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County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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Director

July 26, 2012

To: Supervisor Zev Yaroslavsky, Chairman
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From: Philip L. Browning, Director

RESPONSE TO THE JUNE 26, 2012 BOARD MOTION ON EMERGENCY RESPONSE COMMAND POST

On June 26, 2012, the Board directed the Department of Children and Family Services (DCFS) to report back within 30 days with a plan to ensure the safe placement of children over the age of 10 coming into the Emergency Response Command Post (ERCP). Ensuring safe placement requires the Department to address both older youth safety at ERCP and a plan to mitigate the need for older youth in open cases to go to ERCP.

This report is not intended to be a comprehensive progress report on all ERCP overhaul strategies currently underway. To allow sufficient time to compile necessary additional details, both further expounding on much of the information that follows, as well as, upon information in previous reports provided to the Board, a comprehensive progress report is forthcoming to the Board *between mid to late August 2012*.

Interim Older Youth Safety Plan at the ERCP Site at Broadway

With the opening of the Child Awaiting Placement (CAP) Center adjacent to the LAC-USC Medical Hub CAP Center on July 16, 2012, the existing ERCP site at Broadway was afforded an improved staff-to-youth supervisory ratio as well as additional space to separate older youth awaiting placement by gender. On July 12, 2012, the Department's ERCP and Property Management staff met with representatives of the Chief Executive Office (CEO) to continue space reconfiguration planning at the ERCP site at Broadway. Consensus was reached on one of two proposals to convert the conference room adjacent to the children's room into an additional, much larger children's room. The CEO is currently conducting a cost estimate for the build-out plan. Receipt of cost estimate results is projected *by mid-August*.

At the present time, Group Supervisors, stationed at the entrance of the ERCP children's room, closely monitor youth awaiting placement through a glass wall that allows a clear, unobstructed view of youth. Additionally, Group Supervisors monitor the time youth spend in the restroom and, if excessive, query children to ascertain their safety and well-being.

A Security Guard situated adjacent to the children's room does not interact with youth, rather, frequently roams the area as a reminder of on-site support for a youth's safety and well-being.

All ERCP managerial and Supervising Children's Social Worker staff are trained in the Department of Mental Health (DMH) Psychiatric Mobile Response Team (PMRT) protocols. Should a youth exhibit behavior that poses a threat to him/herself, others or property, social work staff initiate a call to the DMH ACCESS Center - a 24-hour per day, 7-day per week hotline for emergency psychiatric services. While awaiting PMRT arrival to conduct an assessment for involuntary hospitalization pursuant to Welfare and Institutions Codes 5585 or 5150, a Group Supervisor monitors the youth in a location away from other youth concurrently awaiting placement. In instances where additional assistance may be warranted, staff contacts Law Enforcement.

As part of newly-evolving enhancements to ERCP intake security screening procedures, ERCP staff now inquire whether entering youth possess any type of contraband (e.g., weapons or drugs); and request that youth display their possessions. If a youth refuses, ERCP staff do not make physical contact with nor force the youth to make a disclosure. Within the near future, the Department plans to implement enhanced intake security screening procedures for youth arriving at ERCP. Plans include the use of a magnetometer to "wand" youth for undisclosed contraband.

In preparation, the Department developed draft policies to guide staff on legally-mandated restrictions incorporating, as appropriate, recommendations from County Counsel, Judicial Court Services, Dependency Court Judges and Union representatives; verified that the Department's existing Security Guard contract includes weapons screening duties with stipulated requisite training; purchased two (2) magnetometers and a safe to securely store a youth's belongings, i.e., large amounts of jewelry, money, cell phones, iPods, and/or contraband, the latter of which will be turned over to law enforcement or another agency to properly dispense of it.

On July 31, 2012, the Department and County Counsel are scheduled to meet with the Children's Law Center (CLC) to further discuss the policy draft and issues related to searches. Upon CLC review and incorporation of any necessary changes, the policy, which includes use of magnetometers, will be finalized and implemented.

Interim ERCP Overhaul Progress

On June 4, 2012, ERCP administrative oversight was temporarily transferred to an experienced Departmental Administrative Deputy and Regional Administrator, with the charge of developing ERCP operational efficiencies and enhancements. As part of the ERCP operational efficiencies and enhancements underway, the Department is implementing new *ERCP Intake Procedures,* as well as, a centrally-located and managed *Accelerated Placement Team* (APT), referred to in previous Board reports as the "Aggressive Placement Team."

ERCP Intake Procedures

Data on ERCP entries gathered since December 2011 reveals that 70% of children/youth who enter ERCP are in open cases assigned to regional offices. To standardize intake for all children entering both the CAP Center and the ERCP site at Broadway, the administrative oversight team developed protocols and a one-page ERCP Screening and Intake Process

Guide for Children's Social Workers (please see attachment). Created to expedite intake and enhance the safe and timely placement of children being transported to ERCP, the document also serves to remind regional line management of the requisite written approval prior to transporting a child on an open case to ERCP to await placement.

