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County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

425 Shatto Place, Los Angeles, California 90020
(213) 351-5602

PHILIP L. BROWNING
Director

FESIA A. DAVENPORT
Chief Deputy Director

May 28, 2013

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

From: Philip L. Browning
Director

RESPONSE TO THE MARCH 12, 2013 BOARD MOTION REGARDING THE DELINQUENCY PREVENTION PILOT REPORT

On March 12, 2013 and on March 19, 2013, the Board directed the CEO in conjunction with key County departments, including the Department of Children and Family Services (DCFS), to implement the 241.1 Crossover Youth Project recommendations identified in its November 2, 2012 report, and for DCFS to report back in 60 days on the status of its Prevention Pilot, including any outcomes for youth and implementation–related issues. The amended directives of the Motions were as follows:

1. Direct the Chief Executive Officer, in conjunction with juvenile court leadership, and the departments of Public Health, Probation, Children and Family Services and Mental Health, to report back in 60 days on a written plan that ensures these departments engage in coordinated and integrated referrals and high quality service delivery with measurable outcomes for adolescent youth needing substance abuse services. This plan should leverage available Medi-Cal or other funding sources, standardize referral protocols and quality controls across departments, avoid unnecessary disruptions in care and identify any gaps. This report should also include an analysis on the extent to which non-incarcerated probation youth are receiving appropriate substance abuse services.

2. Authorize the Director of DPH, or his designee, to amend applicable existing substance abuse disorder services agreements by incorporating new Statements of Work to increase service capacity and expedite implementation, increasing the current contractual maximum obligations by a pro-rated amount for fiscal year 2012-13 and $1,143,000 annually thereafter, unless otherwise directed by the Board of Supervisors, for treatment slots dedicated to the 241.1 Crossover

Youth Project, subject to review and approval by County Counsel and notification to the Board of the particular contract amendments and amendment totals;

3. Instruct the 241.1 DMH PSWs to provide specific recommendations as to the type of mental health services a youth needs, and which agencies in the youth's service area could provide such services;

4. Authorize the Director of DPH, or his designee, to develop a process for referring crossover youth identified by the Multi-Disciplinary Team (MDT) as needing substance abuse services to a DPH contracted provider for substance abuse assessment and treatment, and a process for tracking the number of youth identified as needing substance abuse services and the number of youth who receive these services;

5. Instruct the CEO, DCFS and affected departments to report annually on the 241.1 evaluation measures identified in the CEO's November 2012 report;

6. Instruct County Counsel to review AB 1405 (2008) and submit revised proposed statutory language to the Legislature to prohibit the use of incriminating information obtained during a clinical interview against a youth in any court proceedings; and

7. Direct DCFS to report back to the Board in 60 days on the status of its Prevention Pilot, including any outcomes for youth and implementation–related issues.

This is to provide you with an update regarding the status of the DCFS Delinquency Prevention Pilot (DPP), including any outcomes for youth and implementation–related issues.

In April 2013, the Delinquency Prevention Pilot (DPP) report was prepared by Children's Research Center (CRC). Key findings highlighted in the report include the following:

> In 2010, key Los Angeles County Department of Children and Family Services (DCFS) staff members involved in Los Angeles County's crossover project, along with staff from the County's Probation Department, asked the National Council on Crime and Delinquency (NCCD) Children's Research Center (CRC) to determine whether it was possible to develop an actuarial screening assessment to classify children receiving ongoing child welfare services by their likelihood of subsequent delinquency. The impetus for the study was the County's desire to target delinquency prevention services to the highest-risk children in an effort to stem the flow of children from child welfare into the juvenile justice system.
>
> CRC completed the research study in September 2011 and provided DCFS with a screening assessment tool that could validly classify children receiving ongoing services into three distinct groups (low, moderate, and high risk) based

on their likelihood of becoming involved with the juvenile justice system. The assessment allows DCFS to screen children at the time of a new case opening in order to triage delinquency prevention resources and provide more targeted and intensive services to youth at the highest risk of delinquency. To evaluate the effectiveness of the delinquency screening assessment tool and associated delinquency prevention services, DCFS launched a pilot initiative in four offices (Compton, Glendora, Palmdale, and South County) in October 2012. Management in the pilot sites is alerted on a weekly basis through electronic email alerts of children identified at high risk of subsequent delinquency. Case work staff are then notified of the child's high risk status in order to cater specialized and intensive delinquency prevention services to youth who meet the criteria. Services can include Child and Family Team Meeting, linking youth to a mentor or significant adult, substance abuse treatment, mental health services and involvement in sports or extracurricular activities. The criteria focuses on deficits associated with mental health, substance abuse, delinquency (past issues that did not rise to the level of an arrest or probationary status), and educational needs.

The report is a profile of youth assigned to the delinquency prevention pilot (DPP) in four offices, including a profile of family and youth risk characteristics, youth strengths and needs, and the strengths and needs of the youths' families. It is the first report to examine the characteristics of DPP youth.

There were 93 youth who met eligibility criteria and participated in the DPP during the report period. About one quarter of the youth were assigned to each of the four pilot offices. Twenty-two (23.7%) youth were ages 10 to 12 at the start of delinquency prevention services, 28 (30.1%) were age 13 or 14, and 43 (46.2%) youth were age 15 or older. About 40% of youth were in out-of-home placement at the start of delinquency prevention services. Nearly all children had a prior history with child welfare. Most youth were experiencing problems with family relationships, educational deficits, and/or exhibited emotional or behavioral limitations. In addition, parenting skills in more than two-thirds of families were considered inadequate, and caregivers in about half of the families were struggling with mental health issues. Most youth's families were at high or very high risk of becoming involved with child protective services in the future.

CRC also reviewed baseline data collected in the DPP database and in CWS/CMS. At the time of service provision, few children had been linked to a mentor and about one-fourth had been linked to a significant adult. Data related to attendance/enrollment, suspensions, high school credits earned, and grade level were missing or not recorded in the DPP database or CWS/CMS for more than half of the youth in the pilot.

While conducting analyses for the profile report, CRC identified several key issues and recommendations.

- The number of youth in the DPP database did not match the number of eligible youth for whom an alert was created. The County should carefully monitor the number of youth assigned to the program to ensure that all eligible youth are enrolled. In addition, all youth for whom the County receives an alert should be placed in the DCFS database; if the youth is no longer eligible for participation, the Supervising Children's Social Worker or Children's Social Worker should document the reason.

- Baseline data was missing for many youth in the pilot. The County should establish reliable data-recording processes and procedures to ensure that data is systematically collected and recorded.

- Examination of delinquency screening criteria identified an issue with the formula used to generate alerts, which resulted in some youth receiving a high-risk classification when the youth should have been classified as moderate risk. CRC will provide a list of all DPP youth whose risk levels were affected by the prior history over count for further analysis. The DPP team should determine whether to continue delinquency prevention services and outcome tracking for the affected youth.

- Future efforts should focus on conducting a process and impact evaluation of the pilot to determine whether the DPP process was implemented with fidelity, including gathering outcome data and whether the pilot initiative improved outcomes for children and their families. The evaluation should also include a screening assessment validation to help ensure that it accurately classifies children served by DCFS by their likelihood of future delinquency.

DCFS will continue to meet monthly with staff from the pilot offices and work with CRC to refine the data collection process and implement the previously aforementioned key issues and recommendations. DCFS will report back in approximately six months on its implementation efforts.

If you have any questions, please call me or have your staff contact Aldo Marin, Board Relations Manager, at (213) 351-5530.

PLB:RRS:lsk

Attachment

Prepared for the Los Angeles County
Department of Children and Family Services

A Profile of Youth in the Los Angeles County Delinquency Prevention Pilot

April 2013

Prepared by
Andrea Bogie, MSW
Janice Ereth, PhD
Theresa Healy, MS

NCCD | Children's Research Center

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Children's Research Center is a nonprofit social research organization and a center of the National Council on Crime and Delinquency.

EXECUTIVE SUMMARY

Children who experience maltreatment are more likely than other children to be arrested and/or referred to juvenile court for delinquent offenses. They are also more likely to commit offenses as adults. Abused and/or neglected children are more likely to become delinquent at a younger age and more likely to commit a violent offense.

In 2010, key Los Angeles County Department of Children and Family Services (DCFS) staff members involved in Los Angeles County's crossover project, along with staff from the county's probation department, asked the NCCD Children's Research Center (CRC) to determine whether it was possible to develop an actuarial screening assessment to classify children receiving ongoing child welfare services by their likelihood of subsequent delinquency.[1] The impetus for the study was the county's desire to target delinquency prevention services to the highest-risk children in an effort to stem the flow of children from child welfare into the juvenile justice system.

CRC completed the research study in September 2011 and provided DCFS with a screening assessment that could validly classify children receiving ongoing services into three distinct groups (low, moderate, and high risk) based on their likelihood of becoming involved with the juvenile justice system in the future. The assessment allows DCFS to screen children at the time of a new case opening in order to triage delinquency prevention resources and provide more targeted and intensive services to youth at the highest risk of delinquency.

To evaluate the effectiveness of the delinquency screening assessment and associated delinquency prevention services, DCFS launched a pilot initiative in four offices (Compton, Glendora, Palmdale, and South County) in October 2012.[2] Managers in the pilot sites receive weekly email alerts that inform them which children served by their offices are at high risk of subsequent delinquency. Managers share the information with staff so that workers assigned to the case can provide specialized and intensive delinquency prevention services to youth who meet criteria and have mental health, substance abuse, delinquency (past issues that did not rise to the level of an arrest or probation), and/or educational needs.

This report is a profile of youth assigned to the delinquency prevention pilot (DPP) in four offices, including a profile of family and youth risk characteristics, youth strengths and needs, and the strengths and needs of youth's families. It is the first report to examine characteristics of DPP youth.

There were 93 youth who met eligibility criteria and participated in the DPP during the report period. About one quarter of the youth were assigned to each of the four pilot offices. Twenty-two (23.7%) youth were ages 10 to 12 at the start of delinquency prevention services, 28 (30.1%) were age 13 or 14, and 43 (46.2%) youth were age 15 or older. About 40% of youth were in out-of-home placement at the start of delinquency prevention services. Nearly all children had a history with child welfare. Most youth were experiencing problems with family relationships, had educational deficits, and/or exhibited emotional or behavioral limitations. In addition, parenting skills in more than two thirds of families were inadequate or destructive, and caregivers in about half of families were struggling with

[1] Maryam Fatemi, Deputy Director, and Dick SantaCruz, CSA III, Service Bureau 3, both of DCFS, provided the critical leadership for this study.

[2] Between completion of the research study and the launch of the pilot, Casey Family Programs funded the collaborative work between CRC and DCFS staff required to design the delinquency prevention pilot protocols, data gathering mechanisms, training materials, and evaluative framework.

mental health issues. Most youth's families were at high or very high risk of becoming involved with child protective services in the future.

CRC also reviewed baseline data collected in the DPP database and in CWS/CMS. At the time of service provision, few children had been linked to a mentor and about one-fourth had been linked to a significant adult. Data related to attendance/enrollment, suspensions, high school credits earned, and grade level were missing or not recorded in the DPP database or CWS/CMS for more than half of the youth in the pilot.

While conducting analyses for the profile report, CRC identified several key issues and recommendations.

- The number of youth in the DPP database did not match the number of eligible youth for whom an alert was created. The county should carefully monitor the number of youth assigned to the program to ensure that all eligible youth are enrolled. In addition, all youth for whom the county receives an alert should be placed in the DCFS database; if the youth is no longer eligible for participation, the supervising children's social worker or children's social worker should note the reason in the comments section.

- Baseline data were missing for many youth in the pilot. The county should establish reliable data-recording processes and procedures to ensure that data are systematically collected and entered into CWS/CMS and the Excel spreadsheet.

- Examination of delinquency screening criteria identified an issue with the formula used to generate alerts, which resulted in some youth receiving a high-risk classification when the youth should have been classified as moderate risk.[3] CRC will provide a list of all DPP youth whose risk levels were affected by the prior history over-count prior to the April correction. The DPP team should determine whether to continue delinquency prevention services and outcome tracking for the affected youth.

Future efforts should focus on conducting a process and impact evaluation of this pilot to determine whether the DPP process was implemented with fidelity, including gathering outcome data and whether the pilot initiative improved outcomes for children and their families. The evaluation should also include a screening assessment validation to help ensure that it accurately classifies children served by DCFS by their likelihood of future delinquency.

[3] The formula was corrected at the beginning of April 2013.

I. INTRODUCTION

Children who experience maltreatment are more likely than other children to be arrested and/or referred for delinquent offenses (English, 1998; Fagan, 2005; Jonson-Reid & Barth, 2000; Kaufman & Widom, 1999; Lemmon, 1999; Swanston, Parkinson, O'Toole, Plunkett, Shrimpton, & Oates, 2003; US Department of Justice, Office of Justice Programs, 2001). Children who have experienced maltreatment are also more likely to commit offenses as adults (English, Widom, & Brandford, 2002; Fagan, 2005; Mersky & Topitzes, 2010). A National Institute of Justice (NIJ) study showed that maltreated children were 11 times more likely than a matched control group to be arrested and 2.7 times more likely to be arrested as an adult (English, Widom, & Brandford, 2004). Abused and/or neglected children are more likely to become delinquent at a younger age (Lemmon, 1999; Ryan, Herz, Hernandez, & Marshall, 2007) and more likely to commit a violent offense (English, 1998; English et al., 2002; Kelley, Thornberry, & Smith, 1997; US Department of Justice, Office of Justice Programs, 2001; Widom, 1996). In addition, children who were chronically maltreated are more likely to be delinquent than children who experienced only one or two incidents of maltreatment (Ryan & Testa, 2005; Stewart, Livingston, & Denison, 2008).

Entering the juvenile justice system may be especially harmful for youth who experience maltreatment. Even after controlling for age at first offense, maltreated youth are more likely than other youth to be sentenced to a correctional facility or other suitable placement as opposed to probation (Ryan et al., 2007). Thus, once they become delinquent, maltreated youth tend to be more deeply entrenched in the juvenile justice system.

Previously maltreated youth who enter the juvenile justice system often have severe treatment needs and may pose an elevated risk to public safety. For public agencies, such problems are extremely costly. A child may be initially identified in a child abuse/neglect investigation and then migrate through an entire spectrum of public agencies including foster care, juvenile justice, income

maintenance, and adult corrections (Colman, Mitchell-Herzfeld, Han Kim, & Shady, 2010; Pecora, Kessler, O'Brien, White, & Williams, 2006). The large public and human costs of youth progressing through each of these service systems are compelling reasons to explore early interventions to break this cycle.

