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DEPARTMENT OF MENTAL HEALTH

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October 5, 2005

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

AUTHORIZATION TO IMPLEMENT
COUNTYWIDE ENHANCED SPECIALIZED FOSTER CARE
MENTAL HEALTH SERVICES
IN SERVICE AREAS 1, 6, AND 7
(ALL SUPERVISORIAL DISTRICTS)
(4 VOTES)

JOINT RECOMMENDATION WITH THE DIRECTOR OF THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES THAT YOUR BOARD:

1. Approve the proposal for the Countywide Enhanced Specialized Foster Care Mental Health Services Plan (Plan), as described in Attachment I, to enhance specialized foster care mental health services and ensure that children referred to the Department of Children and Family Services (DCFS) are appropriately screened for mental health issues, and that all children placed under the care of DCFS have ready access to multidisciplinary assessments and mental health treatment services. This plan is consistent with the County's obligations under the settlement agreement reached in the Katie A. class action litigation.

2. Authorize the implementation of the Plan in Service Areas (SAs) 1, 6, and 7, effective upon Board approval. These services represent Phase I of the Plan at a projected annual cost of $19,024,000, as shown in Attachment II, funded with $7,775,000 in Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-State General Funds (SGF), $9,512,000 in EPSDT-Federal Financial Participation (FFP) Medi-Cal, and $1,737,000 in Intrafund Transfer (IFT) from DCFS using net County cost (NCC) from the Designation fund for MacLaren, as detailed in Attachment II. In addition, there are $698,000 in one-time only start-up costs funded with $285,000 in EPSDT-SGF, $349,000 in EPSDT-FFP Medi-

Cal, and $64,000 in Intrafund Transfer (IFT) from DCFS using FY 2004-05 carryover NCC. The projected cost for FY 2005-06 is $13,380,000 funded by EPSDT-SGF, EPSDT-FFP Medi-Cal, and IFT from DCFS.

3. Approve the attached Request for Appropriation Adjustment in the amount of $3,121,000 funded by EPSDT-SGF, EPSDT-FFP Medi-Cal, and IFT from DCFS using NCC from the Designation fund for MacLaren, to provide the necessary spending authority that has not yet been included in the FY 2005-06 Department of Mental Health (DMH) Adopted Budget.

4. Authorize DMH to fill 113.0 ordinance positions, as shown in Attachment III, pursuant to Section 6.06.020 of the County Code, subject to allocation by the Department of Human Resources (DHR).

5. Delegate authority to the Director of Mental Health or his designee to prepare, sign, and execute an amendment, substantially similar to Attachment V, to the Affiliation Agreement with the Regents of the University of California, Los Angeles (UCLA) for the David Geffen School of Medicine at UCLA – Department of Psychiatry and Biobehavioral Sciences, to provide program evaluation on an annual basis, for an annual amount not to exceed $50,000.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Approval of the recommended actions will enable DMH and DCFS to develop an expanded comprehensive, community based, culturally relevant treatment program to build upon current and prior efforts to improve child welfare outcomes and improve mental health services for foster children and youth. Such efforts included the DCFS/DMH joint closure of MacLaren Children's Center and the development of several joint programs to address mental health needs of foster youth. While DCFS has made significant strides in reducing the number of children in out-of-home placement and in keeping children in their own homes, there continues to be significant need to augment the mental health delivery system to increase capacity to assess, screen and treat children referred to DCFS for mental health issues in a timely, appropriate and effective manner. Over the past several years, DMH and DCFS have engaged in collaborative efforts to improve and increase crisis response, assessment, treatment, coordinated care, and client outcomes. Although improvements have been achieved, there continue to be some challenges in meeting the growing and continuous demand for specialized services to this very vulnerable population. Services are unevenly distributed across the County with little coordination of effort or attention to service outcomes.

Recent data indicate there are approximately 23,000 children in out-of-home placement in Los Angeles County, with about 31% or 7,130 currently receiving mental health services through the DMH directly operated and contracted programs. Research indicates that 50% of children in foster care require mental health services. Consequently, DMH is currently serving 62% of the children in foster care believed to require mental health services leaving an unmet need of 4,370. Approximately 1,800 of those children reside in SAs 1, 6, and 7. Funding of this project will facilitate the availability of mental health services to as many as 1,800 additional children and families on an annual basis for Phase I.

The Plan and the implementation of Phase I of this Plan represent a coordinated, collaborative effort between DMH and DCFS to further address the specialized mental health needs of foster care children. DMH staff co-located at DCFS Regional Offices will provide the following essential functions: mental health screenings and referrals within 72 hours of placement, coordination of emergency psychiatric responses, centralized client enrollment, case management and tracking, consultation, system navigation, technical assistance and training, and monitoring of services and measurement of treatment outcomes. DMH directly operated and contracted agencies will provide comprehensive and standardized psychosocial and developmental assessments, as well as provide evidence-based treatment approaches shown to be effective in treating the severe emotional and behavioral problems of the foster care population. These services will be provided in a flexible manner reflective of the child's needs and strengths and delivered in the child's home and other appropriate community settings.

It is anticipated that the successful implementation of Phase I of the Plan will serve as a model for expansion of the Plan to the remaining five County Service Areas. Service Areas 2, 3, 4, 5, and 8 will begin developing proposals for specialized foster care mental health services consistent with the components of the joint DMH/DCFS plan in April 2006, refining their implementation plans based on lessons learned during Phase I. Full Countywide implementation is planned by June 30, 2007.

Implementation of Strategic Plan Goals

The recommended Board actions are consistent with the principles of the Countywide Strategic Plan: Organizational Goal No. 1, "Service Excellence" - Provide the public with easy access to quality information and services that are both beneficial and responsive; Goal No. 3, "Organizational Effectiveness" - Ensure that service delivery systems are efficient, effective, and goal-oriented; Programmatic Goal No. 5, "Children and Families Well-Being" - Improve the well-being of children and families in the County of Los Angeles; and Goal No. 7, "Health and Mental Health" - Implement a client-centered,

information-based health and mental health services delivery system that provides cost-effective and quality services across County departments.

FISCAL IMPACT/FINANCING

The annual projected cost of Phase I of the Plan is $19,024,000 funded with $7,775,000 in EPSDT-SGF, $9,512,000 in EPSDT-FFP Medi-Cal, and $1,737,000 in IFT from DCFS using NCC from the Designation fund for MacLaren, as detailed in Attachment II. In addition, there are $698,000 in one-time only start-up costs funded with $285,000 in EPSDT-SGF, $349,000 in EPSDT-FFP Medi-Cal, and $64,000 in IFT from DCFS using FY 2004-05 carryover NCC.

The projected cost for FY 2005-06 is $12,682,000 funded by $5,183,000 in EPSDT-SGF, $6,341,000 in EPSDT-FFP Medi-Cal, and $1,158,000 in IFT from DCFS using NCC from the Designation fund for MacLaren. In addition, there are $698,000 in one-time only start-up costs funded with $285,000 in EPSDT-SGF, $349,000 in EPSDT-FFP Medi-Cal, and $64,000 in IFT from DCFS using FY 2004-05 carryover NCC.

The Request for Appropriation Adjustment will properly align the FY 2005-06 DMH Adopted Budget, which already includes $10,259,000 in appropriation for this Plan. The $3,121,000 Appropriation Adjustment will bring the funding up to $13,380,000.

DMH will develop a FY 2004-05 baseline to identify the funding currently allocated to provide mental health services to children under DCFS supervision. The baseline will identify the amount of Medi-Cal and County General Funds (CGF) currently being expended to provide mental health services to the children under DCFS supervision. This includes services provided by both directly operated and contract providers. DMH will provide DCFS with the necessary documentation to support that the baseline has been met at which time DCFS will only be obligated to provide the funding for unreimbursed services provided above the baseline and specifically related to the services provided in the Plan.

The use of the baseline methodology will ensure that the NCC funding provided by DCFS from the Designation fund for MacLaren, as part of the Plan, is used to augment current service and funding levels, ensuring that there is no supplantation. The match funds provided by DCFS are not authorized to be used to supplant FY 2004-05 funding levels.

The projected annual cost of the total enhanced Countywide program will be determined based on the lessons learned in Phase I and included in the recommendations that will be submitted to your Board for approval next spring.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The requested actions will provide enhanced Specialized Foster Care Mental Health Services in SAs 1, 6, and 7 in accordance with the Plan. The Plan also includes the development of a Child Welfare Division in DMH, reporting directly to the Director of Mental Health. This division will have important responsibilities in the promotion of interdepartmental training for DMH contracted and directly operated programs, as well as DCFS partners in areas such as in-home and evidence based treatment approaches. Additionally, the division will be charged with interdepartmental collaboration and the establishment of an enrollment and tracking system that will allow for the monitoring of service delivery and treatment outcomes. Further, DMH will provide additional staff to the DMH ACCESS Hotline to respond to inquiries and concerns of children/youth and their families, child welfare workers, mental health providers, and others. These staff positions will be dedicated to managing child welfare issues and will coordinate their efforts and information with the 2-1-1 calling system.

The Plan will provide for unprecedented collaboration and coordination between DCFS, DMH, and the countywide network of mental health service providers on behalf of dependent children and youth. Children entering the foster care system, those in congregate care, and those in special needs placements related to emotional and behavioral problems will be targeted for specialized services. The plan also seeks to improve the Departments' ability to collect, share, and track service delivery and outcomes as they relate to both child welfare and mental health goals, thus improving opportunities for ongoing systems adjustments and improvements.

The broad goals of the Plan are to improve coordination between child welfare and mental health efforts and identification of need for and access to mental health services, expand availability of specialized and intensive in-home mental health services, reduce timelines to permanence, reduce placement disruptions, and improve day-to-day functioning of children and youth in essential life domains. Additionally, DMH and DCFS will work closely to ensure that the children and families in the child welfare system have early and maximum access to entitlement programs and benefits. These programs include EPSDT Medi-Cal, Healthy Families, Healthy Kids, and other available State and federal revenue resources.

Service Area 1 Specialized Foster Care Mental Health Services will provide services to a projected 323 children in placement identified by the Palmdale and Lancaster DCFS Regional Offices as requiring mental health services. Of those, about 95 will require intensive levels of treatment described in this Plan, while the remaining 228 children will require less intensive levels of treatment. The existing contracts of the mental health providers in SA 1 will be amended to facilitate the provision of intensive in-home and

basic mental health services. Children to be served in the intensive in-home model include those identified as Seriously Emotionally Disturbed (SED) through the screening and assessment process, from the Team Decision Making conferences, and those placed in D-Rate and group homes.

Additionally, the SA 1 plan calls for the development of a directly operated, small community based children's crisis program to respond to crisis situations requiring immediate assessment and access to mental health services. This service targets children who have not yet been referred to mental health services, but for whom immediate assessment and stabilization is essential. Each licensed or waivered staff will carry a caseload of not more than 30 clients. Also, two teams of DMH directly operated staff will be co-located at the Lancaster and Palmdale DCFS Regional Offices. The staff will provide an array of supportive services to the DCFS Children's Services Workers to facilitate timely and appropriate linkages to enhanced community services, including mental health.

SA 6 Specialized Foster Care Mental Health Services will serve to improve and increase access to screening, assessment and mental health treatment for children under the care of DCFS and their families by augmenting the existing array of services and building upon the unique resources that already exist in that SA. These include the recent opening of the DCFS Compton Regional Office, co-location of DMH staff in the Compton Regional Office, DMH's significant investment in comprehensive children and family services at Augustus F. Hawkins Mental Health Center, and expansion of the services provided by the network of contracted mental health providers.

DMH assumed responsibility for the operation of the Augustus F. Hawkins outpatient psychiatric services almost two years ago. Since then, a foundation for academic and medical teaching services as well as an extensive array of children and family services in the Southern County area has been established, which will benefit foster children and families. In addition to the ability to provide thorough, multidisciplinary assessments, crisis and ongoing therapy for children, adolescents and their families, state-of-the-art approaches will be available in this community through this program. The SA 6 program will serve the DCFS Century, Compton, Hawthorne and Wateridge Regional Offices through County DMH directly operated and contracted programs.

Recent data indicates that a projected 969 children in foster care in SA 6 are not receiving necessary mental health services and interventions. Of those, about 278 will need intensive levels of services. These characteristically are children placed in D-Rate foster homes, congregate care, and those recently discharged from acute hospitals or at risk for a change in placement. The network of contracted mental health providers will provide the intensive in-home services. The remaining 691 children will need less

intensive, or basic mental health services. The SA 6 plan calls for the directly operated programs to provide the full menu of basic mental health services for this target population, as well as specialized programs like the Multidisciplinary Assessment Team (MAT) and Start Taking Action Responsibly Today (START) programs. The clinic staff is expected to carry an average caseload of 30 clients with an anticipated turnover of 10-15 percent over a three-month period. Directly operated clinic staff co-located at all four of the DCFS regional offices will allow participation in the systematic mental health screening and assessment of children as they enter the child welfare system in SA 6.

SA 7 Specialized Foster Care Mental Health Services will provide mental health services to a projected 474 children in placement who are currently being unserved. Of those, about 100 are residing in D-Rate and group homes and will require an intensive level of services. An additional 374 children are believed to need mental health services at a less intense level. The SA 7 contracted providers will provide all of the intensive services and most of the basic mental health services.

The American Indian Counseling Center, with its specialized target population and specially trained staff, will serve the children in foster care who are Native American. The requested additional staff will allow this agency to enhance its already existing collaborative relationship with the DCFS American Indian Unit.