According to the new procedures, prior to transporting a child/youth on an open case to either the CAP Center or to the ERCP site at Broadway, the regional line operations staff must contact the ERCP Supervising Children's Social Worker "on duty" to ensure that a completed Intake Packet, including the ERCP Screening and Intake Form, accompanies the child. The Screening and Intake Form includes a listing of the child's critical developmental, social, behavioral, psychological, and medical factors, as well as a listing of failed placement attempts made during business hours by regional staff. The latter is to prevent ERCP's repeat placement efforts with the same care providers.

The aforementioned protocols are already proving successful in fostering meaningful communications and coordinating efficiencies between business-hour regional line and after-hours ERCP operations. Additionally, the protocols are eliciting the more frequent involvement the Department's Office of the Medical Director and Wraparound Division staff to match children's needs with the most appropriate placement.

Accelerated Placement Team (APT)

APT's mission is twofold: To mitigate, to the extent possible, the ERCP entry of youth assigned to open cases in regional offices; and to shorten ERCP lengths-of-stay for all children awaiting placement or replacement. APT, comprised of existing DCFS staff with expertise on both children's high-risk behavior and available/appropriate placement resources, will prevent and better manage provider "Notices of Discharge;" and expeditiously support the placement needs of the entire Department, including the ERCP site at Broadway, the CAP Center and regional line operations countywide.

APT's objectives are to increase the probability of preserving existing placements or secure access to the most appropriate initial or new placements. It is estimated that there are between seventy and eighty (70-80) "Notices of Discharge" received from group homes and foster family agencies each week. APT staff will apply their expertise to appropriately share pre-placement information regarding the child's developmental, social, emotional, and psychological strengths, needs and behaviors with potential caregivers; and apply their collegial relationships with contracted care providers to assess and distinguish the unique abilities of different providers to serve a specific child, including the need for one-on-one aides, as necessary, to avert placement disruptions. Upon successful completion of an initial placement or replacement and once the responsibility for the child's case is transferred back to the assigned DCFS regional office, a dedicated APT Children's Social Worker will ensure communication and continued implementation of follow-up recommendations by providers; medical and mental health evaluations conducted at the CAP Center, as well as all other assessments gathered by the centralized APT.

In the event that the APT is unable to avert a placement disruption and/or secure an appropriate replacement with contracted care providers within the required timeframes, the APT will utilize a diagnostic tool, being newly-developed by the Department's Medical Director, to determine the most appropriate temporary placement where additional time can be afforded

to conducting a deeper, more comprehensive assessment of the child's unique needs. Further details about this approach are found in the subsection at the bottom of this page.

APT will be physically located at the ERCP site at Broadway and centrally-managed by ERCP administration seven days per week between the hours of 7:00 a.m. and 2:30 a.m. affording seamless placement expertise to all line operations countywide, including the ERCP site at Broadway and the CAP Center. In preparation for a timely launch, the Department's Human Resources Division is currently redirecting existing budgeted items from its Resource Utilization Management (RUM) Unit to the new APT, which is projected to launch *on August 13, 2012*.

Emergency Wraparound Services

In order to explore additional supports to prevent placement disruption and/or ERCP youth from entering higher levels of care in group homes, on June 19, June 25 and July 2, 2012, a workgroup met, comprised of Wraparound service providers and representatives of the Departments of Children and Family Services and Mental Health. The result of this collaboration produced an emergency/after-hours *Emergency Wraparound Service* protocol.

Upon a child's/youth's entry into either the CAP Center or the ERCP site at Broadway with urgent and intensive needs, his/her records will be checked to confirm whether or not the child/youth has an active or suspended Wraparound case. If the child/youth is confirmed to be actively enrolled or on a suspended Wraparound case, an emergency response request to the responsible Wraparound provider agency will result in the provider's emergency response, within 3 hours, to the CAP Center or the ERCP site at Broadway. Ensuing Emergency Wraparound Services will consist of the provider engaging the family, stabilizing the crisis, identifying safety Issues and initiating a child and family team meeting within 24 hours or the following business day.

Emergency Wraparound Services test cases for ERCP children have been conducted since December 2011 through which several successes have been realized in stabilizing placements. The finalization of the protocols and full implementation of Emergency Wraparound Service is projected *by the end of August 2012*.

Four-Tiered System of Emergency Placement Planning for Older Youth

Earlier within the text of this report, reference was made to those instances when all regional staff strategies, as well as those of the newly-formed APT will, for a variety of reasons, still prove unsuccessful in either averting a placement disruption and/or securing an appropriate replacement with the existing census of care providers and within the required timeframes. ERCP is not a placement nor can it shelter children/youth. When regional or APT placement attempts in the homes of relatives, state-licensed foster homes, Foster Family Agency-certified homes and/or group homes prove unsuccessful within 23 hours, the immediate need for a temporary/emergency placement emerges. For those cases, the Department's Medical Director is developing a diagnostic tool for APT staff to triage and determine the most appropriate *temporary/emergency placement*, where more time can be afforded to conducting a deeper, more comprehensive assessment of the child's unique needs. The process is called the "Four-Tiered Emergency Placement Plan for Older Youth."