Although children who experience maltreatment are more likely than other children to become delinquent, not all maltreated children commit delinquent offenses. Examining which maltreated children become delinquent and the factors related to subsequent delinquency can help agencies target intervention efforts for children at greatest risk.

In response to these issues, a number of jurisdictions, including Los Angeles County, developed strategies to identify youth involved concurrently in child welfare and juvenile justice systems. These dual-jurisdiction cases are often called crossover youth. Once youth are identified, staff from both child welfare and juvenile justice collaborate to strengthen and focus case planning for the youth and their families. Efforts to better serve these youth include more systematic screening and assessment of youth needs and strengths; more effective case management, with multidisciplinary teams consulting on treatment plans; and effective supervision of case progress (Federal Advisory Committee on Juvenile Justice, 2010). This type of multi-system collaboration is likely to improve outcomes for children. For example, maltreated youth may have been exposed to violence or other trauma and thus may have mental health needs that sometimes go untreated by the juvenile justice system (Ford, Chapman, Hawke, & Albert, 2007). Preliminary findings suggest that interagency collaboration improves the likelihood that a child with a mental health problem will receive services (Chiodo, Leschied, Whitehead, & Hurley, 2008).

In 2010, key Los Angeles County Department of Children and Family Services (DCFS) staff members, involved in Los Angeles County's crossover project, along with staff from the Los Angeles County probation department, asked the NCCD Children's Research Center (CRC) to determine whether it was possible to develop an actuarial screening assessment to classify children receiving

ongoing child welfare services by their likelihood of subsequent delinquency. The impetus for the study was the county's desire to target delinquency prevention services to the highest-risk children in an effort to stem the flow of children from child welfare into the juvenile justice system. The study found that it is possible to classify youth in the child welfare system by their likelihood of future delinquency, and CRC developed an actuarial screening assessment for use in Los Angeles County (Bogie, Johnson, Ereth, & Scharenbroch, 2011).

Upon the receipt of the CRC report "Assessing Risk of Future Delinquency Among Children Receiving Child Protection Services," Los Angeles County convened a planning group to design a model delinquency prevention pilot (DPP). The focus of this project was to identify and intensively treat maltreated youth *before* they enter the juvenile justice system. The overall goal of the project was to reduce the number of children who might progress from the child welfare system to delinquent or adult offending. Additionally, the project was designed to remediate the specialized needs of the youth and contribute to the likelihood of more positive education, mental health, and substance use outcomes.

In 2012, Los Angeles County became the first jurisdiction in the country to implement an actuarial risk assessment to identify children in the child protective system who are at high risk of delinquency and target youth for specialized delinquency prevention services in an effort to reduce the rates at which youth subsequently become involved in the juvenile justice system (see Appendix A for a copy of the screening assessment).

The county began a pilot of the delinquency screening assessment on October 5, 2012 in four offices in the county.[4] Youth identified as high risk were then enrolled in the DPP and referred for comprehensive delinquency prevention services. This report describes a profile of youth who became

[4] The four pilot offices are Compton, Glendora, Palmdale, and South County.

eligible for and participated in the DPP during the last quarter of 2012.[5] It also describes baseline data that can be used to monitor implementation and for future program evaluation efforts.

II. BACKGROUND

In Los Angeles County, DCFS workers assess risk factors and service needs of families and children entering protective services and record their findings in a web-based system linked to administrative case information. DCFS workers use results from the risk and needs assessments to identify which families require child protective services and the type of services that can help reduce their likelihood of further involvement with CPS. Workers base various decisions on results of Structured Decision Making® (SDM) family strengths and needs, child strengths and needs, and the family assessment of future child abuse or neglect.

Results from the child protective services (CPS) administrative database and the SDM® assessments are then automatically combined into an actuarial delinquency prevention screening assessment that classifies youth as low, moderate, or high risk based on their likelihood of becoming delinquent. An online email notification is generated on a weekly basis to alert the child welfare manager that a youth is eligible for delinquency prevention services if a child is ages 10 to 18; at high risk of future delinquency; and has a substance abuse issue, educational deficits, delinquency behavior issues (that did not result in an arrest), and/or a mental health/behavioral issue.[6, 7]

Once alerted, the designated office staff, supervising children's social worker (SCSW), and children's social worker (CSW) review the case and, unless a child and family team (CFT) meeting has

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[6] Child's age at time of child maltreatment referral to CPS.

[7] When the screening assessment was implemented in October 2012, alerts were sent for all high-risk youth in the pilot offices who were ages 10 to 18 at the time of the CPS referral; due to the large number of children in this group, the alert system was changed in November 2012 to limit the alert to children who were classified as at high risk of subsequent delinquency and who had substance abuse, academic, delinquency, or mental health/behavioral needs (one or more of items R7 through R10 on the child strengths and needs assessment). The alert is generated from the SafeMeasures® reporting system.

already taken place, host a multi-disciplinary team meeting. CFT meetings include an array of participants based on the child's specific needs. The SCSW, CSW, youth, youth's family, and staff from other agencies that offer specialized substance abuse, mental health, educational, and/or delinquency prevention services are typical members of every team. Results from the CFT meeting are used to construct a case plan tailored to meet youth needs and develop solutions to the child's identified challenges.

A. Delinquency Prevention Screening Assessment

In 2011, CRC developed the SDM delinquency prevention screening assessment, an actuarial screening instrument that identifies youth served by DCFS who are at high risk of becoming delinquent. The assessment is based on a retrospective, longitudinal study of children who entered ongoing child welfare services following an investigation of child maltreatment. Risk factors for subsequent delinquency were observed for a standardized follow-up period, and results were used to construct an actuarial screening assessment that effectively classifies child maltreatment victims by the likelihood of future delinquency.

The screening assessment was based on a sample of 3,566 children ages 7 to 15 who 1) were subjects of a maltreatment investigation between April and December 2005 that led to an ongoing service case, and 2) had not "crossed over" into the probation department. Analysis was based on information available in the State of California Child Welfare System/Case Management System (CWS/CMS), a database of assessments completed for each child by child welfare staff, and Los Angeles County Probation Department offense history data.[8] Subsequent arrests and adjudications in Los Angeles County were observed for a standardized three-year follow-up period (2006–2008) for each sample child. CRC tested bivariate relationships between family and child

[8] Los Angeles probation department data were provided, with permission from Los Angeles County, by the University of Michigan.

characteristics and the outcomes and retained those with significant relationships for inclusion on the delinquency screening assessment.

The assessment consists of 10 items that bear a strong statistical relationship to delinquency. Most of these items are extracted from the risk and needs assessments routinely completed by child welfare staff as part of ongoing protective services.

B. Delinquency Prevention Services

Delinquency prevention services for youth are provided simultaneously with DCFS's child protective services. Youth are eligible to participate in delinquency prevention services as long as their family is receiving child welfare services from DCFS.

As part of the DPP, DCFS tracks additional data of particular importance to involved youth. These include the occurrence of a team meeting, engagement with a significant adult or other mentor, educational performance status (i.e., credits, attendance, suspensions, and graduation status), participation in extracurricular activities, participation in substance abuse and/or mental health treatment, mental health hospitalizations, new arrests, referrals to CPS, reunifications, and placement changes (if related to substance abuse) that occur while the youth participates in the pilot. Data recorded at the start of delinquency prevention services (i.e., baseline data) reflect the status of youth as they entered the DPP.[9] In addition, DCFS will track progress every six months while the youth is participating in the pilot.[10] Youth educational outcomes and their subsequent child welfare and

[9] Baseline data include participation in a team meeting; significant relationships with adults; mentor relationships; school enrollment, attendance, and suspensions; involvement in extracurricular activities; and high school credits.

[10] Six-month data include updates to the baseline measures as well as; graduation status; new arrests/citations; whether the youth is substance free; placement changes due to substance abuse; mental health treatment or hospitalization; and new CPS referrals, reunifications, or removals from a parental home. Six-month outcome data were not available for this report.

juvenile justice involvement can be used in future research to evaluate the DPP's effectiveness. Data are recorded in an Excel spreadsheet designed specifically for this effort.[11]

There were 93 youth who met eligibility criteria and participated in the DPP during the report period.[12] Cases were nearly evenly split between the four pilot offices (Table 1).

Table 1

Delinquency Prevention Pilot
Number of Youth by Office

Office	N	%
Compton	23	24.7%
Glendora	25	26.9%
Palmdale	23	24.7%
South County	22	23.7%
TOTAL	**93**	**100.0%**

[11] This report reflects the first database completed by workers for the DPP. The baseline data recorded should reflect youth status at the start of prevention services. However, discussion with the DPP team revealed that workers may have included information/events from the start of prevention services through the end of the data collection period. The time period for baseline data has been clarified and should be correct for subsequent reporting periods.

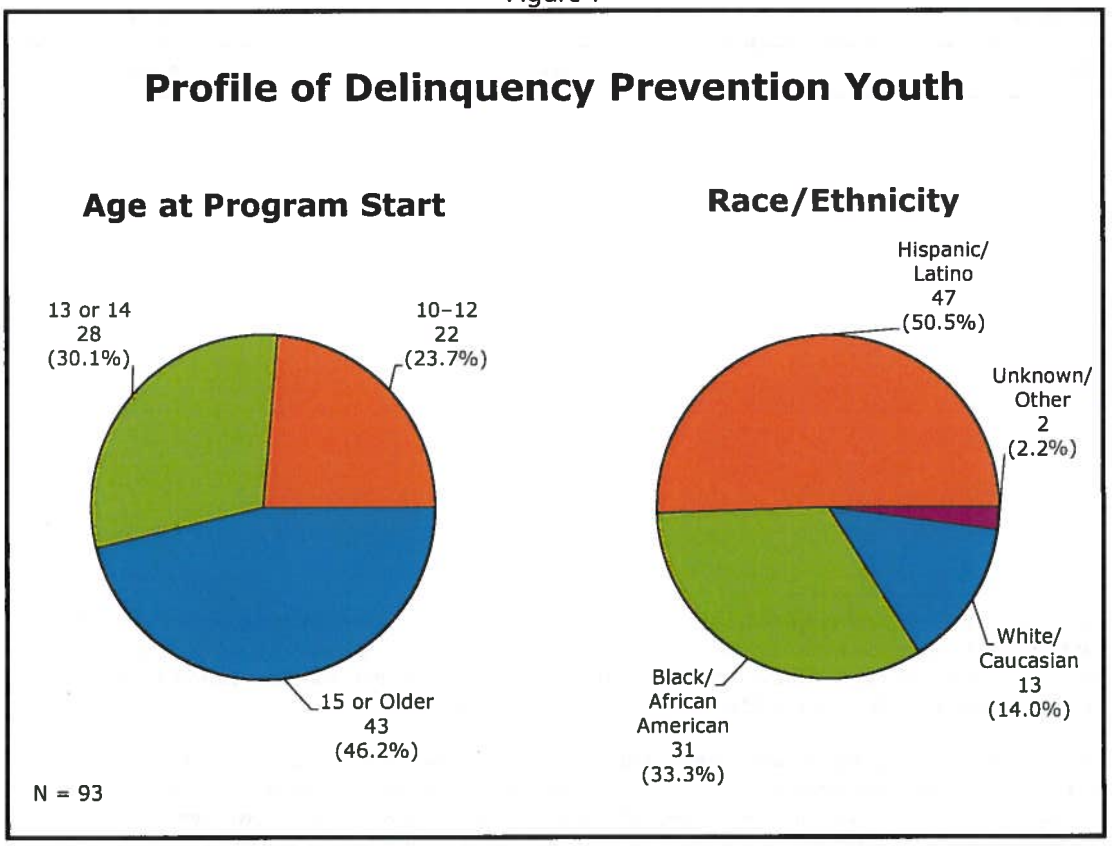
[12] In the four pilot offices, 372 children were screened for delinquency prevention services between October 5 and December 28, 2012. Alerts were created for 122 (32.8%) of those youth (i.e., youth at high risk of subsequent delinquency who met the criteria for delinquency prevention services). Of the 122 youth for whom an alert was sent, 102 were included in the delinquency prevention outcome database provided by Los Angeles County. Note that at the beginning of the pilot, issues arose related to youth who should not be included in the pilot; at that time, there was no way for workers to record why those youth were excluded (e.g., had a prior probation record or was no longer assigned to a pilot office). The database has been revised to address these issues when they arise in the future. Of the 102 youth who were identified via alert and were included in the Los Angeles database, six had ongoing cases that closed prior to the end of December 2012 and three were placed on probation prior to the current case opening. These nine youth were no longer eligible for delinquency prevention services and are therefore not included in this profile.

III. PROFILES

A. Youth Demographics

At the start of the delinquency services, 22 (23.7%) youth in the pilot were ages 10 to 12, 28 (30.1%) were ages 13 or 14, and 43 (46.2%) youth were age 15 or older. More than half (50.5%) of the youth were Hispanic/Latino, 31 (33.3%) were Black/African American, 13 (14.0%) were White/Caucasian, and two (2.2%) were other or unknown race/ethnicity.[13] There were 56 (60.2%) male youth and 37 (39.8%) female. About 40% of youth were in out-of-home placement at the start of DP services (Figures 1–3).

Figure 1



[13]Based on the race code recorded in CWS/CMS.

