan and CAP positions that were previously budgeted with EPSDT. Past experience has demonstrated that the responsibilities of the co-located staff cannot be entirely offset with EPSDT, therefore additional NCC is requested, at a breakdown of 60 percent NCC to 40 percent EPSDT.

County Official with Responsibility for the Action

DCFS Office of the Medical Director, Dr. Charles Sophy and Katie A. Division Chief Adrienne Olson, have responsibility within DCFS to ensure that 100 percent of the Katie A. class members are screened/assessed within the stated timeframes and that policies and procedure in relation to the CSAT and FCS Referral Tracking System are implemented accordingly.

DMH Deputy Director, Olivia Celis, and District Chief, Gregory Lecklitner, have responsibility to ensure that the co-located DMH staff are integrated into the CSAT structure and are referring children not involved in MAT, D-rate, or Wrap/SOC for mental health assessments and linking these children to the appropriate mental health services, when needed.

E. Benchmarks for Tracking Progress

The following quantitative indicators will be tracked to evaluate progress with the implementation of the mental health screening and referral process (CSAT) in SPAs 1, 6, and 7 before being expanded Countywide. The following measures will be tracked on a monthly basis:

- Number of children screened per month using the CIMH MHST per regional office;
- Percent of children screened with CIMH MHST within 60-days of being assigned to a CSW;
- Number of children receiving MAT assessment per month per regional office;
- Percent of children receiving the MAT SOF Report within 60-days of detention;
- Number of days between screening and referral to DMH co-located staff;
- Number of days between screening and linkage to mental health services program; and
- Number of children referred to mental health services per month per regional office:
 - Basic services (traditional outpatient mental health services); and

Intensive services (including Wraparound, Full Service Partnerships (FSP), System of Care (SOC), Multisystemic Therapy (MST), Multidimensional Treatment Foster Care (MTFC), Intensive Treatment Foster Care (ITFC), and the Comprehensive Children's Services Program (CCSP).

These measures will help to inform overall effectiveness with the screening/assessment referral process. As implementation issues emerge, they will be addressed and corrective actions will be implemented to ensure that the process is operating as intended before being rolled out Countywide.

F. Tentative Plan for Countywide Rollout

The plan for Countywide rollout of the CSAT and related mental health screening processes for newly detained children, those receiving FM/VFM/VFR, as well as existing cases will be rolled-out following the same order in which MAT is rolling out. This plan will allow regional staff and administration time in between a number of required trainings, number of new staff coming on board, and will allow the MAT program to be solidly in place before any additional programmatic revisions are introduced. Cohorts of offices will rollout according to the following timeframes:

Cohort 1 – scheduled to be begin January 2010, includes the following regional offices:

- Pasadena
- Pomona

Cohort 2 – scheduled to begin February 2010, includes the following regional offices:

- El Monte
- Glendora

Cohort 3 – scheduled to begin March 2010, includes the following regional office:

- Metro North

Cohort 4 – scheduled to begin April 2010, includes the following regional office:

- West Los Angeles

Cohort 5 – scheduled to begin May 2010, includes the following regional offices:

- Lakewood
- Torrance

Cohort 6 – scheduled to begin June 2010, includes the following regional offices:

- San Fernando Valley
- Santa Clarita

DMH co-located and key regional staffs will be trained alongside their DCFS colleagues at the DCFS area offices. More detail on the development of the training curriculum and format will be discussed in Section IV.

II. MENTAL HEALTH SERVICE DELIVERY

A. Identification of Settlement Agreement Objective Being Fulfilled

Under the terms of the Settlement Agreement, the County is obligated to make a number of systemic improvements to better serve children with mental health needs. Specifically, the County must ensure that class members:

- Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs;
- Receive 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;
- Be afforded stability in their placements, whenever possible; and
- Receive care and services consistent with good child welfare and mental health practice and the requirements of law.

The CAP, completed in response to the November 6, 2006 Findings of Fact and Conclusions of Law Order issued by Judge Matz included language that recognized the continued need to improve the integration of mental health services and a commitment to work with the Katie A. Advisory Panel to improve the delivery, in particular, of intensive home-based mental health services. In many respects, the development and proper deployment of these services for DCFS-involved children and youth is addressed in all four of the Settlement Agreement Objectives.

In addition to improvements in the screening and assessment process discussed earlier in this document, the County and the Panel have worked closely together to review the existing array of mental health services in the County as it relates to the estimated service needs of children within the child welfare system. The County and the Panel have agreed, for planning purposes, that approximately half of the identified Katie A. class members will require mental health services and that one in three of those will need an intensive level of mental health services. Subsequent to the completion of the CAP, the focus of the discussion has been on the availability of intensive mental health services, particularly those that are field or home-based, in contrast to the intensive services that might be available within a residential treatment facility. Examples of such services now available in the County include Wraparound, TFC, SOC, and FSPs.

Given the current levels of availability of these services, it was agreed that the County would need to develop additional intensive home-based service capacity – to serve the needs of an additional 2,800 children - in order to meet the objectives of the Settlement Agreement. A workgroup composed of DMH and DCFS leadership, community mental health providers, DCFS union representatives, along with

participation from Panel members and plaintiff attorneys, has met regularly over the past approximately nine months to prepare a service delivery model, identify the needed financial resources to support the implementation of these services, and propose a management infrastructure to provide for the training and ongoing evaluation of the service programs. The task of the workgroup was also supported by a trip by several workgroup members to Arizona to observe similar programs in operation there, created in response to the J.K. Settlement Agreement.

These new services will employ a Child and Family Team (CFT) approach along with an array of intensive home-based services, both supported by an agreed upon vision and set of practice principles.

B. Description of the Goal and related strategies to deliver the most timely and individualized mental health services to children, in child welfare or in imminent risk of foster care placement, in the most homelike setting appropriate to a child's needs.

Los Angeles County Vision and Practice Principles

Ensuring that the needs of children are identified and that individualized, intensive home-based services to meet their needs and build on the strengths of their relatives and foster families are provided in order to increase placement stability and permanency requires a fusion of practice principles from child welfare and children's mental health. The primary sources for this fusion are the Surgeon General's Report and principles proposed by the Katie A. Panel, which were similar to the R.C. principles in Alabama (*R.C. v. Hornsby*) and the "Arizona Vision" for behavioral health services in the J.K. settlement (*J.K. v. Eden*), as well as those associated with the Los Angeles County Wraparound and Children's System of Care principles.

This fusion of practice principles from child welfare and children's mental health is organized around the three main elements of a system of care approach: family strengths/child needs-based approach; multi-agency collaboration in the community; and cultural competence. The three guiding elements representing the "Los Angeles County Vision" for the delivery of mental health services for children and youth served by the child welfare system and the associated practice principles are:

1. SERVICES ARE DRIVEN BY THE NEEDS OF THE CHILD AND PREFERENCES OF THE FAMILY AND ARE ADDRESSED THROUGH A STRENGTHS-BASED APPROACH

Children and families are more likely to enter into a helping relationship when the worker or supporter has developed a trusting relationship with them. Staff and families work together as partners in relationships based on equality and respect.

The quality of this relationship is the single most important foundation for engaging the child and family in a process of change.

Children and families are more likely to pursue a plan or course of action that they have voice and choice in designing.

When children and families see that their strengths are recognized, respected and affirmed, they are more likely to rely on them as a foundation for taking the risks of change. Programs focus on families' strengths and enhance their capacity to support the growth and development of all family members, adults, youth, and children.

Assessments that focus on underlying needs, as opposed to symptoms, provide the best guide to effective intervention and lasting change.

Plans that are needs based, rather than driven by the availability of services, are more likely to produce safety, stability and permanency.

Children do best when they live with their family or kin or, if neither is possible, with a foster family. Siblings should be placed together. Children should rarely be placed in group or residential care and only when their needs cannot be met by intensive services while they live with their family, kin or a foster home. Group or residential care should not be long-term and should lead to permanent family placement.

Children receive the care and services needed to prevent removal from their families or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and 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.

Incentives are provided for scientifically-proven and cost-effective prevention and treatment interventions that are organized to support families, and that consider children and their caregivers as a basic unit (e.g., home-based treatment, intensive case management, family therapy).

Children receive care when they need it, not when they qualify for it.

2. THE LOCUS AND MANAGEMENT OF SERVICES SHOULD OCCUR IN A MULTIAGENCY COLLABORATIVE TEAM AND ARE GROUNDED IN A STRONG COMMUNITY BASE

Children experience trauma when they are separated from their families. When children must be removed to be protected, their trauma is lessened when they can remain in their own neighborhoods and maintain existing connections with families, schools, friends and other informal supports.

Decisions about child and family interventions are more effective when the family's team makes them. Families should always be core members of the

team. The family participates as a decision-maker in collaboration with members of the multidisciplinary team and a facilitator who assists in the coordination of services and supports.

Coordination of the activities of everyone involved is essential and works most effectively and efficiently when it occurs in regular face-to-face meetings of the family team.

The family's informal helping system and natural allies are central to supporting the family's capacity to change. Their involvement in the planning process provides sustaining supports over time.

Success in school is a reliable predictor of child well-being. When the direction of planning for safety, stability and permanency is fully integrated with school plans and services, children are more likely to make progress.

Common terminology must be used to describe children's well-being (emphasizing adaptive functioning and taking into account ecological, cultural, and familial context) in order to facilitate service delivery across systems.

Issues of confidentiality must be addressed in ways that respect a family's right to privacy, but encourage collaboration among providers in different systems.

Youth must be included in treatment planning by offering them direct information, in developmentally appropriate ways, about treatment options. As much as possible, youth should make choices about preferred intervention strategies.

Untreated mental health problems place children and youth at risk for entering the juvenile justice system. Mental health programs designed to divert youth with mental health problems from the juvenile justice system must be supported.

An infrastructure must be provided for cost-effective, cross-system collaboration and integrated care, including support to providers for identification, treatment coordination, and/or referral to specialty services; and the development of integrated community networks to increase appropriate referral opportunities.

3. THE SERVICES OFFERED, THE AGENCIES PARTICIPATING, AND PROGRAMS GENERATED ARE RESPONSIVE TO CULTURAL CONTEXT AND CHARACTERISTICS

Many of the services and resources that children and families find most accessible and responsive are those established in their own community, provided within their own neighborhoods and culture. A comprehensive and culturally competent system of services and supports for all children should be available and accessible to children and families in their respective local communities.

Programs acknowledge cultural differences, provide culturally competent services, and affirm/strengthen families' cultural, racial, and linguistic identities, while enhancing their ability to function in a multicultural society.

Reunification occurs more rapidly and permanently when visiting between parents and children in custody is frequent and in the most normalized environment possible (office based visits and supervised visits are the least normalized environment).

Children in foster care who are transitioning to adulthood are most successful in achieving independence when they have established relationships with caring adults who will support them over time.

The system of services and supports should be sufficiently flexible to be adapted to the unique needs of each child and family. Services and supports best meet child and family needs when they are provided in the family's home or for children in custody, the child's current placement. Services should be flexible enough to be delivered where the child and family reside.

A menu of seamless (non-categorical) mental health, substance abuse, and related support services and resources should be provided and be fair, responsive, and accountable to the families served.

Overview of the Child and Family Team and Intensive Home-Based Services Models

The Los Angeles Vision and associated practice principles are brought to life through the implementation of intensive home-based services with a CFT planning process.

Intensive Home-Based Services

In order to meet the needs of a large number of underserved DCFS children presenting with intensive mental health needs requires a change from office-based, once a week services to care delivered both to the child and caretaker in their home and community, often several times a week. An intensive home-based service is an individualized, child-focused, family-centered approach that is offered by a range of contracted mental health providers. Examples of current intensive home-based services programs in Los Angeles County include Wraparound, Children's SOC, FSP, Comprehensive Children's Services Programs (CCSP), Multisystemic Therapy (MST), Multidimensional Treatment Foster Care (MTFC), and Intensive Treatment Foster Care (ITFC). Based upon estimates of current intensive home-based services capacity in Los Angeles County and the need for such services, the Departments estimate that capacity for these kinds of services will need to be expanded to serve approximately 2,800 additional children and youth.

Based on the federal Child and Adolescent Service System Program (CASSP) principles and the literature on evidence-based services for severely emotionally disturbed (SED) children and families, intensive home-based services can be defined as:

A well-established intervention designed to meet the child's needs in his/her birth, kinship, foster or adoptive home and in the community where the child lives. The planning and provision of intensive home-based services require an individualized process that focuses on the strengths and needs of the child and the importance of the family in supporting the child. Intensive home-based services incorporate several discrete clinical interventions, including, at a minimum, comprehensive strength-based assessment, crisis services, clinical case management, family teams, and individualized supports including one-on-one clinical interventionists. These services must be provided in a flexible manner with sufficient duration, intensity, and frequency to address the child's needs and guide his/her caregivers.

Individualized services must be designed to meet the unique needs of each child and build on the child's and family's strengths. It is essential to have birth, kinship, adoptive and foster families involved in planning services with professionals from mental health, child welfare, school and other agencies and the family's informal supports. ***The complex needs of these children require integrated services, and team planning is essential and cannot be separated from the interventions.*** Providers will require training and coaching to incorporate the clinical principles and approaches of evidence-based practices as they design culturally-competent intensive home-based services.

Effective services for emotionally disturbed children require enhanced care coordination, often daily individual clinical interventions for the child, and guidance for caregivers (including teachers) for which traditional outpatient therapy is not sufficient in number of hours, flexibility, or family functioning focus. Safety, stability and permanency for children are most likely when birth, kinship, adoptive and foster families are guided to manage their behaviors and do not have to travel to receive intensive services. Usually the team will not plan office-based services for the child and family, with the exception of medical services and medication management that cannot be provided in the home or community. Intensive home-based services do not designate a position to provide one-on-one support to the child (such as a mentor or Therapeutic Behavioral Services (TBS)) or to guide the caregiver (such as a parent advocate or a family specialist): the team decides whether a therapist or a paraprofessional can most effectively meet this child's needs and the provider ensures that this person has the clinical training and supervision to do so. Usually the team will provide crisis services so the child and family know the individuals helping them in a crisis (instead of an unknown mobile crisis team).

When the child is living with kin or a foster family, not only will that family be provided guidance for caring for the child, but the prospective permanent home where the child is likely to be placed will also be prepared for meeting the child's needs with similar intensive home-based services during visits. When a family has several children, the team will likely include several individuals supporting different children. When the child is a teenager, he/she will be actively involved in the team with the goal that she/he will agree with his/her needs list and contribute to the design of services.

Intensive home-based services represent a "WHATEVER IT TAKES" approach and may include, but are not limited to:

- A comprehensive assessment of needs and strengths
- Targeted case management with 24/7 access to services
- Parent/relative/foster parent training and coaching
- Individual and family therapy
- Crisis intervention
- Medication management
- Skills training and other rehabilitative services
- Behavior coaching and other skill building with the child, including support during school and after-school activities
- Access to flexible funds to support non-billable activities, such as:
 - Respite care
 - After school activities
 - Tutoring
 - Behavioral incentives
 - Recreational activities
 - Creation of an informal support activity
 - Emergency rent subsidies
 - Other one time expenses

In creating additional service capacity to provide this approach, the emphasis will be on rehabilitation and support services that can be claimed to EPSDT. Arizona is an example of a jurisdiction that has used such services to develop their intensive in-home services programs, especially those that focus on direct support services. Recently a comparison between the covered services provided in Arizona, as described in the Arizona Department of Health Services-Division, Behavioral Health Services, Covered Services Guide with those contained in the Los Angeles County Organizational Providers Manual was undertaken to determine whether these kinds of services can be claimed within our system. Preliminary analyses indicated that some rehabilitation and support services can be claimed when directly linked with a beneficiary. However, many support services such as personal care, self-help/peer services, unskilled respite care, supported housing, sign language, non-medically necessary services, and transportation are not covered Medi-Cal services.

A broad array of rehabilitation services in Arizona include the provision of education, coaching, training, demonstration and other services including securing and maintaining employment to remediate residual or prevent anticipated functional deficits. California doesn't have the specific rehabilitation codes found in Arizona and the justification for some of these services would only be permitted if billed exclusively to the mental health needs of the beneficiary.