There are four types of temporary/emergency placements, either already in existence or being planned, as follows:

(1) **TIER ONE**: **Emergency Shelter Care Homes** – There are currently *28* Group Home Emergency Shelter Care beds countywide that can serve as temporary/emergency placements for up to 30 days for youth 11 to17 years of age. By the Spring of 2013, the Department anticipates an expansion of Group Home Emergency Shelter Care bed capacity for a total of *80* beds countywide. There is currently limited Emergency Shelter Care bed capacity for youth over age 18. While an established procedure between the Department and Community Care Licensing allows for a case-by-case waiver to enable the placement of a youth over age 18 into an Emergency Shelter Care bed, the Department is exploring the expansion of Emergency Shelter Care bed capacity with extended age licensing accommodations in place.

(2) TIER TWO: Group Home Assessment Centers - These facilities *do not* currently exist for DCFS. However, the Department of Probation has successfully implemented "Probation Assessment Centers" (PAC) as part of their Title IV-E Waiver Strategies. PACs are contracted group home cottages that serve as *30-day assessment centers* for youth under Probation supervision exiting Juvenile Hall or Camp. During the initial 21 days, a youth is comprehensively assessed for treatment needs. During the last 7 days, a permanent suitable placement is located for the youth. Please see below for further plans by our Department to replicate PACs for DCFS.

(3) TIER THREE: **Community Treatment Facilities** – There are currently two Community Treatment Facilities in Los Angeles County - Starview Children and Family Services (40 beds) and Vista Del Mar (21 beds). Created as an alternative to out-of-state placement and state hospitalization for children, Community Treatment Facilities include a lock-down unit. Acceptance of referred youth to a Community Treatment Facility bed is contingent upon the results of a DMH Screening process.

(4) TIER FOUR: Acute Psychiatric Hospitalization – When a child/youth meets the criteria to be determined a danger to self, others or property by DMH, the child/youth may be involuntarily contained for 72 hours in the most restrictive care level. The DMH-PMRT assesses and determines the need to hospitalize.

In preparation to implement the evolving Four-Tiered Emergency Placement Plan, the Department's Medical Director will train the APT staff on the use of a triage tool, currently under development, to best determine the most appropriate temporary/emergency placement tier mentioned above. Temporary/emergency placements are for the sole purpose of stabilizing the youth and affording sufficient time to comprehensively assess or re-assess the youth's needs and appropriate permanent placement. The criteria for Tiers Three and Four are determined by DMH. However, when a child /youth does not present with needs that rise to those two levels, the following is being considered for Tiers One and Two:

Assuming that the 70% of children/youth entering ERCP in open cases assigned to regional offices already have existing mental health assessments and/or services that need further review and/or recalibration; for these children/youth, a TIER ONE placement will be followed by an inter-agency mobile response unit assessment to review existing service/care levels and to make necessary adjustments with the required 30 days or less. One-on-one aides may also be assigned, as necessary, to assist the emergency shelter care providers in stabilizing the child/youth.

For newly-detained children/youth over age 13, for whom regular placement efforts were unsuccessful, the Department is considering the establishment of Group Home Assessment Centers (30-day assessment centers), where an in-house comprehensive assessment can be conducted by contracted professionals, culminating in an appropriate permanent placement within 30 days. The Department of Probation has successfully implemented this model and informs DCFS that assessment language, already contained within existing group home contracts, allowed for a quicker establishment of such facilities. The Department will continue to explore the replication of this 30-day assessment center concept with County Counsel and the Department of Probation and, within the next four weeks or *no later than mid- to late August 2012*, report to the Board with more concrete information for the expansion of the aforementioned TIERS ONE, TWO AND THREE temporary/emergency placement capacities.

Legislative Remedies

The Department has reviewed existing laws governing the placement of children and has identified a need for legislative change. There appears to be no current mechanism whereby youth who voluntarily engage in high-risk or criminal activity such as sex trafficking, prostitution or drug sales, can be restricted from leaving an appropriate placement or temporary/emergency shelter unless they meet specific mental health criteria. To address this deficiency, the Department has drafted proposed legislation which would allow a court to review the circumstances of such youth and, if determined necessary, place them in a more secure setting under heightened and more frequent judicial review. Upon County Counsel review for legal sufficiency, the draft proposal will be provided to your Board for review.

Acknowledging that no single initiative can, on its own, adequately ensure the safe placement of youth coming into ERCP, the Department is instituting layers of safeguards, the totality of which will enhance and improve safety, both for children and for staff, as children await timely and appropriate placement at ERCP. The following are some strategies already implemented or also planned for future implementation.