Further DMH will provide identification, consultation, screening and linkage to mental health services for children referred to or under the care of DCFS. Through this program, DMH clinical staff plans to be co-located in the SA 7 DCFS Regional Offices (Belvedere and Santa Fe Springs) to provide mobile response, crisis intervention, assessment, brief treatment, and linkage services. Mental health clinicians will also have increased involvement in several DCFS processes, including Regional Permanency Review Teams, Family Team Decision Making conferences, and DCFS case planning meetings as well as improved capacity to accompany DCFS staff on field visits. In addition, mental health staff will assist DCFS in developing support groups, self-help groups, and other interventions to target transition age youth, with a particular focus on issues of substance abuse and gang involvement. Finally, the program provides for the expansion American Indian program at Rio Hondo and selected contracted mental health services providers who are yet to be determined. These expansions are intended to provide sufficient capacity to address the special needs of children from birth to five years of age, children at risk for placement changes, those in Foster Family Agencies, those with histories of repeated psychiatric hospitalizations, and those residing in D-Rate placements.

The proposed actions have been reviewed and approved by County Counsel and the CAO.

CONTRACTING PROCESS

DMH will process contract amendments under delegated authority to the extent possible once the contractors are identified. Contract funding for these services will be allocated based on service capacity, demonstrated program quality, and financial viability. Your Board will be notified in advance of any planned sole source contract amendments that exceed $250,000.

DMH is currently working with staff from the Internal Services Department, the Auditor-Controller, County Counsel, and the Chief Administrative Office to develop a streamlined contract solicitation process that will be submitted for Board approval. This process will be designed to ensure compliance with all policies and regulations, while enabling implementation of new and/or expanded contracts in a timelier manner. Contract awards that cannot be made under delegated authority will be submitted to your Board for approval.

IMPACT ON CURRENT SERVICES

The Plan will provide a template for improving access to and provision of specialized mental health services to a high priority, underserved population of children referred to or under the care of DCFS. Implementation of Phase I of this Plan will increase capacity and provide state-of-the-art mental health services tailored to the needs of foster children and their families in SAs 1, 6, and 7. In addition, this Plan will create an environment for enhanced collaboration between DMH and DCFS to address the needs of this high-risk group of children and their families.

CONCLUSION

The Departments of Mental Health and Children and Family Services will each need one (1) copy of the adopted Board's action. It is requested that the Executive Officer of the Board notifies the Department of Mental Health's Contracts Development and Administration Division at (213) 738-4684, and the Department of Children and Family Services, Director's Office, at (213) 351-5600 when these documents are available.

Respectively submitted,

Marvin J. Southard, D.S.W.
Director of Mental Health

David Sanders, Ph.D.
Director of Children and Family Services

MJS:DS:SK
ST

Attachments (5)

c: Chief Administrative Officer
County Counsel
Auditor-Controller
Chairperson, Mental Health Commission

County of Los Angeles
Department of Mental Health (DMH)
Department of Children and Family Services (DCFS)

Countywide Enhanced Specialized Mental Health Services
Joint Plan

Introduction

The Katie A. lawsuit was based on the assertion that Los Angeles County was overutilizing out-of-home placement due to lack of appropriate mental health services for children in the foster care system. Specifically, children were not appropriately screened, assessed, or treated for their mental health needs and were frequently placed in unstable congregate care as a result. Los Angeles County has made tremendous progress in meeting the obligations of the settlement as evidenced by the following.

During the past few years, Los Angeles County has significantly reduced the number of children brought into care as well as improved safety, stability and permanence for children in care including the children represented in the Katie A. plaintiff class. Examples of these improvements are reflected in a number of key indicators. We have had a reduction in the percent of children with a substantiated allegation (within 6 months of the initial allegation) from 9.2% to 7.8%. We have reduced the rate of child abuse/neglect in foster care from 1.62% to .096% and have reduced the rate of recurrence of abuse and/or neglect in homes where children were not removed from 6.9% to 6.5%. We have increased the number of children that are reunified within 12 months from 32% to 40.7%, while reducing subsequent entries into foster care within 12 months of reunification from 6.9% to 4.8%. These achievements are significant and demonstrate that increased efforts to keep children in their home or return them home more quickly with support has not compromised their safety.

We have also made progress in providing stability to children in care by increasing the percentage of children who have had no more than two placements while in care for 12 months or less from 86.7% to 88.6%. In addition, we have continued to maintain and support our rate of primary placements with relatives (most recently at 48.4% - one of the highest relative placement rates in the nation). We have significantly reduced our reliance on congregate care for all children, with significant progress made for the younger children (age 12 and younger) who numbered 570 in August 2003 reduced to 380 in August 2005. In many of the measures noted above, we meet or exceed the State level and/or expected progress toward improvement.

The strategies implemented by Los Angeles County have been broad based and intended to improve the conditions for all children in the foster care system or at risk of entering foster care. Since all youth at risk for entering foster care are potential members of the Katie A. class, it has been imperative for the County to employ these broad-based strategies which have resulted in significant improvements for all youth in care, including those members of the Katie A. class. The strategies utilized by the County have included all elements of Paragraph 7 of the settlement. Furthermore regarding Paragraph 6, indicators outlined above reveal the County has dramatically improved the provision of service intended to prevent removal or facilitate reunification

and the County exceeds the federal child welfare standards for stability in placement. Furthermore, the County has demonstrated improvement in the vast majority of measurements established by both the State and federal government as reflections of overall functioning of the child welfare system.

The remaining element of Paragraph 6 of the settlement that this plan addresses is the provision of necessary individualized mental health services in a child's home or a family setting. The Plan assures that all youth entering foster care will be screened for mental health needs assessed by a mental health professional promptly when necessary and treated in their home or a family-like setting when possible.

The proposed plan builds upon current and prior efforts to improve child welfare outcomes and to improve mental health services for foster children and youth. These included the DCFS/DMH joint closure of MacLaren Children's Center, the development of several joint programs to address the mental health needs of foster youth including the Multidisciplinary Assessment Teams (MAT), the Interagency Consultation and Assessment Teams (ICAT), the Start Taking Action Responsibly Today (START) program, D-Rate assessment, AB 3632, System of Care (SOC), Children's Crisis Teams and the Dependency Court Mental Health Services program, and an expansion of enrolled youth in Wraparound from 322 in January 2003 to 513 in July 2005.

The following plan for Enhanced Specialized Mental Health Services will significantly augment the current mental health service delivery system wherein mental health professionals assess children's strengths and needs, and corresponding individualized services are developed. It will build upon the above detailed achievements while further contributing to increased child safety, reduced reliance on out of home care, and improved timelines to permanency, as well as improved outcomes in functional life domains. This plan is consistent with the County's obligations under the settlement agreement reached in the Katie A. class action.

Scope of Effort and Target Populations

The plan is targeted to those unserved and underserved children/youth in the child welfare system who are in need of mental health services, particularly those who are considered Seriously Emotionally Disturbed (SED) and now placed in congregate care or in D-Rate homes as well as those children/youth who enter the child welfare system.

DCFS currently serves approximately 23,000 children in out-of-home care. DMH estimates that approximately 7,130 of these children/youth are presently receiving mental health services, with approximately 2,080 children receiving a level of care equivalent to the intensive mental health services proposed in the Plan, and another 5,050 receiving more brief symptom-oriented mental health services. The Plan has been developed, in part, to address this gap in overall mental health service delivery.

In addition to the currently unserved population, we also believe there are a number of the 7,130 children/youth who are currently receiving services that lack the intensity, duration, or comprehensiveness that they require. This underserved population consists largely of the children/youth now placed in congregate care and D-Rate group homes.

Based upon a study conducted by John Lyons, Ph.D., of children placed in group homes in Los Angeles County, many of the children/youth in such placements could be better served through an intensive in-home treatment model such as treatment foster care (report dated July 1, 2005). We anticipate that virtually all of the 2,000 children now in congregate care can be better served through a more intensive mental health services model, and that half of the 2,600 children now in D-Rate homes can also be better served through a similar approach.

In addition to providing additional resource capacity to serve unserved and underserved children currently in the child welfare system, the Plan also calls for the development of mental health screening, assessment, and treatment capacity for children as they enter the child welfare system. DCFS detains approximately 9,000 children/youth each year, and each of these children/youth will require mental health screening. We anticipate that approximately 4,500 of these screenings, consistent with the 50% estimated prevalence rate of mental health problems within the child welfare population, will indicate the need for a more thorough mental health assessment to determine service needs and the provision of various levels of mental health services.

The estimates of service provision to be supported by the Plan are presented in the following chart.

Enhanced Specialized Foster Care Mental Health Services Gap Analysis

Levels of Service Provision	Number of Children Currently Served by DMH	Projected Mental Health Service Needs	Numbers of Children to be Served by Plan
Intensive MH Services	2,080	3,300	1,220
Basic MH Services	5,050	8,200	3,150
Totals	**7,130**	**11,500**	**4,370**

Notes:

1. DMH is currently serving 31% or 7,130 of the 23,000 children currently in out-of-home placement.
2. Of the 7,130 children currently served, approximately 2,080 are receiving a level of care (TBS, Wraparound, SOC, RCL 12 & 14 and CTFs) equivalent to the proposed intensive mental health services. Not all children in congregate care receive this equivalent level of service.
3. The remaining 5,050 children are being seen in less intensive or basic mental health services.
4. Current unmet need calculated at $15,000 per child for intensive and $6,000 for basic mental health services.
5. These projections are based on the assumption that the number of children in out-of-home placement will be about the same or less over the next year as children are placed in permanent homes.

6. These projections also assume that the total demand for mental health services at these levels will remain roughly constant in the near future such that children entering the child welfare system will move into service delivery capacities vacated by other children as their needs for services are reduced or no longer present and/or as children move out of the child welfare system.

Overview of Current Mental Health Services Available to Foster Youth

DMH currently administers a wide variety of programs designed to address the mental health needs of DCFS involved children, youth, and their families. Most of these programs "target" children with significant impairments as a result of mental disorders. Many programs also include service integration initiatives and interagency collaboration with other County departments, school districts, and community provider networks. The types of services provided include screening, assessment, treatment, behavioral interventions, special education services, case management, consultation and linkage, family/community support, crisis response, placement, and medication management.

Several DMH efforts provide examples of such services for DCFS involved youth and their families. Included among these models are the Multidisciplinary Assessment Teams (MAT), the Interagency Consultation and Assessment Teams (ICAT), and the Start Taking Action Responsibly Today (START) program. Each of these programs was designed specifically to support the mental health needs of children/youth in the child welfare system. Other DMH-administered programs that address assessment/evaluation for children in care include: D-Rate assessment, AB 3632, and the Dependency Court Mental Health Services program.

DMH also administers the mental health component of the Family Preservation program and participates in a number of DCFS initiatives, including SPA-based Family-Centered Team Decision-Making (FTDM) meetings, Regional Permanency Review Teams (RPRTs), Interagency Screening/Review Committees (ISCs), and Local Interagency Operation Networks (LIONS). Through its ICARE network, the Department further coordinates and provides training, technical assistance and support to a variety of programs which serve the mental health and developmental needs of children from birth to five years of age in the care of DCFS as well as families at risk for maltreatment of young children.

Finally, DMH provides a variety of mental health service options for the highest at-risk children/youth in the child welfare system. Specific populations served by these programs include: SED foster care children with AB 3632 services and special education placements; children placed in D-Rate foster homes or in group homes; children living in residential treatment facilities (RCL 12 and 14 placements); children in Fee-For-Service psychiatric hospitals; children receiving Foster Care emergency services through DMH Enhanced Children's Crisis Teams and other acute assessment and emergency services; children receiving Wraparound, Children's System of Care, and Therapeutic Behavioral Services; and children referred by the Metropolitan State Hospital Screening Committee for interagency consultation, case management, and follow-up. These efforts

provide systematic case coordination and linkage across multiple programs as well as improved access to an array of services.

The types of services provided to this population and their associated costs are presented in the table below. Note that the numbers of clients served reported in this table does not represent unduplicated clients. For example, some clients receive more than one type of service over the course of the year and are therefore reflected in more than one category.

Service Type	Number of Clients Served	Number of Contacts	Amount Billed
Outpatient	17,290	113,495	$118,894,515
Inpatient	1,446	2,530	$21,522,783
Crisis Stabilization	411	539	$627,192
Day Treatment	2,042	2,487	$33,558,813
Total Cost			**$174,603,303**

In addition to these services, Fee-For-Service providers report provision of outpatient mental health services to 6,124 DCFS involved clients during the same reporting period.

Overview of Plan

The Plan will provide for the development of a system that assures mental health screening, assessment and the development of individualized and specialized mental health services tailored to the unique needs of the children/youth to enable children to remain with their families or return more quickly to a permanent family home. In addition, the Plan calls for significant organizational and structural changes to increase the accountability of the system and to support the successful implementation of this plan. It calls for the large-scale expansion of mental health service capacity for foster youth as well as the development of specialized treatment service approaches, including evidence-based practices. Children entering the foster care system, those in congregate care, and those in special needs placements related to emotional and behavioral problems will be targeted for specialized services. The Plan also seeks to improve the Departments' ability to collect, share, and track service delivery and outcomes as they relate to both child welfare and mental health goals, thus improving opportunities for ongoing systems adjustments and improvements.