Figure 2

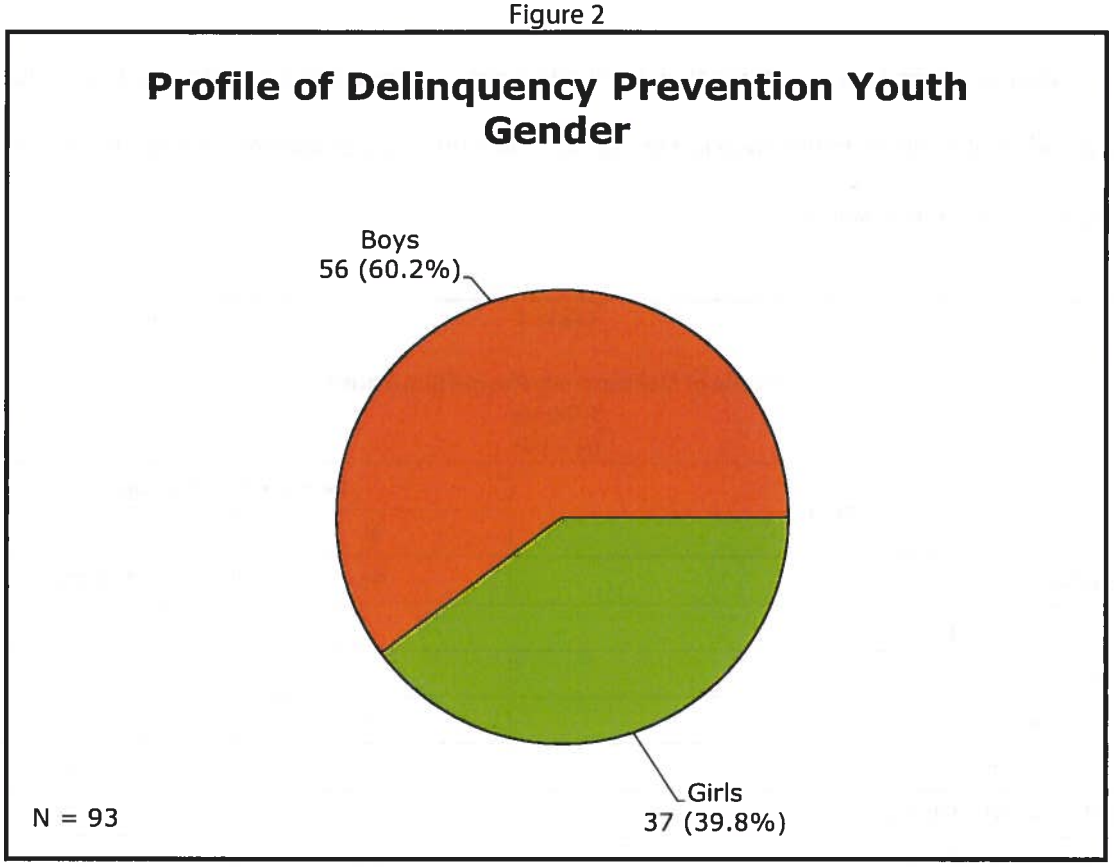
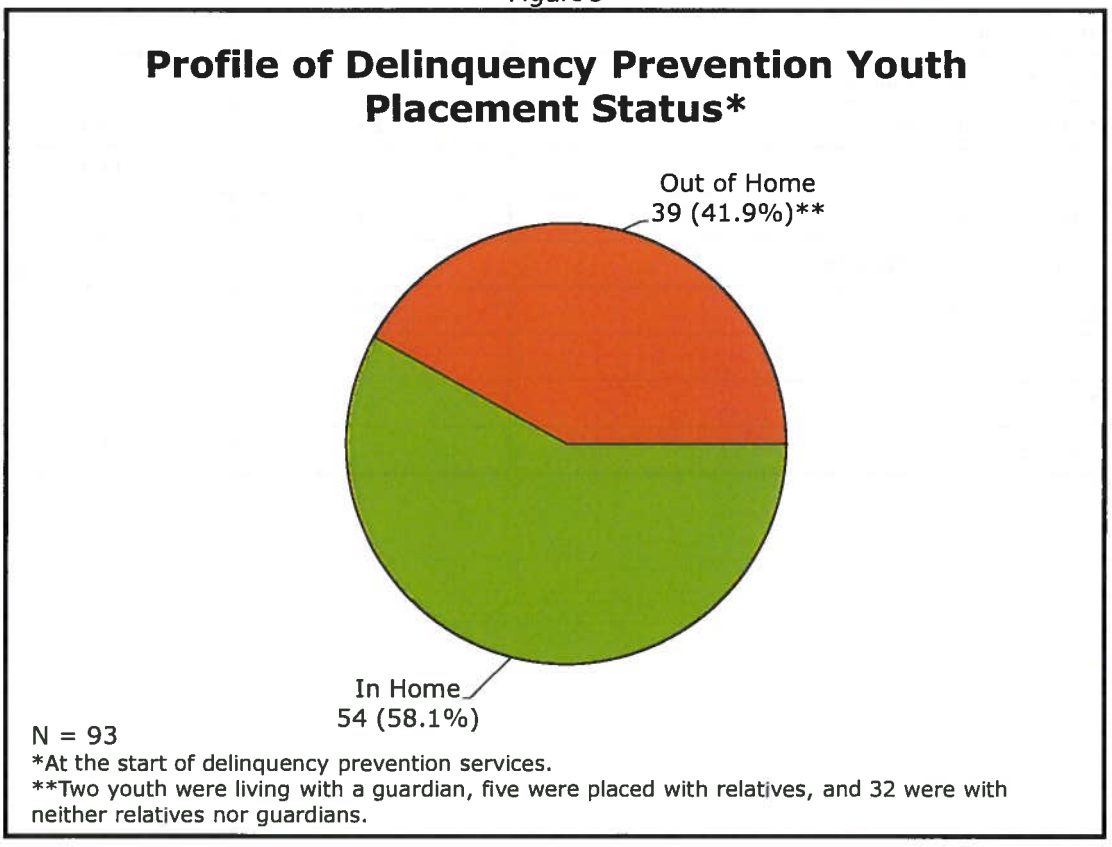


Figure 3



Most youth had siblings. More than half had an older sibling(s), and about three-fourths had a younger sibling(s). Most siblings were not living in out-of-home care at the time the youth started delinquency prevention services (Table 1).

Table 1

Profile of Delinquency Prevention Youth
Siblings
(N = 93)

Item	Sample Distribution	
	N	%
Total Sample	**93**	**100.0%**
Number of Siblings		
None	8	8.6%
One or two	28	30.1%
Three or more	57	61.3%
Number of Older Siblings		
None or no siblings	39	41.9%
One or two	29	31.2%
Three or more	25	26.9%
Number of Younger Siblings		
None or no siblings	25	26.9%
One or two	44	47.3%
Three or more	24	25.8%
Number of Siblings in Placement		
None or no siblings	65	69.9%
One	11	11.8%
Two	6	6.5%
Three or more	11	11.8%

Nearly all children had a history with child welfare. About 95% were subjects of at least one prior investigation of child abuse or neglect, and more than half received child protective services prior to the investigation that led to the newly opened case and subsequent delinquency prevention services. About one-quarter of youth (or their siblings) had experienced physical injury due to abuse; fewer than 10% were in a group home; about one quarter had substance abuse issues; about a third of youth had a history of delinquent behaviors; just over 60% had education issues; and nearly two thirds of children (or their siblings) exhibited serious mental health issues (Table 2).

Table 2

SDM® Delinquency Prevention Screening Assessment Item Results
(N = 93)

Item	Sample Distribution	
	N	%
Total Sample	**93**	**100.0%**
R1. Prior Investigations for Abuse or Neglect		
None	5	5.4%
One or two	29	31.2%
Three or more	59	63.4%
R2. Prior CPS Service Cases		
None	42	45.2%
One	25	26.9%
Two or more	26	28.0%
R3. Prior Physical Injury to a Child Resulting From Child Abuse/Neglect or Prior Substantiated Physical Abuse to a Child (any child in the home)		
No	70	75.3%
Yes	23	24.7%
R4. Child Was Placed in a Group Home as a Result of Current Investigation		
No	84	90.3%
Yes	9	9.7%
R5. Child Age at Time of CPS Referral		
10	3	3.2%
11 or 12	19	20.4%
13 or older	71	76.3%

Table 2

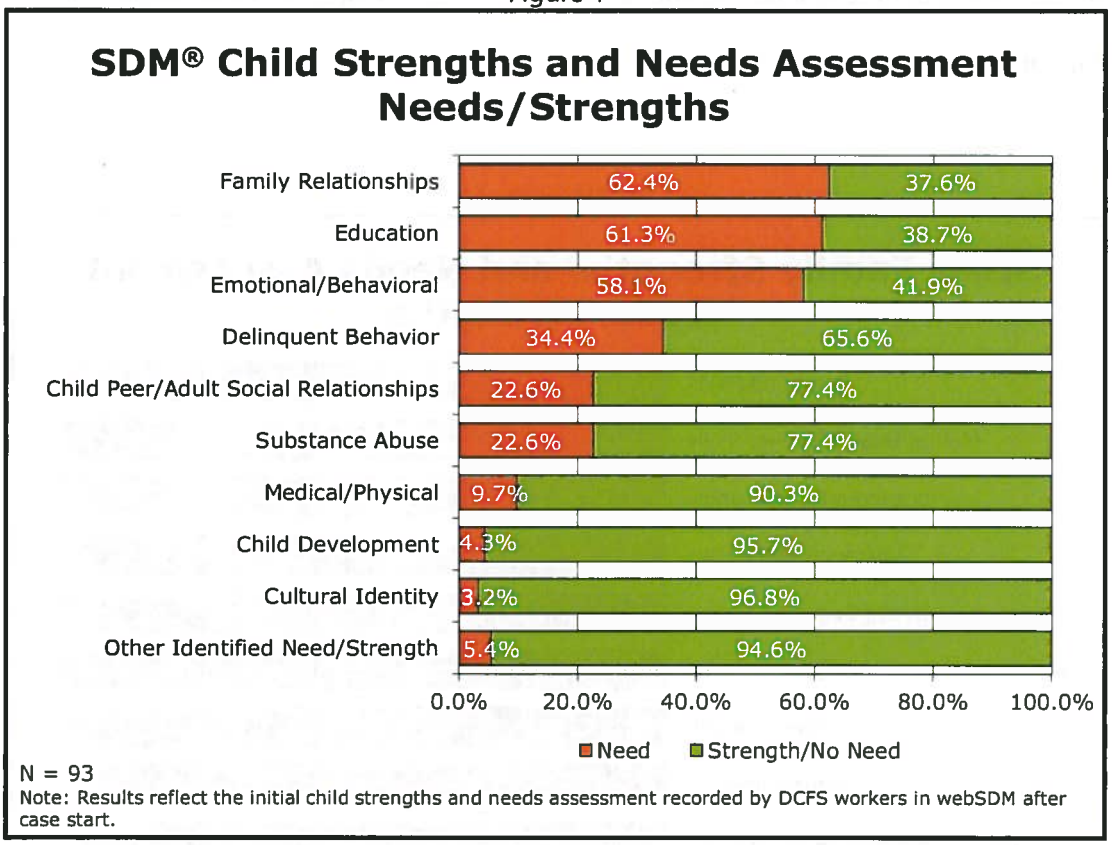
SDM® Delinquency Prevention Screening Assessment Item Results
(N = 93)

Item	Sample Distribution	
	N	%
Total Sample	**93**	**100.0%**
R6. Child Gender		
Female	37	39.8%
Male	56	60.2%
R7. Child Substance Use/Abuse		
No	72	77.4%
Yes	21	22.6%
R8. Child Academic Difficulty		
No	36	38.7%
Yes	57	61.3%
R9. Child Past/Current Delinquency		
No	61	65.6%
Yes	32	34.4%
R10. Child Mental Health/Behavioral Issue (any child in the home)[14]		
No	31	33.3%
Yes	62	66.7%

[14] Item R10 reflects the SDM family risk assessment item score and represents mental health/behavioral issues of *any* child in the household; therefore, the number of children with this item marked does not match the number of children with identified mental health/behavioral issues on the child strengths and needs assessment.

Most youth were experiencing problems with family relationships, had educational deficits, and/or exhibited emotional or behavioral limitations. Nearly all youth had strong connections to cultural identity, were on target developmentally, and/or had no medical and/or physical health issues (Figure 4). See Appendix B for additional child strengths and needs details. [15]

Figure 4



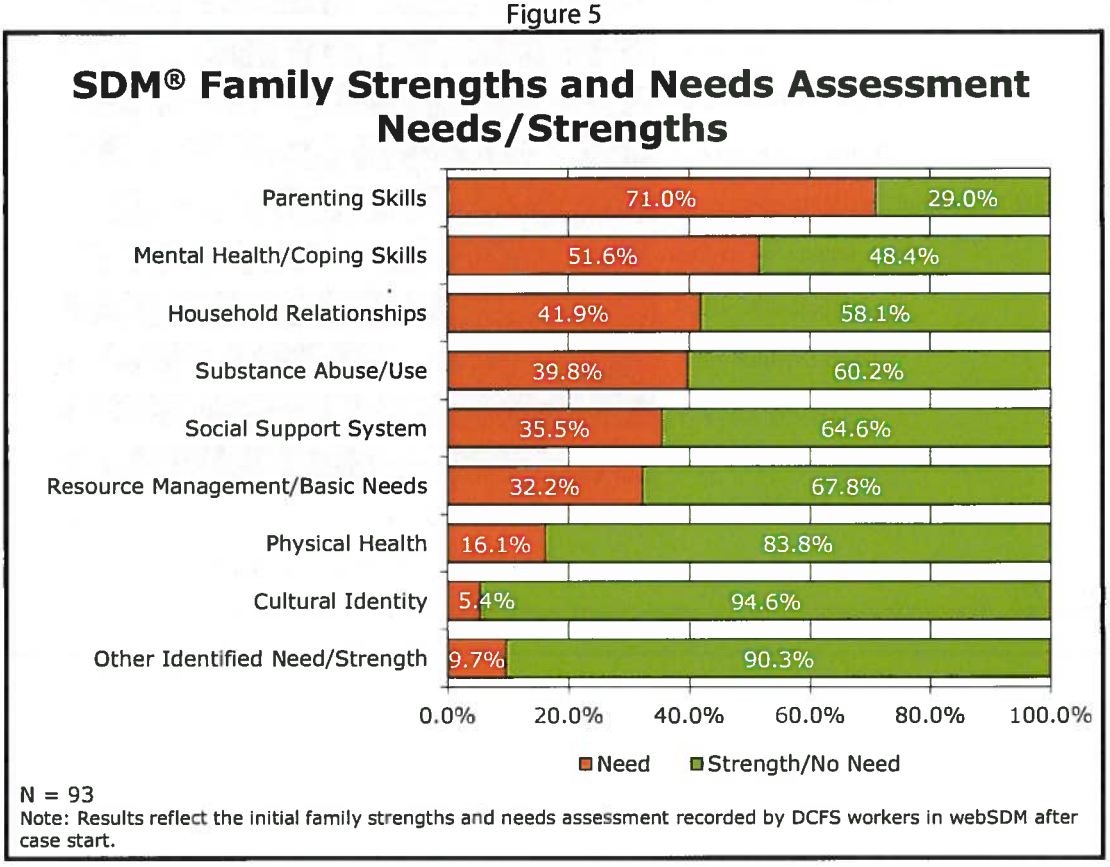
N = 93

Note: Results reflect the initial child strengths and needs assessment recorded by DCFS workers in webSDM after case start.