Child Awaiting Placement Center

On July 16, 2012, the Child Awaiting Placement (CAP) Center adjacent to the LAC-USC Medical Hub became operational, enabling the Department to divert the waiting of younger children, up to age 10, to a separate, more comfortable facility. During its first eight days of operation, between Monday, July 16, 2012 and Monday, July 23, 2012, a total of forty-six (46) children awaited placement at the CAP Center, as follows:

DAY	DATE	# of children
Monday	July 16, 2012	4
Tuesday	July 17, 2012	7
Wednesday	July 18, 2012	4
Thursday	July 19, 2012	9
Friday	July 20, 2012	4
Saturday	July 21, 2012	14
Sunday	July 22, 2012	1
Monday	July, 23, 2012	3
Total number at CAP		**46**

Of the 46 children:

- 27 children (59%) were female and 19 children (41%) were male;
- 39 children (85%) were below age 9 and 7 children (15%) were age 10 and older;
- 35 children (76%) were newly-detained by ERCP staff and 11 children (24%) had been previously detained by regional emergency response staff;
- 26 children (57%) awaited placement for less than 10 hours and 20 children (43%) awaited placement between 10 and 23.5 hours.
- No child awaited placement in excess of 23.5 hours.

During its first two months of operations, between July 16, 2012 and September 16, 2012, the Department is operating the 24 hour per day, 7 day per week CAP Center utilizing volunteer DCFS staff, temporarily borrowed from regional operations; in-kind Department of Health Services (DHS) staff stationed at the LAC-USC Medical Hub; and department-funded Certified Nurse Assistants, contracted with DHS on an on-call basis.

DMH Training and Coaching At ERCP

As part of the DMH's recommendations to improve child safety at ERCP, two suicide prevention/intervention trainings have already been conducted for ERCP staff on June 13 and 20, 2012 for a total of 61 ERCP staff.

Within the next six months, during the Core Practice Model coaching support groups of two hours each, DMH will provide non-violent crisis intervention and suicide prevention training for the remaining ERCP staff. Additionally, since the Violence Intervention Program Community Mental Health Center (VIP-CMHC) will be providing mental health services at the CAP Center, DMH will provide Core Practice Model training to the VIP-CMHC staff who are providing mental health services there.

Child Welfare Mental Health Services

Youth entering ERCP comprise a population supervised either by the Departments of Children and Family Services and/or Probation, a significant percentage of whom either receive or require mental health services. The Departments of Children and Family Services, Probation and Mental Health have developed an integrated service practice model to assure placement stability and to benefit children, youth, families and communities.

Foundational to this practice model are *Child and Family Teams*, comprised of the child/youth, family and informal and formal supports, who work together to identify strengths and needs and to implement the necessary services and supports to meet the needs identified.

The various strategies already implemented and currently managed through the Department's Child Welfare Mental Health Services Division have proven highly-successful in improving safety, permanency and well-being outcomes for children and families. Unfortunately however, a percentage of children/youth continue to frequent ERCP due to placement instability. In its effort to mitigate, to the extent possible, the ERCP entry of youth assigned to open cases in regional offices, the aforementioned new APT will closely coordinate its work with that of the Department's existing Child Welfare Mental Health Services Division strategies, briefly described below. As the APT operations roll-out, the Department is planning

the cross-training of various of the following expert placement support staff in order to enhance efficiencies and streamline duplications of efforts, if any.

Coordinated Services Action Teams

On May 1, 2009, a partnership between the Departments of Children and Family Services and Mental Health resulted in the implementation of Coordinated Services Action Teams (CSAT). Implemented countywide in September 2011, CSATs are mental health service access management teams located in each DCFS regional office to coordinate and track the screening, referral, and service linkage process for DCFS children and families. DMH co-located supervisors serve as CSAT leads and coordinate efforts with DMH Service Linkage Specialists (SLS) and DCFS Multidisciplinary Assessment Team (MAT) Coordinators. CSAT protocols include a mental health screening process, redesigned in October 2010, to identify a child's needs for mental health services and to determine the level of need, whether acute, urgent or routine.

Group Home Approval Process

The Department's Group Home Placement Approval process ensures that group home placements are utilized *only* as a short-term intervention by utilizing intensive care coordination and home-based services to maintain children/youth in a community-based setting, whenever possible. A series of consultation meetings precede the final decision to place a child/youth in a group home. Group home placement forms must bear the approval signatures of the responsible chain of command for a child's entry to the higher level of care or replacement from one group home to another.

For children, ages 12 and younger, initial group home placement or replacement from one group home to another requires the Director's approval. The Director's approval authorization form must document proactive engagement with the Child and Family Team; exploration and/or utilization of other intensive community-based services; consultation with the CSAT; approval by the responsible Regional Administrator, Deputy Director; Resource Management Division Chief and the Medical Director. Following the group home placement or replacement of a child, ages 12 and younger, a permanency planning conference must occur once every four months until a plan for either the child's permanence or for transitioning back to the community is in place.

