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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

KATIE A. by and through her next friend Michael Ludin; MARY B. by and through her next friend Robert Jacobs; JANET C. by and through her next friend Dolores Johnson; HENRY D. by and through his next friend Gillian Brown: AND GARY E. by and through his next friend Michael Ludin; individually and on behalf of others similarly situated,

Plaintiffs,

v.

TOBY DOUGLAS, Director of California Department of Health Care Services; LOS ANGELES COUNTY; LOS ANGELES COUNTY DEPARTMENT OF CHILDREN AND FAMILY SERVICES; PHILIP BROWNING, Director of the Los Angeles County Department of Children and Family Services; WILL LIGHTBOURNE, Director of the California Department of Social Services, and DOES 1 through 100, Inclusive,

Defendants.

Case No. CV-02-05662 JAK (AJWx)

Assigned to The Honorable John A. Kronstadt, Courtroom 10B

ADVISORY PANEL'S REPORT TO THE COURT – ANNUAL REPORT FOR 2017, DECEMBER 21, 2018

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Pursuant to this Court's Order, Plaintiffs are filing the Advisory Panel's Report to the Court – Annual Report for 2017, December 31, 2018. A true and correct copy of the Advisory Panel's Report to the Court is attached hereto.

Dated: January 22, 2019

Respectfully submitted,

By: _____

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The Katie A. Advisory Panel
Draft Report to the Court
Annual Report for 2017
December 21, 2018

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EXECUTIVE SUMMARY

The following Panel Report addresses LA DCFS and DMH performance for the calendar year 2017 and includes a brief summary about implementation initiatives and challenges during 2018 to date. This report identifies major continuing concerns of the Panel about the County's slow progress in implementing the Katie A. Settlement and uncertainty that current County strategies will succeed in implementing the Shared Core Practice Model, which is a key strategy for compliance.

The Panel commends the County's progress in some important areas:

System Strengths

DCFS Staffing

DCFS has increased its overall staffing notably since 2014, when it hired 526 staff. Since then it hired 601 staff in 2015, 682 staff in 2016, and 533 staff in 2017. According to DCFS, this permitted the continuing services caseload to decline from an average of 24.5 cases to 19.2 today. Emergency response caseloads declined from 15.2 to 9.9.

Development of Child and Family Team (CFT) Capacity

DCFS reports that as of August 2018, it has certified 2, 635 CFT facilitators, 500 CFT coaches and 65 coach developers. Development of staff in these skills is an important step in building the capacity necessary to implement the Shared Core Practice Model.

Children in Congregate Placements

DCFS advises that in an effort to identify children in group care settings who may be able to transition to a less restrictive setting, it has assessed over 800 children, 95 percent of whom have already had an initial CFT meeting.

Emergency Child Care Bridge Program

DCFS has initiated a program to provide time-limited child care to caregivers who are providers of licensed and license-exempt caregivers for children. The lack of subsidized child care has been a significant barrier to foster care recruitment, since so many prospective foster parents are employed. DCFS expects to fully spend its $14 million allocation. This amount is far from being sufficient to meet the need for child care, but is a positive step.

School Continuity

Through a partnership with the education community, DCFS used local funds to contribute $300 thousand in FY 17-18 and $800 thousand in FY 18-19 to fund transportation to the school of origin when a child is placed outside of that jurisdiction. This covers transportation costs until a determination is made about whether it is in the child's interest to continue being transported. Over 500 children have been served. Having school stability is a priority for children who are adjusting to being removed from their families.

DMH Coaching

In July 2017, DMH was given authority to add 28 coaches and 3 supervisors, intended to support Shared Core Practice Model implementation among mental health providers. There are currently 25 coaches on board, with the remaining 13 pending start dates.

Continuing County Implementation Challenges

DCFS Staffing

While DCFS has commendably reduced caseloads over the past four years, the County goal of 24 cases per Continuing Services work is higher than the goal it set for staff in immersion offices, which was 20 cases per Continuing Service worker. The caseload standard of 24 cases is significantly higher than the standard in most other child welfare systems under settlement agreements. The goal of 20 cases per CS worker was what was identified as the standard necessary for full Shared Core Practice Model implementation. Currently, over half the CS caseloads exceed that number.

CFTM Implementation

The following table shows how far the County has to go in fully implementing the CFT process. Only two DCFS offices were having initial team meetings with more than 40 percent of cases and performance was quite low in almost all the offices. The percent of follow-up CFT meetings conducted was even lower.

All DCFS Children

Office	ALL DCFS-SUPERVISED CHILDREN	
	Percent with timely Initial CFT Meetings (within 60 days of case opening)	Percent with timely Follow-Up CFT Meetings (within 90 Days of Initial CFT Meeting)
American Indian	23%	6%
Asian Pacific	30%	14%
Deaf Services Unit	26%	13%
El Monte	25%	3%
Glendora	14%	4%
Lancaster	26%	9%
Metro North	18%	2%
Palmdale	16%	2%
Pasadena	23%	5%
Pomona	22%	2%
Santa Clarita	50%	22%
Van Nuys	27%	10%
West LA	17%	9%
West San Fernando Valley	38%	13%
Belvedere	15%	3%
Compton	23%	3%
Santa Fe Springs	41%	13%
South County	15%	2%
Torrance	19%	1%
Vermont Corridor	9%	1%
Wateridge North	14%	2%
Wateridge South	36%	11%

The Immersion Process

In 2016, after demonstrating little progress in implementing the Shared Core Practice Model, the County adopted a process for fully implanting the practice model in only a few offices each eighteen months, which permitted the provision of intense training and coaching and allocation of additional staff in those sites. This approach, called the immersion process, has been used successfully by other systems nationally to provide sufficient supports to permit lasting progress to be sustained. In 2018, the County decided to cease use of this process in favor of again attempting to reform all 19 offices and 3 specialized units simultaneously. Despite the fact that the parties and Panel had treated the immersion approach like part of the strategic plan, neither was formally notified of the change until after the decision had been made. The Panel does not have confidence that without intense training and coaching and the allocation of additional staff, this countywide approach will bring the County any closer to full implementation of the Shared Core Practice Model and in fact, believes it could will delay it further.

Specialized Mental Health Services (Wraparound and Intensive Field Capable Clinical Services - IFCCS)

Both Wraparound services and IFCCS should be effective supports for children with high mental health needs. However, as it has in previous years, the Panel is deeply concerned at the apparent underutilization of these services. The County reports that as of December, 2017, Wraparound was serving 2,177 children and had 573 vacancies, a 21% vacancy rate. IFCCS, which can serve 765 children, had a 33% vacancy rate. The Panel frequently learns of cases from staff and stakeholders that involve children experiencing placement disruptions or placement in more restrictive settings without the involvement of these intensive services. Unfortunately, there is no effective tracking system to know the actual incidence of these missed opportunities or why they are occurring, making it difficult to develop a solution.

Congregate Care

These have been modest reductions in the number of children in congregate care in the past 4 years. However, 2017 data reflect a continuing pattern of 80 or more children age 0-12 in congregate care. Data also show troubling time-in-care trends, as illustrated in the following table.

Age Group	0 to 2 Months in Group Homes	2 to 6 Months in Group Homes	6 to 12 Months in Group Homes	Over 12 Months in Group Homes
0 - 12	314	235	196	273
13 - 17	2354	2685	1814	1420
18 plus	146	349	332	578

Two hundred seventy-three children 12 and younger had group home stays of more than 12 months, a period for two long for this age group in the opinion of the Panel. And 2814 children had stays of 2 months or less, which suggests that if appropriate family based placement settings and intensive home-based services had been available or utilized early, many of these placements could probably be avoided. Given the underutilization of Wraparound and IFCCS, intensive support services should have been available to help some of these children avoid group home placements. It seems clear that additional services for high-need children are necessary.

Practice Quality

In analyzing the QSR Practice Scores for all eighteen offices in the third cycle and comparing them to the baseline, system performance demonstrated slight improvement in the following indicators: Support and Services increased from 66% to 67% and Intervention Adequacy increased from 52% to 57%. System

performance in Engagement remained at 60% in both the baseline and third cycle. In Overall Practice, scores decreased slightly from 47% in the baseline to 42% in the third cycle. Teamwork demonstrated a slight decline from 18% in the baseline to 11% in the third cycle.
Current performance in the third cycle, after eight offices, indicates that:

- 51% of children are making acceptable progress toward permanency
- 73% of children are considered to have acceptable emotional well-being
- 43% of families are making acceptable progress toward adequate functioning
- 11% of children have a functioning family team
- 38% of cases have an overall adequate assessment
- 30% of cases have a long-term view of child and family goals and strategies
- 30% of cases have plans adequate for achievement of case goals
- 42% of cases are adequately tracked toward achievement of goals

These low QSR scores are one of the major reasons for the Panel's concern about the status of Shared Core Practice Implementation. Despite the County's success in developing CFT facilitators and coaches, those gains are not producing a commensurate improvement in actual system performance. The Panel has encouraged the County to develop effective strategies to move beyond being stuck at the current level of performance.

Data Analysis

One promising initiative the County, plaintiffs' and Panel have been involved in is an effort to identify additional progress indicators that are reflective of Shared Core Practice Model implementation, such as placement stability, placement in family based settings and delivery of intensive mental health services. The parties were also considering quantifiable performance goals for these indicators, which were referred to as tipping points, which could indicate proximity to being "good enough" to satisfy settlement agreement objectives.

The County recently advised that it had discovered that the DMH data and payment system would not be able to capture key elements of DMH practice necessary to track DMH performance. The changes in the data system needed to track the indicators were originally forecast to require a multi-year process. However the County now projects that the initiative will be completed in 2019.

The parties are now in discussion about how to employ interim processes that might permit some level of additional data tracking, but as of yet there is no plan to do so. Without the ability to collect critical mental health data, the Panel is limited in its ability to inform the court about DMH progress in implementing the Shared Core Practice Model.

Panel Recommendations

The slow pace of improving practice and providing the right services at the right time to meet children's needs continues to be the primary problem in Katie A. despite the commitment of both DCFS and DMH. The Panel had hoped the County's work on developing data indicators that reflect progress toward full implementation and the identification of tipping points could aid in meeting settlement objectives. However, now that the County has concluded that its data systems will not currently support those tasks, other strategies will be necessary to improve performance. The County reports that it will continue to

work on improving its data systems, but that seems like a long-term effort. DCFS and DMH still must answer the question: To what extent have DCFS staff and DMH providers implemented the Shared Core Practice Model? To what extent do DCFS and DMH provide children and families with timely mental health services specifically designed to meet the child's needs? If this inquiry can produce data that is regularly updated, DCFS and DMH can enhance ongoing methods to ensure that staff change their practice accordingly. If not, other strategies will be required.

1. Ensure the Immediacy and Intensity of Intensive Home-Based Mental Health Services

It is imperative that DMH and DCFS collaborate to provide consistent, accurate and up-to-date data to track (1) immediate response to children at risk of placement disruption, (2) frequency and type of mental health services provided to children, their caregivers and their families, and (3) information dissemination to insure that the slots in IHBS are full.

DCFS and DMH agree that it is important to collaborate on achieving responsiveness of IHBS, especially to prevent placement in emergency shelter, group home, residential facilities and psychiatric settings and placement disruptions, including the speed of identifying the child's needs, making an immediate IHBS referral, IHBS beginning services quickly, and provision of services as many hours a week as necessary to meet the child's needs and support both the caregiver and the parent in visits in meeting those needs. However, there appears to be little progress in DCFS and DMH data collection and analysis on IHBS responsiveness. The CISR does not appear to analyze IHBS responsiveness.

The Panel is doing interview studies of children receiving IHBS and children/youth in group care (including CSW interviews) to collect information about responsiveness of IHBS, IHBS intensity and IHBS success of preventing placement disruptions. We will encourage DCFS and DMH to take action on the findings of those studies. But small studies of IHBS provided to children and families cannot provide the kind of up-to-date systemic data on responsiveness and intensity of IHBS necessary to exit Katie A.

Recent county data indicates that surprisingly, subclass members are not receiving more mental health services than other children, the highest amounts of children's mental health service dollars continue to support services in residential treatment (over $30,000 of services annually per child as compared to $23,000 annually per child in IHBS), a third of IFCCS slots continue to be empty and Wraparound continues to have a large number of unsuccessful terminations. This information is discouraging.

The Panel reiterates its recommendation in our 2016 Report that DCFS and DMH implement improvements driven by data to ensure that (1) soon as DCFS recognizes that a child's placement may disrupt or a child is being considered for placement in any setting outside a family home, an immediate referral to IHBS is made; (2) IHBS is provided immediately to address the child's needs and provide support to caregivers to prevent disruption; and (3) IHBS services have a "whatever it takes" approach, with daily in-home services for the child and caregiver if necessary. A pre-defined team of mental health staff should not determine what services or their intensity are provided—staff assignments should be unique to the child and family; services for the child and support for the caregiver and family should target the child's trauma-related needs.

2. Ensure Placement Stability

DMH and DCFS have a commitment to prevent the trauma of disruption for children. This has been a prominent priority in the tipping points discussion.

- Continuing obstacles to achieving placement close to home appear to be that (1) the FFAs manage their own placements and placement moves and do not prioritize proximity to family (the FFAs are the majority of placements of children in foster homes) and (2) the fledgling Automated Community-Based Home Reservation system encountered difficulties.

- The primary obstacle to ensuring that each child's first placement was their only placement appeared to be insufficient support, including IHBS, for foster parents and kin caregivers to meet the trauma-related needs of children with difficult behaviors.

The Panel encouraged the county to investigate how many children are placed away from their siblings to begin a process of keeping children with at least one sibling to support those important attachments.

One reason for placement close to home is to make frequent visiting between parents and their children in care possible. DCFS is committed to improving the quality of visits, a key ingredient to safe reunification but with court-ordered multiple visits each week and limited staff to transport children long distances and monitor visits, it is unknown how much visit improvement can occur. Visits are less difficult for children when there is shared parenting between parents and caregivers, with agreement between them about the child's needs and how to meet those needs, both during visits and in the caregiver's home.

More than half the children in foster home placement in LA County are placed with relatives. CCR requires licensing of relative placements, but support for kin in meeting the needs of children—especially the subclass—is often overlooked. To ensure placement stability in kin placements, relatives should be involved in CFTs, asked what support they require to meet the child's needs and IHBS provided if other supports do not have sufficient intensity.

3. Ensure Effective Teaming

Teaming is an essential feature of SCPM. Teaming is both the process of collaboration among the family, CSW and providers to ensure needs are met and meetings together so all agree on the child's needs and what the family, caregiver, provider, CSW, informal supports and others will do to meet those needs. As the Panel summarized in its 2016 Report, quality CFT meetings require:

- Ongoing communication among team members before and after team meetings
- The family
- A family support(s) chosen by the family
- The caregiver (kin or foster family)
- The CSW (with some exception if meetings occur more than monthly)
- Key providers such as the child's therapist and school team member,
- Identify the strengths of the child, family and caregiver
- Identify the specific unique needs of the child, especially trauma-related needs
- Craft services to meet each of the child's needs
- Craft supports for the caregiver to meet the child's needs
- Craft supports for the family to meet the child's needs (during visits)
- An agreed-on plan with strengths, needs and supports and services provided to participants and incorporated into the court report and the mental health treatment plan

At this point DCFS and DMH cannot track the degree to which quality CFT meetings with these characteristics are occurring. There is less information available about CFT meetings facilitated by DMH staff than, including IHDS cases, than those facilitated by DCFS staff.

Although in most cases, DCFS and DMH staff actively collaborate with the child, caregiver, and each other, in the most recent QSR cycle, the County scored acceptably on teaming in only 11 percent of cases because the CFT meeting has not occurred and/or all the important individuals in the child's life were not included. The Panel has recommended training for QSR reviewers as well as targeted coaching of DCFS and DMH CFT facilitators regarding how to achieve the above characteristics of CFT meetings.

4. Strengthen the Supervisory Role in Shared Core Practice Model Implementation

The Panel believes that the County cannot meet QSR exit standards without DCFS and DMH supervisors leading Shared Core Practice Model practice, including holding staff accountable for quality CFT meetings in every case that produce CFT plans and mental health treatment plans with services crafted to meet the unique needs, particularly trauma-related needs, of children and supports for caregivers and families to meet those needs.

In the spring, 2018, DCFS and DMH increased the number of coaches and was beginning to provide more supervisory training and guidance for strengths/needs-based serviced service crafting. But the reassignment of coaches to state mandated CCR and to the four offices with the lowest number of CFTs set the county back six months in providing strong countywide support for supervisors. The Panel reiterates its recommendations from the 2016 Panel Report:

- Ensure sufficient coaching and training in strengths/needs-based service crafting is provided to supervisors in DCFS and DMH that they consistently guide the staff in their units include children's underlying needs and unique services and supports to meet those needs in CFT plans, DCFS case plans, DCFS court reports and mental health treatment plans.

- Ensure sufficient coaching is provided to supervisors that they consistently monitor that each family in each worker's caseload has had more than the initial CFT meeting and is having CFT meetings often enough to arrange unique services coordinated with both the parent and caregiver and together assess whether they are the right services at the right frequency.

5. Use the QSR as a Teaching Tool for Shared Core Practice Model

The Panel views the County's development of its QSR team as an important achievement. The system's QSR reviewers are doing a commendable job in providing the County with accurate and valuable feedback on the quality of its practice. The Panel has encouraged DCFS and DMH to get more power from the QSR as a way to teach consistent SCPM across offices and providers. Ascending QSR scoring trend lines will confirm that countywide SCPM is being achieved. Some modest progress is reflected in some QSR scores, while other scores continue to be frustratingly slow in improving. The Panel reiterates past recommendations to enhance the QSR as a teaching tool for SCPM:

- Requiring all DCFS leadership, RAs and ARAs and their DMH manager counterparts and all DCFS and DMH trainers and coaches who have not already done so to shadow a QSR.

- Regularly hold cross learning sessions of QSR staff and coaching/training staff as well as twice annually convening the larger management team for a DCFS/DMH supervisors training that uses SCPM lessons learned from QSRs and selects illustrative QSR stories.

- Inviting QSR experts to lead a discussion of inter-rater reliability and consider possible modifications of (1) the QSR Assessment Indicator to require identification of specific child needs

as a standard for acceptable rating, including a review to see if needs are in the case plan and court report; (2) the QSR Intervention Adequacy Indicator to require service crafting as a standard for acceptable rating and (3) the QSR Teaming Indicator to reflect that if the first CFT is in the review period, team formation may be off to a good start but all the potential team members or all the issues will not be addressed.

- A coaching session for QSR staff using the Panel's analysis of the needs and services in the case stories of the most recent QSRs to guide the reviewers in enhancing how they can inspire SCPM practice by presenting a strong needs list and crafted services in each case story

6. CISR

The CISR is designed to improve IHBS across many DMH providers. The Panel commended the recent CISR Report and recommended that in the next CISR DMH (1) ask more questions of each provider about the reasons for psychiatric hospitalization and placement change after enrollment in IHBS and what IHBS did to intensify services to prevent it and (2) establish a typical range frequency of each type of IHBS service, such as the percentage of children who receive individual therapy once a week or more, the percentage of caregivers who receive in-home guidance in meeting the children's needs once a week or more, and the percentage of children who receive in-home one-on-one support.

7. Immersion

The fact that the County ceased using the immersion process was a surprise to the Panel. The strategy developed for this approach occurred over many months and involved frequent conversations about the design with plaintiffs' and the Panel. Four offices were intensively involved in implementing the approach. The Panel considered the use of immersion as part of the revised Strategic Plan the parties had agreed to. The Panel expressed its reservations about the new system-wide approach previously about this report. We continue to believe that the County does not have the resources to fully implement the Shared Core Practice Model throughout the County at one time and that an immersion approach is the best strategy for meeting settlement objectives. The value of the immersion process includes:

- Providing sufficient training and coaching that all staff are thoroughly trained and coached, leading to greater sustainability of practice

- Thoroughly testing innovations before attempting to implement them system-wide

- Gradually intensifying the service array and staff size (which can be costly), so additional costs rise gradually

We recommend that the County resume the immersion strategy, which could include more than two offices at a time. The County could continue some support in non-immersion sites, as was anticipated in the original plan. If the County choses to continue its system-wide implementation approach, The Panel believes that it needs a detailed plan for that strategy, which includes more than training and coaching.

8. Improve the DMH Data System

The County should fully support the DMH plan to strengthen the ability of its data system so that it tracks key practice areas such as the timeliness of provision of intensive mental health services and the type and frequency of services provided to class members. In the interim, the County should fully explore the use of interim processes that will contribute additional performance data about DMH practice and performance.

2016 Report Recommendations

The Panel has included the recommendations in its 2016 report in the Appendix. This was done in part to illustrate the commonality between issues raised in the 2016 report and many of those in the 2017 report. The Panel is also asking for a County response on the status of these recommendations.

Katie A. Advisory Panel
Draft Report to the Court
Annual Report for 2017
December 21, 2018

I. Introduction

The following Report to the Court outlines the County's progress toward achieving the objectives of the Katie A. Settlement Agreement and includes a description of its compliance with the current Joint DCFS/DMH Plan, Corrective Action Plan and the Strategic Plan. The court will recall that in late 2014, the County, plaintiffs and Panel began to discuss strategies to accelerate Katie A. implementation by undertaking an "immersion process" whereby the County would select two offices/regions per 18-month period in which there would be more intensive supports and resources invested to accelerate implementation. The County adopted this approach because of limited progress to date and the large size of the County, which makes it difficult to bring intense resources to bear in each jurisdiction simultaneously, and to provide an environment where innovation can be tested prior to implementation throughout the County. The first immersion offices were Compton and Van Nuys. The second two sites scheduled for immersion were Pasadena and Belvedere. As will be address later in this section, the County has now ceased using the immersion process.

Panel Report Background

Some background is useful in reviewing this report. This report covers the 2017 monitoring and reporting period. There is always a lag between the end of the reporting period and the publication of the report while end-of-year data are being collated by the County. As a result, the information in monitoring reports is somewhat dated. To make the report more current, some current information on implementation efforts is also included.

Second, of necessity, some County implementation strategies within the Strategic Plan have been revised because of experience with earlier efforts, new challenges and new initiatives. Performance on some of these early strategies reflect substantial compliance, such as in establishing the Medical Hubs and providing mental health screening to children served by DCFS. At this point the Panel monitors ongoing performance in areas such as these to assure that progress is sustained. Some of the newer implementation strategies underway are not reflected in the original Strategic Plan, but are considered by the parties to be functionally part of current planning. The Panel monitors and reports on these as essential functional revisions to the Plan.

Third, because of its limited capacity to continuously track and verify operations within DCFS and DMH, the Panel is unable to generate its own quantitative evaluative data on which to base its appraisal of County performance under the settlement. As a result, the Panel relies on County data to judge

quantitative and some qualitative trends on system performance, outcomes and compliance. The County is asked to provide relevant data and its own analysis of trends, which the Panel utilizes in its reports. As a result, much the content of Panel reports consists of County-produced data, which the Panel has analyzed. The Panel is undertaking several studies in the fall of 2018, on placement stability with children receiving Intensive Home Based Services, and children in group care. Findings will be reported to the court.

II. 2018 Updates

Caseloads

The Panel is interested in tracking caseload size beyond reliance on average DCFS caseloads to better understand the relationship between caseload and performance. The County provided the Panel with actual caseload ranges, based on entries into its data system, The County cautions that the data system does not provide complete accuracy because information is reliant on accurate and consistent CSW input; however, data from this source is far more accurate than averages. The County has established a caseload standard (goal) of 18 cases per Emergency Response (ER) worker and 24 cases per Continuing Services (CS) worker. As of July, 2018, actual county-wide caseloads were in the following ranges.

Program Area	1-18 caseload	19-27 caseload	28 + caseload	Average
ER	752 Staff	33 staff	2 staff	16.20

Program Area	1-10 caseload	11-20 caseload	21-30 caseload	Average
CS	72 staff	674 staff	748 staff	20.03

Unfortunately, because the goal for CS workers is a caseload of 24, the ranges utilized by the County do not capture the exact number of caseloads within the goal. When DCFS was setting expectations for its initial Immersion offices, it utilized a goal of 20 cases per CS worker as the standard for fully implementing the Shared Case Practice Model. Currently, over half the CS caseloads exceed that number.

The Panel reviewed the caseload standards for a number of other systems that are under a settlement agreement and found the following. These mandatory limits provide some national context for LA's caseload sizes.

Oklahoma

Caseload standards are 10 child protection (ER in LA County) cases and 15 children for ongoing services. Peer coach caseworkers have 1/2 of a caseload and there are graduated caseload standards for new workers. The last two requirements (peer coaches and new workers) are not in their settlement document, but reflect State goals.

Tennessee

In Tennessee, which recently exited court supervision, DCS case managers responsible for the case of at least one class member cannot have case responsibility for more than:

- 15 individual children in DCS custody if the case manager is a case manager 1;
- 20 individual children in DCS custody if the case manager is a case manager 2 or 3 with no supervisory responsibility; and
- 10 individual children in DCS custody if the case manager 3 supervises one or two lower-level case managers.

The Settlement Agreement allows DCS to propose a standard for "mixed caseloads" of custodial and non-custodial cases or for some "family case" standard (like New Jersey has), but until they do, the caseload limits are based on the number of children, not the number of families, and no distinction is made between a sibling group of five in a single foster home (or at home with their parent in a non-custodial case) and five individual unrelated children in five separate resource homes.

Supervisory workload limits permit a supervisor (with no caseload) to supervise up to five caseload carrying case managers.

Washington DC

- Child Protection Investigations: 1:12
- In-home services: 1:15 families
- Out of home care 1:15 children
- Home studies 1:30
- Supervisory 1:5

New Jersey

The intake/protective investigations caseload standard is 1:12 and not more than 8 new referrals per month. No intake worker with 12 or more open cases can be given more than 2 secondary assignments per month.
Permanency caseloads are limited to (in-home and out of home) 15 families or fewer with no more than 10 children in out of home care.
Adoption standards are 1:12 children
Supervisory rations cannot exceed 1:5

It is clear that caseload limits are much lower in these systems than in DCFS.

Child and Family Team Meetings (CFT)

The regular use of Child and Family Team Meetings is a primary principle of the Shared Core Practice Model and was considered so important to the parties that it was included within the Qualitative Service Review process as part of the exit conditions. The CFT process provides an effective locus for engaging families, identifying child needs, planning and crafting services to meet identified needs. The County has struggled to provide CFT meetings for children and families with quality and sufficient regularity.

As part of the County's Strategic Plan, the County has worked diligently to develop the capacity to teach front-line staff to facilitate team meetings. As of July 31, 2018, DCFS reports that it has certified (through training and coaching) 3,200 staff as CFT facilitators. A total of 2,635 of these staff are facilitators, 500 staff are coaches and 65 staff are coach developers. DCFS also reports that as of August 2018, 16,989 CFT meetings have been held. Of 800 children placed in group care, 95 percent have had an initial CFT.

DCFS has consistently expressed the view that lower caseloads would permit CFT meetings to be held more frequently with greater numbers of families. From the Panel's review of caseload data it appears that close to half of continuing service caseloads exceed the 20 case per worker average goal for Immersion offices.

The data in the following table is for Continuum of Care Reform (CCR) children (newly-removed since 1/1/17 or already in group care on that date and beyond), not the total children served by DCFS. These two cohorts of children are those covered by the State's CCR requirements. Ordinarily, systems wouldn't combine such different groups in the same table. The table following this one provides a more comprehensive view of CFT performance.

CCR Children

Office	Percent of Children with Initial CFT Meetings within 60 days of case opening	Percent of Children with Follow-Up CFT Meetings within 90 Days of Initial CFT Meeting
American Indian	**67.7%**	**45.2%**
Asian Pacific	**95.7%**	**56.1%**
Deaf Services Unit	**50.0%**	**33.3%**
El Monte	**77.1%**	**31.0%**
Glendora	**63.01%**	**24.2%**
Lancaster	**59.5%**	**37.5%**
Metro North	**39.6%**	**11.9%**
Palmdale	**46.9%**	**14.3%**
Pasadena	**67.8%**	**27.7%**
Pomona	**69.2%**	**33.9%**
Santa Clarita	**71.4%**	**58.4%**
Van Nuys	**65.2%**	**34.7%**
West LA	**67.8%**	**57.9%**

West San Fernando Valley	**77.3%**	**50.4%**
Belvedere	**52.9%**	**13.8%**
Compton	**41.5%**	**14.1%**
Santa Fe Springs	**66.5%**	**61.4%**
South County	**53.9%**	**9.9%**
Torrance	**52.8%**	**5.9%**
Vermont Corridor	**32.0%**	**1.8%**
Wateridge North	**39.4%**	**2.4%**
Wateridge South	**52.7%**	**35.6%**

The CFT data in the table below are for all children with a DCFS case.