For situations in which a family member is determined to have extensive behavioral health needs, (e.g., substance abusing parent) that family member should be enrolled in the system. However, the ability to provide services to non-title XIX/XXI eligible family members may be limited, which presents an ongoing challenge to provide holistic services inclusive of the family's dynamics.

Child and Family Teams

A CFT is a gathering of family members, friends, members of the family's faith community, and professionals who join together to jointly develop an individualized plan to strengthen family capacity, to assure safety, stability and permanency and to build natural supports that will sustain the family over time⁷. The CFT evolved from the way that families form their own natural helping system to meet needs and solve problems. The CFT is the forum in which these individuals come together to help the family craft and change services and supports by:

- engaging and building trusting relationships with families;
- developing capable teams around the child and family;
- using the team to discover strengths and needs, especially the underlying needs that have produced the circumstances and behaviors requiring system attention;
- developing individualized plans with strong child and family involvement that employ child and family strengths in the plan/course of action to resolve critical needs;
- implementing plans in timely and effective ways; and
- tracking and adapting plans, based on results, in order to develop safety and sustainability beyond formal system involvement.

CFTs operate with a Facilitator and access to a Parent Partner. The roles and responsibilities of each are described in more detail below:

The CFT Facilitator is the person who assures that the Los Angeles County vision, practice principles, and the steps of the CFT process are provided to the child and family in a timely manner with high fidelity. The facilitator is generally a clinical staff member of a mental health agency who has been trained and credentialed in the CFT process, though the role of the facilitator may be assumed by other members of the CFT.

⁷ Definition provided by the Child Welfare Policy and Practice Group.

Parent Partners are former primary caretakers of children of either the mental health or child welfare system. Parent Partners are members of the CFT and facilitate/support the engagement and involvement of family in the process. In this role, they may assume a number of responsibilities, including serving as a community liaison/outreach coordinator, acting as a family advocate, providing informal supports to families, developing resources for families, evaluating activities of the child welfare and mental health service systems, providing training to professionals, and serving on various committees.

Families in which children need protection also require a supportive circle of allies that includes extended family, friends, neighbors, other members of the family's informal support system and community resources like churches and civic organizations, as well as professional supports from a variety of community agencies. Sometimes families in crisis can, themselves, mobilize part of the support system. However, they often need assistance in structuring this process and developing a full array of members for the team. Partners who see their role as helping the family in the change process can make a more effective contribution if a team facilitator is responsible for bringing the team together.

These supports should be brought together in a CFT at a time and place accessible to the family, focusing on safety and permanency, engaging team members, assessing needs, facilitating the development of a plan, recording specific responsibilities of team members, coordinating actions, ensuring that steps are accomplished and monitoring progress towards change. Team members are critical to identifying strengths, identifying options for accomplishment of goals, contributing their skills and resources as family supports, holding others accountable for their commitments, identifying critical decisions and providing feedback about progress. Whether the family is functioning well enough to organize its own team or needs help with facilitation, it is vital that the family feels that they are central and influential participants in the team and not just the passive object of the team's efforts. Bringing a team together contributes a variety of constructive benefits including:

- Preventing abuse and neglect and speeding permanency;
- Preventing removal and placement disruptions;
- Strengthening engagement with families and older youth;
- Improving the quality of assessments about strengths and needs;
- Increasing the likelihood of matching the appropriate service to needs;
- Identifying kinship placement opportunities;
- Increasing the variety of options for solutions;
- Increasing the capacity to overcome barriers; and
- Creating a system of supports that will sustain the family over time and provide a safety net after agency involvement ends.

The CFT is a solution-focused method that draws on the family's past success in solving problems, determines circumstances when the family is currently able to solve the problem (even if only for a brief period) and develops the family's vision for

a preferred future. The CFT can work to strengthen families in a way that they can find immediate solutions to needs and provide long-term solutions for issues related to safety, permanence and well-being.

The CFT acknowledges that the team member with whom the child and family has the most trusting relationship, even if it is an informal support, can facilitate the process if they have been well-trained and have developed the practice skills referenced previously. This recognizes the inevitable necessity of the team members understanding that the CFT process is not a simple intervention, but rather a process that is owned by the family and can be sustained after all the formal supports are no longer needed.

The tension between the “family-owned plan” and perceived agency obligations is sometimes raised in the implementation of the CFT, especially related to child safety issues. Child welfare practitioners might ask, for example, if they would be expected to accede to a parents wish for reunification when parental capacity is insufficient to assure child safety. Obviously, the answer to that question is no. In such a circumstance, however, the team could provide an environment where the parent could exercise choices about steps, services and supports through which a safe alternative to removal could be implemented or parental capacity could be most effectively strengthened.

When considering this issue it is important to remember that the CFT is foremost a planning process. Decision-making is a part of that process, but it is expected that a child and family will have a continuing team with which they develop a trusting relationship lasting throughout their encounter with the system. Many major decisions arise after the team has formed and partnership relationships have been solidified. Even in circumstances when the team is newly formed, for example following an emergency removal, the CFT is designed to enlist the family as partners in protecting their children.

Experience has shown that the “Who decides?” choice rarely occurs when a well-functioning team is operating. Some key elements to avoiding differences and confrontations about decisions are the early involvement and ongoing participation of the child welfare worker and the facilitation process itself. Early in the first meetings with family the team reaches a working agreement about the nature of the challenge or problem(s) facing the family and what success will look like (family’s vision and the team’s mission statement). Any non-negotiables like court orders and child safety and permanency are clearly identified and become part of the plan. Inevitably there will be some circumstances where regardless of family commitment to the plan or decision – or lack of it, circumstances necessitate that the team must conclude with a plan that resolves safety concerns.

One of the reasons that CFTs are effective is that they recognize the family’s strengths and potential capacity, a value that underlies all of the team’s functioning. If the approach to teaming begins with an assertion of control by the professionals,

the team conference has turned into a conventional staffing. As practitioners begin to experience the benefits of the teaming process and greater success in actual cases, fears of the potential negative consequences of meaningful family empowerment begin to subside.

Another reason that CFTs are effective is that they are responsive and adaptive to the unique characteristics of the needs and the services involved. The CFT remains the constant planning process for the child regardless of the involvement of other services.

Target Population

The initial target population for intensive home-based services and the associated CFTs is those members of the Katie A. class with urgent and/or intensive mental health needs. Focal populations for intensive home-based services, at least initially, will be:

- Children in family or relative placements (including VFM/VFR/FM);
- Children in D-rate placements;
- Children in Foster Family Agencies;
- Children and families receiving Family Preservation Services;
- Children and families that can be diverted from entering the Child Welfare system through the provision of such services;
- Children and families whose exit from the Child Welfare system can be facilitated by the provisions of such services; or
- Children in or at risk of placement in a RCL 10 or above placement.

Identification of potential children and families to be served by intensive home-based services can be initiated in one of two ways:

1. **Urgent Need:** Intensive home-based services can be provided in response to urgent child needs for crisis stabilization services for short periods of time (up to 60 days) without the formal provision of a CFT.
2. **Intensive or Complex Needs:** For children who do not require the immediate provision of intensive home-based services, a CFT will be identified and will initiate the service planning process.

Identification of potential children and families to be served by intensive home-based services will be initiated through the CSAT Referral and Tracking Process. For those DCFS regional offices in which the CSAT is not yet operational, they will link with the SOC/Wraparound Liaisons, similar to the method they use now for Wraparound referrals, to connect children and families to intensive home-based services. Once the CSAT is operational in a regional office, the procedure will be to go through the CSAT for linkage to requested services. Intensive home-based services can be initiated at a variety of key decision-making points within this

process, i.e. new referral recommending detention, new referral recommending FM/VFM/VFR or Family Preservation, existing case (court-ordered or voluntary), or key triggering events (see list under Section I, Screening and Assessment, page 12). Liaisons participating on the CSAT, as previously discussed under Screening and Assessment page 16, will assist in routing referrals to the appropriate individual(s) for service linkage.

Children in Court-ordered placements, such as relative care or foster families, whose behavior is threatening the stability of their current placement, would be linked to CSAT staff via the RMP. In order to mitigate the risk of a child transitioning into a high-level placement such as a RCL 6-14, the complement of expert staff housed within the CSAT would determine with the CSW and RUM using the CANS tool, which children require intensive levels of mental health care. When necessary, these intensive home-based services can be provided in response to urgent child needs for crisis stabilization services without requiring an authorization process, i.e. Inter-agency Screening Committee, in order to rapidly link the child to either a short-term crisis stabilization service or long-term intensive treatment resource to pre-empt a change in placement.

It should be noted that children who have mental health needs that do not rise to the intensive level will be referred to the appropriate services from within the array of mental health services across the County, including outpatient, day treatment, therapeutic behavioral services, and so forth. Additionally, DCFS will be issuing an RFP for the provision of services related to the Providing Safe and Stable Families Act and Child Abuse Prevention Intervention and Treatment in September of 2009 and the expectation is that the Los Angeles County vision and basic practice principles described in this document related to CFTs and intensive home based services will be integrated into that service request.

The Three-Tiered Wraparound Approach to Child and Family Teams and Intensive Home-Based Services

The County is proposing a three-tiered CFT model, anchored in the Wraparound approach, to offset the shortfall of 2,800 slots needed to augment capacity for intensive home-based mental health services. The initial placement in one of these Wraparound/CFT tiers would be based on service need and children would move from one tier to another based on changing service needs.

Tier One

Tier One represents the most intensive service level and is directed toward those children whose emotional and behavioral problems have resulted in a placement in a RCL 10 or above placement or placed them at risk of such a placement. Tier One represents the County's current Wraparound program, now with an allocation of 1,400 slots and funded through the current Wraparound program. Approximately 1,000 of these slots are filled by children served by DCFS, while the remaining slots

are used by children referred to the program from either DMH (AB3632) or the Probation Department.

Tier Two

Tier Two will be an entirely newly created service capacity, employing a Wraparound/CFT approach to intensive home-based services. These Wraparound/CFTs will be slot-based and supported via an alternative funding model, including monthly allocations of funds associated with a case rate, supplemented by EPSDT. The County proposes to develop 2,051 such slots over a period of approximately five years. These slots will be targeted to children, who don't present the acuity of need for the Tier One Wraparound/CFT.

Tier Three

Tier Three represents the lowest level of intensive mental health services for the CFT continuum and is designed for those children whose behavioral and emotional problems are not or have not been able to be adequately resolved with a less intensive intervention. For this purpose, the County proposed to deploy MHSA Full Service Partnerships, augmented with Child and Family Teams. A total of 749 such slots, including 523 Child FSP slots and 226 Transition Age Youth (TAY) slots dedicated to Katie A. class members will be used for this purpose. These slots will be funded with EPSDT, and augmented with a monthly case rate.

These MHSA FSP programs also employ a "whatever it takes" philosophy, consistent with the Los Angeles County Vision and Practice Principles. Among the services available through these programs are:

- 24 hours a day, 7 days a week availability of appropriate services and supports, including multidisciplinary teams to provide crisis intervention and assessment services;
- Field-based and/or in-home services, not just clinic-based services;
- Client to staff ratios not to exceed 10:1;
- Peer and parent support groups and collaboration with community-based self-help groups as appropriate, based on the age of the focal population;
- and
- Trauma-informed and trauma-specific treatment services, particularly for individuals with co-occurring disorders.

In addition to the general capacities listed above, providers are required to meet the age-specific capacities relevant to the focal population(s) for which they provide service. For example, for children (ages 0-15) providers must be able to:

- Provide intensive in-home and school-based services;
- Access to Therapeutic Behavioral Services (TBS);

Demonstrate ability to provide evidence-based practice models, as well as promising and emerging effective practices, including those that provide intensive in-home services where appropriate;

Commitment to utilizing parent partners, extended care-providing family members, and other caregivers as integral members of the intergenerational family team;

Ability to provide services to family members when essential for the achievement of outcomes for the child;

Ability to provide mental health treatment for parents of SED children who may not meet the target population definition in the adult system; and

Commitment to advocacy for parents and extended care-providing family members.

Providers serving TAY, in addition to meeting the general criteria discussed above, must be able to:

Provide intensive in-home and school-based services;

Commitment to utilizing parent partners, extended care-providing family members, and other caregivers as integral members of the intergenerational family team;

Emphasis on the assisting clients with the development of basic living skills that will promote independence to the extent possible;

Emphasis on promoting access to an array of educational opportunities including supported education;

Emphasis on employment as a desired outcome with provision of an array of supported employment services.

Emphasis on social integration as a desired outcome with provision of an array of community integration services. Such services include a variety of supports to enable greater participation of consumers in the life of the community at large;

Ability to create opportunities for exposure to or modeling of age-appropriate roles in order to ensure progress toward independence;

Commitment to advocacy for parents, extended care-providing family members, and other caregivers; and

Demonstrated ability to provide Therapeutic Behavioral Services (TBS). The FSP lead agency may elect to provide TBS-type interventions or ensure they are provided through collaboration with other providers as appropriate.

It should be noted that the formation of the Wraparound/CFTs that is associated with these three tiers will not always be able to operate as a part of some of the existing intensive in-home service models that now exist in Los Angeles County. For example, several of the evidence-based programs such as MTFC, CCSP and MST do not employ a CFT as described in this document, nor do the current FSP programs. The relationships between these programs will need to be more clearly defined, but it may be the case, for example, that the CFT determines that MST is

the recommended service. Since the treatment planning approach for MST does not use a literal CFT, the CFT would take a secondary role during the MST services.

Interagency Screening Committees

The Interagency Screening Committees (ISCs) are currently operational in each of the eight SPAs. These committees are collaboratively staffed by DMH, DCFS and Probation at the supervisor and coordinator level. DMH and DCFS intend to augment each ISC with additional staff to accommodate the service expansion described above. Each ISC will manage the three tiered program in their service area including, tracking enrollments, disenrollments, and graduations, reviewing CFT Plans of Care (POC), system navigation, technical assistance and trouble shooting. The ISC will work closely with the DMH and DCFS centralized management teams and the CSAT to monitor service delivery and outcomes and ensure appropriate matching of service need and delivery.

The CFTs will determine which of the three tiers is most appropriate to meet the needs of the child and family and will have the authority to transition services across these three tiers as necessary. Providers will be responsible for notifying the ISCs in their SPA of any changes that are made and providing a rationale for such changes. The ISCs, as part of their routine reviews, will evaluate the relationship between the tier services provided and the needs of the child and family, and may suggest that a change in tier be made, either to a higher or lower tier, to provide the most appropriate level of service.

C. Implementation Timeline

Pending Board approval of the funding and staffing requests to deliver intensive home-based services for Tiers One, Two, and Three, and State budget finalization, the following timeline is proposed to guide the implementation of the newly created services. The program will be rolled out over a five-year period, with the first year devoted to the development and implementation of the Tier Three approach (FSP with CFTs). The Third Tier will be implemented Countywide and will include an additional 523 Child FSP slots and 226 TAY slots. Tier One will continue to be available Countywide during this time. The major activities for Year One include:

- DMH to prepare Request for Interest (RFI) for prospective contract providers by January 2009 and issue the RFI to prospective providers (e.g. those providers in the County that have both FSP and Wraparound contracts);
- Finalizing policies and procedures for the three-tiered program and the related management of the program by January 2009;
- Selection and contracting with CFT/intensive Health Behavioral Services training organization by March 2009;
- Hiring for key support positions discussed in more detail in Section D. commences in March 2009, pending Board approval;
- DMH to select contract providers by March 2009;

DMH to amend service contracts by April 2009;
Training curriculum for DMH and DCFS staff finalized by April 2009, in order to begin the training and rollout of the Tier Three model; and
Implementation will be closely monitored for 6 months, and adjustments/corrections will be made as necessary to facilitate the implementation of the program.

During the subsequent four years of the rollout of the program, Tier Two will be implemented at the rate of approximately 410 slots per year until the total service capacity dedicated to Katie A. class members across the three tiers is 3,800 slots (representing 1,000 Tier One slots for children involved exclusively with DCFS or that cross-over with Probation as well, 2,051 Tier Two slots, and 749 Tier Three slots).