For youth, ages 13 and older, group home placement requires the approval of every level within the responsible chain of command, including the Regional Administrator. Continued group home placement beyond six to nine months is reviewed through regular team meetings. Between January and June 2012, 525 children/youth were placed in a group home, of whom 456 children/youth (87%) were replacements from one group home to another. The total number of children, ages 12 and under, placed in group homes has steadily declined from *179* in January 2012 to *143* in June 2012.

Exodus Urgent Care Center

The Exodus Urgent Care Center (Exodus) is an outpatient facility that provides voluntary crisis stabilization services not to exceed 23 hours for youth ages 12 and older. Exodus is not a locked placement facility and is open 24 hours per day, 365 days per year, on a walk- in basis, offering comprehensive care by an interdisciplinary team of physicians, nurse practitioners, registered nurses and therapists.

Children's Social Workers may initiate an Exodus referral for approval by the Department's Child Welfare Mental Health Services Division staff for any DCFS-involved youth ages 12 and over with mental health needs that do not meet hospitalization criteria. Referred youth must consent to enter Exodus, stay and be served; and may revoke consent at any time. The Child Welfare Mental Health Services Division is responsible for referral approval and care coordination. Transportation of youth to and from Exodus is the responsibility of either regional or ERCP staff within the 23-hour limit.

If a youth refuses to enter Exodus, the Child Welfare Mental Health Services Division determines whether additional emergency services could stabilize the situation; alerts the responsible regional office CSAT team of the Children's Social Worker's need for assistance; supports the Children's Social Worker's efforts to identify an appropriate D-Rate foster home or temporary shelter placement; and/or supports requests for PMRT assistance.

During the latter part of FY 2012-2013 (Jan 2012 – June 2012), the Department's Child Welfare Mental Health Services Division conducted 103 Exodus consultations, resulting in 58 youth (56%) entering Exodus.

High-Risk Youth Case Conference Pilot

As of July 20, 2012, the Department's High-Risk Youth database ranked the 35,049 children under DCFS supervision according to eight (8) risk factors. The risk-ranking methodology appropriates greater weight to higher frequencies of certain risk factors, assigning each child a score of 0 to 9; with 9 being the highest risk. The eight risk factors are:

(1) Frequency of replacements within the last 12 months
(2) Frequency of psychiatric hospitalizations within the last 12 months
(3) Frequency of ERCP entries within the last seven months
(4) Assigned Structured Decision Making Risk – "Very High" or "High"
(5) Current Assignment – Runaway Outreach Unit
(6) Current Assignment – Youth Permanency Unit
(7) Current Placement – D-Rate Home; RCL 12 Group Home; RCL 14 Group Home
(8) Pregnant or Parenting Youth

Per the July 20, 2012 High-Risk Children Database report, of the 35,049 children under the Department's supervision, 30,103 (86%) rank between 0 to 2; 4,888 (13%) rank between 3 and 6; and 58 (less than 1%) rank between 7 and 9. (see table below).

RISK SCORE	NUMBER OF CHILDREN
0	3,072
1	12,171
2	14,860
3	3,479
4	931
5	349
6	129
7	39
8	16
9	3
TOTAL	35,049

To further review and expand Child and Family Team formation and function, the Department's Medical Director is leading high-risk youth case conferences for each youth who ranks between 7 and 9. Each youth ranked between 7 and 9 typically has a frequency of entering ERCP at least two times since December 2011. Present at each high-risk case conference are the responsible Deputy Director and Regional Administrator; and as key participants a Revenue Enhancement Manager, Medical Director/Designee and the Wraparound Division Chief. As necessary, the Departments of Mental Health, Public Health and Health Services are consulted in instances when their respective involvement is pertinent to the services and/or placement needs of the identified high-risk youth.

High-risk case conferences occur at a frequency of three to four per week. The assessment is conducted consistently based upon a core practice model questionnaire that assesses whether the high-risk youth's family is fully involved and engaged; whether relevant and important information has been gathered to accurately identify the high-risk youth's *underlying* needs; whether interventions have been planned based upon the high-risk youth's strengths and preferences; and whether DCFS has effectively collaborated with partnering agencies and communities in the child's best interest.

The purpose of the *initial* high-risk case conference is to comprehensively gather relevant information. For 100% of all pilot cases, the Medical Director provides a clinical assessment, diagnostic and medication recommendations; explores former and relative caregivers and non-related extended family members as potential placements; evaluates the efficacy of the current array of services; employs high-level administrative interventions, as necessary, to expedite the delivery of any additional stabilization services; and identifies intervention needs, not within the current service array available to this population.

Upon completion of a high-risk case conference, the Medical Director submits an initial assessment report with an action plan to the Director. Upon receipt of weekly input from the responsible regional staff on progress, by the tenth of each month, the Medical Director submits a monthly update to the Director on each case reviewed during the previous month.