All DCFS Children

Office	**ALL DCFS-SUPERVISED CHILDREN**	
	Percent with timely Initial CFT Meetings (within 60 days of case opening)	**Percent with timely Follow-Up CFT Meetings (within 90 Days of Initial CFT Meeting)**
American Indian	**23%**	**6%**
Asian Pacific	**30%**	**14%**
Deaf Services Unit	**26%**	**13%**
El Monte	**25%**	**3%**
Glendora	**14%**	**4%**
Lancaster	**26%**	**9%**
Metro North	**18%**	**2%**
Palmdale	**16%**	**2%**
Pasadena	**23%**	**5%**
Pomona	**22%**	**2%**
Santa Clarita	**50%**	**22%**
Van Nuys	**27%**	**10%**
West LA	**17%**	**9%**
West San Fernando Valley	**38%**	**13%**
Belvedere	**15%**	**3%**
Compton	**23%**	**3%**
Santa Fe Springs	**41%**	**13%**
South County	**15%**	**2%**
Torrance	**19%**	**1%**
Vermont Corridor	**9%**	**1%**
Wateridge North	**14%**	**2%**
Wateridge South	**36%**	**11%**

These data do not include all CFT cases where the meeting is convened by DMH staff, meaning the number of CFTs in which class members are involved is somewhat greater than that shown in the two tables. The additional number of DMH cases is relatively modest.

Simply having a family meeting is not necessarily an effective strategy for achieving Shared Core Practice Model Practice. Effective CFT meetings provide for meaningful family input into planning, have the family's informal supports present, identify child and family needs, craft services that meet needs and track progress regularly. The QSR process, mentioned earlier, not only captures the incidence of team meetings, but also the quality of the meetings. In the 2015 -2017 third cycle of quality reviews, the County scored acceptably on teaming in only 11 percent of cases.

The Immersion Process

In 2016 the County undertook an implementation recommendation the Panel made shortly after the Panel was formed and again in January 2015. Based on successful experience in other systems, the Panel recommended that rather than trying to reform the system county-wide at one time, the County should focus on a small number of office at one time with the most intensive supports offices would need. The cost of providing such intensity system-wide concurrently would be prohibitive and the County did not possess sufficient capacity to provide the necessary training and coaching for a system-wide initiative.

Once adequate progress occurred in initial offices, the County could then begin the process in another group of offices, following this serial implementation strategy until the entire the entire system completed implementation. Within the immersion model, staff supports frequently include extensive staff coaching and training, additional flexible funds, new services and expanded placement resources within the neighborhoods and communities where families live. Other systems using this approach have described it as the immersion process, as in immersing a locality in the supports needed to implement their new model of practice.

When the County chose to adopt this process, it did provide some additional staff and more intensive training and coaching supports to the selected offices, but did not target new services or other resources for these jurisdictions. Other resource expansion remained system-wide. In the second round of immersion, involving two more offices, no additional staff were allocated. The immersion process was part of the virtual implementation plan developed by the County, which the Panel considered to be a formal strategy the parties had agreed on.

Although the use of the immersion process was part of the virtual strategic plan the County was following in 2017, the Panel has learned that the County is no longer employing it. The Panel recently learned that that in 2018 the County ceased the use of the immersion process and has returned to a County-wide implementation approach. The County explains that with hiring of thousands of new workers in recent years, resulting in caseloads dropping from the high 30's to the low 20's, continued work with the union on expectations for use of the CFT process and development of large numbers or practice coaches, the immersion process was no longer seen as preferable. The County also noted that unlike DCFS, DMH doesn't have the type of local office structure that permits and office-by-office approach. Based on how far offices have to go to fully implement the Shared Core Practice Model, as evidenced, for example, by QSR scores and metrics like CFT frequency, the Panel is not convinced that the County will have any more success in using a system-wide implementation approach than it did in the

first years of the settlement. The scope of the system is, in our opinion, too great to be able to provide the intensity of supports needed in so many different offices at one time.

Children's Intensive Service Review (CISR) Implementation

The Panel reviewed the Department's 2018 CISR Report and found the following. DMH completed a review of 35 cases from Intensive Mental Health Providers (IMHP) between January 1, 2018 and May 31, 2018. Four Intensive Treatment Foster Care cases, 3 Full Service Partnership cases, 18 Wraparound cases and 10 Intensive Field Capable Clinical Services were included in the CISR. Cases from multiple service areas across LA that had been open for six months or longer and were not preparing for the transition phase were included in the CISR. Three-fourths were age 15 and under. About half were described as male and half as female. They were 43% Latino, 31% African American, and 26% other. 17% had 2 or more placements prior to this placement; at least 9% had prior psychiatric hospitalizations. It was disappointing that half had one or more placement changes after enrollment in intensive MH services and 9% had a psychiatric hospitalization after enrollment.

The CISR review focused on 5 elements of Core Practice Model practice in these intensive home-based mental health service cases:

Engagement: *Utilizing trauma-informed engagement strategies and culturally-sensitive outreach efforts to engage the child or youth and family throughout the therapeutic process*. Most of the providers achieved active participation of the child or youth, family members, and caregivers. The majority of the children, youth, and families spoke positively about their IMHPs and reported that the services they received were beneficial. The CISR recommended that creative strategies to engage and integrate biological parents into the CFT process be implemented.

Teamwork: *Utilizing effective interpersonal skills to establish a strong collaborative with the child or youth, family and their support systems to ensure that the "right people" are identified and engaged as part of the Child and Family Team (CFT).* Elements of team formation were present in most cases. The CISR recommended that efforts be increased to team with formal supports from other agencies and informal supports from the children, youth, and family's home, school, work, and community.

Assessing & Understanding: *Having a unified understanding of (1) the child or youth and family's strengths, needs, preferences, and underlying needs; (2) what must change for the child or youth to function effectively day-to-day; (3) what must change for the child or youth and family to have improved overall well-being and family functioning; and (4) the path and pace to permanency.* The preliminary process of identifying the child or youth's underlying needs had begun for most of the cases and that providers appeared to understand what must change for the child or youth and family to improve overall well-being and family functioning. The CISR recommended that providers improve in identifying underlying needs and working from a trauma-informed lens.

Intervention Adequacy: *Utilizing effective clinical interventions at the necessary levels of intensity, duration, consistency, and continuity to produce desired results that match strategies to outcomes.* The interventions addressed the stated concerns of the children, youth, and families and were typically delivered at the necessary levels of intensity, duration, consistency, and continuity warranted by the unique needs of the situation. "Ongoing training around underlying needs and the translation of those needs into specific trauma-informed interventions would highly benefit the children, youth, and families being served. It is also recommended that IMHPs engage in individualized service-crafting when providing trauma-informed interventions. Services should fit the uniqueness of the child or youth and family, and build upon their identified strengths. It is important for IMHPs to avoid providing "one-size-fits-all" interventions…it was not evident that the IMHPs implemented evidenced-based practices in their interventions."

Child Well-Being: *Improving the child or youth's safety, permanency, and sustained functioning in the current placement*. There were notable improvements of the child or youth's safety over the course of their services. While the child or youth's overall well-being was routinely addressed, the IMHPs often overlooked permanency issues. In many cases, the permanency of the child or youth's placement had not yet been finalized, but it was recommended that the IMHPs identify sensitive permanency concerns as early as possible and collaborate and plan throughout the CFT process until a permanency plan is established.

The latest CISR protocol went into effect July 1, 2018 (after this review) and is designed to be similar to the Quality Service Review (QSR) protocol including the same six-point Likert scale used for scoring the QSR practice indicators. The next CISR will use the improved CISR protocol and will report on follow-through on these recommendations and the outcome of DMH's plan for additional training to strengthen the intensive mental health providers' skills in trauma-informed care, underlying needs, CFT facilitation and ICC/IHBS procedural codes.

The Multidisciplinary Assessment Process (MAT)

The MAT process involves utilizing a mental health provider to conduct an initial assessment of families entering the system, using a team meeting to finalize a statement of findings. MAT recommendations are intended to inform the court's decision-making about the child and family. The County has been piloting an integration of its MAT process and the Child and Family Team process in three offices. It has long been the view of the Panel the MAT process duplicates the key elements of the CFT process and that this redundancy is confusing and costly. The Panel commends the efforts to better coordinate the two processes, but remains convinced that the MAT process needs to be replaced by the CFT process, not merged with it. Full implementation of the CFT process is the best solution to this duplication.

Progress Indicators

Over the past (18 months), the Panel and the parties have engaged in promising discussions focused on identifying quantitative progress indicators that help identify critical system performance and class member outcomes. These indicators would complement the qualitative measures within the Qualitative Service Review. Such indicators include measures such as rates of entry into foster care, placement of

children with relatives, proximity of placement to home and community, placement stability, placement in the least restrictive, most normalized environment and permanency achievement, for example. A small number of process measures such as caseload size, the percentage of children having CFT meetings and receipt of Intensive Home-Based Services are also being considered. As part of these discussions, participants have been exploring potential performance targets for these indicators, or "tipping points" as the County describes them. Such targets would be considered goals for improvement and could be a factor in assessing progress toward full implementation of the Shared Core Practice Model.

Unfortunately, the County has recently determined that efforts to create a baseline of performance based on the selected indicators is not possible within the constraints of the DCFS and DMH data systems. Challenges related to the DMH data system are a particular challenge. While the County plans to continue working on addressing this problem, the County initially reported that it will take years to modify and or replace the DMH system so that appropriate DMH actions and outcomes can be tracked. The County now projects completion in 2019. Until those changes are completed, the Panel will be virtually blind to key aspects of DMH performance.

The Resource Family Approval Process (RFA)

The Resource Family Approval Process is a new state mandate that combines all elements of foster parent licensing; Adoptions and Safe Families Act-compliant approvals of relative caregivers; and adoption and guardianship approvals into one singular process. In May 2018, the California department of Social Services mandated that all county child welfare agencies complete RFA approvals for the caregivers of children already placed in their homes by no later than September 1, 2018. In March 2018, the state enacted AB 110, which allowed short-term care and supervision payments for RFA-pending relative caregivers and non-related extended family members already caring for children. To receive this funding, counties were required to submit a plan to eliminate the backlog of pending RFA applications by September 1, 2018. At that time, DCFS had 4,385 RFA approval-pending cases to complete.

According to DCFS, since the Department implemented RFA within existing staffing resources, it found itself inadequately staffed to comply with the state's mandate by September 1, 2018. In order to comply with the state's mandate, DCFS initiated a time-limited reassignment of some non-case-carrying Children's Social Workers and Children's Services Administrators to process RFA cases on a full-time basis; and assigning one RFA case for completion to each qualified DCFS employee – including the Director.

As of 8/24/18, there are 252 pending-RFA cases of caregivers with children already placed in their homes. Many of these await criminal clearances only prior to completion. Others were not completed due to the family's vacation plans. DCFS hopes to complete all or to submit "Good Cause" justification for non-completion to CDSS no later than September 14, 2018.

III. DMH Performance

Section three contains updates of County plans and progress and is supported by progress reports submitted by the County. Where the Panel has comments about these updates, its observations are underlined.

DMH Service Provision to Class Members

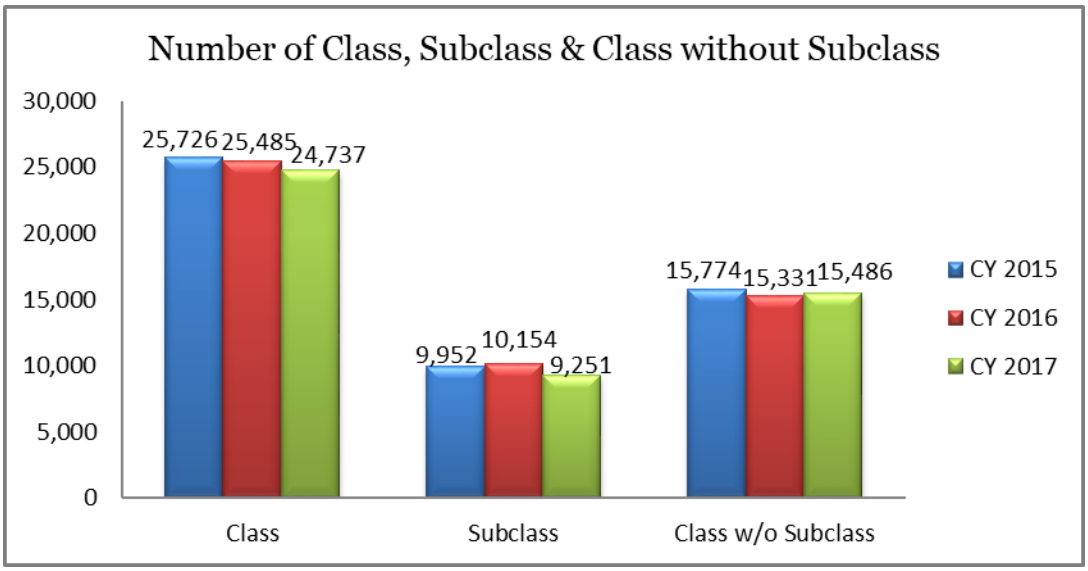
DMH reported that it conducted an analysis to compare matched client data from the last three calendar years (2015-2017), to identify members of the Katie A. class and subclass and determine the levels of mental health services they were provided. The analysis used the definition of the class and subclass contained in the settlement agreement in the Katie A. State case. The data contains only class and subclass members who received mental health services with DMH. The department points out that there are some limitations on the accuracy and comprehensiveness of these data; 1) This report may not fully reflect all class members and mental health services provided, as providers have up to 18 months to submit claims. 2) DMH used two different methods to capture the number of youth that were psychiatrically hospitalized due to limited DMH data available. 3) In CY 2017, there was a change in the method used to capture claims for clients enrolled in Wraparound FSP. Beginning July 2017, the Wrap-FSP billing plan was eliminated and Wrap Providers commenced billing to the FSP plan for these Wrap services. This change created additional challenges due to the utilization of rosters in order to track these clients. Overall, the data provides a useful view of mental health service provision in the County.

1) From the total number of DCFS clients in CY 2017 (54,777), 45% were Katie A. class[1] members, slightly lower than the previous calendar year (CY 2016, 46%). Of the 24,737 class members in CY 2017, 15,486 (63%) belonged to a category identified as Class without Subclass (Class w/o Subclass: class members who are not part of the subclass). During CY 2017, about 37% of the Katie A. class were subclass[2] members and received more intensive mental health services, a decrease from CY 2016 (40%) and CY 2015 (39%). The data indicates that the number of subclass members increased from calendar year 2015 to 2016 and decreased in 2017 (CY 2015: 9,952; CY 2016: 10,154; CY 2017: 9,251). The County believes that the decrease in subclass members in CY 2017 seems to be largely due to a decrease in the number of youth that received three or more placements within 24 months (CY 2016: 4,367; CY

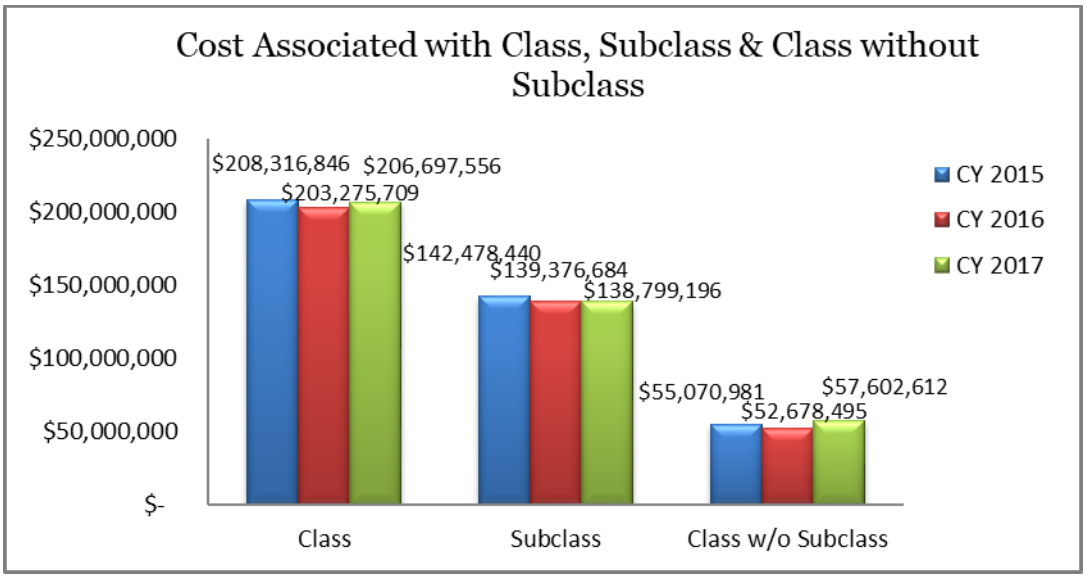
[1] Class: Children/youth who meet all of the following criteria: 1) Have an open child welfare services case; 2) Have full scope medical; 3) Meet medical necessity for mental health services; and 4) Received a mental health service or were considered for Intensive treatment.

[2] Subclass: Children/youth who meet criteria # 1-3 for the class above *and*: 4) Considered for or received *intensive* treatment, i.e., one or more of the following: a) Wraparound (Wrap), b) Intensive Field Capable Clinical Services (IFCCS), c) Full Service Partnership (FSP), d) Treatment Foster Care (TFC), e) Therapeutic Behavior Services (TBS), f) Had a psychiatric hospitalization, g) Received services through Exodus, h) Resided in a Community Treatment Center (CTF), i) Placed in a Group Home RCL 10 and above and/or, j) Had 3 or more placement changes in 24 months due to behavioral needs.

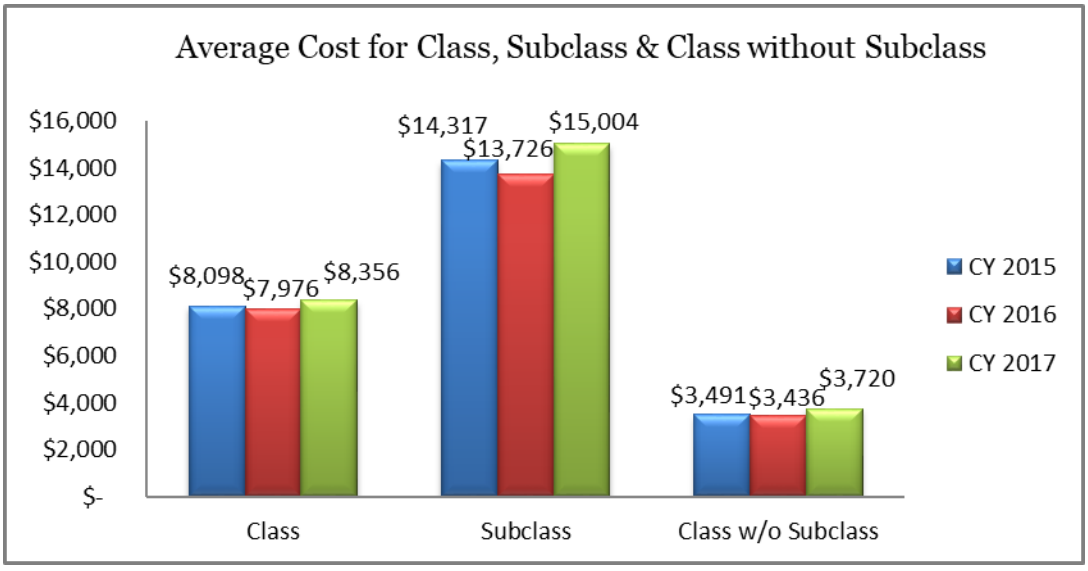
2017: 3,517. The following graph shows the breakdown of the class, subclass and class without subclass for CY 2015-2017.



2) The County reports that the cost associated with providing mental health services to the Katie A. class decreased in CY 2016 and then increased in CY 2017 (CY 2015: $208 million; CY 2016: $203 million; CY 2017: $207 million). The cost associated with providing mental health services to the Katie A. subclass has also decreased since CY 2015 (CY 2015: $142 million; CY 2016: $139 million; CY 2017: $139 million) but the percentage of subclass costs from the total class costs slightly increased in CY 2016 and then slightly decreased in CY 2017 (CY 2015: 68%; CY 2016: 69% and CY 2017: 67%). Overall, the mental health costs associated with providing services to the subclass group is still more than half of the total costs provided to the class w/o subclass.



3) The CY 2017 data shows the average mental health cost associated with subclass members ($15,004) has increased compared to CY 2015 ($14,317) and is still much higher than the average cost of mental health services for class members who are not part of the subclass (CY 2017: $3,720). The average cost for the class without subclass category has increased since CY 2015 (CY 2015: $3,491; CY 2016: $3,436; CY 2016: $3,720). More specifically, subclass members are receiving more services than the average class member not belonging to the subclass.



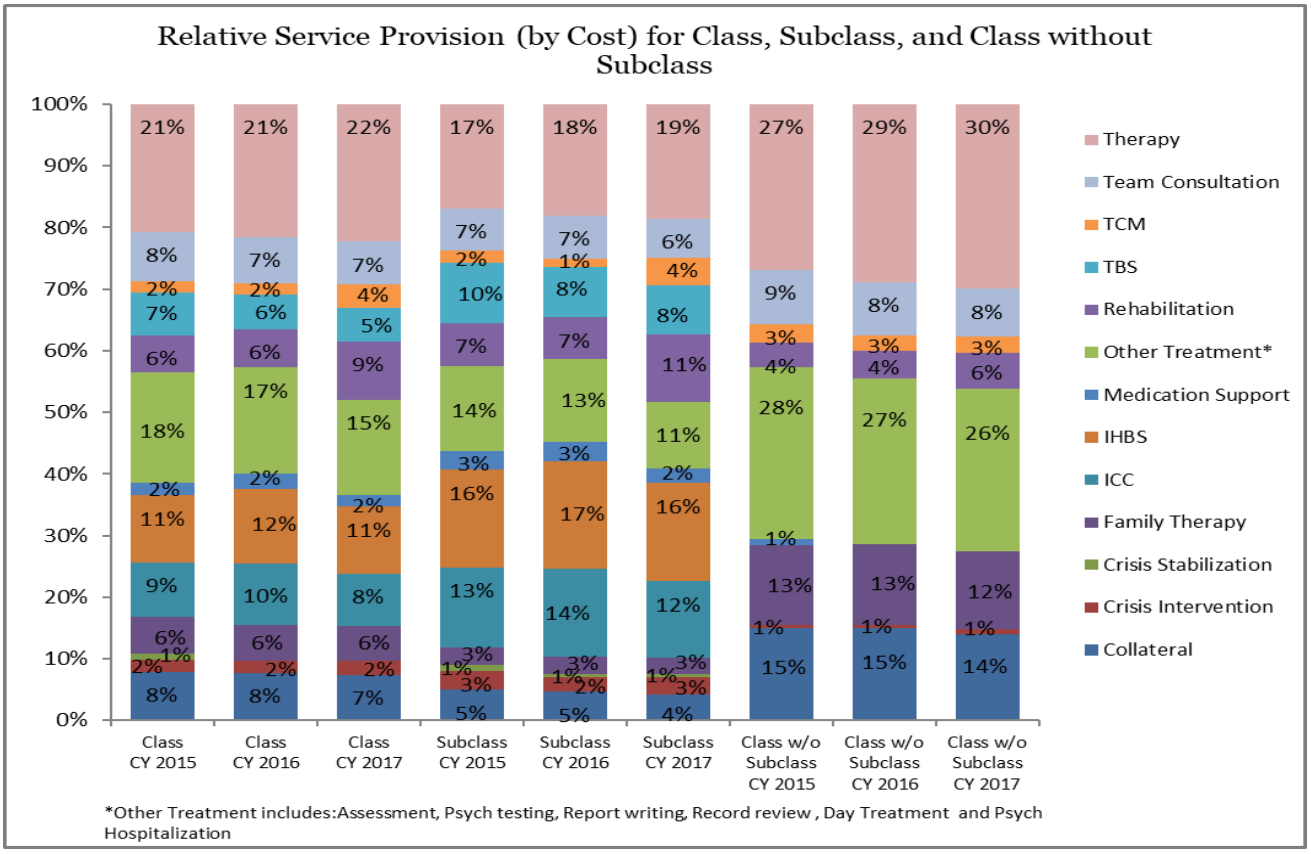
4) The mental health service array varies between class and subclass members. Services included in the array are Team Consultation (TC) and Therapeutic Behavioral Services TBS. TC is a case consultation or team conference, with or without the client present, with the purpose of plan development. It

must include discussion regarding the client's progress, or lack thereof, in treatment and/or discussion of the client's plan for mental health treatment. TBS is an intensive, individualized, one-to-one behavioral coaching program available to children/youth up to age 21 who are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.

In CY 2017, costs analysis indicates that subclass members received less individual therapy than the Class w/o Subclass (Subclass: 19%, Class w/o Subclass: 30%). Subclass members did receive more Targeted Case Management (TCM) and ICC (Subclass: 17%; Class w/o Subclass: 3%), and more rehabilitation services including TBS and IHBS (Subclass: 35%; Class w/o Subclass: 6%).

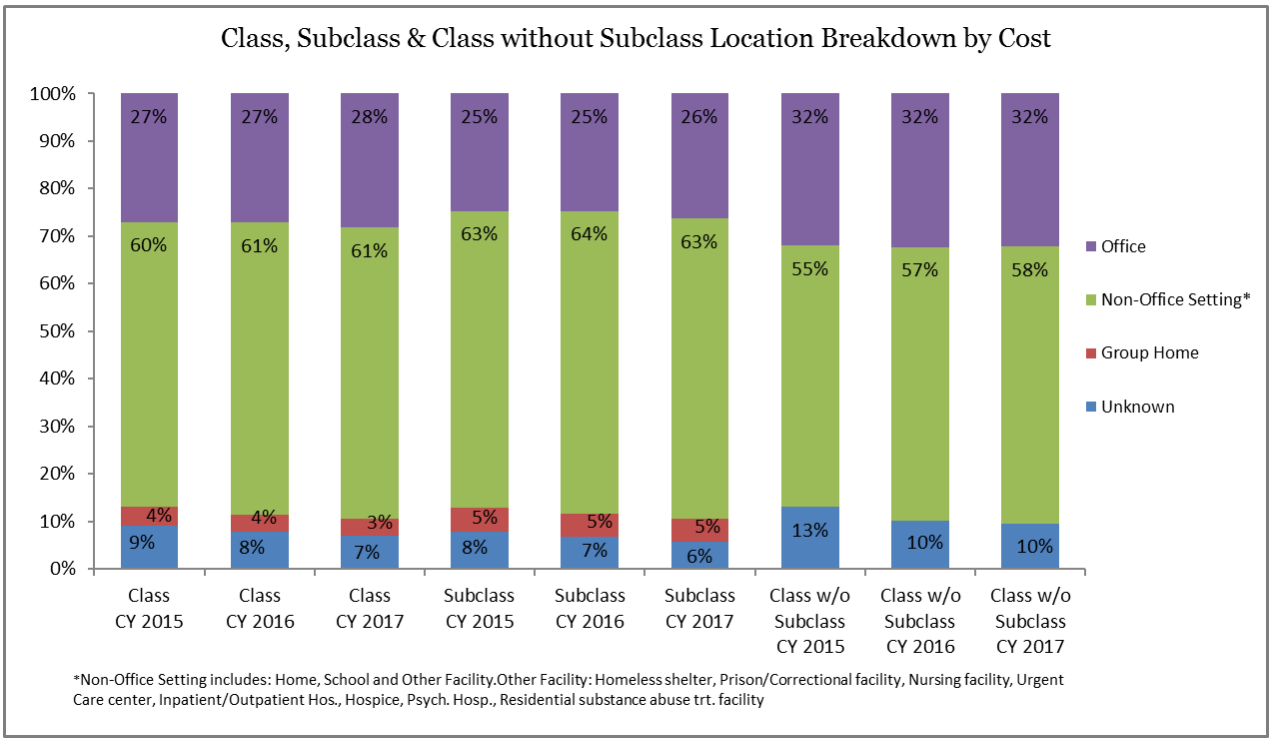
In addition, within the last two calendar years, individual therapy for the Subclass increased slightly (CY 2016: 18%, CY 2017: 19%), TCM and ICC increased (CY 2016: 16%; CY 2017: 17%) as well as rehabilitation services including TBS and IHBS (CY 2016: 32%; CY 2017: 35%). The CY 2017 data indicates that the majority of subclass costs were for individual therapy (19%), IHBS (16%) and ICC (12%).

DMH expects ICC and IHBS services to continue to increase due to recent expansions in the IFCCS and FSP programs. The IFCCS program was expanded from a 100 slot program to 780 slots in CY 2016 and Child FSP providers were allocated additional funding for 30% of their Katie A. slots. Each FSP provider will be accountable for providing a standardized service delivery system to the subclass.