D. Staffing/Funding Required

The following DCFS positions will be required to support the implementation of the three tiered program:

- 1 Quality Assurance manager (CSA II) who would assist in the supervision of the additional CSA I staff listed below.
- 6 CSA I quality assurance staff to handle the additional contractual workload of at least 34 contracts and over 50 separate provider locations providing services to a potential of over 4,000 Wraparound enrollees.
- 1 SCSW who would supervise the additional unit of Wraparound liaisons.
- 7 CSW III (Wraparound liaisons) to handle the significant increase in enrollees Countywide, resulting in a significant increase in the number of Plan of Care reviews and other duties described above.
- 1 ITC to provide additional support to the SCSWs and the additional Wraparound liaisons.
- 1 Secretary II to provide clerical support to both CSA IIs.

The following DMH positions have been identified to provide staffing support to the proposed three-tiered program:

- 8 Psychiatric Social Worker II positions will be requested to support the ISCs in each of the SPAs.
- 3 administrative positions will also be requested to provide management and budget support at DMH headquarters and will consist of: 1 Mental Health Clinical Program Head; 1 Supervising Psychiatric Social Worker; and 1 Mental Health Analyst I. Similar to the additional NCC offset requested for the Mental Health Screening and Assessment positions, the 11 new positions will require additional NCC offset as will 8 previously budgeted positions approved in the CAP.

E. County Official with Responsibility for the Action

DCFS Office of the Medical Director, Dr. Charles Sophy, Katie A. Division Chief Adrienne Olson, Division Chief Michael Rauso, and Deputy Director Lisa Parrish will have responsibility within DCFS to ensure that the plans above are properly implemented.

DMH Deputy Director, Olivia Celis, and District Chief, Gregory Lecklitner, have responsibility to ensure that DMH implements the plan described above.

F. Benchmarks for Tracking Progress

The following quantitative indicators, tracked on a monthly basis, will be tracked to evaluate progress with the implementation of the three-tiered CFT program.

Number of Slots Available;
Number of Children Placed in Available Slots;
Range and Average Units of Service Provided to Clients;
Range and Average Number of Days Between Identification of Service Need and First Provision of Service;
Average Service Provision Based Upon Service Function Code; and
Sample of Wraparound Fidelity Index Scores.

These measures will help to inform overall implementation of the program. As issues emerge, they will be addressed and corrective actions will be implemented to ensure that the process is operating as intended.

The County will also conduct a series of interviews with selected DCFS, DMH, contract provider, clients, and families to inform subsequent rollout of the program.

III. FUNDING OF SERVICES

A. Identification of Settlement Agreement being Fulfilled

The 2006 order from Judge Matz and the development of the CAP prompted the County to refocus their energies and prioritize strategies utilizing the Title IV-E funds, EPSDT dollars, and MHSA FSP slots to fund the mental health services needs for the Katie A. class members. The County is working to redirect any savings through the Title IV-E Waiver to five core strategies intended to promote the overarching mission of DCFS to: 1) improve child safety; 2) improve permanence; and 3) reduce reliance on out-of-home care, which ultimately lead to improved child well-being in general.

Through directed trainings on more effective claiming practices and increased information sharing among service providers and County staff, more EPSDT revenue can be drawn down to support the costs of intensive behavioral health

services. The MHSA FSP service slots provide another resource, particularly now that they are being converted through an augmented case rate and an additional allocation of treatment funds to align more with the Wraparound/Child and Family Team model of service.

The County will continue to work closely with the Panel and heed the Court's recommendation to evaluate the Panel's proposals to obtain new or additional funding and give serious consideration to the pursuit of any proposals the Panel recommends.

A. Description of the Goal and related strategies to achieve:

Maximization of Title IV-E Waiver

The County has just completed its first full year under the Title IV-E Waiver Capped Allocation Demonstration Project. The Waiver is a vehicle to free up flexible funding to help DCFS broaden and deepen its innovative practices, building on its five core strategies: POE, SDM, Team Decision Making TDM, Concurrent Planning and P3. A brief description of each follows:

Points of Engagement Expansion: Point of Engagement (POE) is a collaborative public and private initiative that provides a community safety net for our children and families at risk of child abuse and neglect. POE provides a faster response for the provision of services and, through the use of teams, an emphasis on shared decision-making and comprehensive case evaluations and investigations.

POE utilizes a multi-disciplinary approach that includes the family in the process of selecting and planning for the delivery of needed services. POE engages resources within DCFS and other County Departments such as the Departments of Mental Health, Health, Probation, Public Social Services, Sheriff, and State Parole. POE also engages community-based agencies who work in the areas of domestic violence, drug and alcohol, mental health and health, as well as the Faith-based community to assist in providing support services to our families. During 2006, 4,723 children were served using the alternative response model. During calendar year 2007, 4,365 children were served.

Post POE implementation, rates of case plan "Return Home," timely reunification and number of children served in their own homes has increased; whereas, recurrence of maltreatment has decreased.

POE (initially known as the Compton Project) has been expanded to all offices in the Department. The three areas of focus are:

- Reduction in Emergency Response detentions
- Reduction in Median Length of Stay
- Increase in Effective Concurrent Planning

As part of the POE expansion we are moving toward full implementation of differential response, which is an alternate way of responding to reports of child abuse and neglect. Referrals are evaluated in terms of statutory definitions for child welfare services involvement for immediate safety considerations; for the choice of a response time for initial face to face interview; and, for the “path” of the response. This approach engages families in services based upon the family’s strengths and needs, with a focus on early intervention and community partnerships.

Structured Decision Making (SDM): Structured Decision Making, a groundbreaking practice which provides social workers with simple, objective, and reliable tools with which to make the best possible decisions for individual cases and provides managers with information for improved planning and resource allocation, has now been implemented Countywide with great success.

Team Decision Making (TDM): The use of Team Decision Making meetings have been expanded and are used to create a collaborative effort between DCFS staff, the family, their relatives, friends, community members, caregivers and service providers in the process regarding the child’s safety, possible removal, placement and reunification, and permanency. The focus of the TDM meeting is to preserve the family and at the same time, provide for the child’s safety. The TDM is used to identify family strengths and community supports and resources to form an action/service plan that will enable children to remain safely in their homes. If that is not possible, the TDM is used to immediately review the needs of the child and family, to identify the “best” placement for the child, and to develop a plan for the safe return of the child to his or her home as quickly and as safely as possible.

Concurrent Planning Redesign (CPR): Concurrent Planning Redesign resulted as a joint Labor-Management initiative to facilitate the goal of returning each child who has entered foster care to a safe, stable, and lifelong family. In working toward this goal, Department wide implementation of CPR was completed in July 2007.

The coordinated rollout of CPR in each DCFS office began with the Lakewood office in March 2005. The rollout continued to July 2007 when the last of 17 DCFS offices completed the training and implementation of the first phase of CPR. The rollout of CPR included systematic work-shift changes in the form of:

- Use of new family background information gathering strategies.

- Termination of Parental Rights (TPR) for adoption cases becomes a team responsibility with the Dependency Investigator coordinating the team.

- Permanency (Adoption) staff is assigned the case earlier and assumes full responsibility for all adoption-related activities.

- Family Maintenance and Reunification social worker remains the primary case manager through adoption finalization and termination of jurisdiction, thus maintaining a consistent Children’s Social Worker for the child and stopping a case transfer that can delay permanency.

Integration of CPR with other offices strategies--Points of Engagement (POE), Team Decision Making (TDM), Permanency Partners Program (P3), Multidisciplinary Assessment Team (MAT) and Family Finding.

Full disclosure with children, birth parents, caregiver and others involved in the child's life by all Children Social Workers (CSWs) throughout the life of the case.

Monthly office-based Continuous Quality Improvement (CQI) meetings, which facilitate teamwork, office review and action items related to the CPR process.

Participation in central monthly Continuous Improvement Process (CIP) meetings that facilitate CPR evaluation, review and action items by representatives from the offices. Representatives are staff from all levels and from a variety of programs.

The Permanency Partners Program (P3): The Permanency Partners Program and other permanency efforts have resulted in continued reductions in the number of children and youth in long term foster care. More than 2,000 youth have been served by the Permanency Partners Program (P3) since its inception in 2004 and we have therefore expanded the Family Finding and Permanency Partners Program (P3) to include all regional offices.

The Department's Family Finding Steering Committee formed to develop and implement family finding policy and procedures Department wide resulting in a workgroup to improve the due diligence process that has provided analysis and recommendations to the executive team for consideration of its plan to implement family finding strategies through the Title IV-E Waiver.

40 paraprofessionals are being hired to assist case carrying CSWs in an effort to increase the Department's ability to locate and engage families.

We are partnering with the Probation Department regarding the provision of services to children that we serve jointly.

These strategies, which are dependent on the successful utilization of the Waiver, are expected to result in a shift in thinking and practice away from home removal as the safest and best alternative for children. The five core strategies represent the most targeted means by which to achieve long-term outcomes for children and families under the fiscal flexibility provided by the Waiver.

The first Waiver reinvestments were made to expand Family Team Decision Making (FTDM), Family Finding and Engagement through Specialized Permanency Units, and Upfront Assessments for high risk referrals involving substance abuse, domestic violence and mental health issues. Approximately \$3.4 million was identified to fund these activities. Each of these first sequence initiatives is currently underway: Fourteen additional FTDM facilitators have been selected to conduct permanency planning conferences for children in long term foster care without permanency resources; specialized Permanency Units have been established in the Metro North

and Pomona Offices; and upfront assessments are being conducted by Shields for Families in the Compton Office.

The Fiscal Year (FY) closeout process has been completed and DCFS generated \$28.9 million in reinvestment funds. The FY 2008-09 State Budget has also been adopted and fortunately does not include any reductions in child welfare funding. DCFS and Probation will be meeting in October to develop a plan for use of a sustainable portion of the reinvestment funds that will be presented to the Board for approval in November 2008. However, the Strategic Plan includes nine TDM positions that will be funded with reinvestment funds in the amount of \$0.6 million in FY 2008-09 and \$1.2 million annually thereafter. The Board will be asked to approve the use of this funding in October 2008

MHSA FSP Growth Funds

The Mental Health Services Act currently supports 1,733 children's FSP slots at \$16,850 per slot per year and 1,147 transition age youth (TAY) FSP slots at \$17,530 per slot per year. In response to the need for more intensive home based services targeted to children/TAY involved with DCFS, DMH approved an increase of 523 children FSP slots and 226 TAY FSP slots beginning in FY 2008-09 to be dedicated to serve the needs of Katie A. class members.

Data analysis and provider feedback have confirmed that there is a need to increase the funding of the treatment component of the FSP slots by approximately \$5,000 per slot of EPSDT, bringing the total slot allocation for EPSDT from \$14,000 to \$19,000. The current Community Services and Supports plan had allocated a total of \$1.5 million per year for Co-occurring Disorder training with the intent that the dollars would be folded into services after the first three-year cycle. At this point, there is a recommendation to the stakeholders that the Department be allowed to use the \$1.5 million as match for additional EPSDT for the FSP programs. There has also been a recommendation to "pool" the children's FSP family support service dollars (\$2,200 per slot per year) and flexible funding (\$650 per slot) to create more flexibility in service delivery.

DMH is presently analyzing the approval process required, either local or State to make the changes. Once approved a request for interest (RFI) will be initiated to existing FSP providers who also have Wraparound contracts to determine the level of interest in the additional slots, and a competitive process may or may not be required select providers depending on the response to the RFI. Contracts for all existing children's FSP providers will be amended to reflect the changes in the program. The new slots will be dedicated to children/TAY involved with DCFS and will reflect the ethnic composition of this population.

The Funding Model CFT and Intensive Home-Based Services

The programmatic structure of the CFT is described in Section II of this plan. The funding model is based on a case rate ranging from \$1,100 per month to \$4,184 per month (which includes placement costs) depending on the level of service required with Tier One addressing the most acute service needs and Tier Three the least intensive. EPSDT funding is also provided as the primary support to fund services. The funding formulas for the three tiers are as follows:

Tier One

Tier One, which originated with the County's SB 163 Wraparound program, now is funded to provide up to 1,400 slots in FY 2008-09 at the current case rate of \$4,184 per month, which includes placement costs. EPSDT funding is \$1,500 a month per slot and added to the case rate equates to a total gross annual cost of \$95,500,000 and a Net County Cost (NCC) of \$47.2 million. The full implementation of this tier is accounted for in the Proposed FY 2008-09 budget.

Tier Two

Tier Two provides a Wraparound/CFT approach for a total of 2,051 slots, rolled out over a five-year period, with a monthly case rate of \$1,300 exclusive of placement costs and \$2,000 per month in EPSDT funding. The total cost when fully implemented is \$83,400,000 with a NCC of \$35.3 million per year.

Tier Three

Tier Three utilizes 749 FSPs, augmented by a \$1,063 monthly case per child and \$1,006 monthly case rate per TAY to support a CFT approach to delivering these services, in addition to an annual EPSDT allocation of \$19,000 in treatment funds and a one-time yearly flex pool fund of \$2,850 per slot for TAY slots and \$650 per year for children's FSPs. The total yearly cost for the 749 FSPs equates to \$25,915,000 of which, \$9.4 million is NCC.

B. Implementation Timeline

The projected timeline for identifying Title IV-E Waiver funds that can be redirected to provide services to class members is dependent on the County's FY 2007-08 closeout process and adoption of the FY 2008-09 State Budget. It will take approximately 30 days after the completion of the closeout process and the adoption of the State Budget to identify available Title IV-E Waiver funds. Additional recommendations for the use of available reinvestment funds will be developed in October and presented to the Board for approval in November 2008.

C. Staffing/Funding Required

Identification of Title IV-E Waiver funds and the maximization of MHSA FSP Growth Funds that can be redirected to provide services to class members can be done within existing resources.

D. County Official with Responsibility for Action

The County officials with direct responsibility for this action will be Senior Deputy Director, Susan Kerr from DCFS and Deputy Director Olivia Celis from DMH. Additionally, Lisa Parrish, Deputy Director at DCFS and DMH District Chief Greg Lecklitner will have responsibility for implementing the activities described in this section.

E. Benchmarks for Tracking Progress

The quantitative indicators mentioned in Section II, Mental Health Service Delivery, page 41 will be tracked to evaluate implementation progress with the Wraparound/CFT tiered approach to the provision of intensive, home-based mental health services.

Benchmarks to track the effectiveness of the Title IV-E Waiver implementation are still under development at this time.

IV. TRAINING

A. Identification of Settlement Agreement being Fulfilled

The November 2006 Order from Judge Matz referenced the Panel's concerns from their Fifth Report to Court indicating that efforts to train staff fall short of the intended objectives because trainings do not impart the foundations of good practice – engaging families, effective teaming and coordination, thorough assessment of strengths and needs, individualized planning, and effective interventions. The Court directed the County to obtain feedback from DCFS and DMH workers to better inform needed enhancements to the training curriculum.

B. Description of the Goal and related strategies to achieve:

Core Practice Model and Incorporation of Wraparound/CFT Practice Principles

The context for current child welfare practice in Los Angeles County is guided by three key federal outcomes: safety; permanence; and child well-being. These outcomes are supported and reinforced by the California Child Welfare Services Improvement Plan and the Los Angeles County DCFS System Improvement Plan (SIP). The three key goals for Los Angeles County are:

Improved permanence;

Improved safety; and
Reduced reliance on out-of-home care.

Los Angeles County has recognized the need for systemic improvements to better meet the mental health needs of children and families and jointly DCFS and DMH share an interest in promoting the **safety, permanence** and **well-being** of children and families. To ensure that the needs of children are identified and that individualized, intensive home-based services are delivered to meet those needs and build on the strengths of the children, caregivers and foster families to provide increased placement stability and permanency, the two Departments collaboratively developed, with the assistance of the Panel, a Wraparound/CFT process and a system of care approach that fuse practice principles from child welfare and children's mental health. This fusion of practice has been guided by three principles:

- Services are driven by the needs of the child and preferences of the family and are addressed through a strengths-based approach;
- Services should occur in a multi-agency collaborative team and are grounded in a strong community base; and
- Services offered, agencies participating, and programs generated are responsive to the family's cultural context.