[15] DCFS staff assess every child's strengths and needs in all open child protective service cases. Child needs are addressed in the family case plan.

The issues that were evident in children's families are illustrated below.[16] Parenting skills in more than two thirds of families were inadequate or destructive, and caregivers in about half of families were struggling with mental health issues. Caregivers for about 40% of participants had household relationship problems, alcohol or drug issues, and/or limited social support. Caregivers in one third of families had insufficient resources and/or resource management issues. Physical health was an issue in less than 20% of participants' families (Figure 5). See Appendix B for additional family strengths and needs assessment item details.

Figure 5

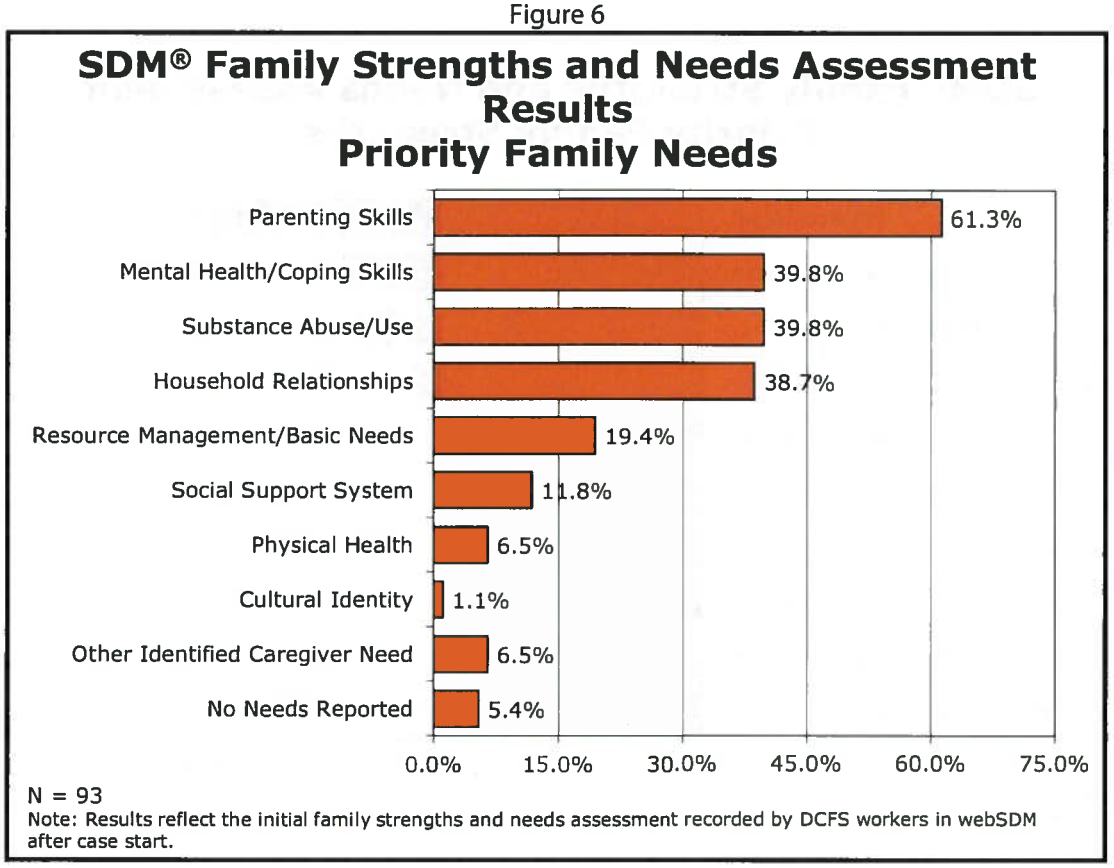


N = 93
Note: Results reflect the initial family strengths and needs assessment recorded by DCFS workers in webSDM after case start.

[16] DCFS staff assess family strengths and needs in all open child protective service cases. Family needs are addressed in the CPS family case plan.

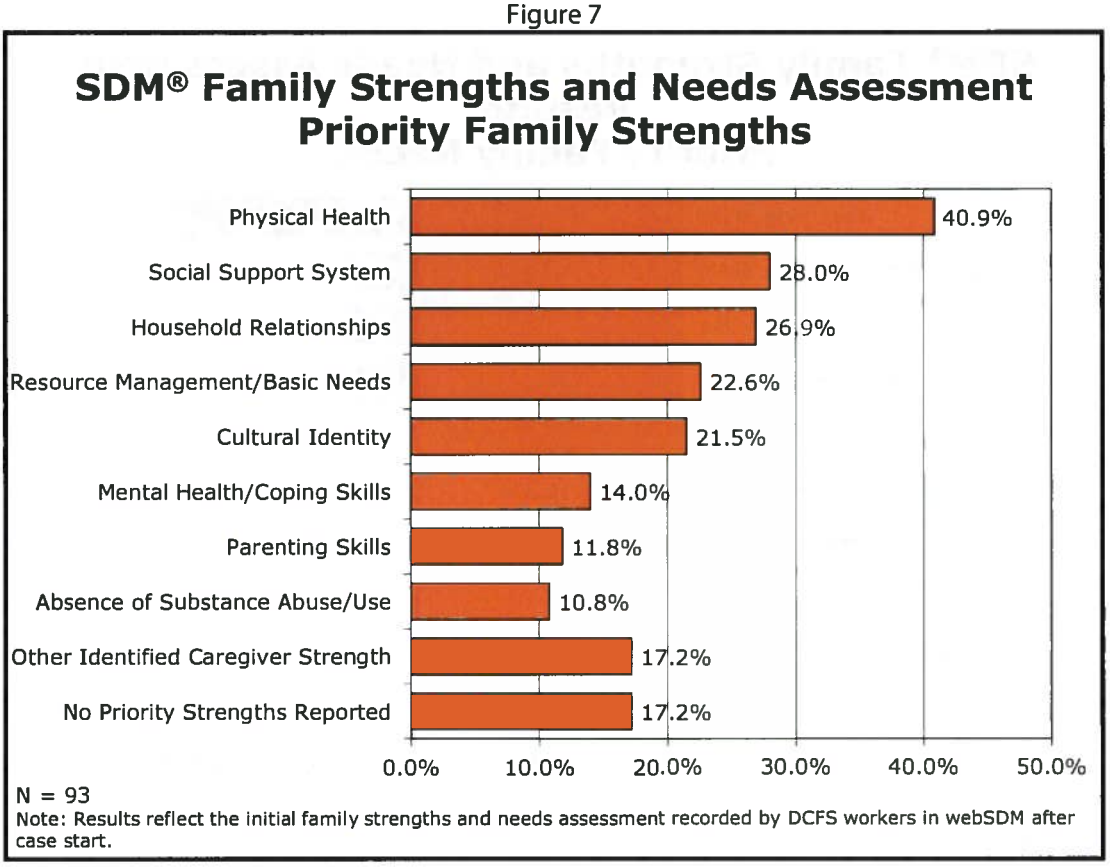
Parents were most often working toward improving parenting skills, developing better mental health/coping skills, and/or dealing with substance abuse issues.

Figure 6



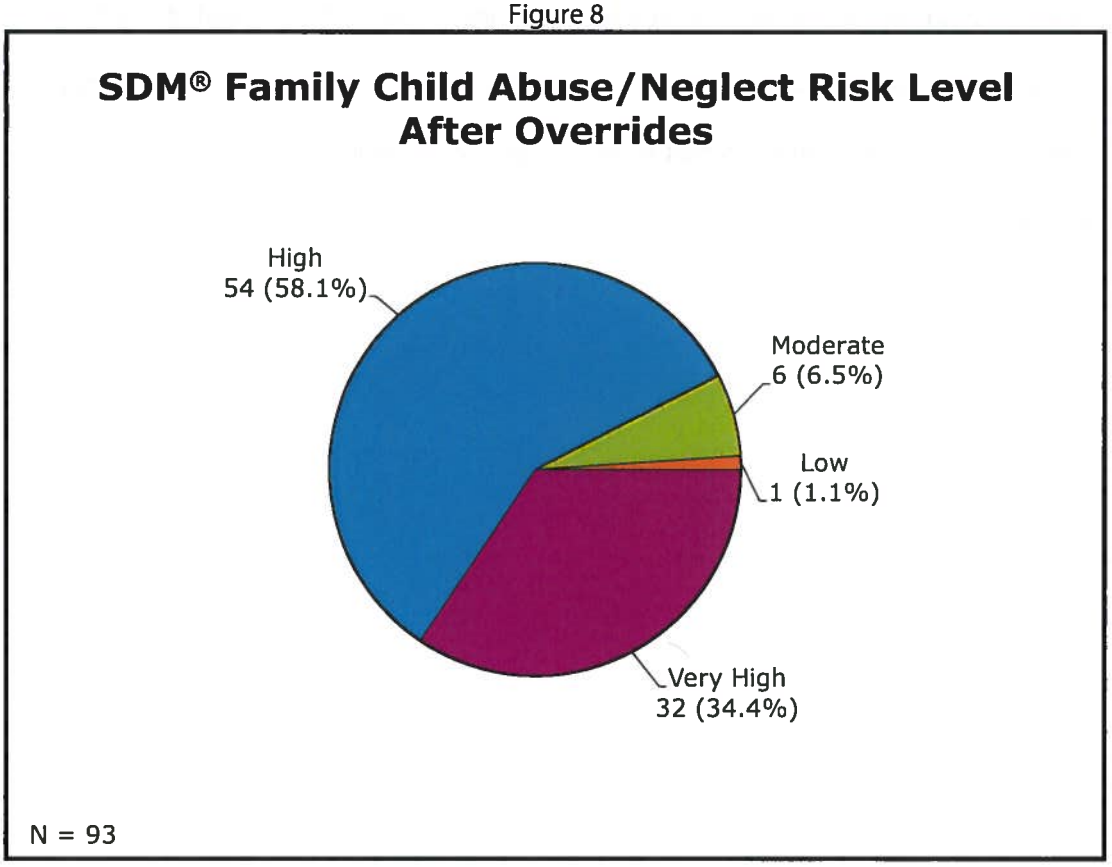
Parental strengths most often relied upon to achieve child welfare case plan goals were physical health, social support, and household relationships (Figure 7).

Figure 7



Most youth's families were at high or very high risk of becoming involved with child protective services in the future, which supports findings from the delinquency prevention screening assessment study that indicate children from high-risk families are more likely to become involved in the juvenile justice system (Bogie, Johnson, Ereth, & Scharenbroch, 2011).[17] Family risk assessment item details are provided in Appendix C.

Figure 8



[17] DCFS assesses every family investigated for child maltreatment for risk of subsequent abuse or neglect. The family risk level is used by DCFS workers to determine which families are most likely to be reported for another incident of child abuse or neglect and which families may benefit most from ongoing services. Some of the items on the delinquency prevention screening assessment also appear on the family risk assessment; however, the family risk level differs from the child's risk of subsequent delinquency, which is measured by the delinquency prevention screening assessment.

B. Baseline Information

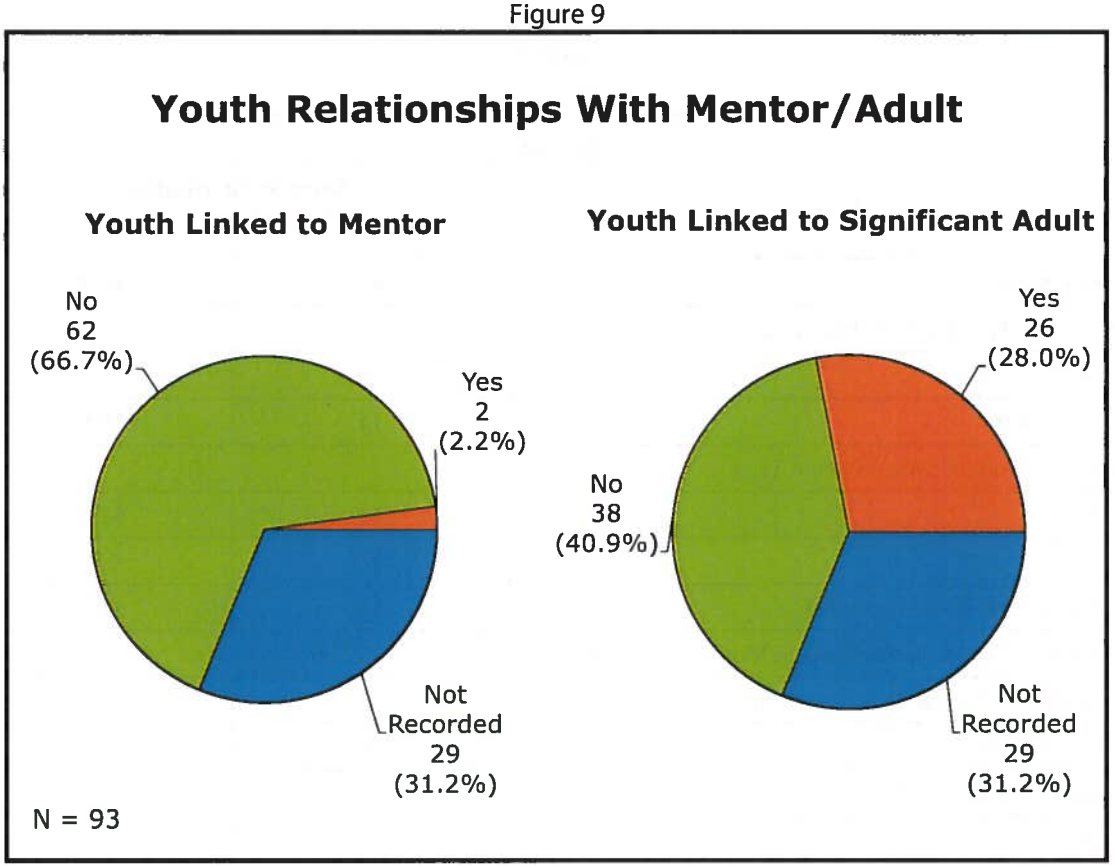
1. Mentor/Adult Relationships

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) has reviewed numerous research studies and found that mentoring can effectively prevent at-risk youth from becoming involved in delinquency; strong mentoring relationships have been shown to improve youth self-esteem, behavior, and academic performance.[18] Therefore, DCFS works to identify and engage each youth with a mentor who is a positive adult/peer role model within his/her extended family or from another community partner agency. DCFS anticipates that mentors will serve as friends, supports, and advocates for these youth as they attempt to address problems within their families and their communities.