5) The data has been consistent and indicates that there are still more services being provided in the office for the Class w/o Subclass (CY 2015: 32%; CY 2016: 32%; CY 2017: 32%) than for the Subclass (CY 2015: 25%; CY 2016: 25%; CY 2017: 26%). Also, somewhat more services are being provided in non-office settings (home, school, other facility) for the Subclass (CY 2015: 63%; CY 2016: 64%: CY 2017: 63%) than for the Class w/o Subclass (CY 2015: 55%; CY 2016: 57%; CY 2017: 58%). DMH thinks that this may be partly due to subclass members being in need of more intensive mental health services within other types of facilities like psychiatric hospitals and urgent care centers.

It should be noted that for CY 2017, the location of services was unknown for the service claims of 7% of the Class, 6% of the Subclass and 10% of the Class w/o Subclass. DMH believes that this is most likely the result of having two billing systems, the Integrated System (IS) and the Integrated Behavioral Health Information System (IBHIS). DMH expects that claim information will improve once all providers transition to one billing system.



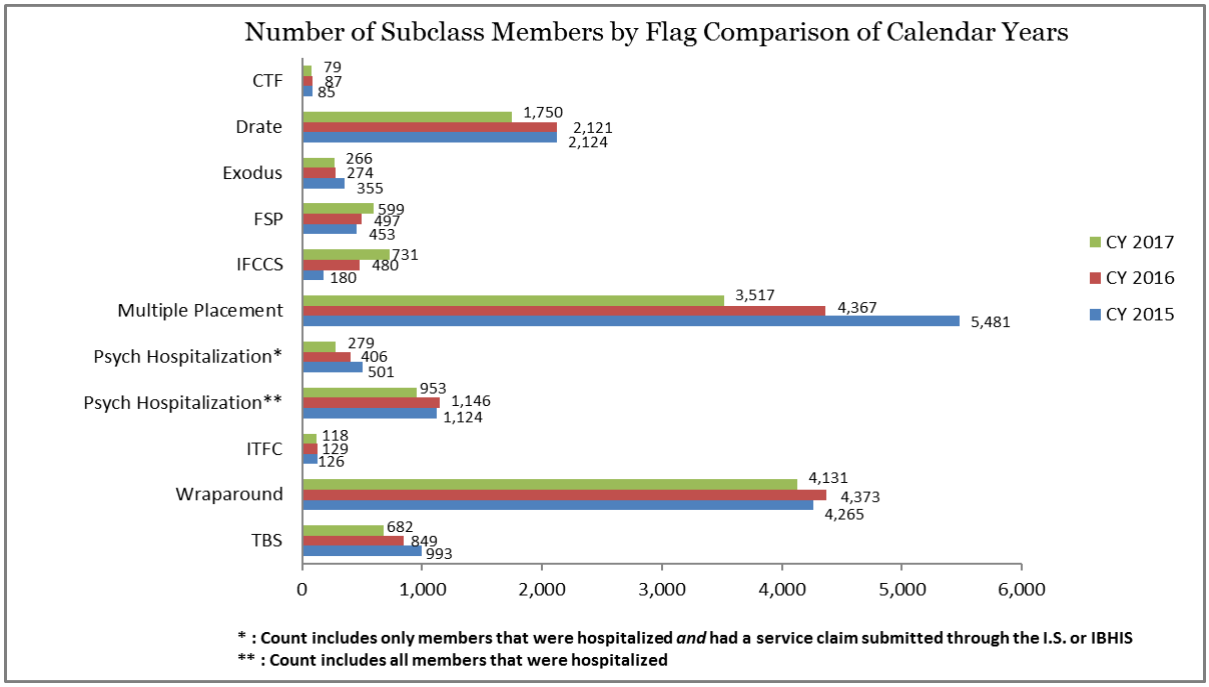
6) DMH developed the following chart that indicates the criteria or programs youth were in that contributed to them being in the subclass. In CY 2017, the majorities of youth were in Wraparound (4,131), had three or more placements (3,517), or placed in a D-Rate home (1,750). Furthermore, many of the youth fell into multiple subclass categories.

There has been an increase in the number of youth enrolled in Full Service Partnership (FSP) (CY 2015: 453; CY 2017: 599) and in IFCCS (CY 2015: 180; CY 2017: 731). The following programs/subclass criteria had a decrease in subclass members since CY 2015: 1) D-Rate (CY 2015: 2,124; CY 2016: 2,121; CY

2017: 1,750), 2) Exodus (CY 2015: 355; CY 2016: 274; CY 2017: 266), 3) Multiple Placements (CY 2015: 5,481; CY 2016: 4,367; CY 2017: 3,517) and TBS (CY 2015: 993; CY 2016: 849; CY 2017: 682).

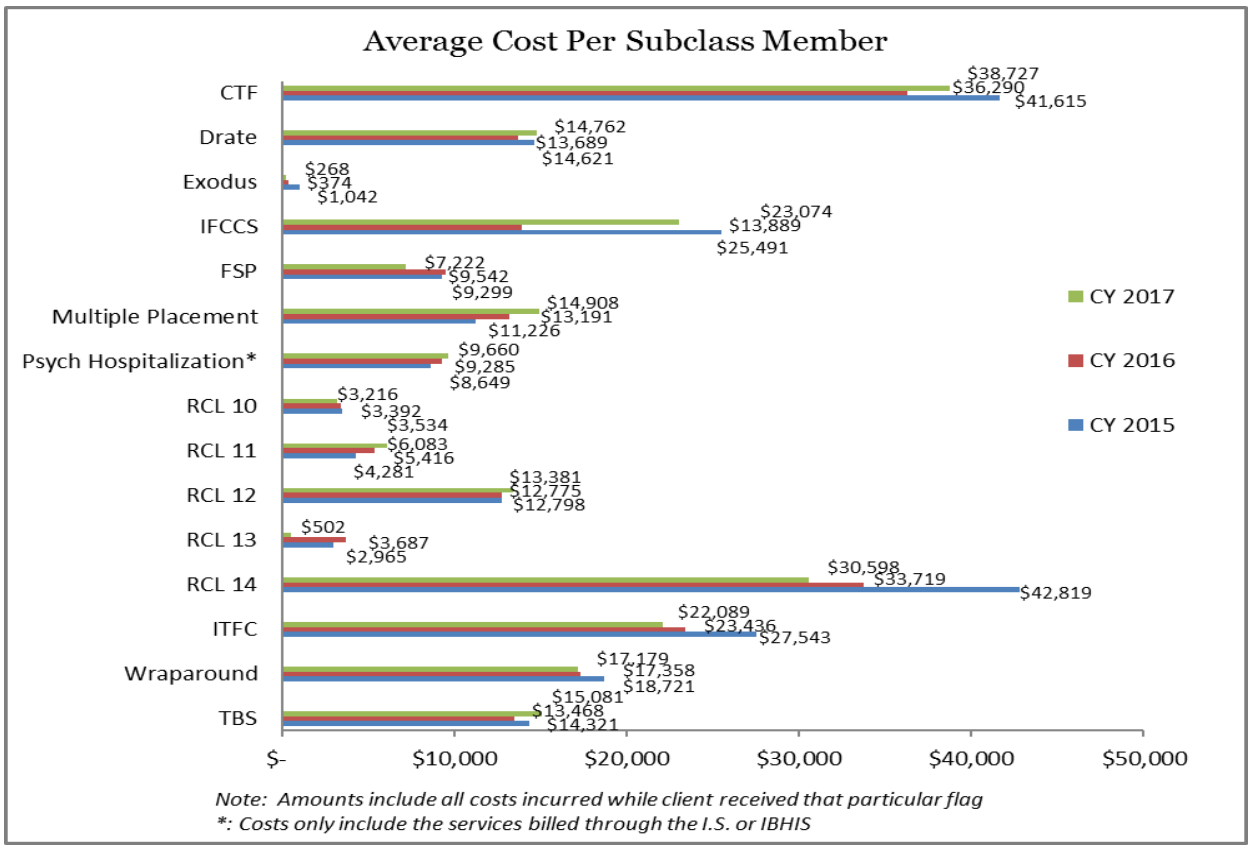
DMH points out that the multiple placement category continues to be refined in an effort to be in line with the State's definition of this category (due to behavioral reasons). The data also show that the number of youth placed in a psychiatric hospital has decreased; however, it is important to note that DMH continues to have difficulty gathering data regarding psychiatric hospitalizations and much of the data is missing or not accurately reported (hospital staff can bypass the I.S. and IBHIS and bill services directly to the State). The graph below includes two hospitalization counts: 1) Psychiatric Hospitalization*: This count only includes members that were hospitalized *and* had a service claim submitted through the I.S. or IBHIS; 2) Psychiatric Hospitalization**: This count includes all members that were hospitalized (regardless of whether a claim was submitted through the I.S. or IBHIS).

[The subclass criteria below include Full Service Partnership (FSP), clients that have had three or more placements within 24 months (Multiple Placement), Intensive Treatment Foster Care (ITFC), Community Treatment Facility (CTF), D-Rate placement, Rate Classification Levels 10-14 (RCL 10–14), Psychiatric Hospitalization (Psych Hospitalization), Wraparound, Exodus, and/or Therapeutic Behavioral Services (TBS)].



7) The average cost associated with the subclass criteria or programs varies greatly, with costs associated with Community Treatment Facilities (CY 2017: $38,727), Rate Classification Level 14 (CY 2017: $30,598) and Intensive Field Capable Clinical Services (IFCCS) (CY 2017: $23,074) being the programs with the highest costs for subclass members in calendar year 2017 (see chart below). The subclass criteria or programs with the lowest average costs were Rate Classification Level 13 (CY 2017: $502) and Exodus (CY: $268).

According to DMH, Psychiatric Hospitalizations only include the costs for claims that were submitted through the I.S. or IBHIS and do not include costs for services that the hospitals may have billed directly to the state. The costs in the following chart only include services billed under one of the procedure code groupers: Therapy, Family Therapy, Collateral, Crisis Intervention, Targeted Case Management (TCM), Therapeutic Behavior Services (TBS), Team Consultation, Rehabilitation, Intensive Care Coordination (ICC), In Home Based Services (IHBS), Medication Support, Crisis Stabilization, Other Treatment (Assessment, Psychological Testing, Report Writing, Record Review, Day Treatment and Psychiatric Hospitalization).



8) Utilization of Evidence-Based and Promising Practices

DMH reports that for CY 2017, 5,675 class members received treatment using an evidence-based or promising practice (EBP). This reflects a decrease from 6,496 in CY 2016. In CY 2017, most class members received Managing and Adapting Practice (MAP) (2,239), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (1,910), Child Parent Psychotherapy (CPP) (799) and Parent-Child Interaction Therapy (PCIT) (570). The only EBP to show a steady of increase of class members since CY 2015 has been Parent-Child Interaction Therapy (PCIT) (CY 2015: 517; CY 2016: 562, CY 2017: 570). The reason for this decline is unknown.

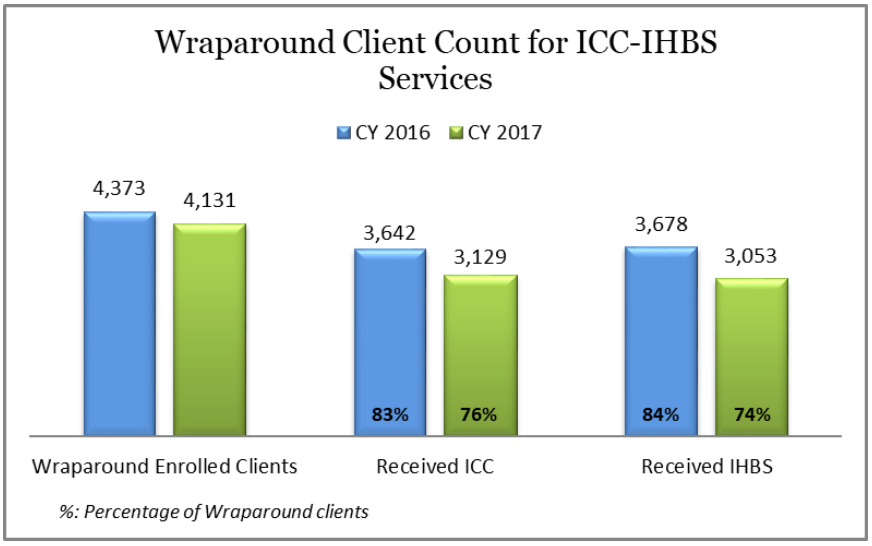
I. EBPs by Calendar Year 2015-2017

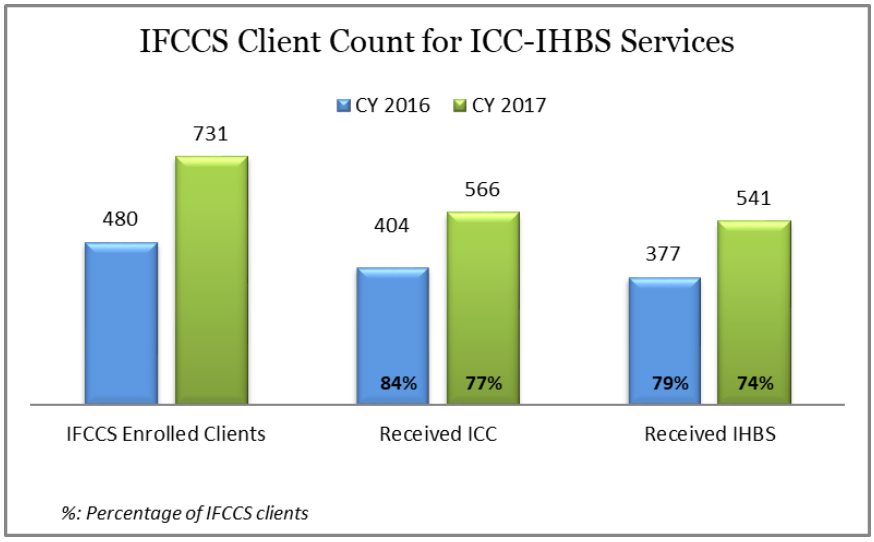
	Number of Clients Served (All Ages)			Number of Legal Entities (All Ages)			Number of Clients Served (Ages 0-5)			Number of Legal Entities (Ages 0-5)		
Evidence Based and Promising Practices	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2015**	**CY 2016**	**CY 2017**
Aggression Replacement Training (ART)	128	**43**	22	16	**11**	7	2	**1**	1	2	**1**	1
Alternatives for Families - Cognitive Behavioral Therapy (AF - CBT)	44	**40**	37	5	**5**	3	2	**1**	1	1	**1**	1
Brief Strategic Therapy	14	**6**	6	7	**3**	4	6	**1**	1	4	**1**	1
Child Parent Psychotherapy (CPP)	1,112	**878**	799	39	**38**	36	1,056	**842**	767	38	**37**	36
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	4	**1**	1	2	**1**	1	2	**0**	0	2	**0**	0
Functional Family Therapy (FFT)	114	**98**	40	10	**9**	4	9	**2**	1	3	**2**	1
Incredible Years (IY)	149	**93**	43	15	**10**	7	65	**35**	12	12	**7**	5
Managing and Adapting Practice (MAP)	2,684	**2,325**	2,239	84	**74**	66	466	**512**	567	52	**51**	47
Multisystemic Therapy (MST)	21	**11**	4	10	**10**	1	2	**3**	2	2	**3**	1
Parent-Child Interaction Therapy (PCIT)	517	**562**	570	42	**44**	37	437	**509**	514	39	**43**	36
Seeking Safety	706	**414**	244	62	**45**	43	7	**3**	1	6	**2**	1
Strengthening Families	5	**4**	2	1	**1**	2	0	**0**	0	0	**0**	0
Trauma Focused - Cognitive Behavioral Therapy (TF-CBT)	2,917	**2,261**	1,910	77	**72**	66	417	**352**	318	46	**49**	40
Triple P Positive Parenting Program	266	**194**	179	29	**27**	25	120	**127**	121	21	**20**	18
UCLA Ties Transition Model	27	**27**	12	2	**2**	2	20	**20**	8	2	**2**	1

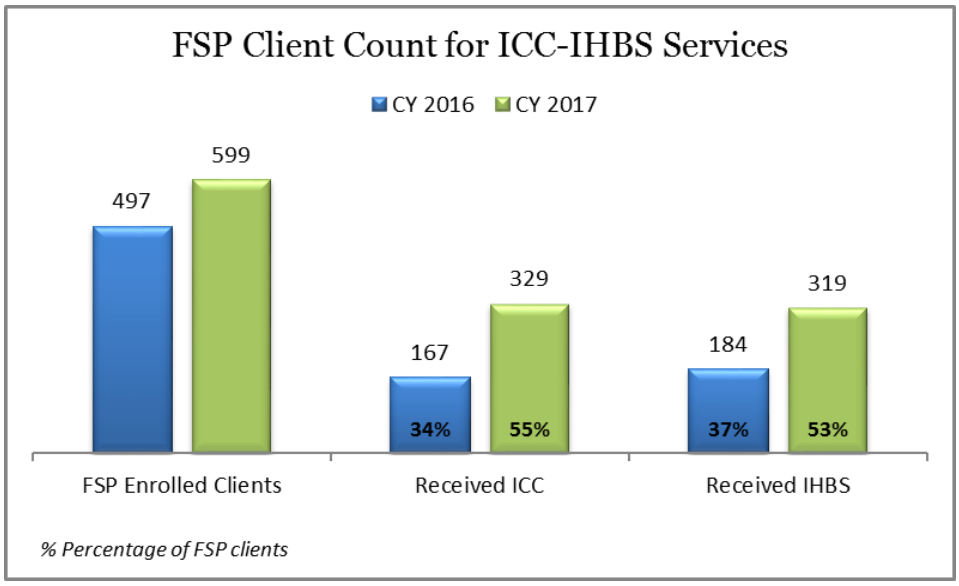
9) Intensive Home-Based Services and Intensive Care Coordination

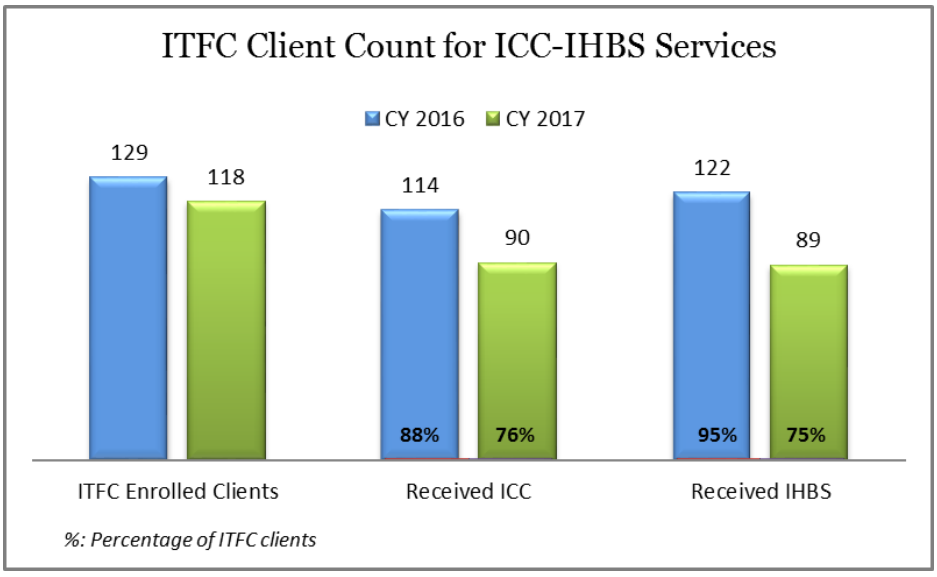
The County has been phasing in ICC and IHBS since FY 12-13. As mentioned previously, DMH expanded IFCCS slots from 100 to 780 in CY 2016. FSP also had a change in FY 2015-16, with providers receiving a funding increase for 1/3 of child FSP slots to be used specifically for Katie A. subclass members.

The graphs below show the number of clients within Intensive Field Capable Clinical Services (IFCCS), Intensive Treatment Foster Care (ITFC), and Wraparound that have received ICC and IHBS during CY 2016 and CY 2017. The percentage of youth that received ICC and IHBS decreased for most of the programs. DMH believes that the decrease is due to claims that are pending submission by providers. As aforementioned, DMH contracted providers have 18 months to submit claims. DMH expects that ICC and IHBS percentages for CY 2017 will increase in the next couple of months as providers submit their claims.



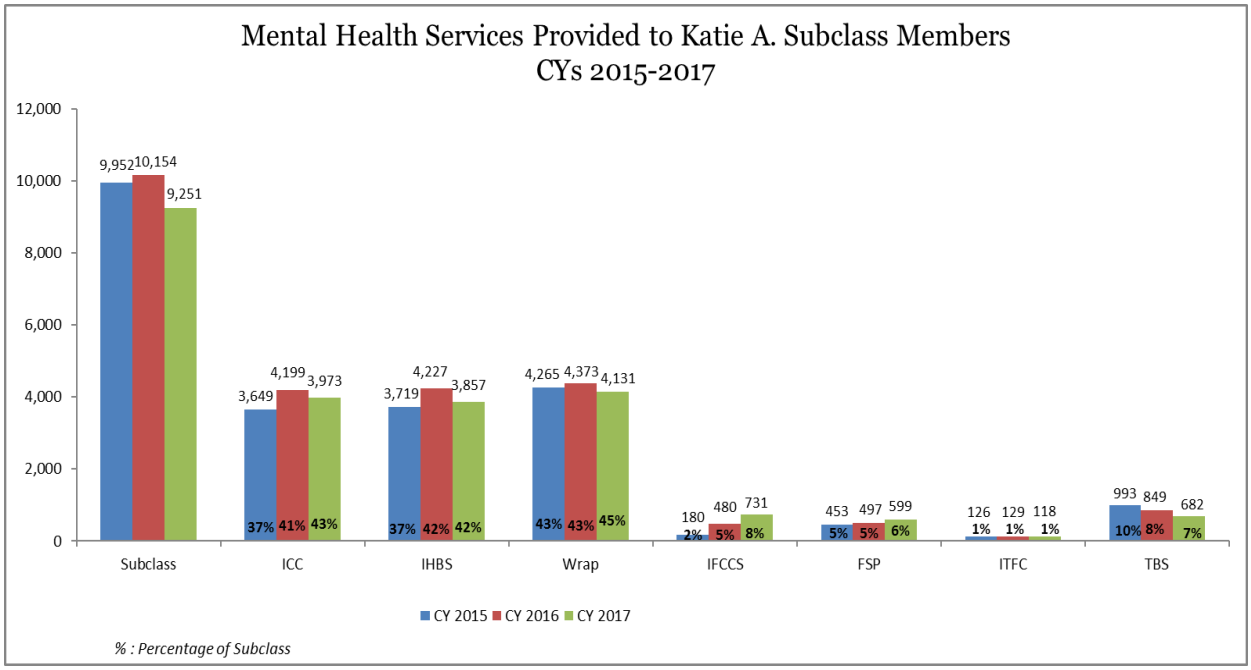






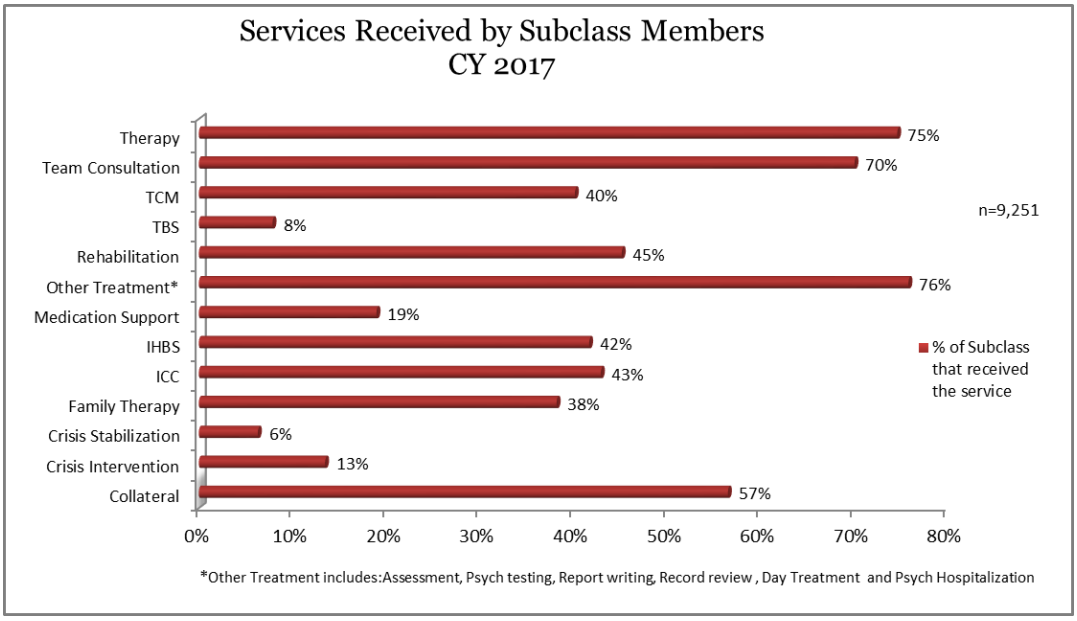
10) Mental Health Services Provided to Katie A. Subclass Members

The following graph provides a breakdown of the numbers and percentages of subclass members during calendar years 2015 to 2017 that have received ICC, IHBS, and other intensives services (Wraparound (Wrap), FSP, IFCCS, ITFC, and TBS). The majority of subclass members received ICC, IHBS and Wraparound services in CY 2017. Some subclass members received more than one service and/or were enrolled in one or more programs during the calendar year.



The graph below indicates the types of mental health services subclass members received CY 2017. Some children/youth received more than one service. The percentage indicates that percent of subclass members that received the service.

The majority of clients received Other Treatment (76%), Therapy (75%), and Team Consultation (70%). IHBS and ICC services were also provided to 42% and 43% of subclass members, respectively.



DMH provided the following summary of its analysis.

1. The data show that the number of subclass members has decreased since CY 2014, making up a smaller percentage of the Katie A. Class. This may be partly due to the decrease in the number of youth that had three or more placements (as subclass indicator) within the last 24 months.

2. While the Subclass made up about 37% of the Class during CY 2017, the Subclass costs made up about 67% of the total Class cost.

3. The average mental health cost associated with subclass members has remained steady over the last three calendar years and is much higher than the average cost of mental health services for class members who are not part of the subclass.

4. In CY 2017, subclass members received less individual therapy than class members who are not part of the subclass. Subclass members did receive more Team Consultation (TC) and Intensive Care Coordination (ICC), and more rehabilitation services including Therapeutic Behavior Services (TBS) and Intensive Home Based Services (IHBS) than the class members who are not part of the subclass.

5. The data have been consistent and indicates that there are still more services being provided in the office for class members who are not part of the subclass (CY 2017: 32%) than for subclass members (CY 2017: 26%). Also, more services are being provided in non-office settings (home, school, other facility) for the subclass (CY 2017: 63%) than for the class w/o subclass (CY 2017: 58%).

6. Consistent with previous years, the majority of youth in the subclass were enrolled in Wraparound, had three or more placements, or were placed in a D-Rate home.

7. The number of class members that received an Evidence-Based Practice or Promising Practice has decreased from CY 2016 (CY 2016: 6,496; CY 2017: 5,675). In CY 2017, the majority of youth received Managing and Adapting Practice (MAP), Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), Child Parent Psychotherapy (CPP) and Parent-Child Interaction Therapy (PCIT).

8. From CY 2016 to CY 2017, the percentage of youth that received ICC and IHBS in Wraparound, IFCCS, and ITFC has decreased while there was an increase in the FSP program. DMH believes that the decrease is due to claims that are pending submission by providers. DMH expects that ICC and IHBS percentages for CY 2017 will increase in the next couple of months as providers submit their claims.

9. In CY 2017, the majority of subclass members received Other Treatment (76%), Therapy (75%), and Team Consultation (70%). IHBS and ICC services were also provided to 42% and 43% of subclass members, respectively.

   Panel Comment: Mental health service data, which is produced by Medicaid claiming reports, covers prior periods, which makes it untimely. For IHBS providers, it is essential that DMH determine the specific elements of rehabilitative services, IHBS and other treatment reported and collect data about quantity of these services provided to subclass members. The one-year data for all subclass members is not informative about what an average subclass member is receiving. It is not possible to determine whether an average of $14,000/year is a lot or a little without know about services being delivered.