Plan Goals

The broad goals of the Plan are to:

1. Improve coordination between child welfare and mental health efforts on behalf of dependent children/youth;

2. Improve identification of need and access to mental health services for children/youth in the child welfare system;

3. Expand the availability of specialized and intensive in-home mental health services for DCFS involved children/youth;

4. Reduce reliance on out-of-home and congregate care settings for children/youth in the child welfare system with emotional and behavioral problems;

5. Reduce timelines to permanency for children/youth identified as in need of mental health services;

6. Reduce placement disruptions as a result of emotional and behavioral problems for DCFS involved children/youth; and

7. Improve day-to-day functioning of children/youth in essential life domains (e.g., emotional/behavioral well-being, supportive relationships, safety and stability, placement stability, etc.).

Organizational and Structural Supports

The Plan includes a number of significant organizational and structural supports to promote successful implementation and achievement of goals and objectives. In addition to the request for additional budgetary support for service provision, the Plan calls for increased collaboration between DMH and DCFS through the co-location of mental health staff within DCFS regional offices, the establishment of service delivery and outcome measures, a jointly developed tracking system, support for mental health access and information via dedicated staffing to the DMH ACCESS Hotline, and the development of a DMH Child Welfare Mental Health Services Division, dedicated to working with DCFS to further develop and implement the Plan.

DMH Child Welfare Mental Health Services Division

The Plan calls for DMH to develop a Child Welfare Mental Health Services Division, directed by a leader knowledgeable in clinical mental health services, child welfare policy and practice, and mental health funding strategies. Due to the critical nature of the work of the division, the Mental Health District Chief heading it will report directly to the Director of Mental Health. This division will have important responsibilities in the promotion of interdepartmental training for DMH contracted and directly operated programs as well as DCFS partners in areas such as in-home and evidence-based programs. Additionally, the division will have responsibility for interdepartmental collaboration and the establishment of an enrollment and tracking system that will allow for the monitoring of service delivery and treatment outcomes.

This Division will work in concert with DMH staff assigned to DMH Service Area District Chiefs and, in turn, with DMH staff co-located within the various DCFS regional offices. DMH staff deployed in the Regional Offices will report to the local Service Area administration. These Service Area administrations will work collaboratively with the DMH Child Welfare Mental Health Services Division to coordinate countywide implementation.

The administrative relationships between the DMH staff co-located in the various DCFS offices, the DMH Service Area administrators, and the new Child Welfare Mental Health Services division are depicted in the organizational chart located in Appendix A.

Child Welfare Mental Health Hotline

DMH will provide additional staff to the DMH ACCESS Hotline to respond to inquiries and concerns of children/youth and their families, child welfare workers, mental health providers, and others. These staff positions will be dedicated to respond to child welfare mental health issues and will be trained regarding resources available Countywide as well as with respect to the unique systems and operations of both child welfare and mental health. Staff will also coordinate their efforts and information with the 2-1-1 calling system recently implemented in Los Angeles County to help residents find health and social service information.

These hotline responders will provide information and referral resources for callers and serve as an important means to identify service needs and systems problems. The hotline will also provide another vehicle by which to promote continuity of care by reporting treatment disruptions and complaints to case managers.

DMH Co-located DCFS Regional Office Operations

Central to the coordination of child welfare and mental health services is the development of DMH Mental Health Units within each of the eighteen DCFS regional offices. Clinicians stationed in these offices, operating as systems navigators/case managers, will play a pivotal role in the identification of children in need of mental health services and the linkage to the appropriate contracted mental health provider. Systems navigation services include consultation, brief assessment of service delivery needs, referral and linkage to comprehensive assessment and service delivery resources, and follow-up to ensure service engagement. Case management services involve the ongoing monitoring of service delivery and outcomes and support for information exchange between service provider and the child welfare system.

DMH co-located staff will:

- identify children and parents in need of mental health services through screening;
- help determine the services needed by a client and family through assessment and evaluation;
- link children and families to mental health service providers smoothly, quickly and efficiently;
- provide crisis intervention and mobile response as needed;
- provide short term treatment when there is an immediate need for intervention to support a child or family until linked to ongoing mental health services;
- participate in RPRT, Family Team Decision Making (FTDM) and other DCFS case planning processes as requested by DCFS;
- accompany DCFS workers on field visits to assess children and parents as needed;

- assist DCFS to develop support groups, self-help groups and other resources for families with children with mental health needs;
- provide workers with expertise in mental health services to the newborn to 5-year-old range population; and
- collaborate with DCFS to develop interventions to address substance abuse and gang involvement of Transition Age Youth with mental health needs.

Accountability Measures

Central to this plan is the deployment of a variety of strategies to promote systems and clinical accountability, opportunities for learning and correction, and decision-making based upon observed results.

At the systems level, DMH and DCFS will agree upon selected performance indicators (e.g., # of screenings and assessments conducted, # of children/youth receiving mental health treatment services, # of children/youth enrolled in intensive in-home treatment, # of co-located mental health staff, # of children/youth in congregate care assessed for needs, and so forth) that can be tracked on an ongoing basis. These performance indicators will also be analyzed by Service Areas, mental health provider, Medical Hub, and regional office. This information will be provided by staff co-located at the Medical Hubs and within DCFS regional offices, supported by data provided via the management information systems of the two Departments. The information will be collected and reviewed on a quarterly basis and will provide one mechanism for analyzing the progress of plan implementation.

For tracking purposes, DMH is developing a Children's System of Care Assessment Application (CSOCAA). Children/youth who are identified as SED will be enrolled and will receive a higher level of tracking, including the capacity to review information associated with service provision and outcomes on a real time basis. This Application will be able to capture clinical outcome indicators and service delivery information that cannot now be captured in existing DMH applications. This information will also be incorporated into the DMH Data Warehouse for monitoring and reporting purposes. Delivery of the first functional version of this application is anticipated to take 8 weeks to 10 weeks from the point at which DMH Children's System of Care finalizes their requirements documentation.

At the clinical level, enhanced tracking capability will be developed around a joint DMH/DCFS Master Person Index (MPI) that will include all DMH clients and all DCFS clients. The MPI will assign a unique number to each client, consistent with County Strategic Plan Goal 7, and facilitate reliable identification of DCFS clients served by DMH and appropriate reporting on the services delivered. Initially the identification of joint clients will take place retrospectively and may lag their entry into DMH services by as much as one week. In a later stage, the intention is to make the identification of DCFS clients real-time at the point of registration for DMH services. We know that in general this is technically feasible, but we do not know yet if this is technically feasible with existing DMH systems. The CSOCAA will incorporate the MPI identifier when it becomes available.

DMH is in the very early stages of specifying, buying, and implementing an Integrated Behavioral Health Information System (IBHIS). DMH is planning on delivering a contract to the Board for an IBHIS in June 2006 with production use planned for two years after that. The IBHIS will make much more clinical information available electronically and will ultimately lead to an electronic clinical record. This will add greater substance to the information about children in foster care that is available to clinicians and case managers regardless of their location or where the child is being treated.

Additionally, DMH will contract with the UCLA School of Medicine to conduct an independent evaluation of the implementation effort and make recommendations for improvements and modifications to the effort.

Examples of the specific types of client outcomes that will be tracked relative to child and family status include:

- *Safety and Stability*
  Child is safe from manageable risks of harm and living/learning arrangements are stable, free from risk of disruption, and likely to endure until child becomes independent (good prospects for permanency).
- *Appropriate Placement*
  If in placement, child is in the most appropriate placement consistent with his/her needs, age, abilities, peer group(s), language, and culture.
- *Health and Physical Well-being*
  Child is in good health and has access to health care services as needed.
- *Emotional/Behavioral Well-being*
  Child is doing well emotionally/behaviorally or making measurable progress toward stable and adequate functioning at home, school, or other community settings.
- *Supportive Relationships*
  Developmentally appropriate, positive interactions and relationships with peers, parents/caregivers.
- *Caregiver/Family Functioning and Resourcefulness*
  Able to provide child with assistance, supervision, and sustain support necessary for daily living; capacity to access needed resources.

In addition to this quantitative assessment of service provision and client outcomes, we propose to conduct a qualitative analysis of child and family functioning as well. This approach will sample selected groups, such as children/youth in congregate care, and include face-to-face interviews with children/youth, their families or other caretakers, and involved service providers, including teachers, social workers, attorneys, and mental health treatment staffs, to better understand child and family needs/strengths, related service provision, and corresponding outcomes. These interviews will be compiled to identify current service delivery and outcome trends and used to make adjustments to improve practice and systems development. The results of the interviews can also be rated on various indicators of client need and system performance, providing a sample measure of progress.

As another method to promote accountability, DMH will move toward a performance-based contracting system, specifying services to be delivered and expected outcomes. Such contracts will be utilized for those contract agencies participating in this Plan, and the same agreements will be developed for directly operated programs with respect to their child welfare mental health service components. These contracts and agreements will be reviewed regularly by the Service Area District Chiefs, and findings will be shared with the centralized Child Welfare Mental Health Services Division of the department.

Of particular importance to the success of the Plan will be the adoption of a qualitatively different treatment approach for SED children/youth. Intensive in-home services will be required for this population. Staff providing these services will need training in this model and ongoing follow up in the form of consultation, technical assistance, and coaching opportunities. Practices will need to be monitored for fidelity. The DMH Child Welfare Mental Health Services Division will take the lead responsibility in this effort, with support from local Service Area District Chiefs, the Training and Cultural Competency Bureau, and agencies such as the California Institute for Mental Health (CIMH)).

The previously detailed information (statistical trends, qualitative analysis of service needs, service provision and outcomes, and adoption of in-home intensive mental health services) as well as other relevant information will be collected and reported in a bi-annual progress report prepared by the Child Welfare Mental Health Services Division, in cooperation with DCFS.

Funding Strategies

DMH is proposing to largely fund this Plan with Early Periodic Screening, Diagnosis and Treatment (EPSDT) Medi-Cal, with match provided by DCFS, since the majority of children in the target population are eligible for this public entitlement by virtue of their out-of-home placement. DMH also expects to utilize Mental Health Services Act funds to support intensive in-home services for children/youth in the target population, though the exact amount of funds available for this purpose has not yet been finalized through the MHSA planning process now underway. In addition, we will continue to use remaining funds in the MacLaren Designation Fund and explore the availability of other funding options to support the non-EPSDT covered services.

Staff Recruitment

This proposal is based on a realistic assessment of the capabilities of both contracted and directly operated programs to recruit clinical staff. An aggressive recruitment strategy will be employed to meet the significant staffing needs necessary to provide the services described here within the projected timeframes. We expect that hiring will be pursued via the use of traditional staffing positions (including clinical, case management, parent advocates, clerical, and administrative positions) as well as non-traditional mental health positions.

Screening for Children in Need of Mental Health Services

The Plan calls for alternative approaches to initial identification of children/youth in need of mental health treatment for youth entering the child welfare system and those already in out-of-home placement.

Children Entering the Child Welfare System

Identification and mental health screening for children entering the child welfare system will take place through the use of multidisciplinary medical Hubs and Team Decision Making meetings within DCFS regional offices.

Medical Hubs

Children who come to the attention of the foster care system are often at an increased risk of medical and mental illnesses, with varied levels of severity. DCFS needs forensic medical and mental health expertise and assessment capacity available 24 hours a day, 7 days a week (24/7) to meet the emergent and ongoing needs to ensure safety and permanency for children at risk of entering or who are already in the foster care system. Currently, traditional hospital emergency rooms and most medical and mental health facilities do not have the forensic expertise necessary to adequately address the needs of foster youth.

DCFS has solicited the involvement of its external partners to develop multidisciplinary medical Hubs countywide. Six Hubs, countywide, are planned participants for the Hub system. One Hub, LAC+USC Medical Center Violence Intervention Program, is currently in operation, and the five others (High Desert Health System, Olive View Medical Center, Harbor-UCLA Medical Center, King-Drew Medical Hub, and Children's Hospital Los Angeles) are scheduled to begin operations during calendar year 2005.

Goals

The goals of the Hubs are to: 1) increase the safety of children in, or at risk of entering the foster care system; 2) decrease timelines to permanency; and 3) reduce reliance on detention. These goals will be achieved by ensuring:

- Access to the expertise necessary to identify and treat severe/complex medical and mental health issues of high-needs children and other children in protective custody resulting in improved placement and detention decision-making;
- Linkage to mental health services for foster care children;
- Availability of 24/7 forensic medical assessments and mental health screenings and ongoing treatment, as determined by the Hub professionals; and
- Coordination of any follow-up medical and mental health treatment needed.

Target Population

The children to be served by the Hubs include: (a) any child who is taken into protective custody; (b) any child who would benefit from a forensic medical examination as part of the DCFS ongoing investigations of physical abuse or sexual abuse, failure to thrive, or severe neglect; (c) any child who has been injured in care while under DCFS supervision; and (d) cases where assistance is needed on an Individualized Health Plan for a special needs child, or on general health care planning for a child, or when a second opinion is needed. This target population includes children within the Katie A. plaintiff class.