[18] For more, visit www.ojjdp.gov/programs/mentoring.html.

At the time of service provision, few children had been linked to a mentor and about one fourth had been linked to a significant adult. Information was missing or not recorded for almost one third of youth (Figure 9).

Figure 9



2. Education

Education and extracurricular activity participation information are collected at pilot start and at specified intervals during program participation. DCFS workers contact the youth's school to get attendance, enrollment, credit accrual, and whether the youth has been suspended from school for disciplinary reasons. These data elements are entered into the delinquency prevention database. Youth grade level is recorded by DCFS staff in CWS/CMS.

Data related to attendance/enrollment, suspensions, high school credits earned, and grade level were missing or not recorded in the DPP database or CWS/CMS for more than half of the youth in the pilot. For example, grade level was recorded for only 12 (14.8%) youth. Participation in extracurricular activities was missing for about one third of youth (Table 3).

Table 3

Education and Extracurricular Activities Baseline Data Record Status (N = 93)

Item	Sample Distribution	
	N	%
Total Sample	**93**	**100.0%**
Attendance/Enrollment In Most Recent Term		
Not recorded	79	84.9%
Recorded	14	15.1%
Youth Suspended in Most Recent Term		
No	40	43.0%
Yes	6	6.5%
Not recorded/Unknown/NA	47	50.5%
High School Credits Earned During Most Recent Term		
Recorded (ranged from 0 to 100)	7	7.5%
Missing/NA	86	92.5%
Education Record in CWS/CMS		
No	12	12.9%
Yes	81	87.1%
Grade Level Recorded in CWS/CMS (n = 81)		
No	69	85.2%
Yes	12	14.8%
Youth Participated in Sports or Extracurricular Activities During Most Recent Term		
No	50	53.8%
Yes	11	11.8%
Missing/NA	32	34.4%

IV. SUMMARY AND RECOMMENDATIONS

Los Angeles DCFS launched the DPP in the fall of 2012 to focus more attention on youth at high risk of entering the juvenile justice system. Specifically, the project was designed to identify delinquency risk factors for youth in newly opened CPS cases early on so that their needs could be addressed with intensive and collaborative solution-focused planning and implementation. The overall goal of this pilot was to reduce the number of youth within the CPS system who become delinquents. DCFS anticipates that this innovative approach will also produce positive outcomes for high-risk youth and their families.

In an effort to track and monitor the effectiveness of early, focused, intensive interventions with high-risk youth, DCFS created a standalone database to gather information on interim outcomes that could be expected to improve as a result of DCFS's engagement with these youth and their families.

This is the first report to describe youth participating in the DPP initiative, and it raises some issues related to program implementation and data collection. Some of the issues have been resolved, and practices adopted by pilot office staff as a result will help the program achieve its short- and long-term goals. However, other areas continue to be challenges for the pilot.

Based on examination of the delinquency prevention criteria and alerts, CWS/CMS, the pilot's Excel data, and issues raised during DPP team phone calls, CRC recommends that the county develop plans to address these issues and ensure that the issues and solutions are shared with all staff involved in the pilot. Following are the issues and recommended solutions.

- Issue: The DPP process was not consistently implemented for all children who met high-risk criteria. For example, all children who meet criteria should be offered services. As described in the report, 102 of 122 youth who met eligibility criteria entered the pilot (i.e., were entered into the DCFS DPP database), but DPP records were not available for the other 20. It is possible that those youth transferred out of a pilot office prior to DPP start, or that they were omitted from the pilot for another reason.

Recommendation: Carefully monitor the number of youth assigned to the program to ensure that all eligible youth are enrolled.[19] Additionally, all youth for whom the county receives an alert should be placed in the DCFS database; if the youth is no longer eligible for participation, the SCSW or CSW should note the reason in the comments section.

- Issue: Data entered into the Excel spreadsheet were not consistent. In many instances, data were not recorded. The absence of some critical data, such as school information and CFT meeting status, will make it difficult to ascertain whether program procedures (e.g., a CFT meeting) are being followed or if the intensive, collaborative interventions (e.g., education, substance abuse, and/or mental health treatment) are resulting in improvement in outcomes for youth, either on a short- or long-term basis. Workers have reported that it is difficult to obtain some of the information in a timely manner and on a regular basis (e.g., education outcomes).

  Recommendation: Establish reliable data-recording processes and procedures to ensure that data are systematically collected and entered into CWS/CMS and the Excel spreadsheet.

- Issue: Examination of delinquency screening criteria indicated that the formula used to generate alerts did not accurately score each youth's prior CPS history—specifically, item R1, prior investigations. This resulted in over-counting prior history and, in some cases, resulted in a high-risk classification when the youth should have been classified as moderate risk.[20] The formula was corrected at the beginning of April 2013.

  Recommendation: CRC will provide a list of all DPP youth whose risk levels were affected by the prior history over-count prior to the April correction. The DPP team should determine whether to continue delinquency prevention services and outcome tracking for the affected youth.

Future efforts should focus on conducting a process and impact evaluation of this pilot to determine whether the DPP process was implemented with fidelity, including the gathering of pertinent outcome data and whether the pilot initiative improved outcomes for children and their families. The evaluation should also include a screening assessment validation to help ensure that it accurately classifies children served by DCFS by their likelihood of future delinquency. Los Angeles County and CRC have already applied to external funding sources for support of a DPP evaluation,

[19] The original intent of the DPP was to accept high-risk youth ages 10 to 18; however, during the first few weeks of implementation, the number of children eligible for pilot participation was higher than expected. Therefore, the county narrowed its focus to serve children who had educational, past delinquency, or substance abuse issues.

[20] Of the 93 youth included in this profile report, 12 would have been classified as moderate risk if the prior history variable (R1) had been counted properly. The analysis includes only youth who entered the pilot between October 7 and December 28, 2012; there may be other youth who entered the pilot after that date who should have had a moderate-risk classification.

with a short-term focus on improved outcomes for high-risk youth in four areas: education, mental health, substance use, and non-deviant behaviors. CRC and DCFS hope to examine the long-term outcomes, including changes in delinquency rates for CPS-involved children, a few years after implementation.

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Appendix A

SDM® Delinquency Screening Assessment

LOS ANGELES COUNTY
SDM® DELINQUENCY SCREENING ASSESSMENT

c: 07/11

Child Name: _____ **Client ID:** _____

Referral ID: _____ **Referral Date:** _____/_____/_____

R1. Prior investigation(s) for abuse or neglect
- a. None 0
- b. One or two 1
- c. Three or more ..... 2 _____

R2. Prior CPS services
- a. None 0
- b. One 1
- c. Two or more ..... 2 _____

R3. Prior injury to any child in the home resulting from child abuse/neglect
- a. No 0
- b. Yes ..... 1 _____

If yes:
☐ Child being assessed ☐ Another child in the home

R4. Child was placed in a group home as a result of investigation that led to current case
- a. No 0
- b. Yes ..... 1 _____

R5. Child age at time of CPS referral that led to current case
- a. 7 to 10 ..... -1
- b. 11 or 12 0
- c. 13 or older ..... 1 _____

R6. Child gender
- a. Female 0
- b. Male ..... 1 _____

R7. Child substance use/abuse
- a. No 0
- b. Yes ..... 1 _____

R8. Child academic difficulty
- a. No 0
- b. Yes ..... 1 _____

R9. Child past or current delinquency
- a. No 0
- b. Yes ..... 1 _____

R10. Child mental health/behavioral issue (any child in the home)
- a. No 0
- b. Yes ..... 1 _____

If yes:
☐ Child being assessed ☐ Another child in the home

Total: _____

Scored Risk Level
-1 to 1 ☐ Low
2 to 4 ☐ Moderate
5+ ☐ High

Preliminary research only. Not to be used without consultation and authorization of NCCD Children's Research Center.

Appendix B

Child Strengths and Needs Assessment Item Responses
Family Strengths and Needs Assessment Item Responses

Table B1 SDM® Child Strengths and Needs Assessment Item Scores* (N = 93)		
Item	**N**	**%**
Emotional/Behavioral		
Strong emotional adjustment	3	3.2%
Adequate emotional adjustment	36	38.7%
Limited emotional adjustment	43	46.2%
Severely limited emotional adjustment	11	11.8%
Physical Health/Disability		
Good health	13	14.0%
Adequate health	71	76.3%
Minor health/disability needs	7	7.5%
Serious health/disability needs	2	2.2%
Education		
Outstanding academic achievement	2	2.2%
Satisfactory academic achievement	34	36.6%
Academic difficulty	46	49.5%
Severe academic difficulty	11	11.8%
Family Relationships		
Nurturing/supportive relationships	6	6.5%
Adequate relationships	29	31.2%
Strained relationships	48	51.6%
Harmful relationships	10	10.8%
Child Development		
Advanced development	0	0.0%
Age-appropriate development	89	95.7%
Limited development	3	3.2%
Severely limited development	1	1.1%
Substance Abuse		
Chooses drug-free lifestyle	5	5.4%
No use/experimentation	67	72.0%
Alcohol or other drug use	21	22.6%
Chronic alcohol or other drug use	0	0.0%

Table B1 SDM® Child Strengths and Needs Assessment Item Scores* (N = 93)		
Item	**N**	**%**
Cultural Identity		
Cultural component supportive and no conflict present	9	9.7%
No cultural component that supports or causes conflict	81	87.1%
Cultural component that causes some conflict	3	3.2%
Cultural component that causes significant conflict	0	0.0%
Peer/Adult Social Relationships		
Strong social relationships	1	1.1%
Adequate social relationships	71	76.3%
Limited social relationships	18	19.4%
Poor social relationships	3	3.2%
Delinquent Behavior		
Preventive activities	1	1.1%
No delinquent behavior	60	64.5%
Occasional delinquent behavior	26	28.0%
Significant delinquent behavior	6	6.5%
Identified Child Strength/Need Not Covered in Other Items		
Significant strength	1	1.1%
Not applicable	87	93.5%
Minor need	4	4.3%
Significant need	1	1.1%

*Based on child strengths and needs assessment completed by DCFS worker at start of CPS case service.

Table B2 SDM® Family Strengths and Needs Assessment Item Scores* (N = 93)		
Item	**N**	**%**
Substance Abuse/Use		
Teaches and demonstrates a healthy understanding of alcohol and drugs	6	6.5%
Alcohol or prescribed drug use	50	53.8%
Alcohol or drug abuse	23	24.7%
Alcohol or drug dependency	14	15.1%
Household Relationships		
Supportive	9	9.7%
Minor/occasional discord	45	48.4%
Frequent discord	28	30.1%
Chronic discord	11	11.8%
Social Support System		
Strong support system	10	10.8%
Adequate support system	50	53.8%
Limited support system	31	33.3%
No support system	2	2.2%
Parenting Skills		
Strong skills	0	0.0%
Adequately parents and protects children	27	29.0%
Inadequately parents and protects children	50	53.8%
Destructive/abusive parenting	16	17.2%
Mental Health/Coping Skills		
Strong coping skills	0	0.0%
Adequate coping skills	45	48.4%
Mild to moderate symptoms	39	41.9%
Chronic/severe symptoms	9	9.7%
Resource Management/Basic Needs		
Resources sufficient to meet basic needs and are adequately managed	8	8.6%
Resources are limited but are adequately managed	55	59.1%
Resources are insufficient or not well managed	23	24.7%
No resources, or resources severely limited and/or mismanaged	7	7.5%

Table B2 SDM® Family Strengths and Needs Assessment Item Scores* (N = 93)		
Item	**N**	**%**
Cultural Identity		
Cultural component supportive and no conflict present	10	10.8%
No cultural component that supports or causes conflict	78	83.9%
Cultural component that causes some conflict	5	5.4%
Cultural component that causes significant conflict	0	0.0%
Physical Health		
Preventive health care is practiced	11	11.8%
Health issues do not affect family functioning	67	72.0%
Health concerns/handicaps affect family functioning	11	11.8%
Serious health concerns/handicaps result in inability to provide care for child	4	4.3%
Identified Caregiver Strength/Need Not Covered in Other Items		
Significant strength	3	3.2%
Not applicable	81	87.1%
Minor need	6	6.5%
Significant need	3	3.2%

*Based on family strengths and needs assessment completed by DCFS worker at start of CPS case service.

Appendix C

Family Risk of Future Child Maltreatment Item Responses

Table C1 SDM® Family Risk Assessment Item Scores* (N = 93)		
Neglect Scale Item	**N**	**%**
N1. Current Complaint Is for Neglect		
No	32	34.4%
Yes	61	65.6%
N2. Prior Investigations		
None	8	8.6%
One or more, abuse only	8	8.6%
One or two for neglect	34	36.6%
Three or more for neglect	43	46.2%
N3. Household Has Previously Received CPS		
No	50	53.8%
Yes	43	46.2%
N4. Number of Children Involved in CA/N Incident		
One, two, or three	60	64.5%
Four or more	33	35.5%
N5. Age of Youngest Child in the Home		
2 or older	87	93.5%
Under 2	6	6.5%
N6. Characteristics of Children in Household		
Not applicable	25	26.9%
One or more present	68	73.1%
Developmental, learning, or physical disability	11	11.8
Developmental	6	6.5%
Learning	9	9.7%
Physical	0	0.0%
Medically fragile or failure to thrive	3	3.2%
Mental health or behavioral problem	62	66.7%
N7. Primary Caregiver Provides Physical Care Inconsistent With Child Needs		
No	72	77.4%
Yes	21	22.6%
N8. Primary Caregiver Has a History of Abuse or Neglect as a Child		
No	68	73.1%
Yes	25	26.9%

Table C1 SDM® Family Risk Assessment Item Scores* (N = 93)		
Neglect Scale Item	**N**	**%**
N9. Primary Caregiver Has/Had a Mental Health Problem		
No	73	78.5%
Yes	20	21.5%
N10. Primary Caregiver Has/Had an Alcohol and/or Drug Problem		
None/not applicable	61	65.6%
One or more apply	32	34.4%
Alcohol, last 12 months	11	11.8%
Alcohol, prior to the last 12 months	4	4.3%
Drugs, last 12 months	13	14.0%
Drugs, prior to the last 12 months	15	16.1%
N11. Primary Caregiver Has Criminal Arrest History		
No	46	49.5
Yes	47	50.5
N12. Current Housing		
Not applicable	85	91.4%
One or more apply	8	8.6%
Physically unsafe	2	2.2%
Family homeless	6	6.5%

*Based on risk assessment completed by DCFS worker during child abuse/neglect investigation.