Intensive field Capable Intensive Services (IFCCS)

The County reports that Intensive Field Capable Clinical Services (IFCCS) is a field-based program developed in direct response to the State's expansion of services available to Katie A. Subclass members who have intensive mental health needs that are best met in a home-like setting. The goal of these services is to provide a coordinated child and family team approach to service delivery by engaging and assessing children and their families' strengths and underlying needs to minimize psychiatric hospitalizations, placement disruptions, out-of-home placements and involvement with the juvenile justice system. The County provided the following status update.

On July 1, 2016, the IFCCS program expanded from five (5) Legal Entities to twenty one (21) Legal Entities and from one hundred (100) slots to seven sixty five (765) slots. The IFCCS referral portals were expanded from four (4) portals to thirteen (13) portals.

The IFCCS referral portals include the following:

- Child and Youth Crisis Stabilization Team (funded by SB 82)
- DCFS High Risk Services Division
- DMH Emergency Outreach Bureau
- DMH MAT Staff
- DMH Wraparound Liaisons
- Medical HUBs
- Urgent Care Centers/Valley Coordinated
- DCFS Transitional Shelter Care Facilities
- DMH D-Rate Assessment Unit
- DMH Hospital Discharge Unit
- DMH Specialized Foster Care
- IFCCS Providers
- Service Area Child and TAY Navigators

Referrals were received from the following referral portals in 2017:

DMH Specialized Foster Care – 43%
IFCCS Providers – 15%
DCFS Transitional Shelter Care Facilities – 13%
DMH MAT Coordinators – 9%
DMH Hospital Discharge Unit – 5%
DMH Child and TAY Navigators – 2%
Remaining Referral Portals – 12%

The Panel has learned that as of December 30, 2017, IFCCS currently has the capacity for 765 children, but 252 or 33% of those slots are unfilled. In light of the examples brought to the Panel's attention of high

need children disrupting due in part to the lack of intensive mental health intervention, it is surprising and disappointing to learn of this vacancy rate. Ensuring that these services are promptly available to class members should be a high priority for both DMH and DCFS.

IFCCS Program Evaluation:

The Panel has consistently encouraged the County to evaluate its mental health practice, to which the County responded with the Children's Intensive Service Review (CISR). DMH describes the CISR as follows.

> Children's Systems of Care (CSOC) Administration created the Children's Intensive Service Review (CISR) to evaluate the IFCCS Program. DMH views the purpose of the evaluation process as to ensure that IFCCS staff are adhering to the principles of the Shared Core Practice Model and consistently providing high quality mental health services to children and youth meeting the Katie A. Subclass criteria. The CISR process will be conducted by teams of two or more reviewers and can include clinicians, administrators, and parent partners. Parent Partners will lead the interviews with the client's family in order to create an environment most conducive to candid and honest feedback. The IFCCS providers will be scored on the following performance indicators: Engagement, Teaming, Assessment and Understanding, Intervention Adequacy, Child Well-Being. In 2017, the CISR evaluation tool was updated based on feedback from the Katie A. Panel. The primary update was creating a more comprehensive scoring mechanism to accurately evaluate the mental health services. The CISR cases were randomly selected based on being enrolled for six (6) months or more of service and having a history of a psychiatric hospitalization. CSOC Administration successfully completed eleven (11) CISR evaluations in 2017.

Coaching and Training of DCFS and DMH Staff in the Shared Core Practice Model (SCPM)

DMH Coaches provided two Webinars to reach out to supervisors and administrators from the Wraparound agencies in SA 3 and 7. The first webinar was conducted on 3/30/17 on the Leadership and Implementation of the CFT process.
The second webinar was conducted on 5/17/17 that focused on documenting the CFT plan.

DMH COACHING AND TRAINING ACTIVITIES

DMH provided the Panel with the following summary of its coaching and training efforts in 2017.

According to DMH updates, The Child Welfare Division Coaches implemented the Shared Core Practice Model (SCPM), Child and Family Team (CFT) Model, and Underlying Needs training during the reporting period from January through December of 2017. During this reporting period the DMH Coaches trained staff from the Wraparound agencies in the Immersion Service Areas (SA) 3 and 7 in addition to the DMH Wraparound Administration staff. The staff trained participated in the CFT training sequence that included the following trainings:

1. 6 HR SCPM with an emphasis in underlying needs
2. CFT Overview: Preparing for Child and Family Teaming
3. 2 Day CFT Facilitator Training
4. Underlying Needs Training
5. Where Privilege Meets Oppression: Using a cultural lens with the child welfare population

Upon completion of the CFT training sequence DMH coaches offered coaching and consultation to the trained Wraparound Facilitators as they implemented the SCPM and CFT process with children that were identified from the Immersion Pasadena and Belvedere DCFS Offices.

The DMH Coaches developed a 2 Day CFT Facilitator Training which provided an in-depth training on the tenets of the CFT process and the specific facilitation skills required to implement and effective teaming process with children and families. The 2 Day CFT Facilitator Training included mock videos of the CFT process and role play exercises. This new training replaced the see one do one model for training CFT Facilitators, and provided the DMH Coaches with the capacity to train a larger number of CFT Facilitators in a shorter amount of time.

In January of 2017 the DMH Coaches began the CFT training sequence for the Wraparound agencies in SA 3 and SA 7. The DMH Coaches provided several trainings on the SCPM and CFT Overview: Preparing for Child and Family Teaming in both service areas to reach all 11 Wraparound agencies in SA 3 and all 14 Wraparound agencies in SA 7.

By March the DMH Coaches began training Wraparound Facilitators in the 2 Day CFT Facilitator Training. Each agency selected two staff to be trained during the first round of trainings in each service area. DMH states that "By the end of March, 40 CFT Facilitators were fully trained in the CFT process and had acquired the skills to successfully implement the CFT process with children and families. "

DMH also reported the following regarding agency training in Immersion sites.

> Intensive coaching was offered by the DMH Coaches to agencies with identified cases for Immersion. Intensive coaching was individualized and tailored to meet the agency's needs. It provided continuous modeling of CFT facilitation skills. It reinforced strength-based practice principles including family's voice and choice. It emphasized service crafting; individualized, out of the box interventions, tailored to meet the client's underlying needs and recognizing the impact of trauma. The agencies participating in SA 3 were Benvenidos/Hillsides Family Agency, California Mentor Family Support Services Foothill Family Services, and Spiritt. The agencies participating in SA 7 were Alma Family Services, Florence Crittenton Services, Helpline Youth Center and Masada Homes. For agencies without identified cases for immersion, they were invited to participate in monthly coaching conference calls that provided an opportunity for consultations and continued learning of the CFT process.

Additionally, the DMH coaches were available to provide individualized coaching sessions and consultations as needed.

With the transition of the Wraparound Program to DMH, the Coaching Unit provided a 1 Day of the Overview of the CFT Process and the CFT Matrix training to over 100 participants. This training focused on providing participants with an understanding of the CFT process and the expectations of teaming with children and families. In addition, participants received training on how to document the CFT process.

Immersion Provider Meetings

The DMH Coaches hosted Immersion Provider Meetings during this period with staff from all of the Wraparound agencies trained in addition to those providers trained during the Immersion Pilot in SA 6 and SA 2. The first meeting for the year was held on 4/26/17. During this meeting results from the Post CFT Interviews were shared. There was also a skills building workshop on underlying needs. The second meeting was held on 8/16/17 where there was a discussion on the strengths and challenges of the integration of the CFT Process at their agency, and a skills building workshop on the 3 levels of listening to support engagement and teaming practice. The last meeting for this reporting period was held on 12/06/17. There was discussion on how the CFT Process is supporting outcomes for children and families. There was also presentation on developing effective "worry" statements, to support engagement with children, youth, and families.

DMH Administrative Staff

During the last quarter of this reporting period, the DMH Coaches focused their training on the newly hired DMH staff for the expansion of Wraparound, Coaching and QSR Programs. The DMH Coaches provided two round of the CFT Training Sequence to fully train the newly hired DMH administration staff.

DMH Staff Trainings (January 2017 to December 2017)

Child Welfare Division's Training division coordinates monthly trainings to support on-going learning and skill development of mental health staff, community providers and child welfare workers to deliver services to support strengths and needs of children and their families. These trainings are specifically designed and targeted for Department of Mental Health (DMH) Child Welfare Division programs that provide mental health services such as Specialized Foster Care, MAT, Family Preservation, Wraparound, and Treatment Foster Care services to children, youth, and families in the Child Welfare System.

Trainings	Date	Participants
Shared Core Practice Model with an Emphasis on Underlying Needs	1/12/17	SA 7 Children's Wraparound Providers
Shared Core Practice Model	1/12/17	Pathways Community Services
Shared Core Practice Model	1/17/17	DMH Staff and Children's Providers Countywide
Infant and Toddler Development within a Relational Context	1/17/17	DMH staff and Contracted Providers working with Birth to 5 population SA7
Shared Core Practice Model with an Emphasis on Underlying Needs	1/19/17	SA 3 Children's Wraparound Providers
Core Practice Concepts in Working with LGBTQ Youth	1/25/17	DMH Staff and Children's Providers Countywide
Infant and Toddler Development within a Relational Context	1/25/17	DMH staff and Contracted Providers working with Birth to 5 population SA2
Infant and Toddler Development within a Relational Context	1/26/17	DMH staff and Contracted Providers working with Birth to 5 population SA8
Shared Core Practice Model with an Emphasis on Underlying Needs	1/26/17	SA 7 Children's Wraparound Providers
Trauma Informed Practice	1/26/17	DMH Staff and Children's Wraparound; IFCCS; ITFC; and FSP providers Countywide
Infant and Toddler Development within a Relational Context	1/27/17	LA+USC VIP CMHC
Shared Core Practice Model with an Emphasis on Underlying Needs	2/2/17	SA 7 Children's Wraparound Providers
Shared Core Practice Model with an Emphasis on Underlying Needs	2/7/17	SA 3 Children's Wraparound Providers
Shared Core Practice Model with an Emphasis on Underlying Needs	2/9/17	SA 7 Children's Wraparound Providers
Infant and Toddler Development within a Relational Context	2/15/17	SA 7 MAT Assessors
Trauma Informed Practice	2/16/17	DMH Staff and Children's Wraparound; IFCCS; ITFC; and FSP providers Countywide
Shared Core Practice Model	2/16/17	DMH Countywide Resource Services staff
Shared Core Practice Model	2/17/17	El Centro De Amistad
Infant and Toddler Development within a Relational Context	2/22/17	DMH Children's System of Care

Trainings	Date	Participants
Culturally Sensitive Practice: Integration of Core Practice Concepts	2/23/17	DMH Staff and Children's Providers Countywide
Underlying Needs: A Strengths/Needs-Based Service Crafting Approach	3/7/17	DMH Staff and Children's Providers SA2
Core Concepts in Working with LGBTQ Youth	3/16/17	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	3/20/17	Pacific Clinics Family Preservation Program
Child and Family Team Facilitator Training	3/21/17 & 3/22/17	DMH Staff and Wraparound Providers in SA3
Trauma Informed Practice for the Mental Health Professionals	3/23/17	DMH Staff and Children's Providers Countywide
Culturally Sensitive Practice: Integration of Core Practice Concepts	3/28/17	DMH Staff and Children's Providers Countywide
Culturally Sensitive Practice: Integration of Core Practice Concepts	3/29/17	DMH Staff and Children's Providers Countywide
Underlying Needs: A Strengths/Needs-Based Service Crafting Approach	4/4/17	DMH Staff and Children's Providers SA2
Underlying Needs: A Strengths/Needs-Based Service Crafting Approach	4/11/17	DMH Staff and Children's Providers SA2
Shared Core Practice Model	4/18/17	Tessie Cleveland SA6
Shared Core Practice Model	4/25/17	Almansor—Outpatient and Family Preservation
Trauma Informed Practice for the Mental Health Professionals	4/27/17	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	4/28/17	Aviva—SA 4
Infant and Toddler Development within a Relational Context	4/28/17	Star View children's mental health services.
Shared Core Practice Model	5/9/17	Los Angeles Child Guidance Clinic—SA 6
Core Concepts in Working with LGBTQ Youth	5/10/17	DMH Staff and Children's Providers Countywide
Culturally Sensitive Practice: Integration of Core Practice Concepts	5/10/17	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	5/11/17	Children's Institute Inc.—SA 8 Family Preservation

Trainings	Date	Participants
Shared Core Practice Model	5/16/17	Los Angeles Child Guidance Clinic—SA 6
Infant and Toddler Development within a Relational Context	5/17/17	SA 3 DMH MAT and Specialized Foster Care staff
Underlying Needs: A Strengths/Needs-Based Service Crafting Approach	5/19/17	The Help Group SA2
Culturally Sensitive Practice: Integration of Core Practice Concepts	5/24/17	DMH Staff and Children's Providers Countywide
Trauma Informed Practice for the Mental Health Professionals	5/25/17	DMH Staff and Children's Providers Countywide
Infant and Toddler Development within a Relational Context	5/25/17	Helpline Counseling Services—SA 7
Where Privilege Meets Oppression: Utilizing a Cultural Lens with the Child Welfare Population	6/7/17	DMH Staff and Children's Providers Countywide SA2
Core Concepts in Working with LGBTQ Youth	6/8/17	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	6/20/17	DMH Staff and Children's Providers Countywide
Trauma Informed Practice for the Mental Health Professionals	6/22/17	DMH Staff and Children's Providers Countywide
Sensory Integration in School-Aged Children and Youth	6/22/17	DMH staff and Children's Contracted Providers Countywide
Best Practice Interventions with Complex Trauma Victim	6/30/17	DMH staff and Children's Contracted Providers Countywide
Infant and Toddler Development within a Relational Context	7/17/17	Penny Lane Center—Family Preservation
Infant and Toddler Development within a Relational Context	7/21/17	The Help Group—SA 2
Shared Core Practice Model	7/25/17	DMH staff and Children's Contracted Providers Countywide
Infant and Toddler Development within a Relational Context	8/3/17	Pathways Community Services—Family Preservation Program
Shared Core Practice Model	8/4/17	Pacific Clinics Family Preservation and Outpatient
Shared Core Practice Model	8/24/17	DMH staff and Children's Contracted Providers Countywide
Infant and Toddler Development within a Relational Context	8/24/17	DMH staff and Contracted Providers working with Birth to 5 population SA3

Trainings	Date	Participants
Shared Core Practice Model with an Emphasis on Underlying Needs	8/29/17	DMH CWD New-Hire staff
Infant and Toddler Development within a Relational Context	8/30/17	The Children's Center of the Antelope Valley SA1
Where Privilege Meets Oppression: Utilizing a Cultural Lens with the Child Welfare Population	9/6/17	DMH CWD New-Hire staff
Module 1a: Overview Preparing for the Child and Family Teaming	9/13/17	DMH CWD New-Hire staff
Shared Core Practice Model	9/25/17	D 'Veal Family Preservation and Outpatient programs
Underlying Needs: A Strengths/Needs-Based Service Crafting Approach	9/27/17	DMH CWD New-Hire staff
Shared Core Practice Model	9/27/17	Uplift Family Services SA4
Shared Core Practice Model with an Emphasis on Underlying Needs	9/28/17	DMH staff and Children's Contracted Providers Countywide
Module 1a: Overview Preparing for the Child and Family Teaming	10/03/17	DMH CWD New-Hire staff
Infant and Toddler Development within a Relational Context	10/3/17	DMH staff and Contracted Providers working with Birth to 5 population SA7
Child and Family Team Facilitator Training	10/10/17 & 10/11/17	DMH CWD New-Hire staff
Shared Core Practice Model with an Emphasis on Underlying Needs	9/19/17	DMH staff and Children's Contracted Providers Countywide—SA 3
Child and Family Team Facilitator Training	10/25/17 & 10/26/17	Children's Contracted Providers Countywide—SA 3
Infant and Toddler Development within a Relational Context	10/31/17	DMH CWD New-Hire staff
Shared Core Practice Model	11/7/17	DMH staff and Children's Contracted Providers Countywide—SA 7
Shared Core Practice Model with an Emphasis on Underlying Needs	11/9/17	DMH staff and Children's Contracted Providers Countywide—SA 3
Underlying Needs: A Strengths/Needs-Based Service Crafting Approach	11/16/17	DMH staff and Children's Contracted Providers Countywide—SA 3
Module 1a: Overview Preparing for the Child and Family Teaming	12/04/17	DMH CWD staff and Wraparound Contracted Providers
Underlying Needs: A Strengths/Needs-Based Service Crafting Approach	12/08/17	DMH staff and Children's Contracted Providers Countywide—SA 3

Trainings	Date	Participants
Infant and Toddler Development within a Relational Context	12/08/17	The Village Family Services—SA 2
Quality Service Review Foundational Training	12/20/17	DMH staff and Children's Contracted Providers Countywide

The Panel is pleased that DMH is expanding the number of mental health professionals who can facilitate child and family team meetings. However, the DMH strategy to forego the opportunity for staff to observe an actual team meeting and then facilitate a team meeting with a trained coach supporting them as part of the development process in favor of classroom training alone raises serious concerns. DMH took this step to speed up the facilitator certification process; however the Panel believes that this compromise will impair the quality of the CFT process.

IV. DCFS Performance

Training and Coaching

DCFS also provided updates on its coaching and training initiatives.

The Core Practice Model (CPM) team has been collaborating and partnering with various stakeholders in different ways - through presentations, shared collaboration, team meetings, conference calls and in focus groups. Partners have included: the DCFS training section, the Office of Child Protection (OCP), DPSS, DMH, Casey Family Foundation, Recognize Intervene Support Empower (RISE) and the L.A. Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Center, Eliminating Racial Disparity and Disproportionality (ERDD) and GARE (Government Alliance on Race and Equity), Juris Partners, State Partners, community and families. The shared goal is to align and integrate the Shared Core Practice Model (SCPM) and Child and Family Teams (CFT) into everyday Social Work practice. This is an intentional effort to skillfully coach and train staff in the Strengths, Needs, Service Crafting model of practice. To this end, the CPM team's focus has been:

1. Alignment and Integration;
2. Crafting a Coaching Practice; and
3. Installing the practice using an Implementation Structures framework.

Alignment and Integration

Messaging has been a particular focus for the team. When interacting with partners and communities, the team uses several tools to ground the CPM work:

- Gettothecore.org
- CPM Handbook

- CPM cube
- 23 Practice Behavior flashcards
- QSR pamphlet
- Tool and Resource Kit from the State, received 3/2018

Strengths Needs Service Crafting (SNSC)

The CPM team has continued to work directly with Dr. Marty Beyer, Katie A. Panel member, since in August 2015, to align practice across systems, using a **Strengths Needs Service Crafting** lens. We have learned that Strengths Needs Service Crafting (SNSC) is a way of thinking and being; it's how staff practice with providers, stakeholders, partners, other staff and families. The CPM team co-created curriculum that is responsive to the needs of the various partners. This collaborative approach has inspired the team to build a framework for sustainable practice.

The CPM team, in partnership with Dr. Marty Beyer, convened several focus groups which included:

- ER/DI/CS SCSWs
- Coaching skills groups
- Coaching Roundtable team
- DMH community providers
- Immersion offices
- New hire Academy group

These focus groups served as learning opportunities to expose staff to SNSC practice, deepen understanding and practice, and support the transfer of learning and skill development. These focus groups helped to inform teaching strategies, as the small teams allowed for practice and feedback.

With the guidance of Dr. Marty Beyer, the SNSC Curriculum team has begun to focus outside of the CFT and to look at practice in unit meetings during home visits and family visits, and to consider every meeting as an opportunity for engagement, teamwork and practice.

In August 2017, the team launched the first SNSC practice module with the Van Nuys office. Below is a very broad overview of the curriculum the team co-created with Dr. Beyer.

Strengths Needs Service Crafting
Curriculum is delivered to staff in small groups, while sitting at tables of 6-7. Context Setting, Opening/Welcome (.5hr) Video is recommended: • Morning Session for CSWs and SCSWs 1. (1.25 hr.) Strengths-Functional Strengths (SFS). Functional Strengths are everyday activities that can be operationalized to support case planning. SFS Tablework. ▪ ACT (Affirm, Counter and Transform) Role Play ▪ IVI (intent, value, and impact) ▪ Documentation discussion and examples, integrated throughout the discussion. 2. (1.25 hr.) Underlying Needs and Service Crafting, Tablework.

3. Tools

- Afternoon Session for SCSWs
  1. (1hr.) Tablework to practice facilitating the SNSC in a unit meeting, to deepen practice and develop skills at the SCSW level.
  2. (1hr.) Facilitation team panel discussion; Feedback and debrief with SCSW.

Offices	Date	Participants	Skills	CPM practice behaviors
Van Nuys	August 29, 2017	About 30 CSWs 8 SCSWs	- Identify and affirm strengths - Convert strengths to functional strengths identifying underlying needs, trauma needs and developmental needs - Practice crafting unique services and supports - Exploring solutions - asking who can help - Documentation	Ask global questions Use understandable language Engagement Facilitating honest dialogue Assessment and Visitation Activities Solution focused
Palmdale	March 12, 2018	About 30 CSWs 12 SCSWs		
Metro North, South County and Vermont	March 15, 2018	About 30 CSWs and 9 SCSWs		

Skills Lab

Dr. Beyer visited a skills lab and was supportive of this coaching and training approach.

The CFT Skills Lab is designed to strengthen the understanding of Core Practice Model (CPM) and Child and Family Team (CFT) practice, support use of the CPM, and expose participants to the four steps of the CFT meeting process for the purposes of alignment and integration. The CFT Skills Lab is provided by the CPM Coaching Team and is offered to staff in the regional offices and specialized programs. SCSWs are expected to attend to provide leadership and support to their unit and to support practice change. The county-wide coaching team supports the process through demonstration of CPM skills that promote staff development and use of the model. Participation in the skills lab serves as a "See One" for the CFT certification process.

Goals: Strengthen staff's understanding of the Core Practice Model and Child and Family Teaming (CFT) through exposure and practice; connect outcomes to practice**;** provide a supportive, experiential environment for staff that builds competencies and supports use of the model.

Objectives: Provide opportunities for staff to practice facilitation, with an SCSW coach/facilitator and unit member support; help staff understand the power of the CFT, through participation in vignettes, as they take on different roles; reduce/eliminate staffs worries of facilitation by providing SCSW and coaching support through an observation and feedback process**;** thread the significance of outcomes throughout the lab.

2017 CPM Skills Labs

Dates	Selected Location	Number Attendees
Nov 9/10	West L.A.	55
Dec 21/Jan 17	Torrance	50
Jan 26/Feb 02	Santa Fe Springs	45

Feb 13 /17	Palmdale	70
Feb 23	Chatsworth	51
Mar 9/23	Metro North	70
Mar 7/14	Wateridge (N) & (S)	70
Mar 21	Santa Clarita	40
Apr 13/20	Vermont Corridor	60
April 6	Compton	45
May 4	Torrance	35
May 9	Pasadena	21
May 18/ 30	Pomona	104 w/ Marty
June 15/21	Glendora	32
July 6	South County	35
July 12/18	Van Nuys	50
Sept 12/Oct 3	Lancaster	50
Sept 19/Sept 26	MCMS	50
Total		**933 Participants**

CFT Skills Lab Outcome Summary Report

The following summary reflects data that was collected for the CFT Skills Labs in participating regional offices to date. Subsequent evaluations of the CFT Skills Lab will be provided as data becomes available.

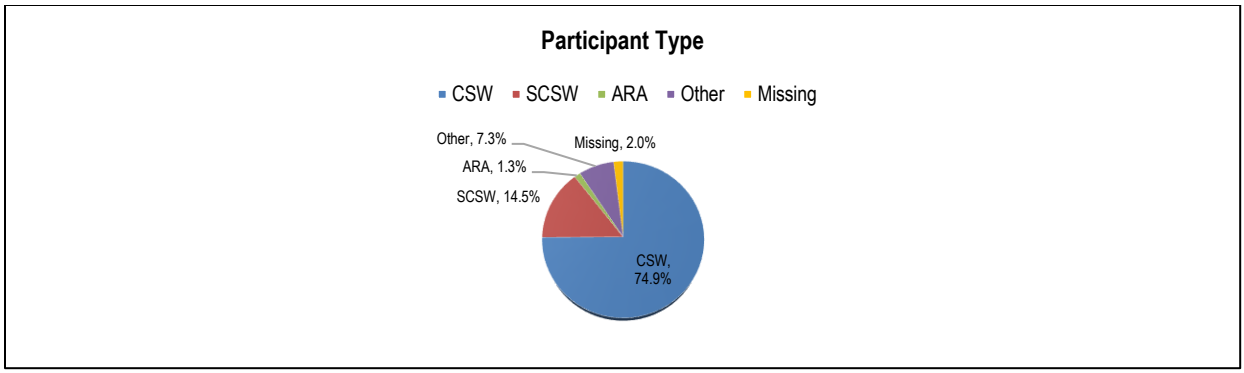
Methodology:

The CFT Skills Lab Evaluation Questionnaire was developed to evaluate the skills acquired during the CFT Skills Lab. The questionnaire is administered at the conclusion of each lab and consists of 10 items rated on a Likert-type scale where "1" indicates "strongly disagree", and "4" indicates "strongly agree." Additionally, demographic data is collected from participants.

Results:

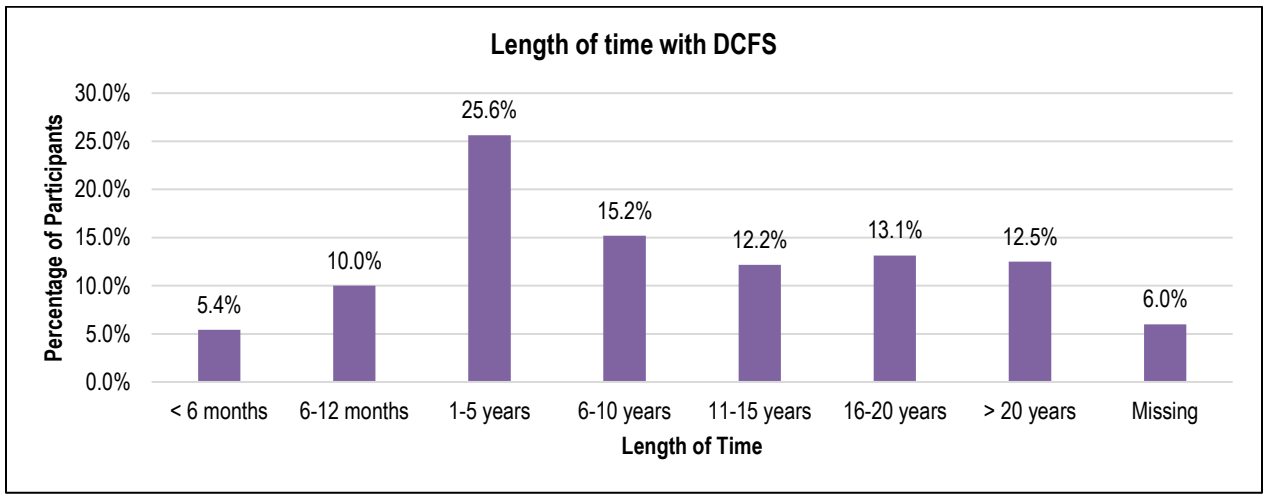
A total of 921 participants took part in the CFT Skills Lab and completed an evaluation questionnaire. Most participants (74.9%) were CSWs. The length of time that participants had been with the department varied across time (see Figures 1 and 2 below).

Figure 1. *Participant Type (N = 921)*



Data Source: CFT Skills Lab Evaluation Questionnaire, SurveyMonkey database. Extracted on 1/4/18.

Figure 2. *Length of Time with DCFS (N = 921)*



Data Source: CFT Skills Lab Evaluation Questionnaire, SurveyMonkey database. Extracted on 1/4/18.

Regarding participants' experience during the CFT Skills Lab, a weighted average of 3.00 or higher was achieved for each statement/measure asked except for the statements regarding understanding how to enter data into the CFT database (mean = 2.62) (see Table 1).