These goals are supported and addressed by DCFS through staff training using a Core Practice Model approach. The Core Practice Model identifies five key practice components: Engaging families; building teams around families including informal and formal community supports; using teams to gather information and develop assessments; using teams to create service plans and interventions (that build on a family's strengths to resolve needs); and using teams to track and adapt plans based on results. These elements are supported by a foundation of basic values, practice principles, knowledge as it relates to child welfare and mental health services (see Appendix C Core Practice Model). This model creates a road map for workers to work with families within a continuum of activities focused on achieving the best outcomes for children/families, instead of being compliance-driven – it is needs and outcomes-driven. The Core Practice Model serves to align and inform worker learning objectives for training and reinforces priority programmatic and service outcomes for children and families. This model is an enhanced way of doing business for DCFS and aligns the training curriculum with the Departmental philosophy of involving community/family engagement in the decision-making process where families have voice and choice, conducting comprehensive case evaluations and investigations, and harnessing the strengths of teaming to design holistic case plans. Efforts described in this section support the translation of the Core Practice Model into practice through training (knowledge and skill development), and coaching and mentoring for DCFS, DMH and provider staff

Principles: Training, Coaching, Feedback and Transfer/Application of Learning to Practice

Consistent with the November 2006 Order of Judge Matz, the County will solicit feedback on training and coaching associated with implementation of the plan. Where appropriate, Level II evaluation (pre and/or post tests) for targeted learning objectives and targeted trainings to measure learning and to support continuous improvement will be employed. This is in addition to the Level I feedback (participant feedback/reaction and suggestions for improvement) that are traditionally gathered. For training referenced below, the County will work to insure inclusion of activities that support pre-training readiness and post-training application and transfer of learning, especially in key areas of practice change. These activities will target direct service staff as well as supervisors who are key to supporting these practice changes.

Training Support: Katie A. Plan Components

Training support and resources will be utilized and deployed to support key elements of the Strategic Plan. These areas include:

- Training to support targeted strategies for resource development and process change;

- Joint Overview/Orientation Training (Core Practice Model, Values, Practice Principles etc);

- Training to support Coordinated Services Action Team (CSAT) and it's related processes and protocols; and

- Training and coaching to support implementation of Child and Family Teams (provider and public agency staff).

Training resources (DMH and DCFS) will be utilized to support the range of strategies described throughout the plan. These include but are not limited to:

- Training to support the expansion and application of Team Decision Making (TDM) at key decision points. This includes the training and equipping of TDM facilitators as well as ongoing reinforcement training for DCFS staff, public agency and community partners, and Family to Family management team.

- Targeted training on Structured Decision Making (SDM) as a key strategy to support improved decision making at key decision points. This is referenced as a key factor in supporting Caseload Reduction strategies (see page 59) described in Section V.

- Training to support the expansion of Multi-disciplinary Assessment Teams (MAT) (pages 9-10).

- Training (provider and public agency staff) to support the Resource Utilization Management (RMP) process (see pages 18-19).

- Training support for the expansion of the provider base for implementation of a Wraparound approach to Child and Family Teams and Intensive Home-Based Services.

- Training support for the range of DCFS strategies associated with achieving improved timelines to permanence (DCFS Concurrent Planning Re-Design, Kin Gap Training, P-3 Training Support and implementation/training for specialized Permanency Units in pilot offices).

Joint Overview/Orientation Training (Core Practice Model, Values, Practice Principles etc.)

Based on the Core Practice Model and to promote a better understanding of the various initiatives relating to the Katie A. Settlement Agreement and support their proper implementation, participants (staff, managers, supervisors from DMH and DCFS) receive an introductory overview of Katie A. and the Settlement objectives the County is fulfilling, as well as the general overview and “drill down” of the roles and responsibilities of the staff of the two Departments respectively and how cooperative/integrated efforts between the two support implementation of the Settlement Agreement and this Strategic Plan. This aspect of training is particularly critical to building core and shared ownership for plan components on the part of operational managers and supervisors, and in setting the stage, context and expectation for ongoing training, coaching, implementation of key protocols and practice change.

Training to support Coordinated Services Action Team (CSAT)

This procedural and practice training will focus on screening and assessment protocols – CSAT – and the directives for screening/assessing newly detained youth (Court-ordered FR cases), newly opened/non-detained cases (VFM, VFR, or Court-ordered FM), and children in existing open cases (Court-Ordered or Voluntary FM, FR, and PP). This module will have technical components instructing both DCFS front-end and back-end workers along with their DMH colleagues in how to apply the CIMH-MHST, CANS, and FCS referral tracking system. The training will also involve a practicum for hands-on learning for staff to apply previous learning content and practice information sharing and problem-solving with specific case examples/vignettes, as well as discussing what the desired outcomes are for the family and the natural supports they have garnered to become their own agents of change.

As policies/procedures and resources regarding the CSAT are finalized, targeted/specialized training will be provided for members comprising the CSAT in terms of the various team members’ roles and responsibilities, the array of specialized mental health services/eligibility requirements, inventory of community programs/resources available by SPA, and Medi-Cal billing policies and procedures. As the system navigators for each regional office, CSAT staff will utilize their programmatic/clinical expertise to assist CSWs to link children and families with appropriate services. Before DCFS and DMH line staff training commences, CSAT staff and Wraparound/CFT providers will receive this targeted training. Associated with roll-out of the CSAT structure, designated staff performing specific functions will receive the necessary training on role responsibilities and protocols as needed to partner with and complete CSAT related tasks and activities. The delivery of this training module will be tied to the development of respective policies and procedures, staffing and programmatic resources being identified for the CSAT, sign-off from the DCFS Union on worker responsibilities for both CSAT and

Wraparound/CFT, and contract amendments (community providers) being completed for the Wraparound/CFT Tier 3 rollout of FSPs in early 2009.

Training and Coaching: Implementation of Child and Family Teams

This aspect of training/coaching will focus on the Wraparound/CFT practice principles, teaming processes, knowledge, skills and desired outcomes for the CFT process; both for community providers and participating public agency staff, managers and supervisors. The cornerstone and most ambitious aspect of the overall training effort; is training and coaching which will support implementation of the four integral phases of the Wraparound/CFT process model as currently envisioned:

- Engagement and team preparation;
- Initial plan development;
- Implementation; and
- Transition.

Coordinated training, coaching and support across DMH and DCFS with private providers will be essential to support implementation of these teams consistent with the definitions/indicators described in the Qualitative Service Review (QSR) discussed in Section VII, which consist of:

CHILD/FAMILY PARTICIPATION

Are family members (parents, grandparents, step parents) or substitute caregivers active participants in the team meetings where service decisions are made about the child and family? Are parents/caregivers partners in planning, providing, and monitoring supports and services for the child? Is the child actively participating in decisions made about his/her future?

CHILD AND FAMILY TEAM AND COORDINATION

Do the people who provide services to the child/family function as a team? Do the actions of the team reflect a pattern of effective teamwork and collaboration that benefits the child and family? Is there effective coordination and continuity in the organization and provision of service across all interveners and service settings? Is there a single point of coordination and accountability for the assembly, delivery, and results of services provided for this child and family?

FUNCTIONAL ASSESSMENT

Are the current, obvious, and substantial strengths and needs of the child and family identified through existing assessments, both formal and informal, so that all interveners collectively have a "big picture" understanding of the child and family and how to provide effective services for them? Are the critical underlying issues identified that must be resolved for the child to live safely with his/her family independent of agency supervision or to obtain an independent and enduring home?

CHILD AND FAMILY PLANNING PROCESS

Is the child and family plan individualized and relevant to needs and goals? Are supports, services, and interventions assembled into a holistic and coherent service process that provides a mix of elements uniquely matched to the child/family's situation and preferences? Does the combination of supports and services fit the child and family's situation so as to maximize potential results and minimize conflicting strategies and inconveniences?

TRACKING AND ADAPTATION

Are the child and family status, service process, and results routinely followed along and evaluated? Are services modified to respond to the changing needs of the child and family and to apply knowledge gained about service efforts and results to create a self-correcting service process?

Training for internal agency staff, managers and supervisors will have a strong skill based focus in each of the key practice areas associated with the CFT process (engagement and teaming, initial plan development, implementation/support and transition) with emphasis on follow-up transfer/application of learning both from supervisors/managers as well as through ongoing coaching.

A specific challenge that must be addressed is the time/resource commitment frequently needed for staff to participate fully in extensive skill based training in key practice areas associated with CFT process and how this can/must be managed against day to day caseload demands (when caseload reduction through timely outcome achievement are also central to the Strategic Plan.) As initially envisioned; several days of skill based training (with teams of trainers and relatively small groups) will be needed to fundamentally ground staff in each practice component. The Department also believes that a major investment in training and equipping supervisors/managers in the key practice component of the CFT will be required; both to facilitate ongoing case decision making/support consistent with CFT practices and principles as well as to provide direct coaching (supervisor to worker) in interactions associated with the CFT process.

As CFT providers across Tiers I-III are expanded and/or selected; the County will convene a time limited work group (DCFS, DMH, Provider representatives and Panel members) to review and recommend skill based curricula and coaching resources associated with CFT practices that can be utilized, modified, developed and readied for implementation in the most cost and time efficient manner. Given the need to balance the time, intensity and rigor of skill based training and coaching for line staff against the realities and demands of casework; strong consideration will be given to coaching models and resources that strengthen rank and file supervisory coaching capacity in providing case specific supervision to social workers. This will be supported by the selection, training/coaching of coaches/mentors who will be deployed to support these overall efforts in target offices for both line staff and supervisors.

The Panel has recommended contracting with the Child and Family Support Services experts from Arizona who have a wealth of experience in the CFT model and developing coaching/mentoring supports for staff, so the learning around the Wraparound/CFT process continues to be enhanced outside of the training sessions. The County understands the importance of model fidelity and will consider contracting with the Arizona staff from Child and Family Support Services or similarly qualified staff from the Los Angeles Training Consortium (LATC) to help in the development of the Wraparound/CFT training curriculum, particularly in identifying/certifying coaches within the provider agencies. These coaches would then be responsible for the ongoing coaching and mentoring of Wraparound/CFT staff as well as in orienting child welfare and mental health staff to the basic principles and practices that would support the proper use of the Wraparound/CFT model. Since the CFT process will be grounded in the Wraparound approach, the coaches will provide staff with any extra training/technical assistance needed to fully adapt to the Wraparound/ CFT model. Moreover, the coaches will employ many of the quality assurance components embedded in Wraparound to guarantee that model fidelity is maintained.

SABA Learning Management System/E-Learning Formats

The County is migrating to the SABA Learning Management System (LMS), which is an automated enrollment system and database designed to streamline the attendance, feedback, and tracking processes for employee training. Both DCFS and DMH employees will receive credit for attending the respective Departmental trainings as well as their own Department-sponsored trainings. Pre and post-test surveys evaluating training effectiveness will be automated enabling quick production for review and analysis. Moreover, standardized feedback concerning overall satisfaction with content, instructor knowledge, practical application etc. can be collected and readily produced in ad hoc reports for management review and, if necessary, to implement needed revisions to the curriculum based on student feedback.

More on-line training is being developed in partnership with UCLA as a more convenient method for staff to fit in trainings according to their schedules, and it reduces the staff resources required to deliver the trainings, particularly basic/introductory and refresher courses. The timeline for converting/launching the SABA LMS is scheduled for October 2008. This LMS will be a great benefit to both DCFS and DMH in tracking enrollment, attendance, and content feedback from students experiencing standard classroom, as well as e-learning training environments. It's envisioned that modules for Katie A. refresher trainings concerning the CSAT and/or CFT, as well as additional e-learning to support Wraparound/CFT practice around the four key constructs of engagement and team preparation; initial plan development; implementation; and transition could be accessed on-line, as could the introductory training explaining the provisions of the Katie A. lawsuit.

C. Implementation Timeline

Initiate a time limited workgroup in September 2008 to evaluate existing Wraparound training and technical assistance resources, such as the Arizona or LATC staff, will be considered to provide training for County staff and providers in the Wraparound/CFT process and ongoing coaching supports.

Identify, secure, develop and/or modify skill based training curricula and coaching resource to support development of practice skills associated with CFT implementation for Wraparound CFT providers and public agency staff. The Wraparound/CFT training rollout is projected to commence in March 2009. The rollout of Wraparound/CFT training to a particular SPA will be dependent on amending Tier 3 service provider contracts for FSPs and will be rolled out incrementally across the County.

The Katie A. Training Curriculum for the joint overview/orientation and Coordinated Services Action Team (CSAT) Training will be finalized in February 2009, in order to initiate the training rollout in the following regional offices:

- SPA 7 – Belvedere and Santa Fe Springs are trained in March 2009;
- SPA 6 – Wateridge and Vermont Corridor are trained in April 2009;
- SPA 6 – Compton is trained in May 2009; and
- SPA 1 – Palmdale and Lancaster are trained in June 2009.

Just prior to the March 2009 training rollout, identified CSAT staff in the SPA 7 regional office will receive training on policies and procedures for the CSAT, including the delineation of roles and responsibilities, provider resources, Medi-Cal billing policies and procedures, and specialty mental health program requirements. Specialty training will be designed and provided to all CSAT members to ensure the CSAT operates cohesively in a coordinated and structured fashion to receive referrals and expedite mental health assessments and service linkage.

Implementation in the regional offices will be closely monitored for 6 months, and adjustments/corrections will be made as necessary to inform the Countywide rollout of the CSAT and related management structures.

The implementation timeline for key activities is dependent on the Board of Supervisors passing the Strategic Plan in October 2008. Implementation timelines will be adjusted accordingly in relation to the passage of the Plan.

D. Staffing/Funding Required

DCFS is requesting 10 positions to support the training rollout, which consists of:

- 8 CSA Is to provide direct training, planning, coordination, and delivery of training needed to support the three-tiered CFT;
- 1 CSA II to provide operational oversight to the CSA I trainers;

1 STC to provide clerical support to insure coordination/tracking and reporting on all training as required by the Settlement Agreement. Initially, resources for developing, finalizing, piloting and delivering the training curriculum will be collaboratively decided by the Departments (DCFS Training, DMH Foster Care Services Section, DCFS/inter-university consortium contracted resources and input from the Panel).

In relation to the Wraparound/CFT process, training will focus on the Wraparound practice and will include introductory training and on-going coaching and mentoring of provider staff. In addition, training will be offered to agency administrators and program managers to ensure that Wraparound/CFT principles are supported and encouraged agency-wide. For the coaching/mentoring component, DCFS and DMH will determine the resources needed to utilize outside consultants initially to launch this office-based support. Additionally, careful consideration will be given to resourcing a model that allocates, trains and equips internal resources (DCFS and DMH) to provide this coaching, mentoring and training component ongoing and as the Wraparound/CFT concept expands.

The annual budget for training related purposes is \$1,008,000 per year.

E. County Official with Responsibility for Action

The County officials with direct responsibility for this action will be Chief Deputy Director Ted Myers from DCFS, DCFS Medical Director Dr. Charles Sophy, and Deputy Director Olivia Celis from DMH. Additionally, Mark Miller, the Director of the DCFS Training Section Bureau, Katie A. Division Chief Adrienne Olson, and Division Chief Michael Rauso in collaboration with DMH District Chief Gregory Lecklitner and Program Head Angela Shields will have responsibility for implementing Katie A. Training along with local DCFS and DMH Regional Managers.

F. Benchmarks for Tracking Progress

A triangulation of data collection techniques will be implemented to assess the overall effectiveness of the training rollout in SPAs 1, 6 and 7 for module 2, as well as for the Countywide rollout of module 3. These qualitative measures will consist of:

- Survey questionnaires querying students' overall satisfaction with the training, instructor knowledge, practical application, content relevance, etc.;
- Pre and post-test surveys documenting content learning; and
- Information collected through small focus groups revisiting many of the training-oriented questions collected during the HMA evaluation for the phase I rollout of the Specialized Foster Care Plan.

These measures will help to inform training effectiveness for the CSAT piloted SPAs, and where any content revisions are required before being launched Countywide. As implementation issues emerge from the piloted as well as Countywide rollout of the Wraparound/CFTs, they will be addressed and corrective actions will be

implemented swiftly and shared with the previously trained offices to ensure that the training curriculum is consistently received and uniformly implemented across the regional offices.