Table C2 SDM® Family Risk Assessment Item Scores* (N = 93)		
Abuse Scale Item	**N**	**%**
A1. Current Report Is for Physical Abuse		
No	51	54.8%
Yes	42	45.2%
A2. Number of Prior Abuse Investigations		
None	8	8.6%
One or more, neglect only	15	16.1%
One for abuse	22	23.7%
Two or more for abuse	48	51.6%
A3. Household Has Previously Received CPS		
No	50	53.8%
Yes	43	46.2%
A4. Prior Physical Injury to a Child Resulting From CA/N or Prior Substantiated Physical Abuse to a Child		
None/not applicable	70	75.3%
One or more apply	23	24.7%
Prior physical injury to a child resulting from CA/N	7	7.5%
Prior substantiated physical abuse of a child	18	19.4%
A5. Number of Children Involved in the Child Abuse/Neglect Incident		
One, two, or three	60	64.5%
Four or more	33	35.5%
A6. Characteristics of Children in Household		
Not applicable	27	29.0%
One or more present	66	71.0%
Delinquency history	13	14.0%
Developmental disability	6	6.5%
Learning disability	7	7.5%
Mental health or behavioral problem	57	61.3%
A7. Two or More Incidents of Domestic Violence in the Household in the Past Year		
No	79	84.9%
Yes	14	15.1%

Table C2 SDM® Family Risk Assessment Item Scores* (N = 93)		
Abuse Scale Item	**N**	**%**
A8. Primary Caregiver Employs Excessive/Inappropriate Discipline		
No	70	75.3%
Yes	23	24.7%
A9. Primary Caregiver Is Domineering		
No	82	88.2%
Yes	11	11.8%
A10. Primary Caregiver Has a History of Abuse or Neglect as a Child		
No	71	76.3%
Yes	22	23.7%
A11. Primary Caregiver Has/Had a Mental Health Problem		
No	74	79.6%
One or more apply	19	20.4%
During the last 12 months	14	15.1%
Prior to the last 12 months	10	10.8%

*Based on risk assessment completed by DCFS worker during child abuse/neglect investigation.

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WILLIAM T FUJIOKA
Chief Executive Officer

August 8, 2013

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

From: William T Fujioka
Chief Executive Officer

ENHANCING SERVICES TO STRENGTHEN THE 241.1 PROJECT FOR CROSSOVER YOUTH

On March 12, 2013, a motion by Supervisor Ridley-Thomas directed the Chief Executive Officer (CEO), in conjunction with the Departments of Children and Family Services (DCFS), Probation, Public Health (DPH), and Mental Health (DMH), to implement the 241.1 Crossover Youth Project recommendations identified in the CEO's November 2, 2012 report as follows:

1. Authorize the Director of DPH, or his designee, to amend applicable existing substance use disorder services agreements by incorporating new Statements of Work to increase service capacity and expedite implementation, increasing the current contractual maximum obligations by a prorated amount for Fiscal Year (FY) 2012-13 and $1,143,000 annually thereafter, unless otherwise directed by the Board, for treatment slots dedicated to the 241.1 Crossover Youth Project, subject to review and approval by County Counsel and notification to the Board of the particular contract amendments and amendment totals;

2. Instruct the 241.1 DMH psychiatric social workers to provide specific recommendations as to the type of mental health services a youth needs, and which agencies in the youth's service area could provide such services;

3. Authorize the Director of DPH, or his designee, to develop a process for referring crossover youth identified by the Multi-Disciplinary Team as needing substance abuse services to a DPH contracted provider for substance abuse assessment and treatment, and a process for tracking the number of youth identified as needing substance abuse services, the number of referrals made and the number of youth who receive these services;

4. Instruct the CEO, DCFS and affected departments to report annually on the 241.1 evaluation measures identified in the CEO's November 2012 report;

5. Instruct County Counsel to work with the CEO to review AB 1405 (2008) and submit revised proposed statutory language to the Legislature to prohibit the use of incriminating information obtained during a clinical interview against a youth in any court proceedings; and

6. Direct DCFS to report back to the Board in 60 days on the status of its Prevention Pilot, including any outcomes and implementation-related issues.

On March 19, 2013, an additional motion by Supervisor Ridley-Thomas directed the CEO, in conjunction with juvenile court leadership, and the Directors of DPH, Probation, DCFS, and DMH, to report back in 60 days on a written plan that ensures these Departments engage in coordinated and integrated referrals and high-quality service delivery with measurable outcomes for adolescent youth needing substance abuse services. This plan should leverage available Medi-Cal or other funding sources, standardize referral protocols and quality controls across departments, avoid unnecessary disruptions in care and identify any gaps. This report should also include an analysis on the extent to which non-incarcerated probation youth are receiving appropriate substance abuse services.

The CEO created a project plan which outlines the scope and deliverables of these two motions, and established a workgroup to address them. The workgroup, chaired by the CEO, includes representatives from DMH, DPH, DCFS, Department of Health Services, Probation, Public Defender, Juvenile Court, and County Counsel and is focusing on improving the service integration and coordination for 241.1 crossover youth, automating a tracking system for making referrals and reporting outcomes, and determining the most appropriate resources needed. This workgroup began meeting in April and has been meeting bi-monthly since that time.

While we are close to completing this report, it has been determined that additional time is needed to finalize some of the new processes and confirm the needed resources. Therefore, we request a 30-day extension to complete this report.

If you have any questions or need additional information, please contact me, or your staff may contact Antonia Jiménez at (213) 974-7365, or via e-mail at ajimenez@ceo.lacounty.gov.

WTF:AJ
CDM:eb

c: Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Health Services
Juvenile Court
Mental Health
Probation
Public Defender
Public Health

Crossover Youth Board Memo_August Extension Request_2013.doc

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WILLIAM T FUJIOKA
Chief Executive Officer

September 4, 2013

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

From: William T Fujioka
Chief Executive Officer

ENHANCING SERVICES TO STRENGTHEN THE 241.1 PROJECT FOR CROSSOVER YOUTH

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2. Instruct the 241.1 DMH psychiatric social workers to provide specific recommendations as to the type of mental health services a youth needs, and which agencies in the youth's service area could provide such services;

3. Authorize the Director of DPH, or his designee, to develop a process for referring crossover youth identified by the Multi-Disciplinary Team as needing substance abuse services to a DPH contracted provider for substance abuse assessment and treatment, and a process for tracking the number of youth identified as needing substance abuse services, the number of referrals made and the number of youth who receive these services;

4. Instruct the CEO, DCFS and affected departments to report annually on the 241.1 evaluation measures identified in the CEO's November 2012 report;

5. Instruct County Counsel to work with the CEO to review AB 1405 (2008) and submit revised proposed statutory language to the Legislature to prohibit the use of incriminating information obtained during a clinical interview against a youth in any court proceedings; and

6. Direct DCFS to report back to the Board in 60 days on the status of its Prevention Pilot, including any outcomes and implementation-related issues.

On March 19, 2013, an additional motion by Supervisor Ridley-Thomas directed the CEO, in conjunction with juvenile court leadership, and the Directors of DPH, Probation, DCFS, and DMH, to report back in 60 days on a written plan that ensures these Departments engage in coordinated and integrated referrals and high-quality service delivery with measurable outcomes for adolescent youth needing substance abuse services. This plan should leverage available Medi-Cal or other funding sources, standardize referral protocols and quality controls across departments, avoid unnecessary disruptions in care and identify any gaps. This report should also include an analysis on the extent to which non-incarcerated probation youth are receiving appropriate substance abuse services.

The CEO created a project plan which outlines the scope and deliverables of these two motions, and established a workgroup to address them. The workgroup, chaired by the CEO, includes representatives from DMH, DPH, DCFS, Department of Health Services, Probation, Public Defender, Juvenile Court, and County Counsel and is focusing on improving the service integration and coordination for 241.1 crossover youth, automating a tracking system for making referrals and reporting outcomes, and determining the most appropriate resources needed. This workgroup began meeting in April and has been meeting bi-monthly since that time.

On August 8, 2013, a 30-day extension was requested to complete the report and finalize some of the new processes. Additional time is needed to complete the process review and ensure confirmation of the needed resources. Therefore, we request an additional 30-day extension to complete this report.

If you have any questions or need additional information, please contact me, or your staff may contact Antonia Jiménez at (213) 974-7365, or via e-mail at ajimenez@ceo.lacounty.gov.

WTF:AJ
CDM:VH:km

c: Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Health Services
Juvenile Court
Mental Health
Probation
Public Defender
Public Health

County of Los Angeles
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WILLIAM T FUJIOKA
Chief Executive Officer

October 4, 2013

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

From: William T Fujioka
Chief Executive Officer

ENHANCING SERVICES TO STRENGTHEN THE 241.1 PROJECT FOR CROSSOVER YOUTH

On March 12, 2013, a motion by Supervisor Ridley-Thomas directed the Chief Executive Officer (CEO), in conjunction with the Directors of the Departments of Mental Health (DMH), Public Health (DPH) and Children and Family Services (DCFS), to implement the 241.1 Crossover Youth Project recommendations identified in the November 2, 2012 report, as follows:

1. Instruct the 241.1 DMH Psychiatric Social Worker to provide specific recommendations as to the type of mental health services a youth needs, and which agencies in the youth's service area could provide such services;

2. Authorize the Director of DPH to develop a process for referring crossover youth identified by the Multi-Disciplinary Team as needing substance abuse assessment and treatment, and a process for tracking the number of youth identified as needing substance abuse services, the number of referrals made and the number of youth who receive these services;

3. Instruct the CEO, DCFS and affected departments to report annually on the 241.1 evaluation measures identified in the CEO's November 2012 report;

4. Instruct County Counsel to work with the CEO to review AB 1405 (2008) and submit revised proposed statutory language to the Legislature to prohibit the use of incriminating information obtained during a clinical interview against a youth in any court proceedings; and

5. Direct DCFS to report back to the Board of Supervisors (Board) in 60 days on the status of its Delinquency Prevention Pilot, including any outcomes and implementation-related issues.

On March 19, 2013, an additional motion by Supervisor Mark Ridley-Thomas:

6. Directed the CEO, in conjunction with juvenile court leadership, and the Directors of DPH, DCFS and DMH, to report back in 60 days on a written plan that ensured these departments engaged in coordinated and integrated referrals and high-quality service delivery with measurable outcomes for adolescent youth needing substance abuse services. Additionally, the plan should leverage available Medi-Cal or other funding sources, standardized referral protocols and quality controls across departments, and include an analysis on the extent to which non-incarcerated probation youth are receiving appropriate substance abuse services.

Attached is a report detailing actions taken to document and operationalize a substance abuse referral process between DCFS, Probation and DPH for 241.1 crossover youth; document the substance abuse referral process for non-incarcerated probation youth; and identify funding streams available for youth, in general, seeking substance abuse treatment. The report responds to the six Board directives above: mental health referrals and services (pages 4-5); integrated substance abuse referrals (pages 5-7); 241.1 outcome evaluations (page 8); legislative action (page 9); Delinquency Prevention Pilot (page 9); substance abuse funding analysis (pages 9-11); and substance abuse services for non-incarcerated probation youth (pages 11-12). Staffing concerns were also raised by Probation and DMH related to their ability to track, enter and maintain outcome data for 241.1 youth. The resolution of this concern may require Board action.

Additionally, DCFS provided the Board with a report on the Delinquency Prevention Pilot on May 28, 2013.

If you have any questions or need additional information, please contact me, or your staff may contact Antonia Jiménez at (213) 974-7365, or via e-mail at ajimenez@ceo.lacounty.gov.

WTF:AJ:CDM
VRH:ljp

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Juvenile Court
Mental Health
Probation
Public Defender
Public Health

Crossover Youth Board Motion

Phase II

Los Angeles County Board of Supervisors

Supervisor Mark Ridley-Thomas, Chairman

Supervisor Gloria Molina

Supervisor Zev Yaroslavsky

Supervisor Don Knabe

Supervisor Michael D. Antonovich

October 2013

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Introduction

Background Information

A 2011 report by the Conrad N. Hilton Foundation found that transition-aged youth who had been involved in both the dependency and delinquency systems fared significantly worse as young adults than youth who had only been involved in one of these systems. They were 50 percent less likely to be employed, twice as likely to be on public assistance, and three times more likely to have spent time in jail than their counterparts.

Los Angeles County adopted its first comprehensive Welfare and Institutions Code (WIC) Section 241.1 protocol in 1997 that was designed to better serve youth who cross between the dependency and delinquency systems. The protocol required the departments of Children and Family Services (DCFS) and Probation to prepare joint assessments for each child involved in the dependency and delinquency systems, and to recommend to the delinquency court which system could best serve the interest of the child and the community.

In November 2012, a report was issued to the Board of Supervisors (Board) on how to strengthen two projects aimed at preventing foster youth from crossing over into delinquency, and ensuring they get the services and supervision needed. These projects are the 241.1 Project and the Delinquency Prevention Pilot. Based on recommendations included in that report, on March 12th and 19th, 2013, the Board outlined six additional directives to expand mental health and substance abuse services provided as part of the 241.1 project and strengthen the program evaluation.

On March 12, 2013, a motion by Supervisor Ridley-Thomas directed the Chief Executive Officer (CEO), in conjunction with the Directors of the departments of Mental Health (DMH), Public Health (DPH) and DCFS, to implement the 241.1 Crossover Youth Project recommendations identified in the November 2012 report, and:

1. Instructed the 241.1 DMH Psychiatric Social Workers (PSWs) to provide specific recommendations as to the type of mental health services a youth needs, and which agencies in the youth's service area could provide such services;
2. Authorized the Director of DPH to develop a process for referring crossover youth identified by the multi-disciplinary team as needing substance abuse assessment and treatment, and a process for tracking the number of youth identified as needing substance abuse services, the number of referrals made, and the number of youth who receive these services;
3. Instructed the CEO, DCFS and affected departments to report annually on the 241.1 evaluation measures identified in the CEO's November 2012 report;
4. Instructed County Counsel to work with the CEO to review AB 1405 (2008) and submit revised proposed statutory language to the Legislature to prohibit the use of incriminating information obtained during a clinical interview against a youth in any court proceedings; and
5. Directed DCFS to report back to the Board of Supervisors in 60 days on the status of its Delinquency Prevention Pilot, including any outcomes and implementation-related issues.