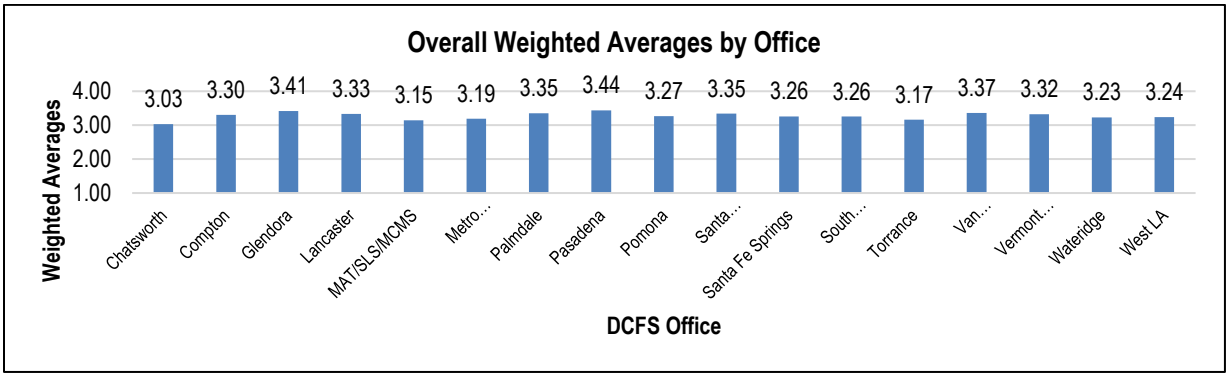
Table 1. *Summary of Percentages and Weighted Averages for the CFT Skills Lab Evaluation Questionnaire (N = 921)*

Measures	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)	Total Responses	Mean
1. I have a clear understanding of the differences between the Core Practice Model and the Child and Family Team (CFT) meeting.	1.5%	3.6%	59.1%	35.7%	915	3.29
2. I understand the importance of the Quality Service Review (QSR) in measuring effective team functioning and CFT performance.	1.4%	9.0%	59.2%	30.3%	910	3.18
3. Reviewing the vignette for the family was effective in helping me build upon the family's story and identifying their underlying needs and strengths.	1.4%	2.9%	53.1%	42.6%	904	3.37

4. I feel confident in creating trustful working relationships with children and their families.	1.1%	0.8%	51.1%	47.0%	919	3.44
5. Modeling the CFT practice helped me to understand how to effectively facilitate CFT meetings.	1.0%	2.7%	52.4%	44.0%	903	3.39
6. I feel that the various CFT tools (e.g., CFT Coaching Guide, Family Engagement Form, and CFT Meeting Notes) are helpful in tracking and documenting the progress of CFT meetings.	1.1%	1.4%	56.5%	41.0%	903	3.37
7. I have a clear understanding of how to enter data from a CFT meeting into the CFT database.	14.0%	29.9%	38.1%	18.0%	866	2.60
8. I feel that the CFT practice is effective in helping families develop their goals and in tailoring plans to meet the child and family's individual needs.	0.9%	1.1%	51.3%	46.7%	906	3.44
9. The Coach/Coach Developer provided adequate instructions and modeling of the CFT practice.	0.9%	1.5%	39.9%	57.7%	907	3.54
10. I feel confident in facilitating CFT meetings.	2.4%	15.6%	59.9%	22.1%	890	3.02

Data Source: CFT Skills Lab Evaluation Questionnaire, SurveyMonkey database. Extracted on 1/4/18.
Note: The "mean" reflects the weighted average for each statement and excludes missing values.

Figure 3. *Overall Weighted Averages for the CFT Skills Lab Evaluation Questionnaire by Office (N = 921)*



Data Source: CFT Skills Lab Evaluation Questionnaire, SurveyMonkey database. Extracted on 1/4/18.

Limitations:

It was later discovered that the measure on understanding CFT data entry was not a part of the core goals of the CFT Skills Lab and has subsequently been removed from the questionnaire.

Conclusion:

The findings presented here indicated that participants had an overall positive experience. They were able to understand the concepts of the CPM and CFT meeting process and understand what the work looks like in everyday practice. The participants also felt that the modeling of the CFT meeting process and the available tools/resources were helpful in understanding how to facilitate a CFT meeting. However, additional training and practice may be needed for participants to build up their confidence in facilitating CFT meetings. In the short term, the results will be used to improve CFT Skills Lab training methods and

delivery. Looking forward, the findings will be used to support the forthcoming *CFT* Evaluation to assess the extent to which the skills and knowledge gained during trainings such as the CFT Skills Lab are effectively applied and maintained in everyday practice.

Module 3:

From April 1, 2016 through September 30, 2017, Tricia Mosher Consultants (TMC) Tricia Mosher and Alissa Kraman facilitated Module 3 training in collaboration with the Core Practice Model team. Module 3 is required to become a Coach or Coach Developer. TMC provided direct coaching and support to DCFS and DMH training facilitators to help align the practice and to build capacity. Effective October 2017, the CPM Coaching team assumed full responsibility for Module 3 delivery. The following table reflects the number of certified facilitators in Calendar Year 2017:

	Facilitator		Coach		Coach Developer		Total
Regional SCSW (592)	118	20%	393	66%	57	9.6%	568
Regional CSW (3114)	1,971	63%	23	1%	0		1,994
*Regional/ Other	55		25		20		100

* includes regional ARAs, CSAs, and program staff

2017/2018 MODULE 3 SESSIONS

Dates	Selected Location (Host Office)	Number of Enrollees
January 3 – 4, 2017	Wateridge Office	14
January 24 – 25, 2017	Lancaster Office	11
February 7 – 8, 2017	Metro North Office	Cancelled
February 22 – 23, 2017	Santa Fe Springs Office	19
March 28 – 29, 2017	Belvedere Office	14
April 4 – 5, 2017	Santa Clarita Office	15
April 19 – 20, 2017	Torrance Office	Cancelled
May 10 – 11, 2017	El Monte Office	21
May 24 – 25, 2017	South County Community Facility	25
June 7 – 8, 2017	Glendora Community Facility	24
August 16 – 17, 2017	Santa Clarita Office	11
August 30 – 31, 2017	Baldwin Park Library	11
September 27 – 28, 2017	Santa Fe Springs Office	11
October 18 – 19, 2017	Van Nuys Office	Cancelled

November 15 – 16, 2017	Compton West Office	10
January 17 – 18, 2018	Belvedere Office	26
February 21 – 22, 2018	Lancaster Office	25
March 21 – 22, 2018	Metro North Office	21
April 18 – 19, 2018	Torrance Office	17
May 16 – 17, 2018	Glendora Office	7

Crafting a Coaching Practice

Coaching Team: The coaching team is comprised of one CSA II, to provide support and guidance, thirteen CSA I County-wide lead Coaches, and one CSA I administrative staff.

The team and its leadership provides the following supports: certification, unit case coaching, individual case coaching, curriculum development, Skills Labs, skill development-coaching cycles/groups, Modules 1a, 1b, 2, 3 and SCPM Implementation Team support, participation on various workgroups as subject matter expert, attendance at the Waiver learning circle, and on steering committees as needed.

Coaching Leadership Opportunities: Participating in national coaching conferences has provided opportunities to share the Los Angeles model, but also to collaborate with other jurisdictions.

Coaching Roundtable: The purpose of the roundtable is to create a shared, supportive learning environment to discuss lessons learned, office protocols, and barriers, while also creating a space to address the operational and developmental needs of Coaches.

The goal is to equip regional staff, partners, stakeholders and agency staff with skills to support and sustain practice. The participants are, in turn, to coach and train their staff to build coaching capacity.

Roundtable Date	**Skill or Discussion Topic**	**Attendees**
March 1, 2018	Operational Follow-up	16 DCFS offices
February 7, 2018	Strengths-Functional Strengths	12 DCFS offices, RISE and DMH
January 3, 2018	Fidelity: review the CFT Agenda	10 DCFS offices, DMH and RISE
December 6, 2017	Fidelity: Review	16 DCFS offices
November 1, 2017	Skill Development: DMH Mapping, Genograms	14 DCFS offices, DMH
October 4, 2017	Fidelity, overview	
September 2017	Skill Development: Family Story	19 DCFS offices
August 2017	Skill Development: deepening Listening skills, Active Listening and Helping Styles	16 DCFS offices, Casey
July 5, 2017	Skill Development: 3 levels of listening	14 DCFS offices, DMH, Casey, sensitive case unit
June 2017	Skill Development: Introducing listening	12 DCFS offices, DMH

May 3, 2017	Skill development: Staff Engagement and Coaching Model (70% skill building -20% reflective practice - 10% support NIRN)	15 offices represented, Sensitive Case unit, DMH, DCFS Training

Coaching Skills Development: Listening Skills

Listening is a skill and one of 23 Practice Behaviors. The CPM countywide Coaches committed to coach and train each of their two offices in reflective listening.

Method

Week 1: SCSW group
Week 2: CSW group and SCSW observation
Week 3: CSW group and SCSW observation
Week 4: SCSW feedback and observation

Three Levels of Listening			
Office	% SCSW Participation	% CSW Participation	Coaching Date
Belvedere Corporate	100%	82%	Oct/Nov 2017
Covina	100%	88%	
El Monte	100%	100%	
Glendora	53%	32%	Sept/Oct 2017
Lancaster	36%	61%	Oct/Nov 2017
Pomona	100%	69%	Oct/Nov 2017
Santa Clarita	80%	76%	Oct/Nov 2017
Santa Fe Springs	100%	92%	Oct/Nov 2017
Torrance	100%	80%	Oct/Nov 2017
Van Nuys	62%	65%	Nov/Dec 2017
Vermont	58%	53%	Oct/Nov 2017
Wateridge N/S	75%	25%	
West San Fernando Valley	95%	89%	Sept/Oct 2017
WLA	38%	31%	Oct/Nov 2017
Total	73% SCSW participation	63% CSW participation	

**Staffing as of August 2017 info is point in time. Surveys were distributed; the information is currently being compiled.*

Implementation Technical Assistance

The CPM team was a part of the California Partners for Permanency (CAPP) grant, which earmarked funds to focus on the disproportionate outcomes for African American and Native American children in the child welfare system. Technical support from the CAPP grant included weekly conference calls with Implementation Specialists who supported LA practice and helped to provide an implementation lens for installing CPM. The 23 Practice Behaviors were co-created by community and CAPP funded the Los Angeles County supply of flash cards.

Implementation Drivers

- Coaching and Training: Much of the work through Coaching and Training is represented above.

- Data and Tracking: Los Angeles County has a team that works with BIS regarding CFT data collection.

- Selection and Retention: The Coaching team has tested an approach from Humboldt County as a part of its selection process.

- Linked Leadership: Historically CPM practice structures include both Design and Implementation teams at the county-wide level and at the regional level. The CPM teams regularly attend and support these meetings.

- Community Engagement: The CPM team has worked to have a collaborative and shared approach to CPM and CFT installation.

Implementation Terms of Reference

The CPM team crafted terms of reference, to help define the role of the countywide coaching team in the organization.

- Mission: The countywide coach team supports the development of staff's skillful and ongoing use of, and confidence in, the **Core Practice Model 23 Practice Behaviors**.

- Objectives and Functions: To support staff's skillful and ongoing use of the CPM 23 Practice Behaviors and, through system coaching, to create a nurturing environment for use of CPM 23 at all levels. This includes ongoing attention to supporting staff and other functions.

The team also identified values and principles, characteristics and competencies, team membership and communication, deliverables, authority and boundaries.

Likewise, every Regional Office developed terms of reference for the functioning of their implementation structures. Copies of these documents were collected and bound to support a formal implementation charter.

Wraparound Services

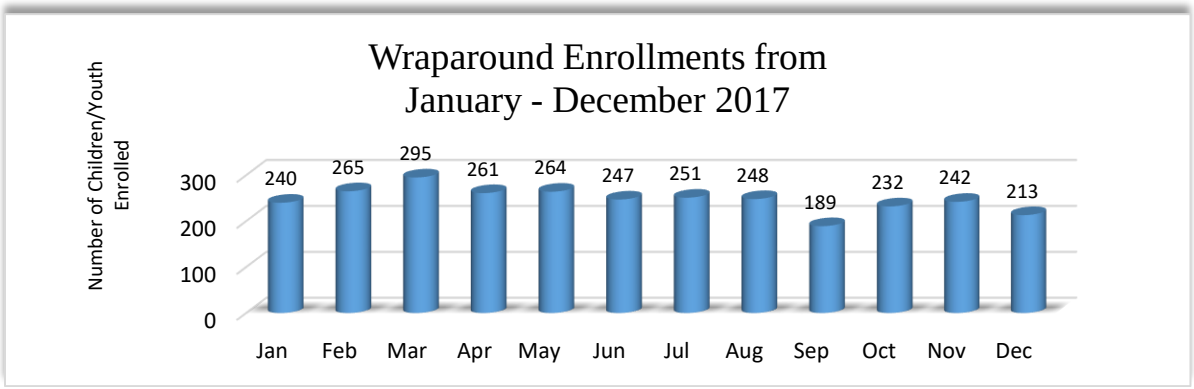
In April 2015, the Los Angeles County Board of Supervisors approved a motion instructing the Chief Executive Officer to work with the Directors of DCFS and DMH to achieve optimal arrangements for administrative and programmatic oversight of Wraparound and transition the administration of the contracts from DCFS to DMH. DCFS and DMH planned a two-phase transition, beginning in June 2016. In Phase I, which was completed in May 2017, DMH amended its Legal Entity (LE) Agreements with all Wraparound providers to incorporate the Wraparound services into the LE Agreements. DCFS retained

the client start/stop function and the case rate payment function until DMH could develop its own electronic system for these functions and implement them in Phase II.

The County provided the update below to describe Wraparound developments in 2017.

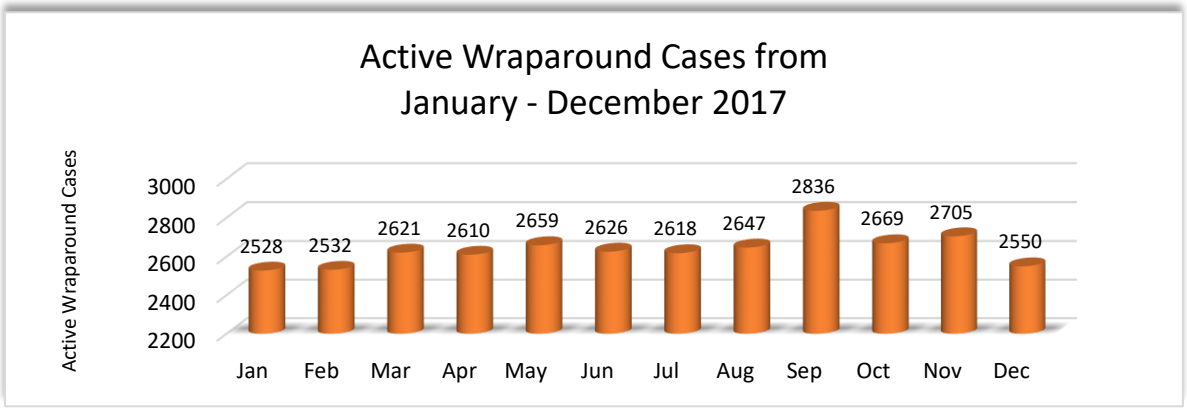
DMH has now developed a Wraparound Tracking System (WTS) for the client start/stop function and payment of the case rate. DMH has provided trainings for Wraparound Providers on the newly established WTS. DMH is currently targeting July 1, 2018 as the date that Providers will be responsible for the timely inputting of case rate claims into the WTS for reimbursement by DMH.

From January through December, 2017, a total of 2,947 children/youth were enrolled in Wraparound. The following tables show monthly enrollments and active cases by month.



Data Source-DCFS Wraparound System - 5/10/2018

From January through December 2017, there was an average of 2,633 monthly active Wraparound cases:



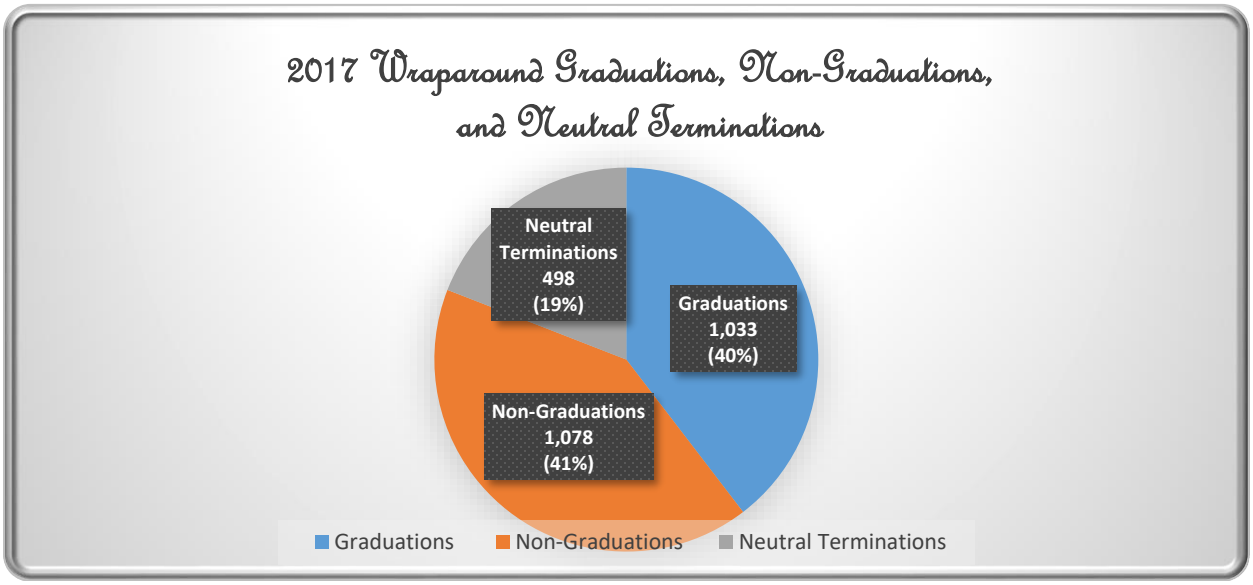
Data Source-DCFS Wraparound System – 5/10/2018

Wraparound Graduations, Neutral Terminations and Terminations by Category

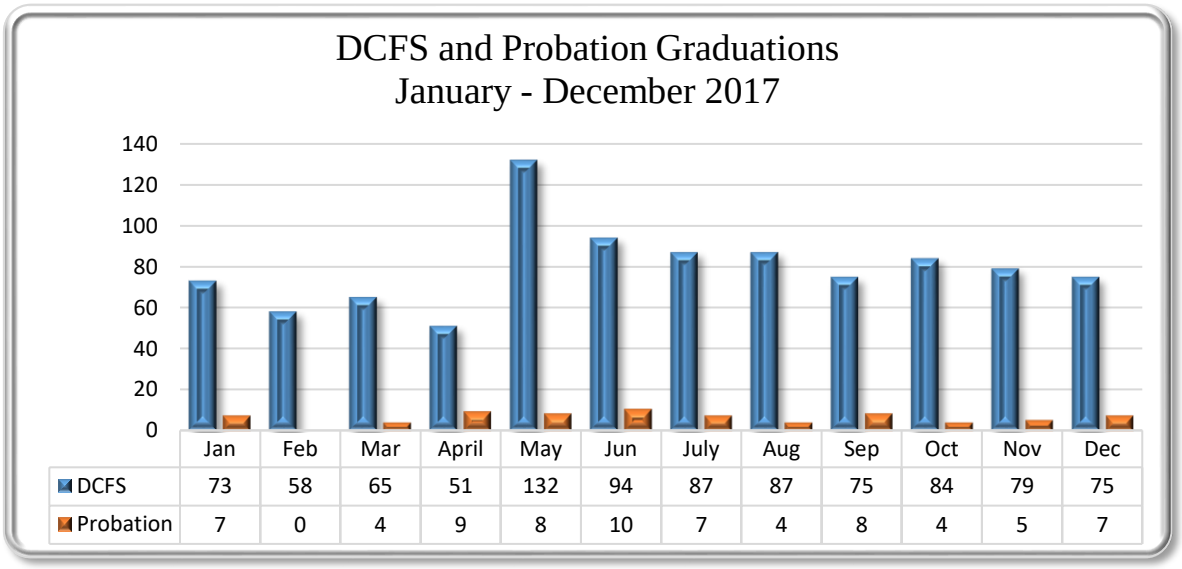
Wraparound exits from both DCFS and the Department of Probation totaled 2,609:

- Graduations for both departments totaled 1,033
- Non-Graduations for both departments totaled 1,078
- Neutral terminations for both departments totaled 498

Graduation is defined when a Wraparound child, youth and family successfully exits the Wraparound program. Non-graduation (i.e. termination) is defined when a Wraparound child, youth, and family prematurely exits the Wraparound program. These terminations include subcategories that have been identified by DCFS as a neutral termination under the following categories: County Case Closure under DCFS and Probation, Family Moving, or Out of County or State Placements.



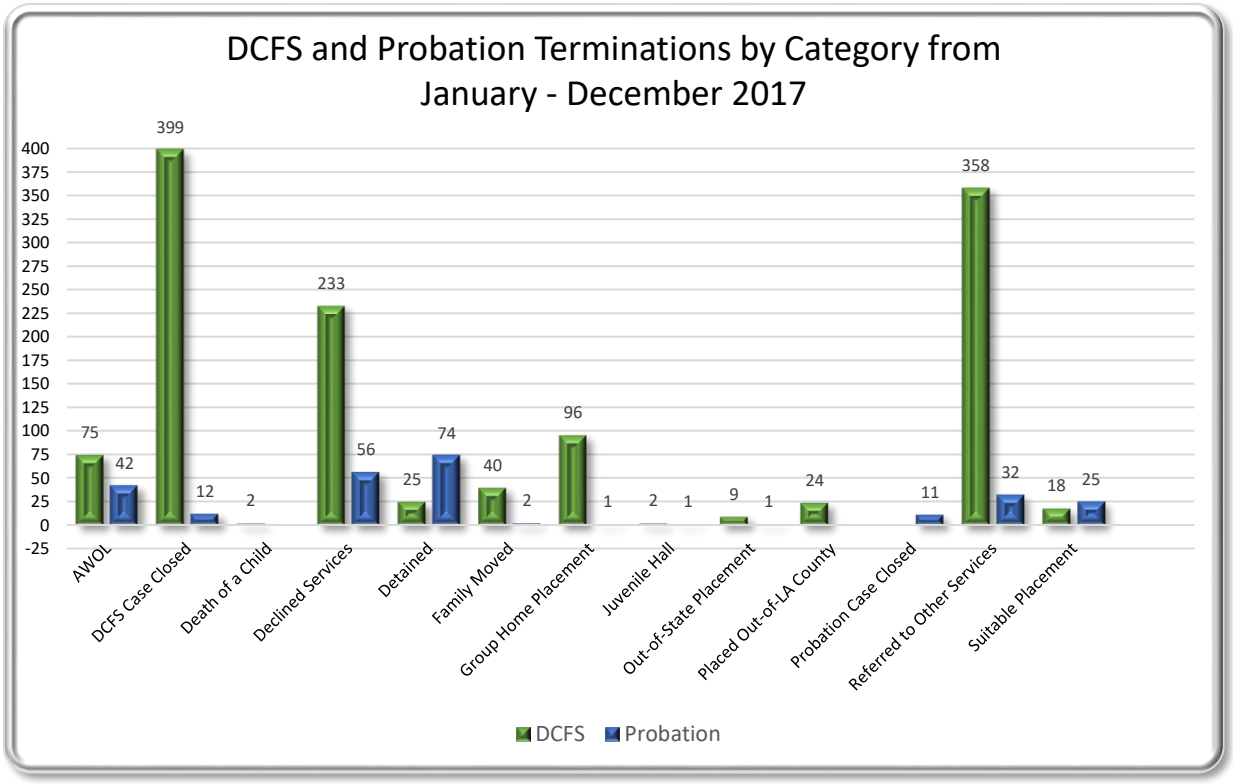
Data Source-DCFS Wraparound System – 5/10/2018



	Jan	Feb	Mar	April	May	Jun	July	Aug	Sep	Oct	Nov	Dec
DCFS	73	58	65	51	132	94	87	87	75	84	79	75
Probation	7	0	4	9	8	10	7	4	8	4	5	7

DCFS Graduation Total - 960 **Probation Graduation Total – 73** **Grand Total = 1,033**

Data Source-DCFS Wraparound System – 5/10/18



Data Source-DCFS Wraparound System – 5/10/2018

As of December 30, 2017, Wraparound was serving 2,177 children and had 573 vacancies or a 21% vacancy rate. The Panel has raised concerns about the Wrap vacancy rate in prior reports. Many of the children with unmet high mental health needs could be served if more efficient use of this resource was made.

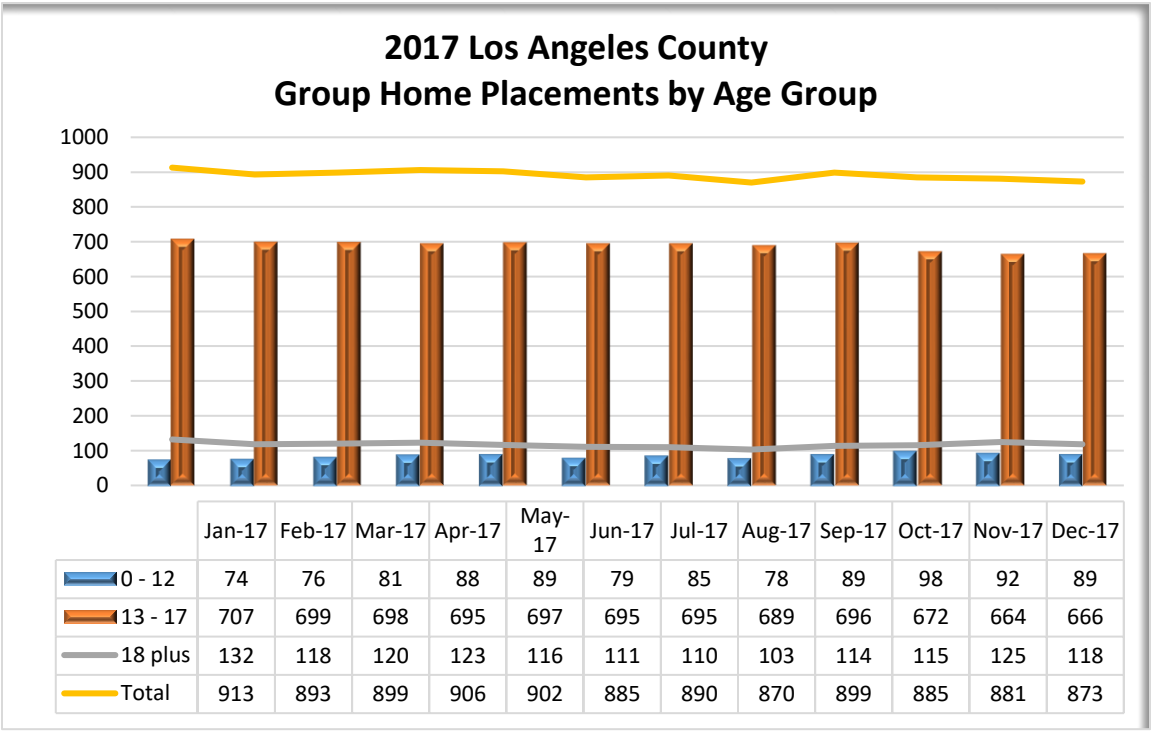
Placement of Children and Youth in Group Homes and Short-Term Residential treatment Facilities (STRTP)

In each monitoring report the Panel provides a snapshot of patterns of placement in group homes. The following tables reflect those patterns.

The following table and graph shows the monthly group home census, by age range and purpose of placement for 2017. The County reports that the average census was 891 children for that period (excluding Emergency Shelter Care and Specialized Placement for Medically Fragile Children).