To date, since inception of the pilot on May 23, 2012, twelve high-risk youth case conferences have taken place, with an additional four case conferences rescheduled due to last minute scheduling conflicts. Of the twelve cases reviewed, the average risk score was *7.3*. From the results of the twelve cases reviewed the following trends emerged: 5 youth (44%) were stabilized in their group home settings; and 7 youth (56%) returned either to the home of their parent or to the home of an extended family member with wraparound services. For only one case, because the family member resides outside of Los Angeles County, linkage to intensive mental health services remains pending. None returned to ERCP. All high-risk youth case conferences for the 58 youth scoring between 7 and 9 are projected to be completed *by March 2013*.

The following lists the top ten clinical issues leading to trend findings emerging from the twelve high-risk case conferences completed to date:

	TOP TEN CLINICAL ISSUES		TOP TEN TRENDS
1.	Conduct Disorder	1.	Lack of meaningful engagement/working relationship with the youth.
2.	Oppositional Defiant Disorder	2.	Lack of meaningful engagement/working relationship with parents.
3.	Adjustment Disorders	3.	Significant unmet mental health and substance abuse needs.
4.	Impulse Control Disorders	4.	Developmental delays, misunderstood by caregiver(s).
5.	Posttraumatic Stress Disorder	5.	Services and supports, not designed to address underlying needs.
6.	Attention Deficit Hyperactivity Disorder	6.	Underpowered services to parents, not well-designed to effectively support them in those areas of parenting most challenging for them.
7.	Major Depressive Disorder	7.	Angry youth, refusing services and acting out unmet needs. (These are not withdrawn, isolating and sad youth who "act in.")
8.	Bipolar Disorders	8.	Lack of meaningful family treatment.
9.	Learning Disorders	9.	No effective treatment to address trauma, resulting in Post Traumatic Stress Disorder.
10.	Substance Related Disorder	10.	History of symptom control by several different psychopharmaceutical approaches.

ERCP Repeaters CSAT Pilot in Compton

The High-Risk Youth database revealed thirteen (13) youth who entered ERCP more than twice since December 2011 and who are on open cases assigned to the DCFS Compton Regional Office. Compton's DMH Service Linkage Specialist was assigned to partner with the responsible social workers, supervisors, DMH co-located staff or existing mental health provider and coaches to coordinate Child and Family Team meetings, review strengths and underlying needs, and implement services and supports to ensure placement stability and prevent the youth's return to ERCP.

As a result of these efforts, none of the thirteen youth have since returned to ERCP; and seven (7) youth have been stabilized in placement; five (5) were and continue to be AWOL; and one (1) youth was already doing exceptionally well at home with his mother with services in place. Several common themes emerged among Compton children who were "ERCP Repeaters":

- The children's current behaviors are challenging for caregivers to manage;
- Some caregivers bring the children into the regional office without notice;
- Some caregivers provide "Notices of Discharge" without reasonable justification; and
- Some caregivers are not willing or capable of the necessary flexibility to address the child's *underlying* needs.

The ERCP Repeaters Pilot in Compton revealed that 24-hour support to caregivers would go along way in helping to ensure on-going placement stability. The DMH Service Linkage

Specialist spent significant time engaging the caregivers of the thirteen children to learn that caregivers need more support. Two placement disruptions were averted simply by being accessible when things happened in the home. Accordingly, the APT can serve in the role of an extended hours access point from which additional supports can be coordinated in a timely manner.

DMH Training For Intensive Mental Health Service Providers

As part of the DMH's recommendations to improve child safety at ERCP, DMH will work with DCFS, using the High-Risk Youth database, along with the enrollment databases for Wraparound and Full Service Partnerships, to identify high-risk youth who are being served by these two intensive service programs. DMH will begin with those youth having the highest risk scores who are enrolled in these programs and begin a series of Child and Family team meetings, with a focus on Core Practice Model principles and practices, to identify needs and strengths and improved services and supports aimed at stabilizing placements and minimizing the risk of referral to ERCP. DMH will also be discussing this issue at quarterly Katie A. provider meetings and monthly meetings with the Specialized Foster Care Managers.

Longer-term planning will require training of Wraparound and Full Service Provider staff in the importance of addressing the risk of ERCP involvement from the very beginning of treatment planning and to prepare both prevention and intervention strategies for potential ERCP involvement. These efforts are anticipated to be completed *by December 2012*.

Placement Disruption Crisis Mobile Response Teams

As part of the DMH's recommendations to improve child safety at ERCP, DMH and DCFS will begin by coordinating case consultation opportunities for group home providers (Rate Classification Level 12 and above) regarding managing children with mental health issues.

DMH will begin by identifying those group homes believed by DMH and DCFS to have issues with management of children with mental health issues. DMH will then proceed to schedule case consultation meetings with other group home providers, focusing next on the higher level group homes that have contracts with both DMH and DCFS since they would be anticipated to have the most residents who might benefit from group home staff receiving such technical assistance. These efforts are anticipated to be completed *by December 2012*.

DMH is planning to assess the feasibility of implementing children's mobile crisis teams that could be deployed to intervene in those instances where emotional and behavioral problems may be threatening the stability of a child's placement. These teams would include participation by the DCFS Children's Social Workers whenever possible and would help to de-fuse crises, provide support for caregivers and children, and assure that needed services and supports are in place to reduce the risk of ERCP involvement.