G. Tentative Plan for Countywide Rollout

The tentative plan for Countywide rollout of the CSAT screening/assessment/referral process - will occur in cohorts for the following regional offices according to the timeframes listed below:

Cohort 1 – scheduled to be begin January 2010, includes the following regional offices:

- Pasadena
- Pomona

Cohort 2 – scheduled to being February 2010, includes the following regional office:

- El Monte
- Glendora

Cohort 3 – scheduled to begin March 2010, includes the following regional offices:

- Metro North

Cohort 4 – scheduled to begin April 2010, includes the following regional offices:

- West Los Angeles

Cohort 5 – scheduled to begin May 2010, includes the following regional offices:

- Lakewood
- Torrance

Cohort 6 – scheduled to begin June 2010, includes the following regional offices:

- San Fernando Valley
- Santa Clarita

V. CASELOAD REDUCTION

A. Identification of Settlement Agreement Being Fulfilled

Although caseload reduction is not a mandated component of the Katie A. Settlement Agreement or 2006 Court order, DCFS senior managers, in concurrence with the Katie A. Panel, view reduced caseloads as a vital objective necessary to execute the objectives of the Katie A. Settlement Agreement and subsequent orders. Additionally, with the current State budget crisis, practical cost reductions must occur which is best accomplished by careful determination of when to open and subsequently close cases. Further, under the provisions of the Title IV-E Waiver, cost savings will be realized in each of the next four years with careful planning to reduce foster care cases or costs. In July 2007, DCFS officially adopted the Casey Family Program's 2020 strategy to reduce the number of children in care by 50

percent. As referral and case rates are reduced, best practice principles will increase, stronger outcomes will be achieved and recidivism rates will be reduced. While these goals are part of an overall Departmental strategy, progress will occur over time - not immediately. DCFS recognizes and wants to avoid the danger and potential pitfalls to quick-fix solutions, such as increased recidivism rates with increased family-reunification and adoption rates.

B. Description of the Goal and Related Strategies to Achieve Caseload Reduction

DCFS' continued success in serving children and their families and achieving outcomes is reliant on reasonable caseloads and workloads for social workers. The following provides the Department's major activities and accomplishments related to caseload through end of calendar year 2007:

Continued reductions in the number and percentage of children receiving services from the Department who reside in out-of-home care has occurred. The number of children in temporary or long-term out of home care has been reduced from a high of nearly 50,000 in 1998 to an all time low of 19,182 by December 2007, a 62 percent reduction.

The percentage of children adopted within twenty-four months of their initial placement rose by 6.3 percent in 2006 and by an additional 1.7 percent in 2007.

The number of children in long term foster care decreased by 9.4 percent in 2006 and by an additional 10.8 percent in 2007.

The median length of stay in out-of-home placement decreased by 17.4 percent in 2006 and by an additional 6.5 percent in 2007.

The average length-of-time children spent in foster care decreased by 11 percent in 2006 and by an additional 7.4 percent in 2007.

In 2006, the Department realized an annual reduction of 3.8 percent in the number of children abused and/or neglected in foster care and an additional reduction of 2.4 percent in 2007.

The Department reduced the number of FM cases remaining open for over 12 months by 24.4 percent.

A multi-year backlog of relative and non-relative ASFA assessments was reduced by 95 percent, resulting in a net County cost savings of nearly \$800,000 dollars per month.

During the 2007 fiscal year, the Permanency Partners Program (P3) provided services to 2,311 youth who were previously in long term foster care. As a result

of the tremendous success of P3, approximately 32 percent of the youth now have a legally permanent plan identified or established. The P3 program was expanded to include all regional offices.

During calendar year 2007, the number of DCFS runaway youth decreased by 29.1 percent.

A total of 2,121 children were adopted during calendar year 2007.

Moving forward, DCFS recently identified three primary goals to reduce its number of referrals and cases, which include:

1. Reduced front-end referral rates and case openings;
2. Increased permanency practice and rates; and
3. Increased or improved human resource practice and rates.

One of the key outcomes will be to reduce ER and Generic caseloads by 15 percent. Over the next three years the Departmental goal is to reduce ER caseloads down to the following child/family case counts:

Child Count of 22 by June 2009; Family Count of 12
Child Count of 18 by June 2010; Family Count of 10
Child Count of 14 by June 2011; Family Count of 8

While the goal for Generic caseload targets consist of the following child/family case counts:

Child Count of 24 by June 2009; Family Count of 13
Child Count of 20 by June 2010; Family Count of 11
Child Count of 15 by June 2011; Family Count of 8

Reduced Front-End Referrals and Case Openings

A current goal for DCFS is to reduce the number of children under the Department's supervision by preventing abuse and neglect, strengthening families and community supports, providing quality after-care and offering differential response to families in crises. DCFS has been actively leading the design and planning of this Countywide SPA-based prevention initiative, which has been designed to incorporate community-specific strategies for reducing the incidence of child abuse and neglect. By enlisting the services of community agencies to provide supportive services to families before their issues rise to a level warranting the Department's direct intervention, families can receive the support and assistance they need without entering the child welfare system.

Beyond the various prevention initiatives, caseload reduction will be formally addressed at the front end of the Department through the Child Protective Hotline (CPHL). Currently, CPHL screens in for investigation 88 percent of all child abuse referrals received. The State acceptance average is 69 percent. Of these assigned referrals, 52 percent are currently coded as Immediate Responses, significantly above the California State average of 28 percent. The goal will be to reduce IR and Emergency Response (ER) rates to a more representative rate expected for a jurisdiction utilizing Structured Decision Making (SDM). The following five objectives at the hotline have been identified to achieve the goal.

1. Proposal to Divert Referrals: Currently, a staffing and cost analysis proposal is underway to use \$1.5 million Family Support dollars for case management services on referrals diverted from the CPHL to community based organizations. To achieve this, by July 31, 2008, CPHL Assistant Regional Administrators (ARAs) will conduct a one-day review sample of June 2008 referrals to the CPHL to project the number of referrals impacted. The final proposal will be presented to the DCFS Executive Team by September 1, 2008.
2. Training Plan: Planning meetings have been completed and dates have been set to implement a comprehensive training plan involving focus groups and a sample review of 300 referrals involving an independent consultant and national experts. The following will be completed:
 - Train new Hotline staff (CSWs and SCSWs) on the SDM tool, policy and procedures;
 - Review the tool, policy and procedures for current staff;
 - Train staff on interviewing for pertinent information; and
 - Clarify Hotline policy and procedures for ER staff.
3. Policy Development: On June 24, 2008, work began with the DCFS Policy Section to draft policy to support change in how CPHL will accept referrals. Policy from other counties will be reviewed including those counties with outstanding performance.
4. Productivity/Cognos Reports: Current management utilization reports are being designed to provide monthly reports and feedback for each CSW and SCSW.
5. Communication: A communication plan to key stakeholders regarding the changes underway at CPHL is being developed. This will ensure the Department's ongoing effort to enlist the community's cooperation, collaboration, and service satisfaction.

Emergency Response Command Post (ERCP) Detentions

ERCP CSWs work after-hours and on weekends to respond to all IR referrals. Detentions often occur due to a lack of intervention resources available during off-hours. In July 2008, ERCP implemented two agreements with local Community Based Organizations (CBOs) to provide up-front assessments and timely service linkage on new referrals to avoid otherwise likely detentions. Up-Front Assessments will provide ERCP staff with additional information regarding a family's level of involvement with domestic violence, substance abuse and mental health issues. With this information, ERCP Staff will make more informed decisions regarding the type of DCFS intervention.

Up-Front Assessments will be conducted by either a licensed or registered clinician. The assessment instrument to be used is the Behavioral Severity Assessment Program (BSAP). The BSAP is a computerized program comprised of standardized questions which assist in the writing of the clinical report. While ERCP workers focus their assessment on child safety/risk, the BSAP focuses on the caregiver(s) capacity to care for the child. The results of both assessments will be used to determine the most appropriate plan.

Children's Institute, Inc.(CII) will provide services to the SPA 4 Metro North regional office and Shields for Families is providing supportive services to the SPA 6 Compton, Wateridge and Vermont Corridor offices. Through a detailed evaluation process, the impact of reduced detentions will be measured, and if effective, expanded to the other offices. CII and Shields will also identify community resources and connect families to community providers. This should ultimately enable families to function more autonomously by utilizing community based safety nets without DCFS supervision. The primary goal of Up-Front Assessments is to increase child safety by reducing reliance on detentions and keeping families together.

Additionally, as discussed in Section I, the TDM process has not yet been integrated into the practice at ERCP, therefore, additional staffing is being requested to provide TDMs at ERCP or within 72 hours of taking a child into temporary custody. This will enable TDMs to occur on weekends, holidays, and after-hours, ultimately reducing the wait time to connect children/families to needed services, as well as helping to reduce ERCP's reliance on out-of-home care.

Increased Permanency Practice and Rates

Kin Gap

One key strategy for lowering caseloads is to move children in stable relative guardian homes into the Kin Gap program. The Department's goal is to recruit 10

percent (minimum of 36 children per month) of all Kin Gap eligible children. The plan will target the guardianship population in placement more than 2 years. Service Bureau offices are being reminded to check and correct case coding on all Guardianship cases and ensure all terminations pursuant to Kin Gap have been properly processed through the Kin Gap Unit of Revenue Enhancement. Kinship Liaisons will send mailers with follow-up telephone calls to all listed in the Kin Gap Eligible Children Report.

As of June 2008, there were 4,262 children eligible for Kin Gap. Thirteen Kin Gap Summits for relative caregivers have been completed. Kin Gap Training for general staff will be rolling out Department wide starting in Compton on July 14. A document entitled "Kin Gap Made Simple" has been distributed to 3,000 plus caregivers. Moreover, between January - May 2008 there have been 559 new Kin Gap homes established.

Adoptions

Currently, the DCFS Adoption rate within 24 months is 24.2 percent. The Department's goal will be to increase this rate to 30 percent by June 2009. For this to occur, seven different strategies are being employed.

1. Bureau of Information Services (BIS) will develop a tracking system to better measure and manage milestones from ER to the termination of parental rights. This is an area of focus needed to continue to reduce timelines to permanency. Especially helpful will be the establishment of court timeframes from hearing to hearing, including continuances and the reasons (due diligence, publication, Indian Child Welfare Act (ICWA), etc.).
2. Work to centralize the Termination of Parental Rights (TPR) Filing Function within the Adoption and Permanency Resources Division (APRD) is currently underway. This will streamline the process with a decrease in hand-offs and delays, resulting in decreased time to filing the acknowledgements with California Department of Social Services (CDSS). In addition, this will reduce the number of cases each Dependency Investigator is responsible for tracking and will free the regional TPR clerks to do other tasks.
3. There will be a time decrease to one month from the receipt of TPR acknowledgement from CDSS to adoptive placement, for cases that have an approved adoptive home study, which currently takes an average of 4.61 months, for both attached and unattached cases. APRD is working with BIS to develop a report that will only capture attached cases, resulting in more precise measurements.
4. Due to the average of six to nine months for the Appellate Court to issue a ruling on TPR appeals filed by parents or their attorneys, County Counsel is now providing training and assistance to DCFS staff to improve practice and prevent

appeals. The majority of TPR reversals involve non-compliance with noticing provisions for ICWA.

5. A legislative proposal to increase adoption rates is currently under development. It will seek to decrease the time period a birth parent has to appeal the termination of parental rights from 60 days to no more than 15 days
6. A number of strategies will be implemented to decrease the time taken from completion to finalization of adoptions. In addition to the development of CSAT policy and procedures to improve health and mental health assessments for children in out-of-home care, additional steps will be taken to ensure children's service needs are met and caregivers receive the correct payment rate. Public Health Nurses (PHNs) will be employed to review all cases assigned to pro bono law firms assisting with adoption finalizations to ensure all health issues have been identified and that the child is receiving the proper rate. Additionally, the Department is hiring paralegals to assist adoptive families with finalizing in pro per, and in pro per clinics will be implemented to allow families to file adoption petitions on their own. Further, the Department is working with the pro bono law firms to improve timeframes in assigning cases to pro bono attorneys.

Residentially-Based Services (RBS) Demonstration Project

Finally, the Residentially-Based Services (RBS) demonstration project will permit the Department to transform group homes from long-term placements to planned, short-term and individualized interventions that combine needs-specific treatment with integrated "follow along community-based services" to reconnect youth with their families, schools and communities. Los Angeles was one of the counties selected for this demonstration program and will submit a plan to the State by September 4, 2008 with a projected implementation date of January 2009. The RBS demonstration will be funded from revenue offset generated by the reduced lengths of stay for RCL 12 or 14 youth in the pilot. The offset will pay for the additional family work and Wraparound services after the youth's residential stay. Current tasks to be completed in the RBS demonstration program consist of the following:

Timeline

| | |
|---------------------------------------|---------------|
| Demonstration RFI issued to providers | July 15, 2008 |
| RFI responses due to County | Aug 15, 2008 |
| RBS demonstration provider selection | Sep 01, 2008 |
| Draft County Plan to State | Sep 04, 2008 |
| Final County Plan to State | Oct 17, 2008 |
| CDSS Approval of County Plan | Dec 05, 2008 |
| Provider Contracting Complete | Dec 31, 2008 |
| RBS Demonstration Start | Jan 2009 |

A two-year period is proposed for the demonstration project.

In an effort to improve timelines to permanency, DCFS had considered privatizing case management services for children placed in group homes and Foster Family Agencies (FFAs) using the Purchase of Service (POS) redesign established in Illinois as a model. In Illinois the POS Redesign included shifting to a performance-based rate, to offer incentives for cases closed through a permanency plan. The Department has considered this strategy and does not believe it is viable at this time; pertinent factors include: 1) California law and regulations do not permit FFA social workers to perform Division 31 social work case management duties; 2) Privatization of placement case management services would cause increased contractual complexity and DCFS would then require increased contract monitoring staff to ensure vendor compliance resulting in significant costs to the Department; 3) It is in the interest of DCFS, through best practices and with the provisions of the Title IV-E Waiver, to reduce the number of children placed in out-of-home care.

Improved Human Resource Practice and Rates

Implementation of the Hold Harmless Staff Allocation Plan

To help motivate managers to safely lower caseloads without the negative impact of decreasing line social worker staffing, in July 2008, the Department implemented a new approach to maintaining staffing levels of social workers. This method makes use of caseload averages from April 2007 to determine current and future CSW allocations. This process is referred to as Hold Harmless. The procedure maintains consistent staffing levels and includes new protocols for social worker transfers between offices and the recruitment of line staff for non case-carrying positions. A management report was developed to monitor staffing levels in each office to ensure Hold Harmless is equitably implemented Department wide.

Filling Vacancies

To achieve optimum case load counts further dedication must be directed to utilizing all available items budgeted to the Department. In early June 2008, 160 vacant CSW items existed within the Department. At that time it was determined that those 160 items, plus 23 SCSWs would be filled by December 2008. A mass interview process occurred in late June and 65 CSWs were hired and will be placed in Core Training Academy classes no later than July 28, 2008. To accommodate the resulting slots from CSW applicants, training academies have been scheduled for September and October 2008. A written exam for CSW trainees will be conducted on July 23, 2008. A total of 115 applicants have been scheduled for this exam and another 205 are being processed and reviewed for examination qualification. Further, 386 CSW II applications are currently being processed. If deemed qualified, applicants then complete an oral exam for banding. To support CSWs, 41 Intermediate Clerk Typists (ITCs) have been hired, along with 29 Human Services Aides (HSAs). Monthly HR reports are being issued to track compliance in filling vacant items.

C. Implementation Timeline

The timeline for implementing key caseload reduction tasks are outlined in the table below:

| OBJECTIVE | Timeline |
|---|--|
| CPHL | |
| Proposal to Divert Referrals | 7/08 – 9/08 |
| CPHL Training Plan | 7/08 – 10/08 |
| CPHL Policy Development | 7/08 – 9/08 |
| Productivity/Cognos Reports | 7/08 – 9/08 |
| Communication Plan | 7/08 – 12/08 |
| ERCP | |
| Up-Front Assessments | Currently Underway – Countywide roll-out dependent on evaluation |
| TDMs | 9/08 - 2/09 |
| Permanency | |
| 10 percent increase in Kin Gap cases | 9/09 |
| Milestone Tracking Tool | 7/08 – 2/09 |
| Centralized TRP Filing | 7/08 – 9/08 |
| Decrease TPR – Finalization | 7/08 – 9/08 |
| Training to decrease appeals | 7/08 – 12/08 |
| Decrease time from completions to finalizations (variety of sub-topics) | 7/08 – 6/09 |
| RBS Demonstration | 2/08 – 1/09 (2 yr demo) |
| Increase Human Resource Rate & Practice | 7/08 – 9/08 (on-going) |

D. Staffing/Funding Required

The proposed caseload reduction initiatives can be accomplished with existing resources. Many caseload reduction efforts above are being completed with existing and newly hired staff currently in the Department’s budget. As Differential Response and Upfront Assessment are implemented additional staff and resources for community based family preservation and support services will be required. There will be a need to deploy a complement of TDM facilitators at the Command Post. By December 2008, the Department will develop a cost estimate for fully rolling out Upfront Assessments for all offices. Additionally, the cost analysis for rolling out Differential Response Department wide will be completed.