Monthly Group Home Census
(Excluding Adoptive, Guardian Home, and Non-Foster Care Placement)
January 2017 to December 2017

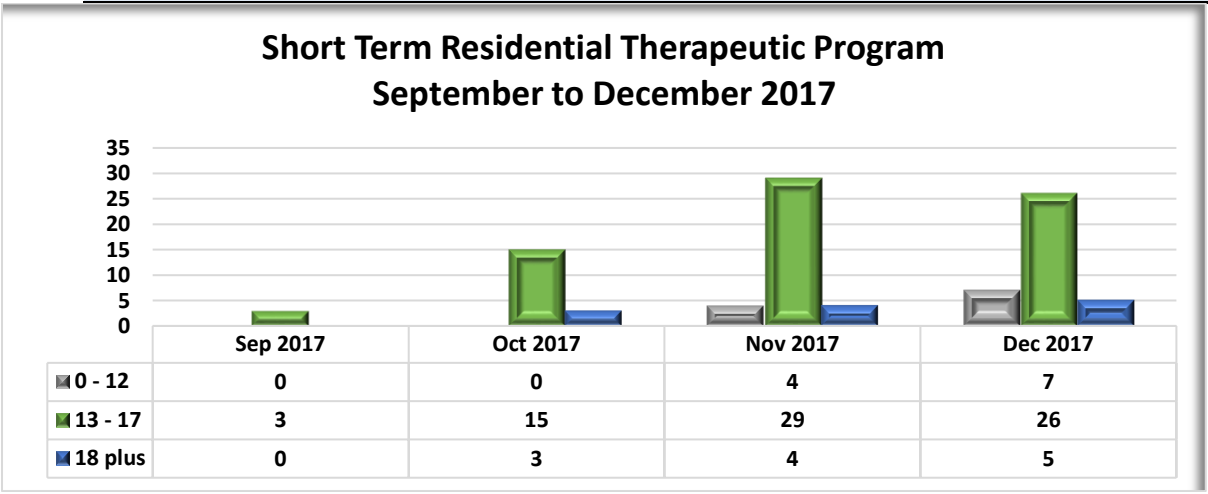
GH	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Average
0 - 12	74	76	81	88	89	79	85	78	89	98	92	89	85
13 - 17	707	699	698	695	697	695	695	689	696	672	664	666	689
18 plus	132	118	120	123	116	111	110	103	114	115	125	118	117
Total	**913**	**893**	**899**	**906**	**902**	**885**	**890**	**870**	**899**	**885**	**881**	**873**	**891**
ESC													
0 - 12	45	48	42	38	36	49	33	30	10	9	10	14	30
13 - 17	43	44	45	53	45	40	41	41	27	23	16	14	36
18 plus	5	4	3	3	3	2	2	2	4	1		1	3
Total	**93**	**96**	**90**	**94**	**84**	**91**	**76**	**73**	**41**	**33**	**26**	**29**	**69**
MCMS													
0 - 12	1	2	2	2	2	4	4	3	2	1	1	1	2
13 - 17	23	22	21	20	23	24	25	21	18	18	16	14	20
18 plus	4	4	5	6	6	7	5	5	6	5	4	4	6
Total	**28**	**28**	**28**	**28**	**31**	**35**	**34**	**29**	**26**	**24**	**21**	**19**	**28**
MCMS/ESC													
0 - 12	0	0	0	0	0	0	0	0	0	0	0	0	0
13 - 17	0	0	0	0	0	0	0	0	1	0	0	0	0
18 plus	0	0	0	0	0	0	0	1	1	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**2**	**0**	**0**	**0**	**0**



Note:
Data source is CWS/CMS History Database.
Data reflects Group Home placement as of May 31, 2018

The following table and graph shows the monthly STRTP census in CY 2017. (STRTP – A Short Term Residential Therapeutic Program that provides intensive psychiatric services to children/youth identified as severely emotionally disturbed – this is a State redefinition of group care).). Only a small number of facilities had been licensed as STRTP prior to the end of the calendar year.

STRTP	Sep 2017	Oct 2017	Nov 2017	Dec 2017
0 - 12	0	0	4	7
13 - 17	3	15	29	26
18 plus	0	3	4	5
Total	**3**	**18**	**37**	**38**
ESC				
0 - 12	0	0	2	0
13 - 17	0	6	5	3
18 plus	0	3	2	1
Total	**0**	**9**	**9**	**4**
MCMS				
0 - 12	0	0	0	0
13 - 17	0	0	1	1
18 plus	0	0	0	0
Total	**0**	**0**	**1**	**1**
MCMS/ESC				
0 - 12	0	0	0	0
13 - 17	0	0	0	0
18 plus	0	0	0	0
Total	**0**	**0**	**0**	**0**



The County reported the following update:

Of the 21,015 DCFS youth reported to be in out-of-home care on December 31, 2017, 4.3% (911) were placed in a Group Home or STRTP. In addition to developing and aligning strategies and resources to support the implementation of the Continuum Care Reform, DCFS has focused considerable effort

and attention into supporting children in the least restrictive placement and reducing the number of children requiring placement in Group Homes. A successful strategy in this area included providing one-to-one behavioral aide services to children in foster, relative, and home-of-parent care. The County continues to struggle with a lack of foster homes willing and able to care for children with intensive mental, developmental, and medical challenges.

Length of Stay in a Group Home Setting

The following chart depicts the average length of placement, by age in a group setting, excluding Emergency Shelter Care and specialized placement for medically fragile children.

Age Group	0 to 2 Months in Group Homes	2 to 6 Months in Group Homes	6 to 12 Months in Group Homes	Over 12 Months in Group Homes
0 - 12	314	235	196	273
13 - 17	2354	2685	1814	1420
18 plus	146	349	332	578

The County summarized the findings as follows.

- A majority of children in congregate care at any given time were between the ages of 13 and 17 years old; 29% of these children exited within 2 months, 61% exited within 6 months, and 83 % exited within 12 months of placement in a Group Home.
- The smallest population of children in a group home was between the ages of 6-12 years old; 31% of these children exited the Group Home within 2 months, 54% exited within 6 months, and 73% exited within 12 months.
- For the young adults, ages 18 years and older, 10% exited the group home within 2 months, 35% exited within 6 months and 59% exited within 12 months.

Almost 3,000 children and youth were placed in care for 2 months or less, which suggests that for many of these children, these were merely interim placements until other settings could be located. Given the trauma children experience with placement disruption, this pattern is deeply concerning. It illustrates the urgent need for more appropriate decision-making, Intensive Home-Based Mental Health Services and placements for these class members.

Multidisciplinary HUBS

As previously reported, the County committed to providing a comprehensive medical examination for all newly detained children in its Strategic Plan. These assessments are completed by the Medical Hubs, located mostly in medical center settings. The County, through a partnership among the Departments of Children and Family Services, Health Services, and Mental Health, continues to implement efforts to ensure that newly detained children are referred to and served by the Medical Hubs. The County reports the following improvement in performance.

For Calendar Year 2017, the County reports that 93.5% of newly detained children were referred to a Medical Hub for an Initial Medical Examination (IME). This is an increase from 91.8 % that was previously reported for Calendar Year 2016. In seeking the goal of 100% of newly detained children referred, the County states that it continues to implement opportunities to educate DCFS staff on the requirement for the newly detained children to be referred and served by the Medical Hubs for an IME. Efforts include periodic DCFS regional office presentations and regular dissemination of a monthly report to management of the regional offices, highlighting the current percentages, recognizing the regional offices that achieved the highest percentages and reminding management of the mandate to refer all newly detained children to a Medical Hub for the IME per DCFS policy.

Along with attention and efforts to increase the percentage of children being referred to the Medical Hubs, efforts have continued since the 2016 Annual Report to address the timeframes for the submission of the referral for the IME for newly detained children. Specifically, there is interest strengthening the alignment of the submission of the referral with the timeframes that are in DCFS policy. Periodic review of data during 2017 identified the need to implement further action over and beyond the e mail communications sent out on a quarterly basis to line operations staff as a reminder of DCFS policy. Stronger alignment will positively impact the newly detained children being seen or examined through the provision of the IME specific to the timelines in DCFS policy. Further, a timely completion of the IME with results of the examination made available sooner will assist in meeting the needs of the child and in case planning. Current consideration is to establish an internal notification to the assigned social worker and his/her chain of command specific to a newly detained child who has not been referred to a Medical Hub with the instruction to take prompt action to submit the referral along with serving as a reminder of DCFS policy.

The Medical Hubs continue to meet the goal of serving the comprehensive needs of children through the provision of on-going/medical home care as one option available to caregivers who serve children placed in out of home care.

The County partners continue to review the effectiveness of the DHS E-mHub System towards identifying and planning for enhancements that contribute to stronger communication between social workers and the Medical Hubs providers on the timely provision of care to children.

As previously reported in 2016, the County implemented the requirement that youth admitted to Temporary Shelter Care, now the Transitional Shelter Care Program, receive a screening examination at a Medical Hub. This effort has served children well such that an unaddressed or inadequately addressed medical issue can come to the attention of Hub medical providers, experts in serving children in foster care, over and above identifying a communicable disease or condition prior to admission into a shelter.

The County has improved on what was already good performance in referring newly detained children to a Medical HUB.

V. Qualitative Service Reviews

Consistent with its Strategic Plan, the County continues to conduct Qualitative Service Reviews (QSR), interview-based evaluations of the quality of frontline practice involving a sample of cases in each office. The Qualitative Service Review permits an examination of the quality of services (not just whether the service was delivered) as well as an assessment of the child's current status. Each DCFS office is reviewed on an 18-24 month cycle. QSR performance is an element of the Katie A. Settlement Agreement's exit criteria for the County.

The QSR Baseline was completed in August 2012, and the corresponding QSR Baseline Report was completed and issued in early 2013. The second QSR Review cycle was completed at the end of October 2014, with the scores finalized in December 2014. The third cycle began in February 2015. Reviews for all 18 offices have been completed. The Santa Clarita Office and the West San Fernando office were reviewed as one office.

The QSR provides a basis for measuring, promoting, and strengthening the Shared Core Practice Model, and the protocol includes two domains. These are Child and Family Status Indicators, which measure how the focus child and the child's parents/caregivers are doing within the last 30 days, and Practice Indicators; which measure the core practice functions being provided with and for the focus child and the child's parents/caregivers for the most recent 90-day period. The team consists of trained DCFS and DMH reviewers who conduct a case review, and conduct interviews within a two-day period with key players in the life of the child and family's case.

The team assesses status and performance indicators to determine facts such as:

Child and Family Status

- Is the focus child safe?
- Is the focus child stable?
- Is the focus child making progress toward permanency?
- Is the focus child making progress emotionally and behaviorally?
- Is the focus child succeeding in school?
- Is the focus child healthy?
- Are the focus child's parents making progress toward acquiring necessary parenting skills and capacity?

Practice Performance

- Are the focus child and family meaningfully engaged and involved in case decision making, referred to as Family Voice and Choice?

- Is there a functional team made up of appropriate participants?
- Does the team understand the focus child and family's strengths and underlying needs?
- Is there a functional and individualized plan?
- Are necessary services available to implement the plan?
- Does the plan change when family circumstances change?
- Is there a stated and shared vision of the path ahead leading to safe case closure and beyond?

Overall, scores are reflective of the aggregate scores of each of the indicators for each case reviewed in the sample. Opportunities for organizational learning and practice development include providing the CSW and their supervisor face-to-face feedback on findings in the cases reviewed. In addition, oral case presentations are made in group debriefings called "Grand Rounds" and a written case story for each case reviewed is produced to provide context for the scores and to enhance learning.

The QSR scores are subject to an exit standard approved by the court. The QSR Exit Standard is stated as follows:

Each Service Planning Area is expected to individually meet passing standards for both the Child and Family Status Indicators and the System Practice Indicators (85 percent of cases with overall score of "acceptable" respectively and 70 percent "acceptable" score on Engagement, Teamwork and Assessment). Once the targets have been reached, at the next review cycle the regional office must not score lower than 75 percent respectively on the overall Child and Family Status and System Practice Indicators, and no lower than 65 percent on a subset of System Practice indicators respectively (Engagement, Teamwork, and Assessment). The County will continue the QSR process for at least one year following exit and will post scores on a dedicated Katie A website.

The first set of three tables reflects the Status Indicators for the Third, Second and Baseline QSR Cycles. The second set of three tables reflects the Practice Indicators for the same three QSR Cycles.

The first table reflects the percentage of cases scoring within the acceptable range for Status Indicators in the Belvedere, Pomona, Compton, San Fernando Valley (now Van Nuys), Vermont Corridor, El Monte, Metro North, Glendora, Lancaster, Wateridge, Santa Fe Springs, Santa Clarita/West San Fernando, South County, West Los Angeles, Pasadena, Torrance, and Palmdale offices during the third cycle, followed by the overall scores combined. All scores are rounded to the nearest full percent.

QSR Third Cycle Status Indicators (2015-2017) Percent Acceptable

Office	Safety Overall	Stability	Permanency	Living Arrangements	Health/ Physical Well-being	Emotional Well-being	Learning & Develop.	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
Belvedere	100%	100%	100%	100%	100%	89%	100%	100%	100%	60%	**100%**
Pomona	78%	67%	56%	89%	100%	67%	67%	50%	75%	50%	**56%**
Compton	89%	67%	33%	100%	89%	56%	44%	17%	83%	63%	**56%**

Van Nuys	100%	89%	44%	89%	78%	89%	78%	25%	86%	44%	**89%**
Vermont Corridor	80%	60%	50%	90%	80%	60%	70%	25%	100%	50%	**60%**
El Monte	100%	80%	50%	100%	100%	70%	80%	0%	100%	67%	**80%**
Metro North	80%	60%	50%	90%	80%	70%	90%	43%	100%	75%	**80%**
Glendora	82%	82%	55%	100%	82%	91%	91%	63%	100%	63%	**82%**
Lancaster	100%	91%	64%	100%	100%	82%	100%	38%	100%	63%	**100%**
Wateridge	73%	100%	64%	100%	91%	73%	64%	57%	75%	88%	**55%**
Santa Fe Springs	92%	100%	58%	75%	75%	75%	83%	38%	80%	91%	**83%**
Santa Clarita West SFV	100%	73%	45%	91%	82%	64%	64%	33%	100%	75%	**91%**
South County	83%	67%	42%	83%	83%	58%	75%	43%	100%	50%	**75%**
West LA	100%	92%	67%	100%	83%	75%	92%	67%	100%	78%	**92%**
Pasadena	91%	91%	50%	91%	100%	73%	82%	57%	86%	67%	**73%**
Torrance	75%	83%	25%	92%	83%	67%	75%	50%	89%	64%	**67%**
Palmdale	83%	83%	25%	75%	100%	83%	83%	33%	88%	30%	**83%**
Overall	**88%**	**82%**	**51%**	**92%**	**88%**	**73%**	**79%**	**43%**	**92%**	**63%**	**78%**

QSR Second Cycle Status Indicators (2012-2013) – Percent Acceptable

Office	Safety Overall	Stability	Permanency	Living Arrangements	Health	Emotional Well Being	Learning & Development	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
Belvedere	100%	83%	92%	100%	100%	92%	75%	57%	100%	67%	**100%**
Santa Fe Springs	92%	83%	58%	100%	100%	83%	75%	50%	100%	67%	**83%**
Compton	92%	67%	67%	92%	100%	83%	67%	63%	100%	38%	**75%**
Vermont Corridor	100%	91%	82%	100%	91%	100%	64%	60%	100%	88%	**100%**
Wateridge	92%	75%	75%	83%	100%	75%	67%	38%	90%	78%	**83%**
Pomona	100%	91%	80%	100%	100%	73%	82%	86%	100%	71%	**100%**
Glendora	90%	80%	60%	90%	80%	70%	90%	50%	88%	75%	**90%**
El Monte	100%	80%	80%	100%	100%	90%	70%	100%	100%	88%	**90%**
San Fernando Valley	100%	89%	56%	100%	100%	78%	78%	40%	100%	67%	**78%**
Lancaster	100%	63%	50%	100%	100%	63%	88%	43%	100%	67%	**88%**
Metro North	89%	78%	78%	89%	89%	78%	78%	40%	100%	67%	**89%**
Pasadena	67%	89%	56%	100%	89%	67%	56%	50%	100%	67%	**78%**
Santa Clarita	78%	56%	67%	89%	78%	67%	67%	50%	86%	71%	**78%**
Torrance	90%	70%	40%	100%	100%	90%	70%	29%	100%	67%	**80%**
West LA	90%	100%	80%	100%	100%	90%	60%	57%	100%	71%	**80%**

South County	90%	90%	60%	100%	80%	90%	70%	71%	100%	75%	**90%**
Palmdale	90%	90%	40%	80%	80%	60%	60%	43%	100%	43%	**60%**
Overall	**92%**	**81%**	**66%**	**95%**	**94%**	**80%**	**71%**	**55%**	**98%**	**69%**	**85%**

QSR Baseline Status Indicators (2011-2012) - Percent Acceptable

Office	Safety Overall	Stability	Permanency	Living Arrange-ments	Health	Emotional Well Being	Learning & Development	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
Overall	**99%**	**80%**	**57%**	**95%**	**97%**	**70%**	**80%**	**61%**	**96%**	**71%**	**88%**

QSR Third Cycle Practice Indicators (2015-2017) – Percent Acceptable

Office	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Belvedere	89%	67%	0%	78%	78%	56%	78%	89%	78%	**78%**
Pomona	100%	78%	44%	56%	44%	67%	89%	78%	78%	**78%**
Compton	89%	56%	0%	33%	22%	22%	56%	33%	56%	**44%**
Van Nuys	44%	56%	11%	44%	22%	22%	56%	44%	44%	**44%**
Vermont Corridor	40%	60%	0%	40%	30%	20%	70%	50%	20%	**20%**
El Monte	80%	30%	10%	40%	30%	40%	70%	60%	50%	**40%**
Metro North	80%	40%	10%	30%	40%	30%	70%	70%	50%	**50%**
Glendora	64%	64%	0%	36%	18%	0%	73%	64%	27%	**18%**
Lancaster	64%	55%	18%	36%	45%	45%	91%	73%	45%	**64%**
Wateridge	73%	82%	0%	55%	36%	55%	73%	55%	45%	**45%**
Santa Fe Springs	50%	42%	8%	33%	17%	8%	67%	33%	42%	**25%**
Santa Clarita West SFV	45%	36%	9%	18%	9%	18%	64%	36%	27%	**36%**
South County	50%	42%	8%	33%	17%	17%	58%	50%	25%	**25%**
West LA	67%	50%	50%	58%	58%	50%	75%	67%	50%	**67%**
Pasadena	36%	45%	9%	27%	36%	27%	64%	64%	45%	**36%**
Torrance	50%	58%	0%	25%	25%	25%	50%	67%	25%	**42%**

Palmdale	25%	8%	8%	17%	0%	17%	42%	42%	25%	**17%**
Overall	**60%**	**50%**	**11%**	**38%**	**30%**	**30%**	**67%**	**57%**	**42%**	**42%**

QSR Second Cycle Practice Indicators (2012-2013) - Percent Acceptable

Office	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Belvedere	92%	64%	33%	58%	67%	50%	67%	55%	58%	67%
Santa Fe Springs	75%	67%	8%	50%	50%	42%	67%	58%	50%	58%
Compton	75%	67%	17%	42%	50%	50%	58%	58%	50%	58%
Vermont Corridor	55%	45%	9%	36%	55%	27%	36%	36%	27%	45%
Wateridge	58%	75%	58%	67%	67%	75%	58%	58%	50%	58%
Pomona	91%	73%	55%	45%	64%	64%	73%	55%	55%	73%
Glendora	80%	70%	40%	70%	60%	60%	70%	70%	40%	60%
El Monte	90%	70%	20%	70%	60%	50%	70%	70%	50%	60%
San Fernando Valley	89%	56%	22%	33%	44%	56%	78%	67%	78%	56%
Lancaster	88%	75%	25%	50%	50%	38%	63%	50%	50%	50%
Metro North	100%	78%	11%	44%	56%	44%	44%	22%	22%	33%
Pasadena	78%	67%	22%	33%	44%	56%	44%	44%	33%	33%
Santa Clarita	44%	67%	11%	33%	56%	44%	89%	56%	44%	44%
Torrance	50%	50%	30%	40%	20%	30%	60%	50%	30%	30%
West LA	70%	70%	20%	30%	50%	30%	60%	60%	40%	50%
South County	50%	50%	20%	40%	20%	30%	70%	60%	40%	50%
Palmdale	70%	50%	20%	30%	40%	30%	50%	30%	20%	30%
Overall	**74%**	**64%**	**25%**	**46%**	**51%**	**46%**	**62%**	**53%**	**44%**	**51%**

QSR Baseline Practice Indicators (2011-2012) – Percent Acceptable

	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Overall	**60%**	**52%**	**18%**	**50%**	**39%**	**41%**	**66%**	**52%**	**45%**	**47%**

Analysis of QSR Findings

In analyzing the QSR Practice Scores for all eighteen offices in the third cycle and comparing them to the baseline, system performance demonstrated modest improvement in the following indicators: Support and Services increased from 66% to 67% and Intervention Adequacy increased from 52% to 57%. System performance in Engagement remained at 60% in both the baseline and third cycle. In Overall Practice, scores decreased slightly from 47% in the baseline to 42% in the third cycle. Teamwork demonstrated a slight decline from 18% in the baseline to 11% in the third cycle.

Current performance in the third cycle, after eight offices, indicates that:

- 51% of children are making acceptable progress toward permanency
- 73% of children are considered to have acceptable emotional well-being
- 43% of families are making acceptable progress toward adequate functioning
- 11% of children have a functioning family team
- 38% of cases have an overall adequate assessment
- 30% of cases have a long-term view of child and family goals and strategies
- 30% of cases have plans adequate for achievement of case goals
- 42% of cases are adequately tracked toward achievement of goals

The County offered the following as an explanation of the modest progress in raising QSR scores. "The shift from Team Decision Making (TDM) meetings to a more family-centered practice of Child and Family Team (CFT) meetings appears to have had an impact on the number and frequency of meetings occurring with children, youth and families. The lengthy certification process and learning curve required to ensure model fidelity in a county as large as Los Angeles, is likely contributing to the lower scores being seen in Teamwork during the current cycle. As practitioners learn and embed the process more deeply into practice, it is more likely that the scores will improve in the fourth cycle which began in February 2018 with the Van Nuys office."

Identification of System Barriers

The following system barriers were identified in two Qualitative Service Reviews, one in the Compton Office and one in the Van Nuys office. These two offices were the initial immersion sites. In each case reviewed, reviewers note any system barriers impeding Shared Case Practice Model practice. Barriers were noted in 23 cases of the 24 cases selected randomly for review. The full list of barriers is placed in the appendix. Some the more frequently identified barriers are as follow.

- Teaming and communication barriers – Team meetings not being held, informal supports and other key members not present

- Lack of case communication and coordination – Mainly occurring when there are not regular team meetings
- Lack of family housing
- Lack of placements, especially for some older youth
- Language and other cultural barriers
- Delays in initiation mental health services
- Delays in paying relative caregivers due to RFA backlog
- Workload
- Underlying needs, especially trauma-related needs not understood
- Confidentiality barriers between agencies
- Lack of family engagement
- Reliance primarily on court ordered services rather than the services actually needed
- MediCal policies that prevent key professionals being in the family home on the same day (double-billing issue)

DMH- QSR Provider Training and Outreach

The County reported that "DMH takes multiple steps to increase the understanding of the QSR by the Mental Health Providers by conducting a "QSR Foundational Training for Providers" prior to each review in the Service Area where the review is based. The three-hour session includes an overview of the Katie A. Lawsuit, explains the connection between the lawsuit, SCPM, and the QSR, and gives in-depth training of how the key QSR indicators are utilized to measure the implementation of the model. A scoring exercise is included to help participants connect practice behaviors to QSR outcomes. DMH QSR team began tracking these numbers in the Third Cycle. At the end of the Third Cycle, 358 individuals from agencies countywide completed the QSR Foundational Training,

The DMH QSR team conducts Mental Health Debriefings, an individually-tailored 90-minute feedback session, with every mental health provider agency actively providing services to focus children in the QSR sample. Debriefings are typically conducted two to six weeks after the QSR and utilize the QSR case summary to highlight strengths and challenges of the case. The Debriefing allows a space to provide individualized training to agency participants based on the results of the review. Key topics such as the role of the therapist in the CFT, formulation of underlying needs statements, and development of next steps are explored. Participants typically include the Agency Director, Clinical Supervisors, Managers, Quality Assurance Staff, Therapists, Wraparound staff, Psychiatrists, Case Managers, and any other individuals that agency administration includes. The DMH QSR team began tracking these numbers in the Third Cycle. At the end of the Third Cycle, 269 individuals participated in 71 Debriefings facilitated by QSR staff."

The Panel views the County's development of its QSR team as an important achievement. The system's QSR reviewers are doing a commendable job in providing the County with accurate and valuable feedback on the quality of its practice. The Panel also remains deeply concerned over the continuing low QSR scores. It is the Panel's view that the County must significantly improve the quality and

frequency of CFT meetings to fully implement the Shared Case Practice Model and that lower caseloads are an essential step in achieving that goal.

VI. Outcome Measures

A series of child outcomes in the areas of safety and permanency have been identified to be tracked over time to show progress. As part of this process, the parties agreed to exit targets for each indicator, meaning that the targets would have to be met as one of several conditions for ending court oversight. There is a "minimum level of performance" target and an "aspirational" target assigned to each indicator. The aspirational target is an improvement goal unrelated to exit from Court oversight. Minimum Performance Levels were set only after this data became available and essentially assured that current performance, at that time, would be a baseline below which the County does not fall. The Panel considers the minimum levels of performance, which were established during the budget shortfalls of the recession, to be so minimal that they don't provide meaningful standards for system adequacy.

The table below provides data for all newly opened cases, by calendar year. The table sorts data by DCFS initial case plans of Family Maintenance (Children Remained Home) or Family Reunification (Children Removed from Home), each of which is further sorted according to whether or not DMH services are in place. This table reflects that the number of open cases has once again dropped from 20,011 (CY 2015) to 19,500 (CY 2016). The percentage of cases that were provided Family Maintenance Services as the initial case plan decreased slightly over that period of time, as did the percentage of Family Maintenance cases receiving services from DMH.

Population of CY 2009- 2016

Calendar Year	All Children					With DMH Services					Without DMH Services				
	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total
2009	11,915	*57.7%*	8,747	*42.3%*	**20,662**	3,660	*41.2%*	5,216	*58.8%*	**8,876**	8,255	*70.0%*	3,531	*30.0%*	**11,786**
2010	14,061	*62.8%*	8,318	*37.2%*	**22,379**	4,867	*46.3%*	5,654	*53.7%*	**10,521**	9,194	*77.5%*	2,664	*22.5%*	**11,858**
2011	15,252	*67.1%*	7,468	*32.9%*	**22,720**	6,377	*53.4%*	5,565	*46.6%*	**11,942**	8,875	*82.3%*	1,903	*17.7%*	**10,778**
2012	14,743	*65.5%*	7,766	*34.5%*	**22,509**	6,645	*51.2%*	6,322	*48.8%*	**12,967**	8,098	*84.9%*	1,444	*15.1%*	**9,542**
2013	15,121	*64.3%*	8,406	*35.7%*	**23,527**	6,989	*50.6%*	6,828	*49.4%*	**13,817**	8,132	*83.7%*	1,578	*16.3%*	**9,710**
2014	13,992	*63.8%*	7,935	*36.2%*	**21,927**	5,376	*46.9%*	6,075	*53.1%*	**11,451**	8,616	*82.2%*	1,860	*17.8%*	**10,476**
2015	12,644	*63.2%*	7,367	*36.8%*	**20,011**	4,915	*51.7%*	4,583	*48.3%*	**9,498**	7,729	*73.5%*	2,784	*26.5%*	**10,513**
2016	12,057	*61.8%*	7,443	*38.2%*	**19,500**	5,129	*46.4%*	5,936	*53.6%*	**11,065**	6,928	*82.1%*	1,507	*17.9%*	**8,435**

Notes:

1. *The Entry Cohort Report includes children whose DCFS case started in the Calendar Year indicated.*

2. *Children with DMH services are those who received DMH services 12 months before and 12 months after the case start date.*
3. *Data Source is CWS/CMS DataMart as of 12/13/17.*

Safety Indicator 1
Repeated Reports of Abuse and Neglect

This indicator tracks the degree to which children who are the subject of a substantiated referral for abuse or neglect, but are not removed from home, do not experience another substantiated report during the subsequent 12 months. The County's goal is to assess risk and provide supportive services, so that maltreatment does not reoccur. Data shows that the County's performance on this indicator has improved from 80% of class members having no subsequent substantiated referrals within 12 months for FY 2002-2003 (previously reported) to 92% of Class members having no subsequent referrals within 12 months in CY 2016.

The parties agreed to a Minimum Performance Level of 82.8% and the County aspires to a goal of 83.3%. The County currently exceeds both the Minimum Performance Level goal and the aspirational goal.

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

Calendar Year 2009 – 2016

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children initially remained home	Children without any substantiated referrals	%	Children initially remained home	Children without any substantiated referrals	%	Children initially remained home	Children without any substantiated referrals	%
2009	11,915	10,736	*90.1%*	3,660	3,093	*84.5%*	8,255	7,643	*92.6%*
2010	14,061	12,659	*90.0%*	4,867	4,150	*85.3%*	9,194	8,509	*92.5%*
2011	15,252	13,804	*90.5%*	6,377	5,520	*86.6%*	8,875	8,284	*93.3%*
2012	14,743	13,350	*90.6%*	6,645	5,838	*87.9%*	8,098	7,512	*92.8%*
2013	15,121	13,671	*90.4%*	6,989	6,103	*87.3%*	8,132	7,568	*93.1%*
2014	13,992	12,773	*91.3%*	5,376	4,701	*87.4%*	8,616	8,072	*93.7%*
2015	12,644	11,576	*91.6%*	4,915	4,385	*89.2%*	7,729	7,191	*93.0%*
2016	12,057	11,107	*92.1%*	5,129	4,558	*88.9%*	6,928	6,549	*94.5%*

Minimum Performance Level **82.8%**

Aspire to **83.3%**

Notes:

1. Intent of indicator: Of those children who initially remained home in the Calendar Year, and did not experience any new (first occurrence of re-abuse) substantiated referrals during the case open period, up to 12 months.
2. The table above excludes evaluated-out referrals.
3. Children with DMH services are those who received DMH services 12 months before and 12 months after the DCFS case start date.
4. Data Source is CWS/CMS DataMart as of 12/11/2017.