DMH will begin by placing one DMH clinician each in Service Areas 3 and 6, to be available for crisis response between the hours of 3:00 p.m. and 11:00 p.m., which seems to be the time period of greatest need. This effort will be used to determine needed structures, policies, and practices, and resources that would be needed to expand the effort countywide. The pilot will *begin in September* and will be evaluated at the end of the year.

CONCLUSION

The Department thanks the Los Angeles County Board of Supervisors for the heightened attention to the challenges facing the Emergency Response Command Post, as well as the Chief Executive Office, County Counsel, all affected County agencies, the Association of Community Human Services Agencies and SEIU Local 721 for their partnership on accomplishing much of the aforementioned progress. The third Inter-Agency Emergency Response Command Post Task Force meeting, during which continued progress will be presented and discussed on these initiatives and beyond, will take place on Tuesday, July 31, 2012. Following this meeting, the Department intends to issue a broader ERCP progress report to the Board *no later than mid to late August 2012*.

The Department of Children and Family Services continues to make efforts to improve services provided to children in need of out-of-home care. Increased awareness brought forth by the Board of Supervisors has supported the tighter and more urgent service integration of all affected County agencies in pursuit of viable and cutting-edge solutions. If you have any questions, please call me or your staff may call Aldo Marin, Manager, DCFS Board Relations Section, at (213) 351-5530.

PB:HB

c: Executive Officer, Board of Supervisors
Chief Executive Officer
County Counsel
Department of Mental Health
Department of Health Services
Department of Public Health
Probation Department

Enclosure

draft

ERCP SCREENING AND INTAKE PROCESS GUIDE FOR CHILDREN'S SOCIAL WORKERS

Refer to PG 0100-510.36 "Screening and Intake Process Prior to Transporting Children to ERCP"

Please ensure adherence to these procedures and steps as your consistent compliance assure an efficient and complete transition while promoting the safety of both the children and staff.

- ✓ The regional office CSW must contact the ERCP Duty SCSW at (213) 639-4500 before arriving at ERCP to obtain approval for the formal intake at ERCP.

- ✓ The ERCP Transport Packet must be filled out completely with all appropriate approval signatures and submitted to the ERCP intake staff or the ERCP Duty SCSW.

- ✓ All children need to be medically cleared if there are any signs of marks, bruises, burns, or special medical conditions that need immediate attention, i.e., the HUB/SCAN examination or Emergency Room. This must be done **before** arriving at ERCP with the child.

- ✓ If a child is on medication, the CSW must bring the medication, a listing of ALL the medications, and instructions on the medicine's dosages and schedules. Please submit the medications and information to the intake staff or Duty ERCP SCSW for secure storage during the ERCP intake process.

- ✓ Please bring documentation of the placement search(es) conducted by regional staff/TAs in order to decrease the amount of time a child remains at ERCP and to avoid duplicative search efforts. Provide the list to the ERCP intake staff or Duty SCSW during the ERCP intake process.

- ✓ Please do not bring more than three changes of clothing for the child. ERCP does not have available storage space to accommodate the child's belongings. The Regional CSW will need to make the necessary arrangements for the storage and delivery of all of the child's remaining property to his/her placement.

- ✓ The regional CSW shall inform the children of items they cannot have access to while awaiting placement at ERCP, such as cell phones, weapons, drugs, cigarettes, lighters, electronic games, etc. **While checking in with the ERCP guard, children are subject to a security screening process, including the scanning with hand-held metal detectors for any items that could pose a danger to children and staff.**

- ✓ Check-in will occur at the intake desk, which is located outside the children's room. Complete the sign-in log and turn in all necessary forms containing the required appropriate approval signatures.

- ✓ Regional staff must obtain a clearance from the ERCP Duty supervisor prior to leaving ERCP and provide their contact information should questions arise while the child is at ERCP.

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WILLIAM T FUJIOKA
Chief Executive Officer

August 3, 2012

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

BOARD MOTION RESPONSES: REPORT ON IN-HOME SUPPORTIVE SERVICES ANTI-FRAUD PLAN BECAUSE OF STATE TRIGGER CUTS AND QUARTERLY REPORT ON IN-HOME SUPPORTIVE SERVICES ANTI-FRAUD PLAN

This is in response to the June 26, 2012 Board Motion, introduced by Supervisor Antonovich, directing the Chief Executive Officer (CEO) and the Director of the Department of Public Social Services (DPSS) to report back in 30 days on the current In-Home Supportive Services (IHSS) anti-fraud staffing level with recommendations on ways the Department can leverage its resources to combat fraud and enhance its anti-fraud investigative methods to capture potential kick-backs by the providers.

In addition, this is the seventh and final quarterly report relative to In-Home Supportive Services (IHSS) anti-fraud strategies and related program integrity efforts, in response to the November 24, 2009 Board Motion introduced by Supervisor Ridley-Thomas.