Services

For newly removed children, the Children's Social Worker (CSW) will be mandated to make a Hub referral immediately or within the first 72 hours of removal as per DCFS policy. The Hub will provide a comprehensive medical assessment (including a forensic exam, as needed), a Child Health and Disability Program (CHDP) exam (as needed), and an age appropriate mental health screening using a standardized screening tool. A mental health screening which results in an identified need for a mental health assessment and mental health services will be forwarded to the CSW. The CSW will consult with a DMH "systems navigator" who will provide assistance to ensure that children who are in need of a mental health assessment will receive one as well as related mental health services. The systems navigators will be co-located in regional offices and serve as experienced clinicians who are highly knowledgeable about the mental health issues and resources in the immediate community. They will monitor and track referrals to make sure that the children are seen in a timely manner, as well as facilitate the appropriate sharing of information between CSWs and the treating clinicians to inform the case-planning process.

Regional Office Team Decision Making

When Hub services are not available, DCFS will use the existing Team Decision Making (TDM) meetings at their regional offices that occur within 72 hours of removal. These meetings will be facilitated by a DCFS Supervising Children's Social Worker (SCSW) and will involve a variety of stakeholders associated with the individual case. While this meeting focuses largely on immediate safety and placement issues, information related to the child and family history will also be reviewed. Based upon this information the TDM trained facilitator will complete the Mental Health Screening Tool (MHST) developed by the CIMH specifically for use in screening children/youth entering the child welfare system. The results of this screening will be provided to the CSW to consult with the DMH systems navigator as noted above.

As the result of either method of screening, the DMH systems navigator, in collaboration with the CSW and others involved in the decision-making process, will be responsible for identifying the most appropriate mental health resource in the community, linking the child/youth to the service provider, and following up with the CSW, child/youth, and mental health provider to ensure that the child is properly engaged in treatment. The systems navigator will be responsible for making any changes to the assignment of

service provider necessary to ensure that the appropriate services are obtained in a timely manner. Once the child/youth is properly engaged in treatment, the systems navigator will assume case management responsibilities to track and monitor service delivery and outcomes related to treatment. Each systems navigator/case manager will carry an active caseload of 25 to 30 clients, with case monitoring responsibilities to be transferred to mental health program case managers once clients are properly engaged.

Children Currently in the Child Welfare System

DMH system navigators will receive referrals from DCFS staff and will provide a variety of services for referred children/youth including systems navigation, case management, referral, follow up to ensure client engagement, and case consultation. Services will be targeted toward children/youth placed in group home and D-Rate homes and will include participation in TDM meetings related to these children/youth. DMH clinicians will work closely with DCFS staff and DMH contract providers to ensure that services are provided consistent with the needs of the children/youth that services are provided promptly, and that continuity of care is supported.

The DMH staffing within each office mirrors the planned number of TDM facilitators within each office and will allow for regular participation by DMH in TDM meetings related to the target populations.

Specialized Mental Health Assessment and Treatment Services

Formal mental health assessment, treatment planning, and specialized treatment will be provided by DMH directly operated program staff as well as contracted mental health providers, coordinated and jointly trained by DMH and DCFS.

Individualized Mental Health Assessment and Treatment Planning

An individualized assessment and service planning approach will be utilized for all children and youth who are referred via the screening process or otherwise identified by DCFS. Assessment and treatment planning involves the review of each child's unique needs and strengths within the context of their family and community and will utilize a team approach, including the child, family, DMH and DCFS staff, and other child-serving agencies, such as schools, to discuss options for treatment, care, and support. The resulting service plan will need to be agreed upon by all team members, reviewed regularly, and revised as necessary. The assessment and treatment planning process will be integrated into the case planning process via TDM used by DCFS. For example, for children entering the child welfare system, the contracted mental health providers will begin their assessment process immediately upon case referral and will also participate in the TDM scheduled by DCFS 30 days following removal, allowing them to collect information at that time to complete their assessment, to be finalized within 45 days of referral.

Specialized Mental Health Treatment Services

Mental health services under this Plan will move beyond the traditional walls of mental health clinics and be provided to children/youth and their families in their homes or other homelike settings. They will also be developed with particular emphasis to the unique needs and strengths of the child welfare population. The Plan calls for the development of an array of mental health services, including those designed for crisis stabilization and trauma symptom reduction. Additionally, a variety of intensive in-home services are proposed, including evidence-based programs, to better meet the needs of those children identified as SED. While many of these children/youth are now placed in psychiatric hospitals, residential treatment centers, and congregate care facilities, and D-Rate foster homes, this Plan proposes to improve the availability of non-institutional, multi-systemic, intensive services in order to promote stabilization, improved timelines to permanency, and long-term positive outcomes. Those who do not require more intensive levels of service will be provided with briefer symptom-focused interventions appropriate to their treatment needs.

See Appendix B for an overview of anticipated case flow from screening to service provision.

Intensive In-Home Services

This Plan places a strong emphasis on the use of intensive in-home services, particularly for children/youth identified as seriously emotionally disturbed and are primarily targeted for children already in group homes and D-Rate foster care. The plan will develop approximately 1,220 additional intensive in-home service slots, in addition to modifying the current service delivery model for the existing 2,080 intensive service slots. The intensive in-home services are seen as a much preferred alternative to traditional clinic-based approaches that focus on weekly outpatient sessions for the child, provided by a clinically trained professional. More traditional outpatient services are typically time-limited, lack the kind of intensity required for these children and their families, and fail to offer the kind of comprehensive interventions, delivered in homes, schools, and other community-based settings where the problems are seen.

Intensive in-home services are, by no means, a one size fits all approach, but represent a service philosophy and a set of clinical interventions that are employed as appropriate based upon the needs and strengths of the individual child. Minimally, these service interventions include:

- family teams, including the child, his/her family, involved school and agency personnel, and others that might play a role in the child's life;

- a comprehensive, strengths based assessment developed by the family team, working in collaboration to address the individual needs and strengths of the child;

- crisis services, available 24/7, to stabilize acute emotional and behavioral episodes, avoid the need for out of home and residential placement, and stabilize the child and family unit;

- intensive case management services to coordinate service delivery elements, communicate with members of the team, and track progress;

- supportive services for the child and family, often provided daily, through use of a one-on-one clinical interventionist; and

- integrated treatment for co-occurring mental health and substance abuse disorders.

The following hypothetical case illustrates the application of intensive in-home services as well as how the system proposed by this Plan would respond to the mental health needs of a child entering the child welfare system.

> *Following a call to the DCFS Child Abuse Hotline, an Emergency Response CSW visits the home of 10-year-old Billy G. to investigate the allegations of physical abuse made in the hotline report. Using the Structured Decision Making approach, the CSW determines that there is very high risk of physical abuse to the child and transports Billy to the nearest Medical Hub for a medical and mental health screening. The medical evaluation confirms evidence of physical abuse. A DMH medical case worker stationed at the Hub uses the Mental Health Screening Tool and identifies several red flags for mental health related problems. A review of the DMH Integrated System also indicates a prior history, one year earlier, of mental health treatment for Billy at an outpatient clinic where he was diagnosed with Oppositional Defiant Disorder and treated for approximately two months with weekly clinic visits with a psychiatric social worker. The medical case worker notes that Billy is not in crisis at the time of the screening but is in need of more thorough evaluation given the results of the screening and his prior history of mental health treatment.*
>
> *The results of the medical and mental health evaluations are shared with the CSW who decides to detain Billy. After obtaining written authorization from the CSW, the DMH medical case worker contacts the clinic nearest to where Billy will be temporarily placed and schedules a more thorough mental health evaluation to be started two days later. A mental health case manager from the clinic is assigned to the case.*
>
> *A psychiatric social worker (PSW) from the clinic visits the foster home where Billy is placed and speaks with Billy and the foster parents. Billy is restless, frightened, and angry. He wants to go home. The foster parents say that he has been sullen and irritable and has had trouble getting to*

sleep at night. At a court hearing later that day, a juvenile court judge decides to continue Billy's removal and schedules a review in 30 days.

Continuing the assessment the following day, the PSW speaks with the CSW and learns of the continued out-of-home placement for Billy. She meets with Billy's mother, collects information related to the family's history and identifies several key informants, including Billy's fifth grade teacher, his grandmother, and a football coach who worked with Billy at a recreational center in a nearby park. Later that same day, the PSW visits with Billy and his foster parents, who complain that Billy's temper and defiance is troubling them and express concerns about whether they will be able to continue with him. The PSW helps to negotiate a practical set of behavioral expectancies and contingencies that are agreed upon by Billy and his foster parents. The foster parents are assigned a Parent Advocate to work with them and are invited to attend a foster parent support group later that week. They are also given the number for the DMH ACCESS Hotline to call after hours if needed.

The PSW continues to make daily home visits or phone calls to the foster parents over the course of the next few weeks and also visits with the identified key informants to collect information about Billy and his family. The Parent Advocate also meets several times with the family and offers helpful, practical suggestions for managing Billy's behavior. All informants, including Billy's CSW, are invited to attend a case planning meeting held by the PSW and Parent Advocate. The participants discuss the needs and strengths of Billy and his family and agree upon a set of goals and strategies to be employed over the course of the next several months.

Billy's mother is enrolled in parenting classes, and the PSW will work with Billy and his mother on behavioral management techniques during weekly visits. The PSW will also make twice-weekly visits to the foster home, and Billy's football coach will transport Billy to and from practice so that he can continue with the team. The Parent Advocate will make daily phone calls to Billy's foster parents to check on adherence to a set of behavioral expectations for Billy, and the foster parents will continue to attend weekly foster parent support groups. Billy's grandmother will have Billy at her home on weekends, giving the foster parents some respite and allowing Billy to spend time with a much loved family member. Billy's teacher agrees to put Billy in a special after school reading program two days a week to help him with the reading problem that was identified during the case planning meeting. The mental health case manager will make weekly calls to each of the parties involved to assess progress and will share this information with the assigned CSW.

Over the course of the next few months, Billy's behavior improves and his mother completes her parenting class. The mother is allowed increasing visitation with Billy and eventually he can be returned home, though the

case is kept open for monthly visits by the CSW. Mental health services continue for both Billy and his mother in the form of weekly home visits by the PSW, monthly parent support groups for the mother, and ongoing case management of the ancillary activities by the case manager.

Evidence-Based Treatment Models

While services will be tailored to the individual needs and strengths of each child, an emphasis will be placed on the development of systems capacity for evidence-based practice models, including those that provide intensive in-home services and those that address the unique needs of the child welfare population. These services will be developed through training, supervising, and coaching efforts and contracting with various organizations, such as the CIMH, involved in the dissemination of evidence-based practices, and the developers of the various evidence-based models. Access to these services would be provided through the DMH systems navigators/case managers, TDM, and Wraparound Teams. Examples of models to be considered in this new service matrix are described in the following table.

Service Model	DCFS Target Population	Target Behaviors	Key Components	Age Range
Multidimensional Treatment Foster Care (MTFC)	*Children in or at risk of group home placement*	*Broad range of emotional and behavioral problems*	*Foster Parent Training & Supervision* *Intensive Case Management* *Individual and Family Therapy* *Skills Training* *Academic Skills Assistance* *Home and School-Based Interventions* *Psychiatric Consultation*	*11-18*
Early Intervention Treatment Foster Care	*Young children in or at risk of group home placement*	*Broad range of emotional and behavioral problems*	*Same as MTFC*	*0-7*
MTFC "Lite"	*Children in foster and kinship placements*	*Parenting Skills*	*Parent Training* *Parent Support*	*Children of all ages*
Multisystemic Therapy	*Children in home of parent*	*Aggressive and Violent Behavior* *Substance Abuse*	*Home and Community-Based Interventions*	*Children ages 12-18*

Service Model	DCFS Target Population	Target Behaviors	Key Components	Age Range
Functional Family Therapy	*Children placed in home of parent*	*Conduct Problems* *Family Conflict* *Substance Abuse*	*Structured Family Therapy*	*Children ages 10-18*
Incredible Years	*Children in foster care, kinship placements or in home of parent*	*Aggressive and other Behavioral Problems*	*Parent Training* *Child Social Skills Training*	*Children ages 2-12*
Trauma Focused Cognitive Behavioral Therapy	*Children in foster homes, kinship placements or home of parent*	*Emotional and Behavioral Problems Related to Physical and Sexual Abuse*	*Child Therapy* *Parent Education* *Parent-Child Therapy*	*Children ages 3-18 and their families*
Positive Parenting Program	*Children in kinship placements or in home of parent*	*Wide Range of Child and Adolescent Problem Behaviors*	*Parent Education* *Family Support*	*Children of all ages*

In addition to the services associated with these newly developed programs, children will also be provided with more traditional mental health services (individual therapy, case management, medication management, etc.) as identified in their individual mental health case plan.

Examples of two models that will be tested in the implementation of the Plan include Multidimensional Treatment Foster Care and Trauma Focused Cognitive Behavioral Therapy.

Multidimensional Treatment Foster Care (MTFC)

MTFC is an example of an intensive in-home, evidence-based approach that will be developed as an alternative to congregate care placement for children with serious emotional and behavioral problems. The primary goal of MTFC is to reduce problems behaviors and increase developmentally appropriate and prosocial behaviors for children/youth who are placed out of home. The main objectives of the MTFC program are to:

- provide close supervision
- set fair and consistent limits
- develop and use predictable consequence for rule violation
- establish a supportive relationship with at least one mentoring adult

- reduce exposure to peers with similar problems

MTFC is not a traditional clinic-based model but is multi-faceted and employed in multiple settings. Interventions include:

- behavioral parent training and support for MTFC foster parents
- family therapy for biological parents (or other aftercare resources)
- skills training for children/youth
- supportive therapy for children/youth
- school-based behavioral interventions and academic support
- psychiatric consultation and medication management, when needed

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychotherapeutic intervention designed to help children/youth and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse, the traumatic loss of loved ones, exposure to family, school, or community violence, and other traumatic events. The approach integrates cognitive and behavioral interventions with traditional child abuse therapies that focus on the enhancement of interpersonal trust and empowerment. The program can be provided to children/youth from age 3 to 18 and their parents/caretakers by specially trained mental health professionals in individual, family, and group settings. The model targets the symptoms of posttraumatic stress disorder (PTSD), which often co-occur with depression and behavioral problems. Additionally, the intervention addresses issues often experience by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious and self-destructive behaviors, including substance abuse.