Safety Indicator 2
Incidence of Maltreatment by Foster Parents

This indicator reflects the incidence of maltreatment of children by their foster parents. The incidence is small and the County's performance for Class members has been consistently in the 99th percentile range, meaning that over 99% of Class members in foster home settings experienced no substantiated maltreatment by their foster parents. The chart does not include the experience of Class members in residential settings; incidence of maltreatment is captured differently for this population, and is reflected in the chart on the following page.

The parties agreed to a Minimum Performance Level of 98.4% and the County aspires to a goal of 98.6% for this indicator. The County CY 2016 performance exceeds the Minimum Performance Level goal and the aspirational goal.

Safety Indicator 2:
Of all children served in foster care in the Calendar Year, how many did not experience Maltreatment by their foster care providers?

Calendar Year 2009 - 2016

Calendar Year	All Children			With DMH Services			Without DMH Services		
	All children served in foster care in Calendar Year	Children with no maltreatment	%	All children served in foster care in Calendar Year	Children with no maltreatment	%	All children served in foster care in Calendar Year	Children with no maltreatment	%
2009	24,700	24,379	98.7%	12,505	12,283	98.2%	12,195	12,096	99.2%
2010	23,629	23,284	98.5%	15,297	15,031	98.3%	8,332	8,253	99.1%
2011	22,667	22,393	98.8%	15,710	15,495	98.6%	6,957	6,898	99.2%
2012	22,346	22,073	98.8%	15,522	15,303	98.6%	6,824	6,770	99.2%
2013	23,930	23,702	99.0%	17,943	17,747	98.9%	5,987	5,955	99.5%
2014	22,125	21,978	99.3%	15,625	15,508	99.3%	6,500	6,470	99.5%
2015	24,563	24,319	99.0%	15,130	14,974	99.0%	9,433	9,345	99.1%
2016	40,131	39,878	99.4%	28,308	28,106	99.3%	11,823	11,772	99.6%

Minimum Performance Level **98.4%**

Aspire to **98.6%**

Notes:

1. *The table above excludes children with abuse/neglect in group homes and guardian homes.*
2. *Children placed in group homes are not included in this data.*
3. *Children placed in guardian homes are not included because DCFS policy identifies legal guardianships as permanent placements and not as out-of-home placements.*
4. *The table is based on "Soundex" match of perpetrator's name and substitute care provider's name.*
5. *All children served in foster care includes: children already in foster care on the first day of the Calendar Year, children who initially entered foster care in the Calendar Year, and children who entered foster care as a result of a FM disruption.*
6. *Children with DMH services are: children already in foster care on the first day of the calendar year - those who received DMH services 12 months before and 12 months after the first day of the calendar year; children who initially entered foster care in the calendar year, and children who entered foster care as a result of an FM disruption – those who received the DMH services 12 months before and 12 months after the DCFS case start date.*
7. *Data source is CWS/CMS DataMart as of 12/11/2017.*

This indicator reflects the incidence of maltreatment of children in group homes:

Safety Indicator 2b:
Of all children placed in Group Homes in the Calendar Year, how many did not experience maltreatment by their foster care providers?

Calendar Year 2009 – 2016

Calendar Year	All Children			With DMH Services			Without DMH Services		
	All children served in group home in calendar year	Children with no maltreatment	%	All children served in group home in calendar year	Children with no maltreatment	%	All children served in group home in calendar year	Children with no maltreatment	%
2009	3,084	3,060	99.2%	2,284	2,266	99.2%	800	794	99.3%
2010	3,133	3,119	99.6%	2,619	2,607	99.5%	514	512	99.6%
2011	3,393	3,371	99.4%	2,907	2,890	99.4%	486	481	99.0%
2012	3,407	3,383	99.3%	2,832	2,808	99.2%	575	575	100.0%
2013	3,675	3,665	99.7%	3,186	3,178	99.7%	489	487	99.6%
2014	4,253	4,247	99.9%	3,629	3,625	99.9%	624	622	99.7%
2015	3,959	3,957	99.9%	2,890	2,888	99.9%	1,069	1,069	100.0%
2016	3,897	3,883	99.6%	3,281	3,268	99.6%	616	615	99.8%

Notes:

1. *Table includes children placed in a group home anytime during the reporting period.*
2. *Table includes group home placement count. If children were placed in the two different group homes, it was counted twice.*
3. *The maltreatment is based on Non Protecting Parent Code indicator on CWS/CMS.*
4. *Data Source is CWS/CMS DataMart as of 12/11/2017.*

Safety Indicator 3
Recurrence of Maltreatment within 6 Months

This indicator measures the percentage of all children who were victims of a substantiated abuse and neglect referral who were not victims of another substantiated referral within six months. It provides some

evidence of the effectiveness of efforts to prevent subsequent abuse and neglect. Class members are not identified separately in this indicator. The data shows improvement in reducing subsequent substantiated referrals between FY 2002-2003 (previously reported), when 90.4% of children did not experience subsequent substantiated referrals within six months and in CY 2016, when 99.6% of children did not experience a subsequent substantiated referral.

The parties agreed to a Minimum Performance Level of 92.3%, and the County aspires to a goal of 92.8% for this indicator. The County FY 2016 performance exceeds the Minimum Performance Level goal and the aspirational goal.

Safety Indicator 3:
No recurrence of maltreatment within 6 months.

Calendar Year 2009 - 2016

Calendar Year	Time Period	No Maltreatment	Total	Percent
2009	Jan-2009	9,440	10,187	92.7%
	Jul-2009	11,779	12,752	92.4%
2010	Jan-2010	12,345	13,555	91.1%
	Jul-2010	12,838	13,869	92.6%
2011	Jan-2011	13,693	14,694	93.2%
	Jul-2011	12,362	13,250	93.3%
2012	Jan-2012	12,977	13,919	93.2%
	Jul-2012	12,270	13,186	93.1%
2013	Jan-2013	12,786	13,755	93.0%
	Jul-2013	12,250	13,124	93.3%
2014	Jan-2014	12,145	13,078	92.9%
	Jul-2014	11,570	12,433	93.1%
2015	Jan-2015	10,923	11,797	92.6%
	Jul-2015	10,576	11,239	94.1%
2016	Jan-2016	10,172	10,845	93.8%
	Jul-2016	9,769	10,335	94.5%

Minimum Performance Level **92.3%**

Aspire to **92.8%**

Notes:

1. *Intent of indicator: Of all children who come into contact with DCFS and were victims of a substantiated maltreatment referral during the 6-month time period, what percent were victims of another substantiated maltreatment referral within the next 6 months?*
2. *The table includes children who had a substantiated referral in the 6-month time period indicated.*
3. *The table above excludes allegations of "at risk, sibling abused" and "substantial risk".*
4. *No maltreatment includes children who were not victims of another substantiated maltreatment referral within 6-months of the initial substantiated referral of maltreatment.*
5. *This is a referral based report and DMH match is not applicable*
6. *Data Source is CWS/CMS DataMart as of 12/11/2017*

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Permanency Indicator 1

Median Length of Stay in Out-of-Home Care

This indicator measures the median number of days that Class members are in out-of-home care, grouped by the year they entered care. The County has reduced the median length of stay for Class members from 656 days in FY 2002-2003 (previously reported) to 156 in CY 2016.

The parties agreed to a Minimum Performance Level of 409 days and the County aspires to a goal of 383 for this indicator. Data for CY 2016 reflects a sustained improvement, and exceeds both the Minimum Performance Level and the Aspirational Performance Level.

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

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children initially removed from home	No. of children who exited foster care	Median Days	Children initially removed from home	No. of children who exited foster care	Median Days	Children initially removed from home	No. of children who exited foster care	Median Days
2009	8,747	3,805	283	5,216	3,456	349	3,531	349	181
2010	8,318	7,915	300	5,654	5,324	378	2,664	2,591	118
2011	7,468	6,891	301	5,565	5,065	368	1,903	1,826	110
2012	7,766	6,734	358	6,322	5,424	405	1,444	1,310	112
2013	8,406	6,340	299	6,828	5,062	322	1,578	1,278	140
2014	7,935	4,465	187	6,075	3,221	241	1,860	1,244	40
2015	7367	3573	153	4583	2144	187	2784	1429	108
2016	7,443	3,695	156	5,936	2,791	207	1,507	904	32

Minimum Performance Level **409 days**

Aspire to **383 days**

Notes:

1. *Intent of indicator: Of all the children who were initially placed into foster care within the calendar year, what is the median number of days that the children remained in foster care?*
2. *Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.*
3. *Data Source is CWS/CMS DataMart as of 12/11/2017.*

Permanency Indicator 2
Reunification within 12 Months

This indicator reflects the County's success in quickly returning children to their parents. The County continues to be challenged with this Permanency Indicator. The percentage of children who are reunified within 12 months has remained around 30% for the last several calendar years.

The parties agreed to a Minimum Performance Level of 36.4% and the County aspires to a goal of 45.6% for this indicator. The County currently does not meet the Minimum Performance Level.

Permanency Indicator 2:
Reunification within 12 months

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children initially removed from home	Children reunified within 12 months	%	Children initially removed from home	Children reunified within 12 months	%	Children initially removed from home	Children reunified within 12 months	%
2009	8,747	3,479	*39.8%*	5,216	2057	*39.4%*	3,531	1,422	*40.3%*
2010	8,318	2,999	*36.1%*	5,654	2101	*37.2%*	2,664	898	*33.7%*
2011	7,468	2,761	*37.0%*	5,565	2085	*37.5%*	1,903	676	*35.5%*
2012	7,766	2,471	*31.8%*	6,322	1992	*31.5%*	1,444	479	*33.2%*
2013	8,406	2,659	*31.6%*	6,828	2,216	*32.5%*	1,578	443	*28.1%*
2014	7,935	2,350	*29.6%*	6,075	1,835	*30.2%*	1,860	515	*27.7%*
2015	7,367	2,116	*28.7%*	4,583	1,409	*30.7%*	2,784	707	*25.4%*
2016	7,443	2,182	*29.3%*	5,936	1,787	*30.1%*	1,507	395	*26.2%*

Minimum Performance Level **36.4%**

Aspire to **45.6%**

Notes:

1. *Intent of indicator: How successful is DCFS at reunifying all children under its supervision quickly?*
2. *The table includes all children who exited foster care through reunification within 12 months of removal from home.*
3. *The table is based on removal date and episode end date.*
4. *The table includes placement episodes with 8 days or longer.*
5. *The percent equals children reunified within 12 months divided by children initially removed from home.*
6. *Children with DMH services are those who received the DMH services 12 months before and 12 months after the DCFS case start date.*
7. *Data Source is CWS/CMS DataMart as of 12/11/2017.*

Permanency Indicator 3
Adoption within 24 Months

This indicator reflects the County's success in quickly moving children to adoption who cannot return home.

The parties agreed to a Minimum Performance Level of 2% and the County aspires to a goal of 2.9% for this indicator. The County currently exceeds the Minimum Performance Level, but does not exceed its aspirational performance goal.

Permanency Indicator 3:
Adoption within 24 months

Calendar	All Children	With DMH Services	Without DMH Services

Minimum Performance Level **2.0%**

Year	Children initially removed from home	Children adopted within 24 months	%	Children initially removed from home	Children adopted within 24 months	%	Children initially removed from home	Children adopted within 24 months	%
2009	8,747	270	*3.1%*	5,216	118	*2.3%*	3,531	152	*4.3%*
2010	8,318	303	*3.6%*	5,654	172	*3.0%*	2,664	131	*4.9%*
2011	7,468	249	*3.3%*	5,565	159	*2.9%*	1,903	90	*4.7%*
2012	7,766	265	*3.4%*	6,322	183	*2.9%*	1,444	82	*5.7%*
2013	8,406	219	*2.6%*	6,828	139	*2.0%*	1,578	80	*5.1%*
2014	7,935	211	*2.7%*	6,075	48	*0.8%*	1,860	163	*8.8%*
2015	7,367	198	*2.7%*	4,583	138	*3.0%*	2,784	60	*2.2%*

Aspire to **2.9%**

Notes:

1. *Intent of indicator: How successful is DCFS at moving children under its supervision into finalized adoption quickly?*
2. *The table includes all children who exited foster care through adoption within 24 months of removal from home.*
3. *The table is based on removal date and placement episode end date.*
4. *Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.*
5. *% equals children adopted within 24 months divided by children initially removed from home.*
6. *Data Source is CWS/CMS DataMart as of 12/11/2017.*

Permanency Indicator 4
Re-entry into Foster Care

This indicator reflects the County's success in ensuring that reunified children remain in their parents' care for at least 12 months after reunification. The data indicates that Class members re-entered foster care at a rate of 13.9% in CY 2016.

The parties agreed to a Minimum Performance Level of 13.9% and the County aspires to a goal of 12.9% for this indicator. For the CY 2016, the County did meet the Minimum Performance Level, but did not meet the aspirational performance goal.

Permanency Indicator 4:
Reentry into foster care during the Calendar Year and reentry within 12 months of the date of reunification

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children who were reunified	Children who re-entered foster care	%	Children who were reunified	Children who re-entered foster care	%	Children who were reunified	Children who re-entered foster care	%
2009	7,193	870	*12.1%*	3,458	545	*15.8%*	3,735	325	*8.7%*
2010	7,075	819	*11.6%*	4,357	566	*13.0%*	2,718	253	*9.3%*
2011	6,894	890	*12.9%*	4,663	695	*14.9%*	2,231	195	*8.7%*
2012	6,009	758	*12.6%*	4,107	593	*14.4%*	1,902	165	*8.7%*
2013	5,927	661	*11.2%*	4,346	538	*12.4%*	1,581	123	*7.8%*

Minimum Performance Level **13.9%**

Aspire to **12.9%**

2014	6,367	716	*11.2%*	4,598	529	*11.5%*	1,769	187	*10.6%*
2015	5,740	691	*12.0%*	3,530	456	*12.9%*	2,210	235	*10.6%*
2016	5,067	704	*13.9%*	3,641	548	*15.1%*	1,426	156	*10.9%*

Notes:

1. *Intent of indicator: How successful is DCFS at ensuring children successfully remain with their parents after being reunified with parents?*
2. *The numerator is children who re-entered foster care within 12 months of reunification. The denominator is children who were reunified during the calendar year. Placement episodes less than 8 days were included in accordance with the Federal Methodology.*
3. *Children with DMH services are those who received the DMH services 12 months before and 12 months after the DCFS case start date.*
4. *Date source is CWS/CMS DataMart as of 12/11/2017.*

Permanency Indicator 5a
Placement Stability in First Year of Placement

This indicator measures those children in foster care less than 12 months, who remain in their first or second placement. The County's performance continues to improve, from 74.0% of Class members having two or fewer placements in their first year of care in FY 2002-2003 (previously reported), to 89.2% in CY 2016.

The parties agreed to a Minimum Performance Level of 82.5% and the County aspires to a goal of 84.1% for this indicator, both of which the County is currently exceeding.

Permanency Indicator 5a:
Children in foster care less than 12 months with 2 or less placements

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children in foster care less than 12 months	Children with 2 or fewer placements	%	Children in foster care less than 12 months	Children with 2 or fewer placements	%	Children in foster care less than 12 months	Children with 2 or fewer placements	%
2009	3,788	3,320	*87.6%*	2,218	1,891	*85.3%*	1,570	1,429	*91.0%*
2010	3,342	2,916	*87.3%*	2,271	1,931	*85.0%*	1,071	985	*92.0%*
2011	2,998	2,635	*87.9%*	2,223	1,924	*86.5%*	775	711	*91.7%*
2012	2,698	2,362	*87.5%*	2,159	1,869	*86.6%*	539	493	*91.5%*
2013	2,930	2,606	*88.9%*	2,405	2,112	*87.8%*	525	494	*94.1%*
2014	2,579	2,325	*90.2%*	1,952	1,741	*89.2%*	627	584	*93.1%*
2015	2,321	2,069	*89.1%*	1,513	1,339	*88.5%*	808	730	*90.3%*
2016	2,143	1,911	*89.2%*	1,703	1,501	*88.1%*	440	410	*93.2%*

Minimum Performance Level **82.5%**
Aspire to **84.1%**

Notes:

1. *Intent of indicator: Of those children who are in foster care for less than 12 months, how many remain in their first or second placement?*
2. *This table includes all types of placement moves.*
3. *This table includes children who were in foster care for at least 8 days, but less than 12 months.*
4. *Children in foster care less than 12 months is determined by placement episode end date and removal date.*
5. *Children with DMH services are those who received DMH services 12 months before and 12 months after the DCFS case start date.*
6. *Data Source is CWS/CMS DataMart as of 12/11/2017.*

Permanency Indicator 5b
Placement Stability in Second Year of Placement

This indicator measures children in foster care between 12 and 24 months who did not experience a third or greater placement in the second year. In FY 2002-2003 (previously reported), 89.5% of Class members did not experience a third or greater placement, compared to 88.9% not experiencing a third or greater placement in FY 2016.

The parties agreed to a Minimum Performance Level of 89.2% and the County aspires to a goal of 89.7% for this indicator. Foster home stability for class members currently exceeds Minimum Performance Level and the Aspirational Goal.

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

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%
2009	1,888	1,690	*89.5%*	1,299	1154	*88.8%*	589	536	*91.0%*
2010	1,905	1,721	*90.3%*	1,441	1302	*90.4%*	464	419	*90.3%*
2011	1,672	1,522	*91.0%*	1,362	1,243	*91.3%*	310	279	*90.0%*
2012	2,066	1,892	*91.6%*	1,815	1,669	*92.0%*	251	223	*88.8%*
2013	2,043	1,880	*92.0%*	1,727	1590	*92.1%*	316	290	*91.8%*
2014	2,273	2,051	*90.2%*	1,543	1,388	*90.0%*	730	663	*90.8%*
2015	1,805	1,605	*88.9%*	1,559	1397	*89.6%*	246	208	*84.6%*

Minimum Performance Level **89.2%**

Aspire to **89.7%**

Notes:

1. *Intent of indicator: Of those children in foster care for 12 months but less than 24 months, what percent did not move to a third or greater placement(s) in the second year?*
2. *This table includes all types of placement moves.*

3. The denominator is children who were in foster care 12 months but less than 24 months. The numerator is children who did not move to a third or greater placement in the second year.

4. Children in foster care 12 months but less than 24 months is determined by placement episode end date and removal date.

5. Children with DMH services are those who received DMH services 12 months before and 12 months after the DCFS case start date.

6. Data Source is CWS/CMS DataMart as of 12/11/2017.

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

This indicator is similar to 5a and 5b, except it applies to the stability of children in care more than 24 months. County performance has dropped slightly in this indicator, with 74.9% of Class members in care 24 months or more not experiencing a third or greater move in CY 2016, compared with 79.6% for CY 2015.

The parties agreed to a Minimum Performance Level of 58.8% and the County aspires to a goal of 61.7% for this indicator. Foster home stability for Class members currently exceeds Minimum Performance Level and the aspirational goal.

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

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%
2009	8,342	6,598	*79.1%*	4,200	2,950	*70.2%*	4,142	3,648	*88.1%*
2010	7,292	5,731	*78.6%*	4,588	3,298	*71.9%*	2,704	2,433	*90.0%*
2011	6,570	5,187	*78.9%*	4,101	2,971	*72.4%*	2,469	2,216	*89.8%*
2012	6,312	4,894	*77.5%*	3,649	2,594	*71.1%*	2,663	2,300	*86.4%*
2013	6,394	5,033	*78.7%*	3,830	2,811	*73.4%*	2,564	2,222	*86.7%*
2014	6,640	4,632	*69.8%*	3,775	2,333	*61.8%*	2,865	2,299	*80.2%*
2015	7,102	5,655	*79.6%*	3,961	3,017	*76.2%*	3,141	2,638	*84.0%*
2016	5,794	4,338	*74.9%*	2,916	1,885	*64.6%*	2,878	2,453	*85.2%*

Minimum Performance Level **58.8%**

Aspire to **61.7%**

Notes:

1. Intent of indicator: Of those children in foster care for at least 24 months, what percent did not move to a third or greater placement(s) during the calendar year?

2. This table includes all types of placement moves.

3. The denominator is children who were in foster care on the first day of the calendar year and who have been in foster care for 24 months or more. The numerator is children who have not experienced a move to a third or greater placement(s) during the calendar year.

4. Children with DMH services are those who received DMH services 12 months before and 12 months after the first day of each calendar year.

5. Data Source is CWS/CMS DataMart as of 12/11/2017.

VII. Panel Recommendations

The slow pace of improving practice and providing the right services at the right time to meet children's needs continues to be the primary problem in Katie A. despite the commitment of both DCFS and DMH. The Panel had hoped the County's work on developing data indicators that reflect progress toward full implementation and the identification of tipping points could aid in meeting settlement objectives. However, now that the County has concluded that its data systems will not currently support those tasks, other strategies will be necessary to improve performance. The County reports that it will continue to work on improving its data systems, but that seems like a long-term effort. DCFS and DMH still must answer the question: To what extent have DCFS staff and DMH providers implemented the Shared Core Practice Model? To what extent do DCFS and DMH provide children and families with timely mental health services specifically designed to meet the child's needs? If this inquiry can produce data that is regularly updated, DCFS and DMH can enhance ongoing methods to ensure that staff change their practice accordingly. If not, other strategies will be required.

1. Ensure the Immediacy and Intensity of Intensive Home-Based Mental Health Services

It is imperative that DMH and DCFS collaborate to provide consistent, accurate and up-to-date data to track (1) immediate response to children at risk of placement disruption, (2) frequency and type of mental health services provided to children, their caregivers and their families, and (3) information dissemination to insure that the slots in IHBS are full.

DCFS and DMH agree that it is important to collaborate on achieving responsiveness of IHBS, especially to prevent placement in emergency shelter, group home, residential facilities and psychiatric settings and placement disruptions, including the speed of identifying the child's needs, making an immediate IHBS referral, IHBS beginning services quickly, and provision of services as many hours a week as necessary to meet the child's needs and support both the caregiver and the parent in visits in meeting those needs. However, there appears to be little progress in DCFS and DMH data collection and analysis on IHBS responsiveness. The CISR does not appear to analyze IHBS responsiveness.

The Panel is doing interview studies of children receiving IHBS and children/youth in group care (including CSW interviews) to collect information about responsiveness of IHBS, IHBS intensity and IHBS success of preventing placement disruptions. We will encourage DCFS and DMH to take action on the findings of those studies. But small studies of IHBS provided to children and families cannot provide the kind of up-to-date systemic data on responsiveness and intensity of IHBS necessary to exit Katie A.

Recent county data indicates that surprisingly, subclass members are not receiving more mental health services than other children, the highest amounts of children's mental health service dollars continue to support services in residential treatment (over $30,000 of services annually per child as compared to $23,000

annually per child in IHBS), a third of IFCCS slots continue to be empty and Wraparound continues to have a large number of unsuccessful terminations. This information is discouraging.

The Panel reiterates its recommendation in our 2016 Report that DCFS and DMH implement improvements driven by data to ensure that (1) soon as DCFS recognizes that a child's placement may disrupt or a child is being considered for placement in any setting outside a family home, an immediate referral to IHBS is made; (2) IHBS is provided immediately to address the child's needs and provide support to caregivers to prevent disruption; and (3) IHBS services have a "whatever it takes" approach, with daily in-home services for the child and caregiver if necessary. A pre-defined team of mental health staff should not determine what services or their intensity are provided—staff assignments should be unique to the child and family; services for the child and support for the caregiver and family should target the child's trauma-related needs.

2. Ensure Placement Stability

DMH and DCFS have a commitment to prevent the trauma of disruption for children. This has been a prominent priority in the tipping points discussion.

- Continuing obstacles to achieving placement close to home appear to be that (1) the FFAs manage their own placements and placement moves and do not prioritize proximity to family (the FFAs are the majority of placements of children in foster homes) and (2) the fledgling Automated Community-Based Home Reservation system encountered difficulties.

- The primary obstacle to ensuring that each child's first placement was their only placement appeared to be insufficient support, including IHBS, for foster parents and kin caregivers to meet the trauma-related needs of children with difficult behaviors.

The Panel encouraged the county to investigate how many children are placed away from their siblings to begin a process of keeping children with at least one sibling to support those important attachments.

One reason for placement close to home is to make frequent visiting between parents and their children in care possible. DCFS is committed to improving the quality of visits, a key ingredient to safe reunification but with court-ordered multiple visits each week and limited staff to transport children long distances and monitor visits, it is unknown how much visit improvement can occur. Visits are less difficult for children when there is shared parenting between parents and caregivers, with agreement between them about the child's needs and how to meet those needs, both during visits and in the caregiver's home.

More than half the children in foster home placement in LA County are placed with relatives. CCR requires licensing of relative placements, but support for kin in meeting the needs of children—especially the subclass—is often overlooked. To ensure placement stability in kin placements, relatives should be involved in CFTs, asked what support they require to meet the child's needs and IHBS provided if other supports do not have sufficient intensity.

3. Ensure Effective Teaming

Teaming is an essential feature of SCPM. Teaming is <u>both</u> the process of collaboration among the family, CSW and providers to ensure needs are met and meetings together so all agree on the child's needs and what the family, caregiver, provider, CSW, informal supports and others will do to meet those needs.

As the Panel summarized in its 2016 Report, quality CFT meetings require:

- Ongoing communication among team members before and after team meetings
- The family
- A family support(s) chosen by the family
- The caregiver (kin or foster family)
- The CSW (with some exception if meetings occur more than monthly)
- Key providers such as the child's therapist and school team member,
- Identify the strengths of the child, family and caregiver
- Identify the specific unique needs of the child, especially trauma-related needs
- Craft services to meet each of the child's needs
- Craft supports for the caregiver to meet the child's needs
- Craft supports for the family to meet the child's needs (during visits)
- An agreed-on plan with strengths, needs and supports and services provided to participants and incorporated into the court report and the mental health treatment plan

At this point DCFS and DMH cannot track the degree to which quality CFT meetings with these characteristics are occurring. There is less information available about CFT meetings facilitated by DMH staff than, including IHDS cases, than those facilitated by DCFS staff.

Although in most cases, DCFS and DMH staff actively collaborate with the child, caregiver, and each other, in the most recent QSR cycle, the County scored acceptably on teaming in only 11 percent of cases because the CFT meeting has not occurred and/or all the important individuals in the child's life were not included. The Panel has recommended training for QSR reviewers as well as targeted coaching of DCFS and DMH CFT facilitators regarding how to achieve the above characteristics of CFT meetings.

4. Strengthen the Supervisory Role in Shared Core Practice Model Implementation

The Panel believes that the County cannot meet QSR exit standards without DCFS and DMH supervisors leading Shared Core Practice Model practice, including holding staff accountable for quality CFT meetings in every case that produce CFT plans and mental health treatment plans with services crafted to meet the unique needs, particularly trauma-related needs, of children and supports for caregivers and families to meet those needs.

In the spring, 2018, DCFS and DMH increased the number of coaches and was beginning to provide more supervisory training and guidance for strengths/needs-based serviced service crafting. But the reassignment of coaches to state mandated CCR and to the four offices with the lowest number of CFTs set the county back six months in providing strong countywide support for supervisors. The Panel reiterates its recommendations from the 2016 Panel Report:

- Ensure sufficient coaching and training in strengths/needs-based service crafting is provided to supervisors in DCFS and DMH that they consistently guide the staff in their units include children's underlying needs and unique services and supports to meet those needs in CFT plans, DCFS case plans, DCFS court reports and mental health treatment plans.

- Ensure sufficient coaching is provided to supervisors that they consistently monitor that each family in each worker's caseload has had more than the initial CFT meeting and is having CFT meetings

often enough to arrange unique services coordinated with both the parent and caregiver and together assess whether they are the right services at the right frequency.

5. Use the QSR as a Teaching Tool for Shared Core Practice Model

The Panel views the County's development of its QSR team as an important achievement. The system's QSR reviewers are doing a commendable job in providing the County with accurate and valuable feedback on the quality of its practice. The Panel has encouraged DCFS and DMH to get more power from the QSR as a way to teach consistent SCPM across offices and providers. Ascending QSR scoring trend lines will confirm that countywide SCPM is being achieved. Some encouraging progress is reflected in QSR scores, while other scores continue to be frustratingly slow in improving:

- 51% of children are making acceptable progress toward permanency
- 73% of children are considered to have acceptable emotional well-being
- 43% of families are making acceptable progress toward adequate functioning
- 11% of children have a functioning family team
- 38% of cases have an overall adequate assessment
- 30% of cases have a long-term view of child and family goals and strategies
- 30% of cases have plans adequate for achievement of case goals
- 42% of cases are adequately tracked toward achievement of goals

The Panel reiterates past recommendations to enhance the QSR as a teaching tool for SCPM:

- Requiring all DCFS leadership, RAs and ARAs and their DMH manager counterparts and all DCFS and DMH trainers and coaches who have not already done so to shadow a QSR.

- Regularly hold cross learning sessions of QSR staff and coaching/training staff as well as twice annually convening the larger management team for a DCFS/DMH supervisors training that uses SCPM lessons learned from QSRs and selects illustrative QSR stories.

- Inviting QSR experts to lead a discussion of inter-rater reliability and consider possible modifications of (1) the QSR Assessment Indicator to require identification of specific child needs as a standard for acceptable rating, including a review to see if needs are in the case plan and court report; (2) the QSR Intervention Adequacy Indicator to require service crafting as a standard for acceptable rating and (3) the QSR Teaming Indicator to reflect that if the first CFT is in the review period, team formation may be off to a good start but all the potential team members or all the issues will not be addressed.

- A coaching session for QSR staff using the Panel's analysis of the needs and services in the case stories of the most recent QSRs to guide the reviewers in enhancing how they can inspire SCPM practice by presenting a strong needs list and crafted services in each case story

6. CISR

The CISR is designed to improve IHBS across many DMH providers. The Panel commended the recent CISR Report and recommended that in the next CISR DMH (1) ask more questions of each provider about the reasons for psychiatric hospitalization and placement change after enrollment in IHBS and what IHBS did to intensify services to prevent it and (2) establish a typical range frequency of each type of IHBS service, such

as the percentage of children who receive individual therapy once a week or more, the percentage of caregivers who receive in-home guidance in meeting the children's needs once a week or more, and the percentage of children who receive in-home one-on-one support.

7. Immersion

The fact that the County ceased using the immersion process was a surprise to the Panel. The strategy developed for this approach occurred over many months and involved frequent conversations about the design with plaintiffs' and the Panel. Four offices were intensively involved in implementing the approach. The Panel considered the use of immersion as part of the revised Strategic Plan the parties had agreed to. The Panel expressed its reservations about the new system-wide approach previously about this report. We continue to believe that the County does not have the resources to fully implement the Shared Core Practice Model throughout the County at one time and that an immersion approach is the best strategy for meeting settlement objectives.

The value of the immersion process includes:

- Providing sufficient training and coaching that all staff are thoroughly trained and coached, leading to greater sustainability of practice
- Thoroughly testing innovations before attempting to implement them system-wide
- Gradually intensifying the service array and staff size (which can be costly), so additional costs rise gradually

We recommend that the County resume the immersion strategy, which could include more than two offices at a time. The County could continue some support in non-immersion sites, as was anticipated in the original plan. If the County choses to continue its system-wide implementation approach, The Panel believes that it needs a detailed plan for that strategy, which includes more than training and coaching.

8. Improve the DMH Data System

The County should fully support the DMH plan to strengthen the ability of its data system so that it tracks key practice areas such as the timeliness of provision of intensive mental health services and the type and frequency of services provided to class members. In the interim, the County should fully explore the use of interim processes that will contribute additional performance data about DMH practice and performance.

2016 Report Recommendations

The Panel has included the recommendations in its 2016 report in the Appendix. This was done in part to illustrate the commonality between issues raised in the 2016 report and many of those in the 2017 report. The Panel is also asking for a County response on the status of these recommendations.

GLOSSARY OF TERMS

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

Coaching - Coaching is supportive; solution focused; skillfully listening to others; sensitively asking questions; self-reflective; and strengths-needs driven.

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

DCFS – Department of Children and Family Services

DMH – Department of Mental Health

ER – Emergency response

ESC – Emergency Shelter Care

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

FM – Family maintenance services provided for families with children living in the home of either of his/her parent or LG.

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

ICC - Intensive Care Coordination – ICC is similar to the activities routinely provided as Targeted Case Management (TCM); however, they must be delivered using a Child and Family Team Process to guide the planning and service delivery process. Service Components and Activities are related to the elements of the Core Practice Model.

IFCCS - Intensive Field Capable Clinical Services – phase one of the county's implementation of ICC and IHBS. Target population is youth who are in DCFS' Emergency Response Command Post, Exodus Recovery Urgent Care Center, discharging from a psychiatric hospitalization, or had a response by Field Response Operations or PMRT without a psychiatric hospitalization.

IHBS - Intensive Home-Based Mental Health Services – IHBS are intensive, individualized, and strength-based, needs-driven intervention activities that support the engagement of the child and family in the intervention strategy. IHBS are medically necessary, skill-based interventions.

MAT – Multi-Disciplinary Assessment Team

PCIT – Parent Child Interaction Therapy is an evidence base practice for ages 2 to 5 children with externalized acting out behaviors.

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

SCPM - Shared Core Practice Model is a practice model adopted by the Department of Children and Family Services and the Department of Mental Health to focus our work on identifying and addressing the underlying strengths and needs of children and families.

TFC – Treatment Foster Care – DMH will provide additional information about TFC.
Wraparound - Wraparound is a family-centered, strengths-based, and needs driven planning process for children, youth, and families that take place in a team setting

Appendix

Recommendations from the 2016 Report

1. Ensure the Immediacy and Intensity of Intensive Home-Based Mental Health Services

The Panel has been encouraging DMH and DCFS to collaborate on data-driven improvements in the responsiveness of IHBS, especially to prevent placement in emergency shelter, group home, residential facilities and psychiatric settings and placement disruptions, including the speed of identifying the child's needs, making an IHBS referral, and IHBS beginning services, and whether services were provided as many hours a week as necessary to meet the child's needs and support both the caregiver and the parent in visits in meeting those needs.

Specifically, the County should take the following steps:

- As soon as DCFS recognizes that a child's placement may disrupt or a child is being considered for a higher level of care, an immediate referral to IHBS should be made (not delaying for lengthy triaging or committee process).

- IHBS should begin providing services immediately to address the child's needs and provide support to caregivers to prevent disruption.

- IHBS services should be designed immediately with a "whatever it takes" approach, with daily in-home services for the child and caregiver if necessary. A pre-defined team of mental health staff should not determine what services or their intensity are provided—staff assignments should be unique to the child and family, with some children receiving daily 1:1 services, some caregivers having no parent partner, some families having the assistance of parent partners in visits and sometimes trauma treatment with guidance from the child's therapist for the caregiver and family being the primary service initially.

2. Develop Additional Measures that Reflect IHBS Quality and Effectiveness

The County should develop the capacity to expand its data collection and analysis to include new performance and outcome indicators for intensive home-based mental health services. These indicators might include the following, some of which are already reported.

Indicators reflecting service timeliness (beyond just initial contact)
Indicators reflecting service intensity

Indicators reflecting service duration
Indicators reflecting service tailoring
Indicators reflecting placement stability
Indicators reflecting placement level
Indicators reflecting duration of restrictive placement stays
Indicators reflecting runaway incidence and duration

3. Strengthen Training and Coaching

For staff in all DCFS regional offices and DMH providers to practice according to the SCPM requires (1) identifying each child's unique needs, including trauma-related needs, in discussions with families and caregivers and the rest of their team; and (2) crafting unique services and supports to meet each child's needs, including support for parents and caregivers in meeting the child's needs, and building on child and family strengths. Guiding strengths/needs-based practice relies on coaches and supervisors in DCFS regional offices and DMH providers, and as a result, a range in practice is coached and supervised. For the culture change DCFS and DMH leadership recognize is necessary, supervisors must become more confident in consistent approaches to teaching staff to guide families and teams in reaching agreement about children's underlying needs and crafting unique services and supports. Agreement about children's underlying needs and crafting unique services and supports should be apparent in CFT plans, DCFS case plans, DCFS court reports and mental health treatment plans.

Caseloads in the four DCFS immersion offices are dramatically reduced, and hiring and Academy training is resulting in decreasing caseloads in all the offices. More and more DCFS staff (and DMH providers) are learning how to facilitate a CFT meeting. Now the County has to enable CSWs to regularly utilize CFT meetings for all children and families throughout the family's experience with the system. The recent DCFS report on the frequency with which families experienced multiple CFT meetings confirmed that their incidence remains disappointingly low. Most families must experience more than an initial CFT meeting. The union's resistance to committing to this practice has long been a barrier to achieving compliance in this area.

Specifically, the County should take the following steps:

- Ensure sufficient coaching and training in strengths/needs-based service crafting is provided to supervisors in DCFS and DMH that they consistently guide the staff in their units to children's include children's underlying needs and unique services and supports to meet those needs in CFT plans, DCFS case plans, DCFS court reports and mental health treatment plans.

- Ensure sufficient coaching is provided to supervisors that they consistently monitor that each family in each worker's caseload has had more than the initial CFT meeting and is having CFT meetings often enough to arrange unique services coordinated with both the parent and caregiver and together assess whether they are the right services at the right frequency.

4. Increase Placement Resource Capacity and Stability

DMH and DCFS view their commitment to prevent the trauma of disruption for children as being reflected in the steps taken to develop an Automated Community-Based Home Reservation system, interagency collaboration (that unfortunately does not include Family Foster Care Agencies) to keep children close to their families, school-based recruitment of foster parents, and designing IHBS specifically to prevent each child from having a disrupted placement. Child well-being will be enhanced if each newly placed child remains near the parent with whom reunification is being planned and if the child does not have to change schools. This requires a major change from the past management of foster care placement, especially as the supply of homes has been shrinking.

Improving the quality of visits is a key ingredient to safe reunification. Visits are improved when there is shared parenting between parents and caregivers, with agreement between them about the child's needs and how to meet those needs, both in visits and in the caregiver's home.

DCFS offices have increased efforts to place children in family settings rather than group care, and the Panel has encouraged a new analysis of children in group care, reasons for their placement in the past year, and assessment of adequacy of mental health services for children in group care.

Specifically, the County should:

- Track any increase in placement changes within each office catchment area and identify the factors that make such placements a challenge to sustain

- Direct each immersion office to work with their FFAs to develop a plan for recruitment of additional family foster homes and place children close to home.

5. Expand the Use of the Automated Community-Based Home Reservation System.

This system informs DCFS staff where foster home vacancies in state-licensed homes exist system-wide. The County has been piloting a revision in this process for selected sites, whereby foster home vacancies in nine sites are reserved for that regional office for seven business days to permit the site to use them first. After seven days the vacancies are available system-wide. DCFS has recently implemented an improvement in which there is an automatic alert to staff when a vacancy occurs. The Panel views this innovation as promising in its ability to place children closer to their homes and communities. However, it has significant limitations in that the majority of family foster homes are licensed by private family foster care agencies (FFAs) and these agencies are not included in this application. According to the DCFS, the following table reflects the distribution of family foster homes between state-licensed homes and FFA-licensed homes as of 2017.

State-Licensed Foster Homes			FFA Homes		
Available Homes	Available Beds	Placed Children	Available Homes	Available Beds	Placed Children
954	2,476	**1,838**	3,195	7,366	**4,736**
		(74.2%)			(64.2%)

For the placement system to serve all class members, the application would need to be extended to apply to FFAs as well.

The Panel recommends that DCFS formally approach FFAs about applying the process to their agencies as well.

6. Strengthen the Supervisory Role in Shared Core Practice Model Implementation

The County should develop a supervisory process that guides supervisors in mentoring CSMs and holding them accountable for performance in the CFT process, identification of underlying needs and matching services and supports to needs through service crafting. This process would likely involve case file reviews and court reports (work products) and supervisory case conferences (supervisory forums) as ways to assess performance and skill development needs, underscore accountability and teach workers SCPM skills. The development of a supervisory guide would help structure this process. Supervisors would need training/coaching themselves to fully master this element of the supervisory role. The Panel does not believe that the County can meet QSR exit standards without addressing this vital supervisory role, which is not currently being performed on an ongoing basis beyond the CFT facilitation coaching, which is quite limiting. Continuing low QSR performance in these areas provide clear evidence of the necessity of implementing such supervisory review and mentoring.

7. Complete the CFT Tracking Application

The County should complete the development of a CFT frequency tracking system that provides management data on the performance of CSWs and the percentage of youth and families that have experienced a CFT in the past three months. As part of implementing this process, the County needs to issue policy guidance outlining how staff determine if contacts with families constitute a legitimate and reportable CFT. Because functional CFTs can take varying forms, policy guidance that provides for this variability would need to be carefully crafted, probably consisting of principles. The following examples have been shared with the County by the Panel previously.

Principles of SCPM CFT Meetings

Are usually planned in advance, with participants prepared/notified in advance

Entail ongoing communication among team members before and after team meetings to ensure follow up on service plans and other actions decided by the child and family team

Always involve the family

Should include a family support or supports member chosen by the family

Should include the CSW (with some exception for weekly Wrap meetings) and at least one other team member other than the family. (Teams usually grow in size over time)

Should include the caregiver (kin or foster family)

Should include key providers such as the child's therapist and school team member, where needed

Are strength and needs-based

Identify the strengths of the child, family and caregiver

Identify the needs of the child

Are outcome focused

Specify services to meet the child's needs

Specify supports for the family (during visits) and the caregiver to meet the child's needs

Result in notes about the decisions made in the meeting provided to participants

Result in an agreed-on plan with strengths, needs and supports and services

Systemic Barriers Impacting Practice

The following system barriers were identified in two Qualitative Service Reviews, one in the Compton Office and one in the Van Nuys office. These two offices were the initial immersion sites. In each case reviewed, reviewers note any system barriers impeding Shared Case Practice Model practice. Barriers were noted in 23 cases of the 24 cases selected randomly for review. The barriers that were identified follow.

Compton

Systemic Issues Impacting Practice:

1.
- Key informal and formal supports have not been engaged and are absent from the CFT
- Long waiting periods and ineffective mental health services due to high caseloads
- Homelessness/limited affordable housing impacts client's ability to focus on other case plan goals
- Confidentiality is a barrier to information sharing among systems
- CSWs lack training in mental illness and how to effectively engage clients with mental illness.
- Service providers lack training in the dependency process and what is required for safe case closure.

2.
- Access to medical records or consultation between mental health providers can help the FY meet treatment goals and prevent being re-traumatized by having to re-tell his story
- Sharing information within department programs can expedite referral process, improve recommendations for services, and satisfaction/effectiveness of services received
- Early and ongoing engagement of parents who are distrustful of multiple systems can strengthen the long term view for the FY and family
- Departmental policies and/or billing limitations limit the duplication of services (i.e., sessions provided by two mental health clinicians)

3.
- The roll out and implementation of the Share Core Practice Model takes time. In this case, a team has not been formed and planning is limited.
- When there is little understanding of underlying needs and effects of trauma of the parents it can impact long term view.
- Placing primary emphasis on court-mandated services (particularly related to substance abuse) rather than developing more specific interventions and services based on the family's needs can lead to a long term view without enough power to sustain long term goals.

4.
- A lack of training in the Core Practice Model (CPM) and concerns about breaking confidentiality can impact how providers implement the CPM in their daily practice and can impede the sharing of valuable information that could contribute to the team's assessment and understanding of the strengths & needs of the family.
- When a formal mental health assessment of a child is not completed, important and valuable information can be missed (i.e. infant hair and face pulling).
- Issues with Media-Cal can prevent the timely completion of a mental health assessments and can create concerns about double billing when the linkage agency (DMH) and the provider are able to conduct the assessment on the same day. In this case, the assessment was deferred to the

provider who only completed a partial assessment, when a full assessment could have ultimately been completed by the linkage agency.

- A delay in the Resource Family Approval (RFA) process causes a delay in payment to relative caregivers that results in unnecessary financial stress, even once the RFA is approved. The RFA process can also be a confusing process for relative caregivers.

5.

- **Relative Placements -** Relatives can experience financial challenges when RFA approval is delayed.
- **Resources** - There are challenges to meeting the needs for impoverished clients and the mental health needs of undocumented Spanish speaking adults when they must pay out-of-pocket for services and are struggling financially/unable to pay.

6.

- **Communication and Information Sharing**: When a child/youth is seen by multiple mental health practitioners and given varying and sometimes opposing diagnoses, it can create confusion and a challenge for team members to know how best to support the child and family in the effort to stabilize the child's mental health as part of permanency planning.
- **Lack of Placement Resources:** Systemically, family style placement options are slim to none for a FY who is an older African-American male, with a learning disability, unresolved mental health issues, and placed on probation. The youth's team has not explored the underlying need that drives the youth's resistance to ILP services and adoption.
- **Fear Factor:** Assessing and understanding the placement concerns of a youth and their underlying needs can be a challenge when the youth is guarded and distrustful of the system, and the key party they do trust who is with the child daily has not explored the child's underlying needs.
- **Family Connections:** Teamwork can be impacted when family members no longer participate in the Child and Family Team meeting process due to difficulty engaging the family or family members seeming to be adversarial to the process.

7.

- Sharing of information- there are communication barriers between Adult Mental Health Providers and the Child Mental Health Providers.
- Although the caregivers never complained, the length of the RFA approval process did create a financial strain on the caregivers.
- Engagement of parents in the CFT process can be a challenge when the parent has significant mental health issues and the only person the parent trusts is the CSW.

8.

- Children who have a history of trauma but do not exhibit obvious symptoms and appear to be functioning well do not meet medical necessity for needed trauma based therapy due to billing and funding criteria.
- There may be barriers to establishing permanency when an identified co-guardian lives out of state or an already established guardian chooses to move out of state.
- The fear of loss of professional support to families that already have limited resources can be a barrier to closing cases.

9.

- Development of a CFT is difficult when key individuals in child's life are not aware of each other, nor the roles and purposes of other potential key team members in the child's life.
- The Sharing of Information can improve team functioning and help to move a case forward.
- Ensuring the parent and the focus child have access to the right types of services at the right time, including but not limited to mental health services, can facilitate moving a case forward and prepare a family to function better together.

- Initial and ongoing review of the CG's constraints on ability to ensure timely transportation for mental health, pediatric, and other appointments necessary for the FC's well-being and development of contingency alternatives when the CG's work or other life demands require such assistance.
- Development of a flagging status to ensure a mental health provider does not close a case for the FC missed appointments before alerting the CSW and the Specialized Foster Care of missed appointments and potential case closure.

10.

- Conflicting Policy- Provider agencies may have strict policy about not getting involved in court recommendations related to placement or jurisdiction, which can impact the team's effectiveness to work with the family on their long term view plan affecting the children's stability and permanency.
- Court Requirements - Legal preference for relative placement sometimes may not be in the best interest of the children, and may fail after a short period of time, if done without careful consideration.

11.

- A focus on compliance with having CFTM's when a case is stable and moving expeditiously towards adoption can impact the assessment of underlying needs and planning on how best to meet them.
- Planning and outcomes for families can be impacted when key team members are not present at CFTMs and overall consistent outreach and communication is not occurring on an ongoing basis.
- There are legal barriers in obtaining Regional Center services when educational rights remain with parent's whose whereabouts are unknown.

12.

- CSWs and other professionals working with transitional-age youth face the unique challenge of promoting independence while also providing support when needed. It is crucial that a youth's trauma history be understood and taken into account when developing plans for their transition from DCFS care to independent living.
- When a youth is in a stable home and free of safety concerns, there is a tendency to perceive them as an "easy case" not requiring the close attention of higher-risk cases. This may in turn lead to underpowered interventions that do not adequately prepare the youth for adulthood.
- A cohesive team of formal and informal supports sharing information and resources promotes clear planning and the sharing of responsibility. Without this coordination, fragmented teams may develop in which individuals make efforts that are underpowered without the feedback and assistance from others who are closely involved in the youth's life.

Van Nuys

Systemic Issues Impacting Practice:

1.

- When the court liberalizes parents visits from monitored to unmonitored in Permanent Placement cases when the department is actively searching for an adoptive home, it can create confusion and a challenge for team members as to how best to include the parent in permanency planning.
- It is very difficult to find adoptive homes for sibling sets that are older and of mixed gender.
- Assessing and understanding the placement concerns of a youth, their underlying needs and that of their caregiver can be a challenge when the youth is very guarded and distrustful of the Department, and the key party they do trust who visits weekly, is unaware of the concerns.

- Teamwork can be impacted when family members who remain involved in the youth's life no longer remain as key participants in the Child and Family Team meeting process due to difficulty in engaging them or them seeming to be adversarial to the process.

2.

- A parent's legal status can create challenges in the family immediately accepting and trusting individuals providing services, which can create a delay in services starting and limiting the amount of time a family has to fully address underlying needs.
- Timelines and policies around the maximum amount of time families can receive Voluntary Family Maintenance Services can impact the degree to which a family is able to address underlying needs, especially when services such as Wraparound are viewed and received positively by a family, yet are contingent on having an open DCFS case.

3.

- Communication can be limited without a functioning CFT, where the youth's team members all know one another, are aware of the youth's strengths, needs, and goals. In this case, team members are not all on the same page about how the youth's medical diagnosis affects his needs and strengths.
- Legal status of caregiver impacts the CFT's ability to develop a permanency plan that does not include her pursuing Legal Guardianship or Adoptions, which all team members believe would be the best option for the FC.
- Financial, geographical, and language limitations can make accessing services or providers who have specialty training of certain conditions/diagnoses can be difficult for families.

4.

- Information sharing can improve team functioning and help to move a case forward. When a holder of pertinent information does not share information with other providers involved with the FC and family, it can limit the understanding of the underlying needs of the FC.
- Limited providers of similar cultural and linguistic backgrounds as parents can impede a parent's ability to effectively engage with all service providers.
- There is a need to provide more training to professionals to clarify understanding of what a CFT is and how to successfully develop a CFT with all the "right people".

5.

- *Mental Health Services delays:* Children do not always exhibit outward signs of emotional disturbance and instability. As a result, they may not meet medical necessity for immediate therapeutic intervention, thus delaying assessment for needed services.
- *Funding delays:* The caregiver has not received any foster care funding for over seven months due to the RFA process. In this case, there are no anticipated barriers to RFA approval, but the process is timely, placing extraordinary financial burdens on caregivers, and may affect stability.

6.

- **Information Sharing and CPM Installation**: Family participation is key to the design and implementation of the CFT and communication can be limited without a functioning CFT where all team members know one another and are aware of the strengths, needs, and goals of the FC, BM and SF. Communication between parties has not been supported by a team process in place to ensure that strengths and underlying needs are identified, addressed, information is shared, and effective planning takes place for the child and family.
- **Caseloads and CPM Installation:** High caseloads and highly complex cases can affect teamwork and engagement. This family is involved with multiple systems such as DMH, DCFS, the school system, and potentially Regional Center.

- **Access to Resources:** The family has limited financial means and requires free or low-cost services, many of which have resulted in a wait list. Basic needs such as a functioning stove, refrigerator, transportation and rent have been a challenge for this family.
- **Billing Requirements/Limits:** More intensive services have been recommended for the FC, such as PCIT, however, billing issues will require the FC to stop attending his day treatment program. Additionally, BM was timed out of mental health counseling with limited improvement in goals.

7.

- The roll out and implementation of the Shared Core Practice Model takes time. In this case, a team has not been formed and planning is limited.
- Communication can be limited without a functioning CFT where the FC's team members all know one another and are aware of the child's and family's strengths, needs and goals. In this case, the FC is struggling academically and has been since the case was opened, and the FC's Mo is struggling to find a home.
- The lack of understanding of underlying needs and effects of trauma can impact planning and services.

8.

- Multiple case reassignments in a short period of time can impact the assessment and understanding of the case history, as well as create barriers in identifying the family's underlying needs.
- A lack of ongoing communication and information sharing between DCFS and community based service providers can negatively impact the assessment and understanding of a family's needs.
- When the focus of the CFT process is on compliance, opportunities to engage the family in having input in their case plan and identifying underlying needs can be missed.
- Due to a lack of continuity of CSW's important documentation was not in the case file, therefore creating a barrier in verifying completion of court ordered services.

9.

- Access to Services - Lack of services offered in foreign languages. This is a family where the father is Armenian and his primary language is Russian. Father and the CSW have been challenged to locate services offered in Russian or that would accommodate an interpreter.
- Cultural Sensitivity - There is a need when working with all families, and particularly those who have relocated from other countries, to be aware of the assumptions we make. Through the QSR process, in addition to the parents wanting to convey that the detention of their son could have been handled more professionally, father wanted to express dismay regarding a comment made court that because he could speak English with a good amount of fluidity, that he did not need an interpreter. Mother, is much more proficient in English than father, however, one of her group counselors shared that she often uses a word translator on her cell phone during group meetings to help aide in her understanding of conversations. It is important that the Department make the effort to ensure that interpretations of our words and their nuances are well understood by our families as they work to rebuild their families.

10.

- **Child and Family Team (CFT) and Core Practice Model Installation** Although CFT meetings are designed to allow the voice of the youth along with their supports to plan around the youth's strengths and needs, the youth may feel the meeting is focused on all the accomplishments made by the adults in the room and less about what the youth feels she needs. In this case, it appears that the youth and her team were making progress towards her goals (applying for colleges, obtaining driver's license, etc.) that the meeting did not feel helpful to the youth. Including the

youth in discussions around what she feels she needs and what she feels would make the meetings helpful could create a more child focused meeting.

- **Transitions and Case Handoffs** Training is needed for DCFS and FFA workers about how to ensure necessary placements moves are less traumatic and how to address the harm that is caused by the moves. In this case the FY was replaced from her former foster home, where she resided for approximately 4 years abruptly due to the caregiver allowing an unauthorized person to live in the garage of the home. The FY would have benefited from better communication in the planning and a space where she could have said good bye to this important adult in her life. In response the child experienced some depression surrounding this move where she was picked up from school with all of her belongings in hand.
- **Working with Transition Aged Youth** The opportunities from the AB12 program and some ILP services and benefits are not available to foster youth prior to graduating high school which could be more helpful early on as a youth plans for their future. In this case, the youth felt she did not receive the guidance/support in the college application process from these services when she needed them. She further was not able to obtain resources like a lap top and driver's education until after she turns 18 years of age.

11..

- Extended family members (such as MGM) and persons without a biological relationship with the child (such as stepfather) are often not seen as crucial, fully-participating members of the team despite having a primary role in the child's life.
- Due to high workloads, CSWs have difficulty prioritizing CFTMs and completing them within the required timeframes. (CSW had done a CFTM with this family right before the review and had wanted to do the next one the beginning of February 2018 but he had others that needed to be done first).
- Confidentiality concerns (the concern of DCFS, for example about sharing information with school personnel or the concern of mother's therapist about sharing information with DCFS) can be a barrier to the development of a common understanding of strengths and underlying needs that can help team members form a unified support system helping the family to achieve safe case closure.

12.

- When completion of court-mandated services takes priority over family-specific interventions, family members may feel that compliance with court orders is more important than their contributions.
- Additional efforts must be made to repair professional relationships with family members who feel they were wronged during the initial stages of a case, as it can lead to additional challenges in building relationships based upon mutual trust and respect with families.
- Formal and informal supports who possess valuable insights into a child's or family's needs may be hesitant to disclose this information to people outside of the family system out of concern that such disclosures would negatively impact their relationships with these individuals.

PROOF OF SERVICE
Katie A., et al. v. Diana Bonta, et al.
Case No.V-02-05662 JAK (SHx)

I, the undersigned, say: I am over the age of 18 years and not a party to the within action or proceeding. My business address is 3701 Wilshire Boulevard, Suite 208, Los Angeles, California 90010.

On January 23, 2019, I served the foregoing documents described **ADVISORY PANEL'S REPORT TO THE COURT – ANNUAL REPORT FOR 2017, DECEMBER 21, 2018** on all interested parties in this action by placing copies thereof enclosed in a sealed envelope addressed as follows:

John F. O'Toole
National Center for Youth Law
405 14th St., 15th Floor
Oakland, CA 94612-2701

Kathleen R. Wolfe
US Department of Justice
950 Pennsylvania Avenue N W NYA
Washington, DC 20503

[X] BY MAIL - I deposited such envelope in the mail at Los Angeles, California, with first class postage thereon fully prepaid. I am readily familiar with the business practice for collection and processing of correspondence for mailing. Under that practice, it is deposited with the United States Postal Service on that same day, at Los Angeles, California, in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postage cancellation date or postage meter date is more than one (1) day after the date of deposit for mailing in affidavit; and/or

[X] BY CM/ECF NOTICE OF ELECTRONIC FILING: I electronically filed the document(s) with the Cleark of the Court by using the CM/ECF system. Participants in the case who are registered CM/ECF users will be served by the CM/ECF system. Participants in the case who are not registered CM/ECF users will be served by mail or by other means permitted by the court rules.

I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made.

I declare under penalty of perjury that the foregoing is true and correct. Executed on January 23, 2019, at Los Angeles, California.

Crista Minneci

CRISTA MINNECI