There may be additional costs associated with the legislative proposal to allow Aid to Adoptive Parents to be equal to the foster care rate for FFA foster parents. The Department will develop the costs as part of the legislative proposal process. DCFS expects to hire 5-10 paralegals to improve the adoptions finalization process. Additionally, there may be some attorney costs associated with improving timelines for finalizing adoptions.

There will be start-up costs associated with the January 2009 RBS Demonstration Project. One proposal is to cover these costs out of funds in the pre-existing Wraparound County risk pool. The final budget for the RBS Project is due to the State in October 2008.

E. County Officials with Responsibility for Action

DCFS County officials with direct responsibility for this action include Chief Deputy Director, Ted Myers, and Dick Santa Cruz, Child Services Administrator III.

F. Benchmarks for Tracking Progress

The above strategies involve a cross-section of managers and staff throughout the Department organized into teams to carryout a variety of tasks. Team leaders currently meet on a bi-weekly basis to review and track progress, identify barriers and troubleshoot. A tracking log has been developed to track each goal's plan, actions, due dates, and status. Key milestones are currently under development and will be incorporated in the log.

VI. DATA/TRACKING OF INDICATORS

A. Identification of Settlement Agreement being Fulfilled

The Judge Matz 2006 order corroborated the Panel's concerns regarding the ability of the County to obtain ongoing reliable data for all class members in order to determine whether children are being systematically screened and assessed for mental health services, and when appropriately identified, actually receive those services. The County agrees with the Panel that a reliable system for collecting this information and being able to provide regular data reports to the Panel, in which to evaluate the County's progress in complying with the terms of the Settlement Agreement, will be a top priority for the County. The County is working diligently to address this concern, and the development of the Cognos Cube is a step in the right direction and will enable the County to track the progress of class members, as well as the ability to provide reasonably meaningful outcome indicators attributed to the service provision.

B. Description of the Goal and related strategies to achieve:

Development of the Cognos Cube

The Cognos Cube was developed in March 2008 as the mechanism for storing/reporting data on matched clients, in response to the June 2007 order from Judge Matz, which enabled the sharing of information between the two Departments

as a means to document compliance with the provisions of the Settlement Agreement. Since this order, several cubes have been developed to provide a variety of information on client demographics, service provision, placement type, legal status, and service financing. The cubes provide the technology infrastructure for creating routine reports on topics such as the ones mentioned above, as well as on selected outcome measurements reflecting the effectiveness of the service provision and the overall well-being of children under the care and supervision of DCFS.

A recent data match performed in June 2008 with 222,138 unique DCFS client records and 1,545,727 unique DMH client records, dating from 1998 to March 2008, resulted in 89,386 matched client records representing 40 percent of the DCFS records, which is an increase of 4,000 records over this timeframe. This most recent match will be further refined, once the indicators from the data development agenda are added to the cube and regular reports can be generated on a compilation of indicators that the Panel and County, after being in close discussions for several months, have mutually agreed upon.

Data Development Agenda

The proposed data development agenda for tracking the County's implementation of the Strategic Plan in relation to the systematic screening, assessment and, when necessary, the provision of basic and/or intensive mental health services to class members will be tracked and evaluated to determine the County's overall compliance with the Settlement Agreement. Data elements measuring the timeliness of mental health screenings, assessment, referral to service, provision of treatment, duration of service, as well as the outcomes associated with the delivery of service are included in the overarching questions, referred to as the "Big Seven". Under each of the Big Seven questions are a set of sub-questions that have been compiled from the performance indicators previously agreed to by the County in the April 2004 letter of County Counsel Catherine Pratt as well as selected outcome measures associated with the MHSA Outcomes Measures Application (OMA) used by the current intensive in-home mental health services programs (MST, MTFC, CCSP), and the providers of basic mental health services. These OMA outcomes will also be collected by programs providing Tier Three of the proposed Child and Family Team/intensive home based services programs. The County will need to continue to explore various options for improving the collection of outcomes related to child well-being. Additionally, the County will conduct regular studies of service access and utilization to identify service utilization patterns and assist in future planning. Following are the proposed items/questions for the Katie A. data agenda:

- I. Who are the children served by the Los Angeles County Department of Children and Family Services, across the County and by Service Planning Area, and what are the various dimensions associated with their care?

- A. *Number and rate of children with referrals:* total number of children referred to DCFS (monthly/annually); percent of children referred to DCFS compared to children ages 0-18 in Los Angeles County;
- B. *Number and rate of children by disposition types:* number of referrals that result in the opening of a DCFS case: voluntary family maintenance, voluntary family reunification, family maintenance, or detentions. Percent of children in each category compared to the total number of referrals;
- C. *Number and rate of referrals by response priority:* number of referrals in the following categories: immediate response, 5-day referrals, or evaluated out; and percent in each category compared to total number of referrals;
- D. *Rate of child abuse and/or neglect in foster care:* number of referrals for abuse or neglect in foster care facilities in the following types: relative licensed foster home, small family home, Foster Family Agency (FFA) home; and percent of abuse or neglect referrals compared to the number of children in foster care;
- E. *Number of children who enter out-of-home care after in-home services:* number of children detained in out-of-home care after the family had received in-home services (including family maintenance services, voluntary family maintenance services, Wraparound, Family Preservation);
- F. *Kinship placements:* number of children placed with a relative;
- G. *Number of out-of-home placements:* number of children who are in out-of-home care with 2, 3, 4 or more placements within 12 months from initial removal;
- H. *Number of re-entries:* number of children entering foster care who have been in care in the past;
- I. *Number of re-entries within 12 months:* number of children who re-enter foster care within 12 months of having been reunified with family (this would capture children who reunified with family and were re-detained before the case was closed);
- J. *Median care days:* median number of days in out-of-home care for children in the following categories: those in for less than 24 months and those in care for more than 24 months;
- K. *Adoptions:* number of children adopted within 24 months of removal; number of children adopted greater than 24 months after removal; and average time to adoption finalization, per child;
- L. *Reunification:* number of children reunified with family within 12 months of removal; number of children reunified after 12 months from removal; average time to reunification, per child;
- M. *Exits from care:* number of children who exit foster care in the following categories: adoption; guardianships; reunification; AWOL; deaths; emancipation;
- N. *Siblings:* number of children in foster care who are placed with all siblings;

- O. *Siblings*: number of children in foster care who are placed with some siblings;
 - P. *Setting distribution*: number of children in out-of-home care in each of following categories: relative home; foster home; FFA home; group home; other;
 - Q. *Place Proximity*: number of children placed within 10 miles of the home from which they were detained (excluding children placed with relatives); number of children placed more than 10 miles from home from which they were detained (excluding children placed with relatives); and
 - R. *Runaway incidence*: number of children who leave placements at least one time in the month; will include children who have been gone from placement 48 hours, or more; and will only count each child once, even if he/she leaves, returns and leaves again.
- II. Who are the potential Katie A. class members within this population (e.g. those children within this group that are Medi-Cal eligible)?
- 1) Countywide;
 - 2) By SPA; and
 - 3) By each of the dimensions (A-R) in Section I above.
- III. Have these potential class members been screened in a timely manner for mental health problems? Population consists of:
- 1) Newly detained children/court-ordered FR;
 - 2) Newly open and non-detained under a VFM, VFR, or Court-ordered FM case plan; and
 - 3) Children in existing open cases under all court-ordered or voluntary FM, FR, and PP case plans.

Mental health contacts consist of the following:

- i. Date of initial contact with DCFS;
- ii. Mental Health Screening (Yes/No);
- iii. Identification of person conducting Mental Health Screening;
- iv. Number and percentage of potential class members receiving Mental Health Screening;
- v. Results of Mental Health Screening (positive or negative);
- vi. Number and percentage of children receiving positive Mental Health Screening;
- vii. Date of Mental Health Screening; and
- viii. Number of days between initial contact with DCFS and Mental Health Screening.

- IV. Are children who screen positive for mental health problems receiving a timely and thorough mental health assessment? (For each of the categories mentioned above: 1) newly detained; 2) newly open; and 3) existing cases:

- i. Number of days between positive mental health screening and referral for mental health assessment/services;
 - ii. Consent for Mental Health Services provided (Yes/No);
 - iii. Number and percentage of children for whom Consent for Services is provided;
 - iv. Mental Health Assessment (Yes/No);
 - v. Number and percentage of children receiving a Mental Health Assessment;
 - vi. Date of Mental Health Assessment; and
 - vii. Number of days between positive Mental Health Screening and Mental Health Assessment.

- V. Who are the children who are eligible for mental health services as a result of this screening and assessment process (e.g. medical necessity is established)? (Across categories: newly detained; newly open; and existing cases)

- VI. Do those determined eligible for mental health services receive the appropriate mental health service in a timely manner? (across categories 1, 2, and 3)
 - i. Number and percentage of children with an urgent need for mental health services;
 - ii. Date of first treatment contact;
 - iii. Number of days from date of referral to first treatment contact;
 - iv. Number and percentage of children with a need for intensive mental health services;
 - v. Number and percentage of children receiving intensive home based mental health services consistent with the principles and practices reflected in the intensive home-based services model;
 - vi. Number children who are receiving services from DMH in contrast to number of children in County receiving services from DMH; number of children who are receiving DMH services in the following categories: outpatient, day treatment, inpatient services;
 - vii. Average annual cost of mental health services for children, per child, per category of service; Average annual cost for children receiving mental health services, by category of service;
 - viii. Psychiatric Hospitalizations: Number of children psychiatrically hospitalized, length of stay and diagnostic category;
 - ix. Psychotropic Medication: Number of foster children receiving psychotropic medication support services; number of children (throughout County) receiving psychotropic medication support services; diagnostic criteria for children receiving psychotropic medication support services, as a percentage.

- VII. What are the outcomes associated with mental health services received by this group? (across categories 1, 2, and 3)
 - i. Number and percentage of children with improved school performance;

- ii. Number and percentage of children entering the juvenile justice system;
- iii. Number and average of client living situation changes prior to their mental health services as compared to the average number during their mental health services, by:
 - SPA
 - Provider
 - Program
 - Age group
- iv. Client school attendance frequency prior to their mental health services as compared to school attendance frequency during their mental health services, by:
 - SPA
 - Provider
 - Program
 - Age group
- v. Number/percentage of clients that were seen by Psychiatric Mobile Response Team or 24/7 Response within the last 12 months prior to mental health services as compared to number/percentage who were seen during their mental health services, by:
 - SPA
 - Provider
 - Program
 - Age group

Service Access and Utilization

The County will also need to conduct regular studies of service access (availability) and utilization. These studies will map service availability by service type and location. For example, this examination will allow the County to map the array of directly-operated and contracted children's mental health providers across each SPA and to associate with each one the types of services (outpatient, day treatment, wraparound, crisis intervention, full service partnership, intensive in home mental health services, MAT, etc.) and, to the extent possible, the volume of services which each agency is able to provide per their contract. Through use of data in the Cube and the Integrated System as well as various program specific databases, we can track service utilization across these service types and produce reports that compare service access and utilization across the County. This information is likely to be extremely helpful in service planning and utilization.

C. Implementation Timeline

The projected timeline for creating these fields in the Cognos Cubes and then generating the reporting format is dependent on the staffing of key positions (discussed below); the completion of the data agenda for the entire project is anticipated to take 6-12 months from the date of Board approval of the Strategic Plan, which is scheduled to be heard by the Board in October 2008. However, as

fields are incorporated in the Cubes data reports will be generated to begin tracking and evaluating service access/utilization, as well as system performance and child driven outcomes.

D. Staffing/Funding Required

The DMH Chief Information Office Bureau (CIOB) has recommended that temporary consultants be hired at a one-time approximate cost of \$500,000 to act as a Project Manager, Business Analyst, and Application Developer over the development of a DMH administered Katie A. database and associated cubes. These individuals will be responsible for managing the overall project, for creating and implementing the business rules to extract data fields from the cubes, and for building the application/database from which to transmit information received from DCFS to the cubes, which can then be distilled and formatted into canned reports for both DCFS and DMH management. It is expected that one dedicated consultant on the DCFS side (Project Manager) will be required to provide the same level of management/oversight in relation to the expanded set of indicators to track through the cubes. As discussed under Section I, Screening and Assessment, DCFS has incorporated 5 positions to support the data management processes for both the cube and the FCS referral tracking system.

In addition, DMH CIOB has received approval to hire: 1 Information Systems Analyst II, 1 Research Analyst III, and 1 Research Analyst II to support the work of the consultants in the development of the Katie A. database, cubes and associated business rules. CIOB has hired the Information Systems Analyst and Research Analyst II, and will continue to seek qualified staff to fulfill the other research analyst position by the end of the calendar year. It is anticipated that the CIOB consultants will be hired within the same timeframe – by the end of 2008.

E. County Official with Responsibility for Action

The County officials with direct responsibility for this action will be DCFS Medical Director, Dr. Charles Sophy, and Deputy Director, Olivia Celis from DMH. Additionally, DMH District Chief Greg Lecklitner, DMH CIOB Division Chief John J. Ortega, DCFS Katie A. Division Chief Adrienne Olson, and Information Systems Specialist Cecilia Custodio with the DCFS Bureau of Information Services will be responsible for this action.

F. Benchmarks for Tracking Progress

Benchmarks for tracking progress with the development of the cubes will consist of hiring key staff, i.e. consultants and County research/IT positions, the development of the business rules and systems architecture for creating a Katie A. database that can receive and transmit data from DCFS to the cubes for further analysis, development of the cubes, and the production of formatted reports for the Panel/County to track the County's compliance with the Settlement Agreement.

VII. EXIT CRITERIA AND FORMAL MONITORING PLAN

A. Identification of Settlement Agreement being Fulfilled

The 2006 Order from Judge Matz tasked the County with developing measurable exit conditions and monitoring criteria, in order to demonstrate unequivocally that the County has fulfilled the provisions of (paragraphs 6 and 7) of the Settlement Agreement. The Panel provided a means for operationalizing this approach and suggested a three-fold measure of compliance in which to target activities: 1) successful completion of a meaningful strategic plan; 2) a passing score from a qualitative review; and 3) acceptable progress on tracking indicators. The County is in agreement with the Panel and has committed to undertake a Qualitative Services Review (QSR) to objectively document Strategic Plan implementation progress and overall compliance with the Settlement Agreement.

B. Description of the Goal and Related Strategies to Achieve:

Qualitative Services Review

Through a series of conference calls and face-to-face meetings over the last several months with the Panel, the County has agreed to conduct a QSR and concurs with the Panel regarding the validity that this review extends to the process of assessing compliance with the Settlement Agreement. The Panel has supplied County staff with several QSRs to review from other jurisdictions under similar child welfare court orders to improve qualitative performance and outcomes for children and families. The QSR in many ways is an extension of the Federal Child and Family Services Review (CFSR), which focuses on evaluating improved outcomes for children and families in the areas of: recurrence of maltreatment; incidence of child abuse/neglect in foster care; foster care re-entries; length of time to achieve reunification; length of time to achieve adoption; and stability of foster care placement. However, the QSR places a greater emphasis on qualitative practice, which can inform the attainment of outcome trends, or lack thereof. QSRs generally encompass two levels of review – child status indicators and system performance.

Child status indicators can entail:

- Safety;
- Stability;
- Physical well-being;
- Emotional well-being;
- Learning and development;
- Prospects for permanence;
- Caregiver functioning;
- Family resourcefulness; and
- General satisfaction with care

System performance indicators measure at a minimum:

- Child and family engagement;
- Team coordination;
- Assessment;
- Long-term view;
- Planning;
- Implementation;
- Tracking and adjustment;
- Cultural accommodations;
- Support availability; and
- Overall performance

Based on the research conducted in other jurisdictions, the QSR provides the County with the most objective vehicle for evaluating the County's performance in complying with the Settlement Agreement and eliminates ambiguity surrounding some of the provisions in the Agreement, such as providing care and services consistent with good child welfare and mental health practice.