On March 19, 2013, an additional motion by Supervisor Mark Ridley-Thomas:

6. Directed the CEO, in conjunction with juvenile court leadership, and the directors of DPH, DCFS and DMH, to report back in 60 days on a written plan that ensured the departments engaged in coordinated and integrated referrals and high-quality service delivery with measurable outcomes for adolescent youth needing substance abuse services, that leveraged available Medi-Cal or other funding sources, standardized referral protocols and quality controls across departments. The report was also to include an analysis on the extent to which non-incarcerated probation youth were receiving appropriate substance abuse services.

To address these six Board directives, the 241.1 Workgroup (Workgroup) which included representatives from the departments of the CEO, DMH, DPH, DCFS, Probation, Public Defender (PD), Public Social Services (DPSS), County Counsel and the Juvenile Court that developed the original project recommendations was reconvened.

241.1 Project Newly Implemented Actions

Board Directive 1: Coordination of 241.1 Mental Health Services

The Board requested that the Workgroup determine how best to ensure that mental health referrals made during the 241.1 process were explicit in identifying the types of services needed and where specifically those services could be received.

The 241.1 process includes a Multi-Disciplinary Team (MDT) meeting that brings together the youth, their families and experts from various County departments to provide assessment findings and recommendations that address the unique needs of the youth. The goal of this process is to reduce the length of time a youth spends in the delinquency system and prevent them from re-entering it. As part of this process, DMH staff thoroughly review the youth's records and make treatment recommendations based on that case review.

However, DCFS caseworkers who are tasked with implementing the MDT recommendations have found it difficult to effectively link youth to appropriate mental health services because these recommendations, for those staff who are not mental health experts, often seem vague and do not provide much direction for what types of mental health services are needed. Additionally, caseworkers are often not as familiar with the array of mental health resources available within their respective communities.

To address this issue and ensure that youth are appropriately connected to the mental health services they need, DMH agreed to improve its coordination with DCFS by implementing the following actions:

- DMH staff who are out-stationed in DCFS regional offices will now assist DCFS caseworkers in clarifying the MDT recommendations so that they can identify the specific treatment services needed and agencies within the youth's neighborhood that can provide those services.

- DMH staff will also now ensure that mental health services have been identified for all youth in need of them, or that caseworkers have completed a referral for these services if they have not yet been identified.

DMH and DCFS will continue to monitor program capacity issues in delivering mental health services, and will inform the Board if there are any significant concerns identified.

Board Directive 2: Coordination and Integration of Substance Abuse Treatment Services

The Board also instructed the Workgroup to develop procedures to ensure that 241.1 youth with identified substance abuse issues were referred to treatment, and that the numbers of youth referred to and receiving these services were tracked.

Data from the latest 241.1 project evaluation indicated that 53 percent of 241.1 youth either have a substance abuse only or co-occurring mental health and substance abuse issue. This illustrates how critical it is to ensure that substance abuse screening and treatment services are part of the MDT meeting process. However, the 241.1 practice did not include DPH or its substance abuse providers in these team meetings, nor did it include substance abuse screening for all 241.1 youth. Furthermore, when substance abuse issues were identified, probation officers and DCFS caseworkers would routinely make referrals to providers based on word-of-mouth or those that were easily identifiable instead of utilizing qualified DPH providers. On the other hand, some probation officers would only make referrals to providers with whom they had previously good experiences with which sometimes created capacity issues (i.e. waiting lists) for those specific providers. These practices increased the likelihood of substance abuse issues going undetected, and that when identified, the quality of services received were inconsistent and unclear.

It was also discovered that while DPH's data tracking system, the Los Angeles County Participant Reporting System (LACPRS), collects information on participants receiving substance abuse treatment services from its subcontractors, this system did not contain the information needed to specifically identify probation and DCFS youth who are receiving them.

To address these issues, the following actions have now been implemented:

- **DPH Designated Providers Participate in Post-Disposition MDT Meetings**
    - When the court has ordered drug testing or substance abuse treatment, a DPH designated substance abuse provider closest to the youth's current residence (from the DPH vetted provider list discussed below) is now invited to attend the post-disposition MDT meeting so that they may conduct an in-person screening, initiate the engagement process and make a referral to treatment, if needed. If the provider is unable to attend the meeting, the youth's probation officer or DCFS caseworker will schedule an appointment for the youth at the provider's site to receive this screening.

- **Youth with no Substance Abuse Related Court Order are Screened for Potential Substance Abuse Issues**

    - DPH identified a screening tool that will be used by the probation officer or DCFS caseworker to screen youth for potential undetected substance abuse issues at the post-disposition MDT meeting, by November, in cases where no substance abuse related court order exists (Attachment 1). If the screening test is positive, the youth will be referred to a participating DPH substance abuse provider for further assessment and voluntary treatment, as needed.

    - To increase the likelihood that a youth will readily disclose substance use information, the Presiding Judge of the Juvenile Court has already discussed with, and is preparing a follow-up memorandum, to all juvenile court judges encouraging them to limit their use of court orders, thereby reducing the potential punitive consequences, in 241.1 cases where a youth is voluntarily seeking treatment.

- **DPH Created a Vetted Substance Abuse Provider List**

    - DPH completed a survey of its Adolescent Intervention Treatment and Recovery Programs (AITRP) substance abuse providers to determine their willingness and capacity to provide treatment services to 241.1 youth in order to ensure more consistent and credible treatment resources were being delivered. As a result, a vetted list of fourteen DPH substance abuse providers was created (Attachment 2). DPH will update this list quarterly to ensure that only providers in good standing are included.

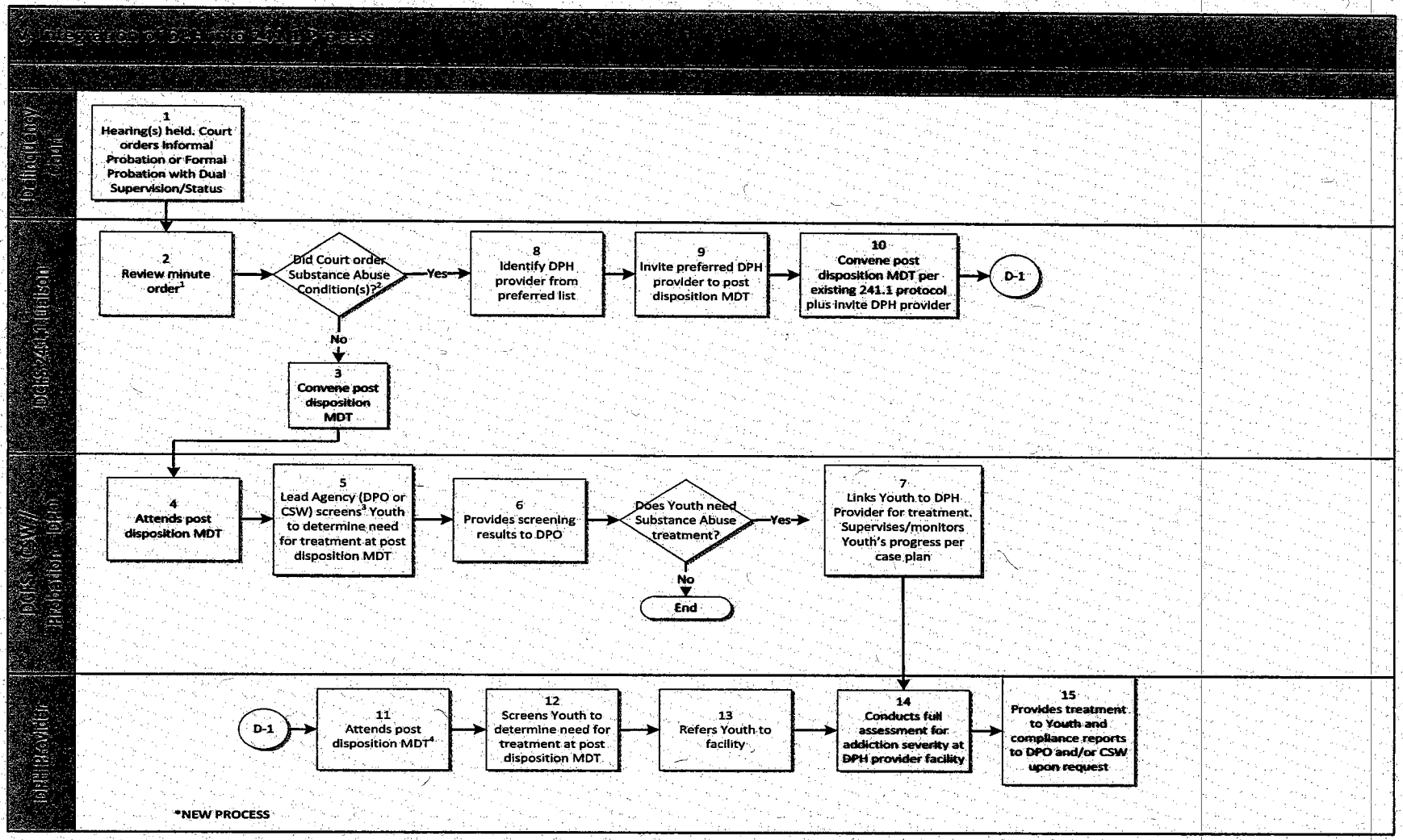
    - A similar survey tool has been developed and distributed to DPH's Drug Medi-Cal (DMC) providers. DPH is conducting an extensive analysis to determine which of its DMC providers should be added to this vetted provider list; this analysis will be completed by June 2014. Additionally, DPH is also determining the feasibility of expanding their referral network to include providers with contracts outside of AITRP and DMC.

- **DPH Enhanced their Electronic Reporting System to Identify Probation and DCFS Youth Receiving their Services**

    - DPH has updated their reporting system to include key questions that now identify probation and DCFS youth receiving substance abuse services. This will also allow for more specific treatment data to be gathered from providers, including length of treatment, discharge status, etc., that can be used for aggregate analyses.

The illustration below outlines how these new actions have been incorporated into the 241.1 process and resulted in a more coordinated and integrated service delivery model, with respect to substance abuse screening and treatment.

Illustration 1: DPH Integration into 241.1 Process



1 Probation clerical staff will fax copy of minute order to DCFS 241.1 liaison upon receipt from Court clerk.

2 If Court orders counseling condition(s), DMH will provide substance abuse screening/treatment.

3 DPH provided assessment tool and accompanying administrative script.

4 In the event DPH provider is not available to attend MDT, lead DPO/CSW to link youth to DPH provider for assessment and treatment using vetted list.

Board Directive 3: 241.1 Project Evaluation Measures

The Board also requested that DCFS develop an annual report detailing the following outcomes for 241.1 youth as identified in the November 2012 report:

- Legal Status of Youth
- Number of MDT meetings including DMH Staff Participation
- Number of Youth with Co-Occurring Substance Abuse and Mental Health Issues compared to Number of Youth with Substance Abuse Only Issues
- Types of MDT Service Recommendations Made
- Number and Type of MDT Service Recommendations Implemented
- Recidivism Rates

Although the 241.1 project has been operating since 2007, outcome data on the services being referred to and received by participating youth were not being collected. After the November 2012 report was released, DCFS, in conjunction with the California State University, Los Angeles, School of Criminal Justice and Criminalistics (CSULA), developed a manual tracking process for collecting this data. As of March 2013, data on MDT services recommended is now being manually collected from DCFS, Probation and DMH on all new 241.1 cases through the Initial Data Collection Form.

A 241.1 Tracking Application has also been recently created to begin tracking outcome data electronically. Currently, this system contains youth demographic data which is obtained electronically through an interface with DCFS' Child Welfare Services/Case Management System. The system is now undergoing configuration and testing so that it will be ready for its scheduled launch in December 2013. Once it is fully implemented, the system will have the capability of tracking youth outcomes electronically and producing data for DCFS' annual report (Attachment 3), the first of which is due in March 2014. Two manual tracking forms, the Initial Data Collection Form and the 241.1 Tracking Form, have been developed to track the MDT meeting service recommendations made and those services received by youth at quarterly intervals. Data from these forms will be entered into this system for all new/recent cases once it has launched.

DCFS' Bureau of Information Systems has developed a project timeline for the programming, testing and system implementation of the 241.1 Tracking Application system enhancements:

241.1 Tracking Web-based Application Project Timeline	
Programming and System Configuration	August - October 2013
Testing and Modification	October – November 2013
System Launch	December 2013

Given the increased work required to enter data on all 241.1 youth from the Initial Data Collection and 241.1 Tracking Forms, as well as correct erroneous entries, Probation and DMH are each anticipating the need for an additional full-time clerical position (Intermediate Typist Clerk). The salary for one full-time equivalent Intermediate Typist Clerk position is $37,321 plus $16,048 in employee benefits. Any such staffing adjustments, if determined to be feasible, would require Board action.

Board Directive 4: Legislative Action

The Board also requested that proposed Assembly Bill 1405 (2008), which was approved by both the California State Assembly and Senate but vetoed by the Governor, be reviewed and that revised language be submitted to the legislature to prohibit the use of incriminating information obtained during a clinical interview against a youth in court.

This bill would have offered protection for some of the information a youth might disclose during a clinical interview by prohibiting its use in court proceedings. The Workgroup reviewed the legislation to determine if the development of additional draft language and possible resubmission of the legislation would provide protection of the youth's legal rights against self-incrimination. After review, the Public Defender's representatives did not believe it was possible to modify the Bill in a manner that would address all of defense counsel's concerns by providing complete protection for a youth who participated in a clinical interview. As such, the Workgroup did not see a significant benefit to pursuing this legislative change any further.

Instead, the Workgroup worked to incorporate changes into the 241.1 post-disposition MDT meeting to strengthen the collaboration between DMH and DCFS staff (as mentioned under Board Directives 1 and 2) and ensure that both mental health and substance abuse issues are appropriately identified and treated regardless of whether a clinical interview takes place.

Board Directive 5: Delinquency Prevention Pilot

DCFS was directed by the Board to report on the status of its Delinquency Prevention Pilot, including any outcomes and implementation-related issues. DCFS provided the Board with a report on the Delinquency Prevention Pilot on May 28, 2013.