Objectives and Key Implementation Strategies

The specific objectives, related key implementation strategies, along with projected timelines and milestones related to Plan implementation will proceed in two related phases. Phase I will implement the Plan in Service Areas 1, 6, and 7 beginning with planning and staff recruitment November 2005. Services are expected to begin in December 2005 and continued implementation through June 30, 2006. Phase II, adding implementation across the remaining Service Areas will begin no later than July 1, 2006, with substantial implementation countywide by July 1, 2007.

The following is a discussion of the objectives and key implementation strategies. The specific timelines are presented in Appendix C.

1) *Improve coordination of child welfare and mental health services* though:

   a) The creation of a DMH Child Welfare Services Division to support countywide planning and coordination, training, implementation, and evaluation of specialized mental health services a well as a dedicated child welfare mental health hotline and a specialized case management unit; and

b) Staff support for DMH Service Area operations, aligned with DCFS regional offices, on behalf of this effort.

2) Establishment of mental health units within each of the DCFS regional offices and Medical Hubs to provide systems navigation, case management, consultation, and training. This will enable the identification and provision *of mental health treatment needs and linkage to needed services* through:

   a) The creation of a system to provide mental health screening of children/youth entering the child welfare system that has been referred for out-of-home placement;

   b) Collaboration between DCFS and DMH to identify children/youth currently under the supervision of DCFS who are in need of mental health treatment, particularly those placed in congregate care and D-Rate homes; and

   c) Development of DMH Systems Navigation capability within each DCFS regional office to link children/youth to appropriate mental health contract agencies and monitor service delivery and client outcomes.

3) *Promptly provide the necessary, individualized mental health services* to these children/youth in their own homes, a family setting, or the most homelike setting appropriate to their needs by:

   a) Improving coordination of service delivery through the use of systems navigators/case managers and a tracking system to monitor service delivery, literally transforming the ability of the child welfare and mental health systems to work together and to provide critical information about service delivery and outcomes;

   b) Expanding service capacity through the use of DMH directly operated programs and the network of local contracted mental health providers to serve DCFS involved children/youth;

   c) Making more effective use of the federal EPSDT resource for mental health and rehabilitation services; and

   d) Developing specialized mental health treatments tailored to the unique needs of foster youth, including crisis stabilization, trauma symptom reduction, and intensive in-home models of service delivery, including evidence-based approaches as an alternative approach to congregate care and in support of children now placed in D-Rate homes.

4) *Enhance accountability at the service provider and systems levels* for improved service delivery and outcomes through:

   a) The use of performance based standards and contracts specifying types of service to be delivered and expected outcomes to be achieved;

   b) Ongoing monitoring of fidelity to specified treatment models, particularly intensive in-home based approaches;

   c) Required training and coaching opportunities for staff to learn and adopt best practices and evidence based practices for serving dependent children/youth;

   d) Enrollment of SED children/youth served and adoption of a tracking system to monitor service delivery and collect service outcome information; and

   e) Preparation of quarterly progress reports, jointly prepared, documenting the status of the major elements of the Plan.

Phased Approach

The Plan provides for two phases. In Phase I (November 2005 – July 2006), services will be augmented via enhancements to both directly operated and contract provider programs in Service Areas 1, 6, and 7 in order to implement the key objectives of the Plan. In Phase II, beginning no later than July 2006, the remaining Service Areas will be implemented consistent with this Plan and "lessons learned" during Phase I. Following the initial start up period, the Plan calls for Countywide services to be substantially operational by June 30, 2007.

Service Area Proposals

Descriptions of the staffing and services proposed in Phase One of this Plan are provided below:

Service Area 1 Staffing Detail

Based upon figures provided by DCFS, approximately 323 children will be identified as requiring mental health services in the course of a year by the two regional offices located in Service Area 1. Of those, approximately 95 will require the more intensive level of treatment described in this Plan, while the remaining 228 children will require a less intensive level of treatment.

Service Area I Intensive In-Home Services

Contractors who are currently providing mental health services in Service Area I will be utilized to provide intensive in-home services to children identified as SED through the screening and assessment process, from the TDM conferences, or those placed in D-Rate homes in the Service Area referred from the Lancaster and Palmdale Regional

Offices. These contract agencies will provide all of the intensive in-home care for approximately 95 children for a total cost of $1,425,000.

Service Area 1 Basic Mental Health Services

Since there are currently no directly operated clinics in Service Area 1, the current contractors will also be utilized to provide the bulk of less intensive mental health services for the remaining 228 children at a cost of $1,368,000. Mental health services include an array of assessment, individual and group therapies, medication support, case management, school based treatment, and other supportive services developed as part of a strength based collaboration. All mental health services will be flexible and provided in natural community settings as appropriate and will incorporate evidence-based practices.

Service Area 1 DMH Directly Operated Community Mental Health Services

The Service Area 1 plan calls for the development of a small community based children's crisis program to respond to immediate crisis and emergency needs, and to provide short-term solution focused interventions. This small program will respond to crises requiring immediate assessment and access to services. Two psychiatric social workers, two medical case workers, and a mental health psychiatrist will respond to immediate emergency situations for children who have not yet been referred to mental health services, but for whom immediate assessment and stabilization is essential. Once stabilized, staff will refer children to longer term and/or more intensive levels of care as needed. Each clinical staff will provide services to a caseload of about 30 children at any given time with an expected turnover rate of 10-15 percent every 3 months.

Service Area 1 Co-located Staff

Two teams of DMH directly operated staff will be co-located at the Lancaster and Palmdale DCFS Regional Offices. Each team will be composed of two psychiatric social workers, one medical case worker, and one senior typist clerk. The staff will provide an array of supportive services to the CSWs related to accessing appropriate and required mental health treatment, including case consultation, training, referral and linkage, systems navigation, benefits establishment, and participation in TDM conferences. The teams will facilitate timely and appropriate linkages to enhanced community resources. Each team will be assigned to work with the DCFS TDM facilitator.

Service Area 1 Administration

One Training Coordinator, MH, and one Staff Assistant II will coordinate local service area foster care interdepartmental cross-training activities, monitoring and outcomes tracking, as well as collaborate with centralized DMH staff and DCFS administrators as needed. These positions will report to the existing Service Area District Chief.

One Supervising Psychiatric Social Worker will provide direct supervision to the co-located staff and the community mental health services staff, directing work,

monitoring productivity, and resolving disputes. This position will report to the existing Clinical Program Head.

Service Area 6 Staffing Detail

Recent data from DCFS indicates that a projected 969 children in the Los Angeles County child welfare system residing in Service Area 6 require mental health services that are not currently being provided. Of that number, approximately 278 will require intensive mental health services, and the remaining 691 will need less intensive mental health services. The communities represented in Service Area 6 include Compton, South Los Angeles, Lynwood, Paramount, and Watts-Willowbrook.

Agencies that are a part of the Service Area 6 network of contracted mental health service providers will provide the intensive in-home services. Providers are expected to adhere to DMH established parameters and guidelines MH relative to service delivery (i.e., staffing, caseloads, frequency of visits, etc.).

Service Area 6 Basic Mental Health Services

For the projected 691 children in foster care in Service Area 6 who will need less intensive mental health services, two DMH directly operated clinics will provide an array comprehensive outpatient mental health services for children served in the Century, Compton, Hawthorne, and Wateridge Regional offices. The DMH clinics are Augustus F. Hawkins MHC and Compton Child and Family Services. Services will include assessments, individual and group therapy, medication support, case-management and other identified supportive services. The services will be delivered in a flexible manner that builds upon the child and family strengths and needs, utilizing evidence based treatment approaches for mental health issues common to children in foster care. The average caseload for each staff will be between 30-35 clients with a projected turnover rate of 10-15 percent every three months.

Service Area 6 Co-Located Staff

Four teams of staff from Augustus F. Hawkins MHC and Compton Child and Family Services will be co-located at each of the four DCFS Regional Offices in Service Area 6. The teams will be comprised of psychiatric social workers, medical caseworkers and senior typist clerks. Additionally since there are six and ten DMH staff at the Compton and Wateridge regional offices, respectively, a supervising psychiatric social worker will be added to the team to provide on-site supervision. The mental health staff will act as DMH systems navigators providing an array of supportive services to the CSWs to facilitate appropriate and timely access to required mental health services. Generally the duties and responsibilities will include, but not limited to consultation, linkage and crisis intervention. Specifically, the team will participate in TDM conferences, assist in plan review and development, cross-training activities and referrals to required and appropriate mental health services.

START Program/Multidisciplinary Assessment Team

Compton Child and Family Services will provide the staff to implement a multi-agency START program at the Compton Regional Office. The DMH staffing will be comprised of a Sr. Community Psychologist and two Clinical Psychologist IIs. Services of the START Program are directed toward youth with high levels of behavioral problems that place them at risk of transfer to the juvenile justice system. Additionally, this directly operated clinic will provide staff for a Multidisciplinary Assessment Team (MAT) to work in concert with the King Drew Medical Hub. Staffing for this program will include one Clinical Psychologist II, one Psychiatric Social Worker II, one Mental Health Counselor, RN, one Mental Health Services Coordinator II, and clerical support. DCFS data indicates that about 1,680 children residing in Service Area 6 will be removed from their homes in 2005-06. Each child will require a MAT assessment. The Service Area 6 MAT is projected to complete approximately 75 of those MAT assessments annually.

Service Area 6 Administrative Staff

The Supervising Psychiatric Social Worker will provide direct supervision to the co-located staff and facilitate effective collaborative relationships between the DCFS and DMH staff. The Staff Assistant II and Training Coordinator, MH, will coordinate all of the monitoring and tracking related to outcomes, as well as local service area level interdepartmental training activities.

Service Area 7 Staffing Detail

It is estimated that the Plan, as implemented in Service Area 7, will need to provide intensive mental health services to 100 children/youth each year and basic mental health services to an additional 374 children/youth annually.

Service Area 7 Intensive In-home Services

Intensive in-home services will be available 24/7. Services (individual, family, group therapy; medication; case management; crisis intervention) will be provided as often as needed by the child and his/her biological or foster parents. Due to the severity of treatment needs, it is projected that services will routinely be provided 3 or more times a week. The services will be provided by small teams of clinicians / case managers, all of whom develop a direct connection with the family. Children in congregate care and D-Rate foster homes are targeted to receive this level of services. Contracted mental health services providers who meet established selection criteria will provide these services.

Service Area 7 Basic Mental Health Services

A projected 374 children/youth will require a less intensive level of care. This treatment may include individual, family, and group therapy, medication, case management, and crisis intervention, but will be provided in the most appropriate community setting, like a local school. It is projected that these children will be seen once a week or less, and may occasionally require crisis intervention services. The average caseload for

clinicians providing this level of service will be about 30-35 children with an expected turnover of 10-15 percent every three months.

The majority of the children requiring basic mental health services will be assigned to the network of contract providers in Service Area 7 who meet the selection criteria established by DMH.

Countywide American Indian Services

The American Indian Counseling Center (AICC) co-located at Rio Hondo Mental Health Center, with its specialized target population and specially trained staff, serves the Native American population with culturally appropriate mental health services that other agencies do not provide. This agency has a working relationship with the DCFS American Indian Unit that will be enhanced and strengthened through the addition of four additional staff. These two units, each of which has countywide responsibilities in their respective Departments, were created to meet the special needs for this ethnic population.

Service Area 7 Co-located DMH Staff

DMH will co-locate staff in the two DCFS offices in Service Area 7. These staff will have the responsibility of working closely with DCFS staff through RPRTs, TDM, D-Rate foster homes and other means to identify child at first contact that need mental health services. They will also have the responsibility for linking these children to those services, of providing crisis intervention when needed during the time of initial contact, and of monitoring cases that are served through intensive in-home services. DMH staff will consist of 3 psychiatric social workers, 2 medical case workers, and a senior typist clerk who will be supervised by a supervising psychiatric social worker.

Service Area 7 Administrative Staff

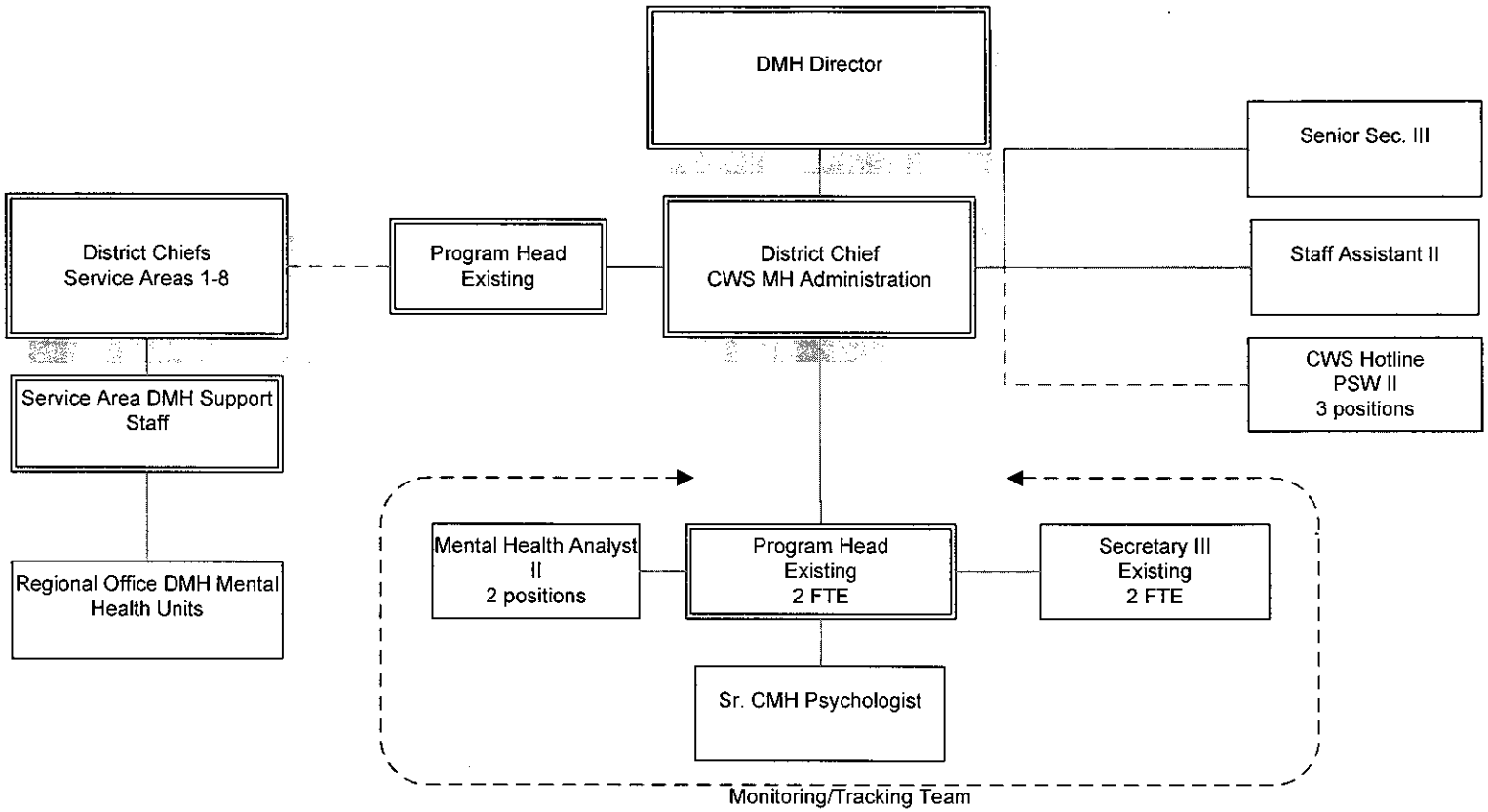
Service Area 7 Administration will be strengthened through the addition of Staff Assistant II, Supervising Psychiatric Social Worker and a Training Coordinator, MH. These positions will be responsible for local service area tracking and monitoring outcomes, as well as coordination of all training and cross training activities related to specialized foster care services.

Summary

The County will assure children entering foster care or at risk of entering care are provided individualized mental health services in their own home or a family-like setting through implementation of this plan. All youth entering care will be screened for their mental health needs, assessed by a mental health professional promptly when indicated by the screening and provided mental health treatment services in their own home or a family-like setting when possible. The implementation of this plan will assure continued improvements in outcomes for all youth served in foster care or at risk of entry into foster care including members of the Katie A. class. Finally, oversight and accountability will be assured through the structural changes described throughout the Plan.

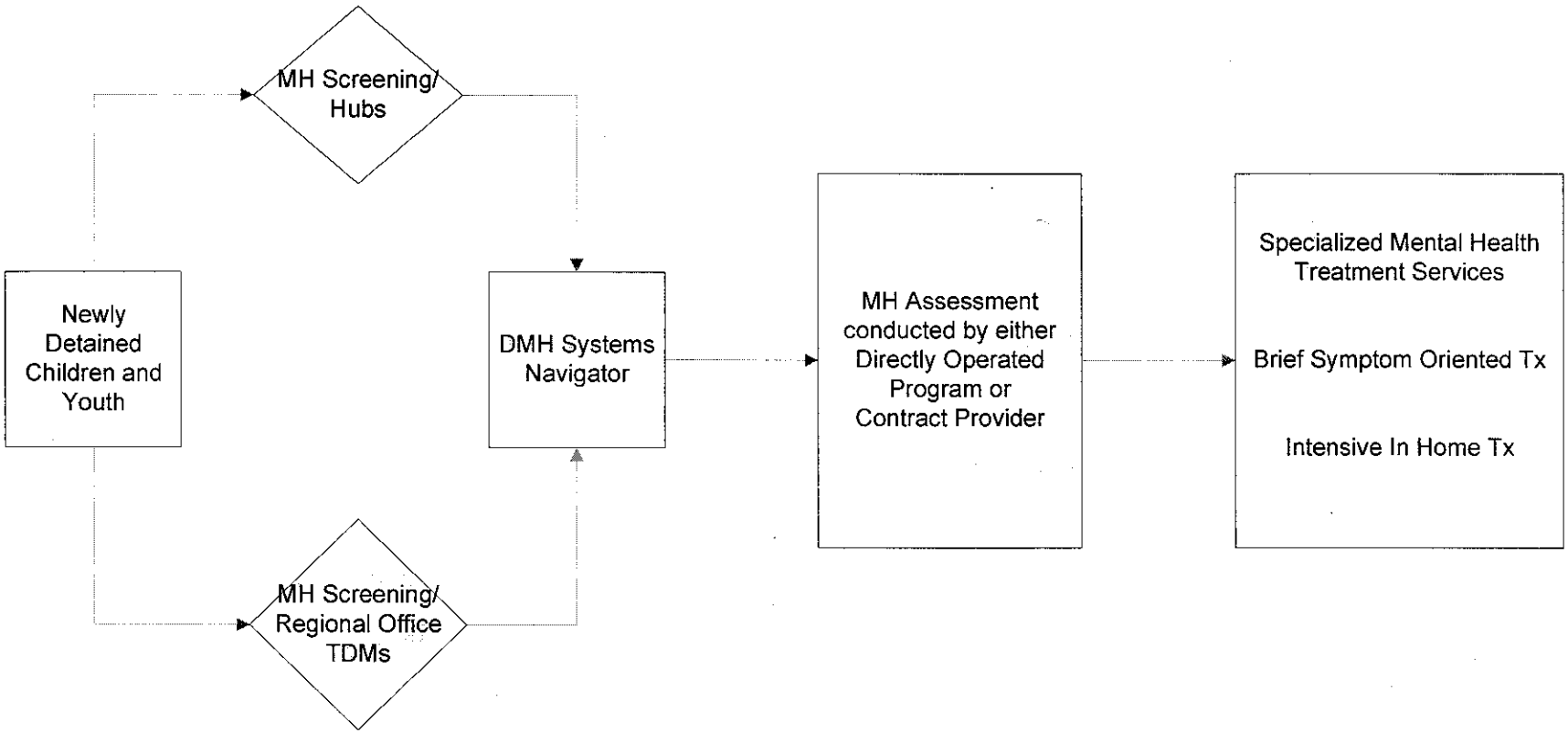
Los Angeles County – Department of Mental Health

Child Welfare Mental Health Services Division
Proposed



Case Flow Analysis of Children/Youth Entering the Child Welfare System

Mental Health Screening | **Mental Health Assessment** | **Treatment Services**



ENHANCED SPECIALIZED FOSTER CARE MENTAL HEALTH SERVICES IMPLEMENTATION TIMELINE

ID	TASK NAME	START DATE	COMPLETION DATE
1	DMH and DCFS to develop joint child welfare mental health services plan and obtain authority to implement plan from Board of Supervisors	May 2005	October 2005
2	PHASE ONE (Service Area 1, 6 & 7) OBJECTIVES AND IMPLEMENTATION STRATEGIES	October 2005	June 2006
3	Improve coordination of child welfare and mental health services	September 2005	October 2005
4	DMH to develop CWS MH Division	September 2005	October 2005
5	DMH to provide dedicated staffing for DMH Service Area operations	October 2005	December 2005
6	DMH to establish mental health units within each of the DCFS Regional Offices	October 2005	December 2005
7	DMH and DCFS to develop joint training program for key managers, staff, and Contract Providers	November 2005	November 2005
8	Provide for the identification of mental health treatment needs and linkage to needed mental health services	December 2005	Ongoing
9	Promptly provide the necessary, individualized mental health for children in their own homes, a family setting, or in the most homelike setting appropriate to their needs	December 2005	Ongoing
10	Enhance accountability at the service provider and systems level for improved service delivery and outcomes	November 2005	December 2005
11	DMH and DCFS to develop shared information system to provide for enrollment and tracking of service delivery and outcomes	October 2005	April 2006

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SPECIALIZED FOSTER CARE MENTAL HEALTH SERVICES
PROPOSED BUDGET
PHASE I - FY 2005-2006

DESCRIPTION	COUNTYWIDE ADMINISTRATION ORD	FTE	Budget	SERVICE AREA 1 ORD	FTE	Budget	SERVICE AREA 6 ORD	FTE	Budget	SERVICE AREA 7 ORD	FTE	Budget	TOTAL ORD	FTE	Budget
PROGRAM COST															
ON-GOING COSTS:															
SALARIES & EMPLOYEE BENEFITS															
Top Step Salary	15.0	15.0	$ 912,223	17.0	17.0	$1,025,476	60.0	58.0	$ 3,253,723	21.0	21.0	$ 1,192,081	113.00	111.00	$ 6,383,503
Less Salary Savings @6 percent			$ (54,733)			$ (61,529)			$ (195,223)			$ (71,525)			$ (383,010)
Net Salaries			$ 857,490			$ 963,947			$ 3,058,500			$ 1,120,556			$ 6,000,493
Plus Employee Benefits @30.4568 percent			$ 261,164			$ 293,588			$ 931,521			$ 341,286			$ 1,827,558
Overtime			45,611			51,274			162,686			59,604			319,175
Rounding			(265)			191			293			(446)			(227)
Total Salaries and Employee Benefits			**$1,164,000**			**$1,309,000**			**$ 4,153,000**			**$ 1,521,000**			**8,147,000**
SERVICES AND SUPPLIES															
Cellular Phones			$ 1,076			$ 1,076			5,381			3,229			10,762
Consultation Services			50,000			-									50,000
Contract Services						2,793,000			4,170,000			2,906,000			9,869,000
Mileage			840			3,360			8,400			8,400			21,000
Office Supplies			15,000			17,000			60,000			21,000			113,000
Pagers			108			144			540			540			1,332
Training									10,000						10,000
Travel									10,000						10,000
Vehicle Maintenance and Gas									54,000			18,000			72,000
Rounding			(24)			420			(321)			(169)			(94)
Total Services and Supplies			**$ 67,000**			**$2,815,000**			**$ 4,318,000**			**$ 2,957,000**			**$ 10,157,000**
Total Space Cost			**$ -**			**$ 170,000**			**$ 350,000**			**$ 200,000**			**720,000**
TOTAL ON-GOING PROGRAM COST			**$1,231,000**			**$4,294,000**			**$ 8,821,000**			**$ 4,678,000**			**19,024,000**
ONE-TIME COSTS															
SERVICES AND SUPPLIES															
Computers and Printers			$ 52,500			$ 59,500			$ 210,000			$ 73,500			$ 395,500
Fax Machine			1,500			1,500			1,500			1,500			6,000
Office Furniture			15,000			17,000			58,000			21,000			111,000
Rounding			-			-			500			-			500
Total One-Time Services and Supplies			**$ 69,000**			**$ 78,000**			**$ 270,000**			**$ 96,000**			**$ 513,000**
FIXED ASSETS															
Vehicles			$ -			$ -			$ 140,000			$ 45,000			$ 185,000
TOTAL ONE-TIME PROGRAM COSTS			**$ 69,000**			**$ 78,000**			**$ 410,000**			**$ 141,000**			**$ 698,000**
TOTAL COST (ON-GOING AND ONE-TIME)			**$1,300,000**			**$4,372,000**			**$ 9,231,000**			**$ 4,819,000**			**$ 19,722,000**
AVAILABLE FUNDS AND REVENUES															
EPSDT															
EPSDT SGF			$ 531,310			$1,786,836			$ 3,772,710			$ 1,969,525			$ 8,060,381
EPSDT FFP Medi-Cal			650,000			2,186,000			4,615,500			2,409,500			9,861,000
Rounding			(310)			164			(210)			(25)			(381)
Total EPSDT			**$1,181,000**			**$3,973,000**			**$ 8,388,000**			**$ 4,379,000**			**$ 17,921,000**
Intrafund Transfer from DCFS															
CGF Match to EPSDT			$ 118,690			$ 399,164			$ 842,790			$ 439,975			$ 1,800,619
Rounding			310			(164)			210			25			381
Total Intrafund Transfer from DCFS			**$ 119,000**			**$ 399,000**			**$ 843,000**			**$ 440,000**			**$ 1,801,000**
TOTAL AVAILABLE FUNDS AND REVENUES			**$1,300,000**			**$4,372,000**			**$ 9,231,000**			**$ 4,819,000**			**$ 19,722,000**
NET COUNTY COST			**$ -**			**$ -**			**$ -**			**$ -**			**$ -**

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
STAFFING DETAIL - SALARY COST ANALYSIS
SERVICE AREAS 1, 6 AND 7 SPECIALIZED FOSTER CARE MENTAL HEALTH SERVICES
FISCAL YEAR 2005/06

Item No. & Sub.	Title of Position	Ordinance	Mo./ Days	FTE	TOTAL GROSS SALARY AMOUNT
COUNTYWIDE					
CHILD WELFARE DIVISION					
04729A	MENTAL HEALTH ANALYST II	1	12	1.000	74,021
04722A	MENTAL HEALTH CLINICAL DISTRICT CHIEF	1	12	1.000	119,415
08712A	SR COMMUN MENTAL HLTH PSYCHOLOGIST	1	12	1.000	86,668
00913A	STAFF ASSISTANT II	1	12	1.000	49,401
02102A	SENIOR SECRETARY III	1	12	1.000	48,678
CHILD WELFARE SERVICES HOTLINE					
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
D-RATE CASE MANAGEMENT UNIT					
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728
09038A	SUPVG PSYCHIATRIC SOCIAL WORKER	1	12	1.000	71,863
	Subtotal Countywide	**15**	**180**	**15.000**	**$ 912,223**

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
STAFFING DETAIL - SALARY COST ANALYSIS
SERVICE AREAS 1, 6 AND 7 SPECIALIZED FOSTER CARE MENTAL HEALTH SERVICES
FISCAL YEAR 2005/06

Item No. & Sub.	Title of Position	Ordinance	Mo./ Days	FTE	TOTAL GROSS SALARY AMOUNT
SERVICE AREA 1					
ADMINISTRATION					
00913A	STAFF ASSISTANT II	1	12	1.000	$ 49,401
01865A	TRAINING COORDINATOR, MH	1	12	1.000	71,863
09038A	SUPVG PSYCHIATRIC SOCIAL WORKER	1	12	1.000	71,863
CO-LOCATED STAFF					
LANCASTER/PALMDALE					
02214A	INTERMEDIATE TYPIST-CLERK	1	12	1.000	31,718
02214A	INTERMEDIATE TYPIST-CLERK	1	12	1.000	31,718
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
DIRECTLY OPERATED					
08697A	CLINICAL PSYCHOLOGIST II	1	12	1.000	$ 82,903
02214A	INTERMEDIATE TYPIST-CLERK	1	12	1.000	31,718
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
04735A	MENTAL HEALTH PSYCHIATRIST	1	12	1.000	152,250
09193A	PATIENT FINANCIAL SERVICES WORKER	1	12	1.000	40,351
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
	Subtotal Service Area 1	**17**	**204**	**17.000**	**$ 1,025,476**

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
STAFFING DETAIL - SALARY COST ANALYSIS
SERVICE AREAS 1, 6 AND 7 SPECIALIZED FOSTER CARE MENTAL HEALTH SERVICES
FISCAL YEAR 2005/06

Item No. & Sub.	Title of Position	Ordinance	Mo./ Days	FTE	TOTAL GROSS SALARY AMOUNT
SERVICE AREA 6					
ADMINISTRATION					
00913A	STAFF ASSISTANT II	1	12	1.000	$ 49,401
01865A	TRAINING COORDINATOR, MH	1	12	1.000	71,863
09038A	SUPVG PSYCHIATRIC SOCIAL WORKER	1	12	1.000	71,863
CO-LOCATED PROGRAMS					
COMPTON					
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728
09038A	SUPVG PSYCHIATRIC SOCIAL WORKER	1	12	1.000	71,863
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
WATERIDGE					
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728
09038A	SUPVG PSYCHIATRIC SOCIAL WORKER	1	12	1.000	
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
CENTURY					
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
HAWTHORNE					
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
STAFFING DETAIL - SALARY COST ANALYSIS
SERVICE AREAS 1, 6 AND 7 SPECIALIZED FOSTER CARE MENTAL HEALTH SERVICES
FISCAL YEAR 2005/06

Item No. & Sub.	Title of Position	Ordinance	Mo./ Days	FTE	TOTAL GROSS SALARY AMOUNT
AUGUSTUS F. HAWKINS-MHC-CHILD/ADOLESCENT OUTPATIENT PROGRAM					
08697A	CLINICAL PSYCHOLOGIST II	1	12	1.000	82,903
08694A	CLINICAL PSYCHOLOGY INTERN	1	12	1.000	27,795
08694A	CLINICAL PSYCHOLOGY INTERN	1	12	1.000	27,795
02214A	INTERMEDIATE TYPIST-CLERK	1	12	1.000	31,718
09030A	MENTAL HEALTH CLINICIAN	1	12	1.000	60,923
04735A	MENTAL HEALTH PSYCHIATRIST	1	12	1.000	152,250
09193A	PATIENT FINANCIAL SERVICES WORKER	1	12	1.000	40,351
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728
08242F	STUDENT WORKER	1	2,088	0.000	17,571
05884A	SUBSTANCE ABUSE COUNSELOR	1	12	1.000	38,056
08712A	SR COMMUN MENTAL HLTH PSYCHOLOGIST	1	12	1.000	86,668
COMPTON CHILDREN AND FAMILY SERVICES					
08697A	CLINICAL PSYCHOLOGIST II	1	12	1.000	82,903
09030A	MENTAL HEALTH CLINICIAN	1	12	1.000	60,923
05278A	MENTAL HEALTH COUNSELOR, RN	1	12	1.000	73,140
04735A	MENTAL HEALTH PSYCHIATRIST	1	12	1.000	152,250
09193A	PATIENT FINANCIAL SERVICES WORKER	1	12	1.000	40,351
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09038A	SUPVG PSYCHIATRIC SOCIAL WORKER	1	12	1.000	
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
STAFFING DETAIL - SALARY COST ANALYSIS
SERVICE AREAS 1, 6 AND 7 SPECIALIZED FOSTER CARE MENTAL HEALTH SERVICES
FISCAL YEAR 2005/06

Item No. & Sub.	Title of Position	Ordinance	Mo./ Days	FTE	TOTAL GROSS SALARY AMOUNT
COMPTON CHILDREN AND FAMILY SERVICES PROGRAM: MULTIDISCIPLINARY ASSESSMENT TEAM					
08697A	CLINICAL PSYCHOLOGIST II	1	12	1.000	82,903
05278A	MENTAL HEALTH COUNSELOR, RN	1	12	1.000	73,140
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728
08242F	STUDENT WORKER	1	2,088	0.000	17,571
START PROGRAM					-
08712A	SR COMMUNITY MENTAL HLTH PSYCHOLOGIST	1.0	12	1.0	86,688
08697A	CLINICAL PSYCHOLOGIST II	1.0	12	1.0	
08697A	CLINICAL PSYCHOLOGIST II	1.0	12	1.0	
	Subtotal Service Area 6	**60**	**4,872**	**58.000**	**$ 3,253,723**

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
STAFFING DETAIL - SALARY COST ANALYSIS
SERVICE AREAS 1, 6 AND 7 SPECIALIZED FOSTER CARE MENTAL HEALTH SERVICES
FISCAL YEAR 2005/06

Item No. & Sub.	Title of Position	Ordinance	Mo./ Days	FTE	TOTAL GROSS SALARY AMOUNT
SERVICE AREA 7					
CO-LOCATED PROGRAMS					
SANTA FE SPRINGS DCFS					
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728
09038A	SUPVG PSYCHIATRIC SOCIAL WORKER	1	12	1.000	71,863
BELVEDERE					
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728
09038A	SUPVG PSYCHIATRIC SOCIAL WORKER	1	12	1.0	71,863
ADMINISTRATION					
00913A	STAFF ASSISTANT II	1	12	1.000	$ 49,401
01865A	TRAINING COORDINATOR, MH	1	12	1.000	71,863
09038A	SUPVG PSYCHIATRIC SOCIAL WORKER	1	12	1.000	71,863
AMERICAN INDIAN COUNSELING CENTER					
09002A	MEDICAL CASE WORKER II	1	12	1.000	46,698
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
09035A	PSYCHIATRIC SOCIAL WORKER II	1	12	1.000	64,319
02216A	SENIOR TYPIST-CLERK	1	12	1.000	35,728
	Subtotal Service Area 7	**21**	**252**	**21.000**	**$ 1,192,081**

ATTACHMENT V

CONTRACT NO. **DMH-00964**

AMENDMENT NO. **24**

THIS AMENDMENT is made and entered into this ____ day of _____, 2005, by and between the COUNTY OF LOS ANGELES (hereafter "County") and **The Regents of the University of California, Los Angeles (UCLA) – (Ties for Adoption Program)** (hereafter "Contractor").

WHEREAS, County and Contractor have entered into a written Agreement, dated July 1, 2001, identified as County Agreement No. **DMH-00964**, and any subsequent amendments (hereafter collectively "Agreement"); and

WHEREAS, for Fiscal Year 2005-2006, County and Contractor intend to amend Agreement only as described hereunder; and

WHEREAS, for Fiscal Year 2005-2006, effective upon Board approval through the term of the Affiliation Agreement, which expires on June 30, 2006, County and Contractor intend to amend Agreement by adding $**50,000** to Addendum A (Countywide Academic and Medical Teaching Services Program) for program augmentation at Harbor-UCLA Medical Center and Metropolitan State Hospital to provide program evaluation on an annual basis; and

WHEREAS, for Fiscal Year 2005-2006, the Maximum Contract Amount (MCA) for Addendum A will be increased to $**1,405,007**, and the revised MCA for the entire Affiliation Agreement will be $**3,250,725**.

NOW, THEREFORE, County and Contractor agree that Agreement shall be amended only as follows:

1. Addendum A- Amendment 23, (Countywide Academic and Medical Teaching Services Program) shall be deleted in its entirety and replaced with Addendum A – Amendment 24, (Countywide Academic and Medical Teaching Services Program), attached hereto and incorporated herein by reference. All references to Agreement, Addendum A – Amendment 23, (Countywide Academic and Medical Teaching Services Program) shall be deemed amended to state "Addendum A – Amendment 24, (Countywide Academic and Medical Teaching Services Program)."

2. Contractor shall provide services in accordance with the Contractor's Fiscal Year 2003-2004 Negotiation Package for this Agreement and any addenda thereto approved in writing by Director.

3. Except as provided in this Amendment, all other terms and conditions of the Agreement shall remain in full force and effect.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be subscribed by County's Director of Mental Health or his designee, and Contractor has caused this Amendment to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
MARVIN J. SOUTHARD, D.S.W.
Director of Mental Health

The Regents of the University of California, Los Angeles (UCLA) - Ties for Adoption Program
CONTRACTOR

By _____

Name J. Thomas Rosenthal, M.D.

Title Director, Vice Provost
(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM
OFFICE OF THE COUNTY COUNSEL

APPROVED AS TO CONTRACT ADMINISTRATION:

DEPARTMENT OF MENTAL HEALTH

By _____
Chief, Contracts Development and Administration Division

Addendum A -Amendment 24

Countywide Academic and Medical Teaching Services Program

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AI INTRODUCTION

University and DMH agree that this Addendum A - Amendment 24 shall be adopted under Section 2.1 ("Academic and Medical Teaching Services") of the Agreement of July 1, 2001, between University and DMH. University and DMH further agree that this Addendum A - Amendment 24 shall replace Addendum A - Amendment 23 in its entirety and shall be subject to all of the provisions of the Agreement governing Academic and Medical Teaching Services, except where otherwise specified in this Addendum A - Amendment 24.

A2 DESCRIPTION OF SERVICES

A2.1 Countywide Academic and Medical Teaching Services Program

University shall assign UCLA Department of Psychiatry and Biobehavioral Sciences faculty members ("University Faculty") to provide Academic and Medical Teaching Services in DMH Facilities to DMH personnel.

These services shall be measured and provided in terms of "sessions." The scheduling, content, and location of these sessions shall be described in Sections A2.2 and A2.3.

A2.2 Scheduling and Content of Sessions

The scheduling and content of sessions under this Section shall be developed by the Joint Mental Health Operations Committee ("Committee"). The Committee may delegate responsibility for creating initial scheduling and content to a subcommittee. However, any final session schedule or content must be approved by the full Committee, as required by Section 5.1.1.4.3 of the main Agreement.

The Committee shall develop scheduling and content to implement the following objectives:

a) Developing a comprehensive programmatic approach to evaluate, improve, and expand programs offered to clients in DMH Facilities;

b) Providing DMH physicians, other DMH mental health professionals, and non university public sector mental health providers with training in the state-of-the-art knowledge regarding mental illness, psychopharmacology, and novel approaches to interventions and rehabilitation;

c) Increasing the collaboration between the University and the DMH facilities in establishing quality and outcome procedures to ensure continuous quality improvement in services provided;

d) Improving the ability of DMH to educate and hire qualified physicians and allied mental health professionals through the participation of trainees in public sector training programs;

e) Ensuring the development of personnel and protocols necessary for the establishment of a seamless system of care spanning inpatient and outpatient public and private sector settings;

f) Promoting a diversified and professionally stimulating environment within the community mental health program that ensures improvements in staff recruitment and retention;

g) Enhancing the training opportunities for all UCLA clinical interns and psychiatry residents within the field of community mental health and non university public sector settings; and

h) Including DMH Facilities within the research framework of the University, through the UCLA Neuropsychiatric Institute and Hospital.

In developing the scheduling and content of these sessions, the Committee shall also specifically set forth and describe the forms in which these services shall be provided, taking into account the specific needs of individual DMH Facilities. These forms include, but are not necessarily limited to, the following:

a) Presentations;

b) Seminars;

c) Round table discussion groups;

d) One-on-one tutorials;

e) Case consultations and conferences;

f) Participation in staff meetings;

g) Observation and evaluation of mental health services delivery and client interaction; and

h) Consultations on facility-specific issues.

As set forth in Section 5.1.1.4.3 of the main Affiliation Agreement, the final schedule approved by the Committee shall describe in detail the form by which services will be provided, who shall participate, the anticipated time, date, location, and duration of each session, as well as the specific topics to be covered.

A2.3 Location of Sessions

As provided in Section A2.2, the Committee shall jointly develop a schedule for the provision of Countywide Academic and Medical Teaching Services sessions by University Faculty. The Committee shall schedule these sessions among the following DMH Facilities in a manner to best achieve the goals expressed in Section A2.2, as well as the needs of the individual facilities:

Antelope Valley Mental Health Center
Arcadia Mental Health Center
Augustus F. Hawkins Mental Health Center
Coastal Asian Mental Health Center
Compton Mental Health Center
Downtown Mental Health Center
Edmund D. Edelman Westside Mental Health Center
Forensic Mental Health Services
Hollywood Mental Health Center
Jail Mental Health Services
Long Beach Mental Health Center
Northeast Mental Health Center
Palmdale Mental Health Center
Rio Hondo Mental Health Center
Roybal Family Mental Health Centers
San Antonio Mental Health Center
San Fernando Mental Health Center
San Pedro Mental Health Center
Santa Clarita Mental Health Center
South Bay Mental Health Center
Valley Coordinated Children's Mental Health Services
West Central Mental Health Center
West Valley Mental Health Center

A2.4 Additional Academic and Medical Teaching Services for the Southern Geographic Area of Los Angeles County, in conjunction with the National Institute of Mental Health (NIMH) and the Adult Systems of Care Bureau Initiative Focusing on Improving Services for Underserved Populations Countywide

University, through the Harbor-UCLA Medical Center, shall provide for additional consultation, training, and academic supervision for DMH programs in the Southern Geographic Area of Los Angeles County, in conjunction with the NIMH and the Adult Systems of Care Bureau Initiative focusing on improving services for underserved populations Countywide. These services shall include, but not be limited to, evidence-based, short-term treatment approaches; family treatment approaches; program evaluation; and the rotation of resident physicians, psychology interns, and other disciplines with the attendant supervision and placements. In addition, faculty from Harbor-UCLA Medical Center will provide training to the Southern Geographic Area community, including mental health service providers, clients and family members.

Due to the specialized nature of these services, these services shall not be subject to the planning, content, scheduling, and certification provisions set forth in Section 3.1.2 ("Nature and Scope of Academic and Medical Teaching

Services") of the Agreement and its subsections. Furthermore, the Joint Mental Health Operations Committee shall not conduct any strategic planning, session content and scheduling, or claim resolution activities, as may be called for in Section 5.1.1 ("Joint Mental Health Operations Committee") or its subsections, regarding services provided under this Addendum, Section A2.4.

A2.5 Additional Academic and Medical Teaching Services for the Harbor-UCLA Medical Center and Metropolitan State Hospital, through Harbor-UCLA Medical Center

University, through the Harbor-UCLA Medical Center, shall provide for additional consultation, training, and academic supervision for the inpatient and outpatient programs at Harbor-UCLA Medical Center and for the adult and children's programs at Metropolitan State Hospital. These services shall include, but not be limited to, clinical psychological testing, evaluation, and therapy services provided by clinical psychology interns and fellows as part of their training programs, and teaching and training of psychiatry interns, residents and facility staff in the areas of psychiatric emergency, crisis, and general adult/child outpatient and inpatient services. In addition, faculty from Harbor-UCLA Medical will provide training and consultation to the communities served, including mental health service providers, clients, and family members. Due to the specialized nature of these services, these services shall not be subject to the planning, content, scheduling, and certification provisions set forth in Section 3.1.2 ("Nature and Scope of Academic and Medical Teaching Services") of the Agreement and its subsections. Furthermore, the Joint Mental Health Operations Committee shall not conduct any strategic planning, session content and scheduling, or claim resolution activities, as may be called for in Section 5.1.1 ("Joint Mental Health Operations Committee") or its subsections, regarding services provided under this Addendum, Section A2.4.

Not withstanding the above, services provided under this section must have the prior written approval of a detailed annual budget/spending plan for all covered services and expenditures by the DMH and UCLA Academic Administrator.

A3 FINANCIAL PROVISIONS

A3.1 Countywide Academic and Medical Teaching Services Program

For each year of this Agreement, University shall provide the Academic and Medical Teaching Services described in Section A2.1 according to the levels and rates set forth in the following chart:

Number of Sessions	661
Cost Per Session	$400
Cost for Academic and Medical Teaching Services	$264,400

For purposes of developing and coordinating the Academic and Medical Teaching Services provided under Section A2.1, A2.4, and A2.5 of the Affiliation Agreement, University may devote a portion of the funding for Academic and Medical Teaching Services sessions to program development and coordination activities. The total amount for this function shall not exceed $70,000 annually. Reimbursement for Countywide Program Development and Coordination Activities shall be paid monthly in arrears by invoice from University to DMH based on University's cost for expenditures, subject to the terms and conditions set forth in the main Affiliation Agreement.

A3.2 Additional Academic and Medical Teaching Services for the Southern Geographic Area of Los Angeles County, in conjunction with the NIMH and the Adult Systems of Care Bureau Initiative Focusing on Improving Services for Underserved Populations Countywide

For the services described in A2.4, DMH shall pay to University an amount not to exceed $622,375 annually for the term of the Agreement for the Southern Geographic Area and the collaborative work being done with the NIMH related to special-populations with the Adult Systems of Care Bureau. Reimbursement for these services shall be paid monthly in arrears by invoice from University to DMH based on one twelfth of the annual academic service plan and budget, with the written approval of the Deputy Director, Adult Systems of Care and subject to the terms and conditions set forth in the main Agreement.

Reimbursement under this section must have the prior written approval of the Deputy Director, Adult Systems of Care or his designee. Resources and funding under this section may be reallocated between identified areas in this section with the prior approval of the Deputy Director, Adult Systems of Care or his designee, based on changes in service needs.

A3.3 Additional Academic and Medical Teaching Services for Harbor-UCLA Medical Center and Metropolitan State Hospital through Harbor-UCLA Medical Center

For the services described in A2.5, DMH shall pay to University an amount not to exceed $468,232 annually for the term of the Agreement for the Harbor-UCLA Medical Center and Metropolitan State Hospital programs. This amount shall be in addition to, and not in lieu of, any amounts called for in Addendum A - Amendment 23 prior to this Amendment. Reimbursement for these services shall be paid monthly in arrears by invoice from University to DMH based on one twelfth of the annual academic service plan and budget, subject to the terms and conditions set forth in the main Agreement. Services to Harbor-UCLA Medical Center and to Metropolitan State Hospital shall be invoiced separately.

A3.4 MCA for Addendum A

The new MCA for Addendum A is:

Program	**FY 2005-2006**
Countywide Academic and Medical Teaching Services Program	$264,400
Additional Academic and Medical Teaching Services for the Southern Geographic Area and Adult Systems of Care Bureau countywide Initiative with NIMH through Harbor- UCLA Medical Center	$622,375
Additional Academic and Medical Teaching Services for Harbor-UCLA Medical Center and Metropolitan State Hospital	$468,232
Program Evaluation – on an annual basis	$50,000
Total MCA for Addendum A	$1,405,007

A3.5 Administration and Management

In recognition of the collaborative nature of this Affiliation Agreement, University shall contribute, at no cost to DMH, the managerial and administrative activities necessary to implement the program of services described in this Addendum. These activities include participation in the Joint Mental Health Operations Committee as called for in this Addendum and the Agreement.

The parties anticipate that the administrative and managerial efforts required to implement the program will be substantial, due to its novel and innovative nature.

In addition, the parties recognize that this program will need to be continually monitored, improved, and refined in order to implement its objectives.

In light of these considerations, University has agreed to commit University personnel to providing, at no cost to DMH, no less than 240 hours per Contract Year to the particular administrative and managerial activities required to implement, monitor, and develop this new program. The parties anticipate that the greater part of these hours will be devoted to the Committee's responsibilities set forth in Sections A2.2 ("Scheduling and Content of Sessions") and A2.3 ("Location of Sessions"). University shall provide adequate documentation, such as meeting minutes, to DMH of these administrative and managerial services.

Minimum Number of Hours for Initial Period	240
Cost to DMH	$0.00

A3.6 Payment Procedures

University and DMH understand and agree that persons providing Academic and Medical Teaching Services under this Agreement are faculty members of the Harbor-UCLA Medical Center - Department of Psychiatry, Charles R. Drew University - Department of Psychiatry, and/or David Geffen School of Medicine at UCLA – Department of Psychiatry and Biobehavioral Sciences or guest lecturers. The parties understand and agree that the University shall be responsible for submitting monthly claim and certification forms and invoices as described in Section 6 under the Affiliation Agreement ("Financial' Provisions") and in this Section A3 for Academic and Medical Teaching Services provided by Harbor-UCLA Medical Center, Charles R. Drew University, and David Geffen School of Medicine at UCLA faculty at DMH designated sites. Upon receipt and approval of invoices from the University, DMH shall directly reimburse each aforementioned practice plan for services set forth in Section A2.2, ("Scheduling and Content of Sessions), A2.4 and A2.5 according to the levels and rates set forth in A3.1 ("Countywide Academic and Medical Teaching Services Program"), and A3.2 and A3.3 (Additional Academic and Medical Teaching Services).

University shall submit invoices to:

DMH CONTRACT MANAGER
COUNTY OF LOS ANGELES- DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
550 SOUTH VERMONT AVENUE, 12TH FLOOR
LOS ANGELES, CALIFORNIA 90020

DMH shall send payment to:

UCLA-NEUROPSYCHIATRIC INSTITUTE
DEPARTMENT OF FINANCE
760 WESTWOOD PLAZA, ROOM B7-35
LOS ANGELES, CALIFORNIA 90024-1759
ATTENTION: ASSISTANT DIRECTOR OF FINANCE

UCLA-HARBOR MEDICAL FOUNDATION, INC.
21840 SOUTH NORMANDIE AVENUE, SUITE 200
TORRANCE, CALIFORNIA 90502
ATTENTION: CHIEF EXECUTIVE OFFICER

CHARLES R. DREW UNIVERSITY
DEPARTMENT OF PSYCHIATRY - HAWKINS BUILDING 1021
1720 EAST 120TH STREET LOS ANGELES, CA 90059
ATTENTION: CHAIRMAN OF PSYCHIATRY & HUMAN BEHAVIOR

76R 352M (11/83)

BOARD OF SUPERVISORS OFFICIAL COPY

COUNTY OF LOS ANGELES

REQUEST FOR APPROPRIATION ADJUSTMENT

DEPT'S. NO. 435

DEPARTMENT OF Mental Health

19

AUDITOR-CONTROLLER.
THE FOLLOWING APPROPRIATION ADJUSTMENT IS DEEMED NECESSARY BY THIS DEPARTMENT. WILL YOU PLEASE REPORT AS TO ACCOUNTING AND AVAILABLE BALANCES AND FORWARD TO THE CHIEF ADMINISTRATIVE OFFICER FOR HIS RECOMMENDATION OR ACTION.

ADJUSTMENT REQUESTED AND REASONS THEREFOR

4-VOTES

Sources:

Department of Mental Health
Other State Aid-Health
A01-MH-20500-8771
$1,382,000

Department of Mental Health
Federal Aid - Mental Health
A01-MH-20500-9025
$1,691,000

Department of Mental Health
Intrafund Transfer
A01-MH-20500-6800
$48,000

Uses:

Department of Mental Health
Salaries and Employee Benefits
A01-MH-20500-1000
$67,000

Department of Mental Health
Services and Supplies
A01-MH-20500-2000
$3,054,000

This adjustment is requested to increase Salaries and Employee Benefits appropriation by $67,000 and Services and Supplies appropriation by $3,054,000 to provide spending authority for the Specialized Foster Care Program. This appropriation increase is fully funded by Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) State General Fund (SGF); $1,382,000, Federal Financial Participation (FFP) Medi-Cal, $1,691.000, and Intrafund Transfer (IFT) from the Department of Children and Family Services (DCFS), $48.000. There is no increase in net County cost.

Marvin J. Southard, D.S.W.
Director of Mental Health

CHIEF ADMINISTRATIVE OFFICER'S REPORT

REFERRED TO THE CHIEF ADMINISTRATIVE OFFICER FOR — ACTION ✓ RECOMMENDATION

BY [signature] OCT. 5 2005

AUDITOR-CONTROLLER
NO. 38

APPROVED AS REQUESTED — AS REVISED

October 5 2005 19

[signature]
CHIEF ADMINISTRATIVE OFFICER
FOR DAVID JANSSEN

APPROVED (AS REVISED): BOARD OF SUPERVISORS — 19

BY
DEPUTY COUNTY CLERK

SEND 5 COPIES TO THE AUDITOR-CONTROLLER