The QSR fuses both qualitative and quantitative review criteria for evaluating and monitoring performance and is closely aligned with the movement toward Continuous Quality Improvement (CQI). CQI practices can assist agencies to transform from compliance-driven organizations into true learning organizations that rely on their vision, mission, and values to constantly improve practice. Both the Departments of Mental Health and Children and Family Services are focused on improving practice to serve children and families more effectively through coordinated systems collaboration and self-evaluations such as the QSR.

C. Implementation Timeline

The County, in partnership with the Panel, recommends drafting a proposal to the Court requesting the adoption of the Panel's three-pronged compliance approach: 1) successful completion of a meaningful strategic plan; 2) a passing score from a qualitative review; and 3) acceptable progress on key tracking indicators as the measurable exit criteria for fulfilling the Settlement Agreement. The recommended timeframe for submitting this proposal is October 2008 when the Panel submits its next report to Court. However, this date is dependent on the Board of Supervisors passing the Strategic Plan in October 2008. Implementation rollout of the CSAT in SPAs 1, 6, and 7 along with the Countywide implementation of the Wraparound/CFT continuum of intensive mental health services will be delayed along with all of the other dependent activities, if passage of the Strategic Plan does not occur by October 2008 or shortly thereafter. Upon the Court's approval, a draft QSR protocol, collectively agreed upon by County and Panel, identifying the discrete child status and system performance indicators and associated standards of review and methods for scoring could be completed in 2009. Countywide implementation of the Wraparound/CFT continuum of intensive mental health services along with the CSAT screening/assessment referral process would need to be discussed to

determine an optimal review date in 2010, and possibly beyond if a passing score is not achieved on the first review.

D. Staffing/Funding Required

At this time, no additional staffing is necessary to develop the QSR review criteria or instrument. In-house research services from the Chief Executive Office's (CEO) Service Integration Branch could assist in developing the instrument, data collection procedures, methodology for evaluating the scored review criteria, data analyses, and in producing the final QSR report(s). The projected budget for these services is approximately \$1,500,000. If workload considerations prevent SIB offering the needed research assistance necessary, consultant services will be requested.

E. County Official with Responsibility for Action

The County officials with direct responsibility for this action will be Medical Director, Dr. Charles Sophy from DCFS and Deputy Director Olivia Celis from DMH. Additionally, DCFS Division Chiefs Mitch Mason and Adrienne Olson along with DMH District Chief Greg Lecklitner, and DCFS Information Systems Specialist Cecilia Custodio and DMH Division Chief John Ortega will be responsible for this action. CEO'S Research and Evaluation Services will provide technical assistance, as will the DCFS Bureau of Information Services and the DMH Chief Information Office Bureau.

F. Benchmarks for Tracking Progress

QSR Implementation progress will be informed by the development of the following key activities:

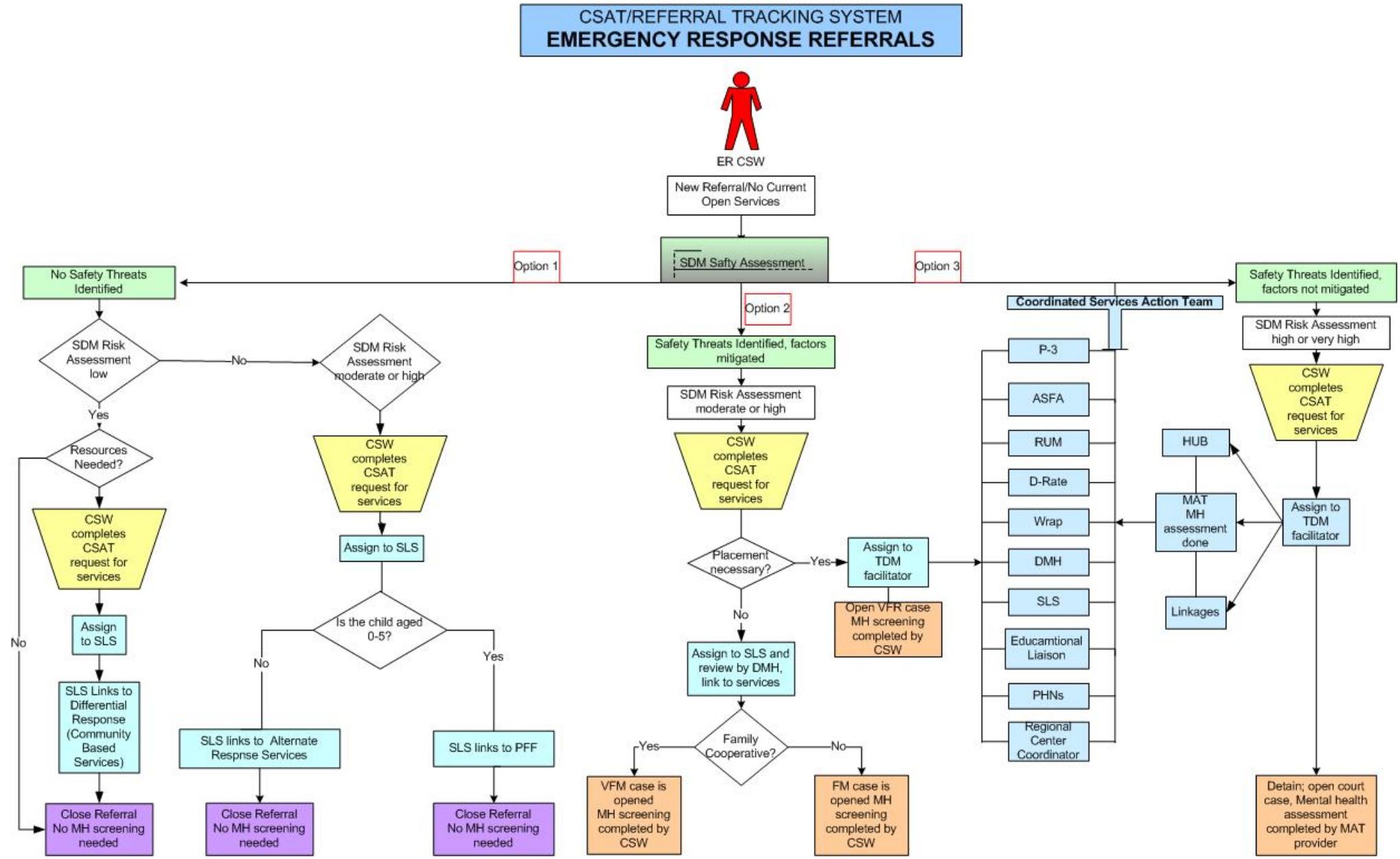
- Identification of key child and system indicators;
- QSR case review and interview protocol development;
- Development of QSR instrument;
- Agreement on case/interview sample;
- Agreement on review team; and
- Completion of QSR.

GLOSSARY

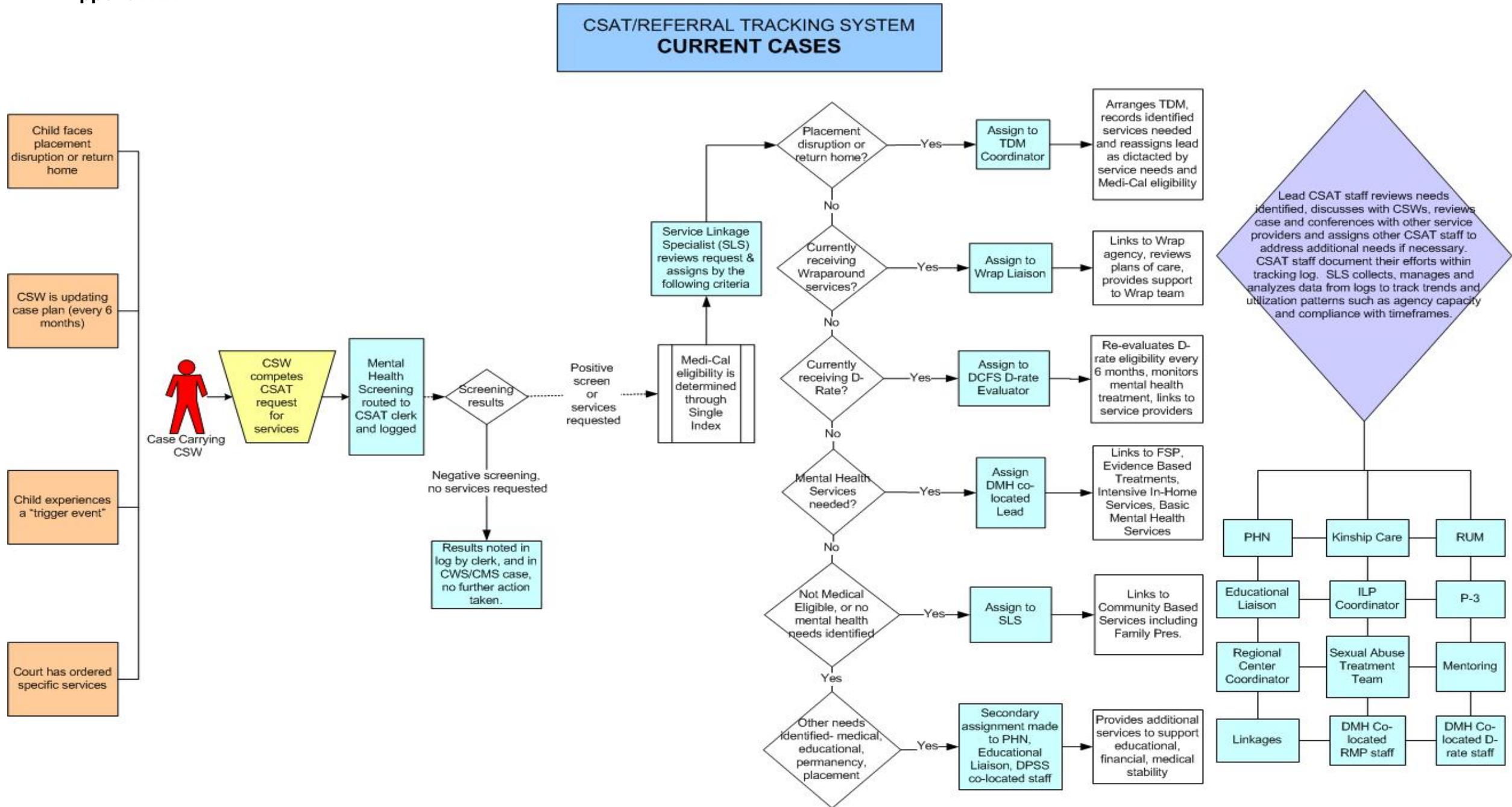
| Acronym | Definition |
|---------|---|
| ARAs | Assistant Regional Administrators |
| ARPD | Adoption and Permanency Resources Division |
| ARS | Alternative Response Services |
| ASFA | Adoption and Safe Families Act |
| BIS | Bureau of Information Services |
| BSAP | Behavioral Severity Assessment Program |
| CANS | Child and Adolescence Needs and Strengths |
| CAP | Corrective Action Plan |
| CBO | Community Based Organizations |
| CCSP | Comprehensive Children's Services Program |
| CDSS | California Department of Social Services |
| CFSR | Federal Child and Family Services Review |
| CFT | Child and Family Teams |
| CII | Children Institute, Inc. |
| CIMH | California Institute for Mental Health |
| CIOB | Chief Information Office Bureau |
| CPHL | Child Protective Hotline |
| CPR | Concurrent Planning Redesign |
| CQI | Continuous Quality Improvement |
| CSA | Children's Services Administrator |
| CSAT | Coordinated Services Action Team |
| CSW | Children Social Worker |
| CSW | Children's Services Worker |
| DCFS | Department of Children and Family Services |
| DHS | Department of Health Services |
| DMH | Department of Mental Health |
| EPSDT | Early & Periodic Screening, Diagnosis and Treatment |
| ER | Emergency Response |
| ERCPC | Emergency Response Command Post |
| FCS | Family Centered Services |
| FFA | Foster Family Agency |
| FM | Family Maintenance |
| FR | Family Reunification |
| FTDM | Family Team Decision Making |
| HMA | Health Management Associates |
| HSA | Human Services Aides |
| ICWA | Indian Child Welfare Act |
| IR | Immediate Response |
| ISCs | Interagency Screening Committees |
| ISWs | Intensive Services Workers |
| ITC | Intermediate Typist Clerk |

| Acronym | Definition |
|---------|---|
| ITFC | Intensive Treatment Foster Care |
| LMS | Learning Management System |
| MAT | Multidisciplinary Assessment Team |
| MHSA | Mental Health Services Act |
| MHST | Mental Health Screening Tool |
| MST | Multisystemic Treatment |
| MTFC | Multidimensional Treatment Foster Care |
| NCC | Net County Cost |
| OMA | Outcomes Measures Application |
| P3 | Permanency Partners Program |
| Panel | Katie A. Advisory Panel |
| PHN | Public Health Nurse |
| Plan | Countywide Enhanced Specialized Mental Health Services Joint Plan |
| POC | Plan of Care |
| POE | Points of Engagement |
| POS | Purchase of Services |
| PP | Permanent Placement |
| QSR | Qualitative Services Review |
| RBS | Residentially-Based Services |
| RFI | Request for Interest |
| RMP | Resource Utilization Management Process |
| RUM | Resource Utilization Management |
| SACWIS | Statewide Automated Child Welfare Information System |
| SCSW | Supervising Children's Services Worker |
| SDM | Structured Decision Making |
| SED | Severely emotionally disturbed |
| SFC | Specialized Foster Care |
| SI | Service Linkage |
| SOC | System of Care |
| SOF | Summary of Findings |
| SPAs | Service Planning Areas |
| STC | Supervising Typist Clerk |
| TAY | Transitional Age Youth |
| TBS | Therapeutic Behavioral Services |
| TDM | Team Decision Making |
| TPR | Termination of Parental Rights |
| VFM | Voluntary Family Maintenance |
| VFR | Voluntary Family Reunification |

Appendix A.



Appendix B.



Appendix C.

Core Practice Model (Re-Draft)

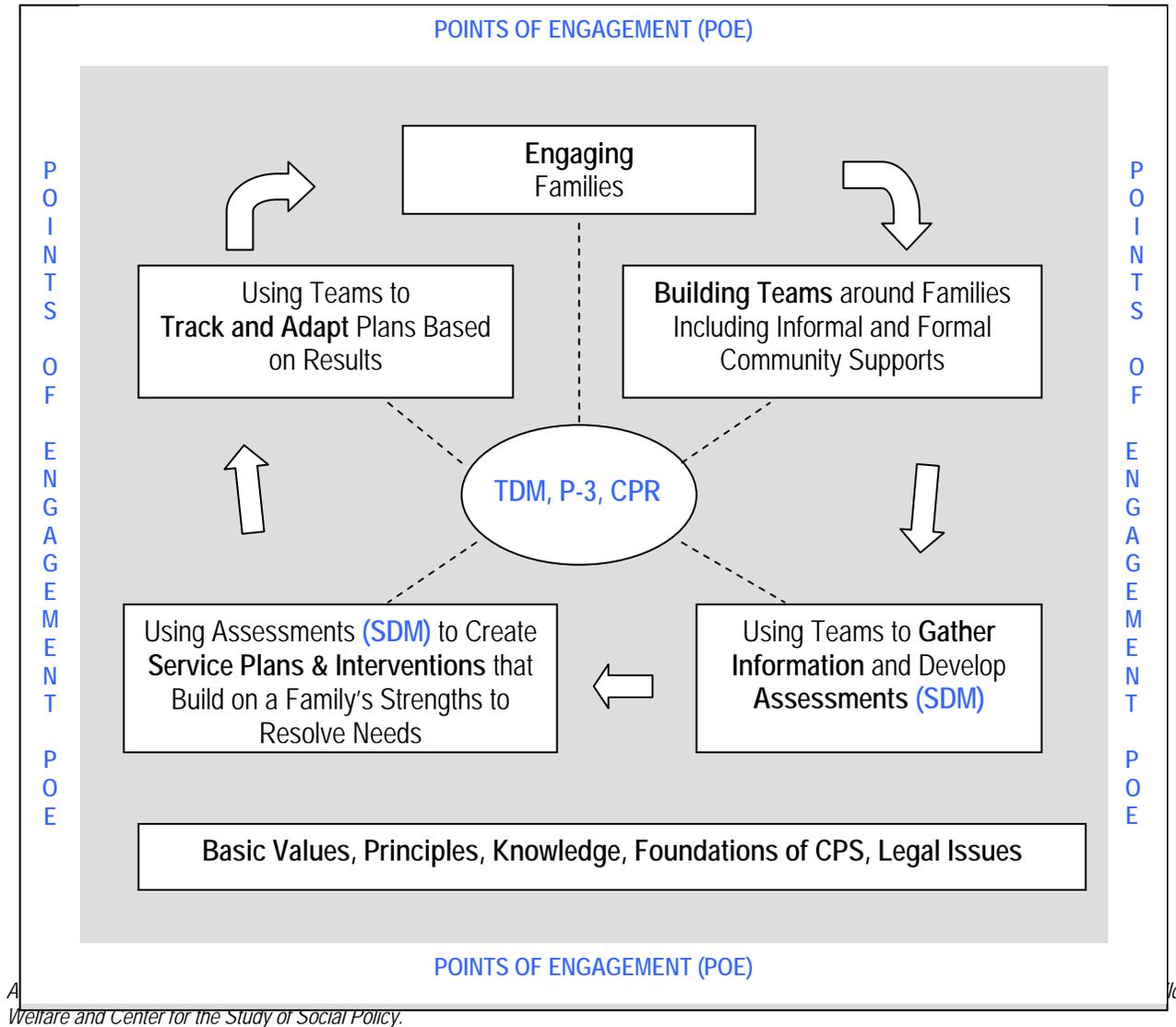
- The context for current child welfare practice in Los Angeles County has been set by the three **federal** key outcomes of *safety, permanence and well-being* for children.
- These outcomes are supported and reinforced by the **California** Child Welfare Services Improvement Plan and the **Los Angeles County** DCFS System Improvement Plan (SIP).
- The three key goals for **LA County DCFS** are:
 - Improved permanence**
 - Improved safety**
 - Reduced reliance on out-of-home care**
- The five major strategies used to reach these DCFS goals include:
 - Structured Decision Making (SDM)** researched-based assessment tools designed to increase accuracy and consistency in decision making at critical decision points in a case.
 - Team Decision Making (TDM)** that involves families, service providers and community representatives in a strength-based team guided process to make an immediate decision regarding a child's placement, with an eye towards a reduced reliance on out-of-home placements.
 - Permanency Partners Program (P-3)** to locate family and find more permanent placements and adult connections for older youth.
 - Points of Engagement (POE)** service delivery system to provide thorough investigations, assessments and needed services to children and families within their homes and communities.
 - Concurrent Planning Redesign (CPR)** to assist in reunifying children with their families quickly, while working on alternate permanency plans for children who cannot return home safely.

Additionally, Los Angeles County has recognized the need for systemic improvements to better meet mental health needs of children and families; DCFS and the Department of Mental Health (DMH) share an interest in the **safety, permanence and well-being** of children and families. To ensure that the needs of children are identified and that individualized intensive home-based services that meet those needs and build on the strengths of their caregivers and foster families are provided to increase placement stability and permanency, the two Departments have committed to collaboratively develop a child and family team process and a system of care approach that fuse practice principles from child welfare and children's mental health. This fusion of practice has been guided by three principles:

- Services are driven by the needs of the child and preferences of the family and are addressed through a strengths-based approach.
- Services should occur in a multi-agency collaborative team and are grounded in a strong community base.
- Services offered, agencies participating, and programs generated are responsive to cultural context.

Appendix C.

This enhanced Child Welfare Core Practice Model encompasses the Federal mandates, the State SIP and C-CFSR outcomes, DCFS goals, the departmental strategies to meet these goals, and the DCFS and DMH partnership's guiding principles. The model diagrams the continuous sets of activities performed by CSWs in the five key practice components (Engaging, Building Teams, Information Gathering and Assessing, Service Planning, and Tracking and Adapting), all relying on a basic knowledge of the legal and professional foundations of CPS. The model incorporates departmental and stakeholder priority initiatives and illustrates how services are provided within a Points-of-Engagement context, utilizing SDM guidance and TDM, P-3, and CPR strategies with the goal of improved outcomes for families and children. The model also allows for modifications as departmental needs and initiatives emerge. The Core Practice Model serves as the framework for both formal and on-the-job training and field activities during the new CSW's probationary period.



The following table explicates the model in greater detail and indicates where key elements of the Adoption and Safe Families Act (ASFA), the Katie A. Settlement Agreement, and DCFS Executive Team feedback have been incorporated.

Appendix C.

A CORE PRACTICE MODEL

(Incorporating ASFA, Katie A. Settlement Agreement, and DCFS Executive Team feedback)

| Core Practice Model Defined | Engaging Families | Building Teams (Networks) Around Families | Using Teams to Gather Information and Develop Assessment | Create Individualized Service Plans and Ensure Safety and Permanent Placement | Track and Adapt Plans Based on Results |
|--|---|--|---|--|--|
| <p>The Core Practice Model is a continuous set of activities applied by every caseworker.</p> <p>-----</p> <p>“Focus of core practice model is outcomes, not compliance and builds on the three ASFA outcomes of Safety, Permanence and Child & Family Well-being.”</p> | <p>Foundation to building trusting and mutually beneficial relationship between family members and caseworker.</p> <p>Demonstrating and communicating respect for the family and empathy for its struggles.</p> <p>Understanding the culture of the family and helping identify all potential team members.</p> <p>Provides a strong role for parents to be included in decision making about services and supports needed to be active participants in finding solutions to family issues and concerns about child safety.</p> | <p>Teams are useful to gather important info about strengths and needs that contribute to overall assessment of a family’s situation.</p> <p>Network members can identify the risk of maltreatment before it occurs, respond to issues of safety promptly, and provide a range of services and support for the family.</p> <p>Workers help families build or enhance their own informal support systems that might include family members, neighbors and friends, and reps of formal systems (schools, counselors, community orgs, DV & MH care systems, substance abuse prevention and tx agencies).</p> <p>The family and team are empowered to plan and make decisions about what services are needed, how they should be delivered, how to track success of plan and make individualized adaptations as necessary.</p> | <p>Continuous process of gathering and analyzing info that supports sound decision making</p> <p>Done by the entire family, not by worker alone.</p> <p>Assessment should determine family’s strengths, skills and motivation for change as well as concrete and immediate needs.</p> <p>Should explore the underlying causes of child maltx or risk of abuse and neglect, and the factors that prevent the family from making necessary changes to keep its children safe.</p> <p>Should know the overall assets of the community.</p> <p>Should know possible MH or physical health issues and signs of substance abuse or domestic violence.</p> | <p>Families are more invested in a plan when they have been actively involved in decision-making about needed services and supports.</p> <p>Requires workers to keep family focused on key concerns and establish clear linkages between the identified needs, desired changes, and how family strengths can be used to reach the plan’s goals.</p> <p>Goals need to be behaviorally specific, realistic, time-limited, measurable, and understood by family.</p> <p>Plans are not constant and evolve and are flexible to respond to family’s emerging issues and needs; incremental steps that move families from where they are to better level of functioning. Includes ways to sustain the success beyond the end of formal services.</p> <p><u>Standards:</u> General Service Provision; Health; Education; Social Worker Visits; OH Services; Placement selection; Family Relationships; Permanency & Stability</p> | <p>Monitor results, not just compliance.</p> <p>Determine whether services and supports are meeting needs identified in plan are critical to achieving desired results.</p> <p>If supports/services do not meet important needs, the team is responsible for assessing the family and adapting the plan in timely manner.</p> <p><u>Sustaining Success and Closure</u> Essential needs have been met; goals related to safety, risk of harm and permanency have been achieved.</p> <p>A team/network is in place that can detect and identify recurrent or emerging needs.</p> <p>Family has sufficient trust to call on their team/network for help if needed.</p> <p>Services and supports in place to assure child and family a smooth, timely and successful transition when changes occur, when families are reunited, or when case closed.</p> |

Appendix C.

| Core Practice Model (cont.) | Engaging Families | Building Teams (Networks) Around Families | Using Teams to Gather Info and Develop Assessments | Create Individualized Service Plans (Interventions) | Track and Adapt Plans Based on Results |
|---|---|--|--|---|---|
| <p>Basic Values, Knowledge, Skills and Abilities of Core Practice</p> | <p>Experience in building helping relationships;</p> <p>Interpersonal skills that demonstrate genuine interest in and respect and empathy for all children and families;</p> <p>Active listening skills, including the ability to clarify, reframe, question, reflect, and summarize;</p> <p>Knowledge of and respect for cultural differences among individuals, families and communities;</p> <p>Ability to partner with and appreciate individuals and families in the context of their cultures, including ethnicity, religion and nationality;</p> <p>Willingness to meet w/ families in their homes or community-based environments that are safe and inviting;</p> | <p>Experience in: assembling and leading a group, designing meeting agendas and facilitating meetings, helping to identify priorities, becoming a member of an established group, resolving conflict among group members, coordinating services and supports to prevent duplicating or conflicting services and to avoid overwhelming children and families;</p> <p>Ability to bring together a circle of helpers;</p> <p>Respect for nonprofessional and non-traditional helpers;</p> | <p>Experience in conducting interviews with children and families;</p> <p>Relevant experience w/ or knowledge about DV, substance abuse, MH, child development, and family systems;</p> <p>Knowledge of safety issues and risks of harm to children;</p> <p>Ability to identify strengths and underlying needs in individuals, families and communities.</p> | <p>Ability to develop individualized plans that build motivation for change and are based on strengths and needs of families;</p> <p>Awareness of community resources;</p> <p>Ability to help families craft clear, behaviorally specific, measurable goals for change;</p> <p>Willingness to seek help from supervisors and colleagues;</p> <p>Solution-focused skills;</p> <p>Experience with balancing child safety with the need for family attachments and engaging community helpers, networks and systems of support;</p> <p>Coaching and modeling skills;</p> <p>Ability to identify individual and family strengths and build upon them;</p> | <p>Personal self-evaluation ethic;</p> <p>Organizational and analytic skills;</p> <p>Ability to use a circle of helpers to analyze what is and what is not working and why;</p> <p>Ability to plan and support successful transitions and sustainable independence;</p> |
| <p>Katie A Objectives Tasks Outcomes</p> | <p>Engagement (SBFCP)</p> | <p>Teaming (TDM, FGDM)</p> | <p>Reduce OHC, Safety, Perm Decision Making Safety, Perm, OHC</p> | <p>MH, Safety, Perm, Srvc Srvc, MH, Perm Safety, Perm, MH, Srvc</p> | <p>Decision Making</p> |
| <p>LA DCFS Executive Team Priorities</p> | | <p>Teaming and Collaboration</p> | <p>Investigation, Assessment and Intervention: Risk and Safety, Decision Making, Interviewing and Investigation;</p> | <p>Intervention Quality Visitation</p> | <p>Decision Making</p> |
| <p style="text-align: center;">Legal Issues and Legal Partnership Documentation: CWS/CMS, Forms, Case Notes, etc.</p> | | | | | |

Appendix C.

| Core Practice Model (Integrated Re-Draft) | Engaging Families | Building Teams (Networks) Around Families | Using Teams to Gather Info and Develop Assessments | Create Individualized Service Plans (Interventions) | Track and Adapt Plans Based on Results |
|---|--|--|--|---|---|
| <p>The Core Practice Model is a continuous set of activities applied by every caseworker.</p> <p>-----</p> <p>"Focused of core practice model is outcomes, not compliance and builds on the three ASFA outcomes of Safety, Permanence and Child & Family Well-being."</p> | <p><i>Children and families are more likely to enter into a helping relationship when the worker or supporter has developed a trusting relationship with them. Staff and families work together as partners in relationships based on equality and respect.</i></p> <p><i>The quality of this relationship is the single most important foundation for engaging the child and family in a process of change.</i></p> <p><i>Children and families are more likely to pursue a plan or course of action that they have <u>voice and choice</u> in designing.</i></p> | <p><i>Decisions about child and family interventions are more effective when the family's team makes them. Families should always be core members of the team. The family participates as a decision-maker in collaboration with members of the multidisciplinary team and a facilitator who assists in the coordination of services and supports.</i></p> <p><i>Coordination of the activities of everyone involved is essential and works most effectively and efficiently when it occurs in regular face-to-face meetings of the family team.</i></p> <p><i>Children in foster care who are transitioning to adulthood are most successful in achieving independence when they have established relationships with caring adults who will support them over time.</i></p> | <p><i>When children and families see that their strengths are recognized, respected, and affirmed, they are more likely to rely on them as a foundation for taking the risks of change. Programs focus on families' strengths and enhance their capacity to support the growth and development of all family members, adults, youth, and children.</i></p> <p><i>Assessments that focus on underlying needs, as opposed to symptoms, provide the best guide to effective intervention and lasting change.</i></p> <p><i>Youth must be included in treatment planning by offering them direct information, in developmentally appropriate ways, about treatment options. As much as possible, youth should make choices about preferred intervention strategies.</i></p> <p><i>Success in school is a reliable predictor of child well-being. When the direction of planning for safety, stability, and permanency is fully integrated with school plans and services, children are more likely to make progress. Common terminology must be used to describe children's well-being (emphasizing adaptive functioning and taking into account ecological, cultural, and familial context) in order to facilitate service delivery across systems.</i></p> | <p><i>Children do best when they live with their family or kin or, if neither is possible, with a foster family. Siblings should be placed together. Children should rarely be placed in group or residential care and only when their needs cannot be met by intensive services while they live with their family, kin or a foster home. Group or residential care should not be long-term and should lead to permanent family placement. <u>Children receive care when they need it, not when they qualify for it.</u></i></p> <p><i>The family's informal helping system and natural allies are central to supporting the family's capacity to change. Their involvement in the planning process provides sustaining supports over time.</i></p> <p><i>Reunification occurs more rapidly and permanently when visiting between parents and children in custody is frequent and in the most normalized environment possible (office based visits and supervised visits are the least normalized environment). A menu of seamless (non-categorical) mental health, substance abuse, and related support services and resources should be provided and be fair, responsive, and accountable to the families served.</i></p> | <p><i>An infrastructure must be provided for cost-effective, cross-system collaboration and integrated care, including support to providers for identification, treatment coordination, and/or referral to specialty services; and the development of integrated community networks to increase appropriate referral opportunities.</i></p> <p><i>The system of services and supports should be sufficiently flexible to be adapted to the unique needs of each child and family. Services and supports best meet child and family needs when they are provided in the family's home or for children in custody, the child's current placement. Services should be flexible enough to be delivered where the child and family reside.</i></p> |

Appendix C.

Basic Values, Knowledge, Skills and Abilities of Core Practice

Children receive the care and services needed to prevent removal from their families or, when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and 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.

Incentives are provided for scientifically-proven and cost-effective prevention and treatment interventions that are organized to support families, and that consider children and their caregivers as a basic unit (e.g., home-based treatment, intensive case management, family therapy).

Children experience trauma when they are separated from their families. When children must be removed to be protected, their trauma is lessened when they can remain in their own neighborhoods and maintain existing connections with families, schools, friends and other informal supports.

Issues of confidentiality must be addressed in ways that respect a family's right to privacy, but encourage collaboration among providers in different systems.

Untreated mental health problems place children and youth at risk for entering the juvenile justice system. Mental health programs designed to divert youth with mental health problems from the juvenile justice system must be supported.

An infrastructure must be provided for cost-effective, cross-system collaboration and integrated care, including support to providers for identification, treatment coordination, and/or referral to specialty services; and the development of integrated community networks to increase appropriate referral opportunities.

Many of the services and resources that children and families find most accessible and responsive are those established in their own community, provided within their own neighborhoods and culture. A comprehensive and culturally competent system of services and supports for all children should be available and accessible to children and families in their respective local communities.

Programs acknowledge cultural differences, provide culturally competent services, and affirm/strengthen families' cultural, racial, and linguistic identities, while enhancing their ability to function in a multicultural society.