Board Directive 6: Substance Abuse Treatment Funding & Substance Abuse Services for Probation Youth

In addition to requesting the information previous outlined above regarding coordinated, high-quality service delivery, standardizing a referral process for services, and measuring outcomes of youth needing substance abuse services, the Board requested information on how best to leverage DMC or other substance abuse funding sources, and how non-incarcerated probation youth are receiving appropriate substance abuse services.

Medi-Cal Funding

Substance abuse treatment services for probation and 241.1 youth are largely provided through DMH and DPH contractors. When a probation or 241.1 youth has both a mental health and substance abuse issue (co-occurring disorder), DMH takes the lead in the providing treatment for both issues. When a youth has only a substance abuse issue, DPH will now take the lead in providing treatment services. This will occur initially through their AITRP providers, and will eventually be expanded to include qualified DMC providers.

DMH oversees Medi-Cal funded providers who deliver co-occurring disorder services to probation and 241.1 youth. In Fiscal Year 2011-12, $72 million in federal, state and local funding

was leveraged to treat youth with co-occurring disorders Countywide; this funding was sufficient to cover the needs of those youth.

DPH's AITRP network collectively provides outpatient and residential services to youth and young adults, including those involved with the dependency and delinquency systems; funding in Fiscal Year 2011-12 totaled $7.5 million. These agencies provide a comprehensive array of youth appropriate services by staff with the experience to respond to the varied needs of this population. Funding for AITRP includes federal, state and County funds; these funds are generally fully expended each Fiscal Year.

DPH's youth-focused DMC contractors primarily provide either Outpatient Drug Free services (which provides only group counseling except when individual counseling is required to prevent imminent relapse or to complete specific admission and discharge activities) or Day Care Habilitative services (which provides more intensive outpatient services requiring structured activities for a minimum of three hours per day for three days per week). Currently, of the 89 total DMC agencies, 66 of them provide services to youth. While the total annual DMC allocation in Fiscal Year 2011-12 was $116 million for both youth and adult clients, $27.6 million of these funds were used to treat youth. DMC funds include federal and state dollars only; there is no County contribution to this funding stream.

While DMC services are currently more limited than what is offered through AITRP (these services includes family counseling and individual counseling on a wider basis than does DMC), the Affordable Care Act is likely to expand the DMC treatment services available in 2014. With this expansion, the County should be in a better position to more fully utilize its DMC funding allotment to provide the full array of substance abuse treatment services to probation and 241.1 youth in need. DMH and DPH submitted a Board memorandum to explain these changes to DMC, and presented the information at the Health Cluster meeting on July 24, 2013.

DMC reimbursable treatment services are determined by the State, with limited administrative responsibilities assigned to the County. As providers are inclined to offer only those services which will ultimately be reimbursed, the County's ability to dictate the types of evidence-based practices or other specific program regimens offered is hindered. Additionally, this has made some probation officers and DCFS caseworkers reluctant to refer youth to them since they cannot ensure a consistent level or type of treatment administered, thereby creating a potential under-utilization of these service providers.

As noted in the chart below, both AITRP and DMC services include assessment, treatment planning, and crisis counseling, but DMC services do not currently include individual counseling (except for on a very limited-basis) which is highly recommended for these youth. However, the chart also highlights the DMC services that should become available January 1, 2014, which includes individual counseling. The expanded DMC services will also include inpatient detoxification, hospitalization for medical management of withdrawal symptoms, outpatient chemical dependency services (i.e. day treatment, intensive outpatient, and individual and group counseling), and transitional residential recovery services, and therefore more closely mirror the services offered through AITRP. Once this occurs, the services available to probation and 241.1 youth should be sufficient to cover their full array of substance abuse needs, with an ability to

rely more heavily on State and federal dollars. This should further make probation officers and DCFS caseworkers more likely to refer youth to them.

FY 2011-12 Overview of Substance Abuse Treatment Programs Available to Youth			
County Department	**Mental Health (DMH)**	**Public Health (DPH)**	
Service Type	Medi-Cal funded Treatment for Co-Occurring Disorder (substance abuse and mental health)	Substance Abuse Only	
		Adolescent Intervention, Treatment and Recovery Programs (AITRP)	**Drug Medi-Cal (DMC)**
Total Expenditures	$72M	$7.5M	$27.6M
Total Providers	133 Providers	14 Providers[1]	101 Providers
Treatment Types	Outpatient Treatment Residential Treatment[2]	Outpatient Treatment Residential Treatment	Outpatient Drug Free[3] Day Care Habilitative[4]
Reimbursable Treatment Elements	Assessment Treatment Planning Individual Group Family Counseling Targeted Case Management Medication Management	(DPH Recommended Youth Treatment Services) Screening Assessment Treatment Planning Individual Counseling Crisis Counseling Group Counseling Family Counseling Case Management Collateral Services Referral for Supportive Services (Aftercare)	Assessment Treatment Planning Crisis Counseling Group Counseling Collateral Services _____ **New Changes January 1, 2014[5]:** In-patient Detoxification Medical Treatment for Withdrawal Day Treatment Intensive Outpatient Individual Counseling Transitional Residential Recovery
Countywide Youth Participants[6]	6,313[7]	1,086	10,711
AITRP Reimbursable Treatment Elements reflect the primary recommended services needed for comprehensive and effective youth treatment services. Currently, Federal Substance Abuse and Mental Health Services Administration Block Grant , which funds the AITRP Programs, permit reimbursement for more recommended youth treatment services than those permitted under DMC. Therefore, AITRP contractors are able to provide more services (e.g., individual counseling, family counseling, and residential treatment) to respond to the varied needs of youth, including one-to-one work and involvement of parents/guardians. In addition, AITRPs are contractually expected to hire staff experienced/trained in youth services and to provide evidence based/informed youth services. The expansion of DMC is expected to significantly lessen the distinction between AITRP services and those provided under DMC.			

[1]This includes 13 outpatient and four residential providers
[2]Primary treatment/cause of residential must be mental health related
[3]Services are limited to group counseling except when individual counseling is needed to prevent imminent relapse or to complete specific admission and discharge activities
[4]A more intensive outpatient treatment requiring structured services for a minimum three hours per day, three days per week
[5]Reimbursable treatment elements may be expanded under Drug Medi-Cal due to health care reform
[6]Both DMH and DPH participant numbers include probation youth
[7]All diagnosed cases of substance abuse along with mental health were treated

Non-Incarcerated Probation Youth

The Workgroup reviewed survey results on the substance abuse treatment services received by 3,803 probation youth who were residing in community and had either a drug testing or treatment court order. Camp and placement youth were excluded from the survey.
As reflected in the chart below, fifty-six percent (2,117) of the non-incarcerated youth surveyed were either currently receiving substance abuse treatment or had already completed a treatment

program. Of the 1,662 youth who were not receiving substance abuse services, the main reasons were: youth absconding from probation jurisdiction (430), jurisdiction terminated (262), youth being detained in juvenile hall (162), or pending program enrollment (316). There were 379 youth who had unique reasons for not receiving services like: youth is pregnant, detained in Camp, not compliant with treatment order, or was transferred out of County, etc. Reasons for pending program enrollment included cases that were newly assigned to probation officers, missed appointments by the youth, youth waiting for a referral from the probation officer, and youth waitlisted as a result of agency capacity issues. Survey results did not identify wait times.

PROBATION YOUTH SUBSTANCE ABUSE TREATMENT SURVEY

PROBATION YOUTH RECEIVING SUBSTANCE ABUSE SERVICES	TOTAL
Yes	1,684
No	1,662
Completed Treatment	433
Case Closed (over 18)	10
No Response	14
GRAND TOTAL	**3,803**

56% of probation youth are either currently receiving substance abuse services or have already completed a treatment program.

REASONS FOR YOUTH NOT RECEIVING SUBSTANCE ABUSE TREATMENT	TOTAL
Bench Warrant/Abscond	430
Detained in Juvenile Hall	162
Did Not Enroll	39
Not Ordered By Court	74
Pending Enrollment	316
Jurisdiction Terminated	262
Other Youth-Specific Reasons	379
GRAND TOTAL	**1,662**

Probation officers working with non-incarcerated youth tend to rely heavily on DMC providers when referring youth for substance abuse treatment services. While the number of treatment slots available are suitable among these particular providers, the lack of information on specific services and evidence-based practices offered is a real concern for probation officers and DCFS caseworkers referring youth to them. The Workgroup concluded that probation officers and DCFS caseworkers should be given a vetted list of providers with details on the specific services and practices offered by them. Having this list would ensure that probation youth referred to substance abuse treatment were consistently receiving the types of services and treatment regimens that were in line with DPH's standards.

As discussed under Board Directive 2 above, DPH has now created a vetted list of DPH AITRP providers for probation officers and DCFS caseworkers to use, and is working to expand this list by adding in its vetted DMC providers. However, until the expanded list is completed and there are ample service providers identified, the potential to over-utilize the currently vetted providers exists, causing possible capacity issues among those providers.

241.1 Project Next Steps

1. By November 2013, probation officers and DCFS caseworkers will begin screening youth for potential undetected substance abuse issues at the post-disposition MDT meeting, in cases where no substance abuse related court order exists.
2. DPH will ensure that along with the list already provided, an expanded listing of substance abuse providers is developed for probation officers and DCFS caseworkers by June 2014.
3. By March 2014, DCFS, with CSULA, will produce an annual report on the 241.1 Project that includes data collected through the 241.1 Tracking Application and the LACPRS enhancements.

Attachments

Attachment 1

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

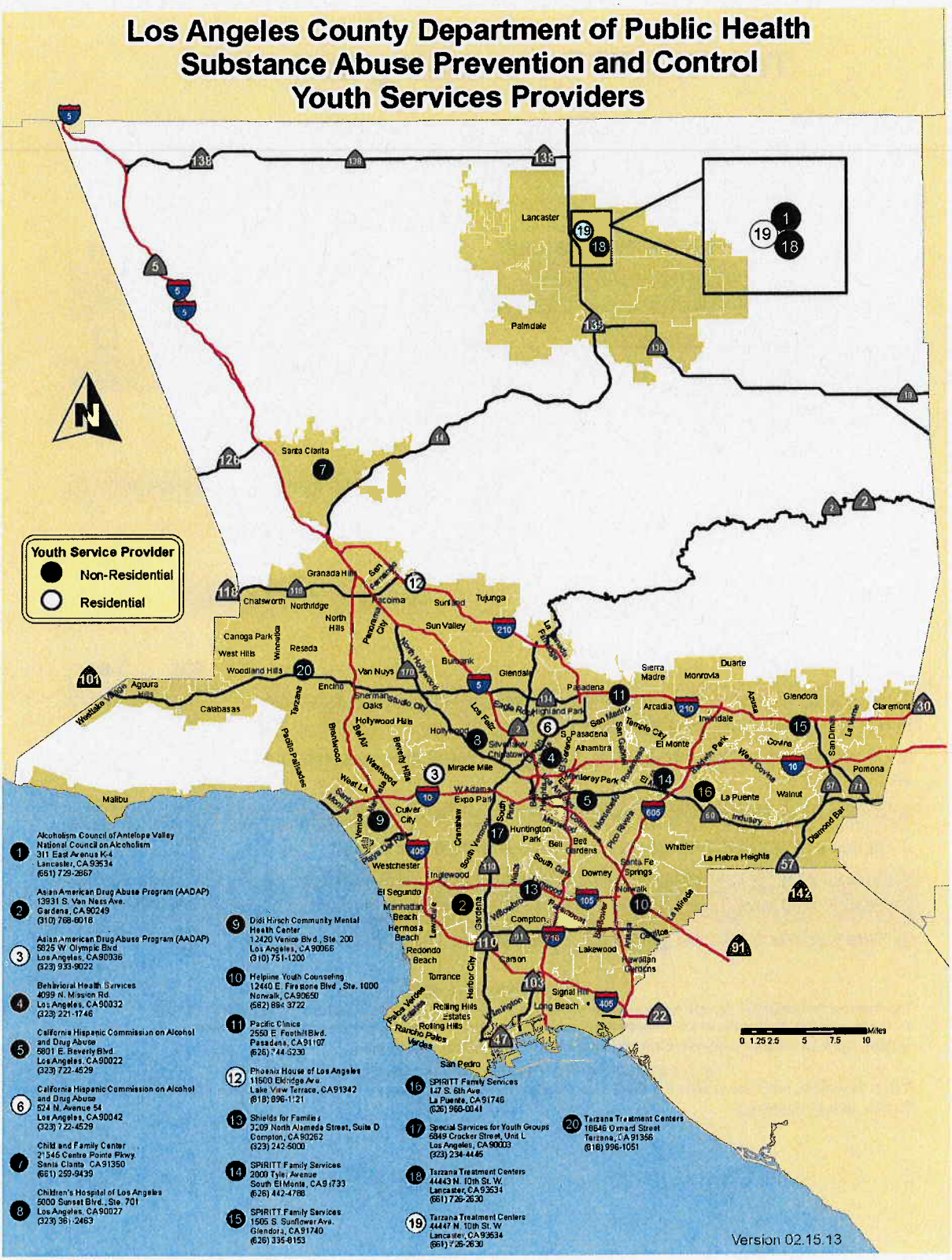
For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐	Yes ☐
↓	↓
Ask CAR question only, then stop	**Ask all 6 CRAFFT questions**

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

Attachment 2



Attachment 3

241.1 Crossover Youth Outcomes Tracked

Outcomes Measured	Collection Method	Responsible Agency
DMH Participation in MDT Meetings	Initial Tracking Form	DCFS
Youth and Family Outcomes • *Youth residential status* • *Permanency planning*	Post-Disposition Tracking Form	DCFS
241.1 Disposition/Legal Status • *Number of dual supervised (654.2WIC, 725aWIC, 790WIC)* • *Number of dual jurisdiction (300WIC/602WIC)* • *Number of delinquent wards (602WIC)*	Initial Tracking Form	Probation
Substance Abuse and/or Mental Health Issues Identified • *Number of youth with mental health issue* • *Number of youth with co-occurring disorders* • *Number of youth with substance abuse only issues*	Initial Tracking Form	DMH
Education and Pro-Social Activities • *School enrollment/school attendance* • *Academic /behavioral concerns*	Initial Tracking Form	DCFS
Post-Disposition MDT Services Recommended and Received • *Substance abuse treatment initiated/completed* • *Mental health treatment initiated/completed* • *Educational progress* • *Behavioral/social interventions*	Post-Disposition Tracking Form	DMH, DCFS, and Probation
Continued Delinquency Behavior • *Number of new arrests* • *Number of new sustained petitions*	Post-Disposition Tracking Forms	Probation