Current IHSS Staffing Levels

- **Welfare Fraud Investigators**: A unit of five Welfare Fraud Investigators (WFI) and one Supervising WFI continues to partner with the California Department of Health Care Services in the investigation of IHSS fraud allegations.

- **IHSS Quality Assurance Staff**: The current IHSS Quality Assurance (QA) unit, composed of one Social Services Supervisor and six Social Workers continues to conduct IHSS case reviews consistent with the Department's IHSS Annual Plan. In addition to other IHSS targeted reviews, during the period of January 2012

through June 2012, IHSS QA staff conducted 825 desk reviews and completed 121 home visits in support of program integrity and fraud detection. Any identified inconsistencies in case information are referred to the case-carrying Social Worker to assess the need for a fraud referral and/or corrective action. As appropriate, the case-carrying Social Worker initiates the fraud referral. Since the last report to the Board, the Department did not receive any additional overpayment collections from IHSS providers for terminated cases resulting from the FY 2010-11 Hospital Stay Error Rate Study conducted by the IHSS QA Anti-Fraud Unit.

Leveraging Resources to Combat Fraud

- **IHSS Data Mining**: The Data Mining Solutions Amendment Number Two was approved by the Board on May 15, 2012, for expansion of the Data Mining technology to the IHSS Program. The kick-off meeting for this effort was held on June 6, 2012. DPSS, CEO, District Attorney and SAS (the data mining vendor) are working together to develop an anti-fraud data mining model for IHSS that will make the best use of the Department's reduced IHSS anti-fraud staffing. This effort includes evaluating the need for an IHSS Triage Team to handle high profile IHSS alerts, similar to what is being done in the child care data mining model. Implementation is targeted for April 2013.

- **Automated System to Track All IHSS Investigations**: IHSS fraud referrals are being tracked on the LEADER System. DPSS is in the process of expanding the tracking system to capture IHSS overpayments detail. Although we indicated in our last quarterly report that the target completion date was May 2012, due to other LEADER priorities, this change request has been delayed until December 2012.

- **LexisNexis**: In February 2012, DPSS began using LexisNexis "Accurint for Law Enforcement Plus" technology in its investigative methods. This system utilizes cutting edge investigative technology and provides a new way to access crucial information, visualize complex relationships and rapidly identify potential investigative leads. The use of this service provides welfare fraud investigative staff with instant access to IHSS consumers and providers, undeclared businesses, employment, properties, and allows for quick verification of identities and other information, such as names, addresses, social security numbers, and federal tax identification numbers. The technology is used for all investigative activity including IHSS.

Funding

- **Current IHSS Anti-Fraud Funding**: Although the IHSS Anti-Fraud State funding was eliminated as part of the trigger cuts for FY 2011-12, DPSS received approval from the California Department of Social Services in February 2012 to extend the IHSS Anti-Fraud Plan through FY 2011-12 and to administratively claim Medi-Cal Federal Financial Participation for allowable IHSS anti-fraud expenditures retroactive to July 1, 2011. As a result, funding was reduced from $10.4 million to $3.1 million. Effective July 1, 2012, the Department is absorbing the cost of data mining as an allocable cost and covering the costs of the welfare fraud staff still dedicated to the IHSS anti-fraud effort with regular IHSS administration funding.

- **District Attorney Activities**: Due to lack of funding, the DA's office discontinued their participation as specified in the IHSS Anti-Fraud Plan effective January 1, 2012. However, the DA continues to prosecute IHSS fraud cases filed with their office as a part of their Central Complaint Division.

Fraud Referrals/Outcomes: The attached chart depicts the total number of IHSS fraud referrals and their outcomes for 2010-11 and the first half of 2012.

Please let me know if you need additional information.

WTF:AJ:DS
JAB:ljp

Attachment

c: Executive Office, Board of Supervisors
County Counsel
District Attorney
Public Social Services

ATTACHMENT

FRAUD REFERRALS/OUTCOMES*	2010	2011	2012
Total number of fraud referrals	592	496	88*
Number of convictions	61	72	16
Amount of funds involved in the convictions	$1,114,814	$733,874	$74,670
Amount of funds recovered**	$ 120,126	$243,989	$49,397

*Reduced fraud referrals are due to elimination of FEVR staff in November 2011 due to elimination of State funding.

**Includes funds recovered for convictions from current and prior years. There is no estimate on cost avoidance due to case terminations.

FEVR/QA OUTCOMES*	2010	2011	2012
Cases reviewed	3,000	1,962	825*
Overpayments Identified*	$561,000	$496,195	N/A
Amount Repaid/Agreed to Repay**	$264,000	$ 2,142	N/A

*Reduced case reviews are due to six months of data and elimination of one IHSS QA unit due to elimination of State funding.

**Overpayments Identified and Amount Repaid/Agreed to Repay were reported by the FEVR units during 2010-11. We will no longer report FEVR outcomes for 2012, since the FEVR units were disbanded effective November